

NHS Forth Valley

Carseview House
Castle Business Park
Stirling
FK9 4SW

Telephone: 01324 566292
Fax:



Private and Confidential

MMA Legal
43-59 Princes Street
Stockport
SK1 1RY

Date: 30 April 2026
Your Ref: 100338
Our Ref: GDP/0021235

Enquiries to: Legal Admin Team
Extension:
Direct Line: 01324 566292

Dear Sir/Madam

Re: Scott Dowell DOB 26/02/1980

With reference to your recent access request please find enclosed copy health records as requested.

Please note that records held by Forth Valley Royal Hospital will include records for Falkirk Community Hospital and Stirling Health & Care Village.

If we can be of any further assistance then please do not hesitate to contact us.

Yours Sincerely

Legal Admin Team

E-mail: fv.healthrecs-legal@nhs.scot

NHS Forth Valley
Headquarters: Carseview House, Castle Business Park, Stirling, FK9 4SW

 nhsforthvalley.com  [/nhsforthvalley](https://www.facebook.com/nhsforthvalley)
 [@nhsforthvalley](https://twitter.com/nhsforthvalley)  [@nhsforthvalley](https://www.instagram.com/nhsforthvalley)

SOAPER= Subjective, Objective, Action, Planning, Evaluation & Review.

0570

DATE	SOAP CODE	TREATMENT NOTES	Medical History
23/1/2023	(N)	12/8/22 PTA: (P) wife phoned (P) just out of Puff to cane appt - <u>Deborah</u> <u>D. CHANAN</u>	
5/2/2023	(P)	no changes with feet, been in hospital with liver failure. In CG all medications (S) nails need cut + no lesions present (P) no repeat lichen nail cut + filed (P) 12/8/22	
03/11/2022	(S)	No changes. (S) BIT nails long with Oils. P11 th TNA nail growing back. Cables to B11 th 12/1 Medic. (S) nail p.o. Nails cut + filed. Nail spike P11 th cut + filed. Cables desanded. (P) Prevention 12/152. Tany Vignaraleia Phonics frigate. PT C10 long nails. On the in - low cut then last time bit 1st are him very often. In also on biologics so worried about anyone else cutting my nails. PT put on waiting list for appt to be sent at NO KILLS MANA	
15/8/22			
2pm			
31/5/23	(S)	no changes - nails have turned in a bit (S) nails need cut + no lesions present (P) no repeat lichen nail cut + filed (P) 12/8/22 (P) no changes Fibromyalgia (S) nails need cut + no lesions (P) no repeat lichen nail cut + filed (P) 12/8/22	

★ Update medical history using codes C = Changed U = Unchanged

PODIATRY ASSESSMENT RECORD

CLINIC	DOM	CARE HOME	NAIL SURGERY	BIOMECHANICS	OTHER
Patient Details Male / Female Mrs/Miss/Mr Surname <u>DOWELL</u> First Name <u>SCOTT</u> CHI Number <u>2602800570</u> Address <u>11 DON STREET</u> <u>GRANGEMOUTH</u> Postcode <u>EK3 8HD</u> Tel No <u>01324 262719</u> Mobile No <u></u> D.O.B. <u>26/02/1980</u>			GP Details Name <u>DR DEREK DUNN</u> Address <u>WESTBURN MEDICAL PRACTICE</u> <u>FREE KILK COMMUNITY HOSPITAL</u> <u>WESTBURN AVENUE, FALKIRK</u> Tel No <u>01324 623577</u> Referral/Relative Details Name <u></u> Contact No. <u></u>		
Referred by GP/BNH/Other Name of person referring <u></u> Date referral received <u>1/1</u> Date patient assessed <u>1/1</u> Date patient discharged <u>1/1</u>			Reason for Referral <u></u>		
CURRENT HEALTH STATUS					
Type 1 Diabetes	Year Diabetes Diagnosed	RA	Current Smoker		
Type 2 Diabetes		Neurological Illness	Ex-Smoker		
Heart Condition		Learning Disabled	Non-Smoker		
CVA	Other (please specify in box below)	Physical Disabled	Mental Health Condition		
Previous Medical/Surgical History/Current Medication Humira Ranitidine Rapinole Zenna Esmopradole Colminalis Biologics - Casertex Liver failure Ankylosing Spondylitis Hip replacement					

Podiatry Assessment

R		L		Venous Assessment		Neurological	
DP	✓			Venous Return ✓			
PT	✓			Normal	✓	✓	
Temp. Gradient	✓			Varicose			
✓ for normal x for abnormal				Does patient wear surgical stockings?			
Skin Colour	✓			Oedema ✓ for present			
Normal	✓			Foot Structure			
Pallor				✓ for present			
Cyanosed							
Hypaemic							
Dependant Rubor							
Skin Condition	✓						
Normal	✓						
Dry	✓						
Molt							
Atrophy (dewitched skin)							
Dorsal foot hairs present							
Ischaemic Pain	✓			HbA1c			
None	✓			Latest Result			
Intermittent Claud.				Target Set			
Rest pain							
✓ for present							
Amputation status	✓						
None	✓						
Toes/s							
Forefoot							
Below knee							
Above knee							
Cause of Amputation							
Date/s of amputation							
Footwear							
Appropriate							
Inappropriate							
Surgical/Stock							
Verbal Advice							
Leaflet Given							
Previous Foot Care							
Self							
Private							
Health Education							
Foot care advice given							
Leaflets given							

DATE 1/1/1 OUTCOME CAREPLAN

R.A. Rheumatoid
 Maintenance due to
 Ankle/hip spasticity
 unable to attend to feet

SOAPER= Subjective, Objective, Action, Planning, Evaluation & Review.

DATE	SOAP CODE	TREATMENT NOTES	Medical History
	③	Unable to get to nail due to Ankylosing spondylitis + hip replacement	
	②	nails need cut no lesions	
	④	pt on Humira + unable to get to feet	
	②	no more lesions need cut + file	
21/8/19	③	1st surgery at moment	
	②	nails need cut + no lesions present	
	④	pt + post hip surgery need cut + file	
	②	no changes	
13/1/19	③	nails need cut + no lesions	
	④	post post hip surgery need cut + file	

★ Update medical history using codes C = Changed U = Unchanged

CONFIDENTIAL MEDICAL HISTORY FORM

To ensure the best, and safest, treatment is given, your Podiatrist needs to know of any problems which may affect your treatment. Please answer all the questions below, giving any details as necessary. (Please ask someone else to complete this form on your behalf if you are unable to do so yourself).

Please print in block capitals when filling in this form.

Surname: <u>DOWELL</u>	First name: <u>SCOTT</u>
Date of Birth: <u>26-2-1980</u>	Male/Female: <u>MALE</u>
Address: <u>11 Don St</u>	Telephone (home):
Post code: <u>FK3 8HD</u>	
Doctors name and address: <u>Dr Dunbar Westburn Practice</u>	
Postcode:	Telephone no: <u>01326 623577</u>

Please give the reason why you require Podiatry treatment. Anklelosing Spondylitis
Left hip replacement 20-7-2018

1/ Are you attending or receiving treatment from a doctor, hospital, clinic or specialist?

Yes

☒

No

☐

Details Anklelosing Spondylitis

2/ Are you taking or have you ever taken steroids in the last 2 years?

Yes

☐

No

☒

Details

3/ Are you allergic to any medicines, food or materials?

Yes

☐

No

☒

Details

4/ Have you attended a Podiatrist before at any time?

Yes

☒

No

☐

Details Inguinal hernia

5/ Are you registered blind

Yes

☐

No

☒

Have you had any of the following illnesses or complaints:

1/ Diabetes

Yes

☐

No

☒

Details

2/ Stroke, heart murmur, heart problem, angina, high blood pressure, heart attack or have been fitted with a pacemaker?

Yes

☐

No

☒

Details

PLEASE TURN OVER

3/ M.R.S.A., jaundice, liver/kidney disease or Hepatitis?

Yes

☐

No

☒

Details

4/ Arthritis?

Yes

☒

No

☐

Details

Ankylosing Spondylitis

5/ Bronchitis, asthma or other chest conditions?

Yes

☐

No

☒

Details

6/ Fainting attacks, giddiness, blackouts or epilepsy?

Yes

☐

No

☒

Details

7/ Bad reaction to a local or general anaesthetic?

Yes

☐

No

☒

Details

8/ Have you ever been hospitalised for any serious medical problem?

Yes

☐

No

☒

Details

9/ Are there any other aspects concerning your health which you think the Podiatrist should be made aware of?

Yes

☒

No

☐

Details

Biological injections

Medication (please list all the medication that you are taking at the moment, a repeat prescription form can be attached here)

This form has been completed by:

Signature

Jeff Donnell

Date

17.1.2019

Name (PLEASE PRINT)

SCOTT BULL

Relationship to person if applicable

PLEASE BRING THIS FORM WITH YOU TO YOUR APPOINTMENT

PODIATRY/PHONE TRIAGE RE-ASSESSMENT FORM FOR EXISTING PATIENTS

TITLE: Mr	FORNAME: Scott	SURNAME: Forth Valley Dowell
ADDRESS: 11 On Street Glasgow		CHI: 2602800570
(ATTACH PATIENT LABEL ABOVE) CONSENT OBTAINED, CHECK P.O.A/GUARDIANSHIP, IF NOT SPEAKING TO THE PATIENT DIRECTLY		YES ☐ N/A ☐
How have you been managing over the past 2 years re-foot care?	family member	
Are you happy to continue with this? • Yes=Discharge with advice to re-ref if required via G.P./personal foot care guidelines/ Top Toes.		
Are you happy to continue with this? • No = Why do you feel you require an NHS Podiatry appointment?(Ask patient to describe foot condition, check against patient/notes Podiatry access criteria/update meds)	No - Im on Biologics	
Are you attending other NHS services?	Rheumatology, Physio	
Are you Diabetic? (Check SCI DC re-risk)	No	
Is there any redness/inflammation?	No	
Is there any bruising/dicolouration?	No	
Have you attended the foot clinics at FVRH?	No	
REASON FOR PODIATRY APPT REQUEST		
Side: ☐ Left ☐ Right ☒ Both		
Region: ☐ Toes ☐ Foot ☐ Heel ☐ Ankle ☐ Leg ☐ Knee ☐ Hip		
Structure: ☒ Nails ☐ Skin ☐ Joint ☐ Muscle/tendon		
Is the problem are(s): ☐ Red ☐ Swollen ☐ Bleeding/discharging/weeping		
Are you on antibiotics for this problem? ☐ Yes ☒ No		
How long have you has this complaint? ☐ Days ☐ Weeks ☐ Months ☒ Years		
Are your symptoms worsening? ☐ Yes ☒ No	Are you off work with this problem? ☐ Yes ☐ No N/A	
Medication - Co-Codamol, Morphine - if needed Esumprazole, Biologics,		

GENERAL HEALTH

☐ Diabetes:

☐ Low risk

☐ Moderate risk

☐ High risk

☐ Active foot ulceration

☐ don't know

☐ never had foot checked

☐ Neurological disorders, please specify

☐ Mental health conditions, please specify

☐ Physical disability, please specify

Wheelchair user: Yes ☐ No ☒

☐ Dementia

☐ Lymphoedema

☐ Raynaud's disease

☐ Communication difficulties

☒ Rheumatoid arthritis

☐ Peripheral vascular disease

☐ Learning difficulties

DOES PATIENT MEET PODIATRY ACCESS CRITERIA? YES ☒ - F2F - *pt on biologics*
NO ☐ - DISCHARGE /ADVICE

Discharge Script for Return Patients.

"Your triage assessment today indicates that you require personal foot care. Personal Foot care includes tasks such as cutting and filing your toenails and the self-management of corns and callus."

Should the patient reply stating they have reasons to attend which do not fit the criteria for access.

"Podiatry is the management of problems of the foot and lower limb which is at risk. It is a medical service offering care to those who have specific Podiatry problems or medical conditions that require specialist medical and/or preventative treatment. We have an information letter which we can send to you which provides personal foot care advice and signposts to useful resources."

COPY

FALKIRK AND DISTRICT ROYAL INFIRMARY TRUST
IMMEDIATE DISCHARGE SUMMARY
TELEPHONE NUMBER: 01324 624000

Consultant: DR PETER MCSORLEY

Specialty: MEDICINE

Ward: WARD 03

Admission type: EMERGENCY

Validation / contact name: DR HASAN JILAIHAWI Ext: page: 155

Practice Code 25671

DR LILA HILLAN

COMMUNITY CENTRE

2 DAVIDS LOAN

BAINSFORD

FK2 7NR

Admitted: 9.01.2002

Discharged: 11.01.2002

Discharged to: HOME - OWN ADDRESS

Date of this letter: January 11, 2002

Episode: 02110340

Dear DR HILLAN

SCOTT DOWELL: Date of Birth: 26.02.80 Hosp No: 207472

11 DON STREET GRANGEMOUTH FK3 8HD

ACTIVE PROBLEMS:

1: K101. N10X (LEFT) ACUTE PYELONEPHRITIS

INACTIVE PROBLEMS:

Prescribed drugs and comments on drugs at discharge were as follows:

ALLERGIES/ADVERSE EFFECT : NONE RECORDED

Generic Name	Route	Dose	Frequency / at	Start Date	End Date	By
--------------	-------	------	----------------	------------	----------	----

PARACETAMOL	ORAL	1g	PRN 4-6 HRLY	11.01.02		
OFLOXACIN	ORAL	400mg	B.D.	11.01.02	31-01-02	

MOVICOL	ORAL	1 sachet	DAILY	11.01.02		
---------	------	----------	-------	----------	--	--

<i>*Ciprofloxacin</i>	<i>Oral</i>	<i>750mg</i>	<i>bd</i>	<i>11/1/02</i>	<i>20/1/02</i>	
-----------------------	-------------	--------------	-----------	----------------	----------------	--

Information given to patient: The patient may have a personal copy of this letter, and has discussed the content.

Additional comment:

This 21 year old gentleman was admitted with a temperature and left sided loin pain. He also described dysuria for the preceeding 2 days.

He has no renal history or history of trauma to the flanks.

On examination he was pyrexial with a tender left flank and some guarding. His chest XR was clear and his abdominal XR showed faecal loading.

His wcc was 14.3 and his U+Es were normal. His urine had 2+ of protein and a trace of blood.

A diagnosis of acute pyelonephritis was made and he was commenced on iv fluids, antibiotics and was catheterised. Gradually, he began to pass more urine and after 2 days his bowels opened. He has now been apyrexial for 2 days and is able to get home on oral antibiotics (~~Ofloxacin 400mg~~ *Ciprofloxacin 750mg* bd for 10 days)

He was reviewed by the urology team during his stay and they would like to see Mr Dowell again in clinic in 2 weeks and will organise an cystoscopy when his infection settles down.

COPY

Many thanks.

Follow-up plan: MR JAMES TWEEDLE, UROLOGY OPD

SCOTT DOWELL 207472

A further letter may follow.

Yours sincerely



Dr R. Stewart

JHO, Medical Directorate

PHARMACY COPY.

COPY

**Falkirk & District Royal Infirmary
Majors Loan
Falkirk
FK1 5QE**

Phone: 01324 624000

Fax: 01324 616068

Department of Urology

REF:JT/MSM/F207472

TYPED:24.01.02

DICTATED:24.01.01

Dr J G Duggie
Group Medical Practice
Health Centre
Kersiebank Avenue
GRANGEMOUTH
FK3 9EL

Dear Dr Duggie,

SCOTT DOWELL (26.02.80) 11 DON STREET, GRANGEMOUTH

Further to Mr Dowell's recent admission with a confirmed pseudomonas urinary tract infection he attended for a flexible cystoscopy today and I am pleased to say that this showed a normal urinary tract. Previous ultrasound scan and KUB have shown normal kidneys and therefore it would appear that his urinary tract infection was not due to any underlying anatomical abnormality and hopefully will prove to be a one off event given that he is currently asymptomatic with regards to his urinary tract. I enclose a copy of KUB and ultrasound report and as you will see there are some abnormalities particularly relating to sacral iliac joints that you may wish to be aware of. No routine urological follow up, however has been arranged.

With kind regards.

Yours sincerely

J Tweedle
Consultant Urologist

COPY

*Falkirk & District Royal Infirmary,
Major's Loan,
FALKIRK. FK1 5QE
Telephone 01324 624000
Fax 01324 616073*

DEPARTMENT OF UROLOGY
Consultant – Mr. J. Tweedle

JT/CC

Unit No. 207472.

31st JANUARY, 2002

Dr. J. Duggie,
Grangemouth Health Centre,
Kersiebank Avenue,
GRANGEMOUTH. FK3 9EW

Dear Dr. Duggie,

Scott DOWELL, (d.o.b. 26.2.80), 11 Don Street, Grangemouth

Mr. Dowell came to my clinic today where I simply reinforced that he has had a pseudomonas urinary tract infection which has been treated and he now no longer has any symptoms. Given the negative investigations in terms of ultrasound, KUB and cystoscopy no routine urological follow up has been arranged. He does suffer from low back pain and as I said previously his KUB has shown some evidence of inflammation of the sacro iliac joint which may well be of relevance.

With kind regards.

Yours sincerely,

MR. J. TWEEDLE,
CONSULTANT UROLOGIST

COPY

FALKIRK AND DISTRICT ROYAL INFIRMARY TRUST
IMMEDIATE DISCHARGE SUMMARY
TELEPHONE NUMBER: 01324 624000

Consultant: DR PETER MCSORLEY

Specialty: MEDICINE

Ward: WARD 03

Admission type: EMERGENCY

Validation / contact name: DR HASAN JILAIHAWI Ext: page: 155

Practice Code 25671

DR LILA HILLAN

COMMUNITY CENTRE

2 DAVIDS LOAN

BAINSFORD

FK2 7NR

Admitted: 9.01.2002

Discharged: 11.01.2002

Discharged to: HOME - OWN ADDRESS

Date of this letter: January 11, 2002

Episode: 02110340

Dear DR HILLAN

SCOTT DOWELL: Date of Birth: 26.02.80 Hosp No: 207472

11 DON STREET GRANGEMOUTH FK3 8HD

ACTIVE PROBLEMS:

1: K101. N10X ? (LEFT) ACUTE PYELONEPHRITIS

INACTIVE PROBLEMS:

Prescribed drugs and comments on drugs at discharge were as follows:

ALLERGIES/ADVERSE EFFECT - NONE RECORDED

Generic Name	Route	Dose	Frequency / at	Start Date	End Date	By
PARACETAMOL	ORAL	1g	PRN 4-6 HRLY	11.01.02		
OFLOXACIN	ORAL	400mg	B.D.	11.01.02	21.01.02	
MOVICOL	ORAL	1 sachet	DAILY	11.01.02		

Information given to patient: The patient may have a personal copy of this letter, and has discussed the content.

Additional comment:

This 21 year old gentleman was admitted with a temperature and right sided loin pain. He also described dysuria for the preceeding 2 days.

He has no renal history or history of trauma to the flanks.

On examination he was pyrexial with a tender right flank and some guarding. His chest XR was clear and his abdominal XR showed some faecal loading.

His wcc was 14.3 and his U+Es were normal. His urine had 2+ of protein and a trace of blood.

A diagnosis of acute pyelonephritis was made and he was commenced on iv fluids and antibiotics and was catheterised. Gradually, he began to pass more urine and after 2 days his bowels opened. He has now been apyrexial for 2 days and is able to get home on oral antibiotics (Ofloxacin 400mg bd for 10 days)

He was reviewed by the urology team during his stay and they would like to see Mr Dowel again in clinic in 2 weeks and will organise an cystoscopy when his infection settles down.

CHECK

MHO

PD

APP

Many thanks.

COPY

Follow-up plan: MR JAMES TWEEDLE, UROLOGY OPD

SCOTT DOWELL 207472

A further letter may follow.

Yours sincerely



Dr R Stewart
JHO, Medical Directorate

TWEEDLE, MR JAMES, PDRI

COPY

DEPARTMENT OF ORTHOPAEDIC SURGERY

Consultant: Mr. I.K. Ritchie

Secretary: Ext. 5298

Falkirk & District Royal

Infirmary,

Major's Loan,

FALKIRK. FK1 5QE

Tel: 01324 624000

IKR/PM/SB/F207472

CHI: 2602800570

5th March, 2007

Dr. L. Hillan,
Ochilview Practice,
Park Drive,
STENHOUSEMUIR.

Dear Dr. Hillan,

Scott Dowell, D.O.B. 26.02.80
11 Don Street, Grangemouth

Diagnosis: Dislocated MCP joint right thumb
Date of injury: 02.03.07

History;

This young gentleman fell off a digger and sustained a hyperextension injury to his thumb. It remained at right angles at that joint and he says that his friend pulled it back and after that the thumb looked normal. He was seen in Casualty and referred here after x-rays. I have reviewed the x-rays and the joint is back in, with no evidence of associated injury. Valgus strain does not reduce any opening of the joint or discomfort. He has got a lot bruising on the volar and dorsal aspects.

Continue with thumb spica and review in 2 weeks time.

Yours sincerely,

Mr. Peter Moses
Associate Specialist Orthopaedic Surgeon

IKR-
COPY

DEPARTMENT OF ORTHOPAEDIC SURGERY

Consultant: Mr. I.K. Ritchie

Secretary: Ext. 5298

Falkirk & District Royal

Infirmery,

Major's Loan,

FALKIRK. FK1 5QE

Tel: 01324 624000

IKR/SHASH/SB/F207472/NN

CHI: 2602800570

20th March, 2007

Dr. Hillan.

Ochilview Practice.

Park Drive.

STENHOUSEMUIR.

Dear Dr. Hillan.

Scott Dowell. D.O.B. 26.02.80

11 Don Street, Grangemouth

Mr. Dowell was seen in the Minor Injuries on 2nd of March, 2007 with injury to the right thumb, possible dislocation. He was treated with a thumb spica. We will send him an appointment to be seen in the out-patient clinic next week.

Yours sincerely.

Mr. S. Shashidhara

Orthopaedic S.H.O.

COPY

DEPARTMENT OF ORTHOPAEDIC SURGERY

Consultant: Mr Ian K Ritchie
Extension: (Secretary) 5298/6236
Direct Line: (Secretary) 01324 616027

Falkirk & District Royal Infirmary
Major's Loan
FALKIRK
FK1 5QE

IKR/CG/F207472
CHI No: 2602800570

1 May 2007

Mr Scott Dowell
11 Don Street
GRANGEMOUTH
FK3 8HD

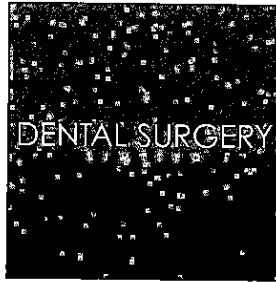
Dear Mr Dowell,

I was expecting to see you in the Out-patient Clinic today. Clearly the appointment has not been suitable. If your problem has resolved itself then you need do nothing further. If, however, you are still experiencing problems and wish to see me, please telephone the Orthopaedic Out-patient Clinic, Suite D, Falkirk & District Royal Infirmary on 01324 624000, extension 5715 for a further appointment.

Yours sincerely

Mr Ian K Ritchie
Consultant Orthopaedic Surgeon

Cc - Dr John Duggie, Group Medical Practice, Health Centre, Kersiebank Avenue,
GRANGEMOUTH



T: 01324 622338
112 Grahams Road
Falkirk
FK2 7BZ

COPY

Treatment started
with Com Dent
Came oral appt
Per Anna Cairns
15/2

RECEIVED 02 NOV 2007

Mr Scott Dowell
11 Don Street
Grangemouth
Falkirk
FK3 8HD

D.O.B 26/02/1980
Tel: 01324474369
Mod :07707657482

Dear Sir/Madam

Mr Dowell attended an examination appointment with myself today, on examination my patient has very poor oral hygiene and most of the dentition requires treatment, when discussing the treatment plan Mr Dowell asked for all remaining teeth to be extracted and full upper and lower dentures put in place, I strongly advised against this but my patient was very adamant and asked to be referred to yourself to have all remaining dentition extracted. I would be grateful if you could review my patient and advise me on what to do next.

Yours truly

Dr Thommy Malki D.D.S

routine

RECEIVED

01 NOV 2007

80

COPY

Department of Orthopaedic Surgery
Associate Specialist: Mr Peter Moses
Tel: 01786 434000 Ext.4063
Fax: 01786 434432

Stirling Royal Infirmary
Livilands
Stirling
FK8 2AU

Ref: ME/JLM/F207472
CHI: 2602800570

Clinic Date: 28 May 2009
Date: 09 June 2009

Dr John Duggie
Group Medical Practice
The Health Centre
Kersiebank Avenue
Grangemouth
FK3 9EW

Dear Dr Duggie

SCOTT DOWELL 26/02/1980
11 DON STREET GRANGEMOUTH FK3 8HD

Diagnosis: Onychogryptosis of right medial solcus of hallux

Plan: Discharge to G.P. for chiropodist referral

This 29 year old chap was referred by A & E for a possible open fracture of his right big toe. On examination he has an in growing toe nail with hyergranulation tissue of the medial solcus of the big toe nail. He has been discharged from clinic and we have advised him to attend yourself with an urgent chiropody referral.

Yours sincerely,

Mark Etherington
FTSTA1 in Orthopaedics

COPY

Date Received: Fri 11/06/10

CHI: 2602800570

Hospital Number: 207472

Referral Notes:

esp.knee

(DAWSON, 14/06/10)

Hospital use only	Clinic	Day Date	Time	Hospital No.
-------------------------	--------	-------------	------	-----------------

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

Trauma and Orthopaedic SurgeryC8
FV Orthopaedic Clinic

Falkirk and District Royal Infirmary
Majors Loan
Falkirk
FK1 5QE

**Consultant / receiving practitioner
and/or specialty clinic**

Hospital and hospital address

Hospital unit no.

V102H

Email address

Urgency of referral

Routine
Orthopaedic Clinic
Referral

PATIENT DETAILS

Surname: Dowell
Forename(s): Scott
Title:
Sex: Male
Date of birth: 26-Feb-1980
CHI no.: 2602800570

Patient's address

11 Don Street
GRANGEMOUTH
FK3 8HD

Contact number(s)

Voice: 01324

REGISTERED GP DETAILS**Practice address****REFERRING PRACTITIONER DETAILS**

Name: Dr. Laura Jack
GMC code: 6024421 GP code: 55913
Practice name: Group Medical Practice (25563)
Practice code: 25563

Practice address

The Health Centre
Kersiebank Avenue
Grangemouth

Contact number(s)

Voice: 08445 769111
Facsimile: 01324 666022

COPY**CLINICAL INFORMATION****History of presenting complaint / examination findings / investigation results****Presenting complaint**

Description: ?cyst anterior to knee

Comment: Thank you for taking a look at this 30 year old manual worker's knee. He has developed a large right knee swelling ?cyst. Large swelling inferior to patella. Very mobile, feels soft in the skin. Feels either cystic or ? bursa.

It is painful to kneel. Interfering with his work.

He is keen to have it removed.

Thank you for your assessment.

Dr D Dundas

Locum GP

Examinations and Investigations

Height(m): 1.75 -
 Weight (kg): 87.5 -
 BMI: 28.57 -
 Blood Pressure-Systolic: 112 -
 Blood Pressure-Diastolic: 70 -
 Murmur present: Not Recorded -
 Is a 12 lead ECG: Not done -
 Recent CXR: Not done -
 FBC: Not Recorded -
 Urea and Electrolytes: Not Recorded -
 LFT: Not Recorded -
 TFT: Not Recorded -
 Lipid Profile: Not Recorded -
 Glucose: Not Recorded -

Investigations

Smoking Advice Recorded: Not Recorded -

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history**Current and recent medication**

<u>Drug name</u>	<u>BNF code</u>	<u>Formulation</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Course started</u>	<u>Duration</u>
Varenicline Tartrate	04.10.00.0	Continuation Pack TABS 1MG	1 Tab	Twice daily	01-Jun-2010	-
Varenicline Tartrate	04.10.00.0	Continuation Pack TABS 1MG	1 Tab	Twice daily	14-May-2010	-
Varenicline Tartrate	04.10.00.0	Continuation Pack TABS 1MG	1 Tab	Twice daily	30-Apr-2010	-
Celecoxib	10.01.01.0	CAPS 100MG	1 Cap	Daily	01-Apr-2010	-
Varenicline Tartrate	04.10.00.0	Continuation Pack TABS 1MG	1 Tab	morning and night	01-Apr-2010	-
Varenicline Tartrate	04.10.00.0	Initiation Pack 11 X 0.5mg 14 X 1mg TABS	1 Tab	morning and night	01-Apr-2010	-

Clinical warnings**Lifestyle risks**

Exercise status: Not Known

Smoking status

Alcohol consumption

Number per day

0

Units per day

?

COPY

Additional relevant information

Administrative information

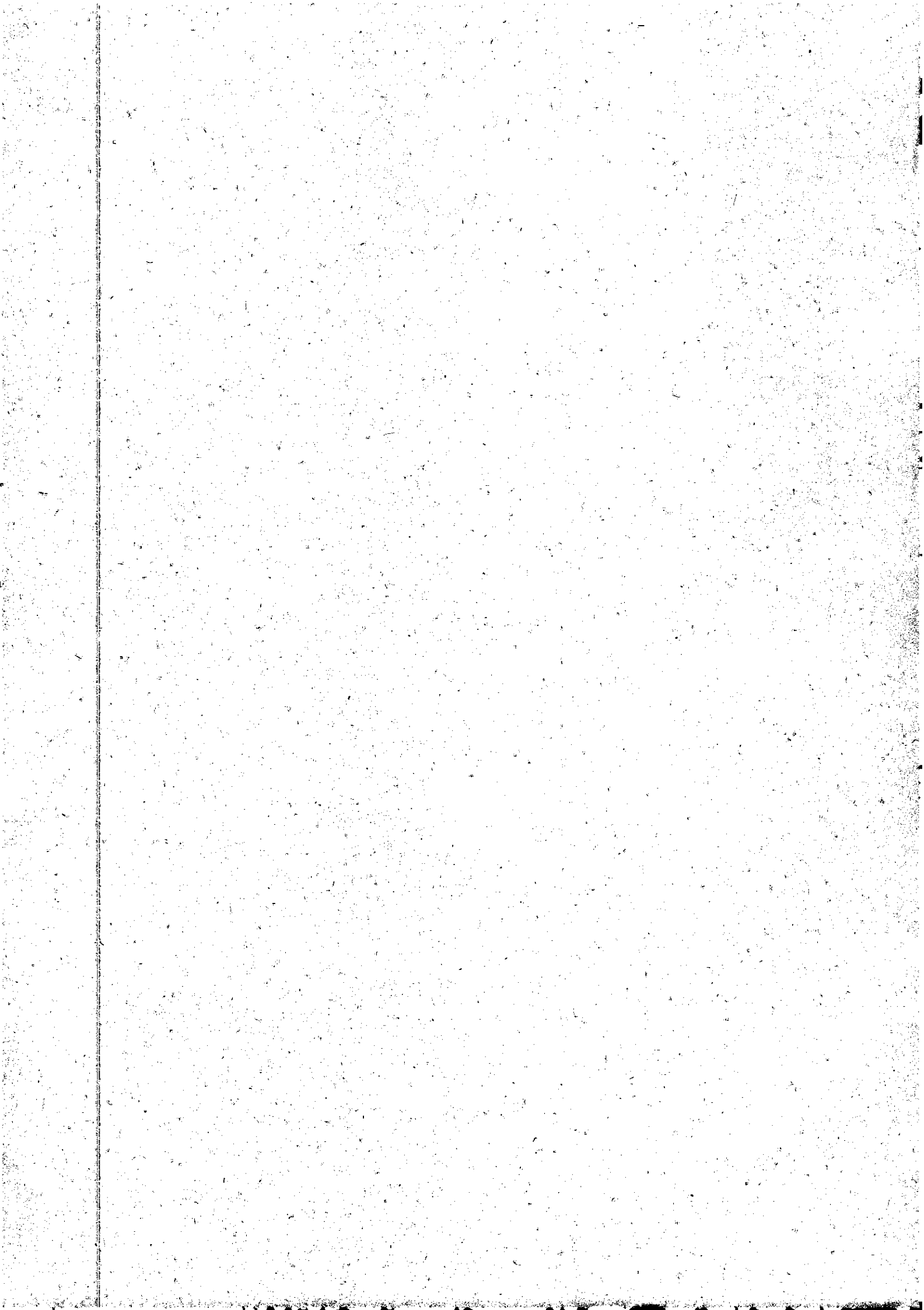
Patient will accept any doctor:Not Recorded

Patient will accept any site:Not Recorded

Patient will accept cancellation or short notice appointment:Not Recorded

Patient has disability or requires wheelchair access:Not Recorded

Signature of referring doctor (or other professional) Date



COPY

Department of Orthopaedic Surgery

Consultant: Mr Michiel Hendrix

Tel: 01786 433652

Fax: 01786 434432

Stirling Royal Infirmary

Livlands

Stirling

FK8 2AU

Ref: MRGH/JSF207472

CHI: 2602800570

Clinic Date: 24 August 2010

Date: 28 August 2010

**Dr Laura Jack
Group Medical Practice
The Health Centre
Kersiebank Avenue
Grangemouth
FK3 9EW**

Dear Dr Jack

Scott Dowell 26/02/1980

11 DON STREET, GRANGEMOUTH FK3 8HD

Diagnosis Acute lower back pain, affected medial meniscus tear left knee

Thank you for referring this gentleman who today presents with an exacerbation of his recurrent acute low back pain. He has no sciatica or incontinence symptoms. He uses analgesia to some good effect. He is also complaining of his left knee. He has a cyst on the antero lateral aspect of the proximal tibia which occasionally gets quite a bit larger. He also complains of medial joint line pain in this knee. He has no past history of significant trauma.

Clinically he is tender in the lower 3 vertebral bodies. Straight leg raising is 90° on both sides and there is no peripheral neurological deficit in either lower limb. Left knee examination elicits the presence of a cyst just lateral to the patella tendon. This is markedly tender mobile subcutaneously. He is tender over the medial joint line with an equivocably positive McMurray's test. The rest of the knee examination is normal. Left hip examination is normal.

Knee x-rays are NAD.

I have referred him to physiotherapy for treatment of his lower back pain. He is awaiting an MRI scan of his left knee and I will see him in the clinic thereafter.

Kind regards.

Yours sincerely

Mr M R G Hendrix

Consultant Orthopaedic Surgeon (Knee Surgery)

COPY

Department of Orthopaedic Surgery
Consultant: Mr Michiel Hendrix
Tel: 01786 433652
Fax: 01786 434432

Forth Valley Royal Hospital
Stirling Road
Larbert

Ref: MRGH/SB/F207472
CHI: 2602800570

Clinic Date: 25 November 2010
Date: 07 December 2010

Dr Derek Dundas
Group Medical Practice
The Health Centre
Kersiebank Avenue
Grangemouth
FK3 9EW

Dear Dr Dundas

Scott Dowell 26/02/1980
11 DON STREET, GRANGEMOUTH FK3 8HD

Diagnosis: Lump anterior right proximal shin

MRI scan shows this to be benign looking cystic lesion in subcutaneous tissues. After discussion his name has been added to the waiting list for excision of lump as a day case procedure.

Kind regards.

Yours sincerely

Mr M R G Hendrix
Consultant Orthopaedic Surgeon (Knee Surgery)

c.c. Waiting Times Department, F.C.H.

COPY

Department of Orthopaedic Surgery

Consultant: Mr Michiel Hendrix

Tel: 01786 433652

Fax: 01786 434432

Forth Valley Royal Hospital

Stirling Road

Larbert

Ref: MRGH/SB/F207472

CHI: 2602800570

Clinic Date: 25 November 2010

Date: 07 December 2010

Dr Derek Dundas
Group Medical Practice
The Health Centre
Kersiebank Avenue
Grangemouth
FK3 9EW

Dear Dr Dundas

Scott Dowell 26/02/1980
11 DON STREET, GRANGEMOUTH FK3 8HD

Diagnosis: Lump anterior right proximal shin

MRI scan shows this to be benign looking cystic lesion in subcutaneous tissues. After discussion his name has been added to the waiting list for excision of lump as a day case procedure.

Kind regards.

Yours sincerely

Mr M R G Hendrix
Consultant Orthopaedic Surgeon (Knee Surgery)

c.c. Waiting Times Department, F.C.H.

Department of Orthopaedic Surgery

Consultant: Mr John De Leeuw

Tel: 01324 566946

Fax:

Forth Valley Royal Hospital

Stirling Road

Larbert

FK5 4WR



Ref: JMDL/JAS/1007/10

CHI: 2602800570



CHI:2602800570

CRN:S679370 26/02/1980

DOWELL SCOTT

11 Don Street,

GRANGEMOUTH,

Stirlingshire

FK3 8HD

Date: 29 January 2011

Dr Derek Dundas
Group Medical Practice
The Health Centre
Kersiebank Avenue
Grangemouth
FK3 9EW

Dear Dr Dundas

Scott Dowell 26/02/1980

11 DON STREET, GRANGEMOUTH FK3 8HD

Daycase: 22 January 2011

Diagnosis: Cystic swelling region left tibial tuberosity

Procedure: Excision cyst

Mr Scott Dowell is a gentleman who had a cystic swelling in the region of the left tibial tuberosity. I warned Mr Dowell prior to surgery that he will have a scar in the region of the cyst instead of the cyst once it has been removed. He accepts this. A longitudinal incision was made over the cyst. The cyst was excised and it appeared to be a sebaceous cyst or a foreign body granuloma. The cyst was in the subcutaneous layer and did not extend through the deep tissues. Mr Dowell has nylon sutures in the front of his knee and a multi layer Mepore dressing. I recommend that his dressing remain intact. Mr Dowell will be needing the sutures removed from the front of his knee in 2 weeks time and we are going to be arranging that with the practice nurse. Mr Dowell should not require any follow-up in my clinic. The cyst was sent off for histology and a specimen was also sent for bacteriology.

Best wishes.

Yours sincerely

Mr J De Leeuw

Consultant Orthopaedic Surgeon



SCOTTISH AMBULANCE SERVICE - PATIENT REPORT FORM

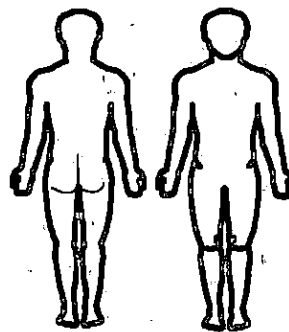
CCS INCIDENT No.	A	A	/	E	B	N	B	N	/	N	N	N
Last Name	D	O	N	E	L							
First Name	S	C	O	T	T							
Location	I	D	O	N	S	T	R	E	E			
	G	R	A	N	G	E	M	O	U	T	H	
Age												
Sex										M	F	
D of B	2	0	0	0	0	0	0	0	0	0	0	

Date	0	8	0	1	0	2
Time of Call	2	2	5	2		
Time at Patient	2	3	0	5		
Time Left	2	3	0	9		
Incident Code	6	1	4	0	1	
Revised Code						

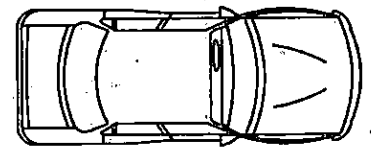
COPY

Airway Clear	☒	Suction	☐	N/OPA	☐	ET	☐	LMA	☐	Successful ?	☐	C-spine Injury	☐
Breathing	☒	Rate	F	N	S	BVM	☐	Ventilation	☐	Successful ?	☐	Paralysis	☐
Pulse	☒	Rate	F	N	S	CPR	☐	IV/IO	☐	Successful ?	☐	ECG	☐
Despite the above unable to													
Clear airway	☐	Detect breathing	☐	Detect pulse	☐	A	V	P	U				

Injury Site	Wound	#	Pain	Splint	Dressed
Head	☐				
Neck	☐				
Abdomen	☒				
Back	☐				
R/Arm	☐				
R/Leg	☐				
L/Arm	☐				
L/Leg	☐				



RTA	☐
Trapped	☐
Ejected	☐
M / cyclist	☐
Cyclist	☐
Pedestrian	☐
>20 min. Extricate	☐



Allergies	1	2	3	4	5	6	7	8	9
Medication	CEPARADINE								
Assisted by and Name -									
Doctor	☒	Nurse	☒	Other	☒				

Time	Pulse	Resp	BP	C / Refill	SpO2 %	GCS	Lpupil	Rpupil
23 05	85	16	S Y S	D I A	F S N	E M V	A R	S R
			S Y S	D I A	F S N	E M V	S R	S R
			S Y S	D I A	F S N	E M V	S R	S R
			S Y S	D I A	F S N	E M V	S R	S R

Time	Fluid/Drug/Gas	Dose	Unit	Route	Effect	Rhythm	No. Joules	Repeat	Result	Rhythm
					+ 0 -					
					+ 0 -					
					+ 0 -					
					+ 0 -					

Condition at	FDR	hospital	Pulse	☒	Breathing	☒	Conscious	☒	Time at Hospital	23 20
--------------	-----	----------	-------	-------------------------------------	-----------	-------------------------------------	-----------	-------------------------------------	------------------	-------

History and Additional Information	URGENT.
PATIENT BEING ADMITTED WITH TISSUE PROBLEM.	
HAS HAD SEVERE PAIN THIS MORNING. ALSO SAW HIS OWN G.P.	
THIS MORNING.	
SEE GP LETTER FOR MORE DETAILS	

Working assessment	PATIENT REMAINED STABLE	Incident Code	01
--------------------	-------------------------	---------------	----

Crew Name 1	A ZUCHANAWAN	Grade	L	P	X	C
Crew Name 2	T MACAWAN	Grade	L	X	T	C

FORTH VALLEY ACUTE HOSPITALS NHS TRUST

PATIENT DETAILS

Name: Scott Dowell		Title: Mr. Mrs. Miss Ms Dr	
Address: 11 Don St GRANGEMOUTH		DOB: 26.2.80	Age: 21
		Unit No:	
Postcode:		Tel No: 07788460257	

COPY

PRESENTING COMPLAINT	FINAL DIAGNOSIS
1 Nausea	1
2 loin Pain	2
3 algona	3
4 Ecch	4
5	5

EPISODE INFORMATION

Admission date: 9.1.2	Admission time: 1145	Admitting Consultant: Dr McGowan
Admitting ward: MAN	Admitted from: CP	Admitting Nurse: ALCH
Expected Length of Stay:		Admitting JHO:
Ready for Discharge Date:		Date of Referral to Social Work Department:
Actual Discharge Date:		Date of Discharge Planning Meeting:

CONSULTANT / NAMED NURSE MOVEMENT

Date:	Consultant:	Ward:	Named Nurse:

PAMS MOVEMENT

Named P/T:	Contact No:	Named O/T:	Contact No:

ALLERGIES	SPECIAL NOTES	ALERTS
None Known		

VISIT REQUIRED BY CHAPLAIN? Y / N	RELIGION:
--	--------------------

RECORDING PROCESS

	Y / N		Y / N
Admitted through Delta	Y / N	Bloods	Y / N
Demography printed	Y / N	Cannulation	Y / N
Admission Book	Y / N	ECG	Y / N
Casenotes ordered	Y / N	X-Ray	Y / N
Hospital Appointments pending: none			

NAME OF GP	ADDRESS	TEL NO:
Dr. Hillan	S. Muir	

COPY

NEXT OF KIN DETAILS	
Next Of Kin: <u>Maureen Dowell</u>	Alternative Next of kin:
Relationship: <u>wife</u>	Relationship:
Other family member details:	
Address: <u>A/G</u>	Address:
Tel No:	Tel No:
Relative/Carer present? Y / N (If answer NO then) <u> </u>	Name of Relative/Carer contacted:
Name of person present on admission:	Tel No:

DISCHARGE ADDRESS (IF DIFFERENT TO HOME ADDRESS)	GP NAME AND ADDRESS (IF NOT OWN)
Name of Carer:	Name of GP:
Address:	Address:
Tel No:	Tel No:

Discharge Date: 11/1/02

DISCHARGE CHECKLIST	DATE	Please circle appropriately	SIGNATURE
Patient involved in discharge planning?	<u>11/1/02</u>	<u>Yes</u> / Not applicable	<u>Fe</u>
Relatives / carers involved in discharge planning?	<u>11</u>	<u>Yes</u> / Not applicable	<u>11</u>
Special preparation for discharge planning arranged?	<u>11</u>	Yes / <u>Not applicable</u>	<u>11</u>
Review home circumstances	<u>11</u>	Yes / <u>Not applicable</u>	<u>11</u>
Pre-discharge home visit undertaken?	<u>11</u>	Yes / <u>Not applicable</u>	<u>11</u>
Provide written information to patient / relative / carers	<u>11</u>	Yes / <u>Not applicable</u>	<u>11</u>
Discharge Summary completed	<u>11</u>	<u>Yes</u> / Not applicable	<u>11</u>
Discharge Summary at Pharmacy	<u>11</u>	<u>Yes</u> / Not applicable	<u>11</u>
Discharge Summary returned from Pharmacy	<u>11</u>	<u>Yes</u> / Not applicable	<u>11</u>
Discharge medication(s) checked	<u>11</u>	<u>Yes</u> / Not applicable	<u>11</u>
Patient educated re: Discharge medications	<u>11</u>	<u>Yes</u> / Not applicable	<u>11</u>
7 day supply of drugs / dressings / appliances	<u>11</u>	<u>Yes</u> / Not applicable	<u>11</u>
Venflon removed?	<u>11</u>	<u>Yes</u> / Not applicable	<u>11</u>
Transport arranged for discharge	<u>11</u>	Yes / <u>Not applicable</u>	<u>11</u>
Referral to Community based services (If discharge is cancelled please inform Home Care Organiser or Liaison Nurse as appropriate)	<u>11</u>	Yes / <u>Not applicable</u>	<u>11</u>
Nursing Transfer Document completed	<u>11</u>	Yes / <u>Not applicable</u>	<u>11</u>
Home Help contacted (if applicable)	<u>11</u>	Yes / <u>Not applicable</u>	<u>11</u>
MECS contacted (if applicable)	<u>11</u>	Yes / <u>Not applicable</u>	<u>11</u>
Meals on Wheels contacted (if applicable)	<u>11</u>	Yes / <u>Not applicable</u>	<u>11</u>
Access to house/Outdoor clothes, shoes etc	<u>11</u>	<u>Yes</u> / Not applicable	<u>11</u>
Heating and food available	<u>11</u>	<u>Yes</u> / Not applicable	<u>11</u>
Follow up hospital appointment arranged	<u>11</u>	Yes / Not applicable	<u>11</u>
Transport arranged for follow up hospital appointment	<u>11</u>	Yes / <u>Not applicable</u>	<u>11</u>
Follow up appointment details:	<u>urology 1/11. They will arrange.</u>		
Other information			

THIS SECTION TO BE COMPLETED ONLY BY A DOCTOR

DATE: 8/1/02 TIME: _____

Surname DOWELL Unit No. _____
Forename _____ Doc. B. **COPY**
Address _____

☒ MALE / ☐ FEMALE (please circle)

AGE OF PATIENT: 21

◆ PRESENTING COMPLAINT

◆ HISTORY OF PRESENTING COMPLAINT

ALERT ~ HIGH RISK FACTORS:

21 ♂

3/7 hx ↑ pain in @ flank

- radiating to groin
- made worse by movement
- colicky pain

this morning - pain still there

- burning when urinating
- urine cloudy but ° blood

→ went to GP - prescribed cephalexin

- after that started vomiting

3x vomit

° blood

- rigors since this am

+ appetite loss

THIS SECTION TO BE COMPLETED BY ANY MEMBER OF INTEGRATED CARE TEAM

◆ **PAST MEDICAL HISTORY**

YES IHD / MI ☐ Rheumatic Fever ☐ CVA / TIA ☐ <u>Remarks:</u> 	NO ☒ Hypertension ☒ Diabetes Mellitus ☒ Asthma	YES ☐ ☐ ☐	NO ☒ ☒ ☒	YES ☐ ☐ ☐	NO ☒ ☒ ☒	YES ☐ ☐ ☐	NO ☒ ☒ ☒
---	---	---	---	---	---	---	---

COPY

◆ **FAMILY MEDICAL HISTORY**

YES IHD / MI ☐ Asthma ☐ CVA / TIA ☐ <u>Remarks:</u> 	NO DM ☐ Cancer ☐ Hypertension ☐	YES ☐ ☐ ☐	NO ☐ ☐ ☐
--	---	---	--

nil signif.

◆ **SOCIAL HISTORY**

Occupation: _____
 Smoking: Yes ☐ Amount per day: 20-30 daily
 No ☐ Ex-smoker: since _____
 Never smoked ☐
 Alcohol: Units per week: none
Home Circumstances: wife + step daughter
 Lives with: _____
 Support: _____

◆ **DRUG HISTORY / MEDICATIONS**
 (including 'over the counter' preparations)

Cephadrine 500mg BD. Started this morning

◆ **DRUG ALLERGIES**

NKDA

◆ **INFORMATION**

DISPENSING AID: Y / N

Filled by (please circle):

Self Carer Pharmacist

Location of Dispensing Aid:

Home Hospital

INHALER:

Type: _____

Technique: Satisfactory Poor

Referral to Ward Link Nurse:

Yes (date _____) No

DOMICILIARY OXYGEN:

Yes No

THIS SECTION TO BE COMPLETED ONLY BY A DOCTOR

Surname DOWELL Unit No. 1
Forename Dr D. of Medicine
Address 100 High Street
London E1 1AA

COPY

◆ SYSTEMS REVIEW

CVS

nil

RESP

◦ cough ◦ wheeze
◦ sputum

GI

◦ indigestion ◦ constipation
◦ heartburn ◦ diarrhoea
◦ blood

GU

poor flow

CNS

+ headaches
+ dizziness

◆ ON PHYSICAL EXAMINATION

General Examination

Temp 38.3 Pulse 104 Resp Rate 18 BP erect 119/89 supine 119/89

Oxygen Saturation 95 Anaemia Y / N Clubbing Y / N

Cyanosis Y / N Jaundice Y / N Lymphadenopathy Y / N

Breast Examination

Normal Y / N If no, please comment:

CVS

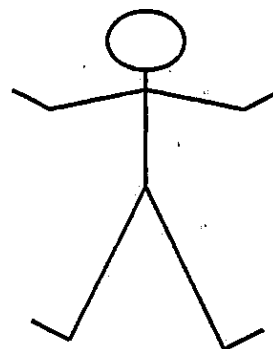
JVP ↔

Apex

Heart Sounds I+II+O ◦ murmur

Neck Bruit Y / N If yes, please comment:

Oedema nil



Peripheral Pulses

THIS SECTION TO BE COMPLETED ONLY BY A DOCTOR

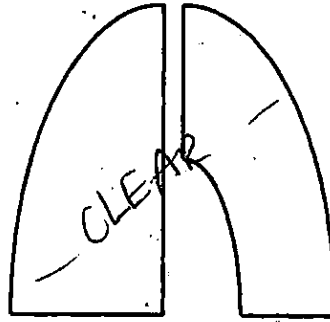
RESP

Trachea

Expansion *equal*

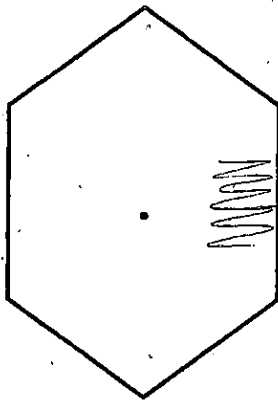
Percussion *resonant*

Breath Sounds *vesicular*
° added sounds



COPY

ABDOMEN



soft

tender

° scars

° rebound

Liver

Kidneys

Spleen

Bowel Sounds

PR Exam

impalpable

present

CNS - complete stroke proforma and insert here if CVA suspected

grossly intact

ABBREVIATED MENTAL TEST SCORE (AMTS)

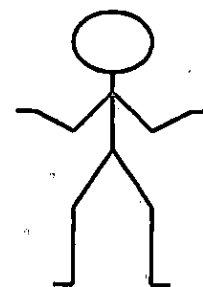
Age Monarch
DOB Recall 42 West Street
Year 20 - 1
Time of Day Home Address
Prime Minister WWI

Score

/10

<8 probable cognitive impairment

	<u>POWER</u>	<u>TONE</u>	<u>COORDINATION</u>	<u>SENSATION</u>
RUL				
LUL				
RLL				
LLL				



REFLEXES

THIS SECTION TO BE COMPLETED ONLY BY A DOCTOR

◆ IMPRESSION AND DIFFERENTIAL DIAGNOSIS

- ? renal calculus
- ? pyelonephritis

Surname Dawson
Forename
Address

Unit No.
Date

COPY

◆ MANAGEMENT PLAN (refer to protocol if appropriate)

- bloods ✓
- blood cultures ✓
- ECG ✓
- CXR ✓
- abdo x-ray ✓
- IV antibiotics ✓
- analgesia
- IV fluids ✓

IS DVT PROPHYLAXIS INDICATED? YES / NO

ANY CONTRA-INDICATIONS TO THIS? YES / NO

PRESCRIBED? YES / NO

DOES PATIENT NEED TO BE ADMITTED?

IS OUTPATIENT / AMBULATORY CARE AN OPTION? YES / NO
IF YES, DISCUSS WITH SHO OR OTHER SENIOR COLLEAGUES

◆ INITIAL INVESTIGATIONS REQUESTED (refer to protocol if appropriate)

☒ FBC

☒ U & E

☒ ESR

☒ Glucose

☐ ABG

☒ CRP

☐ ECG

☒ CXR

Others:

☐ Cardiac markers

☐ Clotting Factors

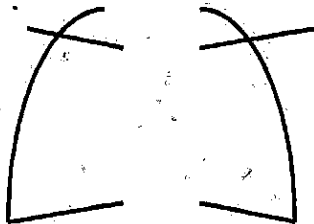
☒ LFT

☒ blood cult

☒ Calcium

☐

◆ CXR



Comments

◆ ECG Interpretation

House Officer's Signature: _____

Name & Pager No: _____

Date: _____

SENIOR HOUSE OFFICER / REGISTRAR REVIEW

COPY

9/1/02

(2)

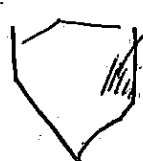
Dysuria, Flank pain, Pyrexia for 2h
 Stable Cystitis by GP - no improvement
 No penicillin hx
 No hx of trauma to flanks

S/E

Psoas c - H - 0.8/3.0

Chest - Clear

S.S. - n



gued,
 R Flank tenderness
 + back ache tend
 - Rest of Abdo Soft
 B/S -
 - 2 Ribs in R Flank
 no tenderness

CXR - (N)

AXR - 0 renal stones

Fused L4/L5 in c.h.

(N) Bone pain

WCC ↑ 14.3 W/E (N)

Imp Acute Pyelophitis

Plan:

- 1. Flank - keep well hydrated
- 2. Cipro 400mg bd
- 3. Paracetamol for analgesia, Paracetamol
- 4. Blood urea, Creatinine, CRP,
- 5. KUB in the morning

CPR STATUS: FOLLOWING DISCUSSION WITH PATIENT / FAMILY (Please indicate)

DOES THE PATIENT NEED TO BE ADMITTED TO HOSPITAL OR IS OUTPATIENT / AMBULATORY CARE AN OPTION?

Signature:

Date:

09/01/02

Name & Pager No.

F. Dabab 116

NURSING ASSESSMENT RECORD

Surname Dowell
Forename Scott
Address _____

Unit No. _____
D of B: _____

ADMITTING NURSE: _____

COPY

REASON FOR ADMISSION

pain Admitted with dysuria, with vomiting + rigors for 2 days

OBSERVATIONS ON ADMISSION

(ensure observations are completed on page 5 – Doctor's clerking notes)

Weight/kgs: _____

Urinalysis: _____

SPECIFIC OBSERVATIONS

Peak Flow: _____

BM: _____

Preg Test (please circle):

Not applicable

Negative

Positive

Previous MRSA:

☐ Yes

☐ No

☐ Unknown

MENTAL STATUS

- ☒ Alert
- ☐ Co-operative
- ☐ Calm
- ☐ Lethargic
- ☐ Withdrawn
- ☐ Depressed
- ☐ Agitated
- ☐ Anxious
- ☐ Aggressive

Orientated to:

- ☐ Time
- ☒ Place
- ☒ Person

COMMENTS: _____

NEUROLOGICAL SYSTEM

- ☒ Pupils: PERLA
- ☐ Dizziness
- ☐ Headaches
- ☐ Numbness
- ☐ Paraplegia
- ☐ Hemiplegia, R / L
- ☐ Hemiparesis, R / L
- ☐ Swallowing deficit
- ☐ Aphasic
- ☐ Expressive dysphasia
- ☐ Receptive dysphasia
- ❖ GCS Score: _____

COMMENTS: _____

CARDIOVASCULAR SYSTEM

- ☒ No problem identified
- ☐ Oedema
- ☐ Cyanosis
- ☐ Cold extremities
- ☐ Palpitations
- ☐ Previous CABG
- ☐ Pacemaker in situ

COMMENTS: _____

RESPIRATORY SYSTEM

- ☐ No problem identified
- ☐ Dyspnoea
- ☒ Cough
- ☐ Haemoptysis
- ☐ Orthopnoea
- ☐ Known COPD
- ☐ Known asthmatic

COMMENTS: _____

SPEECH

- Normal, clear ☒
- Dysarthric
- Hesitant
- Hoarse

COMMENTS: _____

MUSCULOSKELETAL SYSTEM

- ☐ No problem identified
- ☐ Stiffness
- ☒ Pain
- ☐ Weakness
- ☐ Paralysis upper limb R / L
- ☐ Paralysis lower limb R / L
- ☐ Paresis upper limb R / L
- ☐ Paresis, lower limb R / L
- ☐ Limited ROM
- ☐ Tenderness
- ☐ Swelling
- ☐ Arthritis
- ☐ Prosthesis

Physical Activity

- ☒ No limitations
- ☐ Walks with supervision
- ☐ Walks with assistance
- ☐ Uses walking aid
- ☐ Walking stick
- ☐ Zimmer
- ☐ Rolator
- ☐ Crutches
- ☐ Wheelchair independent
- ☐ Wheelchair outside only
- ☐ Other

COMMENTS: _____

no do pain

GI SYSTEM

- ☐ No problem identified
- ☐ Change in appetite
- ☐ Indigestion
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Bleeding
- ☐ Abdominal pain
- ☐ Abdominal distension
- ☐ Ascites
- ☐ Haemorrhoids
- ☐ Constipation
- ☐ Diarrhoea

❖ Last BO: ____ / ____ / ____

❖ Stools per day: _____

❖ Stools per week: _____

☐ Stoma

COMMENTS: _____

MOUTH AND THROAT

- ☒ No problem identified
- ☐ Dentures
- ☐ Sores/plaque on tongue
- ☐ Gum swelling/bleeding
- ☐ Sore throat
- ☐ Diminished taste
- ❖ Eller's score: _____

COMMENTS: _____

DIETARY STATUS ☒ Normal diet ☐ Special diet (specify below) ☐ Diabetic ☐ Low fat ☐ Reducing ☐ Soft ☐ Liquidised ☐ High protein ☐ Low protein ☐ Low sodium ☐ Low residue ☐ Gluten free ☐ Recent weight loss ☐ Recent weight gain ☐ Vegetarian ☐ Vegan ☒ Assessment score: ☐ Referred to dietician COMMENTS	EARS ☒ Normal ☐ Hearing Loss ☐ Hearing aid L / R ☐ Tinnitus ☐ Vertigo ☐ Discharge ☐ Pain COMMENTS	GENITO-URINARY SYSTEM ☐ Normal ☒ Frequency ☐ Urgency ☐ Dysuria ☐ Nocturia ☐ Urinary incontinence COMMENTS <i>Painful</i>	ACTIVITY TOLERANCE ☐ Normal ☐ Weakness ☐ Dizziness ☐ Exacerbated by sea ☐ Dyspnoea at rest ☐ Angina ☐ Pain at rest ☐ Oxygen needed ☐ Intermittent claudication ☐ Unsteady gait COMMENTS
SKIN ☒ Normal ☐ Dry ☐ Moist ☐ Diaphoretic ☐ Rash ☐ Bruising ☐ Burns ☐ Lacerations ☐ Pressure Ulcer ☐ Leg Ulcer ☐ Wound Assessment Chart ☒ Waterlow Score: _____ COMMENTS	EYES ☒ Normal vision ☐ Glasses ☐ Contact lenses ☐ Blind ☐ Prosthesis ☐ Blurred vision ☐ Diplopia ☐ Discharge ☐ Itching ☐ Photophobia ☐ Pain ☐ Cataract ☐ Glaucoma ☐ Sclera colour: COMMENTS	REPRODUCTIVE SYSTEM F ☒ LMP date: ☐ Irregular ☐ Discharge ☐ Vaginal infections ☐ Menopause ☐ HRT ☐ Other COMMENTS	REST PATTERN Sleep habits ☒ less than 8 hours ☒ 8 hours ☐ more than 8 hours ☐ Morning nap ☐ Afternoon nap Sleep difficulties ☒ None ☐ Early awakening ☐ Unrefreshing sleep ☐ Nightmares ☐ Insomnia ☐ Disturbed - nocturia ☐ Disturbed - dyspnoea ☐ Disturbed - pain COMMENTS
REPRODUCTIVE SYSTEM M ☐ Prostate problems ☐ Lesion ☐ Other COMMENTS <i>note</i>			

◆ SELF CARE ABILITY	A			B		
	1	2	3	1	2	3
Dressing and grooming	✓	✓		✓	✓	
Eating and drinking	✓	✓		✓	✓	
Toileting	✓	✓		✓	✓	
Transferring	✓	✓		✓	✓	
Walking	✓	✓		✓	✓	

◆ CHANGE IN HEALTH STATUS	1	2	3
Mental status	✓	✓	
Sleep pattern	✓	✓	
Appetite	✓	✓	
Bowel habit	✓	✓	
Urinary continence	✓	✓	
Pain			✓
Activity tolerance			✓

Key

- A** Prior to current episode of ill-health
B At present time
1 Independent
2 Assistance of Carer
3 Assistance of aid

Key

- 1** No change
2 Experienced change in last week
3 Change related to current illness

SERIAL BLOOD RESULTS

Surname Danell

Unit No

Forename

D. of B

Address

CONSULTANT:

COPY

DATE & TIME

SIGNATURE

ELECTROLYTES & GLUCOSE

NORMAL VALUES

Sodium	135 - 145	138
Potassium	3.5-5.0	3.2
Chloride	97-107	105
Urea	2.5-8.0	5.4
Creatinine	60-130	86
Glucose	3.5-5.5	
Magnesium	0.8-1.0	
Calcium	2.15-2.6	

DATE & TIME

SIGNATURE

CARDIAC ENZYMES & LIVER FUNCTION TESTS

AST	12-31
ALT	11-37
Bilirubin	Up to 17
Total protein	62-80
Albumin	36-52
Alk Phos	Age dep.
Total CK	
CK-Mb	
LDH	195-415

DATE & TIME

SIGNATURE

HAEMATOLOGY & CLOTTING SCREEN

Hb	Sex dep	150
White count	3.5-11.0	14.3
Platelets	150-440	124
APTT		
CT		
Thrombin time		
CT		
PT		
CT		
INR		
ESR		

SERIAL BLOOD RESULTS (CONT'D)

CONSULTANT : _____

Surname _____

Unit No. _____

Forename _____

D.of B. _____

Address _____

COPY

DATE & TIME →

SIGNATURE →

ARTERIAL BLOOD GAS

NORMAL VALUES

H⁺

38-43

PCO²

4.5-6

PO²

10.5-13.5

Base excess

+/- 2.5

Bicarbonate

20-28

FiO²

3.5-5.5

DATE & TIME →

SIGNATURE →

OTHER RESULTS

◆ REFERRALS MADE TO PAMS, SPECIALIST NURSES

Surname Unit No.
Forename D.of B.
Address

COPY

DISCIPLINE	NAME	REFERRAL MADE BY	DATE
Physiotherapy			
Occupational Therapy			
Dietician			
SALT			
FALGO			
Chiropodist			
Pharmacist			
Social Worker			
Community Physiotherapy			
Community Occupational Therapy			
Community Dietician			
Windsor Day Hospital			
Bonnybridge Day Hospital			
Community Liaison Nurse			
Stroke Liaison Nurse			
Respiratory Specialist Nurse			
Diabetic Specialist Nurse			
Oncology Specialist Nurse			
Palliative Care Nurse/Team			
Parkinsons Disease Specialist Nurse			
Cardiac Rehabilitation Nurse			
Community Psychiatric Nurse			
Stoma/Breast Care Nurse			
Leg Ulcer Nurse			
Urology Specialist Nurse			
Chaplain			
Others (Please specify)			

◆ PROGRESS NOTES

Date and Time	
9.1.02	Pyrexia on admission Blood Cultures done commenced on iv fluids and iv antibiotics Given Paracetamol for pyrexia IM rotterol given with some effect further 50mg of pethidine given with good effect N/A
9.1.02	likely to be UTI & pyelonephritis no obvious underlying cause and no visible infection & bladder stones Appexed this am. Plan: ① get urine sample quickly ② do U.I. + pelvis ③ continue iv antibiotics until known renal <i>[Signature]</i>
9.1.02	810 gram stain has been called as 1+ bacteria 2000 WBC 5000 RBC lab called do not do gram stain urine UTI & pyelonephritis await USS repeat U&E mae <i>[Signature]</i> HASIN 810 155

◆ PROGRESS NOTES

Date and Time	
9.1.02	Pyrexia in admission Blood Cultures done commenced on iv fluids and iv antibiotics Given Paracetamol for pyrexia IM rotterol given with some effect further 50mg of pethidine with good effect N/A to do U&E + pyelonephritis rule out underlying cause and to rule out bladder stones passed this am. Plan ① get urine sample quickly ② do U&E + pelvis ③ Continue iv antibiotics until broader spread. <i>[Signature]</i>
9.1.02	840 gram stain has been called as 1+ bacteria 2000 WBC 5000 RBC lab called do not do gram stain urine U&E + pyelonephritis await USS repeat U&E mae <i>[Signature]</i> 8410 155

◆ **PROGRESS NOTES**

Surname: Duncan
Forename: Scott
Address:

Unit No:
D of B:

COPY

Date and Time

9/1/02

for ultrasound today → full full for some

find catheter

AM Output → has now passed urine, N/A
Ultrasound show Normal Bladder
but debris noted suggesting UTI.

16.30

In retention. Abdo: tender

last urine output only 10mls.

→ Catheter inserted; Size 14 Fg

Kendall All Home

using aseptic technique + 10mls saline

— 200 mls drained out

note U/S result; all @ but debris.

For rpt U/S name As

Output 100-120ml/hr what 400

10 fluid catheter

Care = ple

10/2/02

Good urine output overnight via catheter

IV antibiotics as prescribed

IV fluids continue - ventlon very
positional; also taking good fluid intake
orally - IV antibiotic to change to
oral today. Thomas

10/1/2

McSorley

good urine output a/n

feels better

◆ PROGRESS NOTES

Date and Time

COPY

- looks well
- afebrile
- ? urological problem as baby unable pass water
- constipated

Pls oral fluids
↓
slip down

~~Pls~~ urology opinion

→ urology reg cath
? methadone values

Switch to oral antibiotics

MSAN

JULIAN

\$110

155

10 find down auscultation
re catheter

Care = Pls for further
to Id?

10/1/12

Sm

→ Catheter out now

1700

→ communication problem earlier

urology for amaged ✓
cystoscopy in 2/52

if afebrile & not retention tomorrow

MSAN

\$110

155

COPY

RX1561

◆ **PROGRESS NOTES**

Date and Time

em Discharged as planned

7.6.07

COPY

Accident and Emergency Department Falkirk and District Royal Infirmary

F207472



2602800570

A&E No. 07006440

COPY

Surname	DOWELL	Forename	SCOTT	Title:	MR.
Address:	11 DON ST GRANGEMOUTH	Postcode	FK5 4AB	Telephone:	474369
Date of Birth:	26.02.80	Sex:	M	Age:	27 yrs

GP Name:	DUGGIE JOHN				
Address:	GROUP MEDICAL PRACTICE	Postcode	FK3 9EW		
	KERSIEBANK HEALTH C...	Telephone:	01324 471511		
	KERSIEBANK AVENUE				
	GRANGEMOUTH				

Next of Kin	DIANE				
Relationship:	WIFE				
Address:	11 DON ST	Postcode	FK3 8HD		
	GRANGEMOUTH	Telephone:	474369		
Primary Carer:					

Date of Attendance: 02.03.07 16:57

Date of Incident:

Presenting Complaint: INJ RIGHT THUMB

07/20562

Age	Tetanus Cover:
	Allergies:
P=	BP= / RR= Sat= BM=
PF=	GCS=E: M: V: Total:

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time

Clinical Notes

Seen by:	Crain	Time:	1715
Pc	27yr	right hand injury	
Hpc	FOOSH	right after falling off tractor	
	Describes possible thumb dislocation pulled by friend, now no deformity & MCP joint		
Pmb	# left radius (Ob)	Right hand domin	
Dh	0		
AM	0		
O/E	Right hand		
	0 deformity 0 bruising 0 redness		
	minimal swelling over thumb metacarpal		
	Bony tender thumb metacarpal & proximal phalanx, Bony tender index & middle metacarpal		
	0 Bony tenderness radius/ulna, scaphoid or any other part right hand		
	↓ ROM due to pain		
	Unable to assess U/L ligament circulation and sensation now		
Imp	? # thumb metacarpal? possible dislocation		
Plan	x-ray right thumb & hand		
	? # Distal thumb metacarpal		
Rx	Advice		
	Thumb spica splint		
	# clinic review monday		
	Crain		

COPY

Attach continuation sheets here

Attach here onto face of pocket

Guidelines Used:

Accident and Emergency Department Falkirk and District Royal Infirmary

2602800570

2602800570

A&E No. 09011884

COPY

4

Surname: DOWELL	Forename: SCOTT	Title: MR
Address: 11 DON STREET GRANGEMOUTH	Postcode: FK3 8HD	Telephone: 474369
Date of Birth: 26.02.80	Sex: M	Age: 29 yrs

GP Name: DUGGIE JOHN	
Address: GROUP MEDICAL PRACTICE KERSIEBANK HEALTH C... KERSIEBANK AVENUE GRANGEMOUTH	Postcode: FK3 9EW Telephone: 08445769111

Next of Kin: DIANE DOWELL	Relationship: WIFE
Address: 11 DON STREET GRANGEMOUTH	Postcode: FK3 8HD Telephone: 474369
Primary Carer:	

Date of Attendance: 26.05.09 21:56

Date of Incident:

Presenting Complaint: INJURY TO BIG TOE RIGHT FOOT ? INFECTED

Age	MILD PAIN (<4 ON 1-10 SCALE; MINIMALLY DISABLING) • RECENT PROBLEM STUBBED RIGHT GREAT TOE 2 WEEKS AGO AND REMOVED PART OF NAIL HIMSELF. TONIGHT TOE VERY PAINFUL AND APPEARS INFECTED. TEMP 36.9	Tetanus Cover: Allergies:
P=	BP= /	RR=
PF=	GCS=E: M: V: Total:	Sat= BM=

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time

RHC Thurs
10.30 28/5

COPY

Guidelines used

PC 29 yr man with right great toe problem
 HPC: Direct blow to front of great toe 2 weeks ago. Now 50% painful great toe
 0 PMH
 exacerbation to the area involving
 covered for debris
 Apical
 0/5 right great toe - Erythema, swelling, over aspect of
 area medial aspect of head
 No obvious deformity
 No N/U deficit
 CRT = 2 sec Tendon
 1 PT 9 distal phalanx
 no pain elsewhere
 swelling in foot
 Reduced movements
 and weight bearing mainly
 right great toe
 X-ray right great toe: -
 undisplaced # distal phalanx
 met. tarsal
 A Pseudogout developing. Tendon healed
 from wound later
 Induro 2 toe dressing
 Abundant care advice given
 R # C Tlurs 28/5
 Penicillin 500mg qid for
 Penicillin V 500mg 7 days



COPY

Stake (ENP) Time

Seen by

Clinical Notes

Attach here onto face of pocket

Attach continuation sheets here

COPY

CONSENT FORM

NHS

Forth Valley

Agreement to Operation, Investigation or Treatment

COPY

Notes of Guidance for Doctor/Dentist/Healthcare Practitioner

The doctor/dentist/healthcare practitioner must:

- ◆ Be suitably qualified and experienced to explain the procedure to be performed - this should ideally be the operator or consultant.
- ◆ Give the patient sufficient information, in a way he/she can understand, about the proposed procedure, any important risks and the possible alternatives (including no treatment). In broad terms, a significant risk is one which is serious, but uncommon, or one which occurs frequently, even if it is not serious.
- ◆ Give the patient sufficient time to read the form and ask any questions relating to it or their treatment. The patient must be allowed to decide whether he/she will agree to the procedure and they may refuse or withdraw consent at any time.
- ◆ In addition to seeking consent for the procedure, seek written consent from the patient for examination by students.

Children under the age of 16 can give their own consent if the Medical Practitioner attending the child considers the child capable of understanding the nature and possible consequences of the procedure or treatment. If the child is judged capable, the practitioner must seek the consent of the child rather than the parent. This does not mean that the parents must always be excluded from the discussions. Unless there are issues concerning confidentiality, it would be reasonable to involve parents in helping a child to reach a decision. If a child under 16 years of age is giving his/her own consent, the relevant section overleaf, must also be signed.

Writing on the consent form must be legible, unambiguous and contain no abbreviations.

Any alterations to this form must be countersigned by the patient/parent/guardian and the member of the healthcare team taking consent. If the procedure or the information about surgical marking is wrong the form must be re-written.

Surgical Site Marking

- ◆ The site should be marked and documented by the operating surgeon, or nominated deputy, who will be present in the operating theatre at the time of the patient's procedure. If site marking is not applicable, this should be recorded and signed by the person taking consent.
- ◆ The intended site should be ascertained from reliable documentation and/or images.
- ◆ Marking should take place before pre-medication/administration of any sedative.
- ◆ The intended surgical site should, ideally, be marked on the ward or day care area, prior to the patient transfer to the operating theatre.
- ◆ An indelible marker pen should be used.
- ◆ The mark should be an arrow that extends to, or near, the incision site and remains visible after the application of skin preparation.
- ◆ Where possible the mark should remain visible after the application of theatre drapes.
- ◆ Surgical operations involving side (laterality), should be marked at, or near, the intended incision. For digits on the hand or foot, the mark should extend to the correct specific digit.
- ◆ The process of pre-operative marking of the intended site must involve the patient/parent/guardian wherever possible.

NB. There will be circumstances where marking may not be appropriate i.e. Teeth or Mucous Membranes. Emergency surgery should not be delayed due to lack of pre-operative marking.

EXAMINATION FOR THE PURPOSES OF TEACHING

(Please tick) I agree ☐ I do not agree ☐ to an examination by a student during the procedure named on this form under the supervision of the senior doctor undertaking the procedure.

COPY

Signature:

Name (PRINT): Date:

dd	mm	yy

CONFIRMATION OF CONSENT

(to be completed when patient is admitted for the procedure)

I confirm that I have no further questions and wish the procedure to go ahead.

Patient ☐ Parent ☐ Guardian ☐ Other ☐ (please specify)

Date

dd	mm	yy

Signature of Doctor/Dentist/Healthcare Practitioner:

Signature of Patient:

Notes of Guidance for Patients

The Doctor/Dentist/Healthcare Practitioner is here to help you. He or she will explain the procedure. You are entitled to refuse or withdraw consent at any time. You can ask any questions and ask for more information if you wish.

You may ask for a relative, friend or nurse to be present while the Doctor/Dentist/Healthcare Practitioner explains the procedure and asks you to sign the form.

If an anaesthetic or sedation is to be administered by an anaesthetist, it will be his or her responsibility to discuss details with you before the procedure takes place.

Students need to learn how to examine patients and to see how procedures are done. This is important for the future of the Health Service. You may be asked to give consent to be examined by students during the procedure. It is up to you to decide whether to give your consent or not but, whatever you decide, it will not affect your treatment.

NOTES

Forth Valley Surgical Safety Checklist
Version 5

carried out - Confirmed

Date 21.11.11



Anaesthetic pause

Surgical pause

Post-procedure

PATIENT DETAIL (OR PRE-PRINTED LABEL)

Patient's surname: CHI 2602800570
 Patient's first name: DOWELL SCOTT M
 Date of birth: 26/02/1980
 CHI number (or UKH number): FK3 8HD

COPY

Special requirements (e.g. other language/other communication method):

STATEMENT FOR DOCTOR/DENTIST/HEALTHCARE PRACTITIONER

(to be completed by a practitioner with appropriate knowledge of proposed procedure. See Notes for Guidance)

Describe proposed operation, investigation or treatment. Where appropriate specify the site or side:

Excision Subcutaneous lesion
 over Left Tibial Tuberosity

I have explained the procedure named on this form to the: (please tick) patient ☒
 parent ☐ guardian ☐ Other (please specify):

in terms which, in my judgment, are suited to their understanding. In particular I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure e.g. blood transfusion.

[If you have provided any information leaflet/tape, please tick box ☐ and specify title and version]

Signature of Doctor/Dentist/Healthcare Practitioner:

Name (PRINT):

Date: dd mm yy
 22 1 11

STATEMENT OF INTERPRETER (where appropriate)

I have interpreted the information on this form to the patient/parent/guardian to the best of my ability and in a way in which I believe he/she can understand.

Signature: Date: dd mm yy

Name (PRINT):

SURGICAL SITE MARKING

Site marking not applicable
 Correct Patient and Surgical Site verified and marked by:

Signature: Date: dd mm yy

Name (PRINT): Title: 22 1 11

STATEMENT TO BE COMPLETED BY THE PATIENT, PARENT OR GUARDIAN

You should read this form and the notes below and overleaf carefully. If there is anything you do not understand, ask the doctor, Dentist or Healthcare Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

COPY

I am (Please tick)

Patient ☒

Parent ☐

Guardian ☐

I understand:

Yes No

- the procedure, important risks and appropriate alternatives which have been explained to me by the Doctor/Dentist/Healthcare Practitioner named on this form. ☒ ☐
- that the procedure might be carried out by a Doctor/Dentist/Healthcare Practitioner other than the Doctor/Dentist/Healthcare Practitioner who has been treating me/the patient so far. ☒ ☐
- that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to my/the patient's medical treatment, to safeguard or promote my/the patient's physical or mental health. ☒ ☐

I have been told about additional procedures which may become necessary during my/the patient's treatment. I have listed below any procedures which I do not wish to be carried out without further discussion.

I agree:

- to the administration of an anaesthetic or sedation if required.
- to the procedure named on this form.
- that an examination for the purposes of teaching will not be undertaken without my consent.
- that any photographs, video/audio recordings and/or surgical images kept in the records may be used anonymously for research approved by an ethics committee, education and audit to improve the quality of patient care.

If you object to surgical images being used in this way then *please tick box* ☐

Signature of Patient

CHI 2602800570

CRN F207472 26/02/1980

DOWELL SCOTT

M

Name (PRINT):

11 DON STREET

GRANGEMOUTH

Relationship to

FK3 8HD

Scott Dowell

Date: dd mm yy

22 / 11

Only to be completed by the Medical Practitioner where the form is to be signed by a child under 16 years.

I am of the opinion that the patient is capable of understanding the nature and possible consequences of the proposed treatment/procedure.

Name (PRINT): Signature:

Date **22/1/11**

Ward **OSU**

Surname

Procedure and side

First name

CHI 2602800570

CRN F207472 26/02/98

DOWELL SCOTT

11 DON STREET,
GRANGEMOUTH

COPY

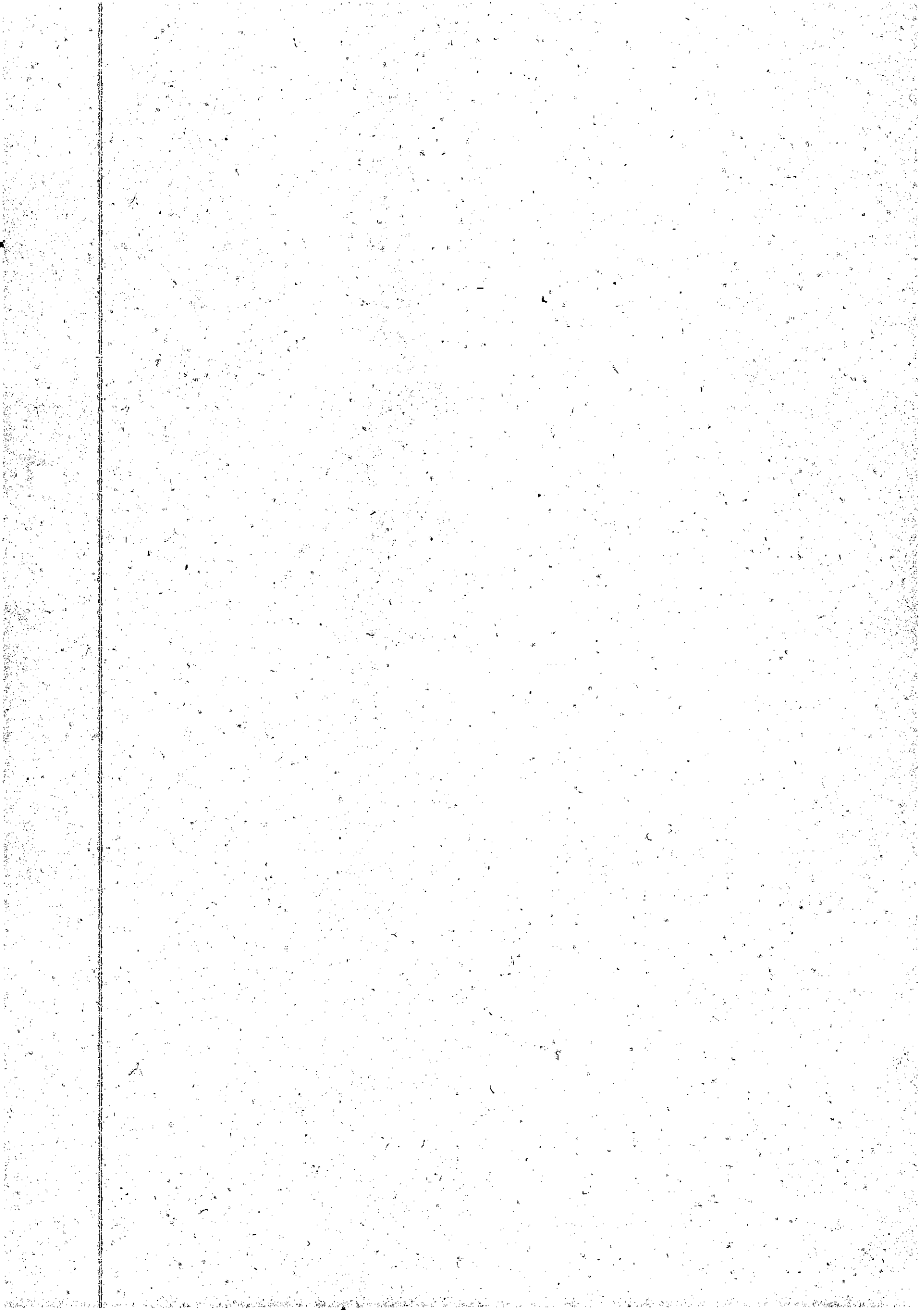
Unit No. / CHI

FK3 8HD

Surgeon **MR DE LEEUW**

Date of Birth

CHECKLIST ITEMS	WARD	HANDOVER CHECKS	BASELINE WARD CHECKS & DATA
Verbal Name Check	✓	✓	Pre-assessment Document
ID Band Checked	✓	✓	Present and Checked ☒
Pre-assess/clerking completed	✓	✓	Any Changes? NONE
Pregnant Yes / No	NO	✓	Temp 36 Weight (kg)
Allergies (see baseline checks) (Yes/ No)	YES	✓	P 89 BP 116/66
Consent / Incapacity completed	✓	✓	RR SaO2 97%
Operation confirmed with patient	✓	✓	BM (Sugar)
Consent form corresponds to list	✓	✓	Allergies
Operation site marked clearly	✓	✓	☐ No ☒ Yes
Nursing notes	✓	✓	HAY FEVER ALLERGIES
Case Notes (SRI, FDRI, Beatson)	✓	✓	FULL SET
Drug Kardex	✓	✓	☐ Own Teeth ☒ Dentures
X-Rays (including angios etc)	X	✓	Hb Na
XMatch / G&S form (Y or N/App)	NA	✓	WCC K
Confirm all results available	NA	✓	Platelet U
Addressograph labels	✓	✓	Clotting Cr
Bone bank consent	X	✓	G and S X-Match
Fasted for solids / milk from (time) 23:00 → 21/1/11	✓	✓	Thromboprophylaxis
Fasted for clear fluids from (time) 06:00 → 21/1/11	✓	✓	☒ None ☐ GECS
Bladder emptied (time or No)	AM	✓	☐ Aspirin ☐ Calf compression
Jewellery removed / taped	X	✓	☐ Clexane
Body piercings taped etc	X	✓	Items to Theatre
Nail varnish / makeup removed	X	✓	No. of Pillows
Contact lenses removed	NO	✓	Cot Sides
Prosthesis (* or No)	NO	✓	Bradford Slings
Orthopaedic implants (* or No)	NO	✓	Charnley Wedge
Pacemaker (Yes or No)	NO	✓	
Hearing aid (Yes or No)	NO	✓	
Able to move by self on trolley	YES	✓	
Ward sign and designation SH/Donnan			
Handover 1 sign and designation C. Dal			
Handover 2 sign and designation			
Comments * LEFT ARM METALWORK *			
Diabetic	YES/NO		
On Beta Blocker	YES/NO		
If "YES" Taken	YES/NO		
If not taken:			
Administered by Nursing Staff			
YES/NO			



Post-operative instructions

Analgesia

Recovery

IV Morphine up to _____ mg

IV Fentanyl up to 200 µg

Anti-emetic

- ☒ Cyclizine 50mg IV
☐ Granisetron 1mg IV
☒ Prochlorperazine 12.5mg IM

COPY

Analgesia

Ward

- ☒ Regular oral analgesia as prescribed

Oxygen - in recovery follow protocol thereafter

..... L/Min via nasal cannula

4 L/Min via facemask

until fully awake

IV Fluids

☐ as charted

☒ Cap off

☒ Oral

Other Care

☒ Routine

Investigations required

☐ Recovery

☐ Ward

FBC
U&E
ABG
CXR
ECG

Signed *[Signature]*

IV Cannula / Removal Record

Name: _____ Ward: _____
Inserted by: SRIKANITH Date: 22/6/16
Size / Colour: 20 G Purple Batch No: _____
Insertion Site: Left Hand
Removed by: _____ Date: _____

9115 174.5

Examination of Lesion (L) leaf

ANAESTHETIC ASSESSMENT Date

Sat 9/7/1

Age 30 BP

ASA

NCEPOD EI ☐

Urg ☐

Sch ☐

Em ☐

PRE-OPERATIVE INSTRUCTIONS

- ☐ Give usual medication
- ☐ EMLA or ametop topical
- ☐ Fast as per Trust guidelines
- ☐ Free clear fluid until
- ☐ Additional results required before theatre

PRE-MEDICATION

COPY

Prescribed by:

Amber (01.0)

Given by:

T. paracetamol 12 { po
T. Diclofenac 50 mg } 9⁰⁰

CO-MORBIDITIES

DRUGS

Generally fit - level Nil.

Hay fever

✓ Headbun 15yr ag
Belh painy

OKI NO AIDS-

Last GA 14 yr ago.

- Allergies
- Previous GA
- Problems?
- FH GA problems
- Reflux/full stomach
- Airway difficulty

☒	No	☒	Yes
☒	No	☒	Yes
☒	No	☒	Yes
☒	No	☒	Yes
☒	No	☒	Yes
☒	No	☒	Yes

Heartburn OCC

Na
K
U
Cr

Hb
WCC
Platelets

Clotting

G and S
X-match

Teeth

Top Dentures MPJ

Verbal consent and explanation ☐

Explained:

☒ GA

☐ RA

☐ Risks

☐ Day Care

Signed / Name

[Signature]

☐ nominal

Excision of Lesion (4) 8/11

☒ Anaesthetist has checked machine and equipment

COPY

Local anaesthetic (LA) ☐ block ☐ spinal ☐ epidural ☒ infiltration

20m4.07 0.25 f
Levelling machine

[illegible]

① $R_{1000} \approx 1000 \text{ m}$

FALKIRK & DISTRICT ROYAL INFIRMARY - THEATRE CARE PLAN

NAM CHI 2602800570
 ADD CRN:F207472 26/02/1980
 DOWELL SCOTT
 11 DON STREET
 GRANGEMOUTH
 UNI
 or FK3 8HD
 AE No.

PROCEDURE: Excision of skin lesion Mr De Leeuw
 left knee
 CONSULTANT
 TH. No.: **COPY**

SURGEON: Mr De Leeuw ELECT/EMER
 DATE: 22/1/11
 NURSE IN CHARGE SSN Lyall

Procedure Start: 17.15

Exit Theatre Time: 1136

Blood Loss:

Urine Output:

Position: Supine
 Positioned By: Trolley

ANAESTHETICS TICK

GA	☒
Spinal	☐
Epidural	☐
Sedation	☐
Block	☐
JA	☒
Amount	20 ml
Chirocaine	2.5%

LOTIONS TICK BOX

Chlorhexidine	Pink	Red	☒	Clear 1:2000	1:5000
Betadine	Alcoholic	Antiseptic	☐	Aqueous Iodine	
Tisept	Unisept	Saline	☒		
Other : Please state					

Diathermy Pad	Position:	Site Check	Comments: Bipolar
Flowtron Boots	Spenko Mattress	Bair Hugger	Fluid Warmer
Tourniquet	Applied by (initial) Mr De Leeuw	17 minutes	

Type	Size	Position	No.
Drain(s)			
Ureteric Stents			
Catheter		Balloon Amt.	
Catheterised by	Name		
Naso Gastric	Yes/No		

Specimens: Yes/No
 Number: 2
 Results sent to: 1 Hist 1 Bac

Sutures : Tick Box

Ethilon	☒	Silk	Staples
Prolene	☐	PDS	Monocryl
Vicryl	☐	Vicryl Rapide	

Dressings : Tick Box

Mepore	☒	Airstrip
Steristrips	☐	Opsite Dressing/Spray
Blue Gauze	☐	Mefix
Pop	☐	Back Slab
Bradford Sling	☐	Tubgauze
Wool or Crepe	☐	Kling
Pad or Pants	☐	Other-

Follow Up Instructions

Sutures Out-	2/52	Seen before Home
Dressing Change-	V48HLS	Return to Clinic NO

Nursing Comments:

HAND & TOE SET

ID 1030413	LOT 00332	User Code 1770005
ID 1053984	LOT 00020	User Code KEY5043892

1. Scrub Person - H. Lyall
 2. Scrub Person - H. Lyall
 Signature of person/s completing care plan
 Initial Count Circ. Person - D. Winters
 Final Count Circ. Person - D. Winters
 Signature of person/s completing care plan

Falkirk and District Royal Infirmary**Patient Details**

Hospital Number **F207472**
 Patient Name **Dowell Scott**
 Date of Birth **26/02/1980**
 Sex **M**
 Category Type
 Patient Type **Day Case**
 Operation Type **Scheduled**
 Date of Operation **22/01/2011**
 Theatre **FRI 1/FVR12**
 Confirmed By

COPY**Staff In Attendance - Team 1**

Anaesthetist **DR ML SRIKANTH**
 Floor nurse 1 **NA DEBORAH WINTERS**
 Floor nurse 2 **N/A ELAINE NIVEN**
 Other **SN LAURA SOMERVILLE**
 Scrub nurse **SSN HAZEL LYALL**
 Surgeon **MR J. DE LEEUW**

Attendees

ODP C McCoil RMR

Recovery Staff In Attendance

SN ELIZABETH MCGUIGAN
 S/N GARY NASH
 SN PAUL COLE

Materials Used

<u>Item Code</u>	<u>Item Description</u>	<u>Qty</u>	<u>LOT1</u>	<u>LOT2</u>	<u>LOT3</u>	<u>LOT4</u>
1030413	HAND & TOE SET	1	1030413			
1053984	G400563 LARYNGEAL MASK SIZE 4, POUCH	1	1053984			

Operation Notes

Side : **LEFT** Op Notes Exc. Anterior lump

Procedures

G-S06800 OTHER EXCISION OF LESION OF SKIN OTHER SPECIFIED

excision cyst left tibial tuberosity
 longitudinal incision
 ?sebaceous cyst removed
 swab and specimen sent
 closed with nylon
 multilayer mepore dressing

POST OP

analgesia
 suggest dressing left intact
 sutures out with practice weeks
 NO ORTHO FF UP NEEDED
 Alternate Codes S068

Falkirk and District Royal Infirmary**Patient Details**

Hospital Number **F207472**
Patient Name **Dowell Scott**
Date of Birth **26/02/1980**
Sex **M**
Category Type
Patient Type **Day Case**
Operation Type **Scheduled**
Date of Operation **22/01/2011**
Theatre **FRI 1/FVR12**
Confirmed By
Procedure Definitions **LEFT, KNEE**

COPY

****** End of Report ******

PART A + B COMBINED DOCUMENT

COPY

Surname:				
Forename:				
Address:				
Postcode:				

PATIENT DETAILS				
Title:	Mr	Mrs	Miss	
	Ms	Dr		
DOB:				
Age:				
CHI No/				
Patient ID:				
Tel No:				

NEXT OF KIN DETAILS			
Next of Kin:	DIANNE	Alt. Next of Kin	
Relationship:	Wife	Relationship:	
Address:		Address:	
Tel:	262719	Tel No:	
Other Family Member Details:			
Name of Relative/		Present on Admission?	Y/N
Carer:		Contacted?	Y/N
		Tel No:	

GP	
Name:	Dr Dundas
Practice:	HIC Kersiebank Ave
Address:	
Postcode:	

Date of Attendance:	Date of Incident/Onset
	PRESENTING COMPLAINT

1	
2	
3	
Triggers: ☐ Drugs ☐ Latex ☐ Metal ☐ Food ☐ Nil known	Alert High Risk Factors:

Named Consultant:

Named Nurse:

SPECIAL REQUIREMENTS	YES	NO	ACTION
Translation Service			
Visual Impairment			
Hearing Impairment			
Learning Disability			
Neck Breather			
Requires assistance with ADLs			
Other relevant information:			
Date	Time	Signature	

Pt

COPY

Practitioners name: Geeta PonnuruSpecialty: Gen SurgeryGrade: CT2Patient age: 31Date: 11 / 12 / 11Time: 21:48Location: A&E

PRESENTING COMPLAINT	Perianal abscess
BACKGROUND Including HISTORY OF PRESENTING COMPLAINT	31, the 10 1/2 hrs of perianal swelling + pain. → Today pain got worse & difficult to lie on back & sit down → Feeling unwell (generally) → Opening bowel normally. No blood in stool → Not diabetic → NO previous hx of abscess.
Previous Medical History	☐ IHD ☐ TIA ☐ Stroke ☐ Diabetes Mellitus ☐ MI ☐ COPD ☐ Hypertension ☐ Asthma Other: Excision of cyst from (L) knee, neck, back. & (R) upper limb bone & plate insertion.

COPY

[illegible]

By: Date:

Pt. Nai

COPY

Can All Practitioners adding to document please sign /date / time each entry

Family History	☐ IHD / MI ☐ Asthma ☐ Diabetes Mellitus ☐ Cancer ☐ Hypertension ☐ Stroke / TIA Other:
Social History	Occupation: Lives with: <i>partner</i> Support/carers ☒ Smoker (Amount per day <i>20</i>) ☐ Ex Smoker (Since.....) ☐ Never Smoked ☒ Alcohol (Units per week) <i>10-15</i> Normal Exercise Capacity: ADLs:
Systems Review	CVS RESP. GI GU CNS
Examination	Weight : kg Height: m BMI:
General	
Obs	Temp: <i>36.0°C</i> Heart Rate: <i>78</i> Resp Rate: <i>16</i> BP _{supine} : <i>124/69</i> BP _{erect} : SpO ₂ <i>98%</i> (FiO ₂ <i>air</i>) Anaemia Y/N Clubbing Y/N Cyanosis Y/N Jaundice Y/N Cervical Lymphadenopathy Y/N Blood Sugar: MEWS SCORE :

Pt:

ressograph

COPY

CVS	JVP Apex Heart Sounds <i>1+1+1+1+1</i> Oedema <i>—</i> Neck Bruit Y / N Peripheral Pulses
Respiratory	Trachea: Expansion: Percussion: Breath Sounds:
Abdomen	Liver: Kidneys: Spleen: Bowel sounds: Rectal examination: <i>did not tolerate PR.</i>
OTHER (eg. face, limbs, trunk, skin)	

Pt Name / CHI / Addressograph

COPY

NEURO

Cranial nerves:

Cerebellar:

Reflexes	B	T	S	K	A	Plantars	Clonus
L							
R							

CNS Exam

Limb	R arm	L arm	R leg	L leg
Tone				
Power				
Sensation				
Co-ordination				

Abbreviated Mental Test Score (AMTS)

How old are you (exact age only)?

What is your date of birth?

What place is this?

What year is it?

A score of 3 or less warrants further investigation

Glasgow Coma Scale

Best Eye Opening

Best Motor Response

Best Verbal Response

Score

X-ray / ECG Interpretation

CXR

AXR

ECG Interpretation

Urinalysis

Pt Name / CHI / Addressograph

COPY

IMPRESSION/ DIFFERENTIAL DIAGNOSIS	① Penanal abscess	
INITIAL MANAGEMENT PLAN	plan → Bloods → Home → To return to OSU tomorrow for It 0 penanal abscess + EUA. → Analgesia. <i>[Signature]</i> Ponnuruvelu 1093 CT2	
Investigations PLEASE TICK BOX IF REQUESTED	☐ FBC ☐ ESR ☐ Clotting Factors ☐ U&Es ☐ LFTs ☐ Glucose ☐ Calcium ☐ Ohc Troponin Date/Time..... ☐ 12 hr Troponin Date/Time.....	☐ CRP ☐ ABG ☐ Blood Cultures ☐ CXR ☐ ECG ☐ HCG ☐ Positive ☐ Negative ☐ Urinalysis ☐ ☐
IV Cannula Insertion/ Removal Record	Ward Date Inserted By Size / Colour Batch No Insertion Site Removed By Date	
DVT Prophylaxis	DVT Prophylaxis Indicated ☐ Yes ☐ No Any Contraindications to this? ☐ Yes ☐ No Prescribed? ☐ Yes ☐ No	

Pt Name / CHI / Addressograph

COPY

Resus Status

Following discussion with patient/family please indicate

PLEASE COMPLETE & ATTACH NHS FV DNAR FORM

Following discussion with patient/family please indicate

PLEASE COMPLETE & ATTACH NHS FV DNAR FORM

Practitioner Signature Date/Time

PRINT NAME : SIGNATURE:
BLEEP NO:
DATE / TIME:

PRINT NAME : SIGNATURE:
BLEEP NO:
DATE / TIME:

PRINT NAME : SIGNATURE:
BLEEP NO:
DATE / TIME:

Family Dialogue

[illegible][illegible]

Pt Name / CHI / Addressograph

COPY

[illegible]

Pt Name / CHI / Addressograph

COPY

Senior Clinician Patient Management Plan

<48 hrs ☐

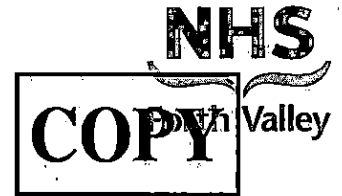
>48 hrs ☐

Consultant

Please sign and date at end of each entry

Date Time	Problem No	Clinical Problem List / Background	Recommendations/ Desired Outcomes and Actions	Complete Sign & date

Pt Name / CHI / Addressograph



Senior Clinician Patient Management Plan

EDD:

<48 hrs ☐

>48 hrs ☐

Consultant

Please sign and date at end of each entry

Date Time	Problem No	Clinical Problem List / Background	Recommendations/ Desired Outcomes and Actions	Complete Sign & date

Pt Name / CHI / Addressograph

COPY

[illegible]

Pt Name / CHI / Addressograph

COPY

Nursing Intervention

Pressure Area Assessment

Pressure Areas Intact Yes ☐ No ☐

Absolute Risk (Score 2)

Unconsciousness
Dehydration
Paralysis

Relative Risk (Score 1)

Age >70yrs
Restricted mobility
Incontinence
Pronounced Emaciation
Redness over bony prominences

Score (Circle)

Low 0

Medium 1

High 2

Intervention

Pain Score

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Analgesia Given Yes ☐ No ☐

Effect of analgesia

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Belongings ☐ With patient ☐ Family ☐ Safe ☐ Bagged ☐ Labeled

Own Medication ☐ Yes ☐ No

Name band ☐ Yes ☐ No

Patient Fasted Food ☐ Yes ☐ No

Food Time **Drink Time**

Relatives with Patient ☐ Yes ☐ No ☐ Informed

Named Nurse:

..... **Time/Date:**

Signature:

STIRLING ROYAL INFIRMARY - THEATRE CARE PLAN

T 9889

N CHI 2602800570
A CHN: F207472 26/02/1980
DOWELL SCOTT
11 DON STREET
GRANGEMOUTH
FK3 8HD
UNIT NUMBER

PROCEDURE *Incision and drainage of Penicilline abscess*
Consultant *Mr Shearer*
For *Dr Tarmyik*
SURGEON
Signature
12/12/11
DATE
Elect- *OP*
EM

Procedure Start *13:05* GA ☒ LA ☐
Closure Time *13:18*
Exit Th Time *13:21*
Blood Loss
Urine Output

SPEC *YES* / NO NUMBER. *ix Backenology*
TEAM LEADER *Dr Llyer*
Radiographer

LOTIONS
Chlorhexidine/Spirit Betadine Antiseptic Methylene Blue
Tisept Chlorhexidine/Water Acetic Acid 5% Aqueous Iodine

NURSING COMMENTS

IRRIGATION FLUID/ANTIBIOTIC

WOUND INFILTRATION (LA)

drops/oint.

Given by: *N/A*

	TYPE	SIZE	POSITION
PACKS			
Drain			
Chest Drain			
Stent - Ureteric Cath			
Catheter			Balloon Amt.
Catheterised by:			

BONE BANK No.

WEDGE/PILLOW

Sling

Splint

Other

SKIN CLOSURE
DRESSING*Aquacell, Bluesnaps mem left*

Th WATERLOW SCORE

SURGEONS INSTRUCTIONS

home to clinic when ready

Sutures Out

Appt.

DATE	TH No	AM	PM	CP No
se/Em No	PRE-OP	TOTAL		INSTRUMENT/TRAYS Adhere tray batch numbers by item name
ABS 10 x 10	10	15		ABSCISS & TOE NAIL TRAY ID 1009129 LOT 00149 User Code 1612003
5 x 5				1400456 LARYNGE MASK SIZE4 ID 1059335 LOT 00001 User Code KEY5073496
PACKS (abd 30 x 30)				
CAESAREAN ROLLS				
PLEDGES				
NEEDLES	1	1		
BLADES				
SLINGS				
OTHER				

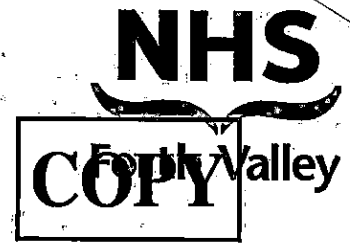
1 - Scrub Person
2 - Scrub Person

1st Count Circ Person
FINAL Count Circ Person

Signature of person/s completing careplan

*Thoyel**Anne Yell*

ING372



Score	0-1	Routine observation - state frequency
	2-3	Inform nurse in charge and initiate appropriate treatment

Definition

- **S**ituation
- **B**ackground
- **A**ssessment
- **R**ecommendations

```
graph TD
    A[Early Warning Score 4 or 5  
or concern with a patients condition] --> B[Inform Nurse in Charge Immediately  
Contact FYI / ANP for review within 20 minutes  
Initiate Treatment / Intervention]
    B --> C[FYI / ANP unable to provide  
review / treatment within  
20 minutes]
    B --> D[No improvement  
despite 20 minutes  
of treatment]
    C --> E[Call appropriate Middle Grade for immediate review]
    D --> E
    F[Early Warning Score 6 or more  
or rapidly deteriorating patient] --> E
    E --> G[Patient re-assessed and treatment initiated]
    G -- NO --> H[MG unable to attend within 20  
minutes or EWS increases]
    G --> I[Patients clinical condition / score improves within 60 minutes]
    I -- NO --> J[Call appropriate Consultant]
    I --> K[Continue treatment and EWS scoring as required]
    H --> J
    J --> L[Consider Critical Care referral  
if score increasing despite  
Consultant treatment plan]
```

Management Plan / Patient Exclusions

[illegible]

EWS KEY 0 1 2 3 4 EWS 0-1: Routine Observation - state frequency 2-3: Inform Nurse in Charge 4 or above: Inform Doctor

DATE: 10/01/11		TIME: 2110	
Is Patient ≥70?			
RESP. RATE	>30		
	26-29		
	21-25		
	9-20	16	
	≤8	48	
SpO ₂	≥94	98	
	92-93		
	86-91		
	<86		
O ₂ Device or Air	refer to key		
O ₂ Flow or Rate			
pt on O ₂ with SpO ₂	<95		
	39°		
	38°		
	37°		
	36°		
	35°		
	34°		
	210		
	≥200		
	190		
	180		
	170		
	160		
	150		
	140		
	130	120	
	120	110	
	110		
	100		
	90		
	80		
	70		
	60		
	50		
	>170		
	160		
	150		
	140		
	130		
	120		
	110		
	100		
	90		
	80	78	
	70		
	60		
	50		
	40		
	30		
NEURO RESPONSE	Alert	✓	
	Verbal		
	Pain		
	Unresponsive		
EWS SCORE (with all obs)			
Blood Glucose	4.6		
PAIN (guidance for scoring and management overleaf)	No pain		
	Mild		
	Moderate		
	Severe	✓	
Nausea Score 0-3			
Initial			

COPY

CODES FOR RECORDING OXYGEN DELIVERY ON OBSERVATION CHART

A Air (not requiring oxygen, or weaning or on "PRN" oxygen)
 N Nasal cannulae
 SM Simple mask
 V24 Venturi 24% V28 Venturi 28% V35 Venturi 35%
 V40 Venturi 40% V60 Venturi 60%

H28 Humidified oxygen at 28%
 (also H35, H40, H60 for humidified oxygen at 35%)
 RM Reservoir mask
 TM Tracheostomy mask
 CP Patient on CPAP system

ly observations See flow chart overleaf and monitor patient

COPY

>30
26-29
21-25
9-20
≤8
≥94
92-93
86-91
<86
refer to key
<95
39°
38°
37°
36°
35°
34°
210
>200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
>170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
Alert
Verbal
Pain
Unresponsive
EWS
Blood Glucose
No pain
Mild
Moderate
Severe
Nausea Score 0-3
Initial

60%)

NIV Patient on NIV system
OTH Other device:
(specify which)

Name:
DOB:
Chi No:
Address:

Conscious Level Chart (only as required for head injury observation)

DATE:																			DATE:		
TIME:																			TIME:		
COMA SCALE	Eyes Open	Spontaneously	4																	Eyes closed by swelling = C	
		To speech	3																		
		To pain	2																		
		None	1																		
	Best verbal response	Orientated	5																	Endotracheal tube or tracheostomy = T	
		Confused	4																		
		Inappropriate words	3																		
		Incomprehensible sounds	2																		
		None	1																		
	Best motor response	Obey commands	6																	Usually record the best arm response	
		Localise pain	5																		
		Withdraws to pain	4																		
Flexion to pain		3																			
Extension to pain		2																			
None		1																			
1 2 3 4 5 6 7 8 Pupil Scale (mm)																					
PUPILS	right	Size Reaction																	+ reacts - no reaction c. eye closed		
	left	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																			
	LEGS	No response																			
		Normal power																			
		Mild weakness																			
		Severe weakness																			
		Extension																			
		No response																			

Pain Assessment and Management Guidelines

Pain Score:

No pain

Mild = No Pain at Rest

Slight Pain on Movement

Moderate = Intermittent Pain at Rest

Moderate Pain on Movement

Severe = Continuous Pain at Rest

Nausea Score (0-3):

0 = No nausea or vomiting

1 = Nausea only

2 = Vomiting once

3 = Vomiting more than once

For Acute and Chronic Pain:

For mild, moderate or severe pain refer to Pain Management Guidelines Forth Valley Formulary Appendix 27 & 28

Implement Pain Assessment Chart.

For Cancer Related Pain:

For a mild, moderate or severe pain score, refer to Palliative Guidelines.

ACCIDENT AND EMERGENCY INTERIM REPORT

COPY

Patient Name

DOWELL, SCOTT

Date Of Birth

26/02/1980

Sex

M

Address

11 Don St
Grangemouth

Unit Number

2602800570

Location

Emergency Centre FVRH

Consultant

Dr Keith Jacques

Lab Number

HR055558S

Date Requested

11/12/2011

Haemoglobin	161	g/l	(133 - 177)
White Blood Count	8.7	10 ⁹ /l	(3.9 - 10.6)
Platelet Count	179	10 ⁹ /L	(150 - 440)
Red Blood Count	5.49	10 ¹² /l	(4.4 - 5.9)
Packed Cell Volume	0.486		(0.40 - 0.52)
Mean Cell Volume	88.5	fl	(81 - 100)
Mean Cell Haemoglobin	29.3	pg	(26.6 - 33.8)
Mean Cell Haemoglobin Conc.	33.1	g/dl	(31.4 - 36.3)
Neutrophil Count	5.20	10 ⁹ /l	(1.8 - 7.7)
Lymphocyte Count	2.60	10 ⁹ /l	(1.0 - 4.8)
Monocyte Count	0.60	10 ⁹ /l	(0.0 - 0.8)
Eosinophil Count	0.20	10 ⁹ /l	(0.0 - 0.45)
Basophil Count	0.00	10 ⁹ /l	(0.0 - 0.20)

Please put Consultant or GP name Clearly on Form. Thank You.

Date And Time Reported 11/12/2011 22:04

Interim Report Of Urgent Results. Discard On Receipt Of Permanent Report.

COPY

ACCIDENT AND EMERGENCY INTERIM REPORT

COPY

Patient Name

DOWELL, SCOTT

Date Of Birth

26/02/1980

Sex

M

Address

11 Don St
Grangemouth

Unit Number

2602800570

Location

Emergency Centre FVRH

Consultant

Dr Keith Jacques

Lab Number

BB695088P

Date Requested

11/12/2011

Sodium	140	mmol/l	(135 - 145)
Potassium	4.7	mmol/l	(3.5 - 5)
Chloride	104	mmol/l	(97 - 107)
Urea	3.7	mmol/l	(2.5 - 8)
Creatinine	90	umol/l	(60 - 130)
eGFR (/1.73m2)	>59	ml/min	
AST	19	iu/l	(12 - 31)
ALT	25	iu/l	(11 - 37)
Bilirubin	9	umol/l	(0 - 17)
Total Protein	79	g/l	(62 - 80)
Albumin	45	g/l	(36 - 52)
Alk. Phosphatase	280	u/l	(0 - 270)
C-Reactive Prot.	33	mg/l	(0 - 5)

Date And Time Reported

11/12/2011 22:30

Interim Report Of Urgent Results. Discard On Receipt Of Complete Cumulative Report.

COPY

ACCIDENT AND EMERGENCY INTERIM REPORT

COPY

Patient Name

DOWELL, SCOTT

Date Of Birth

26/02/1980

Sex

M

Address

11 Don St
Grangemouth

Unit Number

2602800570

Location

Emergency Centre FVRH

Consultant

Dr Keith Jacques

Lab Number

BB695087W

Date Requested

11/12/2011

Glucose 5.0 mmol/l (3.3 - 5.5)

Date And Time Reported

11/12/2011 22:25

Interim Report Of Urgent Results. Discard On Receipt Of Complete Cumulative Report.

COPY

Accident and Emergency Department Forth Valley Royal Hospital

Day Surveys
pleas?



2602800570

A&E No. 11000024151

F207472

COPY
4

Surname	Dowell	Forename	Scott	Title: MR
Address:	11 DON STREET, GRANGEMOUTH	Postcode	FK3 8HD	CHI No: 2602800570
		Telephone:	262719	
Date of Birth:	26.02.80	Sex:	M	Age: 31 yrs



CHI Number: 2602800570

GP Name:	DUNDAS DEREK			
Address:	THE HEALTH CENTRE KERSIEBANK AVENUE GRANGEMOUTH STIRLINGSHIRE	Postcode	FK3 9EL	
		Telephone:		

Next of Kin	DIANNE			
Relationship:	WIFE			
Address:	11 DON STREET, GRANGEMOUTH	Postcode	FK3 8HD	
		Telephone:	262719	

Manual CHI Entry:

Date of Attendance: 11.12.11 17:27

Date of Incident:

Presenting Complaint: ? ABCESS

Apparhet
made at 004
1935

ge	MILD PAIN (<4 ON 1-10 SCALE; MINIMALLY DISABLING) ABCESS ON PERITENEUM 2/7 AGO INCREASE OVER LAST 2 DAYS, NO ANALGESIA TAKEN TEMP 36.7 BP 98/ 54 P 90	Tetanus Cover: Allergies:
P=	BP= /	RR=
PF=	GCS=E: M: V: Total:	Sat= BM=

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time

Clinical Notes

[illegible]

COPY

Attach continuation sheets here

Attach here onto face of pocket

Guidelines Used:

NHS FORTH VALLEY ACUTE OPERATING DIVISION
ADULT SURGICAL AMBULATORY CARE PRESCRIPTION CHART

Patient Name DOB Unit No Allergies/sensitivities

DATE	DRUG	ROUTE	DOSE	ADMINISTRATION TIMES ON DAY OF OPERATION				NURSES SIGNATURE FOR ADMINISTRATION				Dr's signature if required for discharge
				Pre-op A	B	C	D	A	B	C	D	
2.12.14	AS PER DSU PGD											
	Paracetamol	PO	1g		1500				JML			J
	Ibuprofen	PO	400mg		1500				JML			J
	Dihydrocodeine	PO	30 to 60mg									J
	Ranitidine single dose	PO	150mg									

Nursing Staff: Drugs supplied on discharge

DATE	DRUG	ROUTE	DOSE AND DIRECTIONS	FURTHER DOSES DUE AT:	BATCH NUMBER	QUANTITY	NURSE SIGNATURE	REASON NOT SUPPLIED:
12/12/14	Paracetamol 500mg Tablets	PO	Two tablets 4-6 hourly. No more than 8 in 24 hours	7 PM	684A	32	JML RA	
12/12/14	Ibuprofen 400mg Tablets	PO	One tablet 6-8 hourly With or after food	9 PM	721062	24	JML RA	
12/12/14	Dihydrocodeine 30mg tablets	PO	One or Two tablets 4-6 hourly. Max 8/24 hours		8377	30	JML RA	

- It is common for even minor surgery to cause you some pain and discomfort for a few days.
- It is important for you to take painkillers regularly for 3 days after your operation to reduce the pain.
- If pain persists, or is not controlled by the painkillers you have been given, contact DSU x4430 at SRI, x 5861 at DERI or your G.P.

COPY

COPY

Accident and Emergency Department Forth Valley Royal Hospital



2602800570

A&E No. 1 000024151

COPY
4

Surname: Dowell	Forename: Scott	Title: MR
Address: 11 DON STREET, GRANGEMOUTH	Postcode: FK3 8HD	CHI No: 2602800570
	Telephone: 262719	
Date of Birth: 26.02.80	Sex: M	Age: 31 yrs



CHI Number: 2602800570

GP Name: DUNDAS DEREK		
Address: THE HEALTH CENTRE KERSIEBANK AVENUE GRANGEMOUTH STIRLINGSHIRE	Postcode: FK3 9EL	
	Telephone:	

Next of Kin: DIANNE		
Relationship: WIFE		
Address: 11 DON STREET, GRANGEMOUTH	Postcode: FK3 8HD	
	Telephone: 262719	

Manual CHI Entry:

Date of Attendance: 11.12.11 17:27

Date of Incident:

Presenting Complaint: ? ABCESS.

Age	MILD PAIN (<4 ON 1-10 SCALE; MINIMALLY DISABLING) ABCESS ON PERITENEUM 2/7 AGO INCREASE OVER LAST 2 DAYS, NO ANALGESIA TAKEN TEMP 36.7 BP 98/ 54 P 90	Tetanus Cover: Allergies:
P=	BP= /	RR=
		Sat=
PF=	GCS=E: M: V: Total:	BM=

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time

COPY

Contact sheet for Registered Patient

19 30

IHS 24 Calls 0 Walk in Calls 4		PCC: Falkirk		FOR PRACTICE	
Call Number: 0000612542	Date: 11/12/2011	Time: 18:40	Passed:	Received by: thannah	
Patients Present Location		Patient Home Details (2602800576)			
Address: 11 DON ST GRANGEMOUTH FK3 8HD		Name: SCOTT MCWHIRTER Address: 11 DON ST Town: GRANGEMOUTH Postcode: FK3 8HD Sex: M DOB: 26/02/1980 Age: 31 years old Contact: Contact Phone Number:			
Registered GP Details (at time of call)					
Dr Name: DUNDAS, DEREK					
Practice: Group Medical Practice (25563)					
Script No: V55085					
Complaint: Peritoneum abscess					
Started:	Status:	Visit: ☐	Tel: ☐	Attend: ☐	Canc: ☐
Urgency: Within 4 Hours	Visited: ☐	Date:	Time:	Attended: ☐	DNA: ☐
Information To Practice					

COPY

Ischio rectal abscess Unable to sit

Pyrexia 38° tachycardia 120 BP 100/60

OE Tense extremely tender (R) ischio rectal area

Diagnosis: Ischio rectal abscess		Drugs				
Outcome		Name	Form	Strength	No	Category
Death/Presume Life Extinct ☐ GP to Certify ☐ Call Complete ☐ No Further Action ☐ Refer To: Dept: When: Where: Patient to contact GP ☐						
Review by IP: ☐						
Consultation 1: Date Start Time Finish Time		Consultation 2: Date Start Time Finish Time				
Signature Print		Date Time				

11/12/2011

TayCare

COPY

Medication Reconciliation completed by medical staff within 24 hours of admission	
Sign	Date

Other Charts in use (Please tick)	Insulin	Anticoagulant	Pain	Additional Kardex	Other
---	---------	---------------	------	----------------------	-------

FORTH VALLEY ACUTE SERVICES

MEDICATION PRESCRIPTION & ADMINISTRATION RECORD SHEET

COPY

WARD	CONSULTANT	PATIENT DET
ALLERGIES	N K D A (Please circle if appropriate)	
(one of these boxes must be filled in)		HOSPITAL No
☐ Initial here when informed verbal consent to use/destroy P.O.D.'s is received from the patient.		DATE OF BIRTH: AGE:

Drugs administered prior to hospital arrival

Date	Approved Drug Name	Dose	Route	Given by (e.g. SAS, GP)	Time given

ONCE ONLY MEDICATION

PHARMACY	DATE	APPROVED DRUG NAME	DOSE	ROUTE	TIME/INSTRUCTIONS	DR SIGNATURE	GIVEN BY	TIME GIVEN
	11/12/11	TRAMADOL	50mg	PO	2145	[Signature]		
	11/12/11	DICLOFENAC	50mg	PO	2145	[Signature]	[Signature]	2150

INSTRUCTIONS FOR USING THIS SHEET

- Doctors and Nurses must ONLY write in black ink (except for allergies) - Pharmacists must ONLY use <i>green ink</i> - Use the approved drug (RINN) name and write in BLOCK CAPITALS - Enter the specified times and write additional information in the instruction box. - ONLY use the listed abbreviated routes of administration. Where the abbreviation is not listed, write the route in full. - Dose must be stated in either metric or SI units. Quantities less than 1mg must be written in full eg. micrograms. - To cancel a drug draw a diagonal line through the entire entry, initial and date. - TWO nurses must initial each drug administration for ALL Parenteral and Paediatric Medicine. - When a drug is not given - enter the not given code (see list). - ALL of the above MUST be adhered to	ROUTES IV - intravenous IM - intramuscular SC - subcutaneous PO - oral INH - inhaled NEB - nebulised SL - sublingual PR - by rectum PV - by vagina TOP - topical	NOT GIVEN CODES 1. Patient not on ward 2. Patient unable to take 3. Patient vomited 4. Drug not available 5. Drug not required 6. Given > 30 mins late (state time) 7. Patient allergy 8. Patient refused 9. Withheld - medical indication 10. Given by Patient/relative/carer
--	---	---

NAME:

Unit No:

2

General Medication Oral and other routes (regular)

(General Medication starts at page 2 and works forward. Parenteral Medication starts at page 4 and works forward)

- enter dosage times as 24hour clock
- please write in block capitals
- please write in black pen

- Maximum of 3 continuation sheets
- please ensure patient details are on each sheet.

COPY

ALLERGIES - Please use RED INK

N K D A (Please circle if appropriate)

DATE →

TIME ↓

(one of these boxes must be filled in)

Drug OXYGEN

Circle target oxygen saturation:

88-92% 94-98% Other _____

Starting device/flow rate _____

PRN/continuous (refer to O₂ guideline)

Tick here if saturation not indicated* ☐

Date and signature

Print name

APPROVED DRUG NAME

DOSE

ROUTE

INSTRUCTIONS

Clin Pharm.

Reg/New

Date stopped

SIGNATURE

DATE

Reason for stopping

APPROVED DRUG NAME

DOSE

ROUTE

INSTRUCTIONS

Clin Pharm.

Reg/New

Date stopped

SIGNATURE

DATE

Reason for stopping

APPROVED DRUG NAME

DOSE

ROUTE

INSTRUCTIONS

Clin Pharm.

Reg/New

Date stopped

SIGNATURE

DATE

Reason for stopping

APPROVED DRUG NAME

DOSE

ROUTE

INSTRUCTIONS

Clin Pharm.

Reg/New

Date stopped

SIGNATURE

DATE

Reason for stopping

APPROVED DRUG NAME

DOSE

ROUTE

INSTRUCTIONS

Clin Pharm.

Reg/New

Date stopped

SIGNATURE

DATE

Reason for stopping

SUPPLY

SUPPLY

SUPPLY

SUPPLY

SUPPLY

SUPPLY

SUPPLY

NAME:

Unit No:

3

General Medication Oral and other routes (regular)

(General Medication starts at page 2 and works forward. Parenteral Medication starts at page 4 and works forward)

- enter dosage times as 24hour clock
- please write in block capitals
- please write in black pen.

- Maximum of 3 continuation sheets
- please ensure patient details are on each sheet

COPY

ALLERGIES - Please use RED INK

N K D A (Please circle if appropriate)

DATE →

(one of these boxes must be filled in)

TIME ↓

POD	SUPPLY	APPROVED DRUG NAME			DOSE	ROUTE	DATE	TIME
		INSTRUCTIONS			Clin Pharm.	Reg/New		
		APPROVED DRUG NAME			DOSE	ROUTE		
		INSTRUCTIONS			Clin Pharm.	Reg/New		
		SIGNATURE			DATE	Reason for stopping		
		APPROVED DRUG NAME			DOSE	ROUTE		
		INSTRUCTIONS			Clin Pharm.	Reg/New		
		SIGNATURE			DATE	Reason for stopping		
		APPROVED DRUG NAME			DOSE	ROUTE		
		INSTRUCTIONS			Clin Pharm.	Reg/New		
		SIGNATURE			DATE	Reason for stopping		
		APPROVED DRUG NAME			DOSE	ROUTE		
		INSTRUCTIONS			Clin Pharm.	Reg/New		
		SIGNATURE			DATE	Reason for stopping		
		APPROVED DRUG NAME			DOSE	ROUTE		
		INSTRUCTIONS			Clin Pharm.	Reg/New		
		SIGNATURE			DATE	Reason for stopping		
		APPROVED DRUG NAME			DOSE	ROUTE		
		INSTRUCTIONS			Clin Pharm.	Reg/New		
		SIGNATURE			DATE	Reason for stopping		
		APPROVED DRUG NAME			DOSE	ROUTE		
		INSTRUCTIONS			Clin Pharm.	Reg/New		
		SIGNATURE			DATE	Reason for stopping		
		APPROVED DRUG NAME			DOSE	ROUTE		
		INSTRUCTIONS			Clin Pharm.	Reg/New		
		SIGNATURE			DATE	Reason for stopping		

NAME:	Unit No:
-------	----------

Parenteral Medication (Regular)

(General Medication starts at page 2 and works forward. Parenteral Medication starts at page 4 and works forward)

- enter dosage times as 24hour clock
- please write in block capitals
- please write in black pen

- Maximum of 3 continuation sheets
- please ensure patient details are on each sheet
- IV site MUST be checked prior to and after all IV administration.

COPY

ALLERGIES - Please use RED INK	N K D A (Please circle if appropriate)	DATE
(one of these boxes must be filled in)		TIME

APPROVED DRUG NAME	DOSE	ROUTE
		IV
INSTRUCTIONS/ADMINISTER OVER	Clin Pharm.	Reg/New
for flush		
	Date stopped	

SIGNATURE	DATE	Reason for stopping

APPROVED DRUG NAME	DOSE	ROUTE
INSTRUCTIONS/ADMINISTER OVER	Clin Pharm.	Reg/New
	Date stopped	

SIGNATURE	DATE	Reason for stopping

APPROVED DRUG NAME	DOSE	ROUTE
INSTRUCTIONS/ADMINISTER OVER	Clin Pharm.	Reg/New
	Date stopped	

SIGNATURE	DATE	Reason for stopping

APPROVED DRUG NAME	DOSE	ROUTE
INSTRUCTIONS/ADMINISTER OVER	Clin Pharm.	Reg/New
	Date stopped	

SIGNATURE	DATE	Reason for stopping

APPROVED DRUG NAME	DOSE	ROUTE
INSTRUCTIONS/ADMINISTER OVER	Clin Pharm.	Reg/New
	Date stopped	

SIGNATURE	DATE	Reason for stopping

APPROVED DRUG NAME	DOSE	ROUTE
INSTRUCTIONS/ADMINISTER OVER	Clin Pharm.	Reg/New
	Date stopped	

SIGNATURE	DATE	Reason for stopping

APPROVED DRUG NAME	DOSE	ROUTE
INSTRUCTIONS/ADMINISTER OVER	Clin Pharm.	Reg/New
	Date stopped	

SIGNATURE	DATE	Reason for stopping

NAME:	Unit No:
-------	----------

5

PHARMACY USE ONLY

Parenteral Medication (Regular)

(General Medication starts at page 2 and works forward. Parenteral Medication starts at page 4 and works forward)

- enter dosage times as 24hour clock
- please write in block capitals
- please write in black pen

- Maximum of 3 continuation sheet
- please ensure patient details are on each sheet
- IV site MUST be checked prior to and after all IV administration.

COPY

ALLERGIES - Please use RED INK		N K D A (Please circle if appropriate)		DATE												
(one of these boxes must be filled in)				TIME												
APPROVED DRUG NAME		DOSE		ROUTE												
INSTRUCTIONS/ADMINISTER OVER		Clin Pharm.		Reg/New												
SIGNATURE		DATE		Reason for stopping												
APPROVED DRUG NAME		DOSE		ROUTE												
INSTRUCTIONS/ADMINISTER OVER		Clin Pharm.		Reg/New												
SIGNATURE		DATE		Reason for stopping												
APPROVED DRUG NAME		DOSE		ROUTE												
INSTRUCTIONS/ADMINISTER OVER		Clin Pharm.		Reg/New												
SIGNATURE		DATE		Reason for stopping												
APPROVED DRUG NAME		DOSE		ROUTE												
INSTRUCTIONS/ADMINISTER OVER		Clin Pharm.		Reg/New												
SIGNATURE		DATE		Reason for stopping												
APPROVED DRUG NAME		DOSE		ROUTE												
INSTRUCTIONS/ADMINISTER OVER		Clin Pharm.		Reg/New												
SIGNATURE		DATE		Reason for stopping												
APPROVED DRUG NAME		DOSE		ROUTE												
INSTRUCTIONS/ADMINISTER OVER		Clin Pharm.		Reg/New												
SIGNATURE		DATE		Reason for stopping												
APPROVED DRUG NAME		DOSE		ROUTE												
INSTRUCTIONS/ADMINISTER OVER		Clin Pharm.		Reg/New												
SIGNATURE		DATE		Reason for stopping												
APPROVED DRUG NAME		DOSE		ROUTE												
INSTRUCTIONS/ADMINISTER OVER		Clin Pharm.		Reg/New												
SIGNATURE		DATE		Reason for stopping												

POD SUPPLY

POD SUPPLY

POD SUPPLY

POD SUPPLY

POD SUPPLY

POD SUPPLY

POD SUPPLY

NAME:

Unit No:

6

As Required Medication Page All routes

(Prescribers MUST enter indication, dosage interval and maximum daily dose)

COPY

- enter dosage times as 24hour clock
- please write in block capitals in black pen

- Maximum of 3 continuation sheets
- please ensure patient details are on each sheet
- IV site MUST be checked prior to and after all IV administration.

ALLERGIES - Please use RED INK

N K D A (Please circle if appropriate)

DATE →

(one of these boxes must be filled in)

APPROVED DRUG NAME

DOSE

ROUTE

TIME

Symptomatic Relief Policy

GIVEN BY

TIME

INSTRUCTIONS

Clin Pharm.

Reg/New

GIVEN BY

Date stopped

TIME

GIVEN BY

SIGNATURE

DATE

Reason for stopping

TIME

GIVEN BY

APPROVED DRUG NAME

DOSE

ROUTE

TIME

LO-codamol 30/500 2 tabs po

GIVEN BY

TIME

INSTRUCTIONS

Clin Pharm.

Reg/New

GIVEN BY

Date stopped

TIME

GIVEN BY

SIGNATURE

DATE

Reason for stopping

TIME

GIVEN BY

APPROVED DRUG NAME

DOSE

ROUTE

TIME

GIVEN BY

TIME

INSTRUCTIONS

Clin Pharm.

Reg/New

GIVEN BY

Date stopped

TIME

GIVEN BY

SIGNATURE

DATE

Reason for stopping

TIME

GIVEN BY

APPROVED DRUG NAME

DOSE

ROUTE

TIME

GIVEN BY

TIME

INSTRUCTIONS

Clin Pharm.

Reg/New

GIVEN BY

Date stopped

TIME

GIVEN BY

SIGNATURE

DATE

Reason for stopping

TIME

GIVEN BY

APPROVED DRUG NAME

DOSE

ROUTE

TIME

GIVEN BY

TIME

INSTRUCTIONS

Clin Pharm.

Reg/New

GIVEN BY

Date stopped

TIME

GIVEN BY

SIGNATURE

DATE

Reason for stopping

TIME

GIVEN BY

PHARMACY USE ONLY

SUPPLY

SUPPLY

SUPPLY

SUPPLY

SUPPLY

7

PHARMACY USE ONLY.

COPY

- Maximum of 3 continuation sheets
- please ensure patient details are on each sheet
- IV site MUST be checked prior to and after all IV administration.

[illegible]

OXYGEN WEANING CHART

COPY

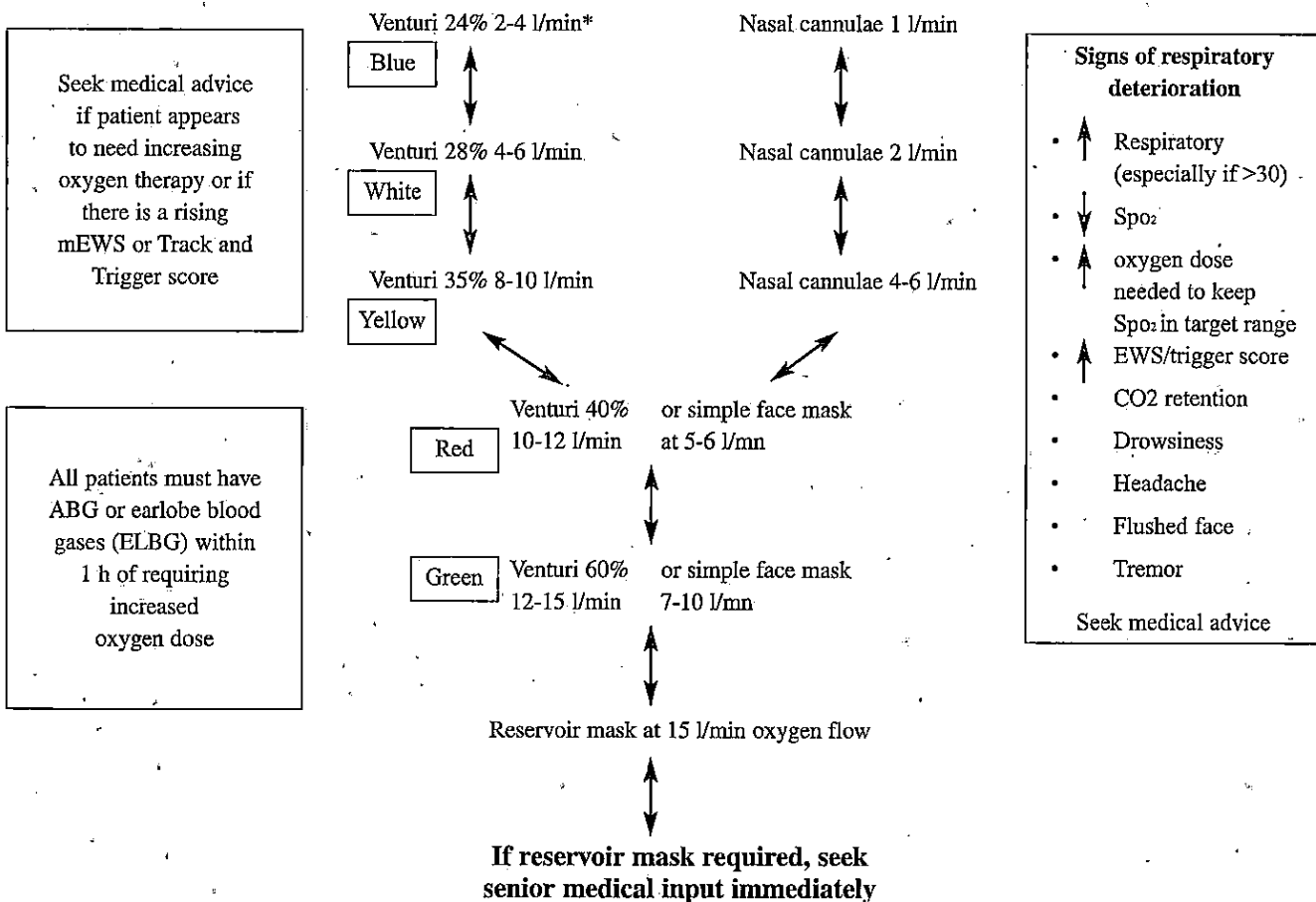
See patient's drug chart for starting dose and target saturation

Choose the most suitable delivery system and flow rate

Titrate oxygen up or down to maintain the target oxygen saturation

The table below shows available options for stepping dosage up or down. The chart does not imply any equivalence of dose between Venturi masks and nasal cannulae.

Allow at least 5 minutes at each dose before adjusting further upwards or downwards (except with major and sudden fall in saturation). Once your patient has adequate and stable saturation on minimal oxygen dose, consider discontinuation of oxygen therapy.



* For Venturi masks, the higher flow rate is required if the respiratory rate is >30

Patients in a peri-arrest situation and critically ill patients should be given maximal oxygen therapy via reservoir mask or bag-valve mask whilst immediate medical help is arriving (except for patients with COPD with known oxygen sensitivity recorded in patient's case notes and drug chart or in the EPR: keep saturation at 88-92% for this subgroup of patients)

Date 12/12/11	Ward DSU	Surname CH2802800570	 COPY
Procedure and side HD Abscess		First name CRN: F207472 26/02/1980 DOWELL SCOTT	
Surgeon		Unit No. 11 DON STREET, GRANGEMOUTH	
		Date of Birth FK3 8HD	

CHECKLIST ITEMS	WARD	HANDOVER CHECKS	BASELINE WARD CHECKS & DATA
Verbal Name Check	YES	✓	Pre-assessment Document
ID Band Checked	YES	✓	Present and Checked ☐
Pre-assess/clerking completed	n/a	NO	Any Changes? ABSCSS
Pregnant Yes / No	n/a	N/A	Temp 36.2 Weight (kg) --
Allergies (see baseline checks Yes / (No))	none	NO	P 90 BP 147/58
Consent / Incapacity completed	YES	✓	RR 16 SaO2 97%
Operation confirmed with patient	YES	✓	BM (Sugar) 119
Consent form corresponds to list	-	Emerg	Allergies ☒ No ☐ Yes
Operation site marked clearly	-	N/A	☐ Own Teeth ☒ Dentures top plate only
Nursing notes	YES	✓	Hb 161 Na 140
Case Notes (SRI, FDRI, Beatson)	no	✓	WCC 8.7 K 4.7 euvole
Drug Kardex	YES	✓	Platelet 79 U 3.7 759.
X-Rays (including angios etc)	n/a	N/A	Clotting Cr 90
XMatch / G&S form (Y or N/App)	n/a	N/A	G and S X-Match
Confirm all results available	n/a	✓	Thromboprophylaxis
Addressograph labels	YES	✓	☒ None ☐ GECS
Bone bank consent	n/a	N/A	☐ Aspirin ☐ Calf compression
Fasted for solids / milk from (time)	midnt	11/12	☐ Clexane
Fasted for clear fluids from (time)	midnt	11/12	
Bladder emptied (time or No)	once	✓	
Jewellery removed / taped	none	None	
Body piercings taped etc	none	NO	
Nail varnish / makeup removed	none	NO	
Contact lenses removed	none	NO	
Prosthesis (* or No)	NO	NO	
Orthopaedic implants (* or No)	X	Caern →	
Pacemaker (Yes or No)	NO	NO	
Hearing aid (Yes or No)	NO	NO	
Able to move by self on trolley	YES	YES	
Ward sign and designation Hraser			
Handover 1 sign and designation Deirdre JN			
Handover 2 sign and designation guyd			

Comments * (L) arm metal plate + 6 pins Diabetic YES/NO On Beta Blocker YES/NO If "YES" Taken YES/NO If not taken: Administered by Nursing Staff YES/NO	Items to Theatre No. of Pillows _____ Cot Sides _____ Bradford Sling _____ Charnley Wedge _____
--	--

RECOVERY CHART

Recovery Nurse

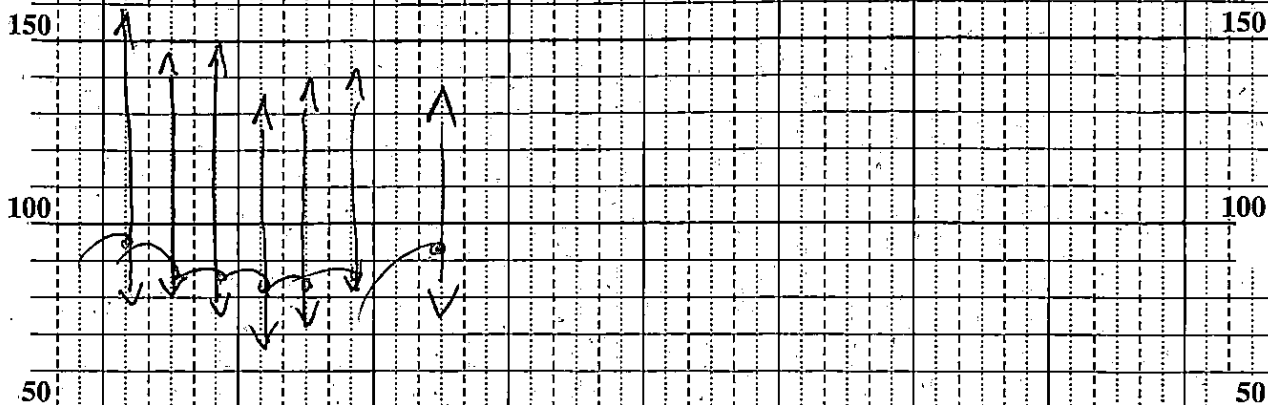
Marag Nayla sw

Operation Performed / Additional Notes

Incision and drainage of pen-and abscess

COPY

Airway	SM →	SM →	SM DSU						
O ₂ l/min	6 →	6	4	4	4	4	4	4	4
SpO ₂	98	98	99	98	98	99	97%		
Resp Rate	18		12			14			
Temp	36.6								
BM	N/A								200
TIME	13	13	14						
	20	25	30	35	40	45	50	55	



A line ☐

Site:-

CVP ☐	0	5	5						0
Analgesic Drugs		F	F						
Sedation Score	1/2	1	1	0/1	0	0			
Pain Score	0	0	2	2	1	0			
Nausea Score	0	0	0	0	0	0			
Wound Site	0		0			0			
Drains	N/A								
NG Tube	N/A					N/A			
Cannula/IVI/Pump	20g	④	hand			→			
Spinal / Epidural	N/A					N/A			
C/S/M	N/A					N/A			
Patient Position	semi-rec		semi-rec			→			
Urinary Catheter	N/A					N/A			
Pressure Areas	not seen					not seen			

Discharge to (ward) DSU

Criteria Met ☒ Time 13⁵⁵

Signed M. N. (NAYLA) sw

M = Morphine mg

F = Fentanyl mg

Patient Valuables

- 1 Dentures Full ☐ Partial ☐
- Glasses ☐
- Hearing Aid ☐
- None ☐
- Other TRAINERS

Nursing notes ☒

Case notes ☒

Op notes ☒

X-Rays ☐

Recovery Sign Ward Sign

Post-operative instructions

Analgesia Recovery

IV Morphine up to _____ mg

IV Fentanyl up to 300 µg

Anti-emetic

- ☒ Cyclizine 50mg IV
☐ Granisetron 1mg IV
☒ Prochlorperazine 12.5mg IM

COPY

- ① 1330WS 50mcg IV fentanyl PIN/VA
② 1336 50mcg IV fentanyl PIN/VA

Analgesia Ward

☐ Regular oral analgesia as prescribed

Oxygen - in recovery follow protocol thereafter

..... L/Min via nasal cannula

..... L/Min via facemask

IV Fluids

☐ as charted

☒ Cap off

☐ Oral

Other Care

☐ Routine

Investigations required

☐ Recovery

☐ Ward

FBC
U&E
ABG
CXR
ECG

Signed _____

IV Cannula / Removal Record

Name: SCOTT POWELL Ward: DS4
Inserted by: DR WATKINS Date: 12/12/14
Size / Colour: 20G PINK Batch No: _____
Insertion Site: LEFT HAND
Removed by: _____ Date: _____

ANAESTHETIC ASSESSMENT Date 12/12/11

Age 31 BP

ASA 2

NCEPOD EI ☐

Urg ☐

Sch ☐

Em ☒

PRE-OPERATIVE INSTRUCTIONS

- ☐ Give usual medication
☐ EMLA or ametop topical
☐ Fast as per Trust guidelines
☐ Free clear fluid until
☐ Additional results required before theatre

PRE-MEDICATION

Prescribed by:

Given by:

COPY

CO-MORBIDITIES

1. CVS - ° symptoms
Cover for wife
2. ° Respiratory symptoms
- 30/day.

DRUGS

NA

Fasted ✓

otherwise well

Allergies
Previous GA
Problems?
FH GA problems
Reflux/full stomach
Airway difficulty

☒	No	☐	Yes
☐	No	☒	Yes
☒	No	☐	Yes
☒	No	☐	Yes
☒	No	☐	Yes
☐	No	☐	Yes

Recent.

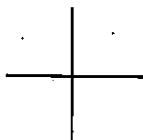
Na
K
U
Cr

Hb
WCC
Platelets

Clotting

G and S
X-match

Teeth



Edentulous
MP 3.JT + MO - small mouth.

Verbal consent and
explanation



Explained:

☒ GA

☐ RA

☐ Risks

☐ Day Care

Signed / Name

Commell (ST3)

CONSENT FORM

Agreement to Operation, Investigation or Treatment

CHI 2802860670
CRN: F207472 26/02/1980
DOWELL SCOTT
11 DON STREET
GRANGEMOUTH
FK3 8HD

NHS
M Forth Valley

COPY

Notes of Guidance for Doctor/Dentist/Healthcare Practitioner

The doctor/dentist/healthcare practitioner must:

- ◆ Be suitably qualified and experienced to explain the procedure to be performed - this should ideally be the operator or consultant.
- ◆ Give the patient sufficient information, in a way he/she can understand, about the proposed procedure, any important risks and the possible alternatives (including no treatment). In broad terms, a significant risk is one which is serious, but uncommon, or one which occurs frequently, even if it is not serious.
- ◆ Give the patient sufficient time to read the form and ask any questions relating to it or their treatment. The patient must be allowed to decide whether he/she will agree to the procedure and they may refuse or withdraw consent at any time.
- ◆ In addition to seeking consent for the procedure, seek written consent from the patient for examination by students.

Children under the age of 16 can give their own consent if the Medical Practitioner attending the child considers the child capable of understanding the nature and possible consequences of the procedure or treatment. If the child is judged capable, the practitioner must seek the consent of the child rather than the parent. This does not mean that the parents must always be excluded from the discussions. Unless there are issues concerning confidentiality, it would be reasonable to involve parents in helping a child to reach a decision. If a child under 16 years of age is giving his/her own consent, the relevant section overleaf, must also be signed.

Writing on the consent form must be legible, unambiguous and contain no abbreviations.

Any alterations to this form must be countersigned by the patient/parent/guardian and the member of the healthcare team taking consent. If the procedure or the information about surgical marking is wrong the form must be re-written.

Surgical Site Marking

- ◆ The site should be marked and documented by the operating surgeon, or nominated deputy, who will be present in the operating theatre at the time of the patient's procedure. If site marking is not applicable, this should be recorded and signed by the person taking consent.
- ◆ The intended site should be ascertained from reliable documentation and/or images.
- ◆ Marking should take place before pre-medication/administration of any sedative.
- ◆ The intended surgical site should, ideally, be marked on the ward or day care area, prior to the patient transfer to the operating theatre.
- ◆ An indelible marker pen should be used.
- ◆ The mark should be an arrow that extends to, or near, the incision site and remains visible after the application of skin preparation.
- ◆ Where possible the mark should remain visible after the application of theatre drapes.
- ◆ Surgical operations involving side (laterality), should be marked at, or near, the intended incision. For digits on the hand or foot, the mark should extend to the correct specific digit.
- ◆ The process of pre-operative marking of the intended site must involve the patient/parent/guardian wherever possible.

NB. There will be circumstances where marking may not be appropriate i.e. Teeth or Mucous Membranes. Emergency surgery should not be delayed due to lack of pre-operative marking.

EXAMINATION FOR THE PURPOSES OF TEACHING

(Please tick) I agree ☐ I do not agree ☐ to an examination by a student during the procedure named on this form under the supervision of the senior doctor undertaking the procedure.

COPY

Signature:

Name (PRINT): Date:

dd	mm	yy

CONFIRMATION OF CONSENT

(to be completed when patient is admitted for the procedure)

I confirm that I have no further questions and wish the procedure to go ahead.

Patient ☐ Parent ☐ Guardian ☐ Other ☐ (please specify)

Date

dd	mm	yy

Signature of Doctor/Dentist/Healthcare Practitioner:

Signature of Patient:

Notes of Guidance for Patients

The Doctor/Dentist/Healthcare Practitioner is here to help you. He or she will explain the procedure. You are entitled to refuse or withdraw consent at any time. You can ask any questions and ask for more information if you wish.

You may ask for a relative, friend or nurse to be present while the Doctor/Dentist/Healthcare Practitioner explains the procedure and asks you to sign the form.

If an anaesthetic or sedation is to be administered by an anaesthetist, it will be his or her responsibility to discuss details with you before the procedure takes place.

Students need to learn how to examine patients and to see how procedures are done. This is important for the future of the Health Service. You may be asked to give consent to be examined by students during the procedure. It is up to you to decide whether to give your consent or not but, whatever you decide, it will not affect your treatment.

NOTES

Forth Valley Surgical Safety Checklist
Version 5

carried out - Confirmed ☒

Date 12/11/11

Anaesthetic pause

Surgical pause

Post procedure

Re-order Ref

Review Date: 2012

PATIENT DETAIL (OR PRE-PRINTED LABEL)

Patient's surname/family name:

Patient's first name(s):

Date of birth: 26-02-1980

CHI number (or other identifier): 2602800570

Special requirements (e.g. other language/other communication method):

COPY

STATEMENT FOR DOCTOR/DENTIST/HEALTHCARE PRACTITIONER

(to be completed by a practitioner with appropriate knowledge of proposed procedure. See Notes for Guidance)

Describe proposed operation, investigation or treatment. Where appropriate specify the site or side:

1st of mild abrasions

risk infection, bleeding

I have explained the procedure named on this form to the: (please tick) patient ☒

parent ☐ guardian ☐ Other (please specify)

in terms which, in my judgment, are suited to their understanding. In particular I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure e.g. blood transfusion.

[If you have provided any information leaflet/tape, please tick box ☐ and specify title and version]

Signature of Doctor/Dentist/Healthcare Practitioner:

Name (PRINT):

Date: 12-12-11

STATEMENT OF INTERPRETER (where appropriate)

I have interpreted the information on this form to the patient/parent/guardian to the best of my ability and in a way in which I believe he/she can understand.

Signature:

Date: - - -

Name (PRINT):

SURGICAL SITE MARKING

Site marking not applicable

Correct Patient and Surgical Site verified and marked by:

Signature:

Date: - - -

Name (PRINT):

Title:

STATEMENT TO BE COMPLETED BY THE PATIENT, PARENT OR GUARDIAN

You should read this form and the notes below and overleaf carefully. If there is anything you do not understand, ask the doctor, Dentist or Healthcare Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

I am (Please tick) Patient ☒ Parent ☐ Guardian ☐

I understand:

Yes No

- the procedure, important risks and appropriate alternatives which have been explained to me by the Doctor/Dentist/Healthcare Practitioner named on this form. ☒ ☐
- that the procedure might be carried out by a Doctor/Dentist/Healthcare Practitioner other than the Doctor/Dentist/Healthcare Practitioner who has been treating me/the patient so far. ☒ ☐
- that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to my/the patient's medical treatment, to safeguard or promote my/the patient's physical or mental health. ☒ ☐

I have been told about additional procedures which may become necessary during my/the patient's treatment. I have listed below any procedures which I do not wish to be carried out without further discussion.

I agree:

- to the administration of an anaesthetic or sedation if required.
- to the procedure named on this form.
- that an examination for the purposes of teaching will not be undertaken without my consent.
- that any photographs, video/audio recordings and/or surgical images kept in the records may be used anonymously for research approved by an ethics committee, education and audit to improve the quality of patient care.

If you object to surgical images being used in this way then *please tick box* ☐

Signature of Patient/Parent/Guardian/Other: 

Name (PRINT):

SCOTT DOWELL

Date:

dd mm yy
12 12 11

Relationship to child:

Only to be completed by the Medical Practitioner where the form is to be signed by a child under 16 years.

I am of the opinion that the patient is capable of understanding the nature and possible consequences of the proposed treatment/procedure.

Name (PRINT): Signature:

Falkirk and District Royal Infirmary

Patient Details

Hospital Number **F207472**
 Patient Name **Dowell Scott**
 Date of Birth **26/02/1980**
 Sex **M**
 Category Type
 Patient Type **Day Case**
 Operation Type **Emergency**
 Date of Operation **12/12/2011**
 Theatre **FVRH 11**
 Confirmed By

COPY

Staff In Attendance - Team 1

Anaesthetist **DR MARK WORSLEY**
 Floor nurse 1 **SR FIONA LLOYD**
 Floor nurse 2 **N/A ANNE YUILE**
 O.D.P. **ODA ROBERT CLARK**
 Other **NA JERRI-LEE NEIL**
 Surgeon **DR LASZLO TERNYIK**

Materials Used

Item Code	Item Description	Qty	LOT1	LOT2	LOT3	LOT4
1009129	ABSCCESS & TOE NAIL TRAY	1	1009129			

Operation Notes

Side : Op Notes

Procedures

G-H58200 **INCISION AND DRAINAGE OF PERI-ANAL ABSCESS**

Indication: perianal abscess

Position: lithotomy

Procedure:

Desinfection with Betadine. Isolation with sterile drapes. Elliptical skin incision over fluctuant area at 11 o'clock position. Pus pouring out of wound. Swab for m/c/s. Betadine washout. 2xAquacel packing. Mefix.

Post op.:

E&D as able

home as able

DN to change dressing

Alternate Codes H582

Procedure Definitions

***** End of Report *****

Falkirk and District Royal Infirmary**Patient Details**

Hospital Number **F207472**
 Patient Name **Dowell Scott**
 Date of Birth **26/02/1980**
 Sex **M**
 Category Type
 Patient Type **Day Case**
 Operation Type **Emergency**
 Date of Operation **12/12/2011**
 Theatre **FVRH 11**
 Confirmed By

COPY**Staff In Attendance - Team 1**

Anaesthetist **DR MARK WORSLEY**
 Floor nurse 1 **SR FIONA LLOYD**
 Floor nurse 2 **N/A ANNE YUILE**
 O.D.P. **ODA ROBERT CLARK**
 Other **NA JERRI-LEE NEIL**
 Surgeon **DR LASZLO TERNYIK**

Recovery Staff In Attendance**SN MORAG NAYLOR****Materials Used**

<u>Item Code</u>	<u>Item Description</u>	<u>Qty</u>	<u>LOT1</u>	<u>LOT2</u>	<u>LOT3</u>	<u>LOT4</u>
1051575	F RECOVERY BTWN PATIENT CLEAN	1	1051575			
1009129	ABSCISS & TOE NAIL TRAY	1	1009129			

Operation Notes

Side : **Op Notes**

Procedures**G-H58200 INCISION AND DRAINAGE OF PERI-ANAL ABSCESS**

Indication: perianal abscess

Position: lithotomy

Procedure:

Desinfection with Betadine. Isolation with sterile drapes. Elliptical skin incision over fluctuant area at 11 o'clock position. Pus pouring out of wound. Swab for m/c/s. Betadine washout. 2xAquacel packing. Mefix.

Post op.:

E&D as able

home as able

DN to change dressing

Alternate Codes: **H582****Procedure Definitions**

***** End of Report *****

CHI 2802800570
CRN: F207472 26/02/1980
DOWELL SCOTT
11 DON STREET,
GRANGEMOUTH

ING HOME

262719

4-250

NAME Mr/Mrs/Miss

ADDRESS FK3 8HD

ADDRESS TO WHICH DISCHARGED IF DIFFERENT

COPY

UNIT No. D.O.B.

G.P. Dr Dundas

SCHOOL NOW ATTENDED

CONSULTANT Mr Greater

group medical

HOSPITAL

FVHE

WARD 1354

DATE OF ADMISSION

DATE OF DISCHARGE

DIAGNOSIS

TREATMENT IN HOSPITAL (DATE OF OPERATION IF APPLICABLE)

incision and drainage per - anvil abscess placed
with a qual Cat. Ribbon

anvil abscess placed

TREATMENT REQUIRED FOLLOWING DISCHARGE (DRESSINGS, INJECTIONS, DIET, CATHETER & CATHETER SIZE)

Daily change of qual Cat dressings.

DRUG	DOSE	FREQUENCY

Services requested - (tick as applicable)

Hospital and Community Nursing Service

District Nursing Sister

Health Visitor

Nursing Aids

Incontinence Aids

Day Hospital

Chiropody

Physiotherapy

Limb Fitting Centre

Speech Therapy

Requested via Social Worker

Home Help

Meals on Wheels

MECS Alarm

Slitter Day/Night

Day Centre

Welfare Waiting List

Social Work support

Requested via Occupational Therapist

Personal Aids

Adaptation to home

any on discharge (underline items applicable)

Lives alone - YES/NO

Walks - Unaided needs help - with frame/stick/tripod

Stairs - Unaided needs help - cannot manage

Bed - Unaided needs help - bedfast

Dressing - Unaided needs help

Toilet - Unaided needs help - can/cannot manage catheter

Bathing - Unaided needs help - unable to bath

Special appliances (e.g. commode)

Additional Information

O.P.D. Follow-up Appointment

NONE

Signed

J. Meek

Sister/Charge/Staff Nurse

Date

12/12/11

Top 2 copies to liaison staff - 3rd copy to be retained.

STE 004

FALKIRK DISTRICT ROYAL INFIRMARY		OPERATION NOTE		Printed : 24-Jan-02 11:47 am	
Theatre : THEATRE 4		D.O.B. : 26-Feb-80		COPY	
Date : 24.01.02		Unit No : 207472			
Specialty : UROLOGY		Forename : SCOTT			
Consultant : TWEEDLE, MR JAMES		Surname : DOWELL			
TWEEDLE					

Surgeon : YACOB, MR NADIR	Grade : SHO	Operation : 1	Status : SURG
---------------------------	-------------	---------------	---------------

Operation 1	Procedure : Diagnos cystoscopy - flexible	7B2A6	Laterality :
	Diagnosis :		Category : WAITING LIST ROUTINE

Procedure notes for Diagnos cystoscopy - flexible

NORMAL URETHRA
ADEQUATE PROSTATIC URETHRA AND BN
NORMAL BLADDER, NO LESION AND NO SIGNS OF CYSTITIS
DRE SMALL PROSTATE, CLINICALLY BENIGN.

HOME
NO FU

COPY

Falkirk and District Royal Infirmary**Patient Details**

Hospital Number **F207472**
 Patient Name **Dowell Scott**
 Date of Birth **26/02/1980**
 Sex **M**
 Category Type
 Patient Type **Day Case**
 Operation Type **Emergency**
 Date of Operation **13/01/2012**
 Theatre **FVRH 11**
 Confirmed By

COPY**Staff In Attendance - Team 1**

Anaesthetist **DR INGRID SEATTER**
 Floor nurse 1 **S/N AUDREY MCCULLOCH**
 Floor nurse 2 **N/A ELAINE NIVEN**
 O.D.P. **ODA ROBERT CLARK**
 Scrub nurse **S/N ANN NORRIE**
 Surgeon **MR REHAN KHAN**

Materials Used

<u>Item Code</u>	<u>Item Description</u>	<u>Qty</u>	<u>LOT1</u>	<u>LOT2</u>	<u>LOT3</u>	<u>LOT4</u>
1009136	ABSCCESS & TOE NAIL TRAY	1	1009136			
1007331	JLFA1360 LARYNGEAL MASK SIZE 4, POUCH 530	1	1007331			
1018650	CRILEWOOD 7", MEDIPLAST 100 & 150	1	1018650			

Operation Notes

Side : **Op Notes**

Procedures**G-S06900 EXCISION OF SEBACEOUS CYST**

Indication: Emergency presentation with lump in right hemiscrotum which was painful. Had usscan which reported a 4x3cm abscess. Clinically felt as a cystic lump with indurated wall. Infected sebaceous cyst. Treated as Abscess and I +D done on emergency list.

Procedure: GA, Lloyd davis position, prep'd and draped, IV Augmentin. Most fluctuant area on cyst incised but NO puss was drained. Clear fluid drained. Looks like infected sebaceous cyst. Cyst wall subsequently excised and sent for histology. Hemostasis with diathermy. In view of possible sebaceous cyst and No abscess, wound closed with Vicryl 3-0 rapide. 9mls 0.5% Chirocaine for local in wound. Jelonet, buccal swabs and scrotal support.

Follow up:
 Home on 3/7 of oral augmentin.
 Follow up with GP if required.
 Alternate Codes **S069**

Procedure Definitions **SCROTUM**

***** End of Report *****

COPY

Accident and Emergency Department

Forth Valley Royal Hospital



2602800570

A&E No. 11000029062

COPY 3

Surname	Dowell	Forename	Scott	Title:	MR
Address:	11 DON STREET, GRANGEMOUTH	Postcode	FK3 8HD	CHI No: 2602800570	
		Telephone:	262719		
Date of Birth:	26.02.80	Sex:	M	Age: 31 yrs	



CHI Number: 2602800570

GP Name:	DUNDAS DEREK				
Address:	THE HEALTH CENTRE	Postcode	FK3 9EL		
	KERSIEBANK AVENUE	Telephone:			
	GRANGEMOUTH				
	STIRLINGSHIRE				

Next of Kin	DIANNE				
Relationship:	WIFE				
Address:	11 DON STREET,	Postcode	FK3 8HD		
	GRANGEMOUTH	Telephone:	262719		
Manual CHI Entry:					

Date of Attendance: 12.01.12 21:58

Date of Incident:

Presenting Complaint: ABSCESS?

36.7°

Age	MODERATE PAIN (5 ON 1-10 SCALE; SOMEWHAT DISABLING). PAINFUL SCROTAL LUMP X 3/52, TODAY PAIN++ NO OTHER SYMPTOMS. HAD SCROTAL SCAN TODAY.			Tetanus Cover:
				Allergies:
P=	BP= /	RR=	Sat=	BM=
PF=	GCS=E: M: V: Total:			

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time

DAY SURGERY 13/01/12 - 8-30am

Clinical Notes

Seen by:

Appucan

Time:

08:30

314 male

2 Rainfall Jock's Jockey.

HPI: For 5/52

had CT scan of scrothum today →

Reported as 4 x 2.8 cm

multiloculated abscess in right

scrothum.

↑ Pain.

PMH: Nil

DM: Nil

AK: Tend 2 x 4 cm nodular lump.

inferior right scrothum.

Tend 36.7

+

NO LUN, irrigated abscess.

Tend scrothum abscess.

PM Good HPI: ✓ Urine dip.

Analysed. ✓

Reflex to scrothum ✓

DM: Jock's Jockey. AMPLIVAT.

2 weeks in dry scrothum

Guidelines Used:

28.30 AM

COPY

Attach continuation sheets here

Attach here onto face of pocket

ACCIDENT AND EMERGENCY INTERIM REPORT

COPY

Patient Name

DOWELL, SCOTT

Date Of Birth

26/02/1980

Sex

M

Address

11 Don St
Grangemouth

Unit Number

2602800570

Location

Emergency Centre FVRH

Consultant

Dr. Campbell

Lab Number

BB780142Y

Date Requested

13/01/2012

Sodium	140	mmol/l	(135 - 145)	
Potassium	HAEM	mmol/l		(a)
Chloride	103	mmol/l	(97 - 107)	
Urea	4.5	mmol/l	(2.5 - 8)	
Creatinine	91	umol/l	(60 - 130)	
eGFR (/1.73m ²)	>59	ml/min		
AST	HAEM	IU/L		(b)
ALT	HAEM	IU/L		(c)
Bilirubin	HAEM	umol/l		(d)
Total Protein	75	g/l	(62 - 80)	
Albumin	43	g/l	(36 - 52)	
Alk. Phosphatase	HAEM	U/L		(e)
C-Reactive Prot.	21	mg/l	(0 - 5)	

- (a) Haemolysed Specimen.
- (b) Haemolysed Specimen.
- (c) Haemolysed Specimen.
- (d) Haemolysed Specimen.
- (e) Haemolysed Specimen.

Date And Time Reported 13/01/2012 01:55

Interim Report Of Urgent Results. Discard On Receipt Of Complete Cumulative Report.

COPY

ACCIDENT AND EMERGENCY INTERIM REPORT

COPY

Patient Name

DOWELL, SCOTT

Date Of Birth

26/02/1980

Sex

M

Address

11 Don St
Grangemouth

Unit Number

2602800570

Location

Emergency Centre FVRH

Consultant

Dr. Campbell

Lab Number

HR081220D

Date Requested

13/01/2012

Haemoglobin	156	g/l	(133 - 177)
White Blood Count	10.1	$10^9/l$	(3.9 - 10.6)
Platelet Count	199	$10^9/L$	(150 - 440)
Red Blood Count	5.25	$10^{12}/l$	(4.4 - 5.9)
Packed Cell Volume	0.467		(0.40 - 0.52)
Mean Cell Volume	89.0	fl	(81 - 100)
Mean Cell Haemoglobin	29.7	pg	(26.6 - 33.8)
Mean Cell Haemoglobin Conc.	33.4	g/dl	(31.4 - 36.3)
Neutrophil Count	6.20	$10^9/l$	(1.8 - 7.7)
Lymphocyte Count	3.20	$10^9/l$	(1.0 - 4.8)
Monocyte Count	0.50	$10^9/l$	(0.0 - 0.8)
Eosinophil Count	0.20	$10^9/l$	(0.0 - 0.45)
Basophil Count	0.00	$10^9/l$	(0.0 - 0.20)

Please put Consultant or GP name Clearly on Form. Thank You.

Date And Time Reported 13/01/2012 01:20

Interim Report Of Urgent Results. Discard On Receipt Of Permanent Report.

COPY

Forth Valley Royal Hospital

COPY**Radiology Report**

Patient Name:	Dowell Scott	Report Date:	12-Jan-2012 16:10
Patient ID:	2602800570	Accession No.:	V213098773201
Patient Birth Date:	26-Feb-1980	Report Status:	F
Referring Physician:	DUNDAS DEREK, GP	Reason For Study:	

Clinical history: scrotal swelling, ? Varicocele/hydrocele.

There is a large, thick walled collection measuring approx 4.0 x 2.8cms present within the inferior pole of the right scrotum. Several fluid levels and loculations were demonstrated within the collection. Appearances are suggestive of an abscess.

Both testicles are of similar size and shape with no evidence of intra testicular focal lesion on either side. Similar internal vascularity was demonstrated bilaterally with colour Doppler. No other pathology was identified on either side.

The patient was also scanned by Dr R Johnstone.

Conclusion: appearances are suggestive of an abscess and urology referral for further evaluation is advised.

Examination Date: 12/01/2012

Examination: US Testes

Date Reported: 12/01/2012

Dictating Radiologist / Clinical Specialist By AILSA MACDONALD

Verified by: AILSA MACDONALD on 12/01/2012

Produced by Carestream Health PACS

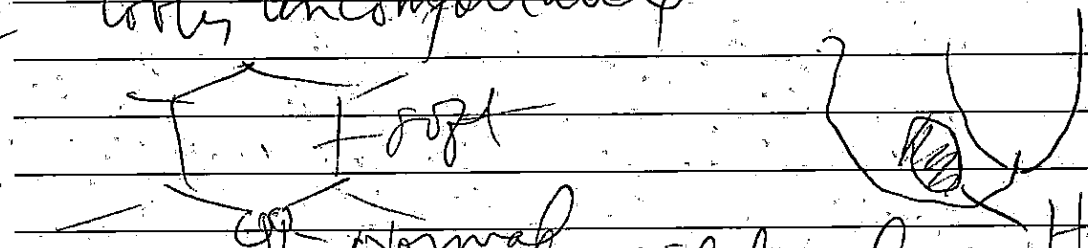
COPY

13/1/12
 1030

CLINICAL NOTES

Urinary (PS) (C) (M)

310 → Presentation with Scrotal swelling for 2 1/2 weeks
 - worsening - Painful - (PS) discharge
 Had perineal abscess drained approx. 9 weeks ago - Scrotal abscess was not present at that time
 Denies any LUTS - Urine infection 10 years ago
 Had an USS scan yesterday - Shows 4.0 x 2.8 cm thick walled collection ? Abscess
 O/E looks uncomfortable



Notes Added

Normal testicles bilaterally
 Right testicle separate from collection
 Hard lumpy swelling in R Hemiscrot
 Slightly fluctuant
 Perineal wound healed well

DIAGNOSIS

? Scrotal wall collection
 ? Abscess
 Patient keen for Incision & drainage

TREATMENTS

- Keep fasted for I+D of abscess

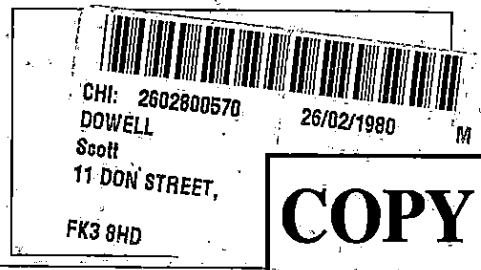
drain off - P/W MR Tweedle

Patient/Legal Guardian Permission to release info for legal purpose including Police		Yes / No
Patient Signature.....	Print Name.....	Date 13/1/12

Pain Score: /10 Analgesia Given? Y / N

Own Meds? Y / N Name Band Y / N

Relative/Carer: Informed: Yes/No Present: Yes/No



PVC INSERTION BUNDLE AND REMOVAL RECORD

Why is PVC clinically indicated for patient?: (please tick)

IV Fluids	☐	Blood Transfusion	☐
IV Drugs	☐	Diagnostics	☐
Predicted clinical need	☐		

The patients skin is decontaminated and allowed to dry YES / NO
 Hand hygiene & gloves donned prior to insertion YES / NO
 Aseptic Non Touch Technique is used to insert PVC YES / NO
 If not possible, use either **STERILE GLOVES** or **MINI CHLORAPREP**
 Sterile dressing & sticker (date & time) applied after insertion YES / NO

Ward/Department: ED
 Inserted by: venepuncture only Date & Time: 13/01/12
 Size/Colour: only Batch No: _____
 Insertion Site: _____
 Removed by: _____ Date & Time: _____

INVESTIGATIONS

☒ FBC	☒ GLU	CLOTTING	TROP	URINALYSIS	XRAY	CXR
☒ H&E	☒ CBP	G&S	D DIMER	HCG	ECG	AXR
☒ LFT	AMY	ESR	ABG	CATHETER	CULTURES	
PARACETAMOL		SALICYLATE		ETHANOL		

Others:

Troponin 0hr result: Troponin 12hr due:

Preliminary Pressure Ulcer Risk Assessment (PPURA):

Mobility: Person is fully mobile without equipment/assistance
 Contenance: Person is fully continent
 Nutrition: Person appears well nourished and able to eat and drink

Points to Consider
 * People who are overweight may not be well nourished
 * please sign after each check

Record your answer in the grid below Y = Yes or N = No
 If the answer is **NO** to any assessments undertake a PPURA and consider any other relevant assessment

DATE	TIME	MOBILITY	CONTINENCE	NUTRITION	SKIN INSPECTED	FULL PPURA	SIGNATURE
13/1/12	00:05	Y	Y	Y	N	N	SV

Over 65s

AMT 4

1. How old are you?	2. What is your date of birth?
3. What is this place?	4. What year is it?

If score is 3 or more proceed to Delirium screen/cam

Confusion Assessment Method (CAM)		Box 1	
1	Acute Onset or fluctuating course	☐ Yes	☐ No
	a) Acute change in mental state from patient's baselines? OR b) Did the (abnormal) behaviour fluctuate in severity or tend to come and go?		
2	Inattention Difficulty focusing attention or keeping track of conversation, easily distractible	☐ Yes	☐ No
If there is a 'yes' answer for questions 1 AND 2 then continue to questions 3 and 4.		Box 2	
3	Disorganised Thinking e.g. disorganised thinking or incoherent speech such as rambling or irrelevant conversation, unclear or illogical flow of ideas	☐ Yes	☐ No
4	Altered Level of Consciousness NB Alert = normal Score 'yes' if vigilant, lethargic, in a stupor or un-arousable	☐ Yes	☐ No
Add total 'Yes' answers for section 1,2,3 and 4. Consider diagnosis of delirium if score is 3 or more			

Medication Reconciliation completed by medical staff within 24 hours of admission	
Sign	Date

Other Charts in use (Please tick)	Insulin	Anticoagulant	Pain	Additional Kardex	Other
---	---------	---------------	------	----------------------	-------

FORTH VALLEY ACUTE SERVICES
MEDICATION PRESCRIPTION & ADMINISTRATION RECORD SHEET

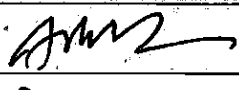
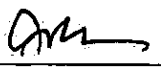
COPY

WARD	CONSULTANT	 CHI: 2602800570 26/02/1980 M DOWELL Scott 11 DON STREET, FK3 8HD AL SITE:
ALLERGIES	N K D A (Please circle if appropriate)	
(one of these boxes must be filled in)		DATE OF BIRTH: AGE:
☐ Initial here when informed verbal consent to use/destroy P.O.D.'s is received from the patient.		

Drugs administered prior to hospital arrival

Date	Approved Drug Name	Dose	Route	Given by (e.g. SAS, GP)	Time given

ONCE ONLY MEDICATION

PHARMACY	DATE	APPROVED DRUG NAME	DOSE	ROUTE	TIME/INSTRUCTIONS	DR SIGNATURE	GIVEN BY	TIME GIVEN
	13/1/12	COCODAMINE (3/mg)	PO	POSS			SV	0115
	13/1/12	LIQUID PPRORIB	600	PO	0155		SV	0115

INSTRUCTIONS FOR USING THIS SHEET

- Doctors and Nurses must ONLY write in black ink (except for allergies) - Pharmacists must ONLY use <i>green ink</i> - Use the approved drug (RINN) name and write in BLOCK CAPITALS - Enter the specified times and write additional information in the instruction box. - ONLY use the listed abbreviated routes of administration. Where the abbreviation is not listed, write the route in full. - Dose must be stated in either metric or SI units. Quantities less than 1mg must be written in full eg. micrograms. - To cancel a drug draw a diagonal line through the entire entry, initial and date. - TWO nurses must initial each drug administration for ALL Parenteral and Paediatric Medicine. - When a drug is not given - enter the not given code (see list) - ALL of the above MUST be adhered to	ROUTES IV - intravenous IM - intramuscular SC - subcutaneous PO - oral INH - inhaled NEB - nebulised SL - sublingual PR - by rectum PV - by vagina TOP - topical	NOT GIVEN CODES 1. Patient not on ward 2. Patient unable to take 3. Patient vomited 4. Drug not available 5. Drug not required 6. Given > 30 mins late (state time) 7. Patient allergy 8. Patient refused 9. Withheld - medical indication 10. Given by Patient/relative/carer
---	---	---

NAME:

Unit No:

2

General Medication Oral and other routes (regular)

(General Medication starts at page 2 and works forward. Parenteral Medication starts at page 4 and works forward)

- enter dosage times as 24hour clock
- please write in block capitals
- please write in black pen

- Maximum of 3 continuation sheets
- please ensure patient details are on each sheet

COPY

ALLERGIES - Please use RED INK

N K D A (Please circle if appropriate)

DATE →

TIME ↓

(one of these boxes must be filled in)

Drug OXYGEN

Circle target oxygen saturation

88-92% 94-98% Other _____

Starting device/flow rate _____

PRN/continuous (refer to O₂ guideline)

Tick here if saturation not indicated* ☐

Date and signature

Print name

APPROVED DRUG NAME

DOSE

ROUTE

paracetamol

1g

PO

18

INSTRUCTIONS

Clin Pharm.

Reg/New

12

Date stopped

SIGNATURE

DATE

Reason for stopping

18

22

APPROVED DRUG NAME

DOSE

ROUTE

ibuprofen

400mg

PO

18

INSTRUCTIONS

Clin Pharm.

Reg/New

12

Date stopped

SIGNATURE

DATE

Reason for stopping

18

22

APPROVED DRUG NAME

DOSE

ROUTE

AUGMENTIN

625mg

P.O

18

INSTRUCTIONS

Clin Pharm.

Reg/New

12

Date stopped

SIGNATURE

DATE

Reason for stopping

18

22

APPROVED DRUG NAME

DOSE

ROUTE

INSTRUCTIONS

Clin Pharm.

Reg/New

Date stopped

SIGNATURE

DATE

Reason for stopping

APPROVED DRUG NAME

DOSE

ROUTE

INSTRUCTIONS

Clin Pharm.

Reg/New

Date stopped

SIGNATURE

DATE

Reason for stopping

NAME:	Unit No:
-------	----------

3

PHARMACY USE ONLY

General Medication Oral and other routes (regular)

(General Medication starts at page 2 and works forward. Parenteral Medication starts at page 4 and works forward)

- enter dosage times as 24hour clock
- please write in block capitals
- please write in black pen

- Maximum of 3 continuation sheets
- please ensure patient details are on each sheet

COPY

ALLERGIES - Please use RED INK		N K D A (Please circle if appropriate)		DATE												
(one of these boxes must be filled in)				TIME												
APPROVED DRUG NAME		DOSE		ROUTE												
INSTRUCTIONS		Clin Pharm.		Reg/New												
		Date stopped														
SIGNATURE	DATE	Reason for stopping														
APPROVED DRUG NAME		DOSE		ROUTE												
INSTRUCTIONS		Clin Pharm.		Reg/New												
		Date stopped														
SIGNATURE	DATE	Reason for stopping														
APPROVED DRUG NAME		DOSE		ROUTE												
INSTRUCTIONS		Clin Pharm.		Reg/New												
		Date stopped														
SIGNATURE	DATE	Reason for stopping														
APPROVED DRUG NAME		DOSE		ROUTE												
INSTRUCTIONS		Clin Pharm.		Reg/New												
		Date stopped														
SIGNATURE	DATE	Reason for stopping														
APPROVED DRUG NAME		DOSE		ROUTE												
INSTRUCTIONS		Clin Pharm.		Reg/New												
		Date stopped														
SIGNATURE	DATE	Reason for stopping														
APPROVED DRUG NAME		DOSE		ROUTE												
INSTRUCTIONS		Clin Pharm.		Reg/New												
		Date stopped														
SIGNATURE	DATE	Reason for stopping														
APPROVED DRUG NAME		DOSE		ROUTE												
INSTRUCTIONS		Clin Pharm.		Reg/New												
		Date stopped														
SIGNATURE	DATE	Reason for stopping														
APPROVED DRUG NAME		DOSE		ROUTE												
INSTRUCTIONS		Clin Pharm.		Reg/New												
		Date stopped														
SIGNATURE	DATE	Reason for stopping														

NAME:	Unit No:
-------	----------

Parenteral Medication (Regular)

(General Medication starts at page 2 and works forward. Parenteral Medication starts at page 4 and works forward)

- enter dosage times as 24hour clock
- please write in block capitals
- please write in black pen

- Maximum of 3 continuation sheets
- please ensure patient details are on each sheet
- IV site MUST be checked prior to and after all IV administration.

COPY

ALLERGIES - Please use RED INK	N K D A (Please circle if appropriate)	DATE →
(one of these boxes must be filled in)		TIME ↓

APPROVED DRUG NAME	DOSE	ROUTE
		IV

INSTRUCTIONS/ADMINISTER OVER	Clin Pharm.	Reg/New
for flush		
Date stopped		

SIGNATURE	DATE	Reason for stopping

APPROVED DRUG NAME	DOSE	ROUTE
Augmentin	1.2g	IV

INSTRUCTIONS/ADMINISTER OVER	Clin Pharm.	Reg/New
Date stopped		

SIGNATURE	DATE	Reason for stopping
ETU	13/0	

APPROVED DRUG NAME	DOSE	ROUTE

INSTRUCTIONS/ADMINISTER OVER	Clin Pharm.	Reg/New
Date stopped		

SIGNATURE	DATE	Reason for stopping

APPROVED DRUG NAME	DOSE	ROUTE

INSTRUCTIONS/ADMINISTER OVER	Clin Pharm.	Reg/New
Date stopped		

SIGNATURE	DATE	Reason for stopping

APPROVED DRUG NAME	DOSE	ROUTE

INSTRUCTIONS/ADMINISTER OVER	Clin Pharm.	Reg/New
Date stopped		

SIGNATURE	DATE	Reason for stopping

APPROVED DRUG NAME	DOSE	ROUTE

INSTRUCTIONS/ADMINISTER OVER	Clin Pharm.	Reg/New
Date stopped		

SIGNATURE	DATE	Reason for stopping

APPROVED DRUG NAME	DOSE	ROUTE

INSTRUCTIONS/ADMINISTER OVER	Clin Pharm.	Reg/New
Date stopped		

SIGNATURE	DATE	Reason for stopping

NAME:	Unit No:
-------	----------

5

Parenteral Medication (Regular)

(General Medication starts at page 2 and works forward. Parenteral Medication starts at page 4 and works forward)

- enter dosage times as 24hour clock
- please write in block capitals
- please write in black pen

- Maximum of 3 continuation sheets
- please ensure patient details are on each sheet
- IV site MUST be checked prior to and after all IV administration.

COPY

ALLERGIES - Please use RED INK		N K D A (Please circle if appropriate)		DATE →																
(one of these boxes must be filled in)				TIME ↓																
APPROVED DRUG NAME		DOSE		ROUTE																
INSTRUCTIONS/ADMINISTER OVER		Clin Pharm.		Reg/New																
		Date stopped																		
SIGNATURE		DATE		Reason for stopping																
APPROVED DRUG NAME		DOSE		ROUTE																
INSTRUCTIONS/ADMINISTER OVER		Clin Pharm.		Reg/New																
		Date stopped																		
SIGNATURE		DATE		Reason for stopping																
APPROVED DRUG NAME		DOSE		ROUTE																
INSTRUCTIONS/ADMINISTER OVER		Clin Pharm.		Reg/New																
		Date stopped																		
SIGNATURE		DATE		Reason for stopping																
APPROVED DRUG NAME		DOSE		ROUTE																
INSTRUCTIONS/ADMINISTER OVER		Clin Pharm.		Reg/New																
		Date stopped																		
SIGNATURE		DATE		Reason for stopping																
APPROVED DRUG NAME		DOSE		ROUTE																
INSTRUCTIONS/ADMINISTER OVER		Clin Pharm.		Reg/New																
		Date stopped																		
SIGNATURE		DATE		Reason for stopping																
APPROVED DRUG NAME		DOSE		ROUTE																
INSTRUCTIONS/ADMINISTER OVER		Clin Pharm.		Reg/New																
		Date stopped																		
SIGNATURE		DATE		Reason for stopping																
APPROVED DRUG NAME		DOSE		ROUTE																
INSTRUCTIONS/ADMINISTER OVER		Clin Pharm.		Reg/New																
		Date stopped																		
SIGNATURE		DATE		Reason for stopping																
APPROVED DRUG NAME		DOSE		ROUTE																
INSTRUCTIONS/ADMINISTER OVER		Clin Pharm.		Reg/New																
		Date stopped																		
SIGNATURE		DATE		Reason for stopping																

PHARMACY USE ONLY

POD
SUPPLY

POD
SUPPLY

POD
SUPPLY

POD
SUPPLY

POD
SUPPLY

POD
SUPPLY

POD
SUPPLY

NAME:	Unit No:
-------	----------

As Required Medication Page All routes

(Prescribers **MUST** enter indication, dosage interval and maximum daily dose)

COPY

- enter dosage times as 24hour clock
- please write in block capitals in black pen

- Maximum of 3 continuation sheets
- please ensure patient details are on each sheet
- IV site **MUST** be checked prior to and after all IV administration.

ALLERGIES - Please use RED INK		N K D A (Please circle if appropriate)		DATE →							
(one of these boxes must be filled in)				13/1/12							
APPROVED DRUG NAME		DOSE	ROUTE	TIME							
Symptomatic Relief Policy											
INSTRUCTIONS		Clin Pharm.	Reg/New	GIVEN BY							
		Date stopped		TIME							
SIGNATURE		DATE	Reason for stopping	TIME							
				GIVEN BY							
APPROVED DRUG NAME		DOSE	ROUTE	TIME							
cyclopam		30mg	IV								
INSTRUCTIONS		Clin Pharm.	Reg/New	GIVEN BY							
8hly		Date stopped		TIME							
SIGNATURE		DATE	Reason for stopping	TIME							
Datta		13/01		GIVEN BY							
APPROVED DRUG NAME		DOSE	ROUTE	TIME							
dihydrocode		30mg	PO	1420							
INSTRUCTIONS		Clin Pharm.	Reg/New	GIVEN BY							
4-6hly		Date stopped		TIME							
SIGNATURE		DATE	Reason for stopping	TIME							
Datta		13/01		GIVEN BY							
APPROVED DRUG NAME		DOSE	ROUTE	TIME							
INSTRUCTIONS		Clin Pharm.	Reg/New	GIVEN BY							
		Date stopped		TIME							
SIGNATURE		DATE	Reason for stopping	TIME							
				GIVEN BY							
APPROVED DRUG NAME		DOSE	ROUTE	TIME							
INSTRUCTIONS		Clin Pharm.	Reg/New	GIVEN BY							
		Date stopped		TIME							
SIGNATURE		DATE	Reason for stopping	TIME							
				GIVEN BY							

7

COPY

(Prescribers **MUST** enter indication, dosage interval and maximum daily dose)

- Maximum of 3 continuation sheets
- please ensure patient details are on each sheet
- IV site **MUST** be checked prior to and after all IV administration.

[illegible]

OXYGEN WEANING CHART

COPY

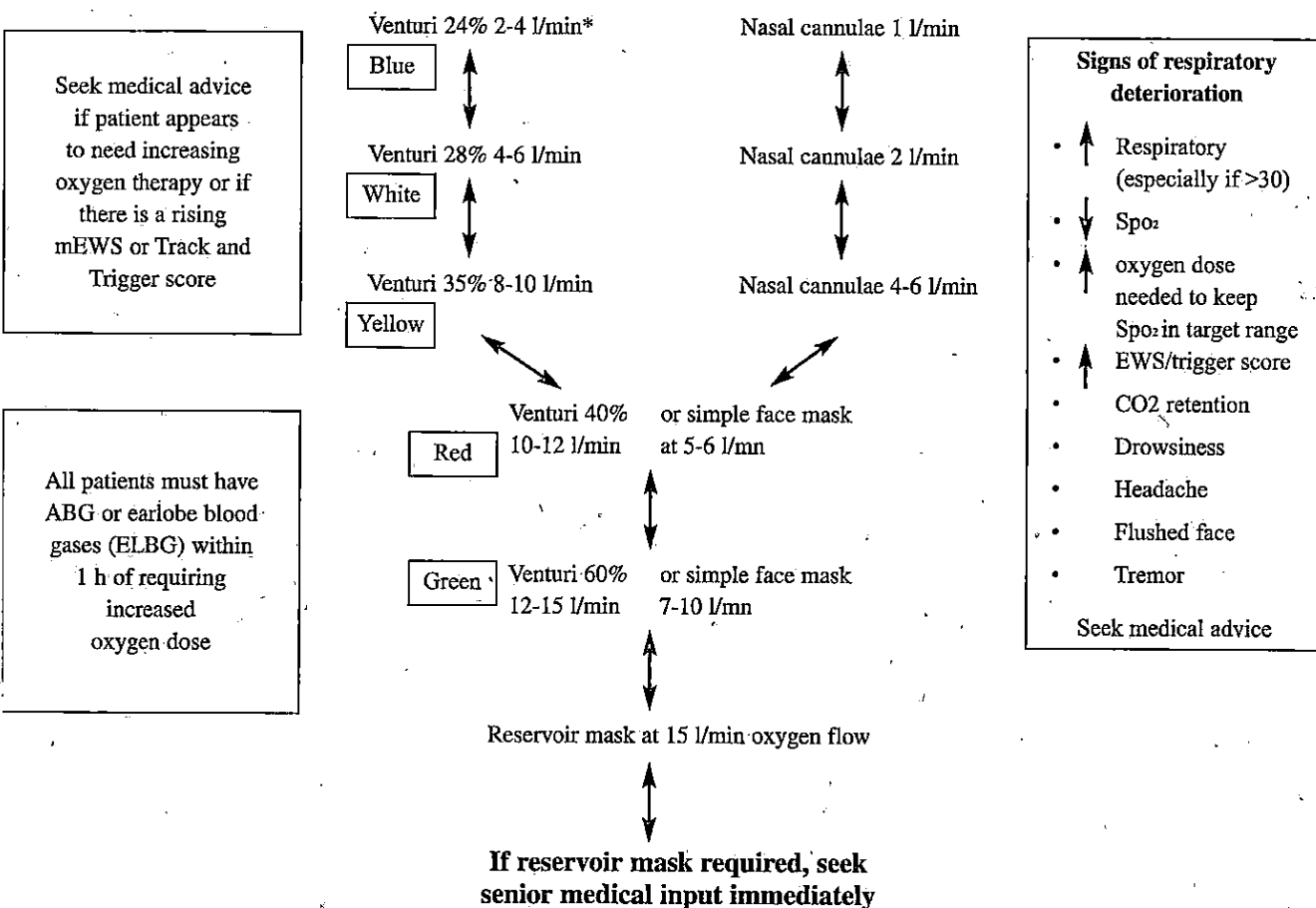
See patient's drug chart for starting dose and target saturation

Choose the most suitable delivery system and flow rate

Titrate oxygen up or down to maintain the target oxygen saturation

The table below shows available options for stepping dosage up or down. The chart does not imply any equivalence of dose between Venturi masks and nasal cannulae.

Allow at least 5 minutes at each dose before adjusting further upwards or downwards (except with major and sudden fall in saturation). Once your patient has adequate and stable saturation on minimal oxygen dose, consider discontinuation of oxygen therapy.



* For Venturi masks, the higher flow rate is required if the respiratory rate is >30

Patients in a peri-arrest situation and critically ill patients should be given maximal oxygen therapy via reservoir mask or bag-valve mask whilst immediate medical help is arriving (except for patients with COPD with known oxygen sensitivity recorded in patient's case notes and drug chart or in the EPR: keep saturation at 88-92% for this subgroup of patients)

CONSENT FORM

NHS

North Valley

Agreement to Operation, Investigation or Treatment

COPY

Notes of Guidance for Doctor/Dentist/Healthcare Practitioner

The doctor/dentist/healthcare practitioner must:

- ◆ Be suitably qualified and experienced to explain the procedure to be performed - this should ideally be the operator or consultant.
- ◆ Give the patient sufficient information, in a way he/she can understand, about the proposed procedure, any important risks and the possible alternatives (including no treatment). In broad terms, a significant risk is one which is serious, but uncommon, or one which occurs frequently, even if it is not serious.
- ◆ Give the patient sufficient time to read the form and ask any questions relating to it or their treatment. The patient must be allowed to decide whether he/she will agree to the procedure and they may refuse or withdraw consent at any time.
- ◆ In addition to seeking consent for the procedure, seek written consent from the patient for examination by students.

Children under the age of 16 can give their own consent if the Medical Practitioner attending the child considers the child capable of understanding the nature and possible consequences of the procedure or treatment. If the child is judged capable, the practitioner must seek the consent of the child rather than the parent. This does not mean that the parents must always be excluded from the discussions. Unless there are issues concerning confidentiality, it would be reasonable to involve parents in helping a child to reach a decision. If a child under 16 years of age is giving his/her own consent, the relevant section overleaf, must also be signed.

Writing on the consent form must be legible, unambiguous and contain no abbreviations.

Any alterations to this form must be countersigned by the patient/parent/guardian and the member of the healthcare team taking consent. If the procedure or the information about surgical marking is wrong the form must be re-written.

Surgical Site Marking

- ◆ The site should be marked and documented by the operating surgeon, or nominated deputy, who will be present in the operating theatre at the time of the patient's procedure. If site marking is not applicable, this should be recorded and signed by the person taking consent.
- ◆ The intended site should be ascertained from reliable documentation and/or images.
- ◆ Marking should take place before pre-medication/administration of any sedative.
- ◆ The intended surgical site should, ideally, be marked on the ward or day care area, prior to the patient transfer to the operating theatre.
- ◆ An indelible marker pen should be used.
- ◆ The mark should be an arrow that extends to, or near, the incision site and remains visible after the application of skin preparation.
- ◆ Where possible the mark should remain visible after the application of theatre drapes.
- ◆ Surgical operations involving side (laterality), should be marked at, or near, the intended incision. For digits on the hand or foot, the mark should extend to the correct specific digit.
- ◆ The process of pre-operative marking of the intended site must involve the patient/parent/guardian wherever possible.

NB. There will be circumstances where marking may not be appropriate i.e. Teeth or Mucous Membranes. Emergency surgery should not be delayed due to lack of pre-operative marking.

EXAMINATION FOR THE PURPOSES OF TEACHING

(Please tick) I agree ☐ I do not agree ☐ to an examination by a student during the procedure named on this form under the supervision of the senior doctor undertaking the procedure.

COPY

Signature:

Name (PRINT): Date:

dd	mm	yy

CONFIRMATION OF CONSENT

(to be completed when patient is admitted for the procedure)

I confirm that I have no further questions and wish the procedure to go ahead.

Patient ☐ Parent ☐ Guardian ☐ Other ☐ (please specify)

Date:

dd	mm	yy

Signature of Doctor/Dentist/Healthcare Practitioner:

Signature of Patient:

Notes of Guidance for Patients

The Doctor/Dentist/Healthcare Practitioner is here to help you. He or she will explain the procedure. You are entitled to refuse or withdraw consent at any time. You can ask any questions and ask for more information if you wish.

You may ask for a relative, friend or nurse to be present while the Doctor/Dentist/Healthcare Practitioner explains the procedure and asks you to sign the form.

If an anaesthetic or sedation is to be administered by an anaesthetist, it will be his or her responsibility to discuss details with you before the procedure takes place.

Students need to learn how to examine patients and to see how procedures are done. This is important for the future of the Health Service. You may be asked to give consent to be examined by students during the procedure. It is up to you to decide whether to give your consent or not but, whatever you decide, it will not affect your treatment.

NOTES

Forth Valley Surgical Safety Checklist
Version 5

carried out - Confirmed ☒

Date 13/11/12

Anaesthetic pause [Signature]
Surgical pause [Signature]
Post procedure [Signature]

Re-order Ref: TF/1012/SS

Review Date: 2013

PATIENT DETAIL (OR PRE-PRINTED LABEL)

Patient's sur

Patient's first

Date of birth

CHI number

Special require



CHI: 2602800570

CRN: F207472 26/02/1980

DOWELL SCOTT

11 DON STREET,

GRANGEMOUTH

M

FK3 8HD

Comments (e.g. other language/other communication method):

COPY

STATEMENT FOR DOCTOR/DENTIST/HEALTHCARE PRACTITIONER

(to be completed by a practitioner with appropriate knowledge of proposed procedure. See Notes for Guidance)

Describe proposed operation, investigation or treatment. Where appropriate specify the site or side:

Incision & drainage of Sural Abscess
Risky: Bleeding, Infection, Pain, Persistent
thickening of Sural wall, Sural pain

I have explained the procedure named on this form to the: (please tick) patient ☐

parent ☐ guardian ☐ Other (please specify):

in terms which, in my judgment, are suited to their understanding. In particular I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure e.g. blood transfusion.

[If you have provided any information leaflet/tape, please tick box ☐ and specify title and version]

Signature of Doctor/Dentist/Healthcare Practitioner

Name (PRINT):

Date:

dd mm yy
13 01 12

STATEMENT OF INTERPRETER (where appropriate)

I have interpreted the information on this form to the patient/parent/guardian to the best of my ability and in a way in which I believe he/she can understand.

Signature:

Date:

dd mm yy
13 01 12

Name (PRINT):

SURGICAL SITE MARKING

Site marking not applicable

Correct Patient and Surgical Site verified and marked by:

Signature:

Date:

dd mm yy
13 01 12

Name (PRINT):

Title:

STATEMENT TO BE COMPLETED BY THE PATIENT, PARENT OR GUARDIAN

You should read this form and the notes below and overleaf carefully. If there is anything you do not understand, ask the doctor, Dentist or Healthcare Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

COPY

I am (Please tick)

Patient ☒

Parent ☐

Guardian ☐

I understand:

Yes No

- the procedure, important risks and appropriate alternatives which have been explained to me by the Doctor/Dentist/Healthcare Practitioner named on this form. ☒ ☐
- that the procedure might be carried out by a Doctor/Dentist/Healthcare Practitioner other than the Doctor/Dentist/Healthcare Practitioner who has been treating me/the patient so far. ☒ ☐
- that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to my/the patient's medical treatment, to safeguard or promote my/the patient's physical or mental health. ☒ ☐

I have been told about additional procedures which may become necessary during my/the patient's treatment. I have listed below any procedures which I do not wish to be carried out without further discussion.

I agree:

- to the administration of an anaesthetic or sedation if required.
- to the procedure named on this form.
- that an examination for the purposes of teaching will not be undertaken without my consent.
- that any photographs, video/audio recordings and/or surgical images kept in the records may be used anonymously for research approved by an ethics committee, education and audit to improve the quality of patient care.

If you object to surgical images being used in this way then *please tick box*

☐

Signature of Patient/Parent/Guardian/Other: *N. J. O'Neill*

Name (PRINT):

Date:

dd

mm

yy

13

01

12

Relationship to child:

Only to be completed by the Medical Practitioner where the form is to be signed by a child under 16 years.

I am of the opinion that the patient is capable of understanding the nature and possible consequences of the proposed treatment/procedure.

Name (PRINT): Signature:

SIEMENS

MULTISTIX 8-SG REPORT

Name S. Down Date 13.01.16
 Ward ED Patient No. _____

COPY

TESTS Please tick appropriate box for each test

LEUCOCYTES 1-2 minutes	NEG. ☒	TRACE ☐	SMALL +	MODERATE ++	LARGE +++	
NITRITE 60 seconds	NEG. ☒	POSITIVE (any degree of pink colour) ☐				
PROTEIN 60 seconds	NEG. ☒	TRACE ☐	0.30 +	1 ++	3 +++	≥ 20 ++++
pH 60 seconds	5.0 ☒	6.0 ☐	6.5 ☐	7.0 ☐	7.5 ☐	8.0 ☐
BLOOD 60 seconds	NEG. ☒	NON HAEMOLYZED TRACE ☐	HAEMOLYZED TRACE ☐	SMALL +	MODERATE ++	LARGE +++
SPECIFIC GRAVITY 45 seconds	1.000 ☐	1.005 ☐	1.010 ☐	1.015 ☒	1.020 ☐	1.025 ☐
KETONE 40 seconds	NEG. ☒	mmol/L TRACE 0.5 ☐	SMALL 1.5 ☐	MODERATE 4 ☐	LARGE 8 ☐	
GLUCOSE 30 seconds	NEG. ☒	mmol/L TRACE 5.5 ☐	14 + ☐	28 ++ ☐	55 +++ ☐	≥ 111 ++++ ☐

X600270 MP&D

DEPARTMENT OF HISTOPATHOLOGY
AREA LABORATORY SERVICE
STIRLING ROYAL INFIRMARY NHS TRUST

COPY

BIOPSY REPORT

Lab No: PH005690W/98

Name: DOWELL, SCOTT
Address: 18 EVAN STREET
LARBERT

DoB: 26/02/1980
PAS No: F207472
Clinician: Mr. N. Harris
Source: WARD 9 OFFICE
Date Rec: 16/06/1998

Falkirk D. Royal Infirmary
Date Issued: 18/06/1998

Biopsy of Lesion from Back

The specimen consists of a 75 x 30 mm. skin ellipse with a 30 x 30 mm. pigmented surface lesion.

Microscopy shows features of a predominantly intradermal compound melanonaevus. Within the surface epithelium there is elongation of the rete ridges and increased pigment in the basal layer.

These appearances are in keeping with the clinical impression of a congenital naevus. There is no evidence of malignancy and excision appears to be complete.

Summary: Congenital Naevus.

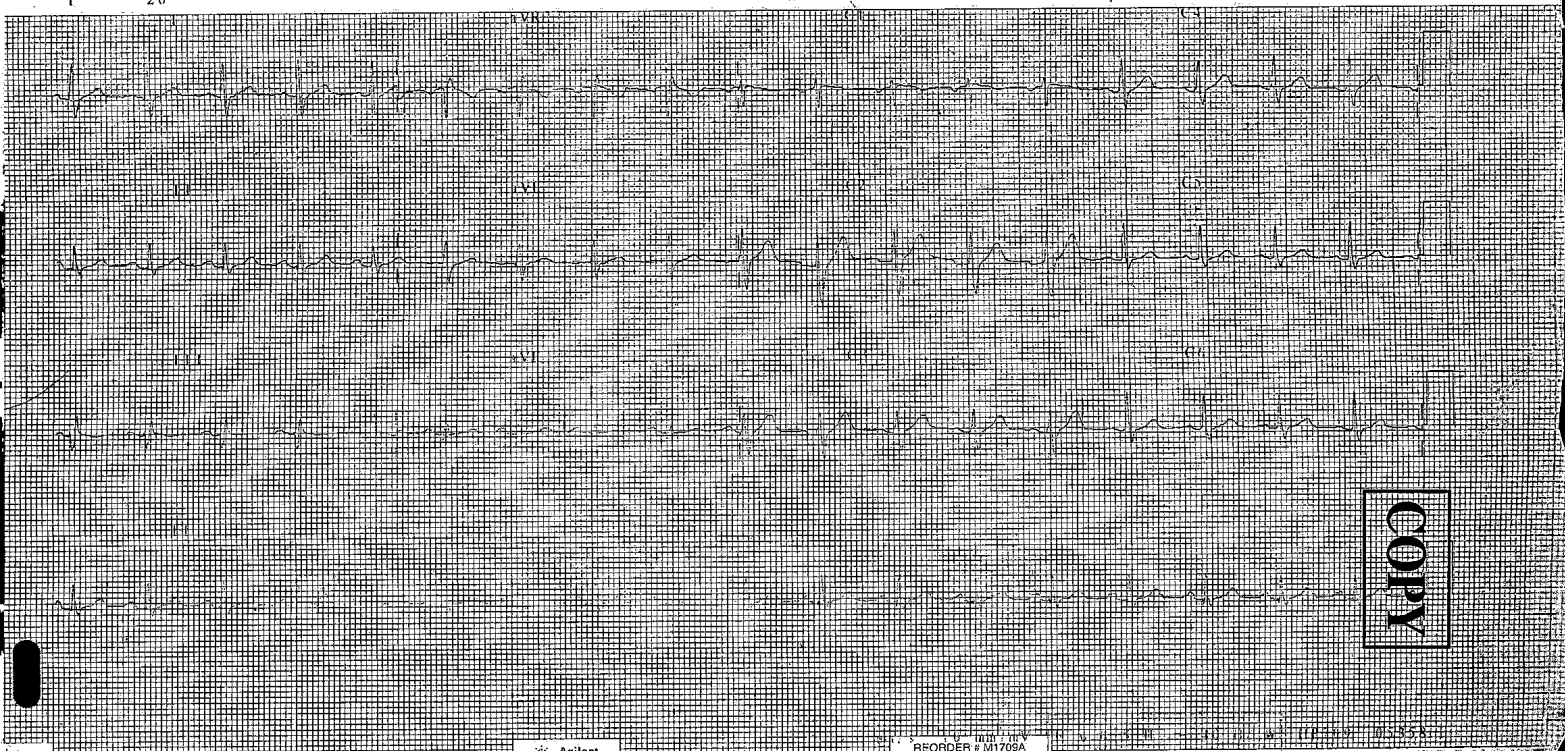
K. Morton
Dr. K. Morton

Typist: 310

copy to GR
ju

Rate 107
PR 147
QRSD 86
QT 279
QTc 372

--Axis--
P 69
QRS 38
T 26



Amilant

REORDER # M1708A

COPY

CLINICAL NOTES



CHI2802800670

CRN:F207472 26/02/1980

DOWELL SCOTT
11 DON STREET,
GRANGEMOUTH

FK3 8HD

Label

Dental No.

M

B.

COPY

Ward / Dept.

Consultant

Date

13/1/12

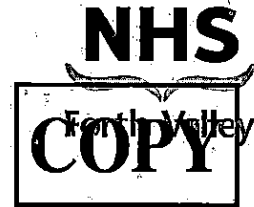
DSN

1615b.

Discharge criteria met. Unventil post-op
recovery. Well at time of discharge
No follow-up required. JKS ON.

Date

COPY



NHS Forth Valley Tobacco Policy

PATIENTS LEAVING CLINICAL AREA TO SMOKE

As smoking is biggest single cause of ill health in Scotland NHS Forth Valley does not permit smoking in any of premises including the grounds and car parks. It is also against the law in Scotland to smoke in any enclosed public place.

Assistance is available from NHS Forth Valley with helping you stop smoking, including Nicotine Replacement Therapy which is a free service. We also can offer you one to one help from nurses whose role is to help / aid / offer advice to people to stop smoking. These nurses will be informed that you are in the ward / department, if you do not wish this support please indicate below.

However should you wish to smoke, you will have to leave NHS Forth Valley premises to do so this includes the grounds of the hospital. Please use the bins provided at the gates to the hospital to extinguish your cigarettes to keep our entrances clear of tobacco.

I have read the above and understand that I must leave NHS Forth Valley premises if I wish to smoke. I understand if I choose to do so that this will be at my own risk to my health, safety and well-being and that of others. I understand that it is illegal to smoke in any enclosed public space.

Name: _____

CHI Number: _____

Ward or Department: _____

Hospital: _____

Signature: (patient) *Scott Dowell*

Date: _____

☐ Please tick this box if you **do not** wish to speak to a smoking cessation nurse.

TOP COPY - FOR PATIENTS NOTES

SECOND COPY - PATIENT

THIRD COPY - SMOKING CESSATION NURSE, HUT 5, FALKIRK ROYAL INFIRMARY

STIRLING ROYAL INFIRMARY - THEATRE CARE PLAN

T 100810

CHI 2602800570
 CRN: F207472 26/02/1980
 DOWELL SCOTT
 11 DON STREET
 BRANGEMOUTH
 M
 FK3 8HD
 DSU

PROCEDURE

~~Incision and Drainage AM~~
~~of Sebaceous cyst~~
 Excision of sebaceous cyst

Consultant

Mr Tweedle

COPY

For

SURGEON Mr R. Khan

Signature

13/1/12

Th No 11
DATEIP
ElectOP
EM

Procedure Start 13.06. GA ☐ LA ☐
 Closure Time 13.34
 Exit Th Time 13.39

Blood Loss

Position

Urine Output

Positioned By

SPEC (YES) NO NUMBER.

x 2.

TEAM LEADER F. Lloyd

Radiographer

LOTIONS

Chlorhexidine/Spirit Betadine Antiseptic ☒ Methylene Blue
 Tisept Chlorhexidine/Water Acetic Acid 5% Bet Alcohol
 Aqueous Iodine

NURSING COMMENTS

Diathermy pad on
 Left thigh.

IRRIGATION FLUID/ANTIBIOTIC 0.9% Sodium chloride.

WOUND INFILTRATION (LA) Chirocaine 5.0mg/ml - 9 ml used.

drops/oint.

Time
 Given by:

	TYPE	SIZE	POSITION
PACKS			
Drain			
Chest Drain			
Stent - Ureteric Cath			
Catheter			Balloon Amt.
Catheterised by:			

BONE BANK No.

WEDGE/PILLOW

Sling
 Splint
 Other

SKIN CLOSURE

DRESSING Vycril rapide
 Jelonat, blue swabs, steri-drap support

Th WATERLOW SCORE

SURGEONS INSTRUCTIONS

Sutures Out

No Follow up

Appt.

DATE 13/1/12	TH No 11	AM PM	CP No
Case/Em No 1	PRE-OP	TOTAL	INSTRUMENT/TRAYS Adhere tray batch numbers by item name
ABS 10 x 10	S	10	ABSCISS & TOE NAIL TRAY JLFA1360 LARYNGEAL MASK SIZE 4, POUCH 530 ID 1009136 LOT 00427 User Code 1251004
5 x 5			ID 1007331 LOT 00032 User Code KEY50438207
PACKS (abd 30 x 30)			CRILEWOOD 7" MEDIPLAST 100 8 ID 1018650 LOT 00046 User Code 5525001
CAESAREAN ROLLS			
PLEDGES			
NEEDLES			
BLADES	1	1	
SLINGS			
OTHER			
diapn np		1	
hypo		1	

1 - Scrub Person
 2 - Scrub Person

1st Count Circ Person
 FINAL Count Circ Person

Elaine Dew
 a McCulloch
 J.E. Nwa

Signature of person/s completing careplan

0 A. D. O. K. I. E. 2 a McCulloch

ING372

HEAT RETAINING / PRESSURE RELIEVING - PADDING EQUIPMENT

	ID No.	APPLIED BY	SETTING/PRESSURE	POSITION	TIME		REM/ CHECK BY
					ON	OFF	
DIATHERMY							
Bipolar							
TOURNIQUET							
SCD/Flowtron							
Insufflator							
Thermamat							
Lithoclast							
Arthrotome							

COPY

	ID No.	CONNECTED	COMMENTS
Camera			
Microscope			
Other			

	ID No.	CONNECTED	COMMENTS	ULTRASOUND TIME	ELAPSED TIME
LASER					
PHACO					

STERIS / AUTOCLAVE BATCH NO. / INSTRUMENT TYPE	QUANTITY	SITE

PROS / IMPLANT / CEMENT ETC	QUANTITY	BATCH No.

Post Operative Plan For Surgical Patients

Combined Surgical & Anaesthetic Instructions for immediate Post Operative care

Tick ALL that apply, document specific parameters.

Ensure kardex is completed in full (To be completed by the Anaesthetist/Surgeon)

COPY

Date: 26/02/1980
CHN: F207472
DOWELL SCOTT
11 DON STREET,
GHANGEMOUTH
FK3 8HD
Medication

Date: 13/01/12 TH: 11

Ward:

Operation: 180 scrotal ablation

Surgeon:

Anaesthetist:

feather

- ☐ 1 Essential medication prescribed on kardex
- ☒ 2 Regular analgesia prescribed on kardex
- ☒ 3 Breakthrough analgesia prescribed on kardex
- ☒ 4 Anti-emetic prescribed on kardex
- ☐ 5 Oxygen prescribed on Kardex
- ☐ 6 PCA device prescribed
- ☐ Epidural - continuous infusion
- ☐ PCEA
- ☒ Other, please specify

1 - 5 Must be completed

6 - 9 Optional for information

Diet / Fluids Minimum of one option must be completed

☒ Oral Diet (Circle all relevant): sips / free clear fluid / soft diet / light diet / full

☐ Nil By Mouth (NBM)

If NBM:

☐ Oral diet to start

☐ Oral diet to start with: (Circle all relevant): sips / free clear fluid / soft diet / light diet / full

☐ Oral diet to start after medical review.

Fluid Therapy Minimum of one option must be completed

☒ Oral Fluids only

☐ IV Fluids only:

☐ Fluids prescribed until at least 09:00hrs next day

☐ IV fluids until adequate oral intake established

☐ Fluids prescribed to cover this anticipated period

Blood Sugar Control Minimum of one option must be completed

☒ N/A (ie. Patient not diabetic)

☐ Target BM = Mmmol/l

☐ Achieve target BM with:

☐ Allow patient to titrate normal insulin/Restart oral hypoglycaemics (Delete as appropriate)

☐ GKI infusion - must be prescribed if above target BM in recovery

☐ Insulin Sliding Scale - must be prescribed if above target BM in recovery

Antibiotic Cover Minimum of one option must be completed

☐ N/A

☐doses post op

☐ Continue

☐ Prescribe number of further doses on front of kardex

☐ Prescribe on kardex

DVT Prophylaxis

Minimum of one option must be completed

- ☒ None
☐ TEDS
☐ Clexane
☐ Rivaroxaban
☐ Other, please state:

COPY

Physiological Targets:

☒ As per Forth Valley National Early Warning Score Chart (NEWS)

☐ Alternative targets

SpO2	Min	Max
RR	Min	Max
HR	Min	Max
SBP	Min	Max
U/O	Min	

Special Instructions - Please document below (Eg. drains, positioning, post op investigations, imaging etc)

☒ None

☐ Medicine reconciliation required on ward

Anaesthetist signature:

I. Beatter

Name:

I. BEATTER (CT2)

Surgeon signature:

Name:

Nard staff please also review the Theatre Operation note for any surgeon specific follow - up instructions

Address CH12 6UJ
CRN:F207472 26/02/1980
DOWELL SCOTT
11 DON STREET,
GRANGEMOUTH

NHS FORTH VALLEY ACUTE OPERATING DIVISION
ADULT SURGICAL AMBULATORY CARE PRESCRIPTION CHART

FK3 8HD

Patient Name DOB Unit No Allergies/sensitivities

Patient Name: _____													
DATE	DRUG	ROUTE	DOSE	ADMINISTRATION TIMES ON DAY OF OPERATION				NURSES SIGNATURE FOR ADMINISTRATION				Dr's signature if required for discharge	
				Pre-op	A	B	C	D	A	B	C		D
13/1/12	AS PER DSU PGD												
13/1/12	Paracetamol	PO	1g										
13/1/12	Ibuprofen	PO	400mg										
13/1/12	Dihydrocodeine	PO	30 to 60mg										
13/1/12	Ranitidine single dose	PO	150mg										
13/1/12	INGENTIN	PO	600mg										
13/1/12	COCAINE	PO											

Nursing Staff: Drugs supplied on discharge

DATE	DRUG	ROUTE	DOSE AND DIRECTIONS	FURTHER DOSES DUE AT:	BATCH NUMBER	QUANTITY	NURSE SIGNATURE	REASON NOT SUPPLIED:
13/1/12	Paracetamol 500mg Tablets	PO	Two tablets 4-6 hourly. No more than 8 in 24 hours		683A	32		
13/1/12	Ibuprofen 400mg Tablets	PO	One tablet 6-8 hourly With or after food		721501	24		
	Dihydrocodeine 30mg tablets	PO	One or Two tablets 4-6 hourly. Max 8/24 hours					

- ♦ It is common for even minor surgery to cause you some pain and discomfort for a few days.
- ♦ It is important for you to take painkillers regularly for 3 days after your operation to reduce the pain.
- ♦ If pain persists, or is not controlled by the painkillers you have been given, contact DSU x4430 at SRI, x 5861 at DFRI or your G.P.

COPY

Distribution 1. G.P. 2. Pharmacy 3. Patient 4. Patients records

COPY

Date 13/1/12 Ward OSU Surname _____ Sex _____
 Procedure and side I + D Testicular Access First name CHI 2602800570
CRN: F207472 26/02/1988 **COPY**
 Unit No. DOWELL SCOTT 11 DON STREET, GRANGEMOUTH
 Surgeon CEPOD Date of L... FK3 8HD

CHECKLIST ITEMS	WARD	HANDOVER CHECKS		BASELINE WARD CHECKS & DATA
Verbal Name Check	✓	✓	✓	Pre-assessment Document
ID Band Checked	✓	✓	✓	Present and Checked ☐
Pre-assess/clerking completed	CEPOD	NO	NO	Any Changes?
Pregnant Yes / No	N/A	N/A	N/A	Temp <u>36.4</u> Weight (kg)
Allergies (see baseline checks Yes / No)	NO	NO	NO	P <u>80</u> BP <u>131/60</u>
Consent / Incapacity completed	NO	✓	✓	RR <u>15</u> SaO2 <u>97%</u>
Operation confirmed with patient	✓	✓	✓	BM (Sugar)
Consent form corresponds to list	✓	✓	✓	Allergies ☒ No ☐ Yes
Operation site marked clearly	NO	NO	N/A	☐ Own Teeth ☒ Dentures
Nursing notes	✓	✓	✓	Hb <u>156</u> Na <u>140</u>
Case Notes (SRI, FDRI, Beatson)	✓	✓	✓	WCC <u>10.1</u> K <u>HAEM</u>
Drug Kardex	✓	✓	✓	Platelet <u>199</u> U <u>4.5</u>
X-Rays (including angios etc)	PACS	PACS	PACS	Clotting <u>Cr 91</u>
XMatch / G&S form (Y or N/App)	NO	N/A	N/A	G and S X-Match
Confirm all results available	✓	✓	✓	Thromboprophylaxis
Addressograph labels	✓	✓	✓	☒ None ☐ GECS
Bone bank consent	N/A	N/A	N/A	☐ Aspirin ☐ Calf compression
Fasted for solids / milk from (time)	2300	12.1.12	12.1.12	☐ Clexane
Fasted for clear fluids from (time)	0200	0200	0200	Items to Theatre
Bladder emptied (time or No)	✓	AM	✓	No. of Pillows _____
Jewellery removed / taped	REMOVED	NO	NO	Cot Sides _____
Body piercings taped etc	NO	N/A	NO	Bradford Sling _____
Nail varnish / makeup removed	NO	N/A	NO	Charnley Wedge _____
Contact lenses removed	NO	N/A	NO	
Prosthesis (* or No)	NO	N/A	NO	
Orthopaedic implants (* or No)	QARM?	YES	NO	
Pacemaker (Yes or No)	NO	NO	NO	
Hearing aid (Yes or No)	NO	NO	NO	
Able to move by self on trolley	YES	YES	YES	
Ward sign and designation	S. Mule S/N			
Handover 1 sign and designation	SUBMIT			
Handover 2 sign and designation	PUSH THE OR			
Comments	Diabetic ☒ YES/NO On Beta Blocker ☒ YES/NO If "YES" Taken YES/NO If not taken: Administered by Nursing Staff YES/NO			
* 2 PLATES, 6 PINS * CASE NOTES ON ROUTE				

Recovery Nurse

COPY

				COPY	
Airway	SV	SV	SV	SV	
O ₂ l/min	4	4	21R	4R	
SpO ₂	96	95	95	94%	
Resp Rate	16	16	16		
Temp	36.3	→	→		
BM					200
TIME	13:35	14:00	14:05		
A line ☐					
Site:-					
CVP ☐	0				0
Analgesic Drugs	/	/	/		
Sedation Score	0	1	1	1	
Pain Score	0	0	0	0	
Nausea Score	0	0	0	0	
Wound Site	0	0	0	0	
Drains	NA	NA	NA		
NG Tube	NA	NA	NA		
Cannula / IVI / Pump	SAT	SAT	SAT		
Spinal / Epidural	NA	NA	NA		
C / S / M	NA	NA	NA		
Patient Position	Supine	Supine	Supine		
Urinary Catheter	NA	NA	NA		
Pressure Areas	Not seen	Not seen	Not seen		

Will be reviewed later
for ? home.

Discharge to (ward) DSU

Criteria Met ☒ Time

Signed L. C. Chosen

Patient Valuables

Dentures Full [] Partial [☒]

Glasses []

Hearing Aid	[]
-------------	-----

None []

Other: DRESSING GOWN / SLIPPERS / BAG

Nursing notes ☒

Op notes ☒

Case notes ☒

X-Rays ☐

Recovery Sign Ryan Howard Sign

Post-operative instructions

Analgesia

Recovery

Anti-emetic

IV Morphine up to _____ mg

IV Fentanyl up to 100 µg

☒ Cyclizine 50mg IV
COPY

☐ Granisetron 1mg IV

☐ Prochlorperazine 12.5mg IM

Analgesia Ward

☒ Regular oral analgesia as prescribed

Oxygen - in recovery follow protocol thereafter

..... L/Min via nasal cannula

..... L/Min via facemask

IV Fluids

☐ as charted

☐ Cap off

☒ Oral

Other Care

☒ Routine

Investigations required

☐ Recovery

☐ Ward

FBC
U&E
ABG
CXR
ECG

Signed

Inta (CN)

IV Cannula / Removal Record
Name: SCOTT Ward: VS4
Inserted by: V. SEARON Date: 13/1/12
Size / Colour: 20G PINK Batch No: _____
Insertion Site: LEFT HAND Date: _____
Removed by: _____ Date: _____

ANAESTHETIC ASSESSMENT Date 13/01/2012

Age 31

BP

ASA

NCEPOD EI ☐

Urg ☐

Sch ☐

Em ☐

PRE-OPERATIVE INSTRUCTIONS

- ☐ Give usual medication
☐ EMLA or amtop topical
☐ Fast as per Trust guidelines
☐ Free clear fluid until
☐ Additional results required before theatre

PRE-MEDICATION

Prescribed by:

Given by:

COPY

CO-MORBIDITIES

31yo ♂
Isotret A skin

passed ✓
away - NP II
good MO

DRUGS

Irregular
on ENAIDS

AKDA

Allergies
Previous GA
Problems?
FH GA problems
Reflux/full stomach
Airway difficulty

☒	No	☐	Yes
☐	No	☒	Yes
☒	No	☐	Yes
☒	No	☐	Yes
☒	No	☐	Yes
☒	No	☐	Yes

Na
K
U
Cr

Hb
WCC
Platelets

Clotting

G and S
X-match

Teeth

top plate

Verbal consent and
explanation

☒

Explained:

☒

RA

Risks

Day Care

Signed / Name

Therapist (CR)

Date 13/01/12

Cons Anaes Woods

☐ present☒ discussed☐ nominal

Anaesthetist

Seatter (C2)

Procedure

120 serial assem

☒ Anaesthetist has verified patient name, id band, procedure and side☒ Anaesthetist has checked machine and equipment**COPY**

20 g cannula

DLH

Local anaesthetic (LA) ☐ block☐ spinal☐ epidural☐ infiltration

	1230	1300	1330	1400	
Intangy (14)	75				
propofol (14)	100000				
granisetron (14)	1				
parecoxib (14)	40				
paracetamol (g)	1				
Augmentin (g)	1.2g				200
Antibiotic					
Airway ☒ Pre O ₂					180
☐ RSI ☐ cricoid P					
☐ mask ☐ guedel					160
☐ MA					
size 4	150				
☐ ITT ☐ cuff					140
size					
☐ oral					120
grade					
☐ pack					100
Maintenance					mmHg
☒ O ₂ ☒ N ₂ O ☐ AIR					80
☒ sevo ☐ iso ☐ des					60
	50				
Circuit					40
☒ circle					
☒ SV					20
☐ hand					
☐ IPPV					
position					CVP
☒ SpO ₂	97	95			
☒ PE'CO ₂	8.5	6.8			
☒ MAC/ET AA	1.2	1.4			
☒ FiO ₂	0.51	0.47			
eyecare					
pressure points					
Warmed ☐ air ☐ fluid ☐ temp					
☐ PNS ☐ Vt/RR					
☐ Alarm ☐ PAWP/PEEP					
urine output (mls)					

① Hartmann 1000ml

COPY

[illegible]

10.01.02 19:53

PROBLEM ADDRESSED BY THIS CAREPLAN

INITIAL ADMISSION CARE PLAN

Name	SCOTT DOWELL			DETAIL OF ASSESSMENTS	INITIATE / REVIEW AT
D.O.B.	26.02.80	Sex	MALE		COPY
Unit No	207472	date	time		
Date First Started	10.01.02	19:53		01. REVIEW PATIENT'S HISTORY	ON ADMISSION
Reviews				02. MONITOR VITAL SIGNS, O2SATS, ECG, BM, I&O	AS INDICATED
Date Ended				03. COMPLETE ADL ASSESSMENT; ADMISSION DOCUMENTS	ON ADMISSION
GOALS				04. OBTAIN SPECIMENS FOR LABORATORY TESTING	AS INDICATED
1. INITIAL ASSESSMENT CARRIED OUT				05. ASSESS WATERLOW, EILERS, NUTRITIONAL STATUS	AS INDICATED
2. RISK FACTORS IDENTIFIED				06. DISCHARGE IMPLICATIONS - TRIGGERS IDENTIFIED	AS INDICATED
3. PATIENT / FAMILY ANXIETY REDUCED				07. COMPLETE TRANSFER DOCUMENTATION	AS INDICATED
4. TRANSFER TO WARD ORGANISED				08. ADMINISTER OXYGEN, ANALGESIA, ANTIBIOTICS	AS PRESCRIBED
5. DISCHARGE PLAN INITIATED				09. ADMINISTER OTHER MEDICATION	AS PRESCRIBED
Workload		Score		10. PROVIDE FULL EXPLANATION OF ALL PROCEDURES	AS INDICATED
				11. MAINTAIN CALM, PROFESSIONAL MANNER	ONGOING

date / time	ONGOING EVALUATION ENTRIES	line	SIGN
10/1/02	Care plan initiated as above	01	
		02	
		03	
		04	
		05	
		06	
		07	
		08	
		09	
		10	
		11	
		12	
		13	
		14	
		15	
		16	
		17	
		18	
		19	
		20	
		21	
		22	
		23	
		24	
		25	
		26	

10.01.02 19:54.

PROBLEM ADDRESSED BY THIS CAREPLAN

ANXIETY

Name	SCOTT DOWELL			DETAIL OF ASSESSMENTS		INITIATE / REVIEW AT
D.O.B.	26.02.80	Sex	MALE			COPY Store d u
Unit No	207472	date	time	01. ASSESS PATIENTS ANXIETY LEVEL:MILD;MOD;SEVERE		
Date First Started	10.01.02	19:54		02. ASSESS PATIENTS COPING MECHANISM.		
Reviews				03. DOCUMENT VERBAL/BEHAVIOURAL EXPRESSION OF ANX		
Date Ended				04. ACKNOWLEDGE AWARENESS OF PATIENTS ANXIETY.		
GOALS				05. REASSURE PATIENT THAT HE IS SAFE.		DAILY
1. PATIENT DESCRIBES A REDUCTION IN THE LEVEL OF ANXIETY EXPERIENCED.				06. MAINTAIN CALM, PROFESSIONAL MANNER.		DAILY
2. PATIENT DEMONSTRATES A POSITIVE COPING METHOD.				07. ASSIST IN DEVELOPING ANXIETY REDUCING SKILLS.		AS ORDERED
				08. ADMINISTER MEDICATION AS PRESCRIBED.		AS PRESCRIBED
				09. ENCOURAGE PATIENT TO TALK ABOUT FEELINGS.		DAILY
				10. ORIENTATE PATIENT TO ENVIRONMENT.		DAILY
Workload		Score	>	11. GIVE CLEAR, SIMPLE EXPLANATION ABOUT TESTS.		DAILY

date / time	ONGOING EVALUATION ENTRIES	line	SIGN
10/1/02	Remains anxious	01	
	Reassured as req	02	
		03	7C
		04	
		05	
		06	
		07	
		08	
		09	
		10	
		11	
		12	
		13	
		14	
		15	
		16	
		17	
		18	
		19	
		20	
		21	
		22	
		23	
		24	
		25	
		26	

10.01.02 19:55

PROBLEM ADDRESSED BY THIS CAREPLAN

URINARY RETENTION

Name	SCOTT DOWELL			DETAIL OF ASSESSMENTS		INITIATE / REVIEW AT
D.O.B.	26.02.80	Sex	MALE			COPY
Unit No	207472	date	time			
Date First Started	10.01.02	19:55		01. EVALUATE PREVIOUS PATTERNS OF VOIDING.		ON ADMISSION
Reviews				02. PALPATE BLADDER TO DETERMINE DISTENSION.		AS ORDERED
Date Ended				03. EVALUATE TIME INTERVAL BETWEEN VOIDING.		DAILY
GOALS				04. ASSESS AMOUNT, FREQUENCY, CHARACTER OF URINE.		DAILY
1. PATIENT EMPTIES BLADDER COMPLETELY.				05. DETERMINE BALANCE BETWEEN INPUT AND OUTPUT.		DAILY
				06. IF CATHETERISED - CHECK PATENCY AND KINKING.		DAILY
				07. MONITOR U&E : (RETENTION OR RENAL FAILURE).		DAILY
				08. ENCOURAGE FLUIDS.		DAILY
				09. POSITION PATIENT - UPRIGHT POSITION ON TOILET		DAILY
				10. INTERMITTENT OR INDWELLING CATHETER.		AS ORDERED
Workload		Score		11. EDUCATE PATIENT/CARER: RETENTION; UTI.		AS ORDERED

date / time	ONGOING EVALUATION ENTRIES	line	SIGN
10/1/02	Catheter removed	01	
	Has PU since	02	
11/1/02	Resolved	03	
		04	
		05	
		06	
		07	
		08	
		09	
		10	
		11	
		12	
		13	
		14	
		15	
		16	
		17	
		18	
		19	
		20	
		21	
		22	
		23	
		24	
		25	
		26	

10.01.02 19:53

PROBLEM ADDRESSED BY THIS CAREPLAN

DISCHARGE PLAN

Name	SCOTT DOWELL			DETAIL OF ASSESSMENTS		INITIATE / REVIEW AT
D.O.B.	26.02.80	Sex	MALE			COPY store edit
Unit No	207472	date	time			
Date First Started	10.01.02	19:53		01. NAMED NURSE IDENTIFIED, ROLE EXPLAINED TO PT		ON ADMISSION
Reviews				02. ASSESSMENT OF PHYSICAL, PSYCHOLOGICAL STATUS		ON ADMISSION
Date Ended				03. ASSESSMENT OF SOCIOCULTURAL, SPIRITUAL STATUS		ON ADMISSION
GOALS				04. "TRIGGER FACTORS" IDENTIFIED, REFERRALS MADE		AS INDICATED
1. OPTIMUM LEVEL OF ACTIVITY/FUNCTIONING				05. ENSURE MULTIDISCIPLINARY INVOLVEMENT		AS INDICATED
2. COMPLICATIONS PREVENTED / RESOLVED				06. ANTICIPATED LENGTH OF STAY IDENTIFIED		AS INDICATED
3. DISEASE PROCESS, TREATMENT UNDERSTOOD				07. PLAN OF CARE, GOALS IDENTIFIED WITH PATIENT		AS INDICATED
4. LIFESTYLE/BEHAVIOUR CHANGES INITIATED				08. WRITTEN/VERBAL INFORMATION RE CONDITION TO PT		AS INDICATED
5. PLAN TO MEET NEEDS POST DISCHARGE SET				09. WRITTEN INFO - MEDICATION, DIET, LIFESTYLE		AS INDICATED
Workload		Score		10. CONFIRM TRANSPORT, APPOINTMENTS, LETTERS		AS INDICATED
				11. WRITTEN CONFIRMATION OF DISCHARGE PLAN TO PT		PRE DISCHARGE

date / time	ONGOING EVALUATION ENTRIES	line	SIGN
10/1/02	? (H) tananas 15 Ct	01	(H)
11/1/02	discharged no plan	02	7c
		03	
		04	
		05	
		06	
		07	
		08	
		09	
		10	
		11	
		12	
		13	
		14	
		15	
		16	
		17	
		18	
		19	
		20	
		21	
		22	
		23	
		24	
		25	
		26	

[illegible][illegible]

START DATE	MEDICINES	ROUTE	DOSE	TIME	SIGNATURE	GIVEN BY
10-12-2024	Pen					

9.1.02	DICLOFENAC	IM	75mg	012.30ml Yang	N. Scott

Diabetic Prescription Sheet

WARD

AGE

WEIGHT (KG)

CONSULTANT

COPY

MEDICINE RECORDING SHEET

STB003

SHEET NO.

ENTER ☐ E IN BOX AND INITIAL WHEN MED ☐ : TAKEN

DATE	6 a.m.	8 a.m.	10 a.m.	12 m.d.	2 p.m.	6 p.m.	8 p.m.	10 p.m.	12 m.n.
9/1/02		(A) N B		(A) A refused				A BN	
	INTS.	(A) B N		A B	SW.	A		A BC	
10/1/02		er ABC							
	INTS.	7c							
4/1/02									
	INTS.								
	INTS.								
	INTS.								
	INTS.								
	INTS.								
	INTS.								
	INTS.								
	INTS.								
	INTS.								
	INTS.								
	INTS.								

OTHER TIMES	
CODE	0 A
TIME	0310
CODE	A
TIME	0500
CODE	
TIME	
CODE	
TIME	
CODE	
TIME	
CODE	
TIME	
CODE	
TIME	
CODE	
TIME	
CODE	
TIME	

NAME Scott Dorell

AGE

CONSULTANT

IF PATIENT ABSENT RECORD ☒ A
IF MEDICINE REFUSED RECORD ☒ A

COPY

[illegible][illegible]

IF MEDICINE REFUSED RECORD **(A)** **IF PATIENT ABSENT RECORD**

Name	Slott Dowed
Address	11, Don St Gmouh. Tel: _____
D.O.B.	26/6/80
Next of Kin Name:	_____
Tel:	_____

Referral to Receiving	Physician				
FDRI	☒	SRI	☐	OTHER	_____

Referring GP (in capitals)	Robertson
----------------------------	-----------

Registered GP (in capitals)	Hillman
-----------------------------	---------

History of presenting complaint and examination findings

Frequency reduction kit for pain
2/3. Varying short delay. Rigors
1/6 day + PR 120/min
+ 37.90
tender L7 loin
pain 3h ago

Reason for referral

pyelonephritis

Additional relevant information (incl. social if appropriate)

Past medical history (incl. recent admissions in past 3 months if known / under which Consultant)

Cognitive functioning

Long term problems

☐

Acute problems

☐

Signature



Current drug history

Cephazolin for 20 days

Dept referrals and admissions in last 6 months

Date

6/1/02

COPY

COPY

FALKIRK & DISTRICT ROYAL INFIRMARY NHS TRUST

Check list for pre-operative patients to be completed by nurse preparing patient immediately before patient leaves the ward and checked again by Theatre Nurse.

COPY

WARD CHECK

THEATRE CHECK

Scott Dawell
207472
DOB 26/2/80
DSU - Uro 24/1/02

Patient's Name
Unit Number
Date of Birth
Ward & Date

Scott Dawell
207472
26.2.80
DSU 24.1.02

Yes/No	Operation consent form signed and countersigned	Yes/No
Yes/No	Premedication time entered and signed	Yes/No
Yes/No	Identification band present and checked	Yes/No
Yes/No	Dentures	Yes/No
Yes/No	Complete set removed	Yes/No
Yes/No	Upper partial set removed	Yes/No
Yes/No	Lower partial set removed	Yes/No
Yes/No	Dental bridge	Yes/No
Yes/No	Own teeth	Yes/No
None/	Position of Crowns	None/

Present/None	Jewellery removed	Present/None
Present/None	Wedding ring taped	Present/None
Yes/None	Hair clips removed	Yes/None
Yes/None	Nail Varnish/make up removed	Yes/None
Present/None/Removed	Contact lens	Present/None/Removed
Present/None/Removed	Artificial eye	Present/None/Removed
Present/None/Removed	Wig - Hair piece	Present/None/Removed
Present/None/Removed	Hearing aid	Present/None/Removed
Yes/No	Deaf/Dumb - which ear	Yes/No

State any Internal Prosthesis

Record BP TPR

Yes/No	X-Match blood slip	Yes/No
Yes/No	Blood available	Yes/No
Yes/No	Has patient passed urine - time	Yes/No
	Time of last meal/drink	

Yes/No	Case notes present	Yes/No
Yes/No	X-Rays present	Yes/No
Yes/No	Operation Site - Marked Clearly	Yes/No
Yes/No	Presence of pressure sores	Yes/No
Yes/No	Drains	Yes/No
Yes/No	Swabs	Yes/No
Yes/No	Dressings	Yes/No
Yes/No	Catheters	Yes/No
Yes/No	Known Allergies	Yes/No
	Water low scale	
	Indicate any physical/mental/medical disabilities	

Ward Signature

Theatre Signature

Date

COPY

**INTRA-OPERATIVE NURSING COMMUNICATION
DAY SURGERY PATIENTS**

COPY

PATIENTS DETAILS NAME UNIT NUMBER D.O.B.	F207472 26/02/1980 SCOTT DOWELL 11 DON STREET GRANGLMOUTH M/S FK3 8HD
PROCEDURE	FLEXIBLE CYTOSCOPY
SUTURE MATERIAL SUTURE REMOVAL	N/A
WOUND DRESSING	None
SPECIMEN OBTAINED	No
VISIT BY MEDICAL STAFF PRIOR TO DISCHARGE	No
CLINIC APPOINTMENT	No
INTRA-OPERATIVE RECOVERY AREA POST-OP PRESCRIPTION	ANALGESIA ANTI-EMETIC N/A
ANY OTHER RELEVANT INFORMATION	Endoscope I.D. Label Sterilising Data Date 24/1/02 Item Flexi Cystoscope ID No Steris Cycle No 1131 Processors Name OBradley

RX 1324

COPY

PATIENTS NAME Scott Downen
UNIT NUMBER 207472

MEDICINE 1
ADVERSE EFFECT 1
2
2

DAY SURGERY MEDICINE PRESCRIPTION SHEET

ADMINISTRATION TIMES

NURSES SIGNATURE

DATE	MEDICINES	ROUTE	DOSE	A	B	C	D	DR SIGNATURE	A	B	C	D
24/11/00	CIPROXIN	O	500mg					MAJOR	MN			12mo

ADMINISTRATION TIMES

WHEN ADMINISTERING THE PRESCRIBED

PLEASE WRITE MEDICATION

MEDICATION, PLEASE SIGN CORRESPONDING BOX.

TIME CLEARLY

DISCHARGE MEDICATION

DATE	MEDICINE	ROUTE	DOSE	DIRECTIONS OF ADMINISTRATION	DOCTORS SIGNATURE	BATCH NUMBER	QUANTITY SUPPLIED

NURSES SIGNATURE

DATE

COPY

Forth Valley Elective Preoperative Assessment Record (Adults)

NHS

Forth Valley

COPY

Patient Details (addressograph)

Surname: **CHI**
 Forename: **2602800570**
 Address: **CRN:F207472 26/02/1980**
DOWELL SCOTT
11 DON STREET,
GRANGEMOUTH
FK3 8HD
 Postcode:
 Marital Status: **M**

Early Assessment

Yes ☐ No ☐

Title: Mr Mrs Miss Ms Dr

D.O.B.

Age: **30**

Telephone - Home: **01324 262719**

Telephone - Mobile: **07707657482**

Occupation: **carer for wife**

Religion: **Protestant**

Next of Kin Details

Next of Kin: **Diane Dowell**

Alternative Next of Kin:

Relationship: **WIFE**

Relationship:

Address: (if different from above)

Address: (if different from above)

A/A

Telephone - Home: **01324 262719**
 - Mobile:

Telephone - Home:
 - Mobile:

GP Details

Name: **Dr. Mears**

Telephone No:

Practice: **Group Medical Practice**

Address: **Ceresbank**

Surgeon: **HENDRIX**

Diagnosis:

Planned Procedure: **EXC. SKIN LESION (L) leg (R) Proximal shin**

Date of Assessment: **5.11.11** Date and time of Admission: **TBA**

Date of Operation: **TBA** Ward: Site: Neck Breather:

Allergies: metal ☒ foods ☒ drugs ☒ latex ☒

specify reaction:

Smoking **40 day** Cessation advice given Yes ☒ No ☐ Referred to S.C.S. Yes ☐ No ☒

Alcohol **Socially**

Previous Surgery/Anaesthesia (list previous surgery and anaesthesia with dates)

ORIF (L) arm (2006)
Removal birth mark
Spine (96)
Excw Cyst neck (92)

Any problems (surgical or anaesthetic)

No ☒ Yes ☒

Family History of Anaesthetic problems

No ☒ Yes ☐

Medical History (please circle)

Exercise Tolerance Yes ☐ No ☒	Distance Walked without stopping <i>Does not reg exercise but can walk 1-2 miles</i> 2 flights of stairs ☒
Shortness of Breath Yes ☐ No ☒	
Hypertension Yes ☐ No ☒	
Ischaemic Heart Disease/valve/murmur/cardiac failure Yes ☐ No ☒ Pillows <i>open</i>	Angina/MI/swollen ankles/ palpations/rheumatic fever/PND/murmur/orthopnoea
Cerebrovascular Disease <i>open</i> Yes ☐ No ☒	
Peripheral Vascular Disease Yes ☐ No ☒	<i>leg cramps constantly.</i>
Diabetes <i>open</i> Yes ☐ No ☒	
Asthma/COPD Yes ☐ No ☒	Steroids/cough/cold/antibiotics/hospitalisation <i>Branchitis - No chest infections for over year</i>
Peptic Ulcer Yes ☐ No ☒	
HH/GORD Yes ☐ No ☒	
Renal/Urological problems Yes ☐ No ☒	Nocturia <i>X1-2.</i>
DVT/PE/Clots Yes ☐ No ☒	
Arthritis Yes ☐ No ☒	Neck movement. <i>Good.</i>
Epilepsy Yes ☐ No ☒	<i>blackouts 15 yrs ago after head trauma</i>
Other medical ☒ Yes ☐ No	<i>Bells Palsy</i>

NHS
Forth Valley

CH12602800570

26/02/1980

DOWELL SCOTT
11 DON STREET
GRANGEMOUTH

COPY

FK3 8HDON EWARD ☐

COMMUNITY PHARMACY:

COMPLIANCE DEVICE: YES ☐ NO ☐

Filed by . . . patient/relative/carer/community pharmacy

Self medicates at home ☐ Supervised by carers ☐

Date: ____/____/____

Obtained by: Edna Date:

Verified by pharmacist Date:

Any Herbal/Over the Counter Medicines:

Comments:

Observations and Investigations

Weight

174.5

Height

91

BMI

30

P

97%

BP

122/64

SaO₂

97%

RR

12

COPY

6°C

Medical Examination/Comments

Cardiovascular System

Respiratory System

ASA 2

Sign

DVT Risk Factors

Suggested thromboprophylaxis required (all patients to be mobilised and well hydrated)

None ☐

CECS ☒

Intraop calf compression ☒

Enoxaparin ☐

Rivaroxaban ☐

Not sure ☐

Risk

Patient has read and understood the booklet describing anaesthetic risk

Yes ☐

No ☐

Patient is happy that the benefits of the procedure outweigh the risk

Yes ☐

No ☐

Patient been advised to read anaesthetic booklet

Yes ☒

No ☐

ASA grade

1

2

3

4

5

Any problems (specify)

To discuss with anaesthetist

Yes ☐

No ☒

To discuss with surgeon

Yes ☐

No ☒

Output

FVRH

SRI

(Circle)

Day Case

23 hours stay

Inpatient - DOSA/DBS

Date

5.1.11

Sign and Print

Liane Adol

Forth Valley Elective Pre-operative Assessment Record (Adults)



CHI 2602800570

CRN: F207472 26/02/1988

DOWELL SCOTT
11 DON STREET,
GRANGEMOUTH

COPY

FK3 8HD

Findings and Results

Enter results OR tick the "not requested in accordance with pre assessment guidelines" box.
If there is no change in the condition/therapy results within 3 months acceptable.

Hb	WCC	Platelets	CRP	ESR	Not requested ☐
Na	K	Ur	Cr	eGFR	Not requested ☐
Blood Glucose ☐ (random or fasting)		HbA1c ☐			Not requested ☐
ECG attached ☐		Not requested ☐		CXR attached ☐	Not requested ☐
GP & save Antibodies ☐		X match ☐ units			Not requested ☐
INR (PT) ☐		CLOTTING ☐			Not requested ☐
MSSU					Not requested ☐
AST	ALT	Bil	TP	Alb	Alk Phos
					Not requested ☐

Tests: ABGS Cardiac Echo, Pulmonary Functions, Exercise Test

HOSPITAL READMISSION CHECK

DATE:

Any changes in health since Pre-op Assessment?

Yes ☐
(document)

No ☐

Any hospital admission since Pre-op Assessment?

Yes ☐
(document)

No ☐

Any Blood Transfusion or blood products since Pre-op Assessment?

Yes ☐
(document)

No ☐

Are you pregnant? Yes ☐ No ☐

LMP ____/____/____

Test:

If "Yes" to any of the above, please repeat the cross match/group and save

Is it safe to proceed

Yes ☐ No ☐

Family Dialogue

COPY

Date & Sign

Forth Valley Elective reoperative Assessment Record (Adults)



CHI 2602800570
CRN: F207472 26/02/1960
DOWELL SCOTT
11 DON STREET,
GRANGEMOUTH

COPY

Nursing Admission Profile

		Yes	No	FK3 BHD Referrals
Some Circumstances				Addiction Team
Yes alone			✓	Dietetics
Yes with: <u>WIFE</u>				Infection Control
Is there a main Carer?			✓	Occupational Therapy
Yes - Social Work Dept. contacted?			✓	Nurse Specialist (specify)
Carer's Co-ordinator contacted?			✓	Physiotherapy
Is patient a main carer? <u>For wife</u>		✓		Podiatry
				Social Work
				Speech/Language Therapy
				Other (specify)
Housing	☐	House	☐	
Bungalow	☐	Residential	☐	
Nursing Home	☐	Sheltered Housing	☐	
Stairs: Inside	☐	Stairs: Outside	☐	
Existing Home equipment?		Yes ☐	No ☐	

Yes give details below Patient

Nursing Admission Profile

Activities of Daily Living Assessment

Admitting Nurse: (PLEASE PRINT)

Normally

On Admission

Admitting Nurse Signature:

Date:

Time:

COPY

Normally

On Admission

COMMUNICATION

Able to communicate

Unable to communicate

Mental State:

- Alert/orientated
- Confused
- Anxious/distressed

Hearing:

- Normal
- Impaired (specify)
- Hearing Aid

Eye Sight:

- Normal
- Impaired (specify)
- Glasses/Contact Lenses

BREATHING

No problems identified

Breathless at rest

Breathless on exertion

Home nebuliser

Home O₂

EATING AND DRINKING

Malnutrition Universal Screening Tool (MUST) Score: (specify):

Dietetic referral required

Special dietary requirements identified

If yes specify:

Special equipment required (specify)

Enteral feeding

Assistance required (specify):

Nil by mouth

Food allergies identified

Cultural/ethnic/religious requirements identified (specify)

ELIMINATING

No problems identified

Constipated

Loose stools

Urinary frequency

Urinary incontinence

Incontinent doubly

Indwelling catheter

Stoma

EXTERNAL ENVIRONMENT

Mobility:

- Tissue viability
- Fully ambulant
- Walks with assistance
- Zimmer
- Walking stick
- Chair bound
- Transfers: 1/2 people
- Bed bound
- Therapeutic Mattress required
- Prosthesis

Patient Handling Assessment completed
Falls Risk Assessment completed

PERSONAL CLEANSING/DRESSING

Self caring

Requires assistance

Totally dependent

Teeth:

- Patient's own
- Crowns
- Loose
- Dentures – upper/lower/both

SLEEPING

No problems identified

Requires sedation

Personal Belongings

Clothing Listed

Dentures Top

Dentures Bottom

Prosthetics

Any valuables: If yes

With patient

Ward Safe

Finance Department

Sent home with relatives

Valuables Policy explained

Forth Valley Elective Record (Adults)



COPY

Nursing Admission Profile

Discharge Checklist (cont.)

Date

Please circle appropriately

Signature

Pre-discharge home visit undertaken		Yes/Not applicable	
Referral to community based services		Yes/Not applicable	
Nursing transfer document completed		Yes/Not applicable	
Home help contacted (if applicable)		Yes/Not applicable	
MECS contacted (if applicable)		Yes/Not applicable	
Meals on wheels contacted (if applicable)		Yes/Not applicable	
Access to house/outdoor clothes, shoes etc.		Yes/Not applicable	
Heating and food available		Yes/Not applicable	
Patient involved in discharge planning		Yes/Not applicable	
Relatives/carers involved in discharge planning		Yes/Not applicable	
Special preparations from discharge planning arranged		Yes/Not applicable	
Discharge summary completed		Yes/Not applicable	
Discharge medicines check by 2 nurses		Yes/Not applicable	
A supply of drugs/dressing/appliances are given		Yes/Not applicable	
Venflon removed/wound checked		Yes/Not applicable	
Transport arranged for discharge		Yes/Not applicable	
Follow up hospital appointment arranged		Yes/Not applicable	
Written and verbal instruction given to patient/carer		Yes/Not applicable	
Day Surgery Unit			
Post op vital signs stable (pulse, blood pressure and sats)		Yes/Not applicable	
Alert and orientated as per Care Plan 1		Yes/Not applicable	
Able to sit and walk unaided		Yes/Not applicable	
Has had something to eat and drink per Care Plan 5		Yes/Not applicable	
Has minimal nausea and is not being sick as per Care Plan 5		Yes/Not applicable	
Operation site checked as per Care Plan 3		Yes/Not applicable	
Has passed urine as per Care Plan 6		Yes/Not applicable	
Pain well controlled as per Care Plan 3		Yes/Not applicable	
Verbal and written instructions given		Yes/Not applicable	
District nurse contacted		Yes/Not applicable	
Collected by responsible adult who will be present for 24 hours		Yes/Not applicable	

COPY

10

GOING HOME

NAME Mr/Mrs/Miss CH12602800570
 ADDRESS CRN:F207472 26/02/1980
DOWELL SCOTT
11 DON STREET,
GRANGEMOUTH
 UNIT No: FK3 8HD

ADDRESS TO WHICH DISCHARGED IF DIFFERENT
COPY

G.P. Dr Meares
 CONSULTANT Mr Debonin
 WARD OSU

SCHOOL NOW ATTENDED
 HOSPITAL FVRH
 DATE OF ADMISSION 22/1/11 DATE OF DISCHARGE 22/1/11

DIAGNOSIS

TREATMENT IN HOSPITAL (DATE OF OPERATION IF APPLICABLE)

Excision of skin lesion under general anaesthetic
closed with ethilon sutures and mepore dressing

TREATMENT REQUIRED FOLLOWING DISCHARGE (DRESSINGS, INJECTIONS, DIET, CATHETER & CATHETER SIZE)

Please remove sutures in 2 weeks (Friday 4th Feb)
and as required
Thankyou

DRUG	DOSE	FREQUENCY
<u>Paracetamol</u>	<u>1gm</u>	
<u>Diclofenac</u>	<u>50mg</u>	

Services requested - (tick as applicable)

Hospital and Community Nursing Service

District Nursing Sister ☒
 Health Visitor ☒
 Nursing Aids ☒
 Incontinence Aids ☒
 Day Hospital ☒
 Chiropody ☒
 Physiotherapy ☒
 Limb Fitting Centre ☒
 Speech Therapy ☒

Requested via Social Worker

Home Help ☒
 Meals on Wheels ☒
 MECS Alarm ☒
 Sitter Day/Night ☒
 Day Centre ☒
 Welfare Waiting List ☒
 Social Work support ☒

Requested via Occupational Therapist

Personal Aids ☒
 Adaptation to home ☒

Ability on discharge (underline items applicable)

Lives alone - YES/NO ☒
 Walks - Unaided ☒ - needs help - with frame/stick/tripod ☒
 Stairs - Unaided ☒ - needs help - cannot manage ☒
 Bed - Unaided ☒ - needs help - bedfast ☒
 Dressing - Unaided ☒ - needs help ☒
 Toilet - Unaided ☒ - needs help - can/cannot manage catheter ☒
 Bathing - Unaided ☒ - needs help - unable to bath ☒
 Special appliances (e.g. commode)

Additional Information

O.P.D. Follow-up Appointment

NO follow up

Signed [Signature] Sister/Charge/Staff Nurse Date 22/1/11

8679370

Lorente

**Department of Rheumatology
Approval for Biologic Therapy**

COPY

Patient Demographics

Scott Dowell, CHI: 2602800570 11 Don Street, Grangemouth, FK3 8HD

The above named patient meets current eligibility criteria for biologic therapy and has been counselled and consented for treatment as follows:

Indication	✓	IPTR Approval (if Required)
Rheumatoid Arthritis		
Ankylosing Spondylitis	X	
Psoriatic Arthritis		
Other (please specify)		

Drug	Route (delete as appropriate)	Treatment			Switched From (if appropriate)
		Initial	2 nd Line	Subsequent	
Orencia (Abatacept)	Subcutaneous Intravenous				
Humira (Adalimumab)	Subcutaneous				
Cimzia (Certolizumab)	Subcutaneous				
Benepali (Etanercept)	Subcutaneous				
Enbrel (Etanercept)	Subcutaneous				
Simponi (Golimumab)	Subcutaneous	X			
Remsima (Infliximab)	Intravenous				
Remicade (Infliximab)	Intravenous				
MabThera (Rituximab)	Intravenous				
RoActemra (Tocilizumab)	Subcutaneous Intravenous				
Stelara (Ustekinumab)	Subcutaneous				

Approved By:.... Sr Carol Ann Davies.....

Date: ...11/08/16.....

Pharmacy Use:

Treatment Date:.....

Review Date:.....

BIOLOGICAL THERAPY FOR ARTHRITIS

Golimumab 50mg monthly injections

Dr D Dundas
Westburn Medical Practice
Falkirk Community Hospital
Westburn Ave
Falkirk
FK1 5SU

Date: 11/08/2016

Dear Dr Dundas

Re: Scott Dowell, CHI: 2602800570 11 Don Street, Grangemouth, FK3 8HD

Mr Dowell is Golimumab (Simponi) a biologic therapy given by s/c injection monthly for management of his Ankylosing Spondylitis. A nurse from Health Care at Home will attend Mr Dowell's home to educate him on administration of this treatment. I have enclosed information regarding Golimumab for your information. The injections will be continued to be delivered to him at home by Health Care at Home and prescribed by us.

This treatment is immunosuppressant in nature. I would be grateful if you could note specifically the section on increased risk of infection whilst on this treatment and the need for prompt intervention and treatment as required. He will require to have pneumococcal immunisation if not previously administered and annual flu immunisation whilst on treatment.

It would be helpful if bloods (FBC, U&E, LFT, CRP & ESR) could be taken 3 monthly however the patient is aware that if this is not an option, then he/she can attend phlebotomy in Forth Valley Royal Hospital, Area 3, Outpatient dept. He will be followed up initially at 3 months following commencement on treatment and then again at 6 months. If he is tolerant and Golimumab is effective he will continue to be followed up 6 monthly in the biologic clinic thereafter.



INVESTOR IN PEOPLE

Chairman Ian Mullen OBE BSc MR PharmS DL
Chief Executive Fiona Mackenzie MA (Hons) MBA MIHM DipHSM

Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SW

www.nhsforthvalley.com



If you have any questions or require further information you can contact us via the nurse advice line on 01324 566934.

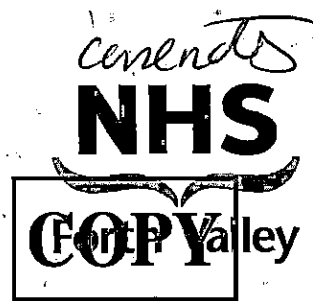
Yours sincerely,

Carol Ann Davies
Rheumatology Specialist Nurse
Forth Valley Royal Hospital
01324 566934

e-mail: carolann.davies@nhs.net

Department of Rheumatology
Rheumatology Nurse Service
Tel: 01324 566934

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Ref: CAD//2602800570

Date: 11/08/16

Scott Dowell,
11 Don Street,
Grangemouth,
FK3 8HD

Dear Mr Dowell

I have completed your prescription to facilitate commencement on Golimumab (Simponi) 50mg monthly injection, the new treatment recommended for management of your Ankylosing Spondylitis.

The home care company Health Care at Home will deliver your injections and provide education on how to give these. A nurse will make arrangements to visit you at home for the first 1-2 injection to make sure you are confident administering your injection independently.

When you receive delivery of your injection I would be grateful if you could store these in the fridge.

I would be grateful if you could attend for blood monitoring before your next appointment. You may be able to have these checked at your GP practice however if they cannot accommodate this for you can attend the phlebotomy dept in Forth Valley Royal Hospital, Area 3, Out Patient Dept. This service is available Mon, Wed, Thurs, Friday from 9:00 to 12:30 and 13:30 to 16:00. If you need to use this service you will require to take a lab request form with you. I have enclosed a form for your convenience.

I have cancelled the appointment you had on 27/09/16 as you should be seen 3-4 months following starting on your new treatment. Dr Else will see you in the Biologic Clinic for review on Thursday 22.12.16 at 9:40am in Outpatient Department, Area 3, Forth Valley Royal Hospital and then further assessment has been arranged for Tuesday 14/02/17 in outpatient dept, Area 2, Stirling Community Hospital with S/N Sharon Menzies. Should you have any questions you can contact us via the nurse advice service on 01324 566934.

Yours sincerely

Sr Carol Ann Davies
Rheumatology Specialist Nurse
Forth Valley Royal Hospital

Nurse advice service: 01324 566934



Chairman: Alex Linkston CBE
Chief Executive: Jane Grant

Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SW

www.nhsforthvalley.com [Facebook.com/nhsforthvalley](https://www.facebook.com/nhsforthvalley) nhsforthvalley

Forth Valley Rheumatology Biologics Checklist

24/5/16

COPY notes

Patient details

Name:	CHI 2602800570 CRN: S679370 26/02/1980
Address:	DOWELL SCOTT 11 Don Street, GRANGEMOUTH, Stirlingshire FK3 8HD
Date of Birth:	
CHI:	
Telephone no:	

Disease

Disease type (erosive, serology, associations etc.)	ANK SPOND 7 CXR on PACS
Date diagnosed	24/5/16
Previous treatments (inc side-effects)	MMARCO BOLUSAN DILUPREN 7/6/16 Endo MR Crumley 21/6/16 minor op's Scott Dowell 26/2/80
Current disease activity (specify score used)	START 5.20 VAS 10
Does patient qualify for biologics?	YES

Qualification Criteria

- RA: Failed 2 standard DMARDs (side-effects or 3 months on therapeutic dose)
DAS28 > 5.1 on 2 occasions at least 1 month apart (DAS28-CRP, DAS28-ESR, DAS28-CRP-3)
- PsA: Failed 2 standard DMARDs (side-effects or 3 months on therapeutic dose)
3 tender and 3 swollen joints (inc. dactylitis) on single occasion
NB. Need 66/68 joint counts at baseline to assess response later on
- AS: Failed 2 NSAIDs (side-effects or 3 months on therapeutic dose)
BASDAI > 4.0 and spinal pain VAS > 4/10 on 2 occasions at least 12 weeks apart

Patient details

COPY

Safety checklist

[illegible]

Ophthalmology Department

Consultant: Jennifer Gillen

Tel: 01324 614369

Fax:

Falkirk Community Hospital

Major's Loan

Falkirk

FK1 5QE



Ref: JG/HR/S679370(rac)

CHI: 2602800570

Clinic Date: 12 August 2016

Date: 15 August 2016

Dr Derek Dundas
Westburn Medical Practice
Falkirk Community Hospital
Westburn Ave
Falkirk
FK1 5SU

Dear Dr Dundas



Scott Dowell 26/02/1980

11 Don Street, GRANGEMOUTH, Stirlingshire FK3 8HD

Diagnosis Right corneal foreign body

This patient attended with a right corneal rust ring. This was removed under local anaesthetic. He should use Oc. Chloramphenicol three times a day until the area is healed and he knows he should wear eye protection at work.

Yours sincerely

Jennifer Gillen
Consultant Ophthalmologist

Department of Rheumatology* **Consultant: Dr Sara Else**

Tel: 01324 566336 / 01324 566337

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WRDr Derek Dundas
Westburn Medical Practice
Falkirk Community Hospital
Westburn Ave
Falkirk
FK1 5SUDate Dictated 24 May 2016
Date Typed 25 May 2016Our Ref SE/bd
CHI 2602800570

Dear Dr Dundas

Scott Dowell 26/02/1980
11 Don Street, GRANGEMOUTH, Stirlingshire FK3 8HD**Diagnosis:**

1. Ankylosing spondylitis
 - Axial disease
 - Evidence of complete ankylosis sacroiliac joints on x-ray
 - Post inflammatory corner changes along with extensive ankylosis on MRI spine
 - Destructive changes to left hip
 - Elevated CRP
2. Indigestion – awaiting OGD

Current Medication:

1. Dihydrocodeine
2. Lansoprazole

Previous Treatments:

1. Diclofenac
2. Ibuprofen
3. Naproxen

Management:

1. Intramuscular Depo-Medrone 120mg given today
2. Referral to Physiotherapy
3. Screening for Anti TNF

Follow Up:Four months – Nurse Specialist Biologics Clinic
Seven months – Consultant Biologics Clinic

Many thanks for referring this 36-year-old gentleman to the rheumatology clinic. Mr Dowell has had problems with pain in his back for many years (since he was at least 16), spine, rib cage and lumbar spine. He gets early morning stiffness, which lasts for approximately one hour and improvement in use.

**INVESTORS**
IN PEOPLE | SilverChairman: Alex Linkston CBE
Chief Executive: Jane GrantForth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SWwww.nhsforthvalley.com Facebook.com/nhsforthvalley @nhsforthvalley

He is also getting pain around the left knee for which he has seen the Orthopaedic team. They have diagnosed that he does not actually got knee pathology, but he has complete obliteration of the hip joint along with a fusion of the sacroiliac joints and changes that are consistent with ankylosing spondylitis on MRI scanning.

COPY

In the past, Mr Dowell has tried a variety of anti inflammatories including Diclofenac, Ibuprofen and Naproxen which have not been beneficial. He is currently getting problems with nausea and indigestion and he is awaiting an OGD, which would contraindicate any further treatment with anti inflammatories.

Mr Dowell has no other significant past medical history of note. He smokes roll up cigarettes but he is planning to quit. He is a full time carer for his wife.

On examination today, there was significant restriction in the range of movement of his neck in all directions. He had minimal (if any) movement of the lumbar spine. This would be in keeping with the changes that were seen on the MRI scan. BASDAI was 5.90 with a spinal pain VAS of 10.

I have explained to Mr Dowell today that he has established ankylosing spondylitis, however given that he is getting ongoing early morning stiffness and that he has elevation of his CRP I am wondering if he still has a degree of active disease which might be amenable to therapy.

I have arranged to give him an intramuscular Depo-Medrone injection to see if this improves his symptoms and I think that he would also benefit from a trial of anti TNF therapy. I am organising for screening for this.

I am also going to refer Mr Dowell for physiotherapy.

Mr Dowell will be seen back in the nurse specialist biologics clinic in four months time and in the consultant biologics clinic in seven months time.

Results

Hep B surface, Hep C and HIV negative
Hep B core awaited
Quantiferon gold awaited
Varicella immune

FBC, U+E, LFTs normal
CRP 15

CXR: NAD (formal report awaited)

Yours sincerely

(Dictated and electronically checked by Dr Sara Else)

Dr Sara Else
Consultant Rheumatologist

cc: **By Email: Anitacarr@nhs.net**
Anita Carr
Physiotherapist
Department of Physiotherapy
SCH

Dear Anita

This gentleman has severe ankylosing spondylitis and desperately needs some physiotherapy.

Many thanks

Sara

cc: Carol Ann Davies
Rheumatology Nurse Specialist
Department of Rheumatology
FVRH

COPY

Dear Carol Ann

This gentleman has ankylosing spondylitis and would qualify for biologic therapy. I have completed screening with him and I would anticipate him going onto Golimumab.

Many thanks

Sara

Date Received: Fri 27/05/16

CHI: 2602800570

Hospital Number: 5679370

COPY

Permanent Flags

- ☐ COLAPPT - COLORECTAL CON ANY
☐ COLOCON - COLORECTAL NAMED
☐ GENERALA - GENERAL ANY CON
☐ SGENERAL - GENERAL NAMED CON
☐ UPPER GI - UPPER GI ANY
☐ VASCULAR - VASCULAR APPOINTMENT

Hospital use only	Clinic	Day Date	Time	Hospital No.
----------------------	--------	-------------	------	-----------------

REFERRAL LETTER

MEDICAL IN
CONFIDENCE

*e Referral Submitted
(date is fixed at hospital end):
27-May-2016

2602800570

CHI No: 2602800570

101011486423P

Unique Care Pathway Number: 101011486423P

REFERRAL TO

General Surgery C1
FV Minor Ops referral

Consultant / receiving practitioner and/or
specialty clinic

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR

Hospital and hospital address

Hospital location code

V217H

Urgency of Referral

Routine Minor Ops Referral

Administrative Information

Patient has special requirements: No

PATIENT DETAILS

Surname: Dowell
Forename(s): Scott
Title: - Sex: Male
Previous Surname: -
Date of birth: 26-Feb-1980
CHI no: 2602800570

Patient's address

11 Don Street
Grangemouth
FK3 8HD

Contact number(s)

Voice: 01324 262719

REFERRING PRACTITIONER DETAILS

Name: Dr Derek Dundas (GMC: 6075873)
Practice: Westburn Medical Practice (18749)
Phone: Voice: 01324 623577
Facsimile: 01324 633636

Practice address:

Westburn Medical Practice
Westburn Avenue
Falkirk
FK1 5QE

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting Complaint

Description: removal of cystic swelling over neck

Comment: Thank you for consider seeing this young man with a cystic swelling over his neck. It has increased in size and he is keen to have it removed.
Grateful for your review.

COPY

Examinations and Investigations

Murmur present: Not Recorded -
Is a 12 lead ECG: Not done -
Recent CXR: Not done -
FBC: Not Recorded -
Urea and Electrolytes: Not Recorded -
LFT: Not Recorded -
TFT: Not Recorded -
Lipid Profile: Not Recorded -
Glucose: Not Recorded -

Patient Measurements

Diastolic	Systolic	Height	Weight	BMI	Date Recorded
122	73				10-May-2016
121	74				06-May-2016

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Medical history

Active Repeat Therapy

Some Repeats may be Active but not Issued. In these instances, the Date Last Issued field contains the date authorised by the GP.

No current medications recorded

Issued Scripts for Acutes and Inactive Repeats (in last 90 days)

Drug name	Drug code	Formulation	Dosage	Frequency
Complan Shake Powder (Mixed Flavours) Sachets 4 x 57 gram sachets	-	1*1 box	ONE SACHET DAILY	- 42 Days
Ondansetron Hydrochloride Tablets 4 mg	040600050AAABAB	10 tablet	ONE TABLET TWICE DAILY	- 5 Days
Metoclopramide Hydrochloride Tablets 10 mg	0406000P0AAAEAE	21 tablet	1 TABLET 3 TIMES DAILY	- 11 Days
Esomeprazole Capsules (Gastro-Resistant) 30 mg	0103050L0AAAAAA	56 CAPSULE	1 Cap Twice daily	- 42 Days
Complan Shake Powder (Mixed Flavours) Sachets 4 x 57 gram sachets	-	1*1 box	ONE SACHET DAILY	- 1 Days
Dioralyte Oral powder	0902012H0BBAEAE	6 sachet	ONE OR TWO SACHETS DAILY	- 42 Days
Dihydrocodeine Tablets 30 mg	0407020G0AAACAC	100 tablet	ONE OR TWO TABLETS TO BE TAKEN UP TO FOUR TIMES DAILY FOR PAIN	- 42 Days
Prochlorperazine Maleate Buccal tablets 3 mg	0406000T0AAAKAK	8 tablet	ONE TO BE DISSOLVED BETWEEN UPPER LIP AND GUM THREE TIMES A DAY	- 3 Days
Gabapentin Capsules 300 mg	0408010G0AAABAB	84 capsule	ONE CAPSULE THREE TIMES DAILY	- 82 Days
Flucloxacillin Capsules 500 mg	0501012G0AAABAB	28 CAPSULE	ONE CAPSULE TO BE TAKEN FOUR TIMES DAILY	- 42 Days
Dihydrocodeine Tablets 30 mg	0407020G0AAACAC	100 tablet	ONE OR TWO TABLETS TO BE TAKEN UP TO FOUR TIMES DAILY FOR PAIN	- 12 Days

Clinical warnings

Smoking status: Number per day: ? (not known)

Alcohol status: Units per day: ? (not known)

Exercise status: Not Known

Additional relevant information

Signature of referring doctor (or other professional)

Date

27-May-2016

COPY

GASTROSCOPY REPORT

Name: **Scott DOWELL (M)**
Date of birth: **26/02/1980**
No: **2602800570**
Case note no.: **F207472**

Address:

11 Don Street,
Grangemouth
Stirling, Sh.
FK3 8HD

COPY

GP: **Dr DW Dundas**
Westburn Medical Practice
Falkirk Community Hospital
Westburn Ave
Falkirk
FK1 5SU

Procedure date: **7th June 2016 (15:11)**
Priority: **Urgent**
Status: **Outpatient/NHS**
Hospital: **FVRH**
Referring Cons: **Dr Santosh Salunke**
(Referring Consultants)

Indications

Nausea and/or vomiting and Epigastric pain.
Clinically important comments: Symtomatic despite PPI

Report

The procedure was completed successfully to D2.

Site a: Lower oesophagus

Non-circular Barrett's epithelium from 39cm to 40cm.
Specimens: 2x biopsy.

Site b: Antrum

Gastritis: mild erythematous/exudative with no bleeding.
Specimens: Urease test for H.pylori.

Site c: First part

Duodenitis: mild.

Diagnosis

OESOPHAGUS. Barrett's mucosa.
STOMACH. Gastritis.
DUODENUM. Duodenitis.

Advice/comments

Widely patent pylorus scope passed into D2 with ease.
Appearances suggestive of C0M1 homogenous Barretts oesophagus.
Mild gastritis and D1 duodenitis, urease test taken to exclude H.Pylori, please eradicate if positive.

Follow up

Awaiting pathology results.

Consultant/Endoscopist

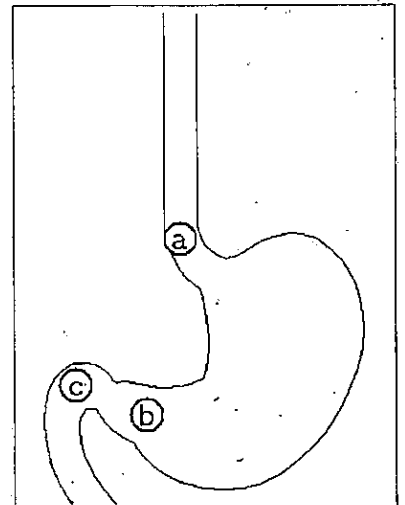
List consultant: Euan MacDonald
Endoscopist No1: Diane Kennedy
Nurses: Pauline Donnelly
Barbara Dowell

Instruments

GIF Q260 (S/N 2644155)
Disposable forceps

Premedication

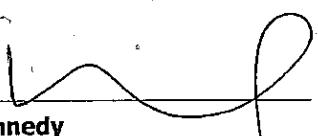
Midazolam (IV) 3 mg



a: Lower oesophagus
(photographed)
b: Antrum
c: First part

Urease test results

☐ Positive
☐ Negative


Diane Kennedy
Nurse Endoscopist

c.c. Dr Santosh Salunke (Referring Consultants)

GASTROSCOPY REPORT

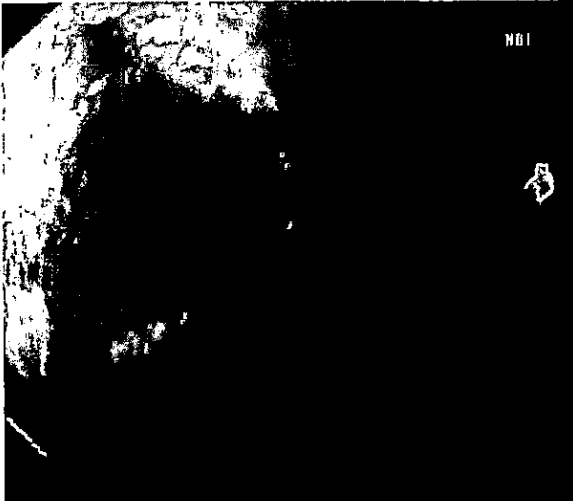
Name: **Scott DOWELL (M)**
Date of birth: **26/02/1980**
No: **2602800570**
Case note no.: **F207472**

Address:

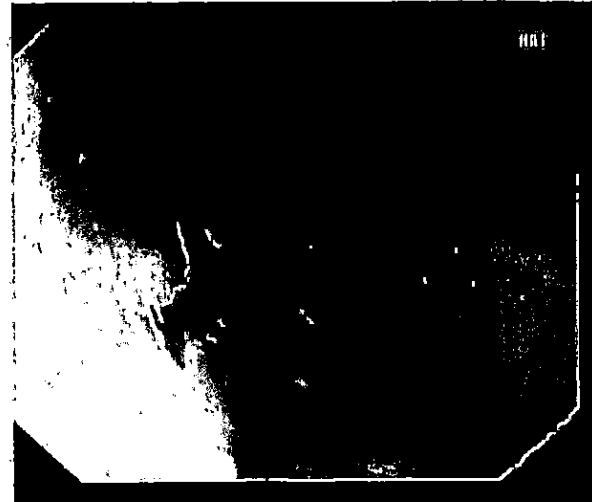
11 Don Street
Grange Road,
Sirlingshire
FK3 8HD

COPY

Procedure date: **7th June 2016 (15:11)**



Site a: Lower oesophagus
Non-circular Barrett's epithelium from 39cm to 40cm.



Site a: Lower oesophagus
Non-circular Barrett's epithelium from 39cm to 40cm.



Site a: Lower oesophagus
Non-circular Barrett's epithelium from 39cm to 40cm.

AC/DK 7/6

Date Received: Fri 06/05/16
CHI: 2602800570

Hospital Number: S679370

COPY

Permanent Flags

- ☐ ugi - UPPER GI APPT
☐ ggi - GENERAL GI APPT
☐ HEP - HEPATOLOGY APPT
☐ IBD - IBD APPT
☐ ENDOCONS - ENDO CONSULTANT ONLY PROC
☐ PS - Suitable for P Sector

Referral Notes:

OGD (09/05/16) (SSALUNKE, 09/05/16)

Hospital only	Clinic	Day Date	Time	Hospital No.
------------------	--------	-------------	------	-----------------

Date Referral Submitted
(This date is fixed at hospital end):
06-May-2016

REFERRAL LETTER

MEDICAL IN
CONFIDENCE

2602800570

CHI No: 2602800570

1010113492304

Unique Care Pathway Number: 1010113492304

REFERRAL TO	
Gastroenterology A9 FV Upper GI Endoscopy	Consultant / receiving practitioner and/or specialty clinic
Forth Valley Royal Hospital Stirling Road Larbert FK5 4WR	Hospital and hospital address Hospital location code: V217H
Urgency of Referral Urgent Upper Gastro-Intestinal Endoscopy Request	
Administrative Information Patient has special requirements: No	

PATIENT DETAILS	
Surname Dowell	Patient's address 11 Don Street Grangemouth FK3 8HD Contact number(s) Voice: 01324 262719
Forename(s) Scott	
Title - Sex Male	
Previous Surname -	
Date of birth 26-Feb-1980	
CHI no. 2602800570	

REFERRING PRACTITIONER DETAILS	
Name: Dr Anna O'Sullivan (GMC: 6071932)	Practice address: Westburn Medical Practice Westburn Avenue Falkirk FK1 5QE
Practice: Westburn Medical Practice (18749)	
Phone: Voice: 01324 623577 Facsimile: 01324 633636	

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting Complaint

Description: epigastric pain and persistent vomiting

Comment: Thanks for organising this 36 year old gentleman who for 2 weeks has had persistent epigastric pain, cramps and persistent vomiting whenever he eats. Can drink and eat only small amounts. He has been on a nsaid for his chronic back pain due to ankylosing spondylitis and hip pain but it was stopped 2 weeks ago but he is no better despite max dose lansoprazole. He is haemodynamically stable, tender epigastric area, soft no guarding or rebound. I have added in metoclopramide and he is restarting his dnc/ gabapentin as stopping them is making his pain worse. I think he needs an urgent endoscopy as I am trying to avoid an admission. I am reviewing early next week and organising bloods.

Kind regards

Dr Anna O'Sullivan

Examinations and Investigations

Previous Gastric Surgery: No -
Previous Endoscopy: No -
Dysphagia: Not Recorded -
Nausea: Yes -
Vomiting: Yes -
Haematemesis: Not Recorded -
Melena: Not Recorded -
Chest Pain: Not Recorded -
Early Satiety: Not Recorded -
Anaemia: Not Recorded -
Anorexia: Not Recorded -
Weight Loss: Not Recorded -
Epigastric Pain: Yes -
Heartburn: Not Recorded -
Bloating: Not Recorded -
Altered Bowel Habit: Not Recorded -
Previous HP eradication therapy: No -
Helicobacter serology: Not Recorded -
FBC: Not Recorded -
Urea and Electrolytes: Not Recorded -
LFT: Not Recorded -
TFT: Not Recorded -
Lipid Profile: Not Recorded -
Glucose: Not Recorded -

Patient Measurements

Diastolic	Systolic	Height	Weight	BMi	Date Recorded
121	74				06-May-2016

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Medical history

Active Repeat Therapy

Some Repeats may be Active but not Issued. In these instances, the Date Last Issued field contains the date authorised by the GP.

No current medications recorded

Issued Scripts for Acutes and Inactive Repeats (in last 90 days)

Drug name	Drug code	Formulation	Dosage	Frequency
Metoclopramide Hydrochloride Tablets 10 mg	0406000P0AAAAEAE	21 tablet	1 TABLET 3 TIMES DAILY	- - 7 Days
Lansoprazole Capsules (Gastro-Resistant) 30 mg	0103050L0AAAAAA	56 CAPSULE	1 Cap Twice daily	- - 42 Days
Complan Shake Powder (Mixed Flavours) Sachets 4 x 57 gram sachets	-	1*1 box	ONE SACHET DAILY	- - 1 Days
Dioralyte Oral powder	0902012H0BBAEAE	6 sachet	ONE OR TWO SACHETS DAILY	- - 42 Days
Dihydrocodeine Tablets 30 mg	0407020G0AAACAC	100 tablet	ONE OR TWO TABLETS TO BE TAKEN UP TO FOUR TIMES DAILY FOR PAIN	- - 42 Days
Prochlorperazine Maleate Buccal tablets 3 mg	0406000T0AAAKAK	8 tablet	ONE TO BE DISSOLVED BETWEEN UPPER LIP AND GUM THREE TIMES A DAY	- - 3 Days
Gabapentin Capsules 300 mg	0408010G0AAABAB	84 capsule	ONE CAPSULE THREE TIMES DAILY	- - 82 Days
Fluoxetine Capsules 500 mg	0501017G0AAABAB	28	ONE CAPSULE TO BE TAKEN FOUR TIMES	- - 42 Days

Prescription	Quantity	Form	Dosage	Days
Dihydrocodeine Tablets 30 mg	0407020G0AAACAC	100 tablet	ONE OR TWO TABLETS TO BE TAKEN UP TO FOUR TIMES DAILY FOR PAIN	12 Days
Co-Codamol 30/500 Tablets	0407010F0AAAH AH	55 tablet	ONE OR TWO UP TO QDS PRN FOR PAIN	42 Days

COPY

Clinical warnings

Smoking status: Number per day: ? (not known)

Alcohol status: Units per day: ? (not known)

Exercise status: Not Known

Additional relevant information

Signature of referring doctor (or other professional)

Date

05-May-2016

COPY

Date Received: Thu 03/03/16

CHI: 2602800570

Hospital Number: S679370

COPY

Permanent Flags

☐ PS - Suitable for P Sector

Referral Notes:

unclear why needs urgent review - downgraded to routine (SELSE, 04/03/16)

Hospital use only	Clinic	Day Date	Time	Hospital No.
----------------------	--------	-------------	------	-----------------

Date Referral Submitted:

(This date is fixed at hospital end):
03-Mar-2016

REFERRAL LETTER

**MEDICAL IN
CONFIDENCE**

2602800570

CHI No: 2602800570

101010951895E

Unique Care Pathway Number: 101010951895E

REFERRAL TO

RheumatologyAR
FV Rheumatology Clinic

Consultant / receiving practitioner and/or
specialty clinic

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR

Hospital and hospital address

Hospital location code:

V217H

Urgency of Referral

Urgent Rheumatology Clinic Referral

Administrative Information

Patient has special requirements: No

PATIENT DETAILS

Surname: Dowell
Forename(s): Scott
Title: - Sex: Male
Previous Surname: -
Date of birth: 26-Feb-1980
CHI no.: 2602800570

Patient's address

11 Don Street
Grangemouth
FK3 8HD

Contact number(s)

Voice: 01324 262719

REFERRING PRACTITIONER DETAILS

Name: Dr Derek Dundas (GMC: 6075873)
Practice: Westburn Medical Practice (18749)
Phone: Voice: 01324 623577
Facsimile: 01324 633636

Practice address:

Westburn Medical Practice
Westburn Avenue
Falkirk
FK1 5QE

COPY

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting Complaint

Description: ?Ankylosing Spondylitis

Comment: This young chap was ref to ortho regarding pain in his knees. Unfortunately his hip was very arthritic and it was felt to be referred pain from there. Interestingly his SI joints were obliterated and the recent scans showed evidence of a "Bamboo spine". Ortho, I think, were ref to yourselves urgently for review of this. Unfortunately you were not copied into their letter and I'm sending this on the off chance they may have forgotten. Grateful for your input.

COPY

Examinations and Investigations

Murmur present: Not Recorded -
Is a 12 lead ECG: Not done -
Recent CXR: Not done -
FBC: Not Recorded -
Urea and Electrolytes: Not Recorded -
LFT: Not Recorded -
TFT: Not Recorded -
Lipid Profile: Not Recorded -
Glucose: Not Recorded -

Reason for referral

Care type requested: Out Patient
Expected outcome: Not Specified

Medical history

Active Repeat Therapy

Some Repeats may be Active but not Issued. In these instances, the Date Last Issued field contains the date authorised by the GP.

No current medications recorded

Issued Scripts for Acutes and Inactive Repeats (in last 90 days)

Drug name	Drug code	Formulation	Dosage	Frequency	
Co-Codamol 30/500 Tablets	0407010F0AAAH	56 tablet	ONE OR TWO UP TO QDS PRN FOR PAIN	-	42 Days
Naproxen Tablets 500 mg	1001010P0AAAEAE	56 TABLET	ONE TO BE TAKEN TWICE A DAY	-	80 Days
Lansoprazole Capsules (Gastro-Resistant) 30 mg	0103050L0AAAAAA	56 CAPSULE	ONE TO BE TAKEN EACH MORNING	-	94 Days

Clinical warnings

Smoking status: Number per day: ? (not known)

Alcohol status: Units per day: ? (not known)

Exercise status: Not Known

Additional relevant information

Signature of referring doctor (or other professional)

Date

03-Mar-2016

Department of Orthopaedic Surgery
Consultant: Mr James Roche
Tel: 01324 566817
Fax:

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Ref: JR/SJC/S679370 n.n
CHI: 2602800570

Clinic Date: 18 March 2016
Date: 18 March 2016

Scott Dowell
11 Don Street,
GRANGEMOUTH,
Stirlingshire
FK3 8HD

Dear Mr Dowell



I have had a chance to review the MRI scan of your lumbar spine. This does show the fused lower vertebra. There is no particular compression of the nerve root from the back and therefore I suspect the significant proportion of your symptoms are coming from the hip. As we noted before I think it would be worth postponing surgery for as long as possible. Hopefully the Rheumatologist will be able to address the underlying cause of the ankylosis otherwise I would be grateful if you could contact the GP about starting on neuropathic pain relief such as Gabapentin and please contact us if your symptoms deteriorate.

Kind regards
Yours sincerely

Mr James Roche
Consultant Orthopaedic Surgeon

CC

Dr Derek Dundas
Westburn Medical Practice
Falkirk Communityhospital
Westburn Ave
Falkirk
FK1 5SU

5679370

**RADIOLOGY REPORT- FORTH VALLEY ROYAL HOSPITAL****CHI NUMBER: 2602800570 Examination Number: 32208158****Name: Dowell, Scott DOB: 26/02/1980****Address: 11 DON STREET, GRANGEMOUTH, FK3 8HD, -- CC: -****Examination: MRI Spine Lumbar/Sacral****Examination Date: 09/03/2016 Examination Time: 13:00****Dictating Radiologist: DR EN HSUN CHOI GMC 4697569****Typed by: None****Referring Consultant: ROCHE, MR J, CONS ORTHOPDC SRG****Referring Department / Location: ORTHOPAEDIC OPD****Clinical History:** Left leg pain. Fused lumbar spine.**Report:**

Standard MRI-lumbar spine. STIR sagittal.

Ankylosis of the lumbar spine, with postinflammatory fatty corner changes. High signal and calcification in the multiple discs without vertebral marrow oedema. No disc herniation. Normal distal cord, conus and cauda equina. No nerve root compromise.

Opinion:

Evidence of previous/ chronic spondylitis with postinflammatory fatty corner changes and extensive ankylosis. No bone marrow oedema to indicate active spondylitis. No neural compromise. I note destructive appearance of the left hip on plain film 03/02/2016.

Examination Date: 09/03/2016**Examination:** MRI Spine Lumbar/Sacral**Date Reported:** 09/03/2016**Dictating Radiologist / Clinical Specialist By** DR EN HSUN CHOI GMC 4697569**Verified by:** DR EN HSUN CHOI GMC 4697569 on 09/03/2016

CR

Department of Orthopaedic Surgery

Consultant: Mr James Roche

Tel: 01324 566817

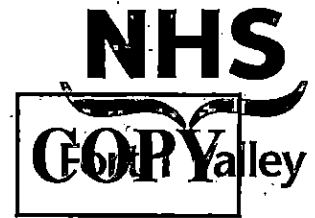
Fax:

Forth Valley Royal Hospital

Stirling Road

Larbert

FK5 4WR



Ref: JR/SJC/S679370 N/N

CHI: 2602800570

Clinic: 19 February 2016

Date: 26 February 2016

Consultant Rheumatologist
Rheumatology Department
Forth Valley Royal Hospital

Dear Doctor



SCOTT DOWELL 26/02/1980

11 Don Street, GRANGEMOUTH, Stirlingshire FK3 8HD

I would be grateful if this 32 year old gentleman could be reviewed in the clinic. He has been referred up to the orthopaedic clinic with significant osteoarthritis of his left hip. He has no precipitant for this in terms of childhood hip disease but plain X ray shows complete obliteration of his sacro iliac joints and a bamboo spine which is fully ankylosed. He has no swelling of his hands or other joint problems but I wonder if he needs further investigation for ankylosing spondylitis or other connective tissue disorder.

Regarding his hip he will need a hip replacement I am sure at some stage but we shall try and delay this as much as possible and I have requested an MRI scan of his lumbar spine to see whether he has got nerve root impingement which could be a cause of the left leg pain. Many thanks for your help.

Kind regards

Yours sincerely

Mr James Roche

Consultant Orthopaedic Surgeon

Department of Orthopaedic Surgery

Consultant: Mr James Roche

Tel: 01324 566817

Fax:

Forth Valley Royal Hospital

Stirling Road

Larbert

FK5 4WR



Ref: JR/SJC/S679370

CHI: 2602800570

Clinic Date: 19 February 2016

Date: 26 February 2016

Mrs Lesley Dawson,
ESP Physiotherapist,
Physiotherapy Department,
F.V.R.H.

Dear Lesley,



SCOTT DOWELL 26/02/1980

11 Don Street, GRANGEMOUTH, Stirlingshire FK3 8HD

Thank you for asking me to see Scott. He is a 36 year old gentleman who is a carer for his wife. He has had pain in the left leg for eight to ten years mainly around the left knee. It currently goes from his groin to the left involving the lateral aspect of the thigh. He also gets pain over the greater trochanter. He has had no hip problems as a child and finds it stiff getting up from the seated position. He gets no night pain or rest pain and has no swelling or other joint problems. He is on Naproxen.

On examination he walks with a very stiff hip and gets out of a chair with a stiff hip. He hip flexes approximately 45 degrees. There is no real rotation. He has no abduction and 10 degrees adduction. Knee movements in isolation do appear to cause some left leg symptoms although there is no effusion of the knee.

X rays show significant osteoarthritis of the left hip but also additionally a total obliteration of his sacral iliac joint and also a bamboo spine with effusion of at least two or three lumbar vertebra.

I have recommended an MRI scan of his lumbar spine to see whether he has any nerve root entrapment which could be contributing to his symptoms. Additionally I shall ask for a rheumatology review to see whether he has any other features of ankylosing spondylitis and whether any further treatment is required. In view of his left hip he will require surgery I am sure but the longer this can be delayed the better. He is due to see his GP next week regarding analgesia and I think this would be definitely beneficial for him to take further tablets. I shall contact him with the results of the scan. This is provisionally booked as an MRI but I understand he has had some metal in his eye so it may need to be revised to possible CT.

Yours sincerely

Mr James Roche

Consultant Orthopaedic Surgeon

Department of Orthopaedic Surgery

ESP: Lesley Dawson

Tel: 01324 566817

Fax:

Forth Valley Royal Hospital

Stirling Road

Larbert

FK5 4WR



Ref: LD/JMcC/S679370

CHI: 2602800570

Date of Clinic: 03 February 2016

Date: 11 February 2016

Consultant Orthopaedic Surgeon

Forth Valley Royal Hospital

Stirling Road

Larbert

FK5 4WR

Dear Colleague

SCOTT DOWELL 26/02/1980

11 Don Street, GRANGEMOUTH, Stirlingshire FK3 8HD

I would be very grateful for your opinion on the management of this gentleman who was referred to orthopaedics with left knee pain for 10 years. However, on examination it became clear that he has a very restricted and painful left hip with active flexion limited to 80 degrees and minimal medial rotation and abduction only to 30 degrees. An x-ray of his pelvis has shown changes at the left hip.

Mr Dowell is young, he is only 35. He is a full-time carer for his wife and cannot recall any injuries or problems in the past that could be related to his hip.

I would be grateful for your opinion on his further management.

Yours sincerely

Lesley Dawson

Extended Scope Practitioner

Cc

Dr Derek Dundas

Westburn Medical Practice

Falkirk Community Hospital

Westburn Ave

Falkirk

FK1 5SU

36 Carer

8-10%

Mainly @ Knee Pain

Acir → Knee, left thigh

GET

• Perms Hip Robs.

Self ptg up.

@ Dr

• Head Inlet

Upover

Self ptg up

undress by

• ylt

Department of Orthopaedic Surgery

ESP: Lesley Dawson

Tel: 01324 566817

Fax:

Forth Valley Royal Hospital

Stirling Road

Larbert

FK5 4WR



Ref: LD/JMcC/S679370

CHI: 2602800570

Clinic Date: 03 February 2016

Date: 11 February 2016

Dr Derek Dundas

Westburn Medical Practice

Falkirk Community Hospital

Westburn Ave

Falkirk

FK1 5SU

Dear Dr Dundas



SCOTT DOWELL 26/02/1980

11 Don Street, GRANGEMOUTH, Stirlingshire FK3 8HD

Thank you for referring this gentleman who describes longstanding left knee pain for at least 10 years. There is no trauma associated with this. He describes pain on the medial and anterior aspect of the knee. This can give way infrequently, approximately once a year and he can have episodes where the knee sticks and this can happen on a daily basis. He has difficulty getting on and off a chair and has problems putting on socks or shoes. The knee can swell every day for several hours with no real known cause and this settles with medication.

He is currently on Lansoprazole and Naproxen. He is not working and is a full-time carer for his wife and has no active hobbies.

His knee was x-rayed last month and shows no bony changes. He had physio a few years ago and is due to start again soon.

On examination there was no evidence of effusion or deformity around the left knee. He had a full range of movement, all ligaments were intact and McMurray's test produced pain on medial rotation of the hip. On closer examination of the hip he had active hip flexion to 80 degrees, minimal medial rotation and abduction to approximately 30 degrees, all limited by groin pain. Consequently his hip was x-rayed today and he has been referred on to one of the Consultants specialising in hip pathology for their advice.

Yours sincerely

Lesley Dawson

Extended Scope Practitioner

Cc Consultant Orthopaedic Surgeon, FVRH, Larbert.

Date Received: Tue 19/01/16

CHI: 2602800570

Hospital Number: 5679370

Permanent Flags

- ☐ BPPLOTT - BACK PAIN PILOT
☐ NOTGJ - NOT SUITABLE FOR GJ

Referral Notes:

esp knee (DAWSON, 20/01/16)

COPY

Hospital use only	Clinic	Day Date	Time	Hospital No.
----------------------	--------	-------------	------	-----------------

REFERRAL LETTER

MEDICAL IN
CONFIDENCE

Date Referral Submitted
(This date is fixed at hospital end):
19-Jan-2016

2602800570

CHI No: 2602800570

101010663674L

Unique Care Pathway Number: 101010663674L

REFERRAL TO

Trauma and Orthopaedic SurgeryC8
FV Orthopaedic Clinic

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR

Consultant / receiving practitioner and/or
specialty clinic

Hospital and hospital address

Hospital location code.

V217H

Urgency of Referral

Urgent Orthopaedic Clinic Referral

Administrative Information

Patient has special requirements:No

PATIENT DETAILS

Surname

Dowell

Forename(s)

Scott

Sex

Male

Previous Surname

-

Date of birth

26-Feb-1980

CHI no.

2602800570

Patient's address

11 Don Street
Grangemouth
FK3 8HD

Contact number(s)

Voice: 01324 262719

REFERRING PRACTITIONER DETAILS

Name:

Dr. Derek Dundas (GMC: 6075873)

Practice:

Westburn Medical Practice (25583)

Phone:

Voice: 01324 623577

Practice address:

Falkirk Community Hospital
Westburn Ave
Falkirk
FK1 5SU

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting Complaint

Description: Knee pain

Comment: Dear Colleague

COPY

Many thanks for your review of this 35 year old man who has a very long history of knee pain.

His knee pain started some 10 years ago. It is not clear as to what caused this. Occasionally he experiences swelling and most recently it has been giving way. There is no evidence of locking. He has had an x-ray performed and there is no obvious reason for this. We have referred him to Physiotherapy and he is still awaiting an appointment. He has however had Physio in the past, which has not proved to be particularly helpful.

Given the length of time he has complained of pain and that he has seen by Physio in the past, and also evidence of the knee giving way now I would be most grateful for your urgent review.

Yours sincerely

Dr D Dundas

Examinations and Investigations

Murmur present: Not Recorded -
Is a 12 lead ECG: Not done -
Recent CXR: Not done -
BC: Not Recorded -
Urea and Electrolytes: Not Recorded -
LFT: Not Recorded -
TFT: Not Recorded -
Lipid Profile: Not Recorded -
Glucose: Not Recorded -

Reason for referral

Care type requested: Out Patient
Expected outcome: Not Specified

Medical history

Active Repeat Therapy

Some Repeats may be Active but not Issued. In these instances, the Date Last Issued field contains the date authorised by the GP.

No current medications recorded

Issued Scripts for Acutes and Inactive Repeats (in last 90 days)

Drug name	Drug code	Formulation	Dosage	Frequency
Naproxen Tablets 500 mg	1001010P0AAAAEAE	56 TABLET	ONE TO BE TAKEN TWICE A DAY	- - 42 Days
Lansoprazole Capsules (Gastro-Resistant) 30 mg	010305010AAAAAA	56 CAPSULE	ONE TO BE TAKEN EACH MORNING	- - 56 Days
Naproxen Tablets 500 mg	1001010P0AAAAEAE	56 TABLET	ONE TO BE TAKEN TWICE A DAY	- - 28 Days

Clinical warnings

Smoking status: Number per day: ? (not known)

Alcohol status: Units per day: ? (not known)

Exercise status: Not Known

Additional relevant information

Signature of referring doctor (or other professional)

Date

19-Jan-2016

COPY

Ophthalmology Department
Consultant: David R A Wardrop
Tel: 01324 614368
Fax:

Falkirk Community Hospital
Major's Loan
Falkirk
FK1 5QE



Ref: DW/LB/hap/S679370
CHI: 2602800570

Clinic Date: 25 September 2015
Date: 28 September 2015

Rapid Access Clinic

Dr Derek Dundas
Westburn Medical Practice
Falkirk Community Hospital
Westburn Ave
Falkirk
FK1 5SU

Dear Dr Dundas

Scott Dowell 26/02/1980
11 DON STREET GRANGEMOUTH FK3 8HD

Diagnosis: 1. Foreign body right eye.

V.A. Right eye: 6/24 improving to 6/7.5 with pinhole.
Left eye: 6/6.

Current treatment: Oc. Chloramphenicol ointment 4 times a day for a week.

Follow-up: None required.

This gentleman attended the Eye Clinic having sustained an injury with a piece of metal to his right eye, which was partly removed in A&E.

Today we were able to fully remove the rest of the rust ring and have given him some antibiotic ointment to use for the next week. We do not need to see him again unless there are any further problems.

Yours sincerely

Laura Butler
ST1 in Ophthalmology

Department of General Surgery

Consultant: Mr Amir Hussain

Tel: 01324 566941

Fax:

Forth Valley Royal Hospital

Stirling Road

Larbert

FK5 4WR



Ref: AH/HS/S679370

CHI: 2602800570

Date: 15 April 2015

Dr Derek Dundas
Kersiebank Medical Practice
Health Centre
Kersiebank Avenue
Grangemouth
FK3 9EW

Dear Dr Dundas

Scott Dowell 26/02/1980

11 Don Street, GRANGEMOUTH, Stirlingshire FK3 8HD

Admission Date: 30/03/2015

Admitted to Ward: DSU

Discharge Date: 30/03/2015

Discharged/Transferred to: Home

Diagnosis: Hidradenitis suppurativa left groin

Procedure: Excision

Follow up: None

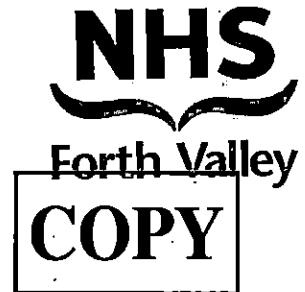
This gentleman was admitted electively with the above diagnosis and underwent excision of 2 infected areas of hidradenitis suppurativa in his left groin. His postoperative period was unremarkable and he was discharged home with no routine follow up appointment.

Yours sincerely

Mr Amir Hussain
Locum Consultant Surgeon

Department of General Surgery
Consultant: John Camilleri-Brennan
Tel: 01324 566939
Fax:

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Ref: JCB/LMCN/F207472
CHI: 2602800570

Clinic Date: 26 February 2015
Date: 27 February 2015

Dr Derek Dundas
Kersiebank Medical Practice
Health Centre
Kersiebank Avenue
Grangemouth
FK3 9EW

Dear Dr Dundas

Scott Dowell 26/02/1980
11 Don Street, GRANGEMOUTH, Stirlingshire FK3 8HD

I have reviewed this gentleman at my clinic today. He is having recurrent abscesses in the skin of his left groin. He has been treated by many courses of antibiotics. He continues to smoke heavily.

On examination this gentleman has full blown hidradenitis of his left groin.

Since his condition is not any better, I have booked him in for excision of hidradenitis skin in the left groin under general anaesthetic as a day case. I will send out an appointment in due course.

Kind regards

Yours sincerely

John Camilleri-Brennan
Consultant General/Colorectal Surgeon

cc. Waiting List

Immediate Discharge Letter

NHS

Forth Valley

COPY

Hospital: Forth Valley Royal Hospital, Larbert
Consultant: Hussain, Mr Amir
Specialty: General Surgery

Tel: 01324 50500
Discharging Ward: FVRH

GP Details	Patient Details	Admission Details
Practice Code: 25864	Patient CHI No: 2602800570	Admission Date: 06/01/2015
	Patient Hospital No: F207472	
GP Name: Dr Derek Dundas	Surname: Dowell	Admission Type: Routine - Elective (From Waiting List, excl. Transfers)
Address: Kersiebank Medical Practice, Health Centre, Kersiebank Avenue, Grangemouth, FK3 9EW	Forename: Scott	Presenting Complaint: Local Infections and Abscesses
	Date of Birth: 26/02/1980	
	Address: 11 Don St, Grangemouth, FK3 8HD	Discharge Date: 06/01/2015
		Discharge To: Private Residence - Living with Relatives or Friends

Diagnosis/Problem List
XE1BM - Hidradenitis

Additional comment (Progress, Investigations, Procedures, Complications etc)
Dear Doctor,

This 35 year old gentleman presented to FVRH on 06/01 with a 5 month history of a left groin swelling. Background: 3x courses of abx from GP - little effect.

A swab from the groin was sent for C+S, result outstanding.
An USS was performed which showed no obvious deep collection.

Impression:
Hidradenitis

Fit for discharge home with antibiotics changed to 7 days oral co-amoxiclav. He will be seen in the surgical outpatient clinic in 4-6 weeks time to review.

Many thanks,
Dr Ewan McConnell, FY1 on Surgery.

Results Outstanding (Y/N) If yes, give details:	Yes - Groin swab
--	------------------

Information to patient/carer (Y/N):	Patient: Yes Carer (if applicable):
-------------------------------------	--

Follow up arrangements
Mr Brennan, Surgical OPD, 4 Weeks

Authorisor's name: Dr E Connell	Authorisor's Signature: COPY
Authorisor's grade: FHO1	
Read/Approved by:	
Date: 06/01/2015	
Discharge Ward Nurse:	

Validation/Contact Name: Hussain, Mr Amir

THIS IS THE FINAL DOCUMENT
CHI: 2602800570

Name: Scott Dowell

Forth Valley Acute Hospitals Acute Division
Medications Discharge Summary

Name:	Scott Dowell	Patient's Tel No:	
Address:	11 Don St, Grangemouth, FK3 8HD	Patient's Tel	474369
Admission Date:	06/01/2015	Eve:	
		Discharge Date:	06/01/2015

COPY

PATIENT ALERTS

Alert Group	Alert	Alert Comment	When Added	Added By
-------------	-------	---------------	------------	----------

PATIENT DRUG REACTIONS

CURRENT PRESCRIPTION (all medicines currently prescribed)	*e.g. clinical indication for prescription monitoring
---	---

** Prescription Not Requested For Discharge **

Drug	Route	Dose	Frequency	Duration (days)	New Drug / Altered Dose	POD
1 CO-AMOXICLAV 500/125 TABLETS	Oral	1 tab	THREE times daily	7 days	ND	

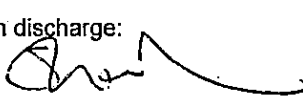
MEDICINES DISCONTINUED

** Prescription Not Requested For Discharge **

No Regular Medication on Admission

Nurse check on discharge:

Signature 1:



Signature 2:



Name: Scott Dowell

CHI: 2602800570

Department of Rheumatology
Biologics Nurse: Sharon Menzies
Tel: 01324 566336 / 01324 566337

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Dr Derek Dundas
Westburn Medical Practice
Falkirk Community Hospital
Westburn Avenue
Falkirk
FK1 5SU

Date Dictated : 28 September 2016
Date Typed : 31 October 2016

Our Ref : SM/RN/S679370
CHI : 2602800570

Dear Dr Dundas

SCOTT DOWELL 26/02/1980
11 DON STREET GRANGEMOUTH STIRLINGSHIRE FK3 8HD

Out-patient: 28/09/2016 at Rheumatology Nurse Led Clinic

Mr Dowell was due to commence Etanercept (Benepali) via the homecare company Healthcare at Home. Unfortunately there was an error with his prescription. When we were arranging this we ordered prefilled syringes. Mr Dowell did not feel comfortable with the idea of injecting himself; he did not like the thought of this, didn't want his wife trained to inject him and was quite adamant he would only go on treatment if he was given a prefilled pen.

I have contacted Healthcare at Home and supplied them with a new prescription ordering him Benepali prefilled pens. I saw him this afternoon in the Nurse Led Clinic as an extra patient. I have given him training on how to operate the Benepali prefilled pen. I have given him written information on Benepali and I carried out his first injection of Benepali using one of his prefilled syringes.

I have advised Mr Dowell if his delivery of pens has not been arranged by next week, Wednesday 5th October, I am more than happy to see him again as an extra patient in our Nurse Clinic and he should contact me via the Rheumatology nurse advice line.

Mrs Dowell accompanied him to clinic today. She was quite anxious and angry that it had taken a few hours for her call to be returned this morning. I have explained to her that the Rheumatology nurse advice line is not an emergency service and calls are aimed to be returned within two to three working days. I had tried to call Mr Dowell early this morning following communication from Healthcare at Home regarding the discrepancy in his prescription. Unfortunately the line was constantly engaged and I did leave a message. I have also explained to Mrs Dowell that we are often in clinics and do cover Stirling Community Hospital so cannot always be at the phone to directly answer calls.



Chairman: Alex Linkston CBE
Chief Executive: Jane Grant

Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SW

www.nhsforthvalley.com Facebook.com/nhsforthvalley @nhsforthvalley

Mr Dowell has follow up with Dr Else in January as previously arranged; this will be for his three month review. Mrs Dowell has pointed out today that this is actually over three months. I have explained to her that this is the earliest appointment we have to carry out the three month/first review. I did look through the appointment system today to see if I could expedite this appointment. Unfortunately there was nothing earlier in any of our Clinics. I have assured Mrs Dowell if Mr Dowell is not doing well they can contact us via the advice line and her call will be returned.

Yours sincerely

(Dictated and electronically checked by Sharon Menzies)

Sharon Menzies
Rheumatology Biologics Nurse

cc. Biologics notes

Immediate Discharge Letter (Authorised)

COPY

DW Dundas
Westburn Medical Practice
Falkirk Community Hospital
Westburn Avenue
Falkirk
Falkirk
FK1 5SU

General Surgery
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

CHI Barcode:



Date of Completion: 03-Feb-2020

Patient Demographics

Patient Name:	DOWELL, Scott	Date Of Birth:	26-Feb-1980
Patient Address:	11 DON STREET Grangemouth Stirlingshire FK3 8HD	Gender:	Male
Telephone No:	01324262719	CHI No:	2602800570

GP Practice

GP Name:	DW Dundas	GP GMC:	6075873
GP Practice Address:	Westburn Medical Practice Falkirk Community Hospital Westburn Avenue Falkirk Falkirk FK1 5SU	GP Practice Code:	6075873/25883
		GP Clinic Code:	25883/1
		GP Telephone:	01324 623577

Admission Details

Patient Location:	General Surgery	Admission Care Provider:	Mr Joey Crozier
Admission Date:	24-Jan-2020	Admission Time:	22:21
Admission Method:	Emergency Admission, type not known	Ward:	FVRH Ward SAU
Source Of Admission:	A&E Ward within Trust		

Discharge Details

Discharge Specialty:	General Surgery	Discharge Care Provider:	Mr Andrew Crumley
Discharge Date:	27-Jan-2020	Ward:	FVRH Ward B11
Discharge Time:	18:55	Discharge Destination:	Private Residence - no additional detail added
Discharge Method:	Regular discharge, no additional detail added		

Clinical Summary including History

Dear Doctor,
Many thanks for continuing the care of Mr Dowell, who was admitted to FVRH on 24/01/20 with epigastric pain + vomiting
Principal Diagnosis:
PMH:
- Barrett's Oesophagus
- Ankylosing spondylitis
Key Events:

- Mr Dowell was admitted to B11 for investigation and treated with IV triple therapy + fluids; it was noted he had an acute transaminitis on LFTs

- Following gastro review, a full liver screen was performed

- Mr Dowell recovered well and was deemed medically fit for discharge on 27/01/20

Procedures/Investigations:

- AUSS - Sludge + thickened gallbladder; no calculi

- MRCP - Biliary sludge tiny gallstones within an otherwise normal gallbladder. No biliary duct abnormality.

Diffuse hepatic steatosis

Medication changes: Oblimumab suspended and to be reviewed

Follow-up arrangements: nil

GP Requests: results from Liver screen still outstanding

Any further questions, please contact the team on B11, FVRH

Kindest regards,

Connor McKee FY1

COPY**Reason for Admission and Presenting Complaint**

Reason for Admission

unwell

InvestigationsMRCP
AUSS**Diagnosis**

Initial Diagnosis:

?biliary sepsis

Final Diagnosis:

transaminitis

Other Active Problems:

Co-morbidities

Patient has Comorbidities : Yes

Other Comorbidities : Left hip replacement

Barretts disease

ankylosing spondylitis

IDL Additional Information

Follow Up Required : No

Please confirm if there have been changes to this patients medication: : Yes – this patients medication has changed

Compliance Aid : No

Final Discharge Letter to Follow : No

Does this patient have a Detention Order? : No

Operations / Procedures**Safety Alerts**

Nil records exist

Allergy/Intolerance - JAC

Allergy/Intolerance

Reaction

dihydrocodeine

Unknown

Allergy records are as recorded at time and date of printing

Medications - JAC						
COPY						
Drug Information:						
Drug	Dose	Route	Frequency	GP to Continue	POD	Days Supply
CO-AMOXICLAV 500/125 Tablets	1 Tablet	Oral	THREE times daily at 8am, 12 midday and 10pm for 6 day(s)	Y	N	
OMEPRazole 20 mg Capsules	40mg	Oral	TWICE daily at 8am and 10pm	Y	N	7
RANITIDINE 150 mg Tablets	150mg	Oral	TWICE daily at 8am and 10pm	Y	Y	0
ROPINIROLE 500 micrograms Tablets	500microgram	Oral	ONCE daily at 10pm	Y	Y	0

Drug Notes:

Drug	Drug Notes
CO-AMOXICLAV 500/125 Tablets	Dispensary check. Patient no longer on ward.

Additional Medicine Information:

Medicines discontinued during admission (Medicines that patient was recorded as admitted on only)

Drug	Discontinued Reason
Nil records exist	

GP Communications:

Changes made to Medication _Yes_ Short Stay Patient _No_ DISCONTINUED MEDICATION_ None MODIFIED MEDICATION_ None SUSPENDED MEDICATION_ None CLINICAL SUMMARY_ to complete course of Abx; Obilimumab suspended and to be reviewed

Outstanding Results - DartOCM		
Responsibility of Hospital		
Discipline	Investigation	Date Ordered
Chem/Haem	Anti Neutrophil Cytoplasmic Antibody (ANCA)	27-Jan-2020
Chem/Haem	Anti-mitochondrial Ab / smooth muscle Ab screen	27-Jan-2020
Chem/Haem	Tissue Transglutaminase (TTG) Antibody	27-Jan-2020
Chem/Haem	Anti Nuclear Factor (ANF)	27-Jan-2020
Microbiology	CMV PCR	27-Jan-2020
Chem/Haem	Erythrocyte Sedimentation Rate (ESR)	03-Feb-2020
Chem/Haem	Full Blood Count	03-Feb-2020
Chem/Haem	Bone Profile (including Calcium)	03-Feb-2020
Chem/Haem	Liver Function Tests	03-Feb-2020
Chem/Haem	Thyroid Stimulating Hormone (TSH)	03-Feb-2020
Chem/Haem	Urea & Electrolytes	03-Feb-2020

Person completing record			
Name:	Dr Connor McKee	Specialty:	
Designation or role:	Doctor	Date completed:	03-Feb-2020

Distribution List		
Recipient Name	Recipient Type	Recipient Organisation
DW Dundas	GP	Westburn Medical Practice

COPY

**Immediate Discharge Letter
(Authorised)****COPY**

DW Dundas
Westburn Medical Practice
Falkirk Community Hospital
Westburn Avenue
Falkirk
Falkirk
FK1 5SU

General Surgery
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

CHI Barcode:



2602800570

Date of Completion: 24-Jan-2020

Patient Demographics

Patient Name:	DOWELL, Scott	Date Of Birth:	26-Feb-1980
Patient Address:	11 DON STREET Grangemouth Stirlingshire FK3 8HD	Gender:	Male
		CHI No:	2602800570
Telephone No:	01324262719		

GP Practice

GP Name:	DW Dundas	GP GMC:	6075873
GP Practice Address:	Westburn Medical Practice Falkirk Community Hospital Westburn Avenue Falkirk Falkirk FK1 5SU	GP Practice Code:	6075873/25883
		GP Clinic Code:	25883/1
		GP Telephone:	01324 623577

Admission Details

Patient Location:	General Surgery	Admission Care Provider:	Mr Christopher Shearer
Admission Date:	24-Jan-2020	Admission Time:	01:37
Admission Method:	Emergency Admission, no additional detail added	Ward:	FVRH Ward SAU
Source Of Admission:	GP Non Obstetrics - other Provider		

Discharge Details

Discharge Specialty:	General Surgery	Discharge Care Provider:	Mr Christopher Shearer
Discharge Date:	24-Jan-2020	Ward:	FVRH Ward SAU
Discharge Time:	05:18	Discharge Destination:	Private Residence - living with relatives or friends
Discharge Method:	Discharge from NHS inpatient/ day case care		

Clinical Summary including History**Reason for Admission and Presenting Complaint**

Reason for Admission

No Clinical Details

Investigations

Normal chest X-ray and ECG

ALT 106 & AST 131 but patient wished to be discharged prior to further investigations being performed.

COPY**Diagnosis****Initial Diagnosis:**

Acute onset upper abdominal pain with associated vomiting.

Final Diagnosis:No acute surgical issue, symptoms resolved and mr Dowell was keen to be discharged prior to consultant review.
Advised to seek further clinical review if symptoms return.**Other Active Problems:**

nil

Co-morbidities

Patient has Comorbidities : Yes

Other Comorbidities : Left hip replacement
Barretts disease
ankylosing spondylitis**IDL Additional Information**

Follow Up Required : No

Please confirm if there have been changes to this patients medication: : No – there has been NO change to this patients medication

Compliance Aid : No

Final Discharge Letter to Follow : No

Does this patient have a Detention Order? : No

Operations / Procedures

nil

Safety Alerts

Nil records exist

Allergy/Intolerance -

Allergy records are as recorded at time and date of printing

Nil records exist

Medications -**Drug Information:**

Drug	Dose	Route	Frequency	GP to Continue	POD	Days Supply
------	------	-------	-----------	----------------	-----	-------------

Nil records exist

Drug Notes:

Drug	Drug Notes
------	------------

Nil records exist

Additional Medicine Information:

Medicines discontinued during admission (Medicines that patient was recorded as admitted on only)

Drug	Discontinued Reason
------	---------------------

Nil records exist

GP Communications:

Outstanding Results - Dart@CM		
Responsibility of Hospital		COPY
Discipline	Investigation	
Radiology	XR Abdomen	24-Jan-2020
Radiology	XR Pelvis	24-Jan-2020
Radiology	XR Chest	24-Jan-2020

Person completing record		
Name:	Specialty:	
Designation or role:	Date completed:	24-Jan-2020

Distribution List		
Recipient Name	Recipient Type	Recipient Organisation
DW Dundas	GP	Westburn Medical Practice

COPY

Date:

Time: 1030

Named Nurse:

Patients preferred name:

HI NO: 2602800570 26/02/1980
 RN: GOTT DOWELL
 1 DON STREET

CCS 1

RANGEMOUTH
 K3 8HD

COPY

G F

S

Situation

Brief history of complaint & pre-hospital treatment:

RUA pain / rib pain last night
 radiates to chest

Details & NOK checked: Y / N

Relative/Carer: Informed? Y / N and present? Y / N

B

Back-ground

MI ☐CVA ☐

Anticoagulated: Y / N

Asthma ☐COPD ☐

Vulnerable adult: Y / N (see SAS PRF)

Angina ☐HTN ☐

Time Critical Medication: Y / N (if Yes give details)

Epilepsy ☐

Diabetes T1/T2

Past Medical History:

Allergies:

Fibro

Social Background: liver alone

Clinical Frailty Score: _____

A

Assessment

ECG ☒

NEWS

0

Care and Comfort Chart Commenced: Y / N

Bloods ☒

BM

PVC ☒

GCS/AVPU

15

Urinalysis ☐

Ketones

1

HCG ☐

Pain:

3 / 3

Analgesia ☐

Mobility:

ind

Name Band ☐

Signature:

u

R

Recommendations

Impression:

abdo pain

Nurse Escort Required: Y / N

Outstanding Treatments:

Referred Specialty:

Medics ☒Ortho ☐Surgeons ☐ENT ☐Gynae ☐

Other _____

Recommendation Falls Care Bundle required Yes / No Falls alert added to Trakcare ☐

NEWS:

0

Signature:

u

**COPY**

Date of attendance: 21/10/2025 23:36

Presenting complaint: r sided abdo pain

Surname: Dowell	Forename: Scott	Title: Mr
Address 11 Don Street	Postcode: FK3 8HD	CHI: 2602800570
Grangemouth Stirlingshire		
Telephone: 01324 262719		
Date of Birth: 26/02/1980	Sex: Male	Age: 45 Years
GP Name: A Syeed		
Address: 26015/4	Telephone: 0330 1289 389	
Health Centre Kersiebank Avenue Grangemouth Grangemouth FK3 9EL		
Next of Kin		
Name: Diane Dowell		
Relationship: Wife	Postcode: FK3 8HD	
Address: 11 DON STREET	Telephone: 07388346682	
Grangemouth Stirlingshire		
Triage Information		
"CHEST PAIN CHART - moderate pain "		
"Pain started last night in right side of ribs, non radiating "		
"Worsening today, no vomit "		
"No trauma to ribs "		
Observations		
P= 101	PB= 121 / 86	RR= 20
		Sat= 97
		BM=
		Temp= 36.5
Peak Flow=	GCS=	News= 1-Incomplete

Emergency Department / Pre-Hospital Drugs				Allergies			
				Nicotine			
Date	Drug	Dose	Route	Signature	Given by	Time	
22/10/25	ORAMORPH 10mg/5ml	10mg	PO	Rec	SH	0015	
~	ONDANSETRON	4mg	PO	Rec	SH	0015	
~	PARACETAMOL	1g	PO	Rec	SH	0015	
~	GLUCOPHAG	20mg	PO	Rec	SH	0015	
22/10	Cu-Glu 1.3g/500	2 tabs	PO	Rec	SH	0415	
22/10	ORAMORPH	10mg	PO	Rec	SH	0555	
22/10	COCODAMOL 30/500	ii	PO	Rec	SH		

Clinical Notes

22/10/25

Seen by:

K MORAN

Time:

0945

COPY

Pl Chest/ECG PR

PMHx

Ankylosing Spondylitis

Fibromyalgia

Hidradenoma

Barrett's oesophagus

Cholestasis 2020

Diets

Lopiramide

Cocaine

Esomeprazole

Doxycycline

Diltiazem

DHx Pregnancy

CHPL

Evening 20/10 onset gradually

"tight band" around chest

beginning of 21/10 sunburn

had moved to RUG. Constant, not clock

Last 6/12 approx had worse of

Barrett's oes - vomiting and

after some meals. often ~ 1 tsp food

in unit. Has had intermitting "gurgles"

ROD. Denies PR bleed/melaena

No Ntamps.

No real cough/urinary sx.

So no prazide,

doxycycline.

Stx

since 20/10

tealish

OE

Alert Indiscernant



initially the creps at side chest, gradually settled
to clear chest

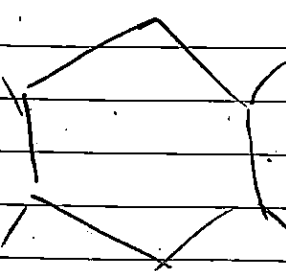
22/14

20/97

BP 178

127/78

36.5



Murphy's tre.

Tender in localised

peritonism on RUG

+rt flank

BSne

RANGEMOUTH
K3 8HD

GOV DOWELL
1 DON STREET

HI NO: 2602800570

M

26/02/1

Attach continuation sheets here

Attach here onto face of pocket

Guidelines Used:

Forth Valley Royal Hospital Assessment Document



Date of arrival 22/10/25 Time of arrival 1150

Source of referral: GP ☒ ED ☐ Other ☐

GP practice: Kersicbank

CHI NO: 2602800570 26/02/1980
 RN: M
 N: COLT DOWELL
 1 DON STREET
 RANGEMOUTH
 A1K3 8HD

Age 45

COPY

Consent for ECS

Yes ☒

No ☐

BM

NEWS score

Tel.

NOK 1 Name Diane Dowell

Relationship Wife

Address

Tel. 07388346682

NOK 2

S Presenting complaint

Abdo pain

B Background

A

NEWS 5 or more or other clinical concern

Yes ☐

No ☐

Temp 38°C or more within 14 days of chemotherapy (possible neutropenic sepsis)

Yes ☐

No ☐

Referred with potassium more than 6.4mmol/L or less than 2.8mmol/L

Yes ☐

No ☐

Referred with diabetic ketoacidosis

Yes ☐

No ☐

Reduced GCS

Yes ☐

No ☐

New limb weakness, speech disturbance or numbness for less than 4.5 hours

Yes ☐

No ☐

Abdominal pain: Does referral or patient give history of aortic aneurysm?

Yes ☐

No ☐

Abdominal symptom in female under 55 with possibility of pregnancy

Yes ☐

No ☐

NEWS 2-4

Yes ☐

No ☐

New oxygen requirement (not on home oxygen)

Yes ☐

No ☐

Chest pain at time of triage- Obtain ECG, Clinician to review/ sign within 10 minutes

Yes ☐

No ☐

New limb weakness, speech disturbance or numbness for 4.5 hours or longer

Yes ☐

No ☐

Requires assistance of 1 or more to mobilise

Yes ☐

No ☐

Able to mobilise independently or using own aids/appliances

Yes ☐

No ☐

R

Very urgent

Urgent

Non-urgent

Ambulant

Actions

Amylase

Cannula

U&E/ LFT/ CRP/ FBC/Glucose

Calcium

ECG- to be signed within 10mins

Cultures

Group and save

Troponin 0 hours / 12 hours

Additional triage comments

Allergies and alerts

NKOA

Name

Signature

Date

Time

Assessment

Practitioners Name HANNAH FRUM
 Grade CTI
 GMC/ NMC 1952167

Date 22/10/25
 Time commenced 12.30
 Location SAH

Patient details

COPY

Presenting Complaint:

- 3/7 epigastric pain, now moving RUQ.
- ~~EXACERBATING~~ of RUQ pain.
- FELT THIS BEFORE w/ GALL STONES
- FEELS CLAMMY/SWEATY

Systemic Enquiry:

- PASSING URINE NORMALLY
- EATING + DRINKING OK

~~SOB.~~
~~COUGH~~

- 2/52 USING

- OPENING BOWELS

Height: 5'9

Weight: 16 stone.

BMI:

Usual level of activity (please circle)

Bedbound Dependent for personal care Requires minimal assistance with ADLs Slowed. Assistance with heavier household tasks "Slowed-up" but not requiring assistance No exercise beyond walking. Occasional exercise Regular exercise

Anger 53
 CLP 9
 LETS NAD
 WBC 8.3

Past medical, surgical and anaesthetic history

Angina	
Hypertension	
COPD	
Stroke /TIA	
Diabetes	
Implement diabetes bundle	

operation on L arm
 LTHR
 Ankylosing Spondylitis
 ? CHOLELITHS
 BARRIERS TO WORK

Social History

Smoking: Never Ex smoker (since _____)

Current 20 /day Pack years _____

Alcohol: 0 Units / week

Occupation N/A

Driving license yes / no

Lives With wife

Support/ Carers N/A

PACKAGE OF CARE YES / NO (please circle)

IF YES CARE PROVIDER _____

NUMBER OF TIMES PER DAY 1/2/3/4 (please circle)

Family History

Travel History

Patient details

COPY

☐ Other

**No Known
Drug
Allergies**

Drug / Substance	Reaction/ Side effect

Drug / Substance	Reaction/ Side effect

[illegible]

NON-PRESCRIPTION MEDICATIONS AND HERBAL MEDICATIONS

Medicine reconciliation verified by?	Name:	Signature:
	Date:	Time:

Examination

Diabetic patients → foot examination and diabetes bundle
GI Bleeding → PR examination
Age > 65 or confusion → AMT
If cognition or alertness impaired → consider delirium

Patient Details

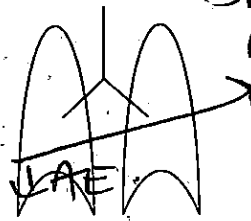
Cardiovascular

BP 123/72

HR 82

MS 1 + 11 + 0

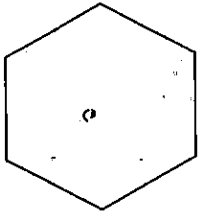
Respiratory



SpO2 97%
RR 14

COPY

Abdominal



SOFT
LOW BOWEL SOUNDS

Bowel sounds:

PR: temp 35.5

AMT (If < 4/4, complete AMT10)

1. Age
 2. DOB
 3. Year
 4. Location
- /4

Ask patient to remember address: "42 West Street"

5. Time to nearest hour
6. Current monarch
7. Date Of WW2
8. Count 20 → 1
9. Identify 2 people
10. Recall address

/10

Neurological (remember speech, visual assessment, balance, gait)

Cranial nerves:

	R arm			L arm			R leg			L leg		
Tone												
Power												
Sensation												
Coordination												
Reflexes	B	T	S	B	T	S	K	A	Plantar	K	A	Plantar

Other

Interpretation of results

ECG sinus

CXR clear

Urine HCG

Other imaging

Urinalysis

	Neg	Trace	+	++	+++	+++
Leucocytes						
Nitrites						
Glucose						
Ketones						
Blood						
Protein						

Additional comments

Differential diagnosis

Patient details

lost at night

COPY

? BUNARY COLE.

Management plan

1. ANALGESIA
2. US (FAST AND TUGS)
3. ARIANA

Additional investigations required (e.g. cultures) Please initial and date when sent

		Initial/ Date
		Initial/ Date

Venous thromboembolism (VTE) risk assessment

Medical patient expected to be mobilising as normal within 2 days	Proceed to VTE risk actions
Medical patient with reduced mobility for ≥ 2 days OR Surgical patient	Assess thrombosis and bleeding risk factors

Thrombosis risk factors. ANY thrombosis risk factor(s) should prompt VTE prophylaxis measures unless contraindicated → Assess bleeding risk.

- | | |
|---|--|
| ☐ Mobility reduced for >2 days
☐ Age >60
☐ Dehydration
☐ Obesity BMI >30 kg/m ²
☐ Significant medical comorbidity (e.g. cardiac, respiratory, endocrine, inflammatory, infectious conditions)
☐ Active cancer or cancer treatment
☐ Thrombophilia
☐ Personal history or first degree relative with history of VTE
☐ Use of hormone replacement therapy or oestrogen containing contraceptive
☐ Pregnancy or $<6/52$ post-partum | ☐ Acute surgical admission with inflammatory or intra-abdominal condition
☐ Surgery with significant reduction in mobility
☐ Critical care admission
☐ Knee or hip replacement
☐ Hip fracture
☐ Total anaesthetic+ surgical time >90 mins
☐ Pelvic or lower-limb surgery with anaesthetic+ surgical time >60 mins
☐ Varicose veins with phlebitis |
|---|--|

Bleeding risk factors. Consider whether sufficient to preclude pharmacological prophylaxis

- ☐ Active bleeding
- ☐ Acquired bleeding disorder (e.g. acute liver failure)
- ☐ Current use of therapeutic anticoagulation (e.g. warfarin, rivaroxaban, dabigatran)
- ☐ Acute stroke
- ☐ Thrombocytopenia ($<75 \times 10^9/L$)
- ☐ Uncontrolled hypertension ($>230/120$ mmHg)
- ☐ Untreated inherited bleeding disorder
- ☐ Neurosurgery, spinal surgery or eye surgery
- ☐ Other procedure with high bleeding risk
- ☐ Lumbar puncture, epidural or spinal anaesthesia expected within the next 12 hours
- ☐ Lumbar puncture, epidural or spinal anaesthesia within the previous 4 hours

VTE risk actions

Information provided Provide if admission is anticipated Yes/ No	LMWH Yes/ No/ Contraindicated	Antiembolism stockings Consider if thrombosis risk factors present and bleeding risk factors preclude LMWH Contraindicated in peripheral neuropathy, PVD, ulceration, cellulitis, gross oedema Yes/ No/ Contraindicated
--	-------------------------------------	--

Name

Signature

Date

Time complete

Mr. [unclear] Guyal Reghbra

COPY

22 October

2023

14th 45 m

known gallbladder

3 AM H/O RUQ pain

No systemic dx

BG: Ankylosing spondylitis
not on Biogen/surgery

O/E clinically well
A16 1

ECG

CXR/Imaging



Results

CRP 9, WBC 8.3

alpha 259, Alpha 53

Bil 44, 25, 15

Consultant Ward Round

Patient details

Diagnoses and significant comorbidities

Plan

COPY

? Bilary Colic

- Analg IV
- NPOH Lap Append

HW to Append

? < EPOD

? HST GB let

> electe

[Signature]

Checklist

Estimated LoS

<24h

24-48h

>48h

Medicine reconciliation

Transfer of Care to:

VTE assessment

Outstanding criteria for ward transfer/discharge (delete as appropriate):

S_pO₂ target prescribed

Fasting

Yes / No

Name

Signature

Date

Time

Resuscitation/ Escalation of care/ Anticipatory Care Planning / Advance Directives

Documentation of Discussion with Patient or Family

Treatment options that may help and patient would wish considered (and in what circumstances):-

Treatment options that may not help or patient would not wish:-

Discussed with patient/family: Y /N/Unable

Documentation (circle all that apply): DNACPR ReSPECT AWI

Name

Signature

Date

Time

Date and Time	Daily MDT and Nursing update			
	Consent (care planning)	Yes ☐		
	Name band	Yes ☐		
	NOK details obtained	Yes ☐		
	Vital Signs	Yes ☐		
	Own medication	Yes ☐	No ☐	
	Dentures	Yes ☐	No ☐	
	Glasses	Yes ☐	No ☐	
	Hearing aids	Yes ☐	No ☐	



CHI NO: 2602800570 26/02/1988
 CMN:
 SCOTT DOWELL
 11 DON STREET
 GIMMINGHAM
 FK3 8HD

COPY

22/10/25 Admitted to SAU

12.25 EWS as charted

Independently mobile.

bloods in ED

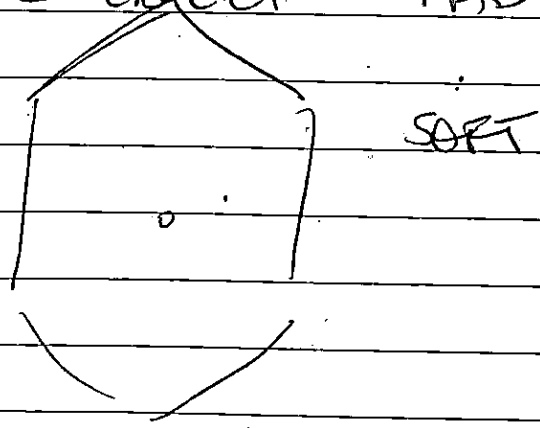
for clert in e Senior Review.

SLN A. Mcdermott

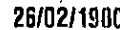
2/10/25 MR MR WADSWORTH

1610 - news 0

- PRIOR CT 2020 - GALLSTONES
- PRIOR MRCP 2020 - Biliary stone
- YAW LAP CHOLE BUT LOST TO FOLLOW UP.
- IN RM @ PRESENT
- NO PRIOR ISS
- CXR EFFECT - NO



- ARM
- ① PO CO-AMOX.
 - ② CONT PO PAIN
 - ③ CHASE US⁸.



GRANGEMOUTH
FK3 8HD

Life and Time

Daily MDT and Nursing update

22/10/25	Scott has been settled today.
18/4/5	has been off ward with wife a few times. Requires pain relief regular but does not ask. Mobile and Independent.
	Neuro stable, meds as per Hepma.

Uebchen
S/N

L. Sargent F41

Pt to get an appt in the elective but gallbladder clinic
Pt keen to go home, Dr Rutherford agrees he can
go home tonight with
oral co-amoxiclav + dicyclanide TTD

L. Sergeant

COPY



CHI NO: 2602800570

26/02/1980

MRN:

M

Scott DOWELL
1 DON STREET

BRANGEMOUTH
K3 8HD

C
C
S
1

G
F

2602800570

CO-AMOXICLAV (25 MG TABLETS)
X1 (ONE) THREE TIMES DAILY
FOR 2 DAYS

DIPHENHYDRAMINE 30 MG TABLETS
X1-2 TABLETS 4-6 HOURLY
MAXIMUM 8 TABLETS DAILY

DANIEL JONES (MR)

9/

22110125

SAU
Larbert FK5 4WR

TEL: 01324 624000

Forth Valley Royal Hospital

V 4 1 0 9

51025517216

Consent Form

Upper Gastrointestinal Endoscopy

I,
of
.....
.....
.....
.....

CHI NO: 2602800570 26/02/1980
CRN: S679370 M
Scott Dowell
11 Don Street,
GRANGEMOUTH,
Stirlingshire
FK3 8HD

I hereby consent
(or hereby consent to the submission of my child/ward)
to the procedure of: **Upper Gastrointestinal Endoscopy +/- Oesophageal Dilatation**
the purpose of which has been explained to me in the document entitled:
"Upper Gastrointestinal Endoscopy - Information for Patients".

I confirm that:

- I have read the document
- I have understood the information that has been given to me
- I understand that I will be given the opportunity to ask questions about the procedure.

I also give consent for any necessary biopsies and for photographs or x-rays to be taken.

Signed (Patient/Parent) Date 29/8/17

Name of Patient/Parent.....(block capitals)

Please ensure that you bring this form with you.

You do not have to sign this before you attend
if you have further questions you would like answered.

Even if you have signed the form you are
under no obligation to proceed with the test.

To be completed by the Endoscopist

I confirm that the patient received written information about the procedure, including the risks, and has been given the opportunity to ask any further questions.

Signed Date 29/8/17
Endoscopist/Medical Practitioner

FORTH VALLEY ACUTE HOSPITALS NHS TRUST

Endoscopy Unit

NHS
Forth Valley

COPY

Date 23/1/17 Time 11:00 Ward/Dept ENDO Name _____

Presenting Complaint Bowel S ? Address _____

Procedure Gastroscopy

Is this a repeat procedure? Yes ☐ No ☒

Unit No. _____

CHI NO: 2602800570
CRN: S679370
Scott Dowell
11 Don Street,
GRANGEMOUTH,
Stirlingshire
FK3 8HD

26/02/1980
M ☒

Contact Number _____

GP Dr Dadas or Westburn Medical

Endoscopy Preparation

Please confirm each check by ticking box or circling item as required. Wards please complete before endoscopy, if not applicable, write N/A in box.

	Ward	Endo
Procedure explained		☒
Written consent		☒
I.D. band checked		☒
Recordings obtained		☒
Premedication given		<u>NA</u>
Correct casenotes		☒
Correct nursing notes		☒
Referral letter		☒
Relevant X-Rays		<u>DAES</u>
Blood results obtained		<u>SCI</u>
On warfarin		<u>NO</u>
INR obtained (If required)		<u>NA</u>
Date LMPO (X-Ray only)		<u>NA</u>
Antibiotics given		<u>NA</u>
I.V. cannula sited		☒
I.V. cannula flushed		☒
I.V. cannula sited by whom		☒

Dentures Retained ☒ Removed ☒ N/A

Top + bottom

Crowns Loose Teeth ☒ N/A

Hearing aid Retained ☒ Removed ☒ N/A

Contact lenses/ Spectacles Retained ☒ Removed ☒ N/A

Prosthesis Yes ☒ No ☒

Orthopaedic implants Type ☒ ARM ☒ PSM Yes ☒ No ☒

Cardiac pacemaker Yes ☒ No ☒

Heart valve replacement Yes ☒ No ☒

Jewellery & Valuables Retained ☒ In locker Removed ☒ Documented

Time last ate or drank 23:00 29/1/17

Pre scope stool (please circle) loose / bloody / solid

Enteric precautions required Yes ☒ No ☒

Bowel preparation (if required) type _____

Result _____

Any side effects / problems _____

History & Medication

Allergies Yes ☒ No (specify) _____

Heart disease Yes ☒ No (specify) _____

Chest problems Yes ☒ No (specify) _____

Rheumatoid arthritis Yes ☒ No Glaucoma Yes ☒ No

Epilepsy Yes ☒ No Diabetes Yes ☒ No

Other problems Spondylitis

Previous surgery Arm Neck Back
(ans in arm)

Present medication 1/7 Benepali
injections
phylloxydine
Contraozole
Ranitidine

Discharge

Sedation score, pain score and nausea score must all be 1 or less for safe discharge. Discharge criteria must be met.

Sedation score = 0 Pain score = 0 Nausea Score = 0

Has patient had a drink

Yes / No

Has patient had food

Yes / No

Has patient been seen by doctor / N.E.

Yes / No

Has patient been seen by nurse

Yes / No

Advice on discharge sheet given

Yes / No

Discharge criteria met

Yes / No

to specify _____

Discharged home (circle as appropriate)

Alone / Accompanied

By ambulance Yes / No

Transfer to ward Yes / No

Which ward _____

Back to ward _____

Personal effects transferred

Teeth Yes / No

Clothes Yes / No

Glasses Yes / No

Valuables Yes / No

COPY

Response to endoscopy

Satisfactory / Unsatisfactory (specify) _____

Patient education

None required / Yes (specify) _____

After care leaflet given Yes

Signature f. Anderson

Condition on leaving endoscopy unit

Drowsy / Slightly Drowsy / Awake

Clinic appointment:- Has one for _____ To be made for _____

To be rescoped :- Yes _____ Referral sent:- Yes _____

Other follow up Dr Salunka to devalue

Additional comments

No problems on discharge

Time left
department

13¹⁵

Signature

f. Anderson

Recovery Needs

Fast until

1410

B.P. Pulse & Resps 1/4 hourly until sedation score 1 and stable

Life in recovery position (circle as required)

Left side

Right side

COPY

Observe for any of the following - Haemorrhage, Perforation, Abdominal pain, Pulse, BP, Change of colour, Change of temperature, Respirations

all

Oxygen must be administered at 2litres a minute until sedation score 1 or less and oxygen saturation level maintained at pre endoscopy saturation level

Reversal of sedation Yes / No (specify)

Type of recovery Uneventful / Eventful (specify)

Have passed urine Yes / No I.V. cannula removed Yes / No / None

I.V. cannula site Satisfactory / Unsatisfactory (specify)

	Time	Admission	Theatre and Recovery
BP & Pulse	190	117	130
	180		133
	170		67
	160		
	150		
	140		
	130		
	120		
	110		
	100		
	90		
	80		
	70		
	60		
	50		
	40		
O2 saturation	97	97	98
O2 therapy	A		
Respirations	18		
Temperature	—		
BM	—		
Sedation score	0	0	0
Nausea score	0	0	0
Comfort score	0	0	0
Staff Initials	HE		

Sedation score

0. Fully aware of self & surroundings
1. Mostly aware of self & surroundings, but sedate
2. Slightly aware of self & surroundings, usually somnolent, arouses easily with stimuli
3. Not aware of self or surroundings, little arousal with stimuli
4. Unconscious, no arousal with painful stimuli

Nausea score

0. None
1. Mild, no treatment required
2. Moderate, helped by treatment
3. Severe, despite treatment

COMFORT SCORE

0. None / minimal
1. Mild
2. Moderate
3. Severe

Endoscopy prescriptions

Date	Medicines	Route	Dose	Time	Dr's Signature	Given By
	Midazolam	I.V.				
	Fentanyl	I.V.				
	Pethidine	I.V.				
	Buscopan	I.V.				
	Voltarol	PR				
	Anexate	I.V.				
	Adrenaline	INJ				
	Botox	INJ				
	Lignocaine	NEB				
	Sodium Chloride	IV				
	Oxygen Therapy					

COPY

Comments

Named nurse present

Post procedure safety brief carried out ☒

Signed

J. Anderson
11.2069B

Endoscope & Equipment decontamination record

Valve No. .

Please attach all decontamination reports / certificates securely to this page

Boston Scientific
Radial Jaw™ 4
2.8mm
GTIN 08714729745488
REF M00513300
LOT 20275884



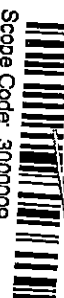
RE-ORDER CODE: FPLB 378
Tel: +44 1454 322777

Manual Wash:
30-05-2017 - 11:59
Processed Time:
30-05-2017 - 12:21

Reprocessor ID: 9
Cycle: 18045

DO NOT USE IF PACKING IS DAMAGED OR OPEN
STORE IN A CLEAN DUST FREE ENVIRONMENT

Scope Code: 3000009
User Code: 8004A00006
Lot No: 00445
Serial No: 2644206



NHS Endoscopy Unit
GASTROSCOPE

Patient safety brief

Procedure Room: 3

Time in

12:40

Time out

13:00

	TICK AS COMPLETED (By Circulating Nurse)	COMMENTS: Please document any comments/concerns below (To be completed below by Named Nurse prior to safety brief)
PATIENT DEMOGRAPHICS Name, Address, DOB, GP	☒	Correct
PROCEDURE/INDICATIONS CONSENT completed/checked	☒	Consented
ANTICOAGULANTS Warfarin, Clopidogrel etc	☒	No
ALLERGIES To what and effect on patient	☒	None Known
MOBILITY STATUS Hoist, glide sheets etc	☒	IND
INFECTION CONTROL SA, C-Diff, TB etc	☒	No
PATIENT ISSUES Same name, confused, fall risk, pacemakers, Diabetic, Artificial joints etc.	☒	Spondylitis ② Arm pins

COPY

Sign below on completion of safety brief

Circulating Nurse Jaqueline Anderson Endoscopist Dr Salunke

Procedure Performed Gastroscopy: Oesophageal Bx
 (a) 40cm (b) Target Bx.

Endoscope decontaminated, prepared & checked prior to use ☒ Yes / No

Throat spray ☒ Yes / No Time _____

Abdominal Pressure Applied Yes ☒ No Where? _____

Diathermy plate Yes / No ☒ Pad site _____ Skin intact Yes / No

APC Applied: Yes / No ☒ Effect: _____ Watts: _____

Present in Procedure Room (Witnessing Safety Brief)

Name Nurse Hather Everingham Circulating Nurse Jaqueline Anderson

Theatre Nurse Jenna Pason Endoscopist Dr Salunke

Trainee Endoscopist Dr Harrington Others S McNabb

Patient Comfort Score: 0 - None ☒ 1 - Mild ☐ 2 - Moderate ☐ 3 - Severe

Comments _____

Mobility Assessment

Complete mobility chart below

Actual or Potential Problems

COPY

Task	Pre Scope		Post Scope		Discharge	
If independently mobile please tick	✓		✓		12h	
	Asst	Equipment	Asst	Equipment	Asst	Equipment
Chair to Chair						
Chair to Couch						
Couch to Chair						
Other Specify						
Signature	Hedrick		Hedrick			

Nursing Assessment

Is Sedation Requested

Yes ☒ No ☐ Undecided

Admitted for Gastroscopy
 Consent form signed
 Procedure explained
 Observations stable
 Discussed at Safety Brief

6

enflon Yes / No Size _____ Lot No. _____ Expires _____

odium Chloride Yes / No Batch No. _____ Expires _____

FORTH VALLEY ACUTE HOSPITALS NHS TRUST

Endoscopy Unit

NHS

Forth Valley

Date 7/6/16 Ward/Dept Endo Name _____

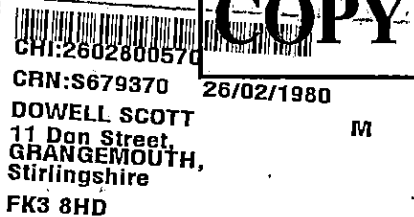
Presenting Complaint Epigastric Pain & Vomiting Address _____

Procedure UGIE

Is this a repeat procedure? Yes / No Unit No. _____

Contact Number Wife returning at 3.30pm

GP Dr O'Sullivan, Westburn MP, Westburn Ave, Falkirk



COPY

26/02/1980

M

Endoscopy Preparation

Please confirm each check by ticking box or circling item as required. Wards please complete before endoscopy, if not applicable, write N/A in box.

	Ward	Endo	Dentures	Retained	Removed	N/A
Procedure explained		☒	<u>Upper plate</u>			
Written consent		☒		Crowns	Loose Teeth	<u>N/A</u>
I.D. band checked		☒	Hearing aid	Retained	Removed	<u>N/A</u>
Recordings obtained		☒	Contact lenses/ Spectacles	Retained	Removed	<u>N/A</u>
Premedication given		<u>N/A</u>	Prosthesis		Yes	<u>No</u>
Correct casenotes		☒	Type			
Correct nursing notes		☒	Orthopaedic implants		Yes	No
Referral letter		☒	Type <u>Pins & Plate</u>	<u>Yes</u>		<u>No</u>
Relevant X-Rays		☒	Cardiac pacemaker		Yes	<u>No</u>
Blood results obtained		☒	Heart valve replacement		Yes	<u>No</u>
On warfarin		<u>N/A</u>	Jewellery & Valuables	<u>Retained</u>	Removed	Documented
INR obtained (If required)		<u>N/A</u>		<u>In locker</u>		
Date LMPO (X-Ray only)		<u>N/A</u>				
Antibiotics given		<u>N/A</u>				
T.V. cannula sited	<u>(NACF)</u>					
V. cannula flushed	<u>NaCl (16/22/019) 8/2018</u>					
I.V. cannula sited by whom	<u>Dr</u>					

Time last ate or drank 6/6/16 5pm - fluid

Pre scope stool (please circle) loose / bloody / solid	Enteric precautions required	Yes / <u>No</u>
Bowel preparation (if required) type-		
Result		
Any side effects / problems		

History & Medication

Allergies Yes No (specify) _____

Heart disease Yes No (specify) _____

Chest problems Yes No (specify) _____

Rheumatoid arthritis Yes No Glaucoma Yes No

Epilepsy Yes No Diabetes Yes No

Other problems Ankylosing Spondylitis

Previous surgery Pins & Plate (L) arm.

Present medication
Gabapentin
Lansoprazole 30mg OD
Dihydrocodone
Co-codamol

Discharge

Sedation score, pain score and nausea score must all be 1 or less for safe discharge. Discharge criteria must be met.

Sedation score = 0 Pain score = 0 Nausea Score = 0

Has patient had a drink Yes / No

Has patient had food Yes / No

Has patient been seen by doctor / N.E. Yes / No

Has patient been seen by nurse Yes / No

Advice on discharge sheet given Yes / No

Discharge criteria met Yes / No

specify _____

Discharged home (circle as required)

Alone / Accompanied

By ambulance Yes / No

Transfer to ward Yes / No

Which ward _____

Back to ward _____

Personal effects transferred

Teeth Yes / No

Clothes Yes / No

Glasses Yes / No

Valuables Yes / No

Response to endoscopy Satisfactory / Unsatisfactory (specify) _____

Patient education None required Yes (specify) _____

Post procedure UGIE booklet - Signature Dr. Salunke

Condition on leaving endoscopy unit Drowsy / Slightly Drowsy / Awake

Clinic appointment:- Has one for _____ To be made for _____

To be rescoped :- Yes _____ Referral sent:- Yes _____

Other follow up Dr. Salunke to decide

Additional comments Uneventful recovery

Observations satisfactory.

Uncomplaining

Collected by wife

Time left department 1605hrs Signature Dr. Salunke

B.P. Pulse & Resps 1/4 hourly until sedation score 1 and stable

Use in reviewing resolution (delete as required)

Right side

COPY

Observe for any of the following - Haemorrhage, Perforation, Abdominal pain, Pulse, BP, Change of colour, Change of temperature, Respirations

Oxygen must be administered at 2litres a minute until sedation score 1 or less and oxygen saturation level maintained at pre endoscopy saturation level

Reversal of sedation Yes/No (specify)

Type of recovery Uneventful / Eventful (specify)

Have passed urine Yes/No

I.V. cannula removed.

Yes / No / None

1. V. cannula site Satisfactory / Unsatisfactory (specify)

Sedation score

0. Fully aware of self & surroundings
1. Mostly aware of self & surroundings, but sedate
2. Slightly aware of self & surroundings, usually somnolent, arouses easily with stimuli
3. Not aware of self or surroundings, little arousal with stimuli
4. Unconscious, no arousal with painful stimuli

Nausea score

0. None
1. Mild, no treatment required
2. Moderate, helped by treatment
3. Severe; despite treatment

COMFORT SCORE

0. None / minimal
1. Mild
2. Moderate
3. Severe

Endoscopy prescriptions

Date	Medicines	Route	Dose	Time	Dr's Signature	Given By
<i>[Signature]</i>	Midazolam	I.V.	3mg	3.10p	<i>[Signature]</i>	COPY <i>[Signature]</i>
	Fentanyl	I.V.				
	Pethidine	I.V.				
	Buscopan	I.V.				
<i>[Signature]</i>	Voltarol	PR				
	Anexate	I.V.				
	Adrenaline	INJ				
	Botox	INJ				
<i>[Signature]</i>	Lignocaine	NEB				
	Entonox					
	Oxygen Therapy	Nasal 2L/min throughout				<i>[Signature]</i>

Comments

Endoscope & Equipment decontamination record

Please attach all decontamination reports / certificates securely to this page

S-20480

1037768

Boston Scientific
Radial Jaw™ 4
2.8mm
GTIN 08714729745488
M00513300
19048552



Reprocessor ID: 1

Cycle: 19141

Manual Wash:

07-06-2016 - 14:24

Processed Time:

07-06-2016 - 15:02

RE-ORDER CODE FPLB 378
Tel: +44 1454 322777

NHS FVRH, Stirling Rd, Larkhall FK5 4WJ

GASTROSCOPE



Scope Code: 3000011

User Code: 8004A000003

Lot No: 00026

Serial No: 2644155

DO NOT USE IF PACKING IS DAMAGED OR OPEN
STORE IN A CLEAN DUST FREE ENVIRONMENT

Patient safety brief

	TICK BELOW	COMMENTS: Please document any comments/concerns below
PATIENT DEMOGRAPHICS Name, Address, DOB, GP	☒	Correct
ANTICOAGULANTS Warfarin, Clopidogrel etc	☒	N/A
ALLERGIES To what and effect on patient	☒	N/A
MOBILITY STATUS Hoist, glide sheets etc	☒	N/A
INFECTION CONTROL MRSA, C-Diff, TB etc	☒	N/A
PATIENT ISSUES Same name, confused, fall risk, Pacemakers, Diabetic, Artificial joints etc.	☒	N/A

COPY

Endoscopy procedure

Theatre:- (

Time in 1510

Time out

15.20

Objective achieved ☒

Caecum reached

☒ N/A

Procedure performed

Gastrosocopy

+ Clot test

+ endoscopy

Comfort Score: 0 - None

1 - Mild

☒ 2 - Moderate

3 - Severe

Comments:

Washed for PAV of the test

Endoscope decontaminated, prepared & checked prior to use

☒ Yes ☐ No

...roat spray

Yes ☒ No ☐

Time

Abdominal pressure applied

Yes / No

☒ N/A

Diathermy plate

Yes ☒ No ☐

Pad site

Skin intact

Yes / No

APC Applied:

Effect:

Watts:

Named Nurse

Dianne Hill

Theatre Nurse

Pauline Donnelly

Circulating Nurse

Barbara Dowell

Endoscopist

Diane Kennedy

Scope Cleaner

Co-operation	Level of acceptability	Description
A	Relaxed	Fully co-operative
B	Struggled	Struggled but managed to co-operate enough to allow procedure to finish
C	Distressed	Procedure shortened or abandoned because of patient distress

Diagnosis

See wrist report

Mobility Assessment

Complete mobility chart below

Actual or Potential Problems

COPY

Task	Pre Scope	Post Scope	Discharge
If independently mobile please tick	✓		✓
	Asst Equipment	Asst Equipment	Asst Equipment
Chair to Chair		While	
Chair to Couch		Seated	
Couch to Chair			
Other Specify			
Signature	Dine	Dine	Dine

Nursing Assessment

Is Sedation Requested

☒ Yes

☐ No

☐ Undecided

Admitted to unit for UGIE
 Procedure explained
 Observations Satisfactory
 Discussed at safety.
 Dine SN

ERILE R



382903932221

MR SCOTT DOWELL

11 DON STREET,
 GRANGEMOUTH,
 STIRLINGSHIRE

FK3 8HD

000000000000

2015-11
 2018-10



Consent Form

Upper Gastrointestinal Endoscopy

I,
of
CHI NO: 2602800570 26/02/1980
CRN: S679370 M.
Scott Dowell
11 Don Street,
GRANGEMOUTH,
Stirlingshire
FK3 8HD

I hereby consent
(or hereby consent to the submission of my child/ward)
to the procedure of: **Upper Gastrointestinal Endoscopy +/- Oesophageal Dilatation**
the purpose of which has been explained to me in the document entitled:
"Upper Gastrointestinal Endoscopy - Information for Patients".

I confirm that:

- I have read the document
- I have understood the information that has been given to me
- I understand that I will be given the opportunity to ask questions about the procedure.

I also give consent for any necessary biopsies and for photographs or x-rays to be taken.

Signed (Patient/Parent) *Scott Dowell* Date *30/5/2017*

Name of Patient/Parent..... *Scott Dowell*(block capitals)

Please ensure that you bring this form with you.

**You do not have to sign this before you attend
if you have further questions you would like answered.**

**Even if you have signed the form you are
under no obligation to proceed with the test.**

To be completed by the Endoscopist

I confirm that the patient received written information about the procedure, including the risks, and has been given the opportunity to ask any further questions.

Signed *[Signature]* Date *30/5/17*

Endoscopist/Medical Practitioner

Consent Form

Upper Gastrointestinal Endoscopy

I,
of
.....
.....
.....
.....

CHI:2602800570
CRN:S679370 26/02/1980
DOWELL SCOTT
11 Don Street
GRANGEMOUTH,
Stirlingshire
FK3 8HD

M

I hereby consent
(or hereby consent to the submission of my child/ward)
to the procedure of: **Upper Gastrointestinal Endoscopy +/- Oesophageal Dilatation**
the purpose of which has been explained to me in the document entitled:
"Upper Gastrointestinal Endoscopy - Information for Patients".

I confirm that:

- I have read the document
- I have understood the information that has been given to me
- I understand that I will be given the opportunity to ask questions about the procedure.

I also give consent for any necessary biopsies and for photographs or x-rays to be taken.

Signed (Patient/Parent) *John Dowell* Date *7/6/16*

Name of Patient/Parent.....(block capitals)

Please ensure that you bring this form with you.

You do not have to sign this before you attend
if you have further questions you would like answered.

Even if you have signed the form you are
under no obligation to proceed with the test.

To be completed by the Endoscopist

I confirm that the patient received written information about the procedure, including the risks, and has been given the opportunity to ask any further questions.

Signed Date *7/6/16*

Endoscopist/Medical Practitioner

Accident and Emergency Department

Forth Valley Royal Hospital



2602800570

A&E No. 1500014581

COPY
4

Surname	Dowell	Forename	Scott	Title:	
Address:	11 DON STREET GRANGEMOUTH	Postcode	FK3 8HD	CHI No:	2602800570
		Telephoné:	262719		
Date of Birth:	26.02.80	Sex:	M	Age:	35 yrs

CHI Barcode:



GP Name:	DUNDAS DEREK	Postcode	FK1 5QE
Address:	WESTBURN MEDICAL P... WESTBURN AVENUE/M... FALKIRK	Telephone:	01324 623577

Next of Kin	DIANE	Postcode	FK3 8HD
Relationship:	WIFE	Telephone:	262719
Address:	11 DON STREET GRANGEMOUTH		

Manual CHI Entry:

Date of Attendance: 24.09.15 22:51

Date of Incident:

Presenting Complaint: FB R EYE

Tr	METAL PARTICLE IN RT EYE AFTER GRINDING THIS AFTERNOON TWO PARTICLES REMOVED ALREADY	Tetanus Cover:
		Allergies:
P=	BP= /	RR=
PF=	GCS=E: M: V: Total:	Sat= BM=

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time

Clinical Notes

Seen by:

NH 5780J
NIDA

Time:

0220

COPY

35yo 07

PC FB in eye (R)

HPC Grinding metal

Aware of pain in (R) eye

Not wearing eye protection
Removed 2x particles himself

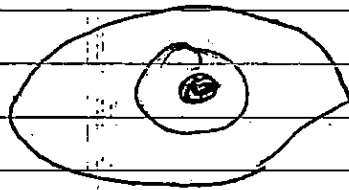
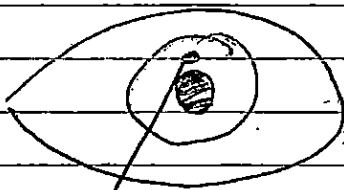
VA

3/3

3/3

R

L



Metal fragment

Small fragment removed w
green needle

Further fragment deeply embedded

(P) Rapid Access Eye Clinic
brothers wedding today
next available

[Signature]
H 5780J

Attach continuation sheets here

Attach here onto face of pocket



Guidelines Used:

Write - Imprint or Attach Label

Vital No.



CHI:2602800570
CRN:S679370 26/02/1980

DOWELL SCOTT
11 Don Street
GRANGEMOUTH,
Stirlingshire
FK3 8HD

COPY

R.A.C

Date

NURSING ASSESSMENT

REFERRAL CP, SELF, OPT, ORTHO, A&E, M.L.U, G.P.

SYMPTOMS FB RE grinding metal bridge
put FB removed @ A&E not very recent

MEDICATION

ALLERGIES

nil

N/K

P.O.H

P.M.H

Pbc
ARC eye

nil

V.A.(R) 6/6-2 V.N

V.A.(L) 6/6 V.N

PH 6/7-5

PH

I.O.P'S

1

R.A.P.D Yes/No L/R

DIL.YES/NO TROP 1% OTHER

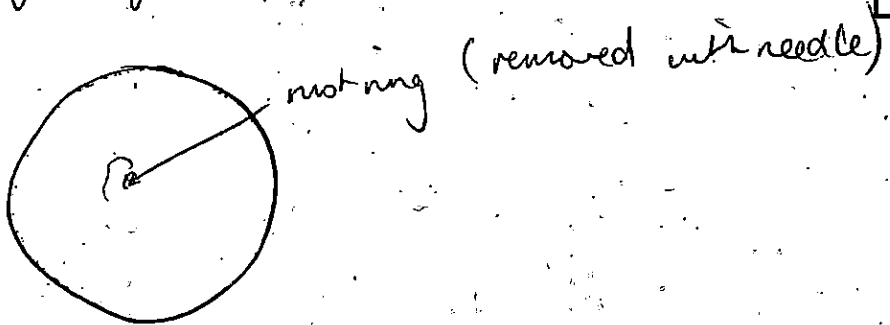
O.C.T.FIELDS PACHYMETRY IFA

Grinding yesterday - not for work

- was not wearing goggles

metal in right eye

COPY



A/c D+CO

Imp Removed successfully

Plan oc chlor QDS 1/52
DISCHARGE.

STUBER
ST1

Emergency Department
Forth Valley Royal Hospital



2602800570

A&E No. 6000006434

COPY

Surname: Dowell Forename: Scott Title:
Address: 11 DON STREET Postcode: FK3 8HD CHI No: 2602800570
GRANGEMOUTH
Telephone: 262719
Date of Birth: 26.02.80 Sex: M Age: 36 yrs

CHI Barcode:



GP Name: DUNDAS DEREK
Address: WESTBURN MEDICAL P... Postcode: FK1 5QE
WESTBURN AVENUE/M...
FALKIRK Telephone: 01324 623577

Next of Kin: DIANE
Relationship: WIFE
Address: 11 DON STREET Postcode: FK3 8HD
GRANGEMOUTH
Telephone: 262719

Manual CHI Entry:

Date of Attendance: 09.08.16 09:12

Date of Incident:

Presenting Complaint: ? FB R EYE

Triage

Tetanus Cover:

Allergies:

BP= / RR= Sat= BM=

GCS=E: M: V: Total:

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time

Clinical Notes

9/8/16

Seen by:

Insertion

Time:

0925

Pictorial Eye wear

Wetting

Gust of wind blew fragrance on eye

6 days ago

PMW An Spine

Mudg DUC

sl. Coren

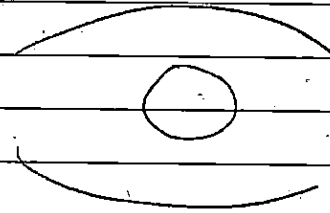
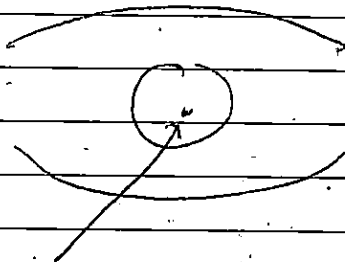
cler

VA 6/6 R = C = (2)

Red inflamed Caprom (R)

(2)

(2)



large nasal fragain

→ L.A

→ Remains Sur. Coars red ring

Small but aware

→ Ophth. fa

Chlorophane

10am

Friday

FC12

12/8

0782 653 2859

Thals

COPY

CHI: 24080057
DOWELL
Scott
11 DON STREET
FK3 8HD

Attach continuation sheets here

Attach here onto face of pocket

Guidelines Used:

CLINICAL NOTES

Attach Label
 Surname: HI:2602800570
 Forename: DOWELL SCOTT
 Address: 11 Don Street, GRANGEMOUTH, Stirlingshire FK3 8HD
 Date: 26/02/1980
 CRN: S679370

COPY

Consultant

Date

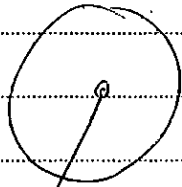
12/8/16

A/C referral '6 FB (R) eye

UAC 6/15/10
 6/7.5014

UAC 6/7.5/10

mesh



Canal FB
 (removed)
 free of pigment bill

no AC no
 de chloramphenicol sh. → Tdo.
 fu SAS
 J. KILLEN

11/11/2019



Presenting complaint: f/b l eye

[illegible]

Clinical Notes

Seen by:

Loren Brown

Time:

19.05

COPY

CHI NO: 2602800570
GRN: 26/02/1980
Scott DOWELL
11 DON STREET
GLoucester
GL1 3BH

P.C FB @ eye

HPC 39 yr old Male - welder - wears glasses at night driving
Welding 3/7 ago - FB in @ eye - Since
pain +++ - photophobic

PHH

Medic

Allergies

OPHX

Barrett's es.

NKDA

previous FB

A-Spondylitis

OE - Both eyes - no peri orbital swelling - anterior
Chamber Clear - red reflex present PERLA size
5 - pupils round L = R - FROETM
VA @ 0.33 @ 0.33

@ eye injection +++ - Intermittently watering
no FB visible to naked eye - no Crusting or discharge
on upper lid eversion - Subtarsal plate Clear -
lower Cornea clear - Sub tarsal sweep clear -
Topical anaesthetic instilled - with relief
Slit lamp white light FB seen at 2 o'clock on
pupil -

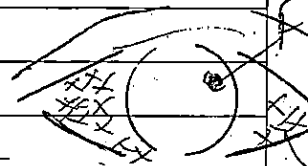
FB - Removed with Sterile green needle -

Slit lamp - white light - no FB remains - rust ring seen

Fluorescein drops instilled uptake as per diagram

Slit lamp blue light - uptake as per diagram -

IMPLD FB @ eye - rust ring



TX - Refer ophthalmology - tomorrow 11.15am -

TTO Chloramphenicol eye ointment QDS 4/7

analgesia if required

Warning advice to return if any further concerns

Attach co

Disp:

ABrown

ABee

Presc:

Stannell

Urban macmillan

Apply to left eye

Attach he

Chloramphenicol 1% Eye

Ointment (4g)

Guidelines Used:

Loren Brown

R.A.C

Write - imprint or Attach Label

Surname DOWELL Hospital No. _____
Forenames SCOTT Sex M
D. of B. 26.02.80
Address _____ (0570)
COPY
Ward / Dept. _____

Date

29.06.19
1130

NURSING ASSESSMENT

1/7 ago
REFERRAL, CP, SELF, OPT. ORTHO, A&E, M.I.U, G.P.

- Welding/grinder 4/7 ago
- LE discomfort for 2/7, photophobic, red

SYMPTOMS

watery
- o/b A&E FB (metal) removed ? not ring
- using occ. chlor. ✓

MEDICATION

ALLERGIES

Tramadol
Biologic Injections
Perindopril
Omeprazole

NIL

P.O.H

P.M.H

NIL

Spondylosis
Barretts Disease

V.A.(R) 6/12

u/A V.A.(L) 6/24

u/A

PH 6/9.5

PH 6/15

G.L. Matheson

I.O.P'S

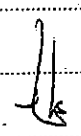
1

R.A.P.D Yes/No L/R

DIL.YES/NO TROP 1% OTHER

O.C.T FIELDS PACHYMETRY FEA

Form

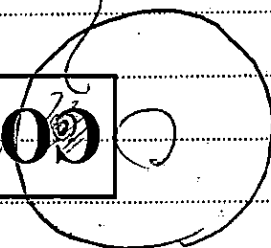


R/O Runk m
Oc elia
4/3

Runk m

to 08D

COPY



Co. Lyndt

29/6/19
Date

100-100000-0000

2602800570

R.A.C

Dr. Miller

Write - imprint or Attach Label

Surname Dowell Hospital No. 0570Forenames Scott SexD of B 260280Address 11 Down StreetGrange Moor

COPY

Ward / Dent.

Date

14/7/23

NURSING ASSESSMENT

17.00

REFERRAL, CP, SELF, OPT. ORTHO, A&E, M.I.U, G.P.

SYMPTOMS

~~Foreign~~ Foreign body - metal

MEDICATION

biological injections

ALLERGIES

nil

P.O.H

nil

P.M.H

rheumatoid arthritis

Barrett's disease

AF

V.A.(R) 6/24

u.a.

V.A.(L) 6/2.5

P.H 6/12

P.H

I.O.P'S

I care

Williams SJ

23 / 22

R.A.P.D Yes/No L/R

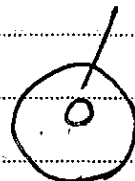
DIL.YES/NO TROP 1% OTHER

O.C.T FIELDS PACHYMETRY FFA

all
on
cur

cin
scen

COPY

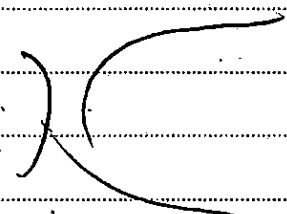


cont
dramas

~ 2m

After New York Convention
with New York

At
New York



lim (V) number of

per of
at 42

with
cont

**Emergency Discharge Letter
(Authorised)****COPY**

R Lal
Health Centre
Kersiebank Avenue
Grangemouth
Grangemouth
FK3 9EL

FVRH Emergency Department
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

CHI Barcode:



2602800570

Date of Completion: 21-Jul-2023

GP Practice

GP Name:	R Lal	GP GMC:	6148077
GP Practice Address:		GP Practice Code:	6148077/26015
		GP Clinic Code:	26015
		GP Telephone:	

Patient Demographics

Patient Name:	DOWELL, Scott	Date Of Birth:	26-Feb-1980
Patient Address:	11 Don Street Grangemouth Stirlingshire FK3 8HD	Gender:	Male
		CHI No:	2602800570
Telephone No:	01324 262719		

Admission Details

Patient Location:	FVRH Emergency Department	Admission Date:	21-Jul-2023
Admission Care Provider:	Dr Stefano Corrieri	Admission Time:	08:54
Source Of Admission:	Same hospital Excl Minor Injuries Unit		

Presenting Complaint

APPT 0900 Eye Complaint

Diagnosis

Diagnosis	Site	Laterality
ED diagnosis - Redirection - ED nurse redirection (as per policy)		

Procedures

No Procedure Results

Medications

Nil records exist

Discharge Details

Discharge Type:	With referral	Discharge Date:	21-Jul-2023
Discharge Destination:	Private Residence - Usual place of residence	Discharge Time:	09:30
Referred To:			

Notes for GP

See previous notes:

COPY

Dear Colleague Mr Dowell presented with multiple metal fragments in right eye while grinding metal with an angle grinder. Right eye showed no difference in acuity, cranial nerves intact, no change to visual fields, no eyelid foreign body, no meningism, pupils equal and reactive to light. Metal fragments shown under blue light with fluorescein staining and all fragments bar one removed. One fragment proved difficult to remove and unable to remove with green needle. Discharged urgent ophthalmology follow up and chloramphenicol ointment Arman Shriandani

Today: no change to above except uptake centrally black mark in appearance patient has injected eye and experiencing discomfort. carbogel given and redirected to eye clinic for continuation of care received 14/07/23

Person completing recordAuthorised by

Name: Mr Martin Coull
Designation or role: Nurse
Specialty:
Date completed: 21-Jul-2023

Clinically completed by

Name:
Designation or role:
Specialty:

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
R Lal	GP	Health Centre

Please tick appropriate box

CLINICAL NOTES

NURSING NOTES

PROGRESS NOTES

☐
☐
☐

Consultant

IL - RAC

Write - imprint or Attach Label

Surr

Fore

CHI.

Addr

CHI NO: 2802800570
CRN: S679370
SCOTT DOWELL
11 DON STREET,
GRANGEMOUTH,
STIRLINGSHIRE
FK3 8HD

26/02/1980

M

COPY

Date and Time

22/7/23

0855 am.

Attended A+E 21/7/23 - due to no improvement
in symptoms. Metallic FB noted in R eye.
Has continued to occ. chloramphenicol

Rva 6/15-1 NA

6/9.5 cph

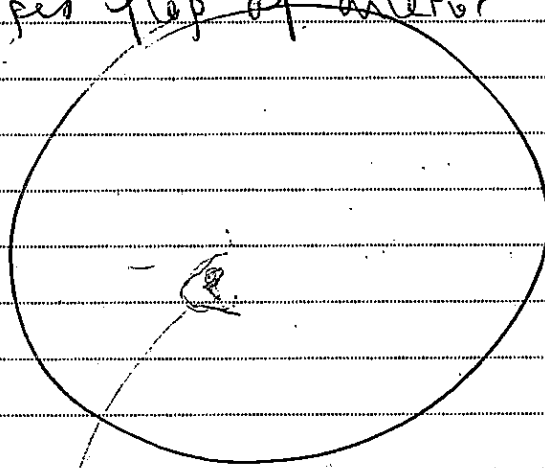
No distance glasses today

Lva 6/7.5

NI.

H. Muldoon SSN

"v"-shaped flap of anterior sclera, likely
from original wound.



I suspect this
is the cause
of symptoms
Sundels -ve

q A/C

Stained
cells

minimal nebul
(occurred in green nebul)

(P)

Exon stat + QDS
clw oc. chbr.

Proxy given as pain ++.
Consider BCL if remains this
symptomatic

Please tick appropriate box

CLINICAL NOTES

NURSING NOTES

PROGRESS NOTES

☒
☐
☐

CHI NO: 2602800570 26/02/1980
CRN: S679370
SCOTT DOWELL
11 DON STREET,
GRANGEMOUTH,
STIRLINGSHIRE
FK3 8HD

ch Label

ipital No.

COPY

Consultant Dr. Chadwick

Ward / Dept. Ophth

Date and Time

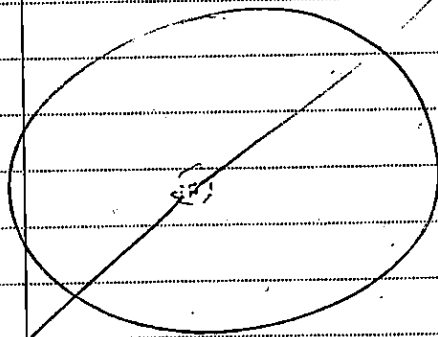
25/7/23
14.45

RVA 6/12 (Uncoded) LVA 6/7.5
+PH 6/9.5
+PH 6/6
As 1/80 8/11.

Better but still sore

g. exci QOS
oc. cpl on.

try area
g. JAI stain



Non-mobile epithelium
No epithelium
At quiet

Plan: Contact contact R

rh 1/2.

Chadwick

Please tick appropriate box

CLINICAL NOTES



NURSING NOTES



PROGRESS NOTES



Consultant

Write - imprint or Attach Label

Surname

Forenames

CHI

Address

CHI NO: 2602800570 28/02/1980
CRN: S679370
SCOTT DOWELL
11 DON STREET
GRANGEMOUTH
STIRLINGSHIRE
FK3 8HD

COPY

Date and Time

11/8/23

14:45 pm

RAC Review

Rva 6/15
6/12

VA

eph

Lva 6/7.5-1

NI

H. Muldoon SSN

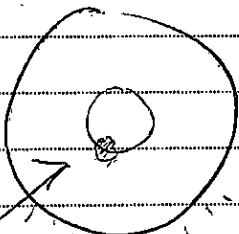
Feels R eye improving but still quite photophobic.

Was using proxy OD to help E pain but has run out of them now.

Using exocin ODS RE

Chlor 1% ointment OD @ night

R



L

Quiet eye

resolving corneal lesion mild pain

ATC quite

lumbar injection inferior

photophobic @ SL

GH = Ankylosing Spondylitis. Attends Chronic pain team

Meds = Co Sentyx
Cocodamol
Ropinirole

omeprazole
morphine

Please tick appropriate box

CLINICAL NOTES ☐

NURSING NOTES ☐

PROGRESS NOTES ☐

Write - imprint or Attach Label

Surname..... Hospital No.....

Forenames..... Sex.....

CHI..... D. of B.....

Address.....

COPY

Consultant

Ward / Dept.....

Date and Time

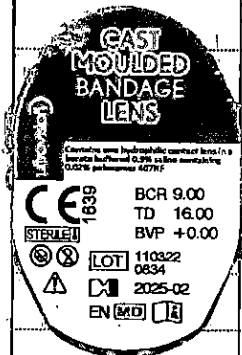


Seen by PF.

Plan - try BCL for 48hrs + return to clinic for review to ensure keeping. Stop antibiotics

Inserted Provention 8.6 / 00 in R eye
pts is high, not covering
limbs

→ removed



Inserted Cast Moulded BCL 9.00 / 16.00 / 00
pts better, still slightly high
but within acceptable range

10-15 mins later - still not settled.



Inserted Cast Moulded BCL 9.00 / 18.00 / 00

Sitting much more central, good alignment.

Given Evolve Carbomer 0.2% to use PRN
but esp @ night + in morning
review RAC 02/7

Shirley

Please tick appropriate box

CLINICAL NOTES

☐

NURSING NOTES

☐

PROGRESS NOTES

☐

Surname

CHI NO: 2602800570

28/02/1980

Forename

CRN: S679370

CHI

11 DON STREET,

Address

GRANGEMOUTH,

STIRLINGSHIRE

FK3 8HD

COPY

Consultant

DR FRAWANAN

Date and Time

03/08/23
1426

RVA 6/9.5
PH 6/7.5

(U/A)

WA 6/7.5
PH 6/7.5 +3

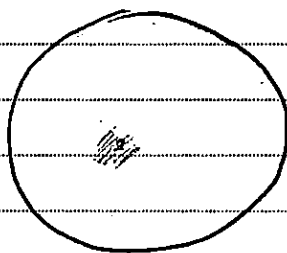
Admission 11/08/23

ABCL - PELL OUT AFTER APPROX 45 MINS.

"LOADS BATTER"

off 6/9.5 VA 6/7.5
4/7.5

BLOOMING CLOS. BLUMING
✓ cos ✓



CONJUGA

NON-STAINING

LIQUID STAINING

PLAT OBSERVED
2/52 (7.1)

FRAWANAN

17/8/23

DATA

(8)



Please tick appropriate box

CLINICAL NOTES

☐

NURSING NOTES

☐

PROGRESS NOTES

☐

Consultant

Write - imprint or Attach Label

Suma

Forer

CHI...

Addr



CHI:2602800570

CRN:S679370 26/02/1980

DOWELL SCOTT

11 Don Street,

GRANGEMOUTH,

Stirlingshire

FK3 8HD

COPY

Date and Time

3/2/16

longstanding 10 years. no trauma.

medial, anterior asp.

Probs. 5 socks. → 1 lb of fibrin

clotches.

Blue cray → approx 1 year.

locks - occasionally. → can happen daily

Sore on left cheek.

Socks. → every day. no reaction from hair
sections & uric acid

Dh - longpassle

Sh - Nor working

- + other.

→ cover for wife

- no acute lobbies

Xray - last week

few years ago - duct stone.

He = 80 -

ML - un.

Ab = 30

Please tick appropriate box

CLINICAL NOTES

☐

NURSING NOTES

☐

PROGRESS NOTES

☐

Consultant

MR Rade

Write - imprint or Attach Label



CHI:2602800570

CRN:S679370 26/02/1980

DOWELL SCOTT
11 Don Street,
GRANGEMOUTH,
Stirlingshire

FK3 8HD

al No.....



Date and Time

19/12/16

Forth Valley Elective Preoperative Assessment Record (Adults)

NHS
Forth Valley

COPY

Patient Details (addressograph)

Surname: 
Forename: CHI NO: 2602800570 26/02/1980
Address: CRN: S679370 M
SCOTT DOWELL
11 DON STREET,
GRANGEMOUTH,
STIRLINGSHIRE
FK3 8HD
Postcode:
Marital Status:

Early Assessment

Yes ☒ No ☐

Title: Mr Mrs Miss Ms Dr
D.O.B.:
Age: 37
Telephone - Home:
Telephone - Mobile: 01329 262719

Occupation: Care
Religion:

Next of Kin Details

Next of Kin: Diane

Alternative Next of Kin:

Relationship: W

Relationship:

Address: (if different from above)

Address: (if different from above)

Telephone - Home:
- Mobile: 01329 262719

Telephone - Home:
- Mobile:

GP Details

Name: Dr. D. D. D.
Practice: Westburn
Address:
Surgeon: Timmins

Have you ever been notified that you are at increased risk of CJD or VCJD by Public Health? Yes ☐ No ☒

Transport: Yes
Diagnosis:

Planned Procedure:

Date of Assessment: 22/9/18 Date and time of Admission: 10.15 20.7.18 08.00

Date of Operation: 29.6.18 FVRH Ambulatory Care: Neck Breather: N

Allergies: metal ☐ foods ☒ drugs ☒ latex ☐

Specify reaction:

Smoking 20 - advised to stop. - didn't want referral
Cessation advice given Yes ☐ No ☐

Alcohol X

Previous Surgery/Anaesthesia (list previous surgery and anaesthesia with dates)

Any problems (surgical or anaesthetic)

No ☒ Yes ☐

Family History of Anaesthetic problems

No ☒ Yes ☐

Sebaceous cyst removed x2.
Infected cyst ITP.
ORIF # arm @
CIA for removal of
birth mark
cyst on knee

Medical History (please circle)

Exercise Tolerance	Distance Walked without stopping very slow on crutches hop on one leg upstairs 2 flights of stairs 2 slides down stairs	COPY
Shortness of Breath Yes ☒ No	can feel out of breath.	
Hypertension Yes ☒ No		
Ischaemic Heart Disease/valve/murmur/ cardiac failure Yes ☒ No 2 Pillows	Angina/MI/swollen ankles/palpitations/rheumatic fever/PND/murmur/orthopnoea oft.	
Cerebrovascular Disease Yes ☒ No	resolved ^{1cc} steroids Bell's Palsy 15 yrs ago	
Peripheral Vascular Disease ☒ Yes ☐ No	restless leg syndrome - to thigh legs - feels swollen medicated. oft.	
Diabetes Yes ☒ No		
Asthma/COPD Yes ☐ No	Steroids/cough/cold/antibiotics/hospitalisation no hump on sternum anx. spasmolysis. poss. Barrett's.	
Gastric Ulcer Yes ☒ No	H. pylori - oesophagitis - on PPI prev. Helicobacter.	
HH/GORD ☒ Yes ☐ No		
Renal/Urological problems Yes ☒ No	Nocturia	
DVT/PE/Clots Yes ☒ No	oft.	
Arthritis ☒ Yes ☐ No	Neck movement ① hip from ank spasmolysis.	
Epilepsy Yes ☒ No	Black out years ago - hit on head age 15.	
Other Medical Yes ☐ No		

NHS
Forth Valley

CHI NO: 2802800570 28/02/1980
CRN: S679370 M
SCOTT DOWELL
11 DON STREET,
GRANGEMOUTH,
STIRLINGSHIRE
FK3 8HD

COPY

ECARE PLAN STARTED ☐ ON EWARD ☐

ECS PERMISSION OBTAINED BY:

Date: ____/____/____

COMMUNITY PHARMACY:

COMMUNITY PHARMACY CONTACTED: YES ☐ NO ☐

COMPLIANCE DEVICE: YES ☐ NO ☐

Filled by . . . patient/relative/carer/community pharmacy

Self medicates at home ☐ Supervised by carers ☐

Drug History Source

Obtained by: [Signature] Date: 2/2/78

Verified by pharmacist Date:

[illegible]

Any Herbal/Over the Counter Medicines:

Comments:

Observations and Investigations

Weight	88	Height	172	BMI	29
P	83	BP	115/76	SaO ₂	96%
				RR	13

COPY

Medical Examination/Comments

Cardiovascular System

Pulse: 80 regular

JVP: Normal

Heart Sounds: 1+1+0

Ankles: 0 oedema

Sign: *[Signature]*

Respiratory System

Trachea: Central

Expansion: Symmetrical

Percussion: Normal

Air Entry: Good, equal
No added sounds

No changes
26.6.18 *[Signature]*

DVT Risk Factors

Suggested thromboprophylaxis required (all patients to be mobilised and well hydrated)

None ☐ CECS ☒ Intraop calf compression ☒ Enoxaparin ☐ Rivaroxaban ☒ Not sure ☐

Risk

Patient been advised to read anaesthetic booklet

Yes ☒

No ☐

ASA grade 1 ☐ 2 ☒ 3 ☐ 4 ☐ 5 Any problems (specify)

To discuss with anaesthetist

Yes ☐

No ☒

Ank Spond.
on Hbua -
advised to stop
2 injections prior

(Circle)

Day Case

23 hours stay

Inpatient - DOSA/DBS

Date 22.1.18

Sign and Print

[Signature]

Forth Valley Elective Preoperative Assessment Record (Adults)



CHI NO: 2602800570 28/02/1980
CRN: S679370
SCOTT DOWELL
11 DON STREET,
GRANGEMOUTH,
STIRLINGSHIRE
FK3 8HD

COPY

Investigations and Results

Date Test Done Enter results OR tick the "not requested in accordance with pre assessment guidelines" box. If there is no change in the condition/therapy results within 3 months acceptable.

22/01/18 ✓ Hb 178↑ WCC 5.2 Platelets 134↓ CRP <5 ESR Not requested ☐

22/01/18 ✓ Na 138 K 4.7 Ur 3.7 Cr 85 eGFR >59 Not requested ☐

Blood Glucose (random or fasting) ☐ HbA1c ☐ Not requested ☐

ECG attached ☐ X-Ray requested ☐ 13/11/17. XR pelvis. Not requested ☐

22/01/18 ✓ GP & save Antibodies ☒ A Positive X match ☐ units Not requested ☐

Positive Antibodies ☐ - None Update EDMS ☐ Phone Secretary ☐ Not requested ☐

INR (PT) ☐ CLOTTING ☐ Not requested ☐

22/01/18 ✓ MSSU: rbc wcc epithelial 6 No Culture req Not requested ☐

22/01/18 ✓ AST 20 ALT 25 Bil 9 TP 73 Alb 44 Alk Phos 83 Not requested ☐

22/01/18 ✓ MRSA Negative Not required ☐

26/6/18 MSSU RBC 3, WBC 0, EC 2, No culture needed
Hb 174↑, WBC 7.3, plate 125↓
Na 139, K 4.3, urea 5.0, creat 73, eGFR >59
AST 19, ALT 32, Bil 6, TP 72, Alb 43, Alkph 68
CRP <5, Gas A positive, no antibodies.

AMT 4

All patients age 65 and over:

- How old are you? ☐
- What is your year of birth? ☐
- What year is it now? ☐
- Where are we at present? ☐

MRSA in progress ☐

If score is less than 4 do: FBC, U&E, Glucose, LFT, TFT, B12 folate (separate yellow bottle)

Complete a letter to GP ☐

Complete a letter to Surgeon ☐

HOSPITAL READMISSION CHECK:

DATE:

20/7/18

Any changes in health since Pre-op Assessment?

Yes ☐
(document)

No ☐
COPY

Any hospital admission since Pre-op Assessment?

Yes ☐
(document)

No ☒

Any Blood Transfusion or blood products since Pre-op Assessment?

Yes ☐
(document)

No ☒

Are you pregnant?

Yes ☐

No ☐

LMP ____/____/____

Test:

NA

If "Yes" to any of the above, please repeat the cross match/group and save

Ok to proceed

Yes ☐

No ☐

Handwritten signature

Family Dialogue

Date & Sign

Forth Valley Elective Preoperative Assessment Record (Adults)



CHI NO: 2602800570 26/02/1980
CRN: 9879370
SCOTT DOWELL
11 DON STREET,
GRANGEMOUTH,
STIRLINGSHIRE
FK3 8HD

COPY

Nursing Admission Profile

Home Circumstances	Yes	No	Referrals	Date
Lives alone		✓	Addiction Team	
Lives with: <u>Wife</u>			Dietetics	
Is there a main Carer?	✓		Infection Control	
Who will supply transport?		<u>transfer</u> ✓	Occupational Therapy	
Is patient a main carer?			Nurse Specialist (specify)	
Housing			Physiotherapy	
Flat ☐	House ☐	Podiatry		
Bungalow ☐	Residential ☐	Social Work		
Nursing Home ☐	Sheltered Housing ☐	Speech/Language Therapy		
Stairs: Inside ☐	Stairs: Outside ☐	Other (specify)		
Existing Home equipment? Yes ☐ No ☐				

If Yes give details below

Wife requires care & JSA will help out while Scott is in hospital.

Day Surgery Unit			
Post op vital signs stable (pulse, blood pressure and sats)		Yes/Not applicable	
Alert and orientated as per Care Plan 1		Yes/Not applicable	
Able to sit and walk unaided		Yes/Not applicable	
Has had something to eat and drink per Care Plan 5		Yes/Not applicable	
Has minimal nausea and is not being sick as per Care Plan 5		Yes/Not applicable	
Operation site checked as per Care Plan 3		Yes/Not applicable	
Has passed urine as per Care Plan 6		Yes/Not applicable	
Pain well controlled as per Care Plan 3		Yes/Not applicable	
Verbal and written instructions given		Yes/Not applicable	
District nurse contacted		Yes/Not applicable	
Collected by responsible adult who will be present for 24 hours		Yes/Not applicable	

Pre Operative Assessment Notes

CHI NO: 2602800570 26/02/1980
CRN: S679370
SCOTT DOWELL
11 DON STREET,
GRANTEMOUTH,
STIRLINGSHIRE
FK3 8HD

COPY

ATTENDED PRE-OPERATIVE ASSESMENT CLINIC

Attended Pre-op Assessment	☒	EDMS	☒
Green Bag	☒	ECG	☐
Length of Stay (PDD)	☒	Fasting Instructions	☒
Any Other Leaflet (Hip/Knee booklet)	☒	Advice on Colds and Flu	☒
"You and Your" Anaesthetic Leaflet	☒		
Anaesthetic Review	Yes ☐ No ☒		

ADULT ELECTIVE SURGERY RISK FACTORS FOR VENOUS THROMBOEMBOLISM

Age >60	Yes ☐ No ☒	Pregnancy/Puerperium	Yes ☐ No ☒
Obesity (BMI >35)	Yes ☐ No ☒	Hormonal Therapy (inc OCP/HRT)	Yes ☐ No ☒
Previous DVT/PTE	Yes ☐ No ☒	Immobility >72 hours in last few days/weeks	Yes ☐ No ☒
FH of VTE (1st deg relative)	Yes ☐ No ☒	Active medical illness (heart failure, recent MI or CVA, severe COPD, inflammatory bowel disease, ephritic syndrome)	Yes ☐ No ☒
Thrombophilia	Yes ☐ No ☒		Yes ☐ No ☐
Current Malignancy	Yes ☐ No ☒	Anything else? If yes, what?	Yes ☐ No ☐

Does the patient have any bleeding risk factors? (Tick all that apply)	
Is this procedure a day case procedure	Yes ☐ No ☒
Active bleeding	Yes ☐ No ☒
Unrelated inherited bleeding disorders (e.g. haemophilia or Von Willebrand's)	Yes ☐ No ☒
Acquired bleeding disorders (e.g. acute liver failure)	Yes ☐ No ☒
Neurosurgery, spinal or eye surgery Thyroid surgery	Yes ☐ No ☒
Concurrent use of warfarin with INR >2	Yes ☐ No ☒
Platelet count 75 or below	Yes ☐ No ☒
Acute stroke	Yes ☐ No ☒
Uncontrolled hypertension (230/120 MMHG or higher)	Yes ☐ No ☒
Lumbar puncture, epidural/spinal analgesia within previous 4 hours	Yes ☐ No ☐
Or expected within the next 12 hours	Yes ☐ No ☐

Sign & Date	<i>James A. Brown</i>
Date	26/6/18
	four group arranged
26.6.18	Returned to pre op. No changes from previous assessment.
09 ³⁰	BP 132/64 P 86 O2 94% on air T 36.8

Clinical Notes

(Please start each note with Practitioner Name and Date)

CHI NO: 2602800570 28/02/1980
CRN: S679370
SCOTT DOWELL
11 DON STREET,
GRANGEMOUTH,
STIRLINGSHIRE
FK3 8HD

COPY

Date

FBC, U+E, LFT, CRP, GTS, MSSU, MRSA + X-ray repeated today.

Aware of instructions re Humira.

Given green bag + footing instructions.

Signs/symptoms of infection: pyrexia

Hb 171

Na 139

AST 19

WCC 7.3

K 4.3

ALT 32

Plat 125

U 5.0

Bil 6

Cr 73

TP 72

GFR 59

Alb 43

Alk Phos 28

GTS APos NO. AB

CRP 5

Rbc 3

WBC 0

Epith?

} NO Growth

Udd

Nose

Throat

} -ve

20/7/18

Admitted for theatre consent obtained MUM MUM

20/7/18

Patient admitted from theatre with left total hip

1323

1330

Wound dressing dry and intact.

1000mls Hartmanns given in theatre

1000mls Hartmanns new bag in situ - running.

800mls blood loss in theatre.

5L O₂ via om in situ

Patient sleepy - easily rousable.

Orientated toward oral buzzer system.

PTD

Clinical Notes

(Please start each note with
Practitioner Name and Date)

Form 11-0116

COPY

Date

pmh

20/7/18

B23

13³⁰

Cont

Ankylosing spondylitis advanced secondary
osteoarthritis left hip

Reflux - well controlled

Patient remains on observations according
to protocol.

NEWS 3 - Oxygen therapy, Manual Pulse 90bpm.
Fluids and nurse call buzzer to hand - IV fluids
Patient voicing no concerns.

PLAN

2x Further Doses IV Anx

Commence rivaroxaban 10mg PO tonight 35
day course

Bleeds and check x-rays 24 hours

Mobilise FWB as per protocols.

Home when safe.

ReS Community 14/7.

Withhold biological ank. spend. Therapy
until clips out and wound confirmed
cytotoxicity.

F/U. Nurse lead armoplasty outcomes clinic
6/52

STIN I-SNALES

STIN Ula Qura

S/N Alwmeza

Clinical Notes

(Please start each note with
Practitioner Name and Date)

COPY

Date

20/07/18

F41 A-Anderson #1299.

16:00

ATSP Vomiting post op

Left hip replacement day 0

PMHx: Ankylosing Spondylitis

Barretts (Islands) / oesophagitis

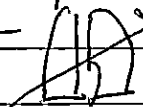
CA

NEWS = 3 (On O2 and tachycardic)

Patient groggy post op and significant N+V. Vomit has some fresh blood and clots in it. 2 episodes of vomiting - now stopped. Mother is attentive, stated that he has had ongoing problems with his oesophagus/reflux/vomiting.

OE

A - patient

B -  clear RR 16
SpO2 98% on 2L O2

C - HS 111110 HR 90 mg

BP 150/90 WWP CRT 2 secs..

D - (A) V PU (sleeping but easily rousable + making conversation)

E - Abdo SNT. Apyrexial. Wand dressing dry + intact
BS +

Impression: Vomiting post op - likely initiated as already.
fragile oesophagus.

Plan 1) w/h Mivoxaban. 

2) w/h oral esomeprazole + start IV esomeprazole 

3) Bloods: FBC, UEs, EBTs, coag 

4) Has valid A+S 

5) Continue IV fluids

6) Anti-emetic prescribed PRN 

7) If further haematemesis consider OGD over weekend.

Anderson

Clinical Notes

(Please start each note with
Practitioner Name and Date)

CHI2602800570

CRN:S679370 26/02/1980

DOWELL SCOTT

M

11 Don Street,
GRANGEMOUTH,
Stirlingshire
FK3 8HD

COPY

20/11/8

Vomit x2 since return.

20/20

IM cycuzine given -> await
effect.

Wound dry & intact

PU 400mls.

Pain well controlled

Care continues.

Shaw MZ
MODERNA

21.7.18

03⁵⁵

Patient alert and orientated

Appears to be here. Had a sexual night and
sleep for spells.

Prenex areas intact. Patient scared the more
self in bed as scared he damages his hip
reached he can make slight movements.

Wound dressing dry.

Cannula in situ and occlude

Feet in situ.

Observations recorded regularly esp 3 obs the 02
therapy and tubiguard.

Medications as per Home IV also given via cannula
aspirally.

Patient looked to be in pain PRN analgesia
given with effect. Encouraged patient to
upfront as if he is here and we can get
him analgesia.

Snacks taken overnight fluid also taken

Fluid chart completed

Painex given via bottles. BM last 30.217 ages
refused laxatives.

Are as planned

Call bell & fluids despatched

Lauren Jones SW 5m 17m

Please tick appropriate box

CLINICAL NOTES ☐

NURSING NOTES ☒

PROGRESS NOTES ☐

Surname SCOTT DOWELL
Forenam 11 DON STREET,
CHI GRANGEMOUTH,
Address STIRLINGSHIRE
FK3 8HD

COPY

Consultant

B23

Ward / Dept.

21/07/18
12:20

Settled & comfortable am -
good diet & fluids taken
Observations stable & as
Charted.
Mobilising well with crutches
(I) Skin reported to be intact.
Wound satisfactory.
Medications given as pxd
Regular analgesia adequate
Pitting via toilet.
Nil concerns otherwise
Care continues. S/W AWM
Imcormor

21/7/18
16:35

Patient had a settled afternoon.
observations stable - O - as per chart.
Patient continues to mobilise with crutches.
Patient was off ward for a period of
time this afternoon.
Pain relief given @ 16:30 as charted.
all medications as per Hepma.

stn nme
S/W AWM

Please tick appropriate box

CLINICAL NOTES ☐

NURSING NOTES ☐

PROGRESS NOTES ☐

Consultant

Surname.....

Forenames.....

CHI.....

Address.....

CHI 2602800570

CRN: S679370

DOWELL SCOTT

11 Don Street

GRANGEMOUTH,

Stirlingshire

FK3 8HD

Attach Label

26/02/1980

COPY

Date and Time

21/7/18

1005

OVEREND FYL

Note review by Dr. Anderson yesterday following post-op vomiting & blood/clot

Elective @THR (20/07/18) 2° to Ankylosing spondylitis associated OA

Bloods taken after vomit yesterday:

Hb 159 DT 11 (11.5) K⁺ 4.0 LFTs (1)

WCC 11.8 APTT 25 (27) Na 139

PLT 139 Cl 107

Crcl 75

Urea 4.0

G+S still valid

Had 1M cychizate yesterday & good effect

No further vomiting today

NEWS = 3

BP 140/70

HR 94 bpm

SpO₂ 98% on 4L O₂

Haemodynamically stable & GBS = 0

① ① PT/OT

② Restart PO cychizate

③ Monitor bloods, especially FBC + urea

④ Monitor for further vomiting

As if further evidence haematemesis may require OGD on Monday or as OP

M U OVEREND

FYL #1296

Surgical Unit Daily Patient Update

Date: 22/7/18.

WARD B23

Page No:

Patient

CHI NO: 2602800570 26/02/1980
 CRN: S679370 M
 SCOTT DOWELL
 11 DON STREET,
 GRANGEMOUTH,
 STIRLINGSHIRE
 FK3 8HD

Age: 38 yrs.

Post op day:

Diagnosis:

Procedure: C-stem mastectomy

PDP

named Nurse

Consultant: Mr. Ginning

COPY

Night Report

Settled night
 Observations stable
 EWS 1 - tachycardic
 Wound intact
 Puring NBO.
 Mobilising well & crutches
 Routine meds/analgesia

Fluid Balance:

In:

Out:

Balance:

Cumulative Balance:

DAILY UPDATES

MUST

Braden

Falls Risk

PVC bundle

Care Plans

Name: MOCONNOR

Signature: Moconnor S/N

Date: 22/7/18

Time: 0320

Orthogeriatrician /FY1 review

Patient Safety Checklist

Discuss & Tick

EWS pain

Fluid Balance

Blood Results

4 AT

kardex/antibiotics

DVT Prophylaxis

xray

wound

Infection Risks

Nutritional Status

Bowels

Patient Questions

Name:

Grade:

Update PDD

Signature:

Time:

Signature:

COMBINED DAY REPORT

Patient Label Page No

Date, time and sign all entries

ENTRY IN FAMILY DIALOGUE

YES NO



CHI2602800570

CRN:S679370 26/02/1980

DOWELL SCOTT

11 Don Street
GRANGEMOUTH
Stirlingshire

FK3 8HD

COPY

22/7/18

OT Carried out initial interview and issued hip precautions sheet and small aids. Mr Dowell is very independent and keen to return home. He is managing chair and bed transfers independently. Has leg lifter for bed transfer. There has been a problem with equipment delivery from JICS - have issued 2 Monbray toilet frames on ward - he has transport home from brother-in-law. The high back chairs are out of stock but he will sit in wife's wheelchair which is correct height. He will have assistance for lower half dressing if required and help with meals etc once home. No further OT issues - safe for d/c from OT. Unimpaired (or)

22/7/18 Patient now physio lot safe for d/c.
1700 Spotting on dressing. Fresh aquacel + tegaderm dressing applied for d/c. Dlx completed for wound check + ROS. 6/52 arthroplasty appt made in diary. Patient keen for d/c today, however script not completed by pharmacy as yet. Dlx full - patient happy to stay for tonight's dose of warfarin - family will return tomorrow for script. Patient d/c home.

Dor SW (Robertson)

Discharge Planning / OT / Physio / Dietetic info

Date

Signature

Physio

OT

DN

Other

CONSENT FORM

Agreement to Operation, Investigation or Treatment

CHI NO: 2602800570 26/02/1980
CRN: S679370 M
SCOTT DOWELL
11 DON STREET,
GRANGEMOUTH,
STIRLINGSHIRE
FK3 8HD

NHS
Forth Valley

COPY

Notes of Guidance for Doctor/Dentist/Healthcare Practitioner

The doctor/dentist/healthcare practitioner must:

- ◆ Be suitably qualified and experienced to explain the procedure to be performed - this should ideally be the operator or consultant.
- ◆ Give the patient sufficient information, in a way he/she can understand, about the proposed procedure, any important risks and the possible alternatives (including no treatment). In broad terms, a significant risk is one which is serious, but uncommon, or one which occurs frequently, even if it is not serious.
- ◆ Give the patient sufficient time to read the form and ask any questions relating to it or their treatment. The patient must be allowed to decide whether he/she will agree to the procedure and they may refuse or withdraw consent at any time.
- ◆ In addition to seeking consent for the procedure, seek written consent from the patient for examination by students.

Children under the age of 16 can give their own consent if the Medical Practitioner attending the child considers the child capable of understanding the nature and possible consequences of the procedure or treatment. If the child is judged capable, the practitioner must seek the consent of the child rather than the parent. This does not mean that the parents must always be excluded from the discussions. Unless there are issues concerning confidentiality, it would be reasonable to involve parents in helping a child to reach a decision. If a child under 16 years of age is giving his/her own consent, the relevant section overleaf, must also be signed.

Writing on the consent form must be legible, unambiguous and contain no abbreviations.

Any alterations to this form must be countersigned by the patient/parent/guardian and the member of the healthcare team taking consent. If the procedure or the information about surgical marking is wrong the form must be re-written.

Surgical Site Marking

- ◆ The site should be marked and documented by the operating surgeon, or nominated deputy, who will be present in the operating theatre at the time of the patient's procedure. If site marking is not applicable, this should be recorded and signed by the person taking consent.
- ◆ The intended site should be ascertained from reliable documentation and/or images.
- ◆ Marking should take place before pre-medication/administration of any sedative.
- ◆ The intended surgical site should, ideally, be marked on the ward or day care area, prior to the patient transfer to the operating theatre.
- ◆ An indelible marker pen should be used.
- ◆ The mark should be an arrow that extends to, or near, the incision site and remains visible after the application of skin preparation.
- ◆ Where possible the mark should remain visible after the application of theatre drapes.
- ◆ Surgical operations involving side (laterality), should be marked at, or near, the intended incision. For digits on the hand or foot, the mark should extend to the correct specific digit.
- ◆ The process of pre-operative marking of the intended site must involve the patient/parent/guardian wherever possible.

NB. There will be circumstances where marking may not be appropriate i.e. Teeth or Mucous Membranes. Emergency surgery should not be delayed due to lack of pre-operative marking.

PATIENT DETAIL (OR PRE-PRINTED LABEL)

Patient's surname/family name:

Patient's first name(s):

Date of birth: --

CHI number (or other identifier):

Special requirements (e.g. other language/other communication method)

CHI NO: 2602800570

26/02/1980

CRN: S679370

SCOTT DOWELL

11 DON STREET,

GRANGEMOUTH,

STIRLINGSHIRE

FK3 8HD

COPY

STATEMENT FOR DOCTOR/DENTIST/HEALTHCARE PRACTITIONER

(to be completed by a practitioner with appropriate knowledge of proposed procedure. See Notes for Guidance)

Describe proposed operation, investigation, or treatment. Where appropriate specify the site or side:

Left Total Hip Replacement

Issues: Infection, Nerve/Vessel Injury,
Blood Clots, Embolism, Dislocation,
Fracture, Deep Wound

I have explained the procedure named on this form to the: (please tick) patient ☐

parent ☐ guardian ☐ Other (please specify)

in terms which, in my judgment, are suited to their understanding. In particular I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure e.g. blood transfusion.

[If you have provided any information leaflet/tape, please tick box ☐ and specify title and version]

Signature of Doctor/Dentist/Healthcare Practitioner:

Name (PRINT): C. T. JENNINGS

Date: 20-02-18

STATEMENT OF INTERPRETER (where appropriate)

I have interpreted the information on this form to the patient/parent/guardian to the best of my ability and in a way in which I believe he/she can understand.

Signature: Date: --

Name (PRINT):

SURGICAL SITE MARKING

Site marking not applicable

Correct Patient and Surgical Site verified and marked by:

Signature: Date: 20-02-18

Name (PRINT): C. T. JENNINGS Title: CTS

STATEMENT TO BE COMPLETED BY THE PATIENT, PARENT OR GUARDIAN

You should read this form and the notes below and overleaf carefully. If there is anything you do not understand, ask the doctor, Dentist or Healthcare Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

I am (Please tick) Patient ☒ Parent ☐ Guardian ☐

I understand:

Yes No

- the procedure, important risks and appropriate alternatives which have been explained to me by the Doctor/Dentist/Healthcare Practitioner named on this form. ☒ ☐
- that the procedure might be carried out by a Doctor/Dentist/Healthcare Practitioner other than the Doctor/Dentist/Healthcare Practitioner who has been treating me/the patient so far. ☒ ☐
- that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to my/the patient's medical treatment, to safeguard or promote my/the patient's physical or mental health. ☒ ☐

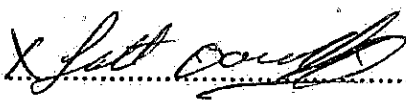
I have been told about additional procedures which may become necessary during my/the patient's treatment. I have listed below any procedures which I do not wish to be carried out without further discussion.

I agree:

- to the administration of an anaesthetic or sedation if required.
- to the procedure named on this form.
- that an examination for the purposes of teaching will not be undertaken without my consent.
- that any photographs, video/audio recordings and/or surgical images kept in the records may be used anonymously for research approved by an ethics committee, education and audit to improve the quality of patient care.

If you object to surgical images being used in this way then *please tick box*

☐

Signature of Patient/Parent/Guardian/Other: 

Name (PRINT):

Date:

dd mm yy
20 07 18

Relationship to child:

Only to be completed by the Medical Practitioner where the form is to be signed by a child under 16 years.

I am of the opinion that the patient is capable of understanding the nature and possible consequences of the proposed treatment/procedure.

Name (PRINT): Signature:

EXAMINATION FOR THE PURPOSES OF TEACHING

(Please tick) I agree ☐ I do not agree ☐ to an examination by a student during the procedure named on this form under the supervision of the senior doctor undertaking the procedure.

COPY

Signature:

Name (PRINT): Date:

dd	mm	yy

CONFIRMATION OF CONSENT

(to be completed when patient is admitted for the procedure)

I confirm that I have no further questions and wish the procedure to go ahead.

Patient: ☐ Parent: ☐ Guardian: ☐ Other: ☐ (please specify)

Date:

dd	mm	yy

Signature of Doctor/Dentist/Healthcare Practitioner:

Signature of Patient:

Notes of Guidance for Patients

The Doctor/Dentist/Healthcare Practitioner is here to help you. He or she will explain the procedure. You are entitled to refuse or withdraw consent at any time. You can ask any questions and ask for more information if you wish.

You may ask for a relative, friend or nurse to be present while the Doctor/Dentist/Healthcare Practitioner explains the procedure and asks you to sign the form.

If an anaesthetic or sedation is to be administered by an anaesthetist, it will be his or her responsibility to discuss details with you before the procedure takes place.

Students need to learn how to examine patients and to see how procedures are done. This is important for the future of the Health Service. You may be asked to give consent to be examined by students during the procedure. It is up to you to decide whether to give your consent or not but, whatever you decide, it will not affect your treatment.

NOTES

NHS Forth Valley Peri-Operative Careplan

CHI NO: 2602800570 26/02/1980
 CRN: S679370 M
 SCOTT DOWELL
 11 DON STREET,
 GRANGEMOUTH,
 STIRLINGSHIRE
 FK3 8HD

Procedure: C-stem pinnacle
 poly up replacement
 (Left)
 Consultant: Mr Timming
 Theatre No: 14
 Ward: B23
 Surgeon: Mr Timming
 MS Nicholson
 Elective/Emerg
 Date: 20.07.18
 Team Leader: J. Forshaw

COPY

Procedure Start: 10:09
 Exit Theatre Time: 11:55
 Blood Loss: 800ml
 Urine Output: N/A

Position: lateral Positioned by: Theatre Team
 Visual check of all pressure areas pre-op, by: Time:
 Sacrum [] Buttocks [] Heels [] Trochanter [] Shoulders [] Head []
 Area of concern & action taken if red/vulnerable: none noted

Lotions -
 Chlorohexidine Alcoholic 2% [✓] + dye Aqueous Chlorohexidine 0.02% [] Sodium Chloride 0.9% [✓]
 Iodine 10% [] Antiseptic Iodine 10% [] Other - Please State Irrigation

Diathermy Pad [✓] Position: back Site Check [✓] By: C. A. WEN
 Mechanical DVT Prophylaxis [✓]
 Tourniquet [x] Applied by: Time: Settings:
 Fluid Warmer [] Patient warming [✓] Blankets + Bearhugger
 Visual check of all pressure areas post-operatively by: Time:
 Sacrum [] Buttocks [] Heels [] Trochanter [] Shoulders [] Head []
 Area of concern & action taken if red/vulnerable: as above

	Type	Size	Position	Number
Drains				
Catheters/Stents				
Packs				
Catheterised by: Balloon volume: mls Instillage Yes/No Amount: mls				

NG Tube Yes (No)
 Skin Closure: Monocryl staples
 Dressings: aquacel tegaderm

Follow up Instructions:
 Sutures Out Seen before home Yes / No
 Dressing Change Return to Clinic Yes / No
 Specimens taken Yes (No) in-patient

Nursing Comments, eg. Eye drops/LA wound infiltration:

Tracking:

C STEM AMT TRAY 2 UIC ST01057 Packed By: DANIEL A PINNACLE QUICK SET ACETABULAR CUP SYSTEM UIC ST00867	C STEM AMT TRAY 1 UIC ST01301 Packed By: DANIEL A PINNACLE QUICK SET ACETABULAR CUP SYSTEM UIC ST01316	BASIC ORTHOPA EDIC SET UIC 1801001 Packed By: DANIEL A BASIC ORTHOPA EDIC SET UIC 1801001	BOWMET CEMENT GUN & CUTTER ID: 1116886 LOT 128 UIC WDP00073- 008 Packed By: MARTIN R
CHARNLEY RETRACTOR, 3 PARTS ID: 1030525 LOT 336 UIC IP00061 Packed By: DANIEL A CHARNLEY RETRACTOR, 3 PARTS ID: 1030525 LOT 336 UIC IP00061	BOWMET CEMENT GUN CUTTER ID: 1116886 LOT 128 UIC WDP00073- 008 Packed By: DANIEL A BOWMET CEMENT GUN CUTTER ID: 1116886 LOT 128 UIC WDP00073- 008	DEPUY QUICK SET REAMERS LONG TERM ON LOAN UIC WP00929 Packed By: DANIEL A DEPUY QUICK SET REAMERS LONG TERM ON LOAN UIC WP00929	LARGE MPX DRIVER/SIN 1201050 UIC ST01489 Packed By: DANIEL A LARGE MPX DRIVER/SIN 1201050 UIC ST01489

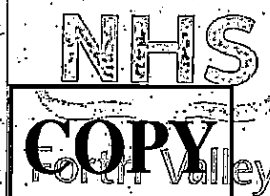
1st Count Scrub Practitioner
 Final Count Scrub Practitioner
 Tray Closure Scrub Practitioner
 1st Count Circ Person
 Final Count Circ Person
 Tray Closure Circ Person
 JULIE FORSHAW
 FRH045

CHI NO: 2602800570
CRN: S679370
SCOTT DOWELL
11 DON STREET,
BRANGEMOUTH,
TIRLINGSHIRE
K3 8HD

M

Surgeon: Mr Tinning
Theatre No: 14

Date: 20.07.18



Tracking labels below

ID: 103494600507

HIP EXTRAS

UC ST00252

STERILE

ID: 106321800382

OSCILLATOR HANDPIECE

SIN 13/04/03

UC ST01515

STERILE

ID: 106334000299

REAMER

SIN 13/01/566

UC KEV50775

STERILE

ID: 112489400033

NORFOLK RETRACTOR

UC KEV50195

STERILE

ID: 111935100170

HOHMANN RETRACTOR

LONG CURVED

UC KEV50883

STERILE

ID: 112492900014

STANDARD COBRA RETRACTOR

UC KEV50940

STERILE

ID: 112167100093

BP HANDLE 3 LONG

UC KEV50940

STERILE

ID: 100606000134

CHARLEY T HANDLE & 2 PINS ON CHAIN

UC KEV50260

STERILE

REF 9632-03-000 LOT D18030777

HARDINGE FEMORAL CEMENT RESTRICTOR

(01)10603295246008

(17)230228(10)D18030777

DePuy (Ireland) Co. Cork, Ireland

to patient's record

3 40002 Refobacin Bone Cement R

LOT A735CA0210 2x40

(01) 0 7350023 77413 0

(17) 200831 (10) A735CA0210

BIOMET Orthopaedics Switzerland GmbH

RIEDSTRASSE 6

CH-8953 DISTIKON

SWITZERLAND

2020-08

REF 4160

Optivac M

Optivac M

LOT 0001289156

2023-01

Manufactured by:

BIOMET France

Plateau de Lautagne

26000 Valence

FRANCE

STERILE R

CE

0459

ID: 104134700346

HEATH MALLET

UC KEV50889

STERILE

ID: 104005500033

HOHMANN RETRACTOR

OR LONG

UC KEV50888

STERILE

REF 1246-03-000 LOT D18030757

APEX™ HOLE ELIMINATOR - PS

(01)10603295019688

(17)280229(10)D18030757

2020-02-29

STERILE R

QTY 1

DePuy Orthopaedics, Inc.

700 Orthopaedic Drive

Warsaw IN 46082

1-800-368-8143

REV.F

REF 1570-14-070 LOT D18050478

C-STEM™ AMT

Cemented Stem High Offset

(01)10603295060284

(17)230430(10)D18050478

DePuy International Ltd.

St. Anthony's Road

Leeds LS11 8DT England

+44(113)270-3451

REV.D

REF 1217-01-052 LOT 7865411

PINNACLE POROCOAT ACETABULAR SHELL 100 SERIES

52mm OD

(01)10603295008552

(17)240229(10)7865411

2024-02

STERILE R

QTY 1

DePuy Orthopaedics, Inc.

700 Orthopaedic Drive

Warsaw IN 46082

1-800-368-8143

REF 9612-10-500 LOT 8770914

C-STEM™ VOID CENTRALISER

10mm

(01)10603295235682

(17)230228(10)8770914

DePuy International Ltd

Leeds LS11 8DT England

2023-02-28

STERILE R

QTY 1

DePuy Orthopaedics, Inc.

700 Orthopaedic Drive

Warsaw IN 46082

1-800-368-8143

REF 1365-36-320 LOT 8796014

BIOLOX® DELTA CERAMIC FEMORAL HEAD

+5.0 35mm DIA 12/14 TAPER

(01)10603295033622

(17)230331(10)8796014

2023-03-31

STERILE R

QTY 1

DePuy Orthopaedics, Inc.

700 Orthopaedic Drive

Warsaw IN 46082

1-800-368-8143

Forth Valley Royal Hospital

Patient Details

CHI Number 2602800570
 Hospital Number S679370
 Patient Name DOWELL SCOTT
 Date of Birth 26/02/1980
 Sex M
 Category Type WAITING LIST INITIATIVE
 ASA Grade 2

Patient Type
 Operation Type ELECTIVE NCEPOD 4
 Date of Operation 20/07/2018
 FVRH 14 - FVRH 14
 Session 1
 Anaes. Confirmed By
 Anaesthetic Type GA/ETT

COPY

Anaes. Pause

Date Performed 20/07/2018 09:31
 Performed By LARAIN DRUMMOND

Surgical Pause

Date Performed 20/07/2018 10:02
 Performed By MAUREEN MACLAREN

Staff In Attendance - Team 1

SURGEON MR CRAIG TINNING
 SURGEON'S SN LORRAINE NICOLSON
 ASSISTANT 1
 ANAESTHETIST DR GORDON WARDALL
 ANAESTHETIST'S CARA MICHE JACKSON
 ASSISTANT
 O.D.P. LARAIN DRUMMOND
 SCRUB NURSE 1 JULIE FORSHAW
 FLOOR NURSE 1 ODP CAITLIN MAY ALLEN
 FLOOR NURSE 2 MAUREEN MACLAREN

Attendees

ST/N DANNIELLE FENSOM

Procedures

OW381008 C-STEM PINNACLE CERAMIC - LEFT

Missed
EDMS

Forth Valley Royal Hospital

Patient Details

CHI Number 2602800570
 Hospital Number S679370
 Patient Name DOWELL SCOTT
 Date of Birth 26/02/1980
 Sex M
 Category Type WAITING LIST INITIATIVE
 ASA Grade 2

Patient Type
 Operation Type
 Date of Operation 20/07/2018
 FVRH 14 - FVRH 14
 Session 1
 Anaes. Confirmed By
 Anaesthetic Type GA/ETT

COPY

ELECTIVE - NCEPOD 4

Description : LEFT C-STEM / PINNACLE CERAMIC ON CERAMIC TOTAL HIP REPLACEMENT

ANKYLOSING SPONDYLITIS AND SECONDARY OA

IV ABXS AS PER PROTOCOLS. 1G IV TRANEXAMIC ACID.
 LATERAL POSITION WITH SUPPORTS. ROUTINE PREP AND DRAPE.
 POSTERIOR APPROACH AND CAPSULOTOMY. HIP DISLOCATED AND
 NECK CUT MADE AT APPROPRIATE LEVEL. LARGE CAPSULAR
 BLEEDING VESSELS WITH SIGNIFICANT OOZE ON ENTRY BUT
 QUICKLY CONTROLLED WITH DIATHERMY HAEMOSTASIS.
 ACETABULUM EXPOSED AND CLEARED OF SOFT TISSUE. TRUE
 FLOOR IDENTIFIED.
 SEQUENTIAL REAMING TO 52MM. TRIAL 52MM CUP SATISFACTORY.
 52MM SOLID BACK PINNACLE CUP INSERTED USING (CALCIFIED) TAL
 AS GUIDE TO ANTEVERSION AND IMPACTED. GOOD PRESS FIT. DOME
 HOLE COVER INSERTED. LARGE ANTERIOR RIM OSTEOPHYTE
 RESECTED. 36MM INNER DIAMETER CERAMIC LINER INSERTED AND
 IMPACTED.
 PROXIMAL FEMUR PREPARED WITH BOX OSTEOTOME, TAPER PIN
 REAMERS AND BROACHED TO SIZE 1. TIGHT CANAL.
 FULL TRIAL STABLE WITH SIZE 1 BROACH, HIGH OFFSET NECK AND
 36MM +5 HEAD.
 HARDINGE CEMENT RESTRICTOR INSERTED AND CANAL WASHED
 AND PACKED.
 CEMENT INJECTED AND PRESSURISED. SIZE 1 HIGH OFFSET C-STEM
 INSERTED AIMING FOR INSERTION DEPTH AND ANTEVERSION AS PER
 FINAL BROACH POSITION.
 FINAL TRIAL SATISFACTORY WITH 36MM +5 HEAD. STABLE UP TO 70
 DEGREES INTERNAL ROTATION.
 DEFINITIVE 36MM +5 CERAMIC HEAD ATTACHED. HIP REDUCED. FINAL
 WASH.
 CLOSURE: 5 ETHIBOND TO CAPSULE AND PIRIFORMIS. 1 PDS TO
 FASCIA LATA. 1 VICRYL TO FAT. CLIPS TO SKIN. AQUACEL AND
 TEGADERM DRESSING.

POST-OP:

- 1) 2 X FURTHER DOSES IV ABXS.
- 2) COMMENCE RIVAROXABAN 10MG PO TONIGHT: 35 DAY COURSE.
- 3) BLOODS AND CHECK XRAYS 24 HOURS.
- 4) MOBILISE FWB AS PER PROTOCOLS.
- 5) HOME WHEN SAFE.
- 6) ROS IN COMMUNITY 14/7.
- 7) WITHHOLD BIOLOGIC ANK. SPOND. THERAPY UNTIL CLIPS
OUT AND WOUND CONFIRMED SATISFACTORY.
- 8) F/U NURSE LED ARTHROPLASTY OUTCOMES CLINIC 6/52.

Performed By : MR CRAIG TINNING
 Confirmed By : CMALLEN
 Alternate Codes: W381

EDMS

Forth Valley Royal Hospital

Patient Details

CHI Number 2602800570
 Hospital Number S679370
 Patient Name DOWELL SCOTT
 Date of Birth 26/02/1980
 Sex M
 Category Type WAITING LIST INITIATIVE
 ASA Grade 2

Patient Type
 Operation Type
 Date of Operation 20/07/2018
 FVRH 14 - FVRH 14
 Session 1
 Anaes. Confirmed By
 Anaesthetic Type GA/ETT

COPY
 ELECTIVE - NCEPOD 4

Definitions :

Operation
 Side

Op Notes

Materials Used

Item Code	Item Description	Qty	Unit Cost	Total cost
1049628	C STEM AMT TRAY 2	1	0.00	0.00
LOT1	1049628			
LOT2				
LOT3				
LOT4				
1040178	PINNACLE ACETABULAR CUP SYSTEM LONG TERM ON LOAN	1	0.00	0.00
LOT1	1040178			
LOT2				
LOT3				
LOT4				
1057741	C STEM AMT TRAY 1	1	0.00	0.00
LOT1	1057741			
LOT2				
LOT3				
LOT4				
1011360	BASIC ORTHOPAEDIC SET	1	0.00	0.00

EDMS

Forth Valley Royal Hospital

Patient Details

CHI Number 2602800570
 Hospital Number S679370
 Patient Name DOWELL SCOTT
 Date of Birth 26/02/1980
 Sex M
 Category Type WAITING LIST INITIATIVE
 ASA Grade 2

Patient Type
 Operation Type
 Date of Operation 20/07/2018
 FVRH 14 - FVRH 14
 Session 1
 Anaes. Confirmed By
 Anaesthetic Type GA/ETT

COPY
 D.Y. CASE
 ELECTIVE

NCEPOD 4

LOT1 1011360

LOT2

LOT3

LOT4

Qty 1 Unit Cost 0.00 Total cost 0.00

1116886 BIOMET TRIAL CEMENT GUN & CUTTER

LOT1 1116886

LOT2

LOT3

LOT4

Qty 1 Unit Cost 0.00 Total cost 0.00

1030525 CHARNLEY RETRACTOR, 3 PARTS

LOT1 1030525

LOT2

LOT3

LOT4

Qty 1 Unit Cost 0.00 Total cost 0.00

1057927 PINNACLE QUICK SET SCREW
INSTRUMENTS

LOT1 1057927

LOT2

LOT3

LOT4

Qty 1 Unit Cost 0.00 Total cost 0.00

1063192 LARGE MPX DRIVER S/N 12/01050

EDMS

Forth Valley Royal Hospital

Patient Details

CHI Number 2602800570
 Hospital Number S679370
 Patient Name DOWELL SCOTT
 Date of Birth 26/02/1980
 Sex M
 Category Type WAITING LIST INITIATIVE
 ASA Grade 2

Patient Type
 Operation Type
 Date of Operation 20/07/2018
 FVRH 14 - FVRH 14
 Session 1
 Anaes. Confirmed By
 Anaesthetic Type GA/ETT

COPY
 ONLY CASE
 ELECTIVE NCEPOD 4

LOT1 -1063192

LOT2

LOT3

LOT4

Qty 1 Unit Cost 0.00 Total cost 0.00

1063218 OSCILLATOR HANDPIECE S/N 13/04003

LOT1 1063218

LOT2

LOT3

LOT4

Qty 1 Unit Cost 0.00 Total cost 0.00

1034948 HIP EXTRAS

LOT1 1034948

LOT2

LOT3

LOT4

Qty 1 Unit Cost 0.00 Total cost 0.00

1040180 DEPUY QUICK SET REAMERS LONG TERM ON LOAN

LOT1 1040180

LOT2

LOT3

LOT4

Qty 1 Unit Cost 0.00 Total cost 0.00

1124929 STANDARD COBRA RETRACTOR

EDMS

Forth Valley Royal Hospital

Patient Details

CHI Number 2602800570
 Hospital Number S679370
 Patient Name DOWELL SCOTT
 Date of Birth 26/02/1980
 Sex M
 Category Type WAITING LIST INITIATIVE
 ASA Grade 2

Patient Type
 Operation Type
 Date of Operation 20/07/2018
 FVRH 14 - FVRH 14
 Session 1
 Anaes. Confirmed By
 Anaesthetic Type GA/ETT

COPY
 DAY CASE
 ELECTIVE - NCEPOD 4

LOT1 1124929

LOT2

LOT3

LOT4

Qty 1 Unit Cost 0.00 Total cost 0.00

1006060 CHARNLEY-T HANDLE & 2 PINS ON CHAIN,
 MEDIPLAST 200 & 250

LOT1 1006060

LOT2

LOT3

LOT4

Qty 1 Unit Cost 0.00 Total cost 0.00

1119391 HOHMANN RETRACTOR LONG CURVED

LOT1 1119391

LOT2

LOT3

LOT4

Qty 1 Unit Cost 0.00 Total cost 0.00

1121671 BP HANDLE 3 LONG

LOT1 1121671

LOT2

LOT3

LOT4

Qty 1 Unit Cost 0.00 Total cost 0.00

1063340 REAMER S/N 13/01566

EDMS

Forth Valley Royal Hospital

Patient Details

CHI Number 2602800570
 Hospital Number S679370
 Patient Name DOWELL SCOTT
 Date of Birth 26/02/1980
 Sex M
 Category Type WAITING LIST INITIATIVE
 ASA Grade 2

Patient Type
 Operation Type
 Date of Operation 20/07/2018
 FVRH 14 - FVRH 14
 Session 1
 Anaes. Confirmed By
 Anaesthetic Type GA/ETT

COPY
 DAY CASE
 ELECTIVE

NCEPOD 4

LOT1 1063340

LOT2

LOT3

LOT4

Qty 1 Unit Cost 0.00 Total cost 0.00

1124894 NORFOLK RETRACTOR

LOT1 1124894

LOT2

LOT3

LOT4

Qty 1 Unit Cost 0.00 Total cost 0.00

1057946 BETWEEN PATIENT CLEAN THEATRE 14

LOT1 1057946

LOT2

LOT3

LOT4

Qty 1 Unit Cost 0.00 Total cost 0.00

1041347 HEALTH MALLET LINER, WHITE CREPE
60X60, FBAG

LOT1 1041347

LOT2

LOT3

LOT4

Qty 1 Unit Cost 0.00 Total cost 0.00

1040954 HOHMANN RETRACTOR LONG

EDMS

Forth Valley Royal Hospital**Patient Details**

CHI Number 2602800570
Hospital Number S679370
Patient Name DOWELL SCOTT
Date of Birth 26/02/1980
Sex M
Category Type WAITING LIST INITIATIVE
ASA Grade 2

Patient Type
Operation Type
Date of Operation 20/07/2018
FVRH 14 - FVRH 14
Session 1
Anaes. Confirmed By
Anaesthetic Type GA/ETT



LOT1 1040954

LOT2

LOT3

LOT4

Qty 1 Unit Cost 0.00 Total cost 0.00

***** End of Report *****

SCOT

Date 20/7/18	Ward DSU	Surname	Sex
Procedure and side	D B23	First name	CHI NO: 2602800570
Left total hip		Unit No. / CHI No.	CRN: S679370
Surgeon N Tinning		Date of Birth	SCOTT DOWELL
			11 DON STREET,
			GRANGEMOUTH,
			STIRLINGSHIRE
			FK3 8HD

CHECKLIST ITEMS	WARD	HANDOVER CHECKS		BASELINE WARD CHECKS & DATA
Verbal Name Check	✓	Yes	Yes	Pre-assessment Document
ID Band Checked	✓	Yes	Yes	Present and Checked ☒
Pre-assess/clerking completed	✓	Yes	Yes	Any Changes? NO
Pregnant Yes / No LMP date	NA	N/A	NA	Temp 36.8 Weight (kg) 88
Allergies (see baseline checks Yes / No)	NO	N/A	NO	P 82 BP 126/85
Consent / Incapacity completed	✓	Yes	Yes	RR 16 SpO2 97
Operation confirmed with patient	✓	Yes	Yes	BM (Sugar) Height
Consent form corresponds to list	✓	Yes	Yes	Allergies
Operation site marked clearly	✓	Yes	Yes	☒ No ☐ Yes
Nursing notes	✓		Yes	Specify reaction
Case Notes	✓		Yes	MRSA +ve / -ve
Drug Kardex	18/18		Yes	Hb 178 Na 138
XMatch / G&S confirmed date & initial	A+	Yes	Yes	WCC 5.2 K 4.7
Confirm all results available	✓		Yes	Platelet 134 U 3.7 CRP 25
Addressograph labels	✓		Yes	Clotting
Bone bank consent	NA		N/A	G and S
Fasted for solids / milk from (time)	Yesterday	19/7	19/7	X-Match
Fasted for clear fluids from (time)	23.50	19/7 23.50	19/7	A POSITIVE CGFR >59
Bladder emptied (time or No)	✓	Yes	Yes	Dental
Jewellery removed wedding band	NA	Taped	Taped	Crowns / Caps ☐
Body piercings taped etc	NA	N/A	NONE	Denture ☒ top set only
Nail varnish / makeup removed	NA	N/A	NONE	Plate ☐
Contact lenses removed	NA	N/A	NONE	Loose ☐
Prosthesis (* or No)	NO	NO	NO	Patient Valuables
Orthopaedic implants (* or No) Left arm DRIF	→	→	Yes	Dentures Full ☒ Partial ☐
Pacemaker (Yes or No)	NO	NO	NO	Glasses ☐ None ☐
Hearing aid (Yes or No)	NO	NO	NO	Hearing Aid ☐
Able to move by self on trolley	assist.	→	Yes	Dressing Gown ☒
Diabetic Yes / No	NO	NO	NO	Slippers ☒
On Beta Blocker Yes / No	NO	NO	NO	Other ① Taped 2mm
If "YES" Taken Yes / No				Sign 1 D. Tinning
If not taken: Administered by Nursing Staff YES / NO				
Ward sign and designation 18/18				
Handover 1 sign and designation 18/18				
Handover 2 sign and designation 18/18				
Comments*				

PRE-OP TEMP **36.7**
 <36 or >37.5 Action :-

RECOVERY CHART

C-stem pinnacle polytip replacement

Recovery Practitioner V. Gasche

Th14 20/7/12

Airway	SM SM SM SM SM SM SM SM SM	
O ₂ l/min	8L 8L 8L 8L 8L 8L 8L 8L 8L	
SpO ₂	95 97 96 96 97 97 97 97 97	
Resp Rate	16 14 14 12	
Temp	36.3 36.3 36.3 36.2	
BM	NA	
TIME	11 12 12 12 13	
	54 00 05 10 15 20 25 30 45 50	

Analgesia

IV Morphine up to

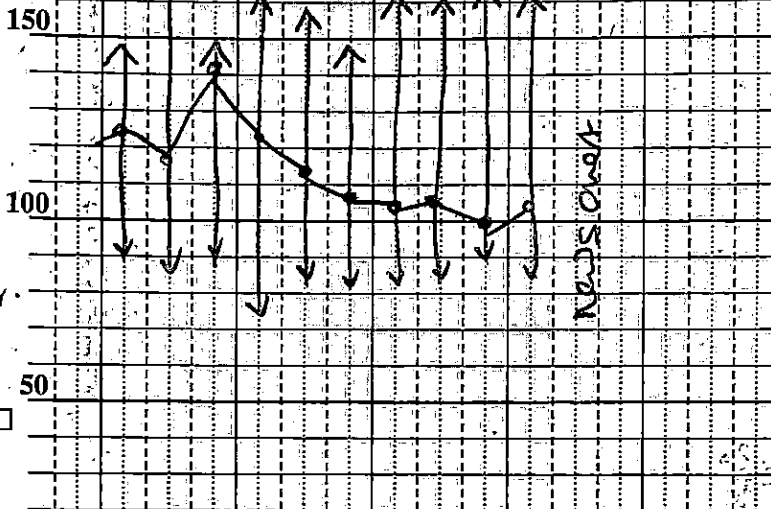
IV Fentanyl up to

Refer to Kardex

See notes

- ① 20mg IV fentanyl - 1213.
- ② 20mg IV fentanyl - 1221
- ③ 20mg IV fentanyl - 1230.
- ④ 20mg IV fentanyl - 1250.

Baseline
126/85
P. 82
11/16
36.8°C
97% sat



A line ☐
Site:-

CVP ☐ 0

Sedation Score	2 2 1 1 0 0 0 0 0 0
Pain Score	0 0 0 2 2 2 0 0 0 0
Nausea Score	0 0 0 0 0 0 0 0 0 0
Wound Site	0 0 0 0 0 0 0 0 0 0
Drains	No
IVI Pump	18g cannula
Spinal / Epidural	No
C/S/M	Post op, good sensation + movement
Urinary Catheter	No
Pressure Areas	Pressure areas intact

Prescribed ☒

Given ☒

Drink of water

SpO₂ given in recovery

Anti-emetic

Cyclizine 50mg IV

Granisetron 1mg IV

Prochlorperazine 12.5mg IM

Oxygen - in recovery follow protocol

SpO₂ range $\geq 95\%$

Duration 1hr

Investigations - in recovery

Anaesthetist

Signed

Order

Name

Pt appears settled, BP remains ↑ and pulse slightly tachy. Phoned in Th14 for Mr Warden to be made aware - stated that as long as pt is comfortable he's not concerned. 16 1245.

Discharge to (ward) B23... (SES)

Criteria Met ☒ Time 1305

Signed *ve* Recovery

Signed Ward

Nursing notes ☐

Op notes ☒

Case notes ☒

Valuables ☒

NEWS ☒

Ward Kardex ☐

DSU Kardex ☐

Post-operative instructions

To be discussed with surgeon at end of procedure

Medication prescribed on Kardex

- 1 ☐ Essential medication) or 1 ☐ Medicine reconciliation required on ward
2 ☐ Regular analgesia)
3 ☐ Breakthrough analgesia)
4 ☐ Anti-emetic)
5 ☐ Oxygen)
6 ☐ PCA device)
7 ☐ Epidural - continuous infusion)
8 ☐ PCEA)
9 ☐ Intrathecal opiates)
10 ☐ Other, please specify.....

OR

☐ DSU Kardex completed

☐ Critical Care Plan

COPY

Hepma ✓

Diet

For all a minimum of one option must be completed

☒ Oral (Circle): sips / free clear fluid / soft / light / full diet

☐ Nil by Mouth (NBM)

If NBM: ☐ Oral diet to start.....(time) or after medical review ☐

Fluid Therapy

☒ Oral Fluids only

☐ IV Fluids only

☐ Fluids prescribed until at least 09.00hrs next day

☐ IV Fluids until adequate oral intake established

☐ Fluids prescribed to cover this anticipated period

Blood Sugar Control

☒ N/A

☐ Achieve target BM.....mmol/l with:

☐ Allow patient to titrate normal insulin / Restart oral hypoglycaemics (delete)

☐ GKI Infusion - prescribed

☐ Insulin Sliding Scale - prescribed

EWS Score ≤ _____

Acceptable for _____ hrs due to Anaesthesia/Sedation as per exclusion criteria.

Signed.....

Antibiotic Cover

☐ N/A

☒2.....doses post op

☐ Continue

☒ Prescribed

☐ Prescribed

DVT Prophylaxis

☐ None

☐ TEDS

☒ Enoxaparin

☐ Rivaroxaban

☐ Other, please state

IV cannula / Removal record

IV cannula (1)

Inserted by: C. Jackson

Size: 18G

Site: L-hand

Batch no.: _____

Removed by: _____

Date: _____

IV cannula (2)

Inserted by: _____

Size: _____

Site: _____

Batch no.: _____

Removed by: _____

Date: _____

Special Instructions - Please document below (Eg. drains, positioning, post op investigations, imaging etc)

☐ None

Sign: Chad
Anaesthetist

Ward Staff please also review the theatre operation note
for any surgeon specific follow-up instructions

ANAESTHETIC ASSESSMENT Date 20.7.18

Age 38

ASA II

NCEPOD EI ☒

Urg ☐

Em ☐

COPY

PRE-OPERATIVE INSTRUCTIONS

☐ Free clear fluid until

PRE-MEDICATION

Prescribed by:

Given by:

CO-MORBIDITIES

Ankylosing spondylitis
advanced secondary osteoarthritis
L. hip.

RS- no probs
no recent colds
no SOB, ex. tol. limited by pain
smoker 20/day

CVS- no probs
BP 115/76

CNS- no probs
Reflux - well controlled, no symptoms today
Not diabetic

DRUGS

Esomeprazole 40mg X
Ranitidine 150mg X
Rivaroxaban 10mg X
Ropinirole 1000mcg X
Co-codamol as req.

Avoids DHC
NSAIDs etc

Allergies
Previous GA
Problems?
FH GA problems
Reflux/full stomach
Airway difficulty

☒ No
☐ No
☒ No
☒ No
☒ No
☒ No

☐ Yes
☒ Yes
☐ Yes
☐ Yes
☐ Yes
☐ Yes

Fasted
overnight

MO - small mouth but opening OK
MP - III
JM - ✓
NM - stiff

Teeth

Dentures - full set

Verbal consent and
explanation ☒

Explained:

☒ GA

☒ RA

☐ Risks

☐ Day Care

Signed / Name

E. Jackson (PAA)

Date 20.7.18 Cons Anaes Wardall

☒ present

☐ discussed

☐ nominal

Anaesthetist Jackson (PAA)

Procedure

L. THIR

COPY

☒ Anaes machine checked

Local anaesthetic (LA) ☒ block

☐ spinal

☐ epidural

☐ infiltration

(1) knee itica block
20ml + 0.375% 1.8%
- lead mark - proceed

9.30 10.00 10.30 11.00

Fentanyl	75mcg			25					
Propofol	200+30								
Rocuronium	40mg	10mg							
Dexamethasone	66mg								
Morphine		3mg+2-2	3		2	2			
Taraxanis acid		1g							
IV Pectand			1g						
o-amoxiclav		1.2g							
Antibiotic	Tetracycline	400mg							200
Airway	☒ Pre O ₂								
☐ RSI	☐ cricoid P								180
☐ mask	☐ guedel								160
☐ LMA									150
size									140
☒ TT	☒ cuff								120
size	☐ oral								100
8-0	☐ nasal								80
grade	☐ pack								60
I									40
Maintenance	☒ O ₂ ☒ N ₂ O ☐ AIR								20
☒ sevo	☐ iso								CVP
☐ des									
50									
Circuit	Position								
☒ circle	R. lateral								
☐ SV									
☐ hand									
☒ IPPV									
0									
Monitoring	☐ SpO ₂	96	96	96	96	96			
☐ ODM	☐ PE/CO ₂	6.7	6.1	5.8	6.9	6.7			
☒ ECG	☐ MAC/ET AA	1.4	1.3	1.3	1.2	1.1			
☐ NIBP	☐ FiO ₂	31	29	41	47	45			
☒ eyecare									
☐ pressure points	taped								
☐ padded									
Warmed	☒ air								
☐ fluid	Temp					37			

45/16 500/16

urine output (mls)

FLUIDS

① Hartmann's 1000ml

☐ Reversal

☐ Blood Loss ml

Throat Pack ☐ IN

OUT

cannula ☒ cvp ☐ artline ☐

tion

[illegible]

ml

CLINICAL NOTES

Write - imprint or Attach Label

CHI 2602800570

COPY

CRN: S679370 26/02/1980

DOWELL SCOTT
11 Don Street,
GRANGEMOUTH,
Stirlingshire
FK3 8HD

M

Consultant

Dr Elise

Date

24/5/16

Wt 92.3 Kgs

urine - no spec.

BP 122/69

36 yr. say you have pain back
at least 16 yrs

some times worst pain
has time to walk

hips, neck, back
- need splint

EMS ~ 1 hour

better in car.

nausea / vomiting - anxiety OGD? PVD.
indigestion

dry decondition

Dr - long term

PM noticeable

valve

low pop

repress

} no benefit

CNP 27.

marital issues

neck + back

gone

Date

COPY

SADAN. - 5.90.

Spine pain - $\frac{10}{10}$

P- 1m dep 120g.

sees, ali - TWP. Aug

physio

4/12 NS 90 7/12 02 RD

DR ELSE

20/4/17 wt 89.8kg

Scott

SIMPSON - mixed thoughts but good response.

BEVERLY - Oct 2016.

in 1st week

some response

not as good as Simpson.

only last 3-4 days

SADAN. 9.00.

Words 1m dep.

P- until to present

for 4/12

Please tick appropriate box

CLINICAL NOTES



NURSING NOTES



PROGRESS NOTES



Consultant

Sharon Menzies

Write - imprint or Attach

Surname

Forename

CHI

Address

CHI:2602800570

CRN:S679370 26/02/1980

DOWELL SCOTT

11 Don Street,
GRANGEMOUTH,
Stirlingshire

FK3 8HD

M

COPY

Date and Time

14/9/17

Dr Elise

14/9/17

wt 88.8kg

Escobedo

better on HMD

- getting used to change for 1 day just
HMD, needs some time with him
as a result

- not too in danger to do this
as kept for full

HMD

ESCOBEDO 11.40mg

DICLOFENAC

ROMAZOLONE for better legs, helpful

RP injured CG → r

SPRINT 7.8

RP RS

for analgesic 150mg

ref back with re @ legs
continue HMD.

6/12.

COPY

[illegible]

Forth Valley Rheumatology Biologics Switch

COPY

Patient details

Name:	Scott Dowell	Date: 07.09.2016
Address:	11 Don Street Grangemouth FK3 8HD	
Date of Birth:	26.02.80	
CHI:	2602800570	

Disease type	AS	
Previous biologics (inc side-effects and response)	Golimumab (Simponi) – changes in mood disc after 1 injection	
Current disease activity (specify score used)		
Any additional tests needed? (e.g. cholesterol, immunoglobulins, HIV, varicella)	None – Quantiferon neg 25.05.16, HEP ABC / HIV neg 25.05.16, CXR NAD 25.05.16, Routine bloods 30.08.16 satisfactory.	
Biologic recommended	Etanercept (Benepali)	
Counselling	Patient counselled on specific therapy ARUK drug leaflet provided Patient information sheet provided Homecare system explained (if needed)	YES -07.09.16 YES – 07.09.16 YES – 07.09.16 N/A – used H@H before
Details of clinician / date	S.Menzies (D/W Dr ELSE) 07.09.2016	
Patient consent to treatment	Verbal – phoned patient 07.09.16	
Prescription completed		
Prescription sent to		

pharmacy

COPY

**Department of Rheumatology
Approval for Biologic Therapy**

COPY

Scott Dowell
11 Don Street, Grangemouth, FK3 8HD
2602800570

The above named patient meets current eligibility criteria for biologic therapy and has been counselled and consented for treatment as follows:

Indication	✓	IPTR Approval (if Required)
Rheumatoid Arthritis		
Ankylosing Spondylitis	x	
Psoriatic Arthritis		
Other (please specify)		

Drug	Route (delete as appropriate)	Treatment			Switched From (if appropriate)
		Initial	2 nd Line	Subsequent	
Orencia (Abatacept)	Subcutaneous Intravenous				
Humira (Adalimumab)	Subcutaneous				
Cimzia (Certolizumab)	Subcutaneous				
Benepali (Etanercept)	Subcutaneous		x		Golimumab – change in mood
Enbrel (Etanercept)	Subcutaneous				
Simponi (Golimumab)	Subcutaneous				
Remsuma (Infliximab)	Intravenous				
Remicade (Infliximab)	Intravenous				
MabThera (Rituximab)	Intravenous				
RoActemra (Tocilizumab)	Subcutaneous Intravenous				
Stelara (Ustekinumab)	Subcutaneous				

Approved By: S.Menzies

Date: 07.09.16

Pharmacy Use:

Treatment Date:.....

Review Date:.....

COPY

BIOLOGICAL THERAPY FOR ARTHRITIS

Switching from Golimumab (Simponi) to Etanercept (Benepali) 50mg weekly

Dr Dundas
Westburn Medical Practice
Falkirk Community Hospital
Westburn Ave
FK1 5SU

Date: 07.09.16

Dear Dr Dundas

Re: Scott Dowell 2602800570 11 Don Street, Grangemouth, FK3 8HD

Mr Dowell is switching biologic therapy from Golimumab (Simponi) to Etanercept (Benepali) 50mg weekly. Golimumab has been discontinued after 1 injection as the patient and his wife reported an acute change in mood/mental state shortly after administration.

Etanercept (Benepali) is also a biologic therapy given by weekly s/c injection for management of his Ankylosing Spondylitis. A nurse from the home care company Healthcare at Home will attend Mr Dowell's home to educate him on the correct storage, administration & disposal of this treatment.

I have enclosed information on Etanercept (Benepali) for your records. The injections will be continue to be delivered to him at home by Healthcare at Home, and repeat prescriptions will be issued by the rheumatology department for the duration of therapy.

This treatment is an Anti TNF therapy and is therefore immunosuppressant in nature. I would be grateful if you could note specifically the section on increased risk of infection whilst on this treatment and the need for prompt intervention and treatment as required.



INVESTOR IN PEOPLE

Chairman Ian Mullen OBE BSc MR PharmS DL
Chief Executive Fiona Mackenzie MA (Hons) MBA MIHM DipHSM

Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SW

www.nhsforthvalley.com



He will require to have pneumococcal immunisation if not previously administered and annual flu immunisation whilst on treatment.

It would be helpful if bloods (FBC, U&E, LFT, CRP & ESR) could be taken 3 monthly however the patient is aware that if this service is not available at your practice, then he can attend phlebotomy in Forth Valley Royal Hospital, Area 3, Outpatient dept.

He will be followed up initially at 3 months following commencement on treatment and then again at 6 months. If he is tolerant and Etanercept (Benepali) is effective he will continue to be followed up 6 monthly in the biologic clinic thereafter.

If you have any questions or require further information you can contact us via the nurse advice line on 01324 566934.

Yours sincerely,

Sharon Menzies
Rheumatology Biologics Nurse
Forth Valley Royal Hospital
01324 566934

e-mail: Sharon.menzies2@nhs.net

**Department of Rheumatology
Approval for Biologic Therapy**

COPY

Scott Dowell
11 Don Street, Grangemouth, FK3 8HD
2602800570

The above named patient meets current eligibility criteria for biologic therapy and has been counselled and consented for treatment as follows:

Indication	✓	IPTR Approval (if Required)
Rheumatoid Arthritis		
Ankylosing Spondylitis	x	
Psoriatic Arthritis		
Other (please specify)		

Drug	Route (delete as appropriate)	Treatment			Switched From (if appropriate)
		Initial	2 nd Line	Subsequent	
Orencia (Abatacept)	Subcutaneous Intravenous				
Humira (Adalimumab)	Subcutaneous				
Cimzia (Certolizumab)	Subcutaneous				
Benepali (Etanercept)	Subcutaneous		x		Golimumab – change in mood
Enbrel (Etanercept)	Subcutaneous				
Simponi (Golimumab)	Subcutaneous				
Remsima (Infliximab)	Intravenous				
Remicade (Infliximab)	Intravenous				
MabThera (Rituximab)	Intravenous				
RoActemra (Tocilizumab)	Subcutaneous Intravenous				
Stelara (Ustekinumab)	Subcutaneous				

Approved By: S.Menzies

Date: 07.09.16

Pharmacy Use:

Treatment Date:.....

Review Date:.....

COPY

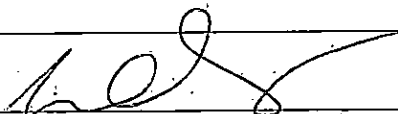
Homecare Prescription For Benepali® (Etanercept)

COPY

Hospital Name:	Forth Valley Royal Hospital	Prescription Status: ☐ New Patient ☒ Treatment Switch ☐ Dose Change ☐ Renewal
Hospital Address:	Stirling Road Larbert FK5 4WR	

Patient Name:	Scott Dowell		
Patient Address & Postcode:	11 Don Street Grangemouth FK3 8HD		
Date of Birth:	26.02.80	Weight (kg):	
Hospital Number:	2602800570	NHS Number:	2602800570
Indication	☐ Rheumatoid Arthritis ☐ N-R Axial Spondyloarthritis ☐ Psoriatic Arthritis ☒ Ankylosing Spondylitis ☐ Plaque Psoriasis		
Known Allergies/Sensitivities: Golimumab (SIMPONI) - acute changes in mood			
Purchase Order Number:			

Drug Name	Presentation (please tick)	Dose (mg)	Route	Frequency of injection
Benepali® Injection (Etanercept)	☒ Pre filled syringe ☐ Pre filled pen.	50 mg	SC	WEEKLY
Please deliver every 4 ☒ 8 ☐ 12 ☐ weeks for a total duration of <u>4</u> weeks				

Prescriber's Signature:			
Prescriber's Name	SR DAVIES Rheum Spec Nurse		
Qualification / GMC	NIP	Date:	7/9/16
Clinical Screening (if applicable)			
Pharmacist Signature:			Date:
Pharmacist Name (print):			Telephone:

Please forward original copy to: Pharmacy Department, Healthcare at Home Ltd., Fifth Avenue, Centrum 100, Burton-upon-Trent, Staffordshire, DE14 2WS. Pharmacy Tel: 01283 501390

COPY

Etanercept (Benepali®) Patient Registration Form

****NHS Service****

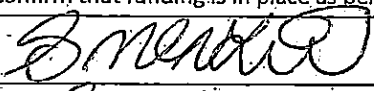
COPY

Patient Details			
Title	Mr	☐ New Patient (biologically naïve)	
First name	Scott	☒ Therapy Switch	
Surname	Dowell	☐ Homecare Provider Switch	
Address including Postcode	11 Don Street, Grangemouth, FK3 8HD	Hospital Number	2602800570
		NHS/CHI Number	2602800570
		Date of Birth	26.02.80
		Carer/Spouse Name	N/A
Tel:	01324 262719	Mobile:	
Email:			
Diagnosis:	☐ Rheumatoid Arthritis ☒ Ankylosing Spondylitis ☐ N-R Axial Spondyloarthritis ☐ Psoriatic Arthritis ☐ Plaque Psoriasis		

Referral Information			
Consultant Name	Dr Brzeski / Strang / Else	Name for Rx Renewals:	S.Menzies / C.Davies / A. Punton
Hospital Name & Address including Postcode	Stirling Road, Larbert, FK5 4WR	Rx Telephone:	01324 566934
		Rx Fax:	
		Rx Email:	sharon.menzies2@nhs.net / carolann.davies@nhs.net / eilidh.macdonald3@nhs.net
Nurse Specialist Name	S.Menzies / C.Davies / A.Punton	Nurse Telephone:	01324 566934
Nurse Email	sharon.menzies2@nhs.net / carolann.davies@nhs.net		
Pharmacist Name	Alison Chaplin	Telephone:	01324 566732

Service Options	
☐ Delivery ONLY (No nursing) ☒ Delivery & Nurse Injection Training	Delivery Frequency: ☒ 4 weekly ☐ 8 weekly ☐ 12 weekly
Date first delivery required by: ASAP (please insert date or leave blank to manage within standard SLA)	
Is the patient to have treatment in combination with: ☐ Methotrexate ☐ Metoject ☒ None (Benepali only)	

Invoicing Details *Please complete in full			
Contact Name or Department for Invoices	Finance Department	Purchase order Number required?	☒ Yes ☐ No
Invoicing Address including Postcode	Trust HQ, Westburn Ave, FALKIRK	Tel:	
		Email:	

To be completed by the referring clinician: Please register the above patient on the NHS Benepali Homecare Service. I confirm that I have explained to the patient/carer that the Homecare Service is provided under contract by Healthcare at Home. I can confirm that the patient/carer has consented to the secure transfer and processing of their data by Healthcare at Home in order to receive the Homecare Service. I confirm that funding is in place as per the details above.			
Signature		Date	07.09.16
Print Name	S. MENZIES	Qualification / GMC	RGJ.

Please return completed form with a valid prescription to: Pharmacy Department, Healthcare at Home Ltd, Fifth Avenue, Centrum 100, Burton-upon-Trent, Staffordshire, DE14 2WS Customer Service Telephone: 0333 207 0344

COPY

Forth Valley Rheumatology Service

COPY

Evaluation of Anti-TNF Medication – AS

Eligibility: 'Active AS'. Failure of conventional treatment with 2 or more NSAID's, each taken sequentially at max tolerated/recommended dose for 4 weeks AND BASDAI >4 AND SPINAL VAS > 4cm on 2 occasions at least 4 weeks apart without change in treatment.

Response: Reduction in BASDAI to 50% of pre treatment value OR a fall of reduction of SPINAL VAS by $\geq$ 2cm



CHI: 2602800570

26/02/1980

Anti – TNF Medication:

Name:

DOWELL

Date Started:

Address:

Scott

Golimumab

Date of Birth:

11 DON STREET,
GRANGEMOUTH,
FK3 8HD

Hosp No:

	Pre Rx	Baseline	3 Months	6 Months	1 Year	18 Months
Date	24/5/16	24/5/16				
Hb						
CRP						
ESR						
BASFI						
BASDAI	5.90					
BASMI	1					
VAS Spine	10/10					
EMS						
Response Y/N						
Seen by	SE					

Quantiferon -ve

radiographic Yes

HIV -ve

Hep virology -ve

Forth Valley Rheumatology Service

Evaluation of Anti-TNF Medication – AS

COPY

Response: Reduction in BASDAI to 50% of pre treatment value OR a fall of $\geq$ 2units AND reduction of SPINAL VAS by $\geq$ 2cm

Anti – TNF Medication:
Date Started:

Name:
Address:

Date of Birth:
Hosp No:

	2 years	2.5 years	3 years	3.5 years	4 years	4.5 years
Date						
Hb						
CRP						
ESR						
BASFI						
BASDAI						
BASMI						
VAS Spine						
EMS						
Response Y/N						
Seen by						

BIOLOGICAL THERAPY FOR ARTHRITIS

Golimumab 50mg monthly injections

Dr D Dundas
Westburn Medical Practice
Falkirk Community Hospital
Westburn Ave
Falkirk
FK1 5SU

Date: 11/08/2016

Dear Dr Dundas

Re: Scott Dowell, CHI: 2602800570 11 Don Street, Grangemouth, FK3 8HD

Mr Dowell is Golimumab (Simponi) a biologic therapy given by s/c injection monthly for management of his Ankylosing Spondylitis. A nurse from Health Care at Home will attend Mr Dowell's home to educate the him on administration of this treatment. I have enclosed information regarding Golimumab for your information. The injections will be continue to be delivered to him at home by Health Care at Home and prescribed by us.

This treatment is immunosuppressant in nature. I would be grateful if you could note specifically the section on increased risk of infection whilst on this treatment and the need for prompt intervention and treatment as required. He will require to have pneumococcal immunisation if not previously administered and annual flu immunisation whilst on treatment.

It would be helpful if bloods (FBC, U&E, LFT, CRP & ESR) could be taken 3 monthly however the patient is aware that if this is not an option, then he/she can attend phlebotomy in Forth Valley Royal Hospital, Area 3, Outpatient dept. He will be followed up initially at 3 months following commencement on treatment and then again at 6 months. If he is tolerant and Golimumab is effective he will continue to be followed up 6 monthly in the biologic clinic thereafter.

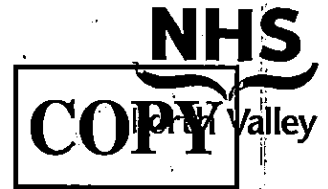


INVESTOR IN PEOPLE

Chairman Ian Mullen OBE BSc MR PharmS DL
Chief Executive Fiona Mackenzie MA (Hons) MBA MHM DipHSM

*Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SW*

www.nhsforthvalley.com



If you have any questions or require further information you can contact us via the nurse advice line on 01324 566934.

Yours sincerely,

Carol Ann Davies
Rheumatology Specialist Nurse
Forth Valley Royal Hospital
01324 566934

e-mail: carolann.davies@nhs.net

24/5/16

Forth Valley Rheumatology Biologics Checklist

COPY

Patient details

Name:	CHI 2602800570 CRN: S679370 26/02/1980
Address:	DOWELL SCOTT M 11 Don Street, GRANGEMOUTH, Stirlingshire FK3 8HD
Date of Birth:	
CHI:	
Telephone no:	

Disease

Disease type (erosive, serology, associations etc.)	ANK SPOND
Date diagnosed	24/5/16
Previous treatments (inc side-effects)	METAXON IBUPROFEN DICLOFENAC
Current disease activity (specify score used)	STAND 5.20 VAS 10
Does patient qualify for biologics?	YES

Qualification Criteria

RA: Failed 2 standard DMARDs (side-effects or 3 months on therapeutic dose)
DAS28 > 5.1 on 2 occasions at least 1 month apart (DAS28-CRP; DAS28-ESR, DAS28-CRP-3)

PsA: Failed 2 standard DMARDs (side-effects or 3 months on therapeutic dose)
3 tender and 3 swollen joints (inc. dactylitis) on single occasion
NB. Need 66/68 joint counts at baseline to assess response later on

AS: Failed 2 NSAIDs (side-effects or 3 months on therapeutic dose)
BASDAI > 4.0 and spinal pain VAS > 4/10 on 2 occasions at least 12 weeks apart

COPY

PMHx

Co-morbidities	INDIGESTION - ANTIACID USE
Current medication	DILTIAZEM 120mg LANSOPRAZOLE
Allergies	
Smoking status / alcohol intake	RSN - N - PLANNING TO QUIT

Patient details

COPY

Safety checklist

	Item	Outcome and date
Basic investigations	FBC, U+E, LFTs, CRP Immunoglobulins (rituximab only) Cholesterol (tocilizumab) Immunology (if not done previously)	order 24/5/16
	CXR within last 6 months X-rays hands and feet	
Infection	Hepatitis B (surface Ab and core Ag) Hepatitis C HIV	✓ 24/5/16 - in
	History of chickenpox? (If not needs varicella serology)	none Immun
	Any history of TB contact or treatment? Had BCG? If so is there BCG scar? Was the patient born outside UK or travelled to countries with high rates of TB? Has patient drunk unpasteurised milk? Do they need T-Spot?	
	Did they 'have any live vaccinations' recently? (e.g. BCG, MMR, Poliomyelitis, Rotavirus, Typhoid, Varicella-Zoster Vaccine or Yellow Fever)	no Quantif
	Any history of recurrent or chronic infections e.g. leg ulcers, recurrent UTIs, recurrent LRTI	no
	Any history of joint sepsis?	no
	Any history of heart failure? If so echo findings and date Current NYHA classification?	no
Specific co-morbidities	Any history of malignancy including skin cancer? If so type of cancer, date and details of treatment	no
	Any history of demyelinating disease?	no
	Diverticular disease (Tocilizumab)	no

Patient details

COPY

Counselling

General	ARUK drug leaflet provided	✓
	Patient information sheet provided	✓
	Helpline number provided	
Infection	Advice regarding infection	✓
	Advice regarding immunisations	
Special circumstances	Advice regarding pregnancy / breastfeeding	
	Advice regarding surgery	
Delivery	Home care system explained	✓

Summary

Indication for treatment	<i>Anti Spond</i>
Treatment regime agreed (as per biologics pathway)	<i>GOI</i>
Details of clinician completing screening and date	<i>Euse 24/5/16</i>
Patient consent to treatment (signed and dated by patient)	<i>NRJON consent</i>
Prescription completed	
Prescription sent to pharmacy	

**Department of Rheumatology
Approval for Biologic Therapy**

COPY

Patient Demographics

Scott Dowell, CHI: 2602800570 11 Don Street, Grangemouth, FK3 8HD

The above named patient meets current eligibility criteria for biologic therapy and has been counselled and consented for treatment as follows:

Indication	✓	IPTR Approval (if Required)
Rheumatoid Arthritis		
Ankylosing Spondylitis	X	
Psoriatic Arthritis		
Other (please specify)		

Drug	Route (delete as appropriate)	Treatment			Switched From (if appropriate)
		Initial	2 nd Line	Subsequent	
Orencia (Abatacept)	Subcutaneous Intravenous				
Humira (Adalimumab)	Subcutaneous				
Cimzia (Certolizumab)	Subcutaneous				
Benepali (Etanercept)	Subcutaneous				
Enbrel (Etanercept)	Subcutaneous				
Simponi (Golimumab)	Subcutaneous	X			
Remsima (Infliximab)	Intravenous				
Remicade (Infliximab)	Intravenous				
MabThera (Rituximab)	Intravenous				
RoActemra (Tocilizumab)	Subcutaneous Intravenous				
Stelara (Ustekinumab)	Subcutaneous				

Approved By:.... Sr Carol Ann Davies.....

Date: ...11/08/16.....

Pharmacy Use: ..

Treatment Date:.....

Review Date:.....



Simponi® Homecare Registration Form

Patient Details			
Title	Mr ☒ / Mrs ☐ / Ms ☐ / Miss ☐	Hospital Number	260280057
First name	Scott	NHS Number	2602800570
Surname	Dowell	Date of Birth	26/02/1980
Address & Postcode	11 Don Street Grangemouth FK3 8HD	Patient Diagnosis	
		Carer/Spouse Name	
		Email	
Tel:	01324 262719	Mobile	
Known Allergies / Sensitivities:			

COPY

Referral Information			
Consultant Name	Dr Brzeski	GP Name	
Hospital Name & Address	Forth Valley Royal Infirmary Stirling, Road, Larbert FK5 4WR	GP Address	
Postcode		Postcode	
Nurse Specialist	Carol Ann Davies	GP Telephone	
Tel: 01324 566331		Contact Name for Rx Renewals	Sharon Menzies, Anne Punton, Carol Ann Davies
Email: carolann.davies@nhs.net		Telephone	01324 566934
Pharmacist		Fax	
Tel:		Email	sharon.menzies2@nhs.net arinpunton@nhs.net, carolann.davies@nhs.net, ellidh.macdonald3@nhs.net
Email:			

Service Details	
Service Requirements	☒ Delivery & Nurse Training ☐ Delivery Only
Treatment details	Has the patient already had their 1 st injection? ☐ Yes ☒ No
	Date delivery required by: As Soon As Possible
Additional comments:	

Invoicing Details **Please complete in full if using Hospital or Private Prescription			
Prescription Type	☐ FP10 ☐ FP10(HP) ☒ **Hospital Prescription ☐ **Private Prescription		
Contact Name or Department for Invoices	Finance Department	Purchase order Number required?	☒ Yes ☐ No
Address	Trust Headquarters Westburn Ave	Tel:	
Postcode	FK1 5 SU	Email:	

To be completed by the Referring Clinician: Please register the above patient on the Simponi Homecare Service. I confirm that I have discussed the service with the patient and/or their carer, and they have consented to receive the service.			
Signature		Date	11/8/16
Print Name	Sr Carol Ann Davies	Qualifications	NIP/ 96C0015S



Healthcare at Home

Private and Confidential

Simponi® (golimumab) Homecare Prescription

COPY

Hospital Name	Forth Valley Royal Hospital	Prescription type
Hospital Address & Post Code	Stirling Road Larbert FK5 4WR	☒ New patient ☐ Renewal ☐ Dose change

Patient Details	
Name (including title)	Mr Scott Dowell
Address & Post Code	11 Don Street Grangemouth FK8 8HD
Hospital Number: 2602800570	NHS Number: 2602800570
Date of Birth: 26/02/80	Weight (kg):
Purchase Order Number (if applicable):	
Known Allergies / Sensitivities:	

Tick to dispense	Drug	Dose mg	Route	Frequency
☒	Simponi 50 mg solution for injection ☒ Pre-filled Pen (SmartJect) ☐ Pre-filled Syringe	50mg	S.C	Monthly
☐	Simponi 100 mg Solution for injection Pre-filled pen (Smartject)		S.C	Monthly

Please deliver on a monthly basis. This prescription is valid for a total duration of 3 months

Signature	Date	Name of Prescriber (Block Capitals)
	10/8/16	Sr Carol Ann Davies
Qualification / GMC 96C0015	Telephone	
Pharmacy Screening – If applicable		
Pharmacist Signature	Date	Name of Pharmacist (Block Capitals)

Please forward signed original copy to: Pharmacy Department, Healthcare at Home Ltd, Fifth Avenue, Centrum 100, Burton-upon-Trent, Staffordshire, DE14 2WS Tel: 01283 501390 For Urgent Requests Fax to: 0870 421 1539

BIOLOGIC CLINIC REVIEWS



CHI:2602800570

CRN:5679370 26/02/1980

COPY
DOVE LANE
11 of Street,
CRANLEIGH,
Stirlingshire

FK3 8HD

Date

14/08/17

Phoned for bloods

Weight

BP

Urinalysis

Infections since last review

No

~~Pregnant / using effective contraception~~

Increased shortness of breath?

No SOB

Side effects

None known

Action

Mr Daseu is doing well he feels his movements are much better only complaint would be his EMS still last a fair bit. Plan - to continue with Humira at present

Prescription signed renew in Sept Dr Elze and Biologix

BSRBR 6 month review form completed Clinic Jan. Aware to

BSRBR 6 month review form posted. Consider advice line should he need advice prior to this

Con Med:

1. Humira
2. Dihydrocalcine
3. Eomeprazole
4. Rampidom
- 5.
- 6.

Stiles
Rheumatologist

**Department of Rheumatology
Approval for Biologic Therapy**

COPY

Name: Scott Dowell

CHI: 2602800570

Postcode:FK38HD

The above named patient meets current eligibility criteria for biologic therapy and has been counselled and consented for treatment as follows:

Indication	✓	IPTR Approval (if Required)
Rheumatoid Arthritis		
Ankylosing Spondylitis	X	
Psoriatic Arthritis		
Other (please specify)		

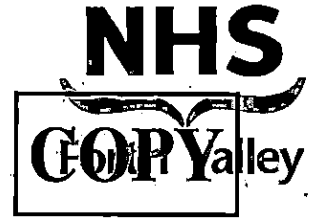
Drug	Route	Treatment			Switched From (if appropriate)
		Initial	2 nd Line	Subsequent	
Orencia (Abatacept)	Subcutaneous				
	Intravenous				
Humira (Adalimumab)	Subcutaneous		X		Switched from Benepali
Cimzia (Certolizumab)	Subcutaneous				
Benepali (Etanercept)	Subcutaneous				
Enbrel (Etanercept)	Subcutaneous				
Simponi (Golimumab)	Subcutaneous				
Remsima (Infliximab)	Intravenous				
Remicade (Infliximab)	Intravenous				
MabThera (Rituximab)	Intravenous				
Cosentyx (Secukinumab)	s/c 150mg				
	s/c 300mg				
RoActemra (Tocilizumab)	Subcutaneous				
	Intravenous				
Stelara (Ustekinumab)	Subcutaneous				
Other (specify)					

Approved By: Dr Else/S Guest

Date:08/05/17

Department of Rheumatology
Rheumatology Nurse Service
Tel: 01324 566934

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Ref: SG/2602800570

Date: 08/05/17

Scott Dowell
11 Don Street
Grangemouth
FK3 8HD

Dear Scott,

I have completed your prescription to facilitate switching from Benepali to Humira which is your new recommended treatment for management of your ankylosing spondylitis.

The home care company will deliver your injections to your home and provide education on how to give these. A nurse will make arrangements to visit you at home for the first 1-2 injection to make sure you are confident to continue administering your injection independently.

When you receive delivery of your injection/s I would be grateful if you could store these in the fridge.

For this treatment you require to attend for blood monitoring 3 monthly. You may be able to have these checked at your GP practice however if they cannot accommodate this you can attend the phlebotomy service in, Area 3, Out Patient Dept, Forth Valley Royal Hospital. This service is available Mon, Wed, Thurs, Friday from 9:00 to 12:30 and 13:30 to 16:00. If you require to use this service you will need to take a lab request form with you. I have enclosed a form for your convenience.

Should you have any questions you can contact us via the nurse advice service on **01324 566934**.

Yours sincerely

Susan Guest
Rheumatology Nurse
Forth Valley Royal Hospital



Chairman: Alex Linkston CBE
Chief Executive: Jane Grant

Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SW

www.nhsforthvalley.com Facebook.com/nhsforthvalley @nhsforthvalley

BIOLOGICAL THERAPY FOR ARTHRITIS

Switching from Benepali to Humira

Dr Dundas
Westburn Medical Practice
Falkirk Community Hospital
Westburn Avenue
Falkirk
FK1 5SU

Date: 08.05.17

Dear Dr Dundas

Re: Scott Dowell 2602800570 11 Don Street Grangemouth FK3 8HD

Mr Dowell is switching biologic therapy from Benepali to Humira with the aim of improving disease management. This is a biologic therapy given by s/c injection for management of his ankylosing spondylitis. A nurse from Healthcare at home will attend Mr Dowell's home to educate him on administration of this treatment. I have enclosed information regarding Humira for your information. The injections will be continued to be delivered to him at home by Healthcare at home and prescribed by us.

This treatment is immunosuppressant in nature. I would be grateful if you could note specifically the section on increased risk of infection whilst on this treatment and the need for prompt intervention and treatment as required. He will require to have pneumococcal immunisation if not previously administered and annual flu immunisation whilst on treatment.

It would be helpful if bloods (FBC, U&E, LFT, CRP & ESR) could be taken 3 monthly however the patient is aware that if this service is not available at your practice, then he can attend phlebotomy in Forth Valley Royal Hospital, Area 3, Outpatient dept. He will be followed up initially at 3 months following commencement on treatment and then again at 6 months. If he is tolerant and Humira is effective he will continue to be followed up 6 monthly in the biologic clinic thereafter.



INVESTOR IN PEOPLE

Chairman Ian Mullen OBE BSc MR PharmS DL
Chief Executive Fiona Mackenzie MA (Hons) MBA MIHM DipHSM

Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SW

www.nhsforthvalley.com



If you have any questions or require further information you can contact us via the nurse advice line on 01324 566934.

Yours sincerely,

Susan Guest
Rheumatology Nurse
Forth Valley Royal Hospital
01324 566934

Forth Valley Rheumatology Biologics Switch

Date 20/4/17
COPY

Patient details

Name:	 CHI:2602800570 CRN:S679370 26/02/1980 DOWELL SCOTT 11 Don Street GRANGEMOUTH, Stirlingshire FK3 8HD
Address:	
Date of Birth:	
CHI:	
Telephone number:	

Disease type	<i>ANK SAND</i>
Current medication	<i>ANKESTI</i>
Previous sDMARDs and biologics (inc side-effects and response)	<i>SIMPONI - NOO OUTRANCE</i> <i>ANKESTI - NOO - RESPONSE</i>
Reason for switch	<i>ACTIVE OUTRANCE</i>
Current disease activity (specify score used)	<i>3.0/11 9-00</i>

Biologic recommended	<i>HUMIRA</i>	
Counselling	Patient counselled on specific therapy ARUK drug leaflet provided Patient information sheet provided Homecare system explained (if needed)	☒ ☒ ☒ ☒
Details of clinician / date	<i>Est 20/4/17</i>	
Patient consent to treatment		
Prescription completed		
Prescription sent to pharmacy		

Safety checklist

CHI 2602800570
 GRN: S679370 26/02/1980
 DOWELL SCOTT
 11 Don Street
 GRANGEMOUTH
 Stirlingshire
 FK3 8HD

COPY

	Item	Ordered	Checked
Basic investigations	FBC	20/4/17	
	U+E		
	LFTs		
	CRP +/- ESR		
	Immunoglobulins (rituximab only)	✓	
	Cholesterol (tocilizumab)		
	Immunology (if not done previously)		
	CXR within last 2 years	25/5/16	✓
	X-rays hands and feet		
Infection	Hepatitis B (surface Ag and core Ab)	one	
	Hepatitis C	ne	
	HIV	ne	
	Quantiferon	ne	
	History of chickenpox? (if not needs varicella serology)	immune	
	Did they have any live vaccinations recently? (e.g. BCG, MMR, Poliomyelitis, Rotavirus, Typhoid, Varicella-Zoster Vaccine or Yellow Fever)	no	
	Any history of recurrent or chronic infections? e.g. leg ulcers, recurrent UTIs, recurrent LRTI	no	
	Any history of joint sepsis?	no	
Specific co-morbidities	Any history of heart failure? If so echo findings and date Current NYHA classification?	no	
	Any history of malignancy including skin cancer? If so type of cancer, date and details of treatment	no	
	Any history of demyelinating disease?	no	
	Any history of diverticular disease (Tocilizumab)	no	

PRE-FIRST TREATMENT APPOINTMENT CHECKLIST

COPY

Patient's details

Scott Dowell
2602800570

Screening		date
Clinician seen		
date		
score		
Front information sheet/assessment	YES/NO	
Patient education sheet	YES/NO	
Consent signed	YES/NO	
Infection/ Malignancy sheet completed	YES/NO	
Bloods		
FBC, U&E's, LFT's, ESR, CRP	YES/NO	03/05/17
Hep A, B, C	YES/NO	03/05/17 25/05/16
HIV	YES/NO	25/05/16
Cholesterol (Tocilizumab)	YES/NO	
Immunoglobulin's (Rituximab)	YES/NO	
Quantiferon -ve		25/05/16
Chest X-ray	YES/NO	
Date		25/05/16
Reported		12/07/16
Allergy		
Any type of allergy?	YES/NO	
What type?		
Any history of infusion reaction?	YES/NO	
Is patient on Methotrexate?	YES/NO	
Advice		
Diverticulitis (Tocilizumab)	YES/NO	
Flu vaccination/ Pneumococcal vaccination	YES/NO	
Appropriate treatment choice as per Biologic pathway?	YES/NO	
Prescription, Registration form, GP letter completed	YES/NO	
Sent to Pharmacy	YES/NO	

CONSENT FORM

NHS

Forth Valley

Agreement to Operation, Investigation or Treatment

COPY

Notes of Guidance for Doctor/Dentist/Healthcare Practitioner

The doctor/dentist/healthcare practitioner must:

- ◆ Be suitably qualified and experienced to explain the procedure to be performed - this should ideally be the operator or consultant.
- ◆ Give the patient sufficient information, in a way he/she can understand, about the proposed procedure, any important risks and the possible alternatives (including no treatment). In broad terms, a significant risk is one which is serious, but uncommon, or one which occurs frequently, even if it is not serious.
- ◆ Give the patient sufficient time to read the form and ask any questions relating to it or their treatment. The patient must be allowed to decide whether he/she will agree to the procedure and they may refuse or withdraw consent at any time.
- ◆ In addition to seeking consent for the procedure, seek written consent from the patient for examination by students.

Children under the age of 16 can give their own consent if the Medical Practitioner attending the child considers the child capable of understanding the nature and possible consequences of the procedure or treatment. If the child is judged capable, the practitioner must seek the consent of the child rather than the parent. This does not mean that the parents must always be excluded from the discussions. Unless there are issues concerning confidentiality, it would be reasonable to involve parents in helping a child to reach a decision. If a child under 16 years of age is giving his/her own consent, the relevant section overleaf, must also be signed.

Writing on the consent form must be legible, unambiguous and contain no abbreviations.

Any alterations to this form must be countersigned by the patient/parent/guardian and the member of the healthcare team taking consent. If the procedure or the information about surgical marking is wrong the form must be re-written.

Surgical Site Marking

- ◆ The site should be marked and documented by the operating surgeon, or nominated deputy, who will be present in the operating theatre at the time of the patient's procedure. If site marking is not applicable, this should be recorded and signed by the person taking consent.
- ◆ The intended site should be ascertained from reliable documentation and/or images.
- ◆ Marking should take place before pre-medication/administration of any sedative.
- ◆ The intended surgical site should, ideally, be marked on the ward or day care area, prior to the patient transfer to the operating theatre.
- ◆ An indelible marker pen should be used.
- ◆ The mark should be an arrow that extends to, or near, the incision site and remains visible after the application of skin preparation.
- ◆ Where possible the mark should remain visible after the application of theatre drapes.
- ◆ Surgical operations involving side (laterality), should be marked at, or near, the intended incision. For digits on the hand or foot, the mark should extend to the correct specific digit.
- ◆ The process of pre-operative marking of the intended site must involve the patient/parent/guardian wherever possible.

NB. There will be circumstances where marking may not be appropriate i.e. Teeth or Mucous Membranes. Emergency surgery should not be delayed due to lack of pre-operative marking.

PATIENT DETAIL (OR PRE-PRINTED LABEL)

Patient's surname/family name:

Patient's first name(s):

Date of birth: --

CHI number (or other identifier):

Special requirements (e.g. other language/other communication)



CHI: 2602800570

CRN: S679370 26/02/1980

DOWELL SCOTT

11 Don Street,
GRANGEMOUTH,
Stirlingshire

FK3 8HD

M

COPY

STATEMENT FOR DOCTOR/DENTIST/HEALTHCARE PRACTITIONER

(to be completed by a practitioner with appropriate knowledge of proposed procedure. See Notes for Guidance)

Describe proposed operation, investigation or treatment. Where appropriate specify the site or side:

Excision of cystic lesion left neck

advised re pain, bleeding, infection, scarring
risk of recurrence

I have explained the procedure named on this form to the: (please tick) patient ☒

parent ☐ guardian ☐ Other (please specify)

in terms which, in my judgment, are suited to their understanding. In particular I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure e.g. blood transfusion.

[If you have provided any information leaflet/tape, please tick box ☐ and specify title and version]

Signature of Doctor/Dentist/Healthcare Practitioner:

Name (PRINT):

Date: dd mm yy
21-06-16

STATEMENT OF INTERPRETER (where appropriate)

I have interpreted the information on this form to the patient/parent/guardian to the best of my ability and in a way in which I believe he/she can understand.

Signature: Date: dd mm yy

Name (PRINT):

SURGICAL SITE MARKING

Site marking not applicable

Correct Patient and Surgical Site verified and marked by:

Signature: Date: dd mm yy

Name (PRINT): Title:

STATEMENT TO BE COMPLETED BY THE PATIENT, PARENT OR GUARDIAN

You should read this form and the notes below and overleaf carefully. If there is anything you do not understand, ask the doctor, Dentist or Healthcare Practitioner for an explanation. The information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

COPY

I am (Please tick)

Patient

☒

Parent

☐

Guardian

☐

I understand:

Yes No

- the procedure, important risks and appropriate alternatives which have been explained to me by the Doctor/Dentist/Healthcare Practitioner named on this form.
- that the procedure might be carried out by a Doctor/Dentist/Healthcare Practitioner other than the Doctor/Dentist/Healthcare Practitioner who has been treating me/the patient so far.
- that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to my/the patient's medical treatment, to safeguard or promote my/the patient's physical or mental health.

☒ ☐☒ ☐☒ ☐

I have been told about additional procedures which may become necessary during my/the patient's treatment. I have listed below any procedures which I do not wish to be carried out without further discussion.

I agree:

- to the administration of an anaesthetic or sedation if required.
- to the procedure named on this form.
- that an examination for the purposes of teaching will not be undertaken without my consent.
- that any photographs, video/audio recordings and/or surgical images kept in the records may be used anonymously for research approved by an ethics committee, education and audit to improve the quality of patient care.

If you object to surgical images being used in this way then please tick box

☐

Signature of Patient/Parent/Guardian/Other:

John O'Neill

Name (PRINT):

Date:

dd

mm

yy

 - -

Relationship to child:

Only to be completed by the Medical Practitioner where the form is to be signed by a child under 16 years.

I am of the opinion that the patient is capable of understanding the nature and possible consequences of the proposed treatment/procedure.

Name (PRINT):

Signature:

EXAMINATION FOR THE PURPOSES OF TEACHING

(Please tick) I agree ☐ I do not agree ☐ to an examination by a student during the procedure named on this form under the supervision of the senior doctor undertaking the procedure.

COPY

Signature:

Name (PRINT):

Date: ^{dd} - ^{mm} - ^{yy}

CONFIRMATION OF CONSENT

(to be completed when patient is admitted for the procedure)

I confirm that I have no further questions and wish the procedure to go ahead.

Patient ☐ Parent ☐ Guardian ☐ Other ☐ (please specify)

Date: ^{dd} - ^{mm} - ^{yy}

Signature of Doctor/Dentist/Healthcare Practitioner:

Signature of Patient:

Notes of Guidance for Patients

The Doctor/Dentist/Healthcare Practitioner is here to help you. He or she will explain the procedure. You are entitled to refuse or withdraw consent at any time. You can ask any questions and ask for more information if you wish.

You may ask for a relative, friend or nurse to be present while the Doctor/Dentist/Healthcare Practitioner explains the procedure and asks you to sign the form.

If an anaesthetic or sedation is to be administered by an anaesthetist, it will be his or her responsibility to discuss details with you before the procedure takes place.

Students need to learn how to examine patients and to see how procedures are done. This is important for the future of the Health Service. You may be asked to give consent to be examined by students during the procedure. It is up to you to decide whether to give your consent or not but, whatever you decide, it will not affect your treatment.

NOTES

Forth Valley Royal Hospital

Patient Details

CHI Number 2602800570
 Hospital Number S679370
 Patient Name DOWELL SCOTT
 Date of Birth 26/02/1980
 Sex M
 Category Type
 ASA Grade 1

Patient Type
 Operation Type ELECTIVE - NCEPOD 4
 Date of Operation 21/06/2016
 MINOR OP 1 - MINOR OP 1
 Session 1
 Anaes. Confirmed By ALYALL
 Anaesthetic Type LA
 Ward HOME

COPY

Anaes. Pause

Date Performed 21/06/2016 10:41
 Performed By HCSW Ella MACKENZIE

Surgical Pause

Date Performed 21/06/2016 10:42
 Performed By SN KIRSTEEN MUIRHEAD

Sign Out Pause

Date Performed 21/06/2016 11:07
 Performed By HCSW Ella MACKENZIE

Staff In Attendance - Team 1

SURGEON SN KIRSTEEN MUIRHEAD
 FLOOR NURSE 1 HCSW Ella MACKENZIE

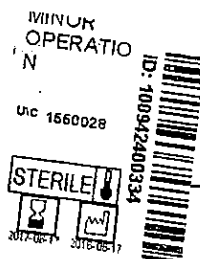
Procedures

OT962000 EXCISION LESION OF SOFT TISSUE NEC - SITE NOT RELEVANT.

Description : EXCISION OF CYSTIC LESION LEFT NECK
 ELLIPTICAL INCISION
 LOCAL ANAESTHETIC XYLOCAINE WITH 1% ADRENALINE
 LOT MC210 EXP 9/ 17 5 MLS
 HEAMOSTASIS SECURED
 CLOSED WITH 3-0 ETHILON 3-0 VICRYL
 SUTURES REMOVED 28/6/16
 SPECIMEN X1

Performed By : SN KIRSTEEN MUIRHEAD
 Confirmed By : KMUIRHEAD
 Alternate Codes: T962

Definitions :



Handwritten signature

Operation
Side

Op Notes

Materials Used

Item Code	Item Description	LOT1	LOT2	LOT3	LOT4
1009424	MINOR OPERATION	1009424			
Qty 1	Unit Cost 0.00	Total cost 0.00			

***** End of Report *****

Forth Valley Royal Hospital**Patient Details**

CHI Number 2602800570
Hospital Number S679370
Patient Name DOWELL SCOTT
Date of Birth 26/02/1980
Sex M
Category Type
ASA Grade 1

Patient Type
Operation Type

Date of Operation

MINOR OP 1 - MINOR OP 1

Session

Anaes. Confirmed By

Anaesthetic Type

Ward

DAY CASE
COPY
ELECTIVE - INCEPOD 4

21/06/2016

1

ALYALL

LA

HOME

Forth Valley Elective Preoperative Assessment Record (Adults)



COPY

Patient Details (address on back)

Surname: 
 Forer: CHI 2602800570
 Address: CRN: S679370 26/02/1980
 DOWELL SCOTT
 11 Don Street,
 GRANGEMOUTH,
 Stirlingshire
 FK3 8HD

Postcode:

Marital Status: M

Early Assessment

Yes ☐ No ☒

Title: Mr Mrs Miss Ms Dr

D.O.B.:

Age: 35

Telephone - Home: 262719

Telephone - Mobile:

Occupation: Carer for wife

Religion: Protestant

Next of Kin Details

Next of Kin: Diane Dowell

Relationship: wife

Address: (if different from above) a19

Telephone - Home: a19
 - Mobile:

Alternative Next of Kin:

Relationship:

Address: (if different from above)

Telephone - Home:

- Mobile:

GP Details

Name: Dr Dundas

Practice: Rosebank

Address:

Surgeon: Brown

Have you ever been notified that you are at increased risk of CJD or VCJD by Public Health? Yes ☐ No ☒

Transport: ☒

Diagnosis:

Planned Procedure: EXW Groin access

Date of Assessment: 24/3/15

Date and time of Admission: 30/3/15

1200

Date of Operation:

FVRH Ambulatory Care:

Neck Breather: NO

Allergies: metal ☒

foods ☒

drugs ☒

latex ☒

Specify reaction:

Smoking 20 day

Cessation advice given Yes ☐ No ☐

Alcohol NONE

Previous Surgery/Anaesthesia (list previous surgery and anaesthesia with dates)

EXW Buth mark spine

ORIF (L) arm
 arthroscopy

EXW cyst neck

Any problems (surgical or anaesthetic)

No ☒ Yes ☐

Family History of Anaesthetic problems

No ☒ Yes ☐

Medical History (please circle)

Exercise Tolerance	Distance Walked without stopping <i>No limits</i> 2 flights of stairs ✓	COPY
Shortness of Breath Yes ☒ No		
Hypertension Yes ☒ No		
Ischaemic Heart Disease/valve/murmur/ cardiac failure Yes ☒ No 2 Pillows	Angina/MI/swollen ankles/palpitations/rheumatic fever/PND/murmur/orthopnoea <i>Drizzy Spells 97 Tilt-test -ve OK -NIL since</i>	
Cerebrovascular Disease Yes ☒ No	<i>Bell's Palsy few years ago</i>	
Peripheral Vascular Disease Yes ☒ No		
Diabetes Yes ☒ No		
Asthma/COPD Yes ☒ No	Steroids/cough/cold/antibiotics/hospitalisation <i>Smoker</i>	
Stomach Ulcer Yes ☒ No		
HH/GORD Yes ☒ No		
Renal/Urological problems Yes ☒ No	Nocturia <i>NO</i>	
DVT/PE/Clots Yes ☒ No		
Arthritis Yes ☒ No	Neck movement <i>Good</i> <i>wear + tear knee, hips</i>	
Epilepsy Yes ☒ No		
Other Medical Yes ☒ No		

[illegible]

No

C

Observations and Investigations

Weight	100	Height	173	BMI	34		
P	88	BP	160/79	SaO ₂	98%	RR	12

COPY**Medical Examination/Comments**

Cardiovascular System

Pulse:

JVP:

Heart Sounds:

Ankles:

Sign

Respiratory System

Trachea:

Expansion:

Percussion:

Air Entry:

DVT Risk Factors

Suggested thromboprophylaxis required (all patients to be mobilised and well hydrated)

None ☐ CECS ☐ Intraop calf compression ☒ Enoxaparin ☐ Rivaroxaban ☐ Not sure ☐**Risk**

Patient been advised to read anaesthetic booklet

Yes ☒No ☐

ASA grade

1

2

3

4

5 Any problems (specify)

To discuss with anaesthetist

Yes ☐No ☒

(Circle)

Day Case

23 hours stay

Inpatient – DOSA/DBS

Date

Sign and Print *ec*

Forth Valley Elective Preoperative Assessment Record (Adults)



CHI/2602800570
CRN:S679370 26/07/1980
DOWELL SCOTT
11 Don Street,
GRANGEMOUTH,
Stirlingshire
FK3 8HD

COPY

Investigations and Results

Date Test Done	Enter results OR tick the "not requested in accordance with 3 months acceptable" box.					
	Hb	WCC	Platelets	CRP	ESR	Not requested ☒
	Na	K	Ur	Cr	eGFR	Not requested ☒
	Blood Glucose ☐ (random or fasting)			HbA1c ☐		Not requested ☒
	ECG attached ☐			X-Ray requested ☐		Not requested ☒
	GP & save Antibodies ☐			X match ☐ units		Not requested ☒
	Positive Antibodies ☐	Update EDMS ☐		Phone Secretary ☐		Not requested ☒
	INR (PT) ☐		CLOTTING ☐			Not requested ☒
	MSSU: rbc wcc epithelials					Not requested ☒
	AST	ALT	Bil	TP	Alb	Alk Phos
						Not requested ☒
	MRSA					Not required ☒

AMT 4

All patients age 65 and over:

- How old are you? ☐
- What is your year of birth? ☐
- What year is it now? ☐
- Where are we at present? ☐

If score is less than 4 do: FBC, U&E, Glucose, LFT, TFT, B12 folate (separate yellow bottle)

- Complete a letter to GP ☐
Complete a letter to Surgeon ☐

HOSPITAL READMISSION CHECK:
DATE:

Any changes in health since Pre-op Assessment?

 Yes ☐
(document)


Any hospital admission since Pre-op Assessment?

 Yes ☐
(document)

Any Blood Transfusion or blood products since Pre-op Assessment?

 Yes ☐
(document)

 No ☐

Are you pregnant?

 Yes ☐

 No ☐

LMP ____/____/____

Test:

If "Yes" to any of the above, please repeat the cross match/group and save

Ok to proceed

 Yes ☐

 No ☐
Family Dialogue

Date & Sign

Forth Valley Elective Preoperative Assessment Record (Adults)



CHI2602800570
CRN:S679370 26/02/1980
DOWELL SCOTT M
11 Don Street,
GRANGEMOUTH
Stirlingshire
FK3 8HD

COPY

Nursing Admission Profile

Home Circumstances	Yes	No	Referrals	Date
Lives alone		☒	Addiction Team	
Lives with: <u>WIFE</u>			Dietetics	
Is there a main Carer?			Infection Control	
Who will supply transport?			Occupational Therapy	
Is patient a main carer? <u>FOR WIFE</u>	☒		Nurse Specialist (specify)	
Housing			Physiotherapy.	
Flat ☐	House ☒	Podiatry		
Bungalow ☐	Residential ☐	Social Work		
Nursing Home ☐	Sheltered Housing ☐	Speech/Language Therapy		
Stairs: Inside ☒	Stairs: Outside ☐	Other (specify)		
Existing Home equipment? Yes ☐ No ☐				

If Yes give details below

Day Surgery Unit		30/03/15	
Post op vital signs stable (pulse, blood pressure and sats)		<u>Yes</u> /Not applicable	
Alert and orientated as per Care Plan 1		<u>Yes</u> /Not applicable	
Able to sit and walk unaided		<u>Yes</u> /Not applicable	
Has had something to eat and drink per Care Plan 5		<u>Yes</u> /Not applicable	
Has minimal nausea and is not being sick as per Care Plan 5		<u>Yes</u> /Not applicable	
Operation site checked as per Care Plan 3		<u>Yes</u> /Not applicable	
Has passed urine as per Care Plan 6		<u>Yes</u> /Not applicable	
Pain well controlled as per Care Plan 3		<u>Yes</u> /Not applicable	
Verbal and written instructions given		<u>Yes</u> /Not applicable	
District nurse contacted		<u>Yes</u> /Not applicable	
Collected by responsible adult who will be present for 24 hours		<u>Yes</u> /Not applicable	

Pre Operative Assessment Notes

CHI 2602800570
CRN: S679370 26/02/1980
DOWELL SCOTT
11 Don Street,
GRANGEMOUTH,
Stirlingshire
FK3 8HD

COPY

ATTENDED PRE-OPERATIVE ASSE.

Attended Pre-op Assessment.	☒	EDMS	☐
Green Bag	☐	ECG	☐
Length of Stay (PDD)	☒	Fasting Instructions	☒
Any Other Leaflet (Hip/Knee booklet)	☐	Advice on Colds and Flu	☒
"You and Your" Anaesthetic Leaflet	☐		
Anaesthetic Review	Yes ☐	No ☒	

ADULT ELECTIVE SURGERY RISK FACTORS FOR VENOUS THROMBOEMBOLISM

Age >60	Yes ☐ No ☒	Pregnancy/Puerperium	Yes ☐ No ☒
Obesity (BMI >35)	Yes ☐ No ☒	Hormonal Therapy (inc OCP/HRT)	Yes ☐ No ☒
Previous DVT/PTE	Yes ☐ No ☒	Immobility >72 hours in last few days/weeks	Yes ☐ No ☒
FH of VTE (1st deg relative)	Yes ☐ No ☒	Active medical illness (heart failure, recent MI or CVA, severe COPD, inflammatory bowel disease, ephritic syndrome)	Yes ☐ No ☒
Thrombophilia	Yes ☐ No ☒		Yes ☐ No ☒
Current Malignancy	Yes ☐ No ☒	Anything else? If yes, what?	Yes ☐ No ☒

Does the patient have any bleeding risk factors? (Tick all that apply)

Is this procedure a day case procedure	Yes ☒ No ☐
Active bleeding	Yes ☐ No ☐
Unrelated inherited bleeding disorders (e.g. haemophilia or Von Willebrand's)	Yes ☐ No ☐
Acquired bleeding disorders (e.g. acute liver failure)	Yes ☐ No ☐
Neurosurgery, spinal or eye surgery Thyroid surgery	Yes ☐ No ☐
Concurrent use of warfarin with INR >2	Yes ☐ No ☐
Platelet count 75 or below	Yes ☐ No ☐
Acute stroke	Yes ☐ No ☐
Uncontrolled hypertension (230/120 MMHG or higher)	Yes ☐ No ☐
Lumbar puncture, epidural/spinal analgesia within previous 4 hours	Yes ☐ No ☐
Or expected within the next 12 hours	Yes ☐ No ☐

Sign & Date

Date

Handwritten signature

24/3/15
19.15

Clinical Notes

(Please start each note with
Practitioner Name and Date)

CHI2602800570
CRN:S679370 26/02/1980
DOWELL SCOTT
11 Don Street
GRANGEMOUTH,
Stirlingshire
FK3 8HD

M

COPY

Date

30/3/15 Admitted for theatre today checklist
completed orientated to ward. ~~OK~~

30/03/15 Returned from theatre following excision
1730 of hidradentitis suppurative from left groin.
Vital signs stable. Dressing dry and intact.
Tolerating diet and fluids.

~~To return to clinic in 8/52 error.~~

Patient happy to reduce dressing in 24 hours.
Sutures to be removed in 10 days at
treatment room nurse.

No C/O pain.

SN RVerity

30/03/15 Venylon removed.

1845 Passed urine.

Discharge prescription and written information
given.

SN RVerity

Clinical Notes

(Please start each note with
Practitioner Name and Date)

COPY

Date

Addressograph



CHI:2602800570

CRN:S679370 26/02/1980

DOWELL SCOTT

11 Don Street,
GRANGEMOUTH,
Stirlingshire

NHS FORTH VALLEY ACUTE OPERATING DIVISION
 ILT SURGICAL AMBULATORY CARE PRESCRIPTION CHART

Patient Name: FK3 SHD

DOB Unit No Allergies/sensitivities

DATE	DRUG	ROUTE	DOSE	ADMINISTRATION TIMES ON-DAY OF OPERATION				NURSES SIGNATURE FOR ADMINISTRATION				Dr's signature if required for discharge
				Pre-op	A	B	C	D	A	B	C	
01/3/15	AS PER DSU PGD											
01/3/15	Paracetamol	PO	1g			1600						
01/3/15	Ibuprofen	PO	400mg									
01/3/15	Dihydrocodeine	PO	30 to 60mg									
	Ranitidine single dose	PO	150mg									

Nursing Staff: Drugs supplied on discharge

DATE	DRUG	ROUTE	DOSE AND DIRECTIONS	FURTHER DOSES DUE AT:	BATCH NUMBER	QUANTITY	NURSE SIGNATURE	REASON NOT SUPPLIED:
01/3/15	Paracetamol 500mg Tablets	PO	Two tablets 4-6 hourly. No more than 8 in 24 hours	2000	8400	32	RV 2	
01/3/15	Ibuprofen 400mg Tablets	PO	One tablet 6-8 hourly With or after food		739603	24	RV 2	
01/3/15	Dihydrocodeine 30mg tablets	PO	One or Two tablets 4-6 hourly. Max 8/24 hours	When Required	7396113	30	RV 2	

- It is common for even minor surgery to cause you some pain and discomfort for a few days.
- It is important for you to take painkillers regularly for 3 days after your operation to reduce the pain.
- If pain persists, or is not controlled by the painkillers you have been given, contact D.S.U. 01324 567537, your GP or NHS 24 on 111

COPY

ING1211

Distribution 1. G.P. 2. Pharmacy 3. Patient 4. Patients records

NHS Forth Valley Peri-Operative Careplan

CHI:2602800570
CRN:S679370 26/02/1980
DOWELL SCOTT
11 Don Street,
GRANGEMOUTH,
Stirlingshire
FK3 8HD.

Procedure: EXCISION OF HIDRADENITIS SUPPURATIVE FROM GROIN LEA.

Consultant: Mr Hussain.

Theatre No: 3

Ward: DSU

Surgeon: Mr Hussain.

Elective/Emerg

COPY

Date: 30/3/15

Team Leader: AnnLaidlaw

Procedure Start: 16.40

Exit Theatre Time: 17.02

Blood Loss:

Urine Output:

Position: Supine. Positioned by: Theatre team

Visual check of all pressure areas pre-op, by:
Sacrum [] Buttocks [] Heels [] Trochanter [] Shoulders [] Head []

Area of concern & action taken if red/vulnerable: NONE NOTED

Lotions:-

Chlorohexidine Alcoholic 2% [red dye]

Aqueous Chlorohexidine 0.02% []

Sodium Chloride 0.9% [✓]

Iodine 10% [] Antiseptic Iodine 10% []

Other - Please State WATER

Diathermy Pad [✓]

Position: right thigh

Site Check [✓] By: A. Laidlaw

Mechanical DVT Prophylaxis [✓]

Time: Settings:

Tourniquet [✓]

Applied by:

Fluid Warmer [✓]

Patient warming: Blankets

Visual check of all pressure areas post-operatively by:

Time:

Sacrum [] Buttocks [] Heels [] Trochanter [] Shoulders [] Head []

Area of concern & action taken if red/vulnerable: Operated on trolley

	Type	Size	Position	Number
Drains				
Catheters/Stents				
Packs				

Catheterised by: Balloon volume: mls Instillage: Yes/No Amount: mls

NG Tube

Yes/No

Skin Closure: PROLENE

Dressings: JELNET, MOPRE, BLUE SWABS MEFIX.

Follow up Instructions:

Sutures Out 10 DAYS

Seen before home Yes/No

Dressing Change REDUCE 24hrs.

Return to Clinic Yes/No 8/52

Specimens taken Yes/No X1 HIST

Nursing Comments, eg. Eye drops/LA wound infiltration:

Levobupivacaine 5mg/ml @ 20 mls used.

Tracking:

ID: 100947400497

LK4180
LARYNGEAL
MASK SIZE 4
POUCH

UIC KEY50939
936

STERILE

2015-03-24 2015-03-24

MEDIUM
BASIC
TRAY

UIC 1616016

STERILE

2015-03-24 2015-03-24

1st Count Scrub Practitioner
Final Count Scrub Practitioner
Tray Closure Scrub Practitioner

1st Count Circ Person
Final Count Circ Person
Tray Closure Circ Person

FRH045

GOING HOME

NAME Mr/Mrs/Miss



CHI:2602800570

CRN:S679370 26/02/1980

ADDRESS

DOWELL SCOTT
11 Don Street,
GRANGEMOUTH,
Stirlingshire
FK3 8HD

ADDRESS TO WHICH DISCHARGED IF DIFFERENT

COPY

UNIT No.

G.P. Dr Dundas

SCHOOL NOW ATTENDED

CONSULTANT Mr. Hassan

HOSPITAL FURH

WARD DSL 1

DATE OF ADMISSION 30/03/15 DATE OF DISCHARGE 30/03/15

DIAGNOSIS

TREATMENT IN HOSPITAL (DATE OF OPERATION IF APPLICABLE)

Excision of hidradenitis suppurative from left groin.
Skin closure - Prolene Dressing - jeloret, napore, blue swabs, metfix

TREATMENT REQUIRED FOLLOWING DISCHARGE (DRESSINGS, INJECTIONS, DIET, CATHETER & CATHETER SIZE)

Removal of sutures in 10 days please

DRUG	DOSE	FREQUENCY

Services requested - (tick as applicable)

Hospital and Community Nursing Service

District Nursing Sister
Health Visitor
Nursing Aids
Incontinence Aids
Day Hospital
Chiropody
Physiotherapy
Limb Fitting Centre
Speech Therapy

Requested via Social Worker

Home Help
Meals on Wheels
MECS Alarm
Sitter Day/Night
Day Centre
Welfare Waiting List
Social Work support

Requested via Occupational Therapist

Personal Aids
Adaptation to home

Ability on discharge (underline items applicable)

Lives alone - YES/NO

Walks - Unaided - needs help - with frame/stick/tripod

Stairs - Unaided - needs help - cannot manage

Bed - Unaided - needs help - bedfast

Dressing - Unaided - needs help

Toilet - Unaided - needs help - can/cannot manage catheter

Bathing - Unaided - needs help - unable to bath

Special appliances (e.g. commode)

Additional Information

O.P.D. Follow-up Appointment

8/52

Signed

[Signature]

Sister/Charge/Staff Nurse

Date

30/03/15

Top 2 copies to liaison staff - 3rd copy to be retained.

NHS Forth Valley**Patient Details**

Hospital Number **S679370**
 Patient Name **Dowell Scott**
 Date of Birth **26/02/1980**
 Sex **M**
 Category Type
 Patient Type **Day Case**
 Operation Type **Scheduled**
 Date of Operation **30/03/2015**
 Theatre **FVRH 3**

COPY

Confirmed By

Staff In Attendance - Team 1

Anaesthetist	DR PHILIP HAMILTON
Floor nurse 1	SN ELLEN PAGUE
Floor nurse 2	NA WAYNE SLOBODZIAN
Other	AUX TONI GRANT
Scrub nurse	TL ANN LAIDLAW
Surgeon	MR AMIR HUSSAIN
Surgeon's assistant 1	Mr M KARIM

Attendees

ODP:- Jim O'Donnell - RMR.
 Student Nurse:- LesleyAnn Edgar.

Materials Used

<u>Item Code</u>	<u>Item Description</u>	<u>Qty</u>	<u>LOT1</u>	<u>LOT2</u>	<u>LOT3</u>	<u>LOT4</u>
1009474	MEDIUM BASIC TRAY	1	1009474			
1119879	LK4180 LARYNGEAL MASK SIZE 4 POUCH	1	1119879			
1057945	BETWEEN PATIENT CLEAN THEATRE 3	1	1057945			
1057959	TERMINAL CLEAN THEATRE 3	1	1057959			

Operation Notes

Side : **Op Notes** breach 21/05/2015

Procedures

G-S0420L EXCISION OF HIDRADENITIS SUPPURATIVE FROM GROIN - LEFT

2 Infected lesion in the left groin
 Elliptical incision around the lesions and excision.
 haemostasis secured
 wound closed with vicryl
 skin closed with prolene
 20 ml of 0.5% of levobupivacaine infiltrated in the wound.

post op:
 eat and drink
 home when comfortable
 simple analgesia
 removal of sutures in 10 days.
 no follow up

Alternate Codes S042

NHS Forth Valley**Patient Details**

Hospital Number **S679370**
Patient Name **Dowell Scott**
Date of Birth **26/02/1980**
Sex **M**
Category Type
Patient Type **Day Case**
Operation Type **Scheduled**
Date of Operation **30/03/2015**
Theatre **FVRH 3**
Confirmed By

COPY**Procedure Definitions**

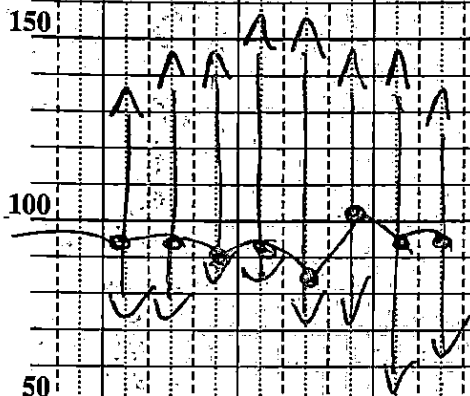
***** End of Report *****

Date 30/3/15	Ward DSU	Surname	Sex M
Procedure and side		First name	CHI:2602800570 CRN:S679370 DOWELL SCOTT 11 Don Street, GRANGEMOUTH, Stirlingshire FK3 8HD
Surgeon NUSSAIN		Unit No. / CHI No.	Date of Birth

CHECKLIST ITEMS	WARD	HANDOVER CHECKS	BASELINE WARD CHECKS & DATA
Verbal Name Check	YES	YES	Pre-assessment Document
ID Band Checked	YES	YES	Present and Checked ☒
Pre-assess/clerking completed	YES	YES	Any Changes? NO
Pregnant Yes / No LMP date	N/A	N/A	Temp 35.8 Weight (kg)
Allergies (see baseline checks Yes / No)	NO	NO	P 92 BP 139/75
Consent / Incapacity completed		YES	RR 98 SpO2 98
Operation confirmed with patient		YES	BM (Sugar) Height
Consent form corresponds to list		YES	Allergies ☒ No ☐ Yes
Operation site marked clearly		YES	Specify reaction
Nursing notes	YES	YES	Hb Na
Case Notes	YES	YES	WCC K
Drug Kardex	YES	YES	Platelet U
XMatch / G&S confirmed, date & initial	N/A	N/A	Clotting Cr
Confirm all results available	N/A	N/A	G and S X-Match
Addressograph labels	YES	YES	Dental
Bone bank consent	N/A	N/A	Crowns / Caps ☐
Fasted for solids / milk from (time)	1030PM	1030	Denture ☐
Fasted for clear fluids from (time)	730am	730	Plate ☒
Bladder emptied (time or No)	AM	AM	Loose ☐
Jewellery removed	NO	NO	Patient Valuables
Body piercings taped etc	NO	NO	Dentures Full ☐ Partial ☐
Nail varnish / makeup removed	NO	NO	Glasses ☐ None ☐
Contact lenses removed	N/A	N/A	Hearing Aid ☐
Prosthesis (* or No)	NO	NO	Dressing Gown ☒
Orthopaedic implants (* or No)	NO	NO	Slippers ☒
Pacemaker (Yes or No)	NO	NO	Other
Hearing aid (Yes or No)	NO	NO	Sign 1 W Stanherd
Able to move by self on trolley	YES	YES	
Diabetic Yes / No	NO	NO	
On Beta Blocker Yes / No	NO	NO	
If "YES" Taken Yes / No			
If not taken: Administered by Nursing Staff YES / NO			
Ward sign and designation	NUSSAIN		
Handover 1 sign and designation	W Stanherd		
Handover 2 sign and designation			
Comments*	* (L) ARM *		

RECOVERY CHART

Airway	LMWMMW	SM	SM	SM	SM		
O ₂ l/min	4	4	4	4	4	4	4
SpO ₂	95	96	96	97	95	96	
Resp Rate	14						
Temp	36.5						
BM							
TIME	16	17					
	48	00	05	10	15	20	25



A line ☐

Site:-

CVP ☐ 0

Sedation Score	5	5	5	1	0	0	0
Pain Score	0	0	0	0	0	0	0
Nausea Score	0	0	0	0	0	0	0
Wound Site	0	0	0	0	0	0	0
Drains	N/A	N/A	N/A	N/A	N/A	N/A	N/A
IVI / Pump	as	as	as	as	as	as	as
Spinal / Epidural	N/A	N/A	N/A	N/A	N/A	N/A	N/A
C / S / M	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Urinary Catheter	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Pressure Areas	as	as	as	as	as	as	as

Recovery Practitioner...

V. Parsons

Analgesia

IV Morphine up to ☐ mg

IV Fentanyl up to ☐ mcg

COPY

Anti-emetic

Cyclizine 50mg IV ☒

Granisetron 1mg IV ☐

Prochlorperazine 12.5mg IM ☐

Oxygen - in recovery follow protocol

SpO₂ range 79-94 %

Duration

Investigations - in recovery

Anaesthetist

Signed

[Signature]

Name

Discharge to (ward) DSU

Criteria Met ☒ Time 17:30

Signed V. Parsons Recovery

Signed Ward

Nursing notes ☒

Case notes ☒

Op notes ☒

Valuables ☒

EWs CHART
TO's
DRUG KARDEX

[X]
[X]
[X]

Post-operative instructions

To be discussed with surgeon at end of procedure

Medication prescribed on Kardex

- 1 ☐ Essential medication)
- 2 ☐ Regular analgesia)
- 3 ☐ Breakthrough analgesia)
- 4 ☐ Anti-emetic)
- 5 ☐ Oxygen)
- 6 ☐ PCA device)
- 7 ☐ Epidural - continuous infusion)
- 8 ☐ PCEA)
- 9 ☐ Intrathecal opiates)
- 10 ☐ Other, please specify.....

or 1 ☐ Medicine reconciliation required on ward

OR

☒ DSU Kardex completed

COPY

Diet

For all a minimum of one option must be completed

- ☒ Oral (Circle): sips / free clear fluid / soft / light / full diet
- ☐ Nil by Mouth (NBM)

If NBM: ☐ Oral diet to start.....(time) or after medical review ☐

Fluid Therapy

- ☐ Oral Fluids only
- ☐ IV Fluids only
- ☐ Fluids prescribed until at least 09.00hrs next day
- ☐ IV Fluids until adequate oral intake established
- ☐ Fluids prescribed to cover this anticipated period

Blood Sugar Control

- ☒ N/A
- ☐ Achieve target BM.....mmol/l with:
- ☐ Allow patient to titrate normal insulin / Restart oral hypoglycaemics (delete)
- ☐ GKI Infusion - **prescribed**
- ☐ Insulin Sliding Scale - **prescribed**

Antibiotic Cover

- ☒ N/A
- ☐doses post op
- ☐ Continue
- ☐ Prescribed
- ☐ Prescribed

DVT Prophylaxis

- ☒ None
- ☐ TEDS
- ☐ Enoxaparin
- ☐ Rivaroxaban
- ☐ Other, please state

IV cannula / Removal record

IV cannula (1)

Inserted by: HAMKTON

Size: 20G

Site: Shard

Batch no.: _____

Removed by: _____

Date: _____

IV cannula (2)

Inserted by: _____

Size: _____

Site: _____

Batch no.: _____

Removed by: _____

Date: _____

Special Instructions - Please document below (Eg. drains, positioning, post op investigations, imaging etc)

☐ None

Ward Staff please also review the theatre operation note.
for any surgeon specific follow-up instructions

ANAESTHETIC ASSESSMENT Date

Age

ASA

NCEPOD EI ☐

Urg ☐

Em ☐

PRE-OPERATIVE INSTRUCTIONS

☐ Free clear fluid until

COPY

PRE-MEDICATION

Prescribed by:

Given by:

CO-MORBIDITIES

DRUGS

Smoker

Fit & well

N:1

Allergies

Previous GA

Problems?

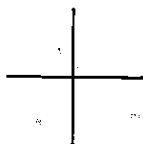
FH GA problems

Reflux/full stomach

Airway difficulty

☒ No	☐ Yes
☒ No	☒ Yes
☒ No	☐ Yes
☒ No	☐ Yes
☒ No	☐ Yes
☒ No	☐ Yes

Teeth



MPI
Edentulous
Saw submax
Neck

Verbal consent and explanation ☒

Explained:

☒ GA

☐ RA

☒ Risks

☐ Day Care

Dental damage

Signed / Name

[Signature]

Date 30/3/15 Cons Anaes

☐ present☐ discussed☒ nominal

Anaesthetist

Hamilton

Procedure

Asplanned

☒ Anaes machine checked**COPY**Local anaesthetic (LA) ☐ block☐ spinal☐ epidural☒ infiltration

Fentanyl		60	50	50					
Propofol		200							
Droperidol		125							
Desflurane		33							
Paracetamol		1g							
Antibiotic									
200									
Airway	☐ Pre O ₂								
☐ RSI	☐ cricoid P								180
☐ mask	☐ guedel								160
☒ LMA									140
size 4		150							120
☐ TT	☐ cuff								100
size	☐ oral								100
grade	☐ nasal								100
	☐ pack								100
Maintenance									
☒ O ₂	☒ N ₂ O	☐ AIR							80
☒ desvo	☐ iso	☐ des							60
☐ ...									40
Circuit									
☒ circle									20
☒ SV									CVP
☐ hand									
☐ IPPV									
Monitoring									
☒ SpO ₂		97							
☐ ODM	☒ PE/CO ₂	6.3							
☒ ECG	☒ MAC/ET AA	1.5							
☒ NIBP	☒ FiO ₂	0.6							
☒ eyecare									
☐ pressure points									
Warmed	☐ air	☐ fluid	Temp						
☐ PNS	☐ Vt/RR								
☐ PAWP/PEEP									

urine output (mls)

FLUIDS

CSL 1000mls

☐ Reversal☐ Blood Loss

ml

Vascular Access

COPY

[illegible]

CONSENT FORM

NHS

Forth Valley

Agreement to Operation, Investigation or Treatment

COPY

Notes of Guidance for Doctor/Dentist/Healthcare Practitioner

The doctor/dentist/healthcare practitioner must:

- ◆ Be suitably qualified and experienced to explain the procedure to be performed - this should ideally be the operator or consultant.
- ◆ Give the patient sufficient information, in a way he/she can understand, about the proposed procedure, any important risks and the possible alternatives (including no treatment). In broad terms, a significant risk is one which is serious, but uncommon, or one which occurs frequently, even if it is not serious.
- ◆ Give the patient sufficient time to read the form and ask any questions relating to it or their treatment. The patient must be allowed to decide whether he/she will agree to the procedure and they may refuse or withdraw consent at any time.
- ◆ In addition to seeking consent for the procedure, seek written consent from the patient for examination by students.

Children under the age of 16 can give their own consent if the Medical Practitioner attending the child considers the child capable of understanding the nature and possible consequences of the procedure or treatment. If the child is judged capable, the practitioner must seek the consent of the child rather than the parent. This does not mean that the parents must always be excluded from the discussions. Unless there are issues concerning confidentiality, it would be reasonable to involve parents in helping a child to reach a decision. If a child under 16 years of age is giving his/her own consent, the relevant section overleaf, must also be signed.

Writing on the consent form must be legible, unambiguous and contain no abbreviations.

Any alterations to this form must be countersigned by the patient/parent/guardian and the member of the healthcare team taking consent. If the procedure or the information about surgical marking is wrong the form must be re-written.

Surgical Site Marking

- ◆ The site should be marked and documented by the operating surgeon, or nominated deputy, who will be present in the operating theatre at the time of the patient's procedure. If site marking is not applicable, this should be recorded and signed by the person taking consent.
- ◆ The intended site should be ascertained from reliable documentation and/or images.
- ◆ Marking should take place before pre-medication/administration of any sedative.
- ◆ The intended surgical site should, ideally, be marked on the ward or day care area, prior to the patient transfer to the operating theatre.
- ◆ An indelible marker pen should be used.
- ◆ The mark should be an arrow that extends to, or near, the incision site and remains visible after the application of skin preparation.
- ◆ Where possible the mark should remain visible after the application of theatre drapes.
- ◆ Surgical operations involving side (laterality), should be marked at, or near, the intended incision. For digits on the hand or foot, the mark should extend to the correct specific digit.
- ◆ The process of pre-operative marking of the intended site must involve the patient/parent/guardian wherever possible.

NB. There will be circumstances where marking may not be appropriate i.e. Teeth or Mucous Membranes. Emergency surgery should not be delayed due to lack of pre-operative marking.

PATIENT DETAIL (OR PRE-PRINTED LABEL)

Patient's surname/family name:

Patient's first name(s):

Date of birth: --

CHI number (or other ident

Special requirements (e.g.

CHI: 2602800570
CRN: S679370 26/02/1980
DOWELL SCOTT
11 Don Street
GRANGEMOUTH,
Stirlingshire
FK3 8HD

M

ation method):

COPY

STATEMENT FOR DOCTOR/DENTIST/HEALTHCARE PRACTITIONER

(to be completed by a practitioner with appropriate knowledge of proposed procedure. See Notes for Guidance)

Describe proposed operation, investigation or treatment. Where appropriate specify the site or side:

excision of left arm
myra dunn's suppurative
Pus infection, wound left open, need for

I have explained the procedure named on this form to the: (please tick) patient ☐ further ☐
parent ☐ guardian ☐ Other (please specify)

in terms which, in my judgment, are suited to their understanding. In particular I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure e.g. blood transfusion.

[If you have provided any information leaflet/tape, please tick box ☐ and specify title and version]

Signature of Doctor/Dentist/Healthcare Practitioner:

Name (PRINT):

Date: dd mm yy
30 02 15

STATEMENT OF INTERPRETER (where appropriate)

I have interpreted the information on this form to the patient/parent/guardian to the best of my ability and in a way in which I believe he/she can understand.

Signature:

Date: dd mm yy
30 02 15

Name (PRINT):

SURGICAL SITE MARKING

Site marking not applicable

Correct Patient and Surgical Site verified and marked by:

Signature:

Date: dd mm yy
30 02 15

Name (PRINT):

Title:

STATEMENT TO BE COMPLETED BY THE PATIENT, PARENT OR GUARDIAN

You should read this form and the notes below and overleaf carefully. If there is anything you do not understand, ask the doctor, Dentist or Healthcare Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

COPY

I am (Please tick) Patient ☒ Parent ☐ Guardian ☐

I understand: Yes No

- the procedure, important risks and appropriate alternatives which have been explained to me by the Doctor/Dentist/Healthcare Practitioner named on this form. ☒ ☐
- that the procedure might be carried out by a Doctor/Dentist/Healthcare Practitioner other than the Doctor/Dentist/Healthcare Practitioner who has been treating me/the patient so far. ☒ ☐
- that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to my/the patient's medical treatment, to safeguard or promote my/the patient's physical or mental health. ☒ ☐

I have been told about additional procedures which may become necessary during my/the patient's treatment. I have listed below any procedures which I do not wish to be carried out without further discussion.

I agree:

- to the administration of an anaesthetic or sedation if required.
- to the procedure named on this form.
- that an examination for the purposes of teaching will not be undertaken without my consent.
- that any photographs, video/audio recordings and/or surgical images kept in the records may be used anonymously for research approved by an ethics committee, education and audit to improve the quality of patient care.

If you object to surgical images being used in this way then *please tick box* ☐

Signature of Patient/Parent/Guardian/Other: *Scott Dowell*

Name (PRINT): *Scott Dowell*

Date: dd mm yy
26 09 15

Relationship to child:

Only to be completed by the Medical Practitioner where the form is to be signed by a child under 16 years.

I am of the opinion that the patient is capable of understanding the nature and possible consequences of the proposed treatment/procedure:

Name (PRINT): Signature:

EXAMINATION FOR THE PURPOSES OF TEACHING

(Please tick) I agree ☐ I do not agree ☐ to an examination by a student during the procedure named on this form under the supervision of the senior doctor undertaking the procedure.

COPY

Signature:

Name (PRINT): Date:

dd	mm	yy

CONFIRMATION OF CONSENT

(to be completed when patient is admitted for the procedure)

I confirm that I have no further questions and wish the procedure to go ahead.

Patient ☐ Parent ☐ Guardian ☐ Other ☐ (please specify)

Date:

dd	mm	yy

Signature of Doctor/Dentist/Healthcare Practitioner:

Signature of Patient:

Notes of Guidance for Patients

The Doctor/Dentist/Healthcare Practitioner is here to help you. He or she will explain the procedure. You are entitled to refuse or withdraw consent at any time. You can ask any questions and ask for more information if you wish.

You may ask for a relative, friend or nurse to be present while the Doctor/Dentist/Healthcare Practitioner explains the procedure and asks you to sign the form.

If an anaesthetic or sedation is to be administered by an anaesthetist, it will be his or her responsibility to discuss details with you before the procedure takes place.

Students need to learn how to examine patients and to see how procedures are done. This is important for the future of the Health Service. You may be asked to give consent to be examined by students during the procedure. It is up to you to decide whether to give your consent or not but, whatever you decide, it will not affect your treatment.

NOTES

Forth Valley Surgical Safety Checklist
Version 14

Carried out - Confirmed ☒
Date 30/5/15

Anaesthetic pause [Signature]
Surgical pause [Signature]
Post procedure [Signature]

Re-order Ref: TF/1012/SS

Review Date: 2016

EMERGENCY & URGENT CARE ASSESSMENT RECORD - VERSION 4

PART A + B COMBINED DOCUMENT



COPY

PATIENT DETAILS			
Surname:		Title:	Mr Mrs Miss
Forename:	CHI: 2602800570		Ms Dr
Address:	26/02/1980 M DOWELL Scott 11 DON ST GRANGEMOUTH FK3 8HD	DOB:	
		Age:	
		CHI No/	
		Patient ID:	
Postcode:		Tel No:	

NEXT OF KIN DETAILS			
Next of Kin:		Alt. Next of Kin	
Relationship:		Relationship:	
Address:		Address:	
No:		Tel No:	
Other Family Member Details:			
Name of Relative/ Carer		Present on Admission?	Y/N
		Contacted?	Y/N
		Tel No:	

GP	
Name:	Tel No:
Practice:	
Address:	
Postcode:	
Date of Attendance:	Date of Incident/Onset
PRESENTING COMPLAINT	
1	
2	

Allergies: ☐ Drugs ☐ Latex ☐ Metal ☐ Food ☐ Nil known		Alert High Risk Factors: 																																	
Named Consultant: 																																			
Named Nurse: 																																			
<table border="1"> <thead> <tr> <th>SPECIAL REQUIREMENTS</th> <th>YES</th> <th>NO</th> <th>ACTION</th> </tr> </thead> <tbody> <tr> <td>Translation Service</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Visual Impairment</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Hearing Impairment</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Learning Disability</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Neck Breather</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Requires assistance with ADLs</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Other relevant information:</td> <td colspan="3"></td> </tr> </tbody> </table>				SPECIAL REQUIREMENTS	YES	NO	ACTION	Translation Service				Visual Impairment				Hearing Impairment				Learning Disability				Neck Breather				Requires assistance with ADLs				Other relevant information:			
SPECIAL REQUIREMENTS	YES	NO	ACTION																																
Translation Service																																			
Visual Impairment																																			
Hearing Impairment																																			
Learning Disability																																			
Neck Breather																																			
Requires assistance with ADLs																																			
Other relevant information:																																			
Date	Time	Signature																																	

Pt Name / CHI / Addressograph

COPY

Practitioners name: M. Farhan

Specialty: GI Surgery

Grade: S.P

Patient age: 35

Date: 6/1/15

Time: 2:30

Location: AAU2

PRESENTING COMPLAINT

pain & swelling LI groin

BACKGROUND

Including

HISTORY OF PRESENTING COMPLAINT

5/12 he had pain & swelling
in LI groin & as abscess
with 3 courses of AB
& no much effect
on 2nd discharge
pain worst last night & discharge
yesterday

Previous Medical History

☐ IHD

☐ TIA

☐ Stroke

☐ Diabetes Mellitus

☐ MI

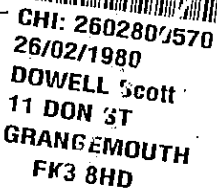
☐ COPD

☐ Hypertension

☐ Asthma

Other:

previous abscess between scrotum
& over new wound under GA



M

九

COPY

[illegible]

Any Herbal / OTC Meds:

Medicines Reconciliation carried out

By: Date:

Pt Name / CHI / Addressograph

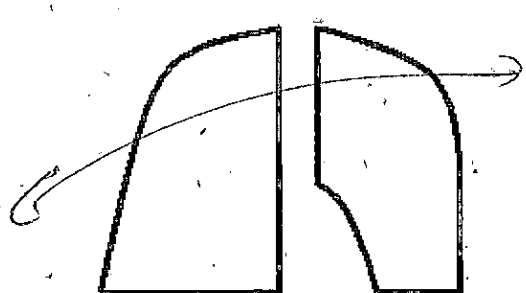
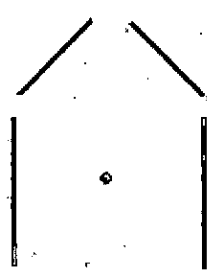
COPY

Can All Practitioners adding to document please sign /date / time each entry

Family History	☐ IHD / MI ☐ Cancer Other:	☐ Asthma ☐ Hypertension	☐ Diabetes Mellitus ☐ Stroke / TIA
Social History	Occupation: <i>carer of wife</i> Lives with: <i>wife</i> Support/carers ☒ Smoker (Amount per day: <i>15-20</i>) ☐ Ex Smoker (Since: <i>2010</i>) ☐ Never Smoked ☐ Alcohol (Units per week) <i>occasional</i> Normal Exercise Capacity: ADLs:		
Systems Review	CVS RESP GI GU CNS <i>n.s.g.</i>		
Examination	Weight : kg Height: m BMI:		
General			
Obs	Temp: Heart Rate: Resp Rate: BP _{supine} : BP _{erect} : SpO ₂ (FIO ₂ :) Anaemia Y/N Clubbing Y/N Cyanosis Y/N Jaundice Y/N Cervical Lymphadenopathy Y/N Blood Sugar: MEWS SCORE :		

Pt Name / CHI / Addressograph

COPY

CVS	JVP Apex Heart Sounds <i>o + = I + II</i> Oedema Neck Bruit Y / N Peripheral Pulses
Respiratory	Trachea: Expansion: Percussion: Breath Sounds: <i>gal on</i> <i>lung</i> <i>h.c.</i>  R L
Abdomen	 Liver: Kidneys: Spleen: <i>Sog!</i> <i>n.a. tend</i> <i>Dischoy</i> <i>LT. grain dischoy</i> <i>stomach</i> <i>SLC fold</i> <i>tender, no glascu</i> Bowel sounds: Rectal examination:
OTHER (eg. face, limbs, trunk, skin)	

Pt Name / CHI / Addressograph

COPY

NEURO

Cranial nerves:

Cerebellar:

Reflexes	B	T	S	K	A	Plantars	Clonus
L							
R							

CNS Exam

Limb	R arm	L arm	R leg	L leg
Tone				
Power				
Sensation				
Co-ordination				

Abbreviated Mental Test Score (AMTS)

How old are you (exact age only)?

What is your date of birth?

What place is this?

What year is it?

A score of 3 or less warrants further investigation

Glasgow Coma Scale

Best Eye Opening

Best Motor Response

Best Verbal Response

Score

X-ray / ECG Interpretation

CXR

AXR

ECG Interpretation

Urinalysis

Pt Name / CHI / Addressograph

COPY

IMPRESSION/ DIFFERENTIAL DIAGNOSIS	<i>Abx can already discharge</i>	
INITIAL MANAGEMENT PLAN	<i>need vis of groin to exclude any collection to come & give gas</i> <i>th</i>	
Investigations PLEASE TICK BOX IF REQUESTED	☐ FBC ☐ ESR ☐ Clotting Factors ☐ U&Es ☐ LFTs ☐ Glucose ☐ Calcium ☐ Ohr Troponin Date/Time..... ☐ 12 hr Troponin Date/Time.....	☐ CRP ☐ ABG ☐ Blood Cultures ☐ CXR ☐ ECG ☐ HCG ☐ Positive ☐ Negative ☐ Urinalysis ☐ ☐
IV Cannula Insertion/ Removal Record	Ward Date Inserted By Size / Colour Batch No Insertion Site Removed By Date	
DVT Prophylaxis	DVT Prophylaxis Indicated ☐ Yes ☐ No Any Contraindications to this? ☐ Yes ☐ No Prescribed? ☐ Yes ☐ No	



CHI: 2602800570

26/02/1980

DOWELL Scott

11 DON ST

GRANGEMOUTH

FK3 8HD

M

graph

COPY

Resus Status	Following discussion with patient/family please indicate
PLEASE COMPLETE & ATTACH NHS FV DNAR FORM	

Practitioner Signature Date/Time	PRINT NAME : SIGNATURE: BLEEP NO: DATE / TIME:
--	--

Family Dialogue	
--------------------	--

Date/Time	Clinical Notes – MEDICAL/SURGICAL MIDDLE GRADE REVIEW
0900	Review locum consultant H. Umar 5/12 history of pain swelling (L) groin treated with x3 courses antibiotics. Symptoms worsening over 24/48 hours. left groin / redness per on palpation no evidence of abscess. Imp. Kidney tests plan /- USS @ - swab - analgesia - not requiring H/D - 7 day course antibiotics Switch to Co-amoxiclav 625mg oral. USS - no obvious deep collection full report filed. Dlx at time → (H) ETZ McConnell F11 #1294

Pt Name / CHI / Addressograph

COPY

Date/Time	Clinical Notes – CONSULTANT REVIEW (Please finish each note with Practitioner Name/Job Title)
6/11/15 1330	note the above - attended for wss d/c home with antibiotics + letter done
	sn 87 Grant S Grant

Pt Name / CHI / Addressograph



Senior Clinician Patient Management Plan

EDD:

<48 hrs ☐

>48 hrs ☐

Consultant.

Please sign and date at end of each entry

Date Time	Problem No	Clinical Problem List / Background	Recommendations/ Desired Outcomes and Actions	Complete Sign & date

Pt Name / CHI / Addressograph

COPY

Senior Clinician Patient Management Plan

<48 hrs ☐

>48 hrs ☐

Consultant

Please sign and date at end of each entry

Date Time	Problem No	Clinical Problem List / Background	Recommendations/ Desired Outcomes and Actions	Complete Sign & date

Pt Name / CHI / Addressograph

COPY

[illegible]

7

**Emergency Department
Forth Valley Royal Hospital**

2602800570

2602800570

A&E No. 18000005377

**COPY
4**

Surname	DOWELL	Forename	SCOTT	Title:	MR
Address:	11 DON STREET, GRANGEMOUTH, STIRLINGSHIRE	Postcode	FK3 8HD	CHI No: 2602800570	
Date of Birth:	26.02.80	Telephone:	01324 262719		
Sex:	M	Age:	38 yrs		

CHI Barcode:

2602800570

GP Name:	DUNDAS DEREK		
Address:	WESTBURN MEDICAL P... WESTBURN AVENUE/M... FALKIRK	Postcode	FK1 5QE
		Telephone:	01324 623577

Next of Kin	DIANE		
Relationship:	WIFE		
Address:	11 DON STREET, GRANGEMOUTH, STIRLINGSHIRE	Postcode	FK3 8HD
		Telephone:	01324 262719

Manual CHI Entry:

Date of Attendance: 31.07.18 23:02

Date of Incident:

Presenting Complaint: ABSCESS BACK

Age	T37.2 SATS97% BP134/72 RR20 HR98	Tetanus Cover:	
	?ABSCESS TO BACK GIVEN ANTIBIOTICS FROM GP 1/ 7AGO C/O FEELING UNWELL	Allergies:	
P=	BP= /	RR=	Sat=
PF=	GCS=E: M: V: Total:	BM=	

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time

Clinical Notes

1/8/18

Seen by:

J ANDERSON EM STV

Time:

0050

COPY

CH 2602800570
DCWELL
SCOTT
1 DOUGLASS STREET
STIRLING
FK3 9NU

26/02/1980

M

(38) → Abscess to back

HPC/ Noted lump to upper back last few days

Started flucloxacillin 500mg QDS

yesterday by GP

↑ pain + swelling No fever/vomiting/diarrhoea

Some discharge noted tonight

but not all coming out

Presents for review

PMN/ Barretts oesophagitis

DM/ AS ELS

Ankylosing spondylitis

* NKDA *

Recent THR

SH/ smoke + alcohol

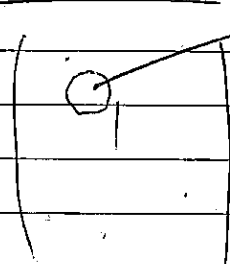
Lives w partner

O/E A little pale but (N) colour for patient
undistressed.

Obs, Temp 37.2 Pulse 98 BP 134/72

RR 20

Back



~ 5cm firm lump in pointed

centre & some discharge

noted to upper back

to left of midline

Two discharging areas

but unable to extract pus

D/w surgical reg who will RV in GAU

Thanks

J ANDERSON

Attach continuation sheets here

Attach here onto face of pocket

Guidelines Used:

PVC INSERTION BUNDLE AND REMOVAL RECORD

PLEASE COMPLETE ALL BOXES

The patient's skin is decontaminated and allowed to dry
Hand hygiene & gloves donned prior to insertion
Aseptic Non Touch Technique is used to insert PVC
If not possible, use either **STERILE GLOVES** or **MINI CHLORAPREP**
Sterile dressing & sticker (date & time) applied after insertion

YES / NO
YES / NO
YES / NO
YES / NO

CHI: 2602800570
DOWELL
SCOTT
11 DON STREET,
STIRLINGSHIRE
FK3 8HD

26/02/1980

COPY

Why is PVC clinically indicated for patient?: (please tick)

IV Fluids

IV Drugs

Predicted clinical need

Blood Transfusion

Diagnostics

Colour:

Insertion Site:

Ward/Department:

Inserted by:

Date & Time:

INVESTIGATIONS

BLOODS TAKEN? YES / NO

Circle where appropriate:

FBC LFT U&E PARACETAMOL GLU CRP AMY G&S CLOTTING
ESR TROP HCG D-DIMER URINALYSIS BLOOD CULTURES ABG* VBG* (*attach to notes)

Others:

Eliminary Pressure Ulcer Risk Assessment (PPURA):

Mobility: Person is fully mobile without equipment/assistance

Continence: Person is fully continent

Nutrition: Person appears well nourished and able to eat and drink

Skin: Skin to pressure points satisfactory/intact

Points to Consider

* People who are overweight may not be well nourished

* Use of repose, mattress or pressure relieving heel protectors.

Record your answer in the grid below Y = Yes or N = No

If the answer is **NO** to any assessments undertake a BRADEN and consider any other assessment

DATE	TIME	MOBILITY	CONTINENCE	NUTRITION	SKIN INTACT	SKIN INSPECTED	BRADEN COMPLETED	SIGNATURE
11/8/18	0115	Y	Y	Y	Y	N	N	VF
SKIN DESCRIPTION i.e. REDNESS, SKIN BROKEN, BLISTER / ULCER						ACTION TAKEN		

4AT

ALERTNESS (assess for drowsiness or agitation, if asleep attempt to rouse)

Normal

0

Mild sleepiness (easily roused <10 seconds)

0

Nearly abnormal

4

MT4 (age, date of birth, place, current year)

No mistakes

0

1 mistake

1

2 or more mistakes

2

ATTENTION (ask for months of the year backwards)

Achieves 7 or more correctly

0

Starts but scores less than 7/Refuses to start

1

Unstable

2

ACUTE CHANGE OR FLUCTUATION (significant change incl. evidence of psychotic symptoms)

No

0

Yes

4

Total score (score of 4 or more indicates likely delirium – initiate TIME Bundle)

FALLS TRIGGER TOOL

65 years or over?

YES / NO

Tries to walk alone and is unsteady?

YES / NO

2 or more falls in the last 6 months?

YES / NO

Patient/relatives anxious about falls

YES / NO

Fall since admission to department?

YES / NO

4AT more than 4/evidence of confusion

YES / NO

Admitted to department with fall?

YES / NO

COMPLETED BY

If you have answered yes to 2 or more questions,

• For patients being admitted please document recommendation that a full care bundle is required to be completed.

• For patients being discharged please refer to Fastrack:

YES / DECLINED

ENTRANCE COPY

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.

Near Patient Testing Results		
TroponinInitials.....	Blood Gases	Fast
Time of Trop	Arterial/venous (circle)	Free fluid identified:
	Time taken	Yes/No (circle)
D-dimer	FiO2	
	pH	AAA
Urine dipstick	pCO2	Aorta clearly seen
Leucs	PO2	Yes/No (circle)
Nitrite	BE	Measured diameter.....
Protein	Lactate	
Blood		Protetanus
Ketones	Urine Pregnancy Test	Immune/Not immune (circle)
Glucose	HCG positive/negative (circle)	

Yes / No

Patient/Legal Guardian Permission to release info for legal purpose including Police		Yes / No
Patient Signature..... Print Name..... Date.....		

Date: 01/08/2018

Time: 0105am

Named Nurse: Kirsten

Triage Nurse:

CHI: 2602800570

26/02/1980

DOWELL

SCOTT

11 DON STREET,

STIRLINGSHIRE

FK3 8HD

COPY

Patients preferred name:

S Situation: Presenting Complaint:

History of presenting complaint

Abscess to back - lump upper back last few days. Started flucloxacillin 500mg QDS yesterday. Pain/swelling

B Background: Relevant medical history, social circumstances etc.

Barrett's oesophagus

Allergies: Nil

Ankylosing Spondylitis

Recent THR

Relative/ Carer informed? ☒ YES ☐ NO

PRESENT? ☒ YES ☐ NO

Patient's details and NOK checked ☐

A Assessment: investigations and treatments undertaken in ED.

☒ A V P U

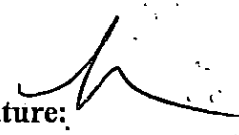
PAIN: 1/3

NEWS 1

GCS 15

Mobility: Yes

Name Band ☒

Signature: 

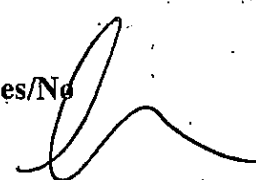
R Directions for admission ward staff, including outstanding treatments.

Impression: Abscess on back

Plan: Refu / Admit SAU

Recommendation Full Care Bundle required Yes/No

NEWS: 1

Signature: 

PATIENT LABEL
COPY

**PATIENT LABEL
COPY**

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There is no text or other markings on the paper.

CONSENT FORM

NHS

Forth Valley

Agreement to Operation, Investigation or Treatment

COPY

Notes of Guidance for Doctor/Dentist/Healthcare Practitioner

The doctor/dentist/healthcare practitioner must:

- ◆ Be suitably qualified and experienced to explain the procedure to be performed - this should ideally be the operator or consultant.
- ◆ Give the patient sufficient information, in a way he/she can understand, about the proposed procedure, any important risks and the possible alternatives (including no treatment). In broad terms, a significant risk is one which is serious, but uncommon, or one which occurs frequently, even if it is not serious.
- ◆ Give the patient sufficient time to read the form and ask any questions relating to it or their treatment. The patient must be allowed to decide whether he/she will agree to the procedure and they may refuse or withdraw consent at any time.
- ◆ In addition to seeking consent for the procedure, seek written consent from the patient for examination by students.

Children under the age of 16 can give their own consent if the Medical Practitioner attending the child considers the child capable of understanding the nature and possible consequences of the procedure or treatment. If the child is judged capable, the practitioner must seek the consent of the child rather than the parent. This does not mean that the parents must always be excluded from the discussions. Unless there are issues concerning confidentiality, it would be reasonable to involve parents in helping a child to reach a decision. If a child under 16 years of age is giving his/her own consent, the relevant section overleaf, must also be signed.

Writing on the consent form must be legible, unambiguous and contain no abbreviations.

Any alterations to this form must be countersigned by the patient/parent/guardian and the member of the healthcare team taking consent. If the procedure or the information about surgical marking is wrong the form must be re-written.

Surgical Site Marking

- ◆ The site should be marked and documented by the operating surgeon, or nominated deputy, who will be present in the operating theatre at the time of the patient's procedure. If site marking is not applicable, this should be recorded and signed by the person taking consent.
- ◆ The intended site should be ascertained from reliable documentation and/or images.
- ◆ Marking should take place before pre-medication/administration of any sedative.
- ◆ The intended surgical site should, ideally, be marked on the ward or day care area, prior to the patient transfer to the operating theatre.
- ◆ An indelible marker pen should be used.
- ◆ The mark should be an arrow that extends to, or near, the incision site and remains visible after the application of skin preparation.
- ◆ Where possible the mark should remain visible after the application of theatre drapes.
- ◆ Surgical operations involving side (laterality), should be marked at, or near, the intended incision. For digits on the hand or foot, the mark should extend to the correct specific digit.
- ◆ The process of pre-operative marking of the intended site must involve the patient/parent/guardian wherever possible.

NB. There will be circumstances where marking may not be appropriate i.e. Teeth or Mucous Membranes. Emergency surgery should not be delayed due to lack of pre-operative marking.

PATIENT DETAIL (OR PRE-PRINTED LABEL)

Patient's surname/family name:

Patient's first name(s):

Date of birth: --

CHI number (or other identifier):

Special requirements (e.g. other language/other communication method):



CHI: 2602800570

26/02/1980

DOWELL Scott

11 DON STREET,

GRANGEMOUTH,

STIRLINGSHIRE FK3 8HD

M

COPY

STATEMENT FOR DOCTOR/DENTIST/HEALTHCARE PRACTITIONER

(to be completed by a practitioner with appropriate knowledge of proposed procedure. See Notes for Guidance)

Describe proposed operation, investigation or treatment. Where appropriate specify the site or side:

Incision and drainage of abscess on
Back

Risks: Bleeding, infection, Pain

I have explained the procedure named on this form to the: (please tick) patient ☐

parent ☐ guardian ☐ Other (please specify)

in terms which, in my judgment, are suited to their understanding. In particular I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure e.g. blood transfusion.

[If you have provided any information leaflet/tape, please tick box ☐ and specify title and version]

Signature of Doctor/Dentist/Healthcare Practitioner:

Name (PRINT):

Date: --

STATEMENT OF INTERPRETER (where appropriate)

I have interpreted the information on this form to the patient/parent/guardian to the best of my ability and in a way in which I believe he/she can understand.

Signature: Date: --

Name (PRINT):

SURGICAL SITE MARKING

Site marking not applicable

Correct Patient and Surgical Site verified and marked by:

Signature: Date: --

Name (PRINT): Title:

STATEMENT TO BE COMPLETED BY THE PATIENT, PARENT OR GUARDIAN

You should read this form and the notes below and overleaf carefully. If there is anything you do not understand, ask the doctor, Dentist or Healthcare Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

COPY

I am (Please tick) Patient ☒ Parent ☐ Guardian ☐

I understand:

Yes No

- the procedure, important risks and appropriate alternatives which have been explained to me by the Doctor/Dentist/Healthcare Practitioner named on this form. ☒ ☐
- that the procedure might be carried out by a Doctor/Dentist/Healthcare Practitioner other than the Doctor/Dentist/Healthcare Practitioner who has been treating me/the patient so far. ☒ ☐
- that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to my/the patient's medical treatment, to safeguard or promote my/the patient's physical or mental health. ☒ ☐

I have been told about additional procedures which may become necessary during my/the patient's treatment. I have listed below any procedures which I do not wish to be carried out without further discussion.

I agree:

- to the administration of an anaesthetic or sedation if required.
- to the procedure named on this form.
- that an examination for the purposes of teaching will not be undertaken without my consent.
- that any photographs, video/audio recordings and/or surgical images kept in the records may be used anonymously for research approved by an ethics committee, education and audit to improve the quality of patient care.

If you object to surgical images being used in this way then please tick box ☐

Signature of Patient/Parent/Guardian/Other:

[Signature]

Name (PRINT):

Date: dd mm yy
01 08 18

Relationship to child:

Only to be completed by the Medical Practitioner where the form is to be signed by a child under 16 years.

I am of the opinion that the patient is capable of understanding the nature and possible consequences of the proposed treatment/procedure.

Name (PRINT): Signature:

EXAMINATION FOR THE PURPOSES OF TEACHING

(Please tick) I agree ☐ I do not agree ☐ to an examination by a student during the procedure named on this form under the supervision of the senior doctor undertaking the procedure.

COPY

Signature:

Name (PRINT):

Date:

dd mm yy
□□-□□-□□

CONFIRMATION OF CONSENT

(to be completed when patient is admitted for the procedure)

I confirm that I have no further questions and wish the procedure to go ahead.

Patient ☐ Parent ☐ Guardian ☐ Other ☐ (please specify)

dd mm yy
Date □□-□□-□□

Signature of Doctor/Dentist/Healthcare Practitioner:

Signature of Patient:

Notes of Guidance for Patients

The Doctor/Dentist/Healthcare Practitioner is here to help you. He or she will explain the procedure. You are entitled to refuse or withdraw consent at any time. You can ask any questions and ask for more information if you wish.

You may ask for a relative, friend or nurse to be present while the Doctor/Dentist/Healthcare Practitioner explains the procedure and asks you to sign the form.

If an anaesthetic or sedation is to be administered by an anaesthetist, it will be his or her responsibility to discuss details with you before the procedure takes place.

Students need to learn how to examine patients and to see how procedures are done. This is important for the future of the Health Service. You may be asked to give consent to be examined by students during the procedure. It is up to you to decide whether to give your consent or not but, whatever you decide, it will not affect your treatment.

NOTES

Forth Valley Royal Hospital

Patient Details

CHI Number 2602800570

Hospital Number

Patient Name DOWELL SCOTT

Date of Birth 26/02/1980

Sex M

Category Type

Patient Type

Operation Type

Date of Operation 01/08/2018

FVRH 11 - FVRH 11

Session 1

Anaes. Confirmed By

Anaesthetic Type GA

COPY
IN PATIENT

URGENT - NCEPOD 2B

Anaes. Pause

Date Performed 01/08/2018 09:31
Performed By ELAINE KERRIGAN

Surgical Pause

Date Performed 01/08/2018 09:44
Performed By SN LYNNE SWAN

Sign Out Pause

Date Performed 01/08/2018 09:52
Performed By SN LYNNE SWAN

Staff In Attendance - Team 1

SURGEON	DR Helen EWAN
ANAESTHETIST	DR ANDREW LONGMATE
O.D.P.	ELAINE KERRIGAN
FLOOR NURSE 1	SN LYNNE SWAN
FLOOR NURSE 2	JANICE GRAHAM
OTHER STAFF	MAUREEN MACLAREN
RECOVERY STAFF 1	SN Karen GRAHAM

Procedures

GS47600 INCISION AND DRAINAGE OF ABSCESS - SITE NOT RELEVANT

Description : INDICATION - ABSCESS ON BACK.

PROCEDURE

GA. RIGHT LATERAL. VERTICAL INCISION OVER ABSCESS
CAVITY DEBRIDED. WASHED OUT 0.9% NACL.
PACKED 1X AQUACEL RIBBON.
BLUE SWABS AND MEFIX TAPE

POST-OP:

HOME TODAY
NO SURGICAL FOLLOW UP
DAILY DRESSINGS DISTRICT NURSE

Performed By : DR Helen EWAN

Confirmed By : HEWAN

Alternate Codes: S476

Definitions : BACK

Patient Details

CHI Number 2602800570

Hospital Number

Patient Name DOWELL SCOTT

Date of Birth 26/02/1980

Sex M

Category Type

Patient Type

Operation Type

Date of Operation 01/08/2018

FVRH 11 - FVRH 11

Session 1

Anaes. Confirmed By

Anaesthetic Type GA



Operation

Op Notes

Recovery Staff In Attendance

SN Karen GRAHAM

Materials Used

Item Code 1059154 Item Description MINOR PROCEDURE TRAY

LOT1 1059154

LOT2

LOT3

LOT4

Qty 1 Unit Cost 0.00 Total cost 0.00

1057949 BETWEEN PATIENT CLEAN THEATRE 11

LOT1 1057949

LOT2

LOT3

LOT4

Qty 1 Unit Cost 0.00 Total cost 0.00

1051575 F RECOVERY BTWN PATIENT CLEAN

LOT1 1051575

LOT2

LOT3

LOT4

Qty 1 Unit Cost 0.00 Total cost 0.00

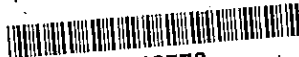
*****End of Report*****

Please tick appropriate box.

CLINICAL NOTES ☐

NURSING NOTES ☐

PROGRESS NOTES ☐



CHI: 2602800570

26/02/1980

DOWELL Scott
11 DON STREET,
GRANGEMOUTH,
STIRLINGSHIRE

FK3 8HD

ach Label

ospital No.

COPY

Consultant

Ms Cunnings

Ward / Dept.

Date and Time

18/8/18
1145

Returned follow up (1-1) of
back abscess
Hip replacement 1/02 ago.

Right & left - abs stable
apynxial.

No seepage to dressing.

Keen to eat - given tea &
sandwich.

wife called will be coming to
collect husband ASAP as prone
to infections due to immunity.
Miles Mikes

12-15

Up to pass urine ✓
Family in attendance - own
anastomosis at home.

Contacted theatre about 3/7
course of antibiotics, to stop
today.

wife will arrange with GP for
DIN to attend as they live
in different area from practice
& GP sorts this all. Asked to
call if any problems.

1230

Rev of advice - letters + dressings

RX1561

NHS Forth Valley Peri-Operative Careplan

CHI: 2602800570
26/02/1980
DOWELL Scott
11 DON STREET,
GRANGEMOUTH,
STIRLINGSHIRE FK3 8HD

Procedure: Incision & Drainage of Back Abscess
Surgeon: MScannings
Consultant: Mrs CANNINGS
Theatre No: 1
Ward: SAT
Elective/Emerg: Emerg
Date: 11/8/18
Team Leader: L SWAN

COPY

Procedure Start: 09.47
Exit Theatre Time: 09.55
Blood Loss: =
Urine Output: =

Position: Left Lateral
Positioned by: Self on trolley
Visual check of all pressure areas pre-op, by: Time:
Sacrum [] Buttocks [] Heels [] Trochanter [] Shoulders [] Head []
Area of concern & action taken if red/vulnerable: No concerns

Lotions -
Chlorohexidine Alcoholic 2% [] Aqueous Chlorohexidine 0.02% [] Sodium Chloride 0.9% []
Iodine 10% [] Antiseptic Iodine 10% [] Other - Please State

Diathermy Pad [X] Position Site Check [] By
Mechanical DVT Prophylaxis [X]
Tourniquet [X] Applied by Time Settings
Fluid Warmer [X] Patient warming [X] Blankets
Visual check of all pressure areas post-operatively by: Time:
Sacrum [] Buttocks [] Heels [] Trochanter [] Shoulders [] Head []
Area of concern & action taken if red/vulnerable: No concerns

	Type	Size	Position	Number
Drains				
Catheters/Stents				
Packs				

Catheterised by Balloon volume: mls Instillage Yes/No Amount: mls

NG Tube Yes / No
Skin Closure: Yes
Dressings: Aquacel Blue Swabs

Follow up Instructions:
Sutures Out Seen before home Yes/No
Dressing Change Return to Clinic Yes/No
Specimens taken Yes/No

Nursing Comments, eg. Eye drops/LA wound infiltration:

MINOR PROCEDURE TRAY
ID: 105915400199
UC ST01334
STERILE
2019-07-25 2019-07-25

1st Count Scrub Practitioner
Final Count Scrub Practitioner No Scrub
Tray Closure Scrub Practitioner
1st Count Circ Person M MacLaren
Final Count Circ Person L Swan
Tray Closure Circ Person L Swan / D Graham

Date 1-8-18	Ward SAU	Surname	CHI: 2602800570	COPY
Procedure and side Incision and Drainage of abscess on back		First name	26/02/1980	
Surgeon		Unit No. /	DOWELL Scott 11 DON STREET, GRANGEMOUTH, STIRLINGSHIRE FK3 8HD	
		Date of Birth		

CHECKLIST ITEMS	WARD	HANDOVER CHECKS	BASELINE WARD CHECKS & DATA
Verbal Name Check	Yes	Yes	Pre-assessment Document
ID Band Checked	Yes	Yes	Present and Checked ☒
Pre-assess/clerking completed	Yes	Yes	Any Changes?
Pregnant Yes / (No) LMP date	N/A	NO	
Allergies (see baseline checks Yes / (No))	None	No	
Consent / Incapacity completed	Yes	Yes	Temp 36.7 Weight (kg)
Operation confirmed with patient	Yes	Yes	P 108 BP
Consent form corresponds to list	Yes	Yes	RR 19 SpO2 97
Operation site marked clearly	Yes	Yes	BM (Sugar) Height
Nursing notes	Yes	Yes	Allergies
Case Notes	Yes	Yes	☒ No ☐ Yes
Drug Kardex	Hepma	Hepma	Specify reaction
XMatch / G&S confirmed, date & initial	No	N/A	
Confirm all results available	Yes	Yes	
Addressograph labels	Yes	Yes	
Bone bank consent	N/A	N/A	
Fasted for solids / milk from (time)	7pm	3/7 7pm	MRSA +ve / -ve
Fasted for clear fluids from (time)	7pm	3/7 7pm	
Bladder emptied (time or No)	Yes	Yes	
Jewellery removed	Ring covered please	taped	Hb Na
Body piercings taped etc	No	None	WCC K
Nail varnish / makeup removed	No	None	Platelet U
Intact lenses removed	No	No	Clotting Cr
Prosthesis (* or (No))	No	No	G and S X-Match
Orthopaedic implants (* or No) Hip replacement 2 weeks ago	No	No	Dental
Pacemaker (Yes or (No))	No	No	Crowns / Caps ☒
Hearing aid (Yes or (No))	No	No	Denture ☒ TOP
Able to move by self on trolley	Yes	ASSIST	Plate ☒
Diabetic Yes / (No)	No	No	Loose ☒
On Beta Blocker Yes / (No)	on Rivoroxen		Patient Valuables
If "YES" Taken Yes / No	tec time yesterday		Dentures Full ☒ Partial ☒ TOP
If not taken: Administered by Nursing Staff YES / NO			Glasses ☒ None ☒
Ward sign and designation Im			Hearing Aid ☒
Handover 1 sign and designation UN			Dressing Gown ☒
Handover 2 sign and designation FK			Slippers ☒
Comments* Left knee replaced HUP & wrist metal work			Other Trainers / PAIR C RUTCHIE
			Sign Bag

PRE-OP TEMP **36.3**
<36 or>37.5 Action :-

RECOVERY CHART

Airway	G G G	SM SM SM	SM SM SM	SM SM SM	SM SM SM
O ₂ l/min	5L 5L 5L	5L 5L 5L	5L 5L 5L	5L 5L 5L	5L 5L 5L
SpO ₂	98 98 100	100 100 100	100 100 100	99 100 100	100
Resp Rate	16 16 16	14 14 14	16 14 14	14 14 14	14
Temp	36.6	36.8	36.8	36.8	36.8
BM				nla	nla
TIME	09 10 10	10 10 10	10 10 10	11 11 11	11 11 11

Recovery Practitioner

Analgesia

IV Morphine up to 10mg

IV Fentanyl up to 100mcg

Refer to Kardex

COPY

1025 30mg IV Fentanyl given ec/KG
1032 20mg IV Fentanyl ec/KG
1042 20mg IV Fentanyl ec/KG

150

100

50

A line ☐

Site:-

CVP ☐ 0

Sedation Score	3-2	2	2/5	2	2	0	0	0	0
Pain Score	x x x	0	0	0	0	2	2	2	0
Nausea Score	x x x	0	0	0	0	0	0	0	0
Wound Site	0	0	0	0	0	0	0	0	0
Drains									
VI / Pump									
Spinal / Epidural									
C / S / M									
Urinary Catheter									
Pressure Areas									

Drink of water ☐

Given ☒

Anti-emetic

Cyclizine 50mg IV ☐

Granisetron 1mg IV ☒

Prochlorperazine 12.5mg IM ☐

Oxygen - in recovery follow protocol

SpO₂ range 94-98 %

Duration

Investigations - in recovery

Anaesthetist

Signed

Name

Discharge to (ward) DSU

Criteria Met ☒ Time 1105

Signed H. Gasser Recovery

Signed Ward

only emergency notes

Nursing notes ☐ Op notes ☐

Case notes ☐ Valuables ☐

EWS ☐ Ward Kardex ☐ DSU Kardex ☐

Not on HEPMA

1015. Wound site dry intact. patient denies any pain at present. sleeping undisturbed in recovery. states pain on

1025. pain in back + hip. states adured can help pain in back, but has not taken meds for his hip

1030. pain 7/10.

Pt has analgesia at home.

Post-operative instructions

To be discussed with surgeon at end of procedure

Medication prescribed on Kardex

- 1 ☐ Essential medication) or 1 ☐ Medicine reconciliation required on ward
2 ☐ Regular analgesia)
3 ☐ Breakthrough analgesia)
4 ☐ Anti-emetic)
5 ☐ Oxygen)
6 ☐ PCA device)
7 ☐ Epidural - continuous infusion)
8 ☐ PCEA)
9 ☐ Intrathecal opiates)
10 ☐ Other, please specify.....

OR

- ☐ DSU Kardex completed
☐ Critical Care Plan

COPY

*needs
med rec*

Diet

For all a minimum of one option must be completed

- ☒ Oral (Circle): sips / free clear fluid / soft / light / full diet
☐ Nil by Mouth (NBM)
If NBM: ☐ Oral diet to start.....(time) or after medical review ☐

Fluid Therapy

- ☒ Oral Fluids only
☐ IV Fluids only
☐ Fluids prescribed until at least 09.00hrs next day
☐ IV Fluids until adequate oral intake established
☐ Fluids prescribed to cover this anticipated period

Blood Sugar Control

- ☒ N/A
☐ Achieve target BM.....mmol/l with:
☐ Allow patient to titrate normal insulin / Restart oral hypoglycaemics (delete)
☐ GKI Infusion - **prescribed**
☐ Insulin Sliding Scale - **prescribed**

Antibiotic Cover

- ☐ N/A
☐doses post op
☐ Continue
☐ Prescribed
☐ Prescribed

EWS Score ≤

Acceptable forhrs due to Anaesthesia/Sedation as per exclusion criteria.

Signed.....

DVT Prophylaxis

- ☐ None
☐ TEDS
☐ Enoxaparin
☒ Rivaroxaban
☐ Other, please state

IV cannula / Removal record

IV cannula (1)

Inserted by: _____
Size: _____
Site: _____
Batch no.: _____
Removed by: _____
Date: _____

IV cannula (2)

Inserted by: _____
Size: _____
Site: _____
Batch no.: _____
Removed by: _____
Date: _____

Special Instructions - Please document below (Eg. drains, positioning, post op investigations, imaging etc)

- ☐ None

Sign: _____
Anaesthetist

Ward Staff please also review the theatre operation note
for any surgeon specific follow-up instructions

ANAESTHETIC ASSESSMENT Date

Age

ASA

NCEPOD EI ☐

Urg ☐

Em ☐

PRE-OPERATIVE INSTRUCTIONS

☐ Free clear fluid until

PRE-MEDICATION

Prescribed by:

No NOTES

Given by:

CO-MORBIDITIES

DRUGS

(38)

- ANK SPOND

- TH2 3 weeks ago ? N

- Barrett Oesophagus

- Jumping / restless legs

rapid

Flucloxacillin

Hydrocortisone
paracetamol

Rivaroxaban

Paracetamol

Morphine

NSAIDS

Allergies
Previous GA
Problems?
FH GA problems
Reflux/full stomach
Airway difficulty

☒	No	☐	Yes
☐	No	☒	Yes
☐	No	☐	Yes
☐	No	☐	Yes
☐	No	☒	Yes
☐	No	☒	Yes

controlled

Fasted today

Teeth

+

Verbal consent and explanation

☒

Explained:

☒ GA

☐ RA

☒ Risks

☐ Day Care

Signed / Name

[Signature]

COPY

Vascular Access

cvp ☐artline ☐

22 COPY

[illegible]

mi

Patient Information

SCOTT DOWELL

Age/Gender: 39 years 7 months 29 days Old Male

Address: 11 DON STREET GRANGEMOUTH, FK3 8HD

DOB: 26/05/1980

CHI:

Ethnicity:

Date: 24/01/2020

Incident Number: CR006225060

Incident Type: EMG

Incident Location: 11 DON STREET
GRANGEMOUTH, FK3
8HD**COPY**

Presenting Complaint

GENERALLY UNWELL

Additional Comments

AS1 CALL TO 38 YOM WHO WAS DISCHARGED FROM SAU AT 6 AM THIS. SAU SAID HE HAD GASTRITIS AND FELT OK AROUND 12 MID DAY PT WENT FOR A SLEEP ON SOFA. PT HAS BEEN VETY SLEEP ALL DAY. OA PT WAS SITTING ON SOFA WITH EYES CLOSED. BPT WAS ALERT, ORIENTATED GCS 14. PT WAS ABLE TO SPEAK TO CREW. OE PT TEMP WAS 37.8 AND ALL OTHER OBS AS RECORDED. PT HAD NO HEADACHE, DOUBLE VISION OR DIZZINESS. PT WIFE GAVE HIM 1G PARACETAMOL AT 4PM AND 1G AT 6PM PT TAKEN TO FVRH FOR FURTHER INVESTIGATION.

PATIENT ASSESSMENT

AVPU	Alert	<C>	No
A	Clear		
B	Breathing Adequately	Yes	Respiratory Rate 16
	Oxygen Given	No	SPO2 97
C	Pulse Rate	BP	Cap Refill
	110	111/78	<=2 Secs
	Rhythm	Arm	Central/Peripheral
	Reg	Right	Peripheral
D	GCS	Eyes	Voice
	15	Spontaneously (4)	Orientated (5)
			Motor
			Obeys Commands (6)
E			PEARL
			Yes

Observations

Time	P	RR	BP	SpO2	CR	GCS	AVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
19:13	112	16	117/78	96	<=2s	15	Alert								E0019798
19:00	110	16	111/78	97	<=2 Secs	15	Alert		37.8	6.1		5	5		E0019798

NEWS

Time	Clinical Risk	NEWS
19:13	LOW Immediate Clinical Risk. Treat as per Clinical Practice Guidelines including considering the use of alternative pathways (if appropriate and available).	2
19:00	POTENTIAL Clinical Risk. Patient is likely to require conveyance to hospital.	1

HISTORY

AMPLE

Allergies	None
Medication	Ranitidine, Omeprazole, Ropinirole, Co codamol
Past Medical History	SPONDYLITIS, BARRATTS, LEFT HIP
Events Prior	PT HAD A HIGH TEMP AND VERY SLEEPY

Social History

Lives alone	No	Living With	WIFE	Patient Occupation	Does Not Work,
Patients General Appearance	Normal,				
Patient Mobility	CRUTCHES SOMETIMES				

1/24/2020

Incident Number: CR036225060

Patient Communication	No Help Required,
Patient Clinical Risk Factors	Smoker,
Patient Environmental Risk Factors	None Identified,

COPY**CLOSE RECORD**

Treatment On Scene	Non Emergency
--------------------	---------------

Conveyance

Transport To Hospital	Normal driving	Pre Alert	No	Patient Accompanied By WIFE
-----------------------	----------------	-----------	----	-----------------------------

INCIDENT LOG

Time Call Received	18:37	Allocated	18:42	Mobile	18:42
--------------------	-------	-----------	-------	--------	-------

First Resource On Scene		Crew On Scene	18:56	Crew Left Scene	19:10
-------------------------	--	---------------	-------	-----------------	-------

Crew At Hosp		Receiving Hospital	FORTH VALLEY ROYAL HOSPITAL	Clear Time	
--------------	--	--------------------	-----------------------------	------------	--

Crew ID

Crew Grade

Driver

E9887361

Student Technician Level 4

YES

E0019798

Paramedic

NO

NHSFV OOH Service

Home Visit Contact Sheet

COPY

2602800570

Case No 94919

Case Active 23/01/2020 22:52

Case Type Attend

Patient Scott Dowell

D.O.B 26/02/1980

Age 40 years

CHI No: 2602800570

Sex Male

Ethnicity White British

Current Address

11 Don Street Grangemouth

Home Address (if currently not at home)

FK3 8HD

Telephone No: 01324 262719

Directions Main Door

Case Origin NHS24

Callers Name Diane

Callers Tel:

Own Doctor Dundas, Derek

Surgery Westburn Medical Practice

Reported Condition

NHS24 Triage Start 22:53

NHS24 Triage End 23:10

WORSENING STOMACH PAIN - 2HRS

NHS24 Recorded Allergies

NHS24 Recorded Medications

NHS24 Recorded Medical History

NHS24 Clinical Summary

Clinical summary created by: Louise Cooper (Call Taker Si) () [23/01/2020 23:10:04]

Reason for call: WORSENING STOMACH PAIN - 2HRS

HAD THE PAIN ALL DAY, WORSE TONIGHT. FEELS LIKE SOMEONE IS WINDING HIM. HAS ANKYLOSING SPONDYLITIS AND BARRATT'S DISEASE. ON BIOLOGICAL INJECTION (SYMPHONY) IMMUNOSUPPRESSED

Confirmed Symptom(s):

Chest pain

Constricting band in chest

Feeling nauseated or vomiting

23:01:2020 22:54:35 COOPERL.. 2 EPISODE OF VOMITING... WORSENING STOMACH PAIN 2HRS - HAD THE PAIN ALL DAY, WORSE TONIGHT. COMING FROM TOP OF STOMACH AND UNDER BREAST BONE AREA. 2 EPISODES OF VOMITING WITH BLOOD, PT IS PRONE TO VOMITING. FEELS LIKE SOMEONE IS WINDING HIM... HAS ANKYLOSING SPONDYLITIS AND BARRATT'S DISEASE. IS IMMUNOSUPPRESSED. DW SCN C MURRAY, ADVISED PCEC 4HRS, HUB TO ARRANGE PLEASE - WORSENING GIVEN..

Outcome: PCEC within 4 Hrs

NHS24 Disposition

Contact GP Practice within 4 Hours (ASAP)

NHS 24 nurse notes

NHS 24 nurse comments

Special Patient Notes

KIS Record

Record Date

Upload Decision

Patient Consent No -

Patient Aware No

Emergenc/Additional Contact None

Medical History

Special Note

[illegible]

COPY

S I T U A T I O N	S	Upper abdo for Ultrasound x2 2/7 hrs	 CHI NO: 2602800570 GRN: Scott DOWELL 11 DON STREET GRANGEMOUTH FK3 8HD 26/02/1980 M
B A C K G R O U N D	B PMH	Darethy Cesarean (4) Hip replacement Allkasing granulitis	
A S S E S S M E N T	A Likely Diagnosis, clinical findings	? Gastritis ? pancreatitis	
R E C O M M E N D A T I O N	R Management Plan, Procedures, Interventions, Treatments	IVFD IVBSID Analgesia D PPI D Fluid balance AUSS D ? MRCP	Gent at 03 ⁰⁰

Staff Nurse: Oliver

Date/time: 25/1/20

Forth Valley Royal Hospital Assessment Document



Date of arrival **24/1/20** Time of Arrival **0140**

Source of referral: **GP** Ed Other

GP practice:

CHI NO: 2602800570 26/02/1988
CRN: Scott DOWELL M
11 DON STREET

COPY

GRANGEMOUTH
FK3 8HD

Consent for ECG

Yes

No

BM

NEWS score

0

Tel

NOK 1 Name **Diane**

Relationship **Wife**

Address

Tel **01324 262719**

NOK 2

Presenting complaint

Upper abdo pain.

Background

**Started on yesterday afternoon.
Vomited x2.**

NEWS 5 or more or other clinical concern	Yes	No	✓
T° 38°C or more within 14 days of chemotherapy (possible neutropenic sepsis)	Yes	No	✓
Referred with potassium more than 6.4mmol/L or less than 2.9mmol/L	Yes	No	✓
Referred with diabetic ketoacidosis	Yes	No	✓
Reduced GCS	Yes	No	✓
New limb weakness, speech disturbance or numbness for less than 4.5 hours	Yes	No	✓
Abdominal pain: Does referral or patient give history of aortic aneurysm?	Yes	No	✓
Abdominal symptom in female under 55 with possibility of pregnancy	Yes	No	✓
NEWS 2-4	Yes	No	✓
New oxygen requirement (not on home oxygen)	Yes	No	✓
Ongoing chest pain - Obtain ECG, Clinician to review / sign within 10 minutes	Yes	No	✓
New limb weakness, speech disturbance or numbness for 4.5 hours or longer	Yes	No	✓
Requires assistance of 1 or more to mobilise	Yes	No	✓
Able to mobilise independently or using own aids / appliances	Yes	No	✓

R Very Urgent Urgent Non-urgent Ambulant ✓

Actions

U&E/LFT/CRP/FBC/Glucose ✓

Cultures

Amylase ✓

Calcium

Group and save

Cannula ✓

ECG - to be signed within 10 mins

Troponin 0 hours / 12 hours

Additional triage comments

Allergies and alerts

None known.

Name

HM Morrison

Signature

HM Morrison

Date

24/1/20

Time

0150

Preliminary Nursing Assessment

Patient Details

Belongings

With family

✓

With patient

✓

In safe

Bagged

COPY

Own medication

Yes

No

Name band

Yes

No

Patient fasted

Yes

No

Food time 18⁰⁰

Drink time 01⁰⁰

Relatives with patient

Yes

Wife

No

Informed

Preliminary Pressure Ulcer Risk Assessment (PPURA)

Mobility: Patient is fully mobile without equipment/ assistance (Y/N)

Continence: Person is fully continent (Y/N)

Nutrition: Person appears well nourished and able to eat and drink (Y/N)

Record answer in grid below Y=Yes N=No

If answer is NO to any assessments, complete Braden within 6 hours

Remember

- People who are overweight may not be well nourished
- Please sign after each check

Date	Time	Mobility	Continence	Nutrition	Skin inspected	Braden complete?	Signature/ PRINT
24/11	01 ⁵⁰	Ind.	Y	Y	Pt. states intact		W. H. M.

Comments if required:

Preliminary falls assessment: if Yes to any, complete falls bundle within 4 hours if being admitted

≥2 falls in last 6 months?	Yes	No	✓
Patient/ Carer/ Referrer anxious about falls?	Yes	No	✓
Tries to walk alone but unsteady/ unsafe?	Yes	No	✓

Additional nursing comments

Name

Signature

Date

Time complete

Bundle stickers

Patient details

COPY

Assessment

Practitioners Name NADIA GUNAR

Date 24/1/2020

Grade SP8

Time commenced 2:44

GMC/ NMC 7593872

Location SAU

CHI NO: 2602800570 26/02/1980
CRN: M
Scott DOWELL
11 DON STREET
COPY
GRANGEMOUTH
FK3 8HD

Presenting Complaint:

1 day history of sudden onset acute upper abdominal pain. Some episodes of vomiting containing blood streaks.

The patient is known for Barrett's oesophagus and ankylosing spondylitis. Report of severe upper abdominal pain that feels like a band around his upper abdomen, and going through and through to the back.

Systemic Enquiry:

Denies any bowel symptoms. Had some episodes of vomiting with a few blood streaks but as per the patient this is normal for him in the setting of known Barrett's disease.

Height: 5'9

Weight: 14

BMI:

Usual level of activity (please circle)

Bedbound Dependent for personal care Requires minimal assistance with ADLs Slowed. Assistance with heavier household tasks "Slowed-up" but not requiring assistance No exercise beyond walking. Occasional exercise Regular exercise

Past medical, surgical and anaesthetic history

MI	X
Angina	X
Hypertension	X
COPD	X
Stroke /TIA	X
Diabetes	X
Implement diabetes bundle	

Hip replacement left
Barrett's disease
Ankylosing spondylitis

Family History

Travel History

Social History

Smoking: Never Ex smoker (since _____)

Current 20 /day Pack years _____

Alcohol: _____ Units / week

Occupation

Driving licence yes / no

Lives With Wife

Support/ Carers

Examination

Diabetic patients → foot examination and diabetes bundle
 GI Bleeding → PR examination
 Age > 65 or confusion → AMT
 If cognition or alertness impaired → consider delirium

CHI NO: 2602800570
 CRN:
 Scott DOWELL
 11 DON STREET
 GRANGEMOUTH
 FK3 8HD

26/02/1980
 M

COPY

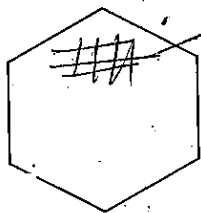
Cardiovascular

NAD

Respiratory

NAD

Abdominal



*Very tight/guarded
 distended
 abdomen,
 tenderness could
 not be elicited*

Bowel sounds:

PR:

*but patient complains
 of pain all over especially epigastrium*

AMT (if <4/4, complete AMT10)

1. Age
2. DOB
3. Year
4. Location

/4

Ask patient to remember address: "42 West Street"

5. Time to nearest hour
6. Current monarch
7. Date Of WW2
8. Count 20 → 1
9. Identify 2 people
10. Recall address

/10

Neurological (remember speech, visual assessment, balance, gait)

Cranial nerves:

	R arm			L arm			R leg			L leg		
Tone												
Power												
Sensation												
Coordination												
Reflexes	B	T	S	B	T	S	K	A	Plantar	K	A	Plantar

Other

Interpretation of results

CHI NO: 2602800570
 CRN:
 Scott DOWELL
 11 DON STREET

26/02/1980
 M

GRANGEMOUTH
 FK3 8HD

ECC

Urin

Urin

Let
 Nit
 Gl
 Kei

Blood
 Protein

Not En
 Not En

GLU Negative
 *BIL 2+
 KET Negative
 SG > 1.030
 BLD Negative
 PH 5.5
 *PPG Trace
 UO Negative
 Nit Negative
 LEU Negative

High SG may cause
 falsely lowered LEU
 results

ments

Differential diagnosis

?? Gastritis
?? Perforated Viscus

CHI NO: 2602800570 26/02/1980
CRN: M
Scott DOWELL
11 DON STREET

GRANGEMOUTH
FK3 8HD

COPY

Management plan

Admit
Analgesia, Antiemetics.
I/v PPIs
ECG, Chest & abdo Xray
Troponins.

Chest & abdo Xray & ECG
unremarkable.
Bloods also NAD.
patient refused I/v medication
refused morphine
and is insisting on going
home.
I have told him that there
is no obvious abnormality
on his investigations but
I can't give him a definite
diagnosis without his co-operation
agreed to take oral meds instead

Additional investigations required (e.g. cultures) Please initial and date when sent

	Initial/ Date		Initial/ Date
	Initial/ Date		Initial/ Date

Venous thromboembolism (VTE) risk assessment

Medical patient expected to be mobilising as normal within 2 days

Proceed to VTE risk actions

Medical patient with reduced mobility for ≥ 2 days OR Surgical patient

Assess thrombosis and bleeding risk factors

Thrombosis risk factors. ANY thrombosis risk factor(s) should prompt VTE prophylaxis measures unless contraindicated → Assess bleeding risk.

Bleeding risk factors. Consider whether sufficient to preclude pharmacological prophylaxis

- | | |
|---|--|
| ☐ Mobility reduced for >2 days
☐ Age >60
☐ Dehydration
☐ Obesity BMI >30 kg/m ²
☐ Significant medical comorbidity (e.g. cardiac, respiratory, endocrine, inflammatory, infectious conditions)
☐ Active cancer or cancer treatment
☐ Thrombophilia
☐ Personal history or first degree relative with history of VTE
☐ Use of hormone replacement therapy or oestrogen containing contraceptive
☐ Pregnancy or $<6/52$ post-partum | ☐ Acute surgical admission with inflammatory or intra-abdominal condition
☐ Surgery with significant reduction in mobility
☐ Critical care admission
☐ Knee or hip replacement
☐ Hip fracture
☐ Total anaesthetic+ surgical time >90 mins
☐ Pelvic or lower-limb surgery with anaesthetic+ surgical time >60 mins
☐ Varicose veins with phlebitis |
|---|--|

- | |
|---|
| ☐ Active bleeding
☐ Acquired bleeding disorder (e.g. acute liver failure)
☐ Current use of therapeutic anticoagulation (e.g. warfarin, rivaroxaban, dabigatran)
☐ Acute stroke
☐ Thrombocytopenia ($<75 \times 10^9/L$)
☐ Uncontrolled hypertension ($>230/120$ mmHg)
☐ Untreated inherited bleeding disorder
☐ Neurosurgery, spinal surgery or eye surgery
☐ Other procedure with high bleeding risk
☐ Lumbar puncture, epidural or spinal anaesthesia expected within the next 12 hours
☐ Lumbar puncture, epidural or spinal anaesthesia within the previous 4 hours |
|---|

VTE risk actions

Information provided Provide if admission is anticipated Yes/ No	LMWH Yes/ No/ Contraindicated	Antiembolism stockings Consider if thrombosis risk factors present and bleeding risk factors preclude LMWH Contraindicated in peripheral neuropathy, PVD, ulceration, cellulitis, gross oedema Yes/ No/ Contraindicated
--	-------------------------------------	--

Name _____ Signature _____ Date _____ Time complete _____

COPY

40 yr. ~~Upper~~ Vomiting / Upper abdominal pain / feeling shivery
 25/1/20. blood streaked food.
 01.00 1hx
 - Abk Brand - on Anti-TNF
 - according to Mother prone to infections.

Barrett's disease -

Has received his anti but wanted to go home
 - now symptomatic in evening with T rumble.

Now - no abdominal pain

- vomited x2 last night - w/ blood streaks

- nausea / no appetite.

Barrett - last noted yesterday

Uric - last time much, but urine biphase

02.00 Obs - T 37.5

✓
 (III) Mottled Red /
 erythema
 Soft
 No petechiae

Bar (noted 24/1/20) → B17 102

CG

AST 112

ALT 200

KR/Imaging

CRP 138

WBC 10.5

Results

CG / AXR → Facet locking RAR.
 What

Imp ? likely cause of sepsis
 - ? more

Barrett's
 Malley - Wens /
 Bond Sherry's
 in front →

Consultant Ward Round

Patient details

Diagnoses and significant comorbidities

Plan

COPY

① IV fluids / IV Ant

② Analgesia / Anti-emetics

③ Can have oral fluids. No food.

④ PPI.

⑤ Rpk widely

⑥ Fluid balance - input/output

⑦ Temp in ax - vs buccal

[Signature]

1180 - 525

Checklist

Estimated LoS

<24h

24-48h

>48h

Medicine reconciliation

Transfer of Care to:

VTE assessment

Outstanding criteria for ward transfer/discharge (delete as appropriate):

S_pO₂ target prescribed

Fasting

Yes / No

Name

Signature

Date

Time

Resuscitation/ Escalation of care/ Anticipatory Care Planning / Advance Directives

Documentation of Discussion with Patient or Family

Name

Signature

Date

Time

Date and
time

Continuation

Please sign and PRINT NAME and POSITION

CHI NO: 2602800570
CRN:
Scott DOWELL
11 DON STREET

26/02/1980
M

GRANGEMOUTH
FK3 8HD

COPY

24/1/20. NEWS O.

01⁵⁰

Patient arrived to SAU via GP.

Alert and orientated.

No diarrhoea but has vomited twice since pain started.

Pt. states he dislikes tablets and refused analgesia when offered some for when it's prescribed.
No new concerns.

Awaiting senior review.

Cannula and bloods ☒ S/N 3RSJ/N Mlin

0315

Blood added for Troponin + Lactate

ECG done + reviewed by Reg.

Esomeprazole IV given

Co-Codamol 2 tab given

Refused for IV morphine

NO other concern at present

S/N 3ES7 ROZAN/S

0510

Patient wishing to go home as pain free.

DN Surgical reg, happy for patient to go (H).

hard number and worsening odour given

PVC removed.

Stanger

SPACE

Date and
time

Continuation

Please sign and PRINT NAME and POSITION

P

CHI NO: 2602800570

26/02/1980

CRN:

Scott DOWELL

11 DON STREET

GRANGEMOUTH
FK3 8HD

COPY

24/1/20 patient returned with ~~feeling~~ ^{low} - 11
2230 Sleepy most of the day, not manage
to eat and drink, not bothering
with pain or anything - Asper family
patient was spiking temp at home -
NEWS → 1 (H.R.T.)
Alert and Oriented

0835 Commenced on IV triple therapy and
IV fluids for 200 today. No c/o
pain raised.

0700 IVF continued, slept for short spells
Repeat bloods + heart level after 0830
No other concern

25/1/20 NR Mr Crumley 3/N JESSY ROJAN/

AUSS □ ? MRCP await results of Auss ; F G/S MRCP
Continue IV fluids
Continue IV ABX'S

25/1/20 Arrived in B11 via SAU.
Orientated to ward, staff and buzzer
system.
Obs stable as charted.
IV fluids ongoing
IV Abx ongoing - reviewed by FY1 PTO

Date and
time

Continuation

Please sign and PRINT NAME and POSITION

Patient Details

COPY

25/1/20 cont

can E+D as a whole

? MROP ? when

nil complaints offered

Chamberlain v/N

Patient Label  CHI NO: 2602800570 26/02/1980 CRN: Scott DOWELL 11 DON STREET GRANGEMOUTH FK3 8HD	Age: 39		Post op day:
	Diagnosis : ? gastritis		COPY
	PDD:		
	Named Nurse	Night shift: A. Muirhead	
		Day Shift:	
Consultant: Mr Crumley			

Overnight Report Settled + slept overnight observations stable as charted medication given as per hepma IVTT continues - Gent given at 02:15 1 lvi running - behind time due to pt going off ward. ? mrcp ind mobile e+d no issues overnight. sin smull	Fluid Balance: In: Out: Balance: Cumulative Balance:	

Patient Safety Checklist	Tick	Additional Ward Round Notes
T of Ward Round	0935	WR CRUMLEY, WE. Sudge + thickened GB - no calcu LFTs improving pain settled. NEWS 3 - SBP 100 / HR 105 Feels better Jaundice improved Plain ① mrcp tomorrow. no stones for discuss E hepar ② mobile ③ lvi down ④ out on 0935
EWS		
Blood Results		
Kardex Check		
DVT Prophylaxis		
Antibiotic Review		
Needs Bloods Tomorrow?	Y/N	
Fluid Balance		
Pain control		
Nutritional Status		
Bowels / Catheter		
Infection issues / risks		
Patient Questions		

Daily Nursing Updates	Signature	Additional Charts	Signature
MUST - Dietary intake?		PVC	
Braden - Pressure areas?		CAUTI	
Falls Risk - Mobility?		Wound Chart	

COPY

Combined Day Report *** Date, time and sign all entries ***

1350 Independent with AOC's
 Medications as per hepma
 IV - ABX cipro as prescribed.
 observations. Stole is charted.
 IV stopped as per WIL
 Eating & drinking well.
 for mrcp ? tomorrow fast after light breakfast
 at 6am.
 off on pass for few hours as approval
 by mr cummies,
 states he will return approx 2000.
Klassen

1815 Remains on Pass at present
 exercise deferred on hepma. Klassen

Discharge Planning / OT / Physio / Dietetic info.		Signature
Physio		
OT		
Dietetics		
District Nurse		

Surgical Unit Daily Patient Update

Date: 27/1/20

Ward B11

Page No: 2

Patient Label

Age: 39

Post op day:

COPY

Diagnosis: Gastritis

Gastritis / Sludge

PDD:

Named Nurse

Night Shift:

J Taylor

Day Shift:

Consultant:

Crumley

Time:

Fluid Balance

In:

Out:

Balance:

Cumulative Balance:

Overnight Report

Settled night. Obs unremarkable.

Meds given as prescribed.

IV Abx ongoing. Gent given at 0215.

Independent. PU spontaneously.

NO complaints.

Fasting from 6 AM. To have light breakfast in AM at 6 before fasting for MRCP.

Name: J Taylor

Signature:

Position:

Patient Safety Checklist

Tick

Additional Ward Round Notes

Time of Ward Round

VS

0

MRCP 11³⁰ today

Blood Results

If no gallstones CBD, for

Kardex Check

upper screen, d/w hepatology

DVT Prophylaxis

2 (H)

Antibiotic Review

Takes Humira for spondylitis

Needs Bloods Tomorrow

Y/N

2 Symphysis

Fluid Balance

Miles

Other results

1291

Pain control

Nutritional Status

Bowels/Catheter

Infection issues/risks

Patient Questions

Name:

Signature:

Grade:

COPY

Please tick appropriate box

CLINICAL NOTES

☐

NURSING NOTES

☐

PROGRESS NOTES

☐

Consultant

BT1
3

Surname

Forenames

CHI

Address



CHI NO: 2602800570

26/02/1980

CRN:

Scott DOWELL
11 DON STREET

GRANGEMOUTH
FK8 8HD

COPY

Ward / Dept

Date and Time

14/15

Independent with AD's
medications as per home
observations stable as charted
Fasting this am for MRCP
Attended for same
but now stopped as eating &
drinking again
off ward for spells to smoke
Await outcome of MRCP then
plan (KASSO18)

27/01/20 McGovern Full, d/w Dr Heron (gastro)

- fatty liver & symptoms unlikely
to cause pain to obtain
- Not obstructive picture (N) Air Prod
- Hepatic picture:

Plan → Hepatitis screen (A-E) - CMV
as immunosuppressed.

- full liver screen
- Sounds like he is improving
regardless.
- Many thanks for input

Moss
1291

Please tick appropriate box

CLINICAL NOTES

☐

NURSING NOTES

☐

PROGRESS NOTES

☐

Write - imprint or Attach Label

Surname..... Hospital No.....

Forenames..... Sex.....

CHI..... D. of B.....

Address.....

COPY

Ward / Dept.....

Consultant

Date and Time

1800

For home as per Mr Crozier's
evening W/L.

Full took live screen this PM

Patient given all medications

from 1100 ————— 1800 ¹¹⁰⁰ 1800

Dr. Derek Dundas
BSc (Hons) MB ChB MRCP
Dr. Anna O'Sullivan
MBChB MRCP DRCOG



Mrs. Jennifer Douglas
Practice Manager
COPY

24 02 2020

To Whom It May Concern

Dear Sir/Madam

Re: Mr Scott Dowell 26/02/1980
11 Don Street
Grangemouth
FK3 8HD
2602800570 01324 262719

Thank you for seeing this 40 year old patient, who present with epigastric pain. Note recent discharge under the care of the surgeons earlier in the month. Nauseated and vomited a few times. Feels pain radiating into his back. Abdo has become distended. BO earlier today. Very acute abdo pain this afternoon.

On examination there is apyrexial. Obse fine. Abdo firm, distended, tympanic, scanty bowel sounds.

Past Medical History

Problem - All

	<i>Details</i>
Active	
23/11/2017	Anti-tumour necrosis factor drug monitoring
11/05/2017	High risk treatment started
18/11/2016	Patient immunocompromised
07/06/2016	Gastritis and duodenitis
24/05/2016	Ankylosing spondylitis
Significant Past	
27/01/2020	Liver function tests abnormal
30/03/2015	Hidradenitis suppurativa
11/02/2015	Cellulitis and abscess NOS

Current Repeat Medication

Medication - All

	<i>Details</i>	<i>Dosage/Quantity</i>
Current Repeat		
11/02/2020O	Secukinumab Solution for injection 150 mg/1 ml pre-filled device	AS DIRECTED BY HOSPITAL, 1 pre-filled disposable injection
07/03/2019P	Laxido Orange Oral Powder Sachets Sugar Free	ONE TO BE TAKEN THREE TIMES A DAY, 30 sachet

Dr. Derek Dundas
BSc (Hons) MB ChB MRCP
Dr. Anna O'Sullivan
MBClin MRCP DRCOG



Westburn

Mrs. Jennifer Douglas
Practice Manager

COPY

05/02/2020P	<i>Ropinirole Hydrochloride Tablets 500 micrograms</i>	<i>TWO TABLETS AT NIGHT, 112 TABLET</i>
05/02/2020P	<i>Esomeprazole Gastro-resistant Capsules 40 mg</i>	<i>1 CAP TWICE DAILY, 56 capsule</i>
05/02/2020P	<i>Ranitidine Tablets 150 mg</i>	<i>ONE TABLET TO BE TAKEN TWICE DAILY, 120 tablet</i>

Clinical Warnings
Allergies - All

Note PMHx on immunosuppressants (biologics).
I am grateful for your further assessment and management.

Yours faithfully

Dr Derek W Dundas

Forth Valley Royal Hospital Assessment Document



Date of arrival **24/2/20** Time of Arrival **1800**

CHI NO: 2602800570 26/02/1980
GRN: Scott DOWELL
11 DON STREET

Age **39**

Source of referral **GP** Ed Other

GP practices **Weston Hill**

GRANGEMOUTH
FK3 8HD

COPY

Consent for ECs **Yes** No

BMI NEWS score

Tel **(01324) 262719**

NOK 1 Name **Diane**

Relationship **wife**

Address **31**

Tel **50**

NOK 2

Presenting complaint

**Central upper abd pain
started this afternoon.
Recent admission 3/02
with same.**

Background

A	NEWS 5 or more or other clinical concern	Yes	No	—
	T° 38°C or more within 14 days of chemotherapy (possible neutropenic sepsis)	Yes	No	—
	Referred with potassium more than 6.4mmol/L or less than 2.9mmol/L	Yes	No	—
	Referred with diabetic ketoacidosis	Yes	No	—
	Reduced GCS	Yes	No	—
	New limb weakness, speech disturbance or numbness for less than 4.5 hours	Yes	No	—
	Abdominal pain: Does referral or patient give history of aortic aneurysm?	Yes	No	—
	Abdominal symptom in female under 55 with possibility of pregnancy	Yes	No	—
	NEWS 2-4	Yes	No	—
	New oxygen requirement (not on home oxygen)	Yes	No	—
	Ongoing chest pain - Obtain ECG, Clinician to review / sign within 10 minutes	Yes	No	—
	New limb weakness, speech disturbance or numbness for 4.5 hours or longer	Yes	No	—
	Requires assistance of 1 or more to mobilise	Yes	No	—
	Able to mobilise independently or using own aids / appliances	Yes	No	—

R Very Urgent Urgent Non-urgent Ambulant

Actions	Amylase	Cannula
U&E/LFT/CRP/FBC/Glucose	Calcium	ECG - to be signed within 10 mins
Cultures	Group and save	Troponin 0 hours / 12 hours
Additional triage comments Nil found		Allergies and alerts NADA

Name

Signature

Date

Time

DM

[Signature]

24/2/20

1800

Preliminary Nursing Assessment

CHI NO: 2602800570 26/02/1980
CRN: M
Scott DOWELL
11 DON STREET

COPY

Belongings	With family		With patient	/	In se	GRANGEMOUTH FK3 8HD
Own medication	Yes		No	/		
Name band	Yes		No	/		
Patient fasted	Yes		No	/	Food time	Drink time
Relatives with patient	Yes		No	/	Informed	

Preliminary Pressure Ulcer Risk Assessment (PPURA)

Mobility: Patient is fully mobile without equipment/ assistance (Y/N)

Continence: Person is fully continent (Y/N)

Nutrition: Person appears well nourished and able to eat and drink (Y/N)

Record answer in grid below Y=Yes N=No

If answer is NO to any assessments, complete Braden within 6 hours

Remember

- People who are overweight may not be well nourished
- Please sign after each check

Date	Time	Mobility	Continence	Nutrition	Skin inspected	Braden complete?	Signature/ PRINT
18/02		Y	Y	Y	Y	Y	

Comments if required:

Preliminary falls assessment: If Yes to any, complete falls bundle within 4 hours of being admitted

≥2 falls in last 6 months?	Yes		No	/
Patient/ Carer/ Referrer anxious about falls?	Yes		No	/
Tries to walk alone but unsteady/ unsafe?	Yes		No	/

Additional nursing comments

Name Signature Date Time complete

Bundle stickers

CHI NO: 2602800570

26/02/1980

GRN:

M

Scott DOWELL
11 DON STREET

GRANGEMOUTH
FK3 8HD

COPY

Assessment

Practitioners Name L. FARWATER Date 24/2/20
 Grade ANP Time commenced 1820
 GMC/NMC Location SAU

CHI NO: 2602800570 26/02/1980
 CRN: Scott DOWELL
 11 DON STREET
 GRANGEMOUTH FK3 8HD

COPY

Presenting Complaint:

39 yr old female

PC - Epigastric pain

NPC - Sudden onset epigastric pain at 1pm today.

Denies any weight loss.

Feels nauseous but no vomiting.

Denies any urinary/bowel symptoms.

On anti-TNF for addressing Spandylitis

Systemic Enquiry:

NEWS = 0

looks well

Height: 5'9 Weight: 15 1/2 st BMI:

Usual level of activity (please circle)

Bedbound Dependent for personal care Requires minimal assistance with ADLs Slowed. Assistance with heavier household tasks "Slowed-up" but not requiring assistance No exercise beyond walking. Occasional exercise Regular exercise

Past medical, surgical and anaesthetic history

MI	
Angina	
Hypertension	
COPD	
Stroke /TIA	
Diabetes	
Implement diabetes bundle	

Alcoholism
Spandylitis
Boneitis
Cesaphegus

① hip replacement

Family History

Travel History

Social History

Smoking: Never Ex smoker (since _____)

Current 20 /day Pack years _____

Alcohol: _____ Units / week NH

Occupation —

Driving licence yes / no

Lives With wife

Support/ Carers NH

Medicines Reconciliation

At least 2 recent sources, one of which must be patient or carer

CHI NO: 2602800570
CRN: Scott DOWELL
11 DON STREET
GRANGEMOUTH FK3 8HD
26/02/1980
M

COPY

☒ Patient (e.g. verbal recollection or handwritten note)

☐ Relative/Carer

☒ Electronic patient record
ECS (issued in last 6 months?)
IDL (within last month?)

☒ Patient's own medicines

☐ Nursing home prescription

☐ Community pharmacy

Verbal
☒ Other TTA 27/1/20

AP ✓

No Known
Drug
Allergies

OR

Drug / Substance Reaction / Side effect

None

'At'

Drug / Substance Reaction / Side effect

Pharm

ADMISSION MEDICATION

AP 01324 023577

No reg. chemist.

Kardex

Comment

Not since 17/1/20 - stopped
Not taken at present

ON ECS = 2n.
40mg BD

Esomeprazole.

Co-codamol tabs 15/500

1-2 PRN

x 60

Spiralol tabs x50

10mg 4 tabs PRN

Not taken in
months.

Morphine sulfate MK tabs

10mg BD

fosphen

(Peds at home)

RECENT ANTIBIOTICS/RECENTLY DISCONTINUED MEDICATION (within 6 months)

* Co-amoxiclav tabs

65mg TDS

NON-PRESCRIPTION MEDICATIONS AND HERBAL MEDICATIONS

No -

Are you satisfied this medication history is complete and accurate?

Yes ☒ No ☐

If 'No' please detail what further action is necessary (e.g. contact GP, carer or access ECS)

CMurphy Pharm tech #1373 11.55 26/2/20

Medicine reconciliation completed by? Name:

Signature:

Date:

Time:

Medicine reconciliation verified by?

Name:

Signature:

Date:

Time:

Examination

Diabetic patients → foot examination and diabetes bundle
GI Bleeding → PR examination
Age > 65 or confusion → AMT
If cognition or alertness impaired → consider delirium

CHI NO: 2602800570

26/02/1980

CRN:
Scott DOWELL
11 DON STREET

M

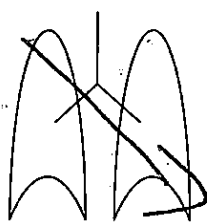
GRANGEMOUTH
FK3 8HD

COPY

Cardiovascular

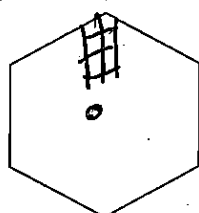
MS I + II + O
well perfused
CRT < 2 sec's

Respiratory



No SOB/Congest
Chest clear
Trachea central

Abdominal



Abdo tender epigastrium
distended. Fullness
over gallbladder.

Bi sounds: present

PR:

AMT (If < 4/4, complete AMT10)

1. Age
2. DOB
3. Year
4. Location

4/4

Ask patient to remember address: "42 West Street"

5. Time to nearest hour
6. Current monarch
7. Date Of WW2
8. Count 20 → 1
9. Identify 2 people
10. Recall address

10 / 10

Neurological (remember speech, visual assessment, balance, gait)

Cranial nerves: CN I - XII INTACT

	R arm			L arm			R leg			L leg		
Tone												
Power												
Sensation												
Coordination												
Reflexes	B	T	S	B	T	S	K	A	Plantar	K	A	Plantar

Other

Calves SNT

Interpretation of results

CG

Multistix® 10 SG
Test date: 25-02-2020
Time: 12:29AM
Operator: 3873
Test number: Not Entered
Color: Not Entered
Clarity: Not Entered
GLU Negative
BIL Negative
KET Negative
SG 1.015
BLD Negative
PH 7.0
BPO Negative
UCB 3.2 umol/L
M Negative

CXR

Other imaging

Additional comments

CHI NO: 2602800570
CRN: Scott DOWELL
11 DON STREET
GRANGEMOUTH
FK3 8HD

M

Final diagnosis

CHI NO: 2602800570 26/02/1980
 CRN: SCOTT DOWELL M
 11 DON STREET
 GRANGEMOUTH FK3 8HD
COPY

? Gastritis, ? gallstones ? cholecystitis ? pancreatitis

Management plan

Sent to A&E

Bloods inc trop, Amg + Coag

ECG - SR 74 bpm

Analgesia

Urine dipstick

Repeat trop at 10pm

Additional investigations required (e.g. cultures) Please initial and date when sent

	Initial/ Date		Initial/ Date
	Initial/ Date		Initial/ Date

Venous thromboembolism (VTE) risk assessment

Medical patient expected to be mobilising as normal within 2 days	Proceed to VTE risk actions
Medical patient with reduced mobility for ≥ 2 days OR Surgical patient	Assess thrombosis and bleeding risk factors

Thrombosis risk factors. ANY thrombosis risk factor(s) should prompt VTE prophylaxis measures unless contraindicated → Assess bleeding risk.

Bleeding risk factors. Consider whether sufficient to preclude pharmacological prophylaxis

- | | |
|---|--|
| ☐ Mobility reduced for >2 days
☐ Age >60
☐ Dehydration
☐ Obesity BMI >30 kg/m ²
☐ Significant medical comorbidity (e.g. cardiac, respiratory, endocrine, inflammatory, infectious conditions)
☐ Active cancer or cancer treatment
☐ Thrombophilia
☐ Personal history or first degree relative with history of VTE
☐ Use of hormone replacement therapy or oestrogen containing contraceptive
☐ Pregnancy or $<6/52$ post-partum | ☐ Acute surgical admission with inflammatory or intra-abdominal condition
☐ Surgery with significant reduction in mobility
☐ Critical care admission
☐ Knee or hip replacement
☐ Hip fracture
☐ Total anaesthetic+ surgical time >90 mins
☐ Pelvic or lower-limb surgery with anaesthetic+ surgical time >60 mins
☐ Varicose veins with phlebitis |
|---|--|

- | |
|---|
| ☐ Active bleeding
☐ Acquired bleeding disorder (e.g. acute liver failure)
☐ Current use of therapeutic anticoagulation (e.g. warfarin, rivaroxaban, dabigatran)
☐ Acute stroke
☐ Thrombocytopenia ($<75 \times 10^9/L$)
☐ Uncontrolled hypertension ($>230/120$ mmHg)
☐ Untreated inherited bleeding disorder
☐ Neurosurgery, spinal surgery or eye surgery
☐ Other procedure with high bleeding risk
☐ Lumbar puncture, epidural or spinal anaesthesia expected within the next 12 hours
☐ Lumbar puncture, epidural or spinal anaesthesia within the previous 4 hours |
|---|

VTE risk actions

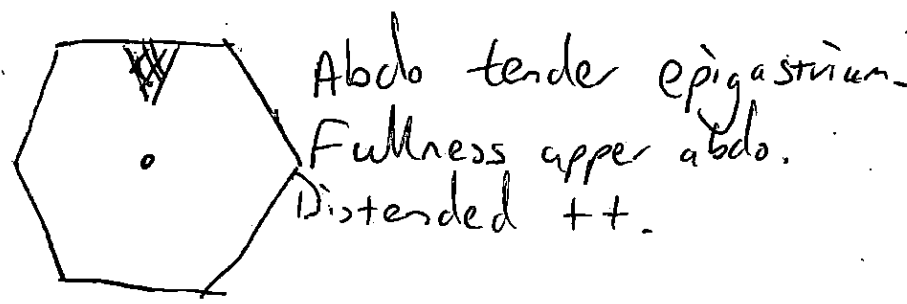
Information provided Provide if admission is anticipated Yes/ No	LMWH Yes/ No/ Contraindicated	Antiembolism stockings Consider if thrombosis risk factors present and bleeding risk factors preclude LMWH Contraindicated in peripheral neuropathy, PVD, ulceration, cellulitis, gross oedema Yes/ No/ Contraindicated
Name	Signature	Date
		Time complete

CHI NO: 2602800570 26/02/1980
 CRN: M
 Scott DOWELL
 11 DON STREET
 GRANGEMOUTH
 FK3 8HD

COPY

MR Miss Morrow 24/2/20 1915

Sudden onset epigastric pain at lpr today.
 Recent admission 3 weeks ago with similar episodes.
 on anti-TNF for ~~also~~ ankylosing spondylitis



Bowels moved this am.

CG
 CR/Imaging
 Results

Ward Round

CHI NO: 2602800570

26/02/1980

CRN:

Scott DOWELL

11 DON STREET

GRANGEMOUTH
FK3 8HD

COPY

Diagnoses and significant comorbidities

Plan

2 cholecystitis
2 pancreatitis
2 Gallstones
2 Gastritis

Chase bloods
Analgesia
erect CXR
Fluids only

Checklist:

Estimated LoS <24h 24-48h >48h

Medicine reconciliation

Transfer of Care to:

VTE assessment

Outstanding criteria for ward transfer/discharge (delete as appropriate):

S_pO₂ target prescribed

Fasting

Yes / No

Name

Signature

Date

Time

Resuscitation/ Escalation of care/ Anticipatory Care Planning/ Advance Directives

Documentation of Discussion with Patient or Family

Name

Signature

Date

Time

Date and
time

Continuation

Please sign and PRINT NAME and POSITION

Print Details

CHI NO: 2602800570

CRN:

SCOTT DOWELL
11 DON STREET

26/02/1980
M

GRANGEMOUTH
FK3 8HD

COPY

24/2/80
18⁰⁰

Elb via gr 1/6 Kbac pm
recent admission - 1/6 see 3/82
age nil found.
vital
Bloods
Access
EWS 0
Anxiety seen

[Signature]

25/2/80
06⁵⁰

Severely overgrown
Anxiety as required
having heard for cigarettes.
As 0
Slept for spans

[Signature]

25/2/80
08⁴⁰

W.R. Mr MacDonald
Ergastic pain - similar episode
three weeks ago
on abt the for alluding podylite -
no upstair since Jan 80.
Cg - nil acute
Hep - 10
Transaminase - 100
AK Phos 171
Abd mildly distended
Soft

Date and
Time

Continuation

Please sign and PRINT NAME and POSITION

CHI NO: 2602800570

26/02/1980

CRN:

M

Scott DOWELL
11 DON STREET

GRANGEMOUTH
FK3 8HD

COPY

Plm CT abd/pelvis -

17@ d/w Thrombolytic

results after scan

U. G. G. G. G.
17/2/80

13-55 Independent with ADL's, vital signs stable, EWS 1 due
to ART, medication given as per heparin. Awaiting
CT Abd/pelvis, no time as yet, transfer to B11,
verbal handover given. Gent level due > 18.00.

25/2/20
1545h-5

R. M. G. G.

Arrived in B11

EWS = 0

Venous in (R) arm

IV abx triple therapy prescribed as per heparin

1755h Gent level due 1800h and sent

Tobacco policy form written at 15/2

Independent around ward at 15/2

Patient Label



CHI NO: 2602800570

26/02/1980

CRN:

M

Scott DOWELL
11 DON STREETGRANGEMOUTH
FK3 8HD

Age: 39

Post op day:

Diagnosis: Abdo pain

PDD:

COPY

Named Nurse

Night shift: V Brannan

Day Shift:

Consultant: Mr Macdonald

Overnight Report

0325 - Complaints of pain 2x PRN

given. Told Scott to buzz if in pain

Scott states he wont buzz he will just

wait. Explained to Scott that we need him to buzz

if he is sore so he can get pain relief. IV abx given

as per HEPMA. On taking down Scott settled and sleeping

never woke while I was in room. Woke and asked to

go outside. Asked Scott if his pain was settled

enough to go outside said yes come back to room

has not buzzed since. Observations stable as

charted. No complaints of nausea. Encourage to buzz

and ask for pain killers.

S. Brannan
V. Brannan

Fluid Balance:

In:

Out:

Balance:

Cumulative Balance:

Patient Safety Checklist	Tick	Additional Ward Round Notes
of Ward Round		BRENNAN WR
NEWS		
Blood Results		
Kardex Check		
DVT Prophylaxis		
Antibiotic Review		
Needs Bloods Tomorrow?	Y/N	
Fluid Balance		
Pain control		
Nutritional Status		
Bowels / Catheter		
Infection issues / risks		
Patient Questions		

NEWS 0

- Still c/a Pain

↑ Analgesia

- Bloods slightly impaired

G. Cont. Current Mx

Abdo Soft

Name:

Signature:

Grade:

Daily Nursing Updates	Signature	Additional Charts	Signature
MUST - Dietary intake?		PVC	
Braden - Pressure areas?		CAUTI	
Falls Risk - Mobility?		Wound Chart	
			COPY

Combined Day Report

*** Date, time and sign all entries ***

19:40
26/2/20 Settled day
Observations stable as changed
meds given as per hepma
etc as able - states is
vomiting everytime he eats
have not witnessed
ind mobile
IV IT continued - Gent given
at 14:40 today
Amalgia given throughout the day
no issues
SIN AM

Discharge Planning / OT / Physio / Dietetic info.	Signature
Physio	
Dietetics	
District Nurse	

Surgical Unit Daily Patient Update

Ward: B11

Date: 27/02/20

Page No: 2

Patient

CHI NO: 2602800570
 CRN: 26/02/1980
 Scott DOWELL
 11 DON STREET
 GRANGEMOUTH
 FK3 8HD

Age: 40

Post op day:

Diagnosis : Abdo pain

PDD:

COPY

Named Nurse

Night shift: R. Faish

Day Shift:

Consultant:

Mr MacDonald

Overnight Report

Settled and slept overnight

Observations stable and as checked

Medications given as per hepma

IV Abco continue

Independently mobile, off ward for periods before settling

No complaints voiced

a/R. Faish

Fluid Balance:

In:

Out:

Balance:

Cumulative Balance:

Patient Safety Checklist

Tick

Additional Ward Round Notes

of Ward Round

EWS

Blood Results

Kardex Check

DVT Prophylaxis

Antibiotic Review

Needs Bloods Tomorrow?

Y / N

Fluid Balance

Pain control

Nutritional Status

Bowels / Catheter

Infection issues / risks

Patient Questions

MORROW WR

- NEWS @

- Still N&V

- Distended Abdo - laxido □

- Off BN Physiology atm - seek advice
from Rheumatology

Name:

Signature:

Grade:

FY

Daily Nursing Updates	Signature	Additional Charts	Signature
MUST - Dietary intake?		PVC	
Braden - Pressure areas?		CAUTI	
Falls Risk - Mobility?		Wound Chart	
			COPY

Combined Day Report

*** Date, time and sign all entries ***

27/12/20

15:30

Settled day
 observations stable as charted
 medication given as per hepma
 IV TT continued - Gent. late as
 pt off ward
 incl mobile
 pm omeprazole given
 e+d as able - states vomits
 everytime but is unwell
 NO changes to care
 no issues

sin fmul

27/12/20

CONNOR MCKEE FY1

1600

d/w RHEUMATOLOGY

↳ Mr Donell to remain off biologics until gallbladder is taken
 out due to risks of complications
 ↳ Can re-start biologics 2 weeks post-op provided clinically
 well
 ↳ Rheumatology will kindly come & review him
 tomorrow - ? prescribe COX-2 inhibitor

CMC
 #1293

Discharge Planning / OT / Physio / Dietetic info.		Signature
Physio		
OT		
Dietetics		
District Nurse		

Patient Label



CHI NO: 2602800570

26/02/1980

CRN:

M

Scott DOWELL
11 DON STREETGRANGEMOUTH
FK3 8HD

Age: 40

Post op day:

Diagnosis :

Abdo pain

COPY

PDD:

Named Nurse

Night shift:

R. Faish

Day Shift:

A. Muirhead

Consultant:

Mr Mac Donald

Overnight Report

Fluid Balance:

In:

Out:

Balance:

Cumulative Balance:

Settled and slept well overnight

Observations stable and as checked

Medications given as per hepna

IV abx continue

~~Temperature prior to settling, corrected after Paracetamol~~ error

Independently mobile

Off ward for spells

R. Faish s/n

Present Safety Checklist	Tick	Additional Ward Round Notes
Time of Ward Round	08:57	NR new au
EWS	0	
Blood Results		- Has not vomited yet today
Kardex Check		- Not managing food
DVT Prophylaxis		- BC last night
Antibiotic Review		
Needs Bloods Tomorrow?	Y/N	
Fluid Balance		
Pain control		
Nutritional Status		
Bowels / Catheter		
Infection issues / risks		
Patient Questions		



Remains disordered

(P) Switch to tacrolimus as no clinical improvement

Regular metoclopramide plus W anti-emetics

Name: ROB BRISAN

Signature: n

Grade:

FPL

Daily Nursing Updates	Signature	Additional Charts	Signature
MUST - Dietary intake?		PVC	
Braden - Pressure areas?		CAUTI	
Falls Risk - Mobility?		Wound Chart	
			COPY

Combined Day Report

*** Date, time and sign all entries ***

28/2/20

15:00 no complaints today
 observations stable as charted
 meds accepted as per hepima -
 Oramorph given pm
 IV TT → TAZ
 ind mobile
 has not eaten today
 off ward frequently - Abx lab
 as off ward
 NO NEW ISSUES: *sin Am*

16:40 afternoon TAZ given at 16:30
 due to VENCIN
 No changes to care. *sin Am*

Discharge Planning / OT / Physio / Dietetic info.	Signature
Physio	
OT	
Dietetics	
District Nurse	

Surgical Unit Daily Patient Update

Date: 29.02.2020

WARD B11

Page No: 11

COPY

Patient Label

Age: 40

Post op day:



CHI NO: 2602800570

GRN:

Scott DOWELL
11 DON STREET26/02/1980
MGRANGEMOUTH
FK3 8HD

Diagnosis: Cholecystitis

PDD:

Named Nurse

Night shift: R. Ivory

Day Shift: K. Russell

Consultant: Ms Cannings

Overnight Report

Fluid Balance:

In:

Out:

Balance:

Cumulative Balance:

Settled evening. Slept for spells.
Independently mobile on feet
on + off ward for cigarette
observations. Stable - news &
medication accepted as px - IV abx administered as px
Passing urine spontaneously.
PB states bowels active
nil issues overnight

RWays/N

Patient Safety Checklist	Tick	Additional Ward Round Notes
Time of Ward Round		Woodley WR
VS		News 1 HR 92bpm
Food Results		Managed to keep fluids down
Index Check		Δ cholecystitis
VT Prophylaxis		Informed about diagnosis
Antibiotic Review		Plan
Beds Bloods Tomorrow?	Y/N	LIVOST
Fluid Balance		2. If ok am home today
In control		3. 6/52 Fu up with Mrs Cannings
Nutritional Status		7633564 7633564
Wells / Catheter		
Infection issues / risks		
Patient Questions		

Daily Nursing Updates	Signature	Additional Charts	Signature
MUST - Dietary intake?		PVC	
Braden - Pressure areas?		CAUTI	
Falls Risk - Mobility?		Wound Chart	

COPY

Combined Day Report
*** Date, time and sign all entries ***

29/02/2020 Settled morning

17:20 Observations stable per news

IV Taz administered. Now MUST D

All medication per Hepma

Refused Laxative

PVC removed

No c/o pain or nausea

Independent with ADL'S

Passing urine spontaneously

For discharge here. & Oral antibiotics

to return to clinic 6/52 ? Lap chg.

Discharged home.

ADAM SPRING

AS PRING S/N

Charge Planning / OT / Physio / Dietetic info.		Signature
Physio		
Dietetics		
District Nurse		

CONSENT FORM

Agreement to Operation, Investigation or Treatment



Notes of Guidance for Doctor/Dentist/Healthcare Practitioner

The doctor/dentist/healthcare practitioner must:

- ◆ Be suitably qualified and experienced to explain the procedure to be performed - this should ideally be the operator or consultant.
- ◆ Give the patient sufficient information, in a way he/she can understand, about the proposed procedure, any important risks and the possible alternatives (including no treatment). In broad terms, a significant risk is one which is serious, but uncommon, or one which occurs frequently, even if it is not serious.
- ◆ Give the patient sufficient time to read the form and ask any questions relating to it or their treatment. The patient must be allowed to decide whether he/she will agree to the procedure and they may refuse or withdraw consent at any time.
- ◆ In addition to seeking consent for the procedure, seek written consent from the patient for examination by students.

Children under the age of 16 can give their own consent if the Medical Practitioner attending the child considers the child capable of understanding the nature and possible consequences of the procedure or treatment. If the child is judged capable, the practitioner must seek the consent of the child rather than the parent. This does not mean that the parents must always be excluded from the discussions. Unless there are issues concerning confidentiality, it would be reasonable to involve parents in helping a child to reach a decision. If a child under 16 years of age is giving his/her own consent, the relevant section overleaf, must also be signed.

Writing on the consent form must be legible, unambiguous and contain no abbreviations.

Any alterations to this form must be countersigned by the patient/parent/guardian and the member of the healthcare team taking consent. If the procedure or the information about surgical marking is wrong the form must be re-written.

Surgical Site Marking

- ◆ The site should be marked and documented by the operating surgeon, or nominated deputy, who will be present in the operating theatre at the time of the patient's procedure. If site marking is not applicable, this should be recorded and signed by the person taking consent.
- ◆ The intended site should be ascertained from reliable documentation and/or images.
- ◆ Marking should take place before pre-medication/administration of any sedative.
- ◆ The intended surgical site should, ideally be marked on the ward, day care area or theatre reception prior to the patient transfer to the operating theatre.
- ◆ An indelible marker pen should be used.
- ◆ The mark should be an arrow that extends to, or near, the incision site and remains visible after the application of skin preparation.
- ◆ Where possible the mark should remain visible after the application of theatre drapes.
- ◆ Surgical operations involving side (laterality), should be marked at, or near, the intended incision. For digits on the hand or foot, the mark should extend to the correct specific digit.
- ◆ The process of pre-operative marking of the intended site must involve the patient/parent/guardian wherever possible.

NB. There will be circumstances where marking may not be appropriate i.e. Teeth or Mucous Membranes. Emergency surgery should not be delayed due to lack of pre-operative marking.

PATIENT DETAIL (OR PRE-PRINTED LABEL)

Patient's surname/family name:

Patient's first name(s):

Date of birth: --

CHI number (or other identifier):

Special requirements (e.g. other language or other communication method):

CHI NO: 2602800570 26/02/1980
CRN: M
Scott DOWELL
11 DON STREET

GRANGEMOUTH
FK3 8HD

COPY

STATEMENT FOR DOCTOR/DENTIST/HEALTHCARE PRACTITIONER

(to be completed by a practitioner with appropriate knowledge of proposed procedure. See Notes for Guidance)

Describe proposed operation, investigation or treatment. Where appropriate specify the site or side:

UPPER LIP
+/- AREN
RINGS: BUCKLE, INTERIOR, ~~EXTERNAL~~
BWL, USAK, DENT, INSIDE

I have explained the procedure named on this form to the: (please tick) patient ☒

parent ☐ guardian ☐ Other (please specify)

in terms which, in my judgment, are suited to their understanding. In particular I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure e.g. blood transfusion.

[If you have provided any information leaflet/tape, please tick box ☐ and specify title and version]

Signature of Doctor/Dentist/Healthcare Practitioner:

Name (PRINT):

Date: --

STATEMENT OF INTERPRETER (where appropriate)

I have interpreted the information on this form to the patient/parent/guardian to the best of my ability and in a way in which I believe he/she can understand.

Signature:

Name (PRINT):

Date: --

SURGICAL SITE MARKING

Site marking not applicable

Correct Patient and Surgical Site verified and marked by:

Signature:

Name (PRINT):

Date: --

Title:

Date **20/11/25** Ward **PSU**

Procedure and side

Lap chole

Surgeon

Crumley

CHI NO: 2602800570
CRN:
Scott DOWELL ✓
11 DON STREET
GRANGEMOUTH
FK3 8HD
Date of Birth

Sex

COPY

CHECKLIST ITEMS	WARD	HANDOVER CHECKS	BASELINE WARD CHECKS & DATA
Verbal Name Check	✓	YES	Pre-assessment Document
ID Band Checked	✓	YES	Present and Checked ☒
Pre-assess/clerking completed	✓	YES	Any Changes? NO
Pregnant Yes / No LMP date	X	N/A	Temp: Weight (kg) 97
Allergies (see baseline checks Yes / No)	✓	N/A	P 79 BP 125/71
Consent / Incapacity completed		YES	RR 18 SpO2 98
Operation confirmed with patient		YES	BM (Sugar) Height 175
Consent form corresponds to list		YES	BMI -31
Operation site marked clearly		N/A	Allergies ☒ No ☐ Yes
Nursing notes	✓	YES	Specify reaction
Case Notes	✓	YES	MRSA +ve / -ve
Cross Match - no. of units	X	N/A	Hb 168 Na 139
G&S confirmed & 2nd sample (if applicable, yes or no)	X	N/A	WCC 5.1 K 4.3
Confirm all results available	X	YES	Platelet 145 U 4.3
Addressograph labels	X	YES	Clotting 82 Cr
Fasted for solids / milk from (time) (9.0)	1800	12MN	G and S X-Match
Fasted for clear fluids from (time)	SIPS	SIPS 120	Dental
Bladder emptied (time or No)	1050	yes	Crowns / Caps ☐
Jewellery removed	X	none	Denture ☒
Body piercings taped etc	X	none	Plate ☒
Nail Varnish / makeup removed	X	N/A	Loose ☐
Contact lenses removed	X	NO	Patient Valuables
* Prosthesis (* or No)	X	NO	Dentures Full ☐ Partial ☒ None ☐
* Orthopaedic implants (* or No)	✓	yes	Glasses ☒
Pacemaker (Yes or No)	X	NO	Hearing Aid ☒
Hearing aid (Yes or No)	X	NO	Dressing Gown ☒
Able to move by self on trolley	✓	YES	Slippers ☒
Diabetic Yes / No	X	NO	Other 1 bag
On Beta Blocker Yes / No	X	NO	Sign CB
If "YES" Taken Yes / No			
If not taken: Administered by Nursing Staff YES / NO			
Ward sign and designation SIN Em			
Handover 1 sign and designation peripatetic (WTAUSR) S/N			
Handover 2 sign and designation			
Comments*			
Cam pins + plates ✓ TW			
(4) THR			

Anaesthetic Checklist

- ☐ Medication prescribed on HePMA
- ☐ Essential medication (admitted with)
- ☐ Regular analgesia
- ☐ Breakthrough analgesia
- ☐ Anti-emetic
- ☐ Oxygen
- ☐ TTA's

Extra Charts

- ☐ Critical Care Plan
- ☐ Intrathecal Opiate
- ☐ Epidural/PCEA
- ☐ PCA
- ☐ Rectus Sheath
- ☐ ERAS / Em Laparotomy Audit
- ☐ Peripheral Nerve Catheter
- ☐ Other

COPY

Postop Plan Anaesthetist..... Surgeon.....

1. Diet/Fluids *For all a minimum of one option must be completed*

- ☐ Oral (Circle): Sips / Free clear fluid / soft / full diet
- ☐ Nil by Mouth (NBM)

If NBM: Oral diet to start

- ☐ Time
- ☐ After surgical review

- ☐ IV Fluids required
- ☐ IV Fluids prescribed

2. Blood Sugar Control

- ☐ Not Applicable
- ☐ Achieve target BM.....mmol/l with:
 - ☐ Allow patient to titrate normal insulin / Restart oral hypoglycaemics (delete as appropriate)
 - ☐ VRII prescribed

3. Antibiotic Cover

- ☐ N/A
- ☐doses post op ☐ Prescribed
- ☐ Continue ☐ Prescribed

4. DVT Prophylaxis

- ☐ Mobilise and keep Hydrated
- ☐ TEDS
- ☐ Enoxaparin (1st Dose @)
- ☐ Rivaroxaban (1st Dose @)
- ☐ Other.....

IV cannula / Removal record

	IV cannula (1)	IV cannula (2)
Inserted by:		
Size:		
Site:		
Removed by:		
Date:		

5. Targets Hb..... MAP..... SP02.....

6. ☐ Medicines requiring review of HEPMA

Please specify (e.g.) ACE-i Reintroduction.....

Special Instructions - Please document below (Eg. drains, positioning, post op investigations, imaging etc.)

Sign: _____
Anaesthetist

Ward Staff please also review the theatre operation note for any surgeon specific follow-up instructions

ANAESTHETIC ASSESSMENT Date: 23/11/25

Height: Weight:

Age

ASA

NCEPOD EI

Em

PRE-OPERATIVE INSTRUCTIONS

- ☐ Free clear fluid until
☐ Premedication on HePMA

COPY

paracetamol
1991
21/20/20

CO-MORBIDITIES

DRUGS

Any changes since preoperative assessment? ☐ Yes ☐ No HRC Letter ☐ Yes ☐ No

AS - neck fused

GA 2018 LMA

Left Hip 1. Arm NW

BMI 31

2018 - GA - hip & LMA

LMA x 2

ED 100

lipid 500 x 2 rest

Insul 600

leg 3000

Dz fentanyl 800

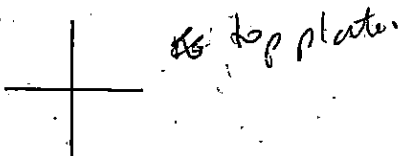
Functional Capacity:

Allergies	☒ No	☐ Yes
Previous GA	☒ No	☐ Yes
Problems?	☐ No	☐ Yes
FH GA problems	☒ No	☐ Yes
Reflux/full stomach	☒ No	☐ Yes
Airway difficulty	☐ No	☒ Yes

NSAIDs Tolerated: ☐ Yes ☐ No

Preop Blood Tests:

Teeth



VERBAL CONSENT

Explained:

☒ GA

☐ Spinal/Epidural

☐ Nerve Block

☐ Sedation

☒ Daycase

Risk:

- ☐ Patient Information Leaflets
☐ Content to proceed
☐ Questions answered

Plan/Discussion:

Signed / Name

Forth Valley Royal Hospital

CHI Number:

COPY

Surname, Forename:

Dowell, Scott

Date of Birth:

26 February 1980

Sex:

M

Theatre:

Theatre 02

Date of operation

20 November 2025

Procedures:

*Total cholecystectomy NEC, Laparoscopic, Not Applicable

procedure	surgeon	localisation	surgical technique
Total cholecystectomy NEC	Crumley Andrew	Not Applicable	Laparoscopic

Staff in attendance:

Surgeon: Crumley Andrew

Participants:

participant	participant role	participant type - ref.	comment
Albiston Julie	Floor Nurse 2	Theatre Practitioner	N.A.
Crumley Andrew	Surgeon	Consultant Surgeon	N.A.
Crutchley Nicholas	Anaesthetist	Anaesthetist	N.A.
Galea Mark	Surgeon's Assistant 1	Doctor	N.A.
Hammond Sarah	Scrub Nurse 1	Trainee Assistant Theatre Practitioner	N.A.
Jackson Cara	Anaesthetic Associate	Anaesthetic Associate	N.A.
Patel Mohil	Floor Nurse 1	Healthcare Support Worker	N.A.
Walker Tracy	Anaesthetic Practitioner	Theatre Practitioner	N.A.
White Suzanne	Floor Nurse 1	Theatre Practitioner	N.A.
Whitmarsh Elaine	Floor Nurse 1	Theatre Practitioner	N.A.

ASA Class: ASA 2 Mild Systemic Disease

Anaesthetic: * GA ETT

Management Intent: 23 Hours

NCEPOD: I - Elective TTG

SURGERY REPORT

Destination after surgery: N.A.

Ward: Day Surgery 23 Hours

COPY

Supra-umbilical open cut-down. Further ports in standard positions.

Significant omental adhesions taken down. Underlying GB thin walled. Peritoneum opened on both sides and a large posterior window created. GB perforated with the grasper with spillage of bile.

Cystic duct and artery identified and cleared. Critical view of safety obtained.

Artery clipped and divided. Cystic duct too wide for clips. GB freed from the liver and the cystic duct ligated with 2 x endo-loop.

GB retrieved in a bag, via the umbilicus.

Washout and haemostasis.

Lateral drain is sub-phrenic and medial drain is sub-hepatic.

Port out under vision.

Closed with vicryl and biosyn to skin.

 PLAN : Clexane tonight

Keep drains until Saturday at earliest.

No more anti-bx

Fluids and diet as tolerated.

Sutures/dressings -

Any follow up required -

Dictated on: 20 November 2025

Dictated by: Crumley Andrew

Surgeon's signature: _____

Please tick appropriate box

CLINICAL NOTES

NURSING NOTES

PROGRESS NOTES

☐
☐
☐

Sur: CHI NO: 2602300570
Fore: CRN:
CHI: Scott DOWELL
Add: 11 DON STREET
GRANGEMOUTH
FK3 8HD

26/02/1980
M

COPY

Consultant

Date and Time

21/2/25

08:15

Wk AC

Legs + feet well
Affects

Small volume leucocytes / platelets

Keep to go @ water the 3 days
observe

→

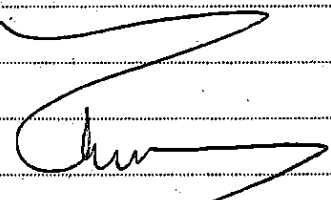
Get down + place in
stoma bag

⊗

Today

Refer to
Maddy

Not since 10:30


Zan

**Immediate Discharge Letter
(Authorised)**S-679370
COPY

A Syeed
Falkirk Community Hospital
Westburn Avenue
Falkirk
Falkirk
FK1 5SU

General Surgery
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

CHI Barcode:



2602800570

Date of Completion: 23-Oct-2025

Patient Demographics

Patient Name:	DOWELL, Scott	Date Of Birth:	26-Feb-1980
Patient Address:	11 Don Street Grangemouth Stirlingshire FK3 8HD	Gender:	Male
Telephone No:	01324 262719	CHI No:	2602800570

GP Practice

GP Name:	A-Syeed	GP GMC:	4615437
GP Practice Address:		GP Practice Code:	4615437/26015
		GP Clinic Code:	26015
		GP Telephone:	

Admission Details

Patient Location:	General Surgery	Admission Care Provider:	Mr Alistair Geraghty
Admission Date:	22-Oct-2025	Admission Time:	11:41
Admission Method:	Emergency Admission, no additional detail added	Ward:	FVRH Ward SAU
Source Of Admission:	A&E Ward within Trust		

Discharge Details

Discharge Specialty:	General Surgery	Discharge Care Provider:	Mr Alistair Geraghty
Discharge Date:	22-Oct-2025	Ward:	FVRH Ward SAU
Discharge Time:	22:14	Discharge Destination:	Private Residence - living with relatives or friends
Discharge Method:	Discharge from NHS inpatient/ day case care		

Clinical Summary including History

Written in retrospect from clinical notes

Dear Doctor,

Primary diagnosis: epigastric and RUQ pain.
Operation/procedure: Nil
GP follow up: Nil

Thank you for your continuing care of this patient. He has a background of ankylosing spondylitis, barretts oesophagous and gallstones. He presented with epigastric and right upper quadrant pain. He received an US which did not show gallstones, (but has had previous gallstones). He was reviewed by the team and discharged with antibiotics and analgesia and worsening advice. He will be reviewed in the gallbladder clinic in due course.

For further information please contact the ward team.

Best wishes,
Dr Sergeant
FY1,SAU

COPY**Safety Alerts**

Nil records exist

Allergy/Intolerance - JAC

Allergy/Intolerance	Reaction
dihydrocodeine	Unknown

Allergy records are as recorded at time and date of printing

Medications - Pharmacy System**Drug Information:**

Drug	Route	Dose	Dose and Frequency	GP to Continue	POD	Days Supply
------	-------	------	--------------------	----------------	-----	-------------

Nil records exist

Drug Notes:

Drug	Drug Notes
------	------------

Nil records exist

Additional Medicine Information:

Medicines discontinued during admission (Medicines that patient was recorded as admitted on only)

Drug	Discontinued Reason
------	---------------------

Nil records exist

GP Communications:**Outstanding Results -****Responsibility of Hospital**

Nil records exist

Person completing record

<u>Authorised by</u>		<u>Clinically completed by</u>	
Name:	Dr Laura Sergeant	Name:	Dr Laura Sergeant
Designation or role:	Doctor	Designation or role:	Doctor
Specialty:		Specialty:	
Date completed:	23-Oct-2025		

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
A Syeed	GP	Falkirk Community Hospital

**Immediate Discharge Letter
(Authorised)****COPY**

A Syeed
Falkirk Community Hospital
Westburn Avenue
Falkirk
Falkirk
FK11 5SU

General Surgery,
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

CHI Barcode:



Date of Completion: 28-Nov-2025

Patient Demographics

Patient Name:	DOWELL, Scott	Date Of Birth:	26-Feb-1980
Patient Address:	11 Don Street Grangemouth Stirlingshire FK3 8HD	Gender:	Male
		CHI No:	2602800570
Telephone No:	01324 262719		

GP Practice

GP Name:	A Syeed	GP GMC:	4615437
GP Practice Address:		GP Practice Code:	4615437/26015
		GP Clinic Code:	26015
		GP Telephone:	

Admission Details

Patient Location:	General Surgery	Admission Care Provider:	Mr Akan Emin
Admission Date:	23-Nov-2025	Admission Time:	13:44
Admission Method:	Emergency Admission, type not known	Ward:	FVRH Ward SAU
Source Of Admission:	A&E Ward within Trust		

Discharge Details

Discharge Specialty:	General Surgery	Discharge Care Provider:	Mr John Camilleri-Brennan
Discharge Date:	26-Nov-2025	Ward:	FVRH Ward B11
Discharge Time:	11:16	Discharge Destination:	Private Residence - no additional detail added
Discharge Method:	Discharge from NHS inpatient/day case care		

Clinical Summary including History

Dear Doctor,

Diagnoses: Post-op pain

Medication changes: Nil

GP actions: Nil

Follow up: District nurses

Inpatient summary:

Mr Dowell was admitted with increasing pain following laparoscopic cholecystectomy 20/11. He was taken back to theatre for a laparoscopic washout, where no obvious cause for pain identified. His drains were removed and his pain settled. For discharge home with follow up by district nurses.

COPY

Kind regards,
Dr Anan Ahmed
FY1 General Surgery

Safety Alerts

Nil records exist

Allergy/Intolerance - JAC

Allergy/Intolerance **Reaction**

***No Known Drug Allergies

Allergy records are as recorded at time and date of printing

Medications - Pharmacy System

Drug Information:

Drug	Route	Dose	Dose and Frequency	GP to Continue	POD	Days Supply
CO-AMOXICLAV 500/125 Tablets	Oral	0Tablet	1 Tablet THREE times daily at 8am, 2pm and 10pm for 5 day(s)	N	N	5
DIHYDROCODEINE 30 mg Tablets	Oral	0mg	60 mg FOUR times daily at 8am 12noon 6pm 10pm when required (PRN) 4-6 hourly for PAIN MAX 240mg in 24h	N	N	7
LAXIDO Sachets	Oral	0Sachet	1 Sachet when required (PRN) for constipation as required	N	N	7

Drug Notes:

Drug **Drug Notes**

Nil records exist

Additional Medicine Information:

Medicines discontinued during admission (Medicines that patient was recorded as admitted on only)

Drug	Discontinued Reason
ROPINIROLE 250 micrograms Tablets	Not prescribed on TTA
TADALAFIL 5 mg Tablets	Not prescribed on TTA
PREGABALIN 300 mg Capsules	Not prescribed on TTA
DULOXETINE 60 mg Capsules	Not prescribed on TTA
LIDOCAINE 5 % Medicated plaster	Not prescribed on TTA
DOXYCYCLINE 100 mg Capsules	Discontinued - Therapeutic switch
ESOMEPRAZOLE 40 mg Tablets	Not prescribed on TTA
COLECALCIFEROL 800 units Tablets	Not prescribed on TTA

GP Communications:

TT0- Co-Amoxiclav, 5 days remain to complete course, laxido and dihydrocodine. GP- No changes have been made to medication during this admission

Outstanding Results

Responsibility of Hospital

Nil records exist

Person completing record

Authorised by	Clinically completed by
Name: Dr Anan Ahmed	Name: Dr Anan Ahmed
Designation or role: Doctor	Designation or role: Doctor
Specialty:	Specialty:
Date completed: 28-Nov-2025	

Distribution List

Recipient Name
A Syeed

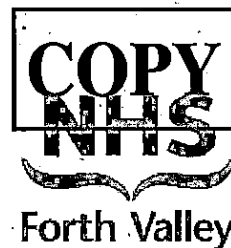
Recipient Type
GP

Recipient Organisation
Falkirk Community Hospital

COPY

Ophthalmology Department
Consultant: Dr Oliver Chadwick
Tel:

Falkirk Community Hospital
Majors Loan
Falkirk
FK1 5QE



Dr R Lal
Health Centre
Kersiebank Avenue
Grangemouth
FK3 9EL

Date Dictated: 25/07/2023
Date Typed: 26/07/2023
Our Ref: OC/RAR/RAC
CHI: 2602800570

Dear Dr R Lal

Scott Dowell DOB: 26-02-1980
11 Don Street Grangemouth FK3 8HD

Diagnosis: Right corneal epithelial flap following previous attempts at foreign body removal

V/A: Right eye 6/12 improving with pinhole to 6/9.5
Left eye 6/7.5 improving with pinhole to 6/6

Treatment: Continue gutte exocin four times a day to the right eye
Continue occ chloramphenicol nocte to the right eye

Outcome: Review in one week

Yours sincerely

Dictated and electronically checked by:

Dr Oliver Chadwick
Consultant Ophthalmologist

CC:

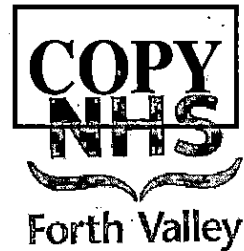
Chair: Janie McCusker
Chief Executive: Cathie Cowan

NHS Forth Valley
Headquarters: Carseview House, Castle Business Park, Stirling, FK9 4SW

[nhsforthvalley.com](https://www.nhsforthvalley.com) [nhsforthvalley](https://www.facebook.com/nhsforthvalley)
 [@nhsforthvalley](https://twitter.com/nhsforthvalley) [@nhsforthvalley](https://www.instagram.com/nhsforthvalley)

Ophthalmology Department
Consultant: Dr David Miller
Tel: 01324 614369

Falkirk Community Hospital
Majors Loan
Falkirk
FK1 5QE



Dr R Lal
Health Centre
Kersiebank Avenue
Grangemouth
FK3 9EL

Date Dictated: 14/07/2023
Date Typed: 17/07/2023
Our Ref: DM/RAR
CHI: 2602800570

Dear Dr R Lal

Scott Dowell DOB: 26-02-1980
11 Don Street Grangemouth FK3 8HD

Diagnosis: Right metallic corneal foreign body

V/A: Right 6/24, left 6/7.5

Medications: Chloramphenicol ointment four times a day for the next three days
Removed completely at slit lamp

Yours sincerely

Dictated and sent electronically unchecked by:

Dr David Miller
Consultant Ophthalmologist

CC:

Chair: Janie McCusker
Chief Executive: Cathie Cowan

NHS Forth Valley
Headquarters: Carseview House, Castle Business Park, Stirling, FK9 4SW

nhsforthvalley.com
 [@nhsforthvalley](https://twitter.com/nhsforthvalley)

[nhsforthvalley](https://facebook.com/nhsforthvalley)
 [@nhsforthvalley](https://instagram.com/nhsforthvalley)

Immediate Discharge Letter (Authorised)

COPY

General Surgery
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

CHI Barcode:



2602800570

Date of Completion: 03-Mar-2020

Patient Demographics

Patient Name:	DOWELL, Scott	Date Of Birth:	26-Feb-1980
Patient Address:	11 DON STREET Grangemouth Stirlingshire FK3 8HD	Gender:	Male
		CHI No:	2602800570
Telephone No:	01324262719		

GP Practice

GP Name:	DW Dundas	GP GMC:	6075873
GP Practice Address:	Westburn Medical Practice Falkirk Community Hospital Westburn Avenue Falkirk Falkirk FK1 5SU	GP Practice Code:	6075873/25883
		GP Clinic Code:	25883/1
		GP Telephone:	01324 623577

Admission Details

Patient Location:	General Surgery	Admission Care Provider:	Mr Euan MacDonald
Admission Date:	24-Feb-2020	Admission Time:	17:49
Admission Method:	Emergency Admission, type not known	Ward:	FVRH Ward SAU
Source Of Admission:	GP Non Obstetrics - other Provider		

Discharge Details

Discharge Specialty:	General Surgery	Discharge Care Provider:	Mr Christopher Shearer
Discharge Date:	29-Feb-2020	Ward:	FVRH Ward B11
Discharge Time:	17:34	Discharge Destination:	Private Residence - no additional detail added
Discharge Method:	Regular discharge, no additional detail added		

Clinical Summary including History:

Dear Doctor,

This man was admitted to FVRH on 24/2/20 with sudden onset epigastric pain.

CT showed uncomplicated cholecystitis for which he was treated with IV antibiotics and analgesia. Once clinically improved he was discharged home with oral antibiotics.

Medications:

Biologic withheld whilst inpatient. To remain withheld until 2 weeks post cholecystectomy.

Follow up:

-Outpatient clinic 6/52

Thank you for your continued care.

Yours sincerely,

Rachael Robertson FY1

COPY

Reason for Admission and Presenting Complaint

Reason for Admission

abdo pain

CT - cholecystitis

Investigations

Diagnosis

Initial Diagnosis:

Final Diagnosis:

Other Active Problems:

No Other Active Problem Results

Co-morbidities

Patient has Comorbidities : Yes

Other Comorbidities : Left hip replacement

Barretts disease

ankylosing spondylitis

IDL Additional Information

Status : Authorised

Follow Up Required : Yes

Follow Up Arrangements : See letter

Please confirm if there have been changes to this patients medication: : Yes - this patients medication has changed

Compliance Aid : No

Final Discharge Letter to Follow : No

Does this patient have a Detention Order? : No

Operations / Procedures

Safety Alerts

Nil records exist

Allergy/Intolerance - JAC

Allergy/Intolerance

Reaction

dihydrocodeine

Unknown

Allergy records are as recorded at time and date of printing

Medications - JAC						
Drug Information:						COPY
Drug	Dose	Route	Frequency	GP to Continue	Days Supply	
AMOXICILLIN 500mg Capsules	500mg	Oral	THREE times daily at 8am, 12 midday and 6pm	N	N	5
CIPROFLOXACIN 500mg Tablets	500mg	Oral	TWICE daily at 8am and 6pm	N	N	5
ESOMEPRAZOLE 40mg Tablets	40mg	Oral	TWICE daily at 8am and 8pm	Y	Y	0
LAXIDO Sachets	2Sachet	Oral	TWICE daily at 8am and 12 midday	Y	N	7
METRONIDAZOLE 400mg Tablets	400mg	Oral	THREE times daily at 8am, 12 midday and 6pm	N	N	5
RANITIDINE 150mg Tablets	150mg	Oral	TWICE daily at 8am and 8pm	Y	Y	0
ROPINIROLE 500micrograms Tablets	1000microgram	Oral	ONCE daily at 10pm	Y	Y	0

Drug Notes:

Drug Nil records exist

Additional Medicine Information: Medicines discontinued during admission (Medicines that patient was recorded as admitted on only)

Discontinued Reason

Drug Nil records exist

GP Communications: Changes made to Medication Yes Short Stay Patient No DISCONTINUED MEDICATION None MODIFIED MEDICATION None SUSPENDED MEDICATION None CLINICAL SUMMARY No changes to regular medication. To complete 5 days oral antibiotics

Outstanding Results - DartCM

Responsibility of Hospital		
Discipline	Investigation	Date Ordered
Microbiology	Gentamicin Level	25-Feb-2020

Person completing record

Name:	Dr Rachael Anne Robertson	Specialty:	
Designation or role:	Doctor	Date completed:	03-Mar-2020

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
DW Dundas	GP	Westburn Medical Practice

Ophthalmology Department
Consultant: Dr Andrew Ferguson
Tel: 01324 614369

Falkirk Community Hospital
Majors Loan
Falkirk
FK1 5QE



Dr Derek Dundas
Westburn Medical Practice
Falkirk Community Hospital
Westburn Avenue
Falkirk
FK1 5SU

Date 29 June 2019
Dictated
Date Typed 01 July 2019

Our Ref AF/RR/F207472 (RAC)
CHI 2602800570



Dear Dr Dundas

Scott Dowell 26/02/1980
11 DON STREET Grangemouth Stirlingshire FK3 8HD

Diagnosis: Left corneal metallic foreign body

V/A: Right 6/12, left 6/24

Management: Foreign body + rust ring removed at slit lamp
Occ Chloramphenicol left eye qid four days
No routine follow-up arranged

Yours sincerely

(Dictated and electronically checked by Dr Andrew Ferguson)

Dr Andrew Ferguson
Consultant Ophthalmologist

Chairman: Alex Linkston CBE
Chief Executive: Cathie Cowan

Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SW

www.nhsforthvalley.com Facebook.com/nhsforthvalley @nhsforthvalley



INVESTORS
IN PEOPLE

Gold
Unit 2021

Immediate Discharge Letter

NHS

Forth Valley

COPY

Hospital: Forth Valley Royal Hospital, Larbert
Consultant: Jabbar, Mr Aijaz
Specialty: General Surgery

Tel: 01324 56 000
Discharging Ward: FVRH - Day Surgery Unit

GP Details	Patient Details	Admission Details
Practice Code: 25883	Patient CHI No: 2602800570	Admission Date: 01/08/2018
	Patient Hospital No: F207472	
GP Name: Dr Derek Dundas	Surname: Dowell	Admission Type: Routine - Elective (From Waiting List, excl. Transfers)
Address: Falkirk Community Hospital, Westburn Avenue, Falkirk, FK1 5SU	Forename: Scott	Presenting Complaint: Abdominal Pain
	Date of Birth: 26/02/1980	
	Address: 11 Don Street,, Grangemouth,, Stirlingshire, FK3 8HD	Discharge Date: 01/08/2018
		Discharge To: Private Residence - Living with Relatives or Friends

Diagnosis/Problem List

XaBj5 - Abscess of back

Additional comment (Progress, Investigations, Procedures, Complications etc)

Dear Doctor

* I was not directly involved in this pt's care history obtained from notes*

Mr Dowell presented with history of pain swelling to back (4cm x 6cm) which was discharging small amounts of pus.
Consent obtained to have same drained under GA.
Discharged home, no surgical follow up required.
Daily dressing - DN.

Kind regards

Results Outstanding (Y/N) If yes, give details:	No
--	----

Information to patient/carer (Y/N):	Patient: Yes Carer (if applicable):
-------------------------------------	--

Follow up arrangements

There are no Reviews planned

Authorisor's name: Louise Doyle	Authorisor's Signature:
Authorisor's grade: Advanced Nurse Practitioner	
Read/Approved by:	
Date: 05/08/2018	
Discharge Ward Nurse:	

Forth Valley Acute Hospitals Acute Division
Medications Discharge Summary

Name: Mr Scott Dowell	Patient's Tel No:
Address: 11 Don Street,, Grangemouth,, Stirlingshire, FK3 8HD	Patient's Tel 474369
Admission Date: 01/08/2018	Eve:
	Discharge Date: 01/08/2018

COPY

PATIENT ALERTS

Alert Group	Alert	Alert Comment	When Added	Added By
-------------	-------	---------------	------------	----------

PATIENT DRUG REACTIONS

CURRENT PRESCRIPTION (all medicines currently prescribed)

**e.g. clinical indication for prescription monitoring*

MEDICINES DISCONTINUED

Nurse check on discharge:

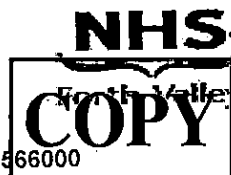
Signature 1:

Signature 2:

Name: Mr Scott Dowell

CHI: 2602800570

Immediate Discharge Letter



Hospital: Forth Valley Royal Hospital, Larbert
 Consultant: Tinning, Dr Craig
 Specialty: Trauma and Orthopaedic Surgery

Tel: 01324 566000
 Discharging Ward: FVRH - Ward B23

GP Details		Patient Details		Admission Details	
Practice Code:	25883	Patient CHI No:	2602800570	Admission Date:	20/07/2018
GP Name:	Dr Derek Dundas	Patient Hospital No:	F207472	Admission Type:	Routine - Elective (From Waiting List, excl. Transfers)
Address:	Falkirk Community Hospital, Westburn Avenue, Falkirk, FK1 5SU	Surname:	Dowell	Presenting Complaint:	Elective Admission
		Forename:	Scott		
		Date of Birth:	26/02/1980	Discharge Date:	22/07/2018
		Address:	11 Don Street, Grangemouth, Stirlingshire, FK3 8HD	Discharge To:	Private Residence - Living with Relatives or Friends

Diagnosis/Problem List

N100. - Ankylosing spondylitis

Additional comment (Progress, Investigations, Procedures, Complications etc)

Final main diagnoses on discharge:

1. Osteoarthritis

Operations / Procedures: (including dates)

- Elective left THR

Key events:

✓ Destructive changes to left hip

✓ Elective THR

Episode of N&V immediately post op - there was some blood (hx of oesophagitis) started on IV PPI and changed back to orals as resolved within 24 hours

Other important conditions treated or diagnosed this admission:

1. N/A
- 2.

Important medication changes: (See Hepma for full medication summary)

Rivaroxaban 35 days total post op

Analgesia for pain

Chronic conditions and important co-morbidities:

✓ Ankylosing Spondylitis

✓ Oesophagitis (islands of Barrets)

Results awaited at time of IDL: (hospital responsibility)

Nil

Follow up and future investigations being arranged by hospital:

ROS in community 2/52

Arthroplasty clinic 6 weeks

Anticipatory planning / DNA-CPR/AWI:
N/A

COPY

Work advice/ MED-3/ Driving advice:
N/A

GP advice/requests for post-discharge:
Ank Spond therapy to be suspended until clips out and wound confirmed satisfactory

Many thanks for your ongoing care of this patient and if you have any questions please contact us.

Dr. Michael Overend
FY1

Results Outstanding (Y/N) yes, give details:	No
---	----

Information to patient/carer (Y/N):	Patient: Yes Carer (if applicable): Yes
-------------------------------------	--

Follow up arrangements
Arthroplasty nurse, Orthopaedic Clinic, 6 Weeks

Authorisor's name: Dr A Anderson Authorisor's grade: FY1 Read/Approved by: Date: 31/07/2018	Authorisor's Signature:
Discharge Ward Nurse:	

Validation/Contact Name: Tinning, Dr Craig

Name: Mr Scott Dowell

THIS IS THE FINAL DOCUMENT
CHI: 2602800570

Forth Valley Acute Hospitals Acute Division
Medications Discharge Summary

Name: Mr Scott Dowell
Address: 11 Don Street,, Grangemouth,, Stirlingshire, FK3 8HD
Admission Date: 20/07/2018

Patient's Tel No:
Patient's Tel 474369
Eve:
Discharge Date: 22/07/2018

COPY

PATIENT ALERTS

Alert Group	Alert	Alert Comment	When Added	Added By
-------------	-------	---------------	------------	----------

PATIENT DRUG REACTIONS

CURRENT PRESCRIPTION (all medicines currently prescribed) **e.g. clinical indication for prescription monitoring*

MEDICINES DISCONTINUED

Nurse check on discharge:

Signature 1:

Signature 2:

Name: Mr Scott Dowell

CHI: 2602800570

Gastroenterology Unit
Consultant: Dr Santosh Salunke
Tel: 01324 566841

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Dr Derek Dundas
Westburn Medical Practice
Falkirk Community Hospital
Westburn Ave
Falkirk
FK1 5SU

Date Dictated 01 May 2018
Date Typed 30 May 2018

Our Ref SS/HS/S679370
CHI 2602800570

Dear Dr Dundas

SCOTT DOWELL 26/02/1980
11 DON STREET, GRANGEMOUTH, STIRLINGSHIRE FK3 8HD

I was delighted to review Mr Dowell back in the clinic. He is completely well and asymptomatic, his appetite and weight are stable. His current weight is 94 kilograms.

He is currently on both Ranitidine and Esomeprazole and it may be that he could discontinue Ranitidine and just stay on Esomeprazole. Otherwise I have reassured him and discharged him from further follow up at the clinic.

Best wishes.

Yours sincerely

(Dictated and electronically checked by Dr Santosh Salunke)

Dr Santosh Salunke
Consultant Gastroenterologist



Chairman: Alex Linkston CBE
Chief Executive: Cathie Cowan

*Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SW*

www.nhsforthvalley.com [Facebook.com/nhsforthvalley](https://www.facebook.com/nhsforthvalley) [@nhsforthvalley](https://twitter.com/nhsforthvalley)

Immediate Discharge Letter



Forth Valley

COPY
Capacity Area 3

Hospital: Forth Valley Royal Hospital, Larbert.
Consultant: McIlhenny, Mr Craig
Specialty: Urology

Tel: 01324 564000
Discharging Ward: FVRH

GP Details	Patient Details	Admission Details
Practice Code: 25883	Patient CHI No: 2602800570	Admission Date: 08/02/2018
	Patient Hospital No: F207472	
GP Name: Dr Derek Dundas	Surname: Dowell	Admission Type: Routine - Elective (From Waiting List, excl. Transfers)
Address: Falkirk Community Hospital, Westburn Avenue, Falkirk, FK1 5SU	Forename: Scott	Presenting Complaint: Testicular Pain
	Date of Birth: 26/02/1980	
	Address: 11 Don Street,, Grangemouth,, Stirlingshire, FK3 8HD	Discharge Date: 08/02/2018
		Discharge To: Private Residence - Living with Relatives or Friends

Diagnosis/Problem List

K28yv - Other scrotal disease

Additional comment (Progress, Investigations, Procedures, Complications etc)

Dear Doctor,

This 37 year old gentleman was admitted to SAU with right scrotal pain and recent dysuria. This pain was worse on voiding.

O/E: Apyrexial, no tachycardia, both testis normal, no particular testicular tenderness

Recent urine culture negative
CT the previous day negative

Plan:

Home with 7 days of co-amoxiclav 625mg 3x daily

No follow up.

Kind regards

L Fagan

FY1 SAU

Not directly involved in patient care, written from clinical notes

Results Outstanding (Y/N) If yes, give details:	No
--	----

Information to patient/carer (Y/N):	Patient: No Carer (if applicable):
-------------------------------------	---------------------------------------

Follow up arrangements

There are no Reviews planned

Forth Valley Acute Hospitals Acute Division
Medications Discharge Summary

Name:	Mr Scott Dowell	Patient's Tel No:	
Address:	11 Don Street,, Grangemouth,, Stirlingshire, FK3 8HD	Patient's Tel Eve:	474369
Admission Date:	08/02/2018	Discharge Date:	08/02/2018

COPY

PATIENT ALERTS

Alert Group	Alert	Alert Comment	When Added	Added By
-------------	-------	---------------	------------	----------

PATIENT DRUG REACTIONS

CURRENT PRESCRIPTION (all medicines currently prescribed)	<i>*e.g. clinical indication for prescription monitoring</i>
---	--

MEDICINES DISCONTINUED

Nurse check on discharge:

Signature 1:

Signature 2:

Name: Mr Scott Dowell

CHI: 2602800570

Immediate Discharge Letter

NHS

Forth Valley

COPY

Hospital: Forth Valley Royal Hospital, Larbert
Consultant: McIlhenny, Mr Craig
Specialty: Urology

Tel: 01324 56 000
Discharging Ward: FVRH - Capacity Area 3

GP Details	Patient Details	Admission Details
Practice Code: 25883	Patient CHI No: 2602800570	Admission Date: 08/02/2018
	Patient Hospital No: F207472	
GP Name: Dr Derek Dundas	Surname: Dowell	Admission Type: Routine - Elective (From Waiting List, excl. Transfers)
Address: Falkirk Community Hospital, Westburn Avenue, Falkirk, FK1 5SU	Forename: Scott	Presenting Complaint: Testicular Pain
	Date of Birth: 26/02/1980	
	Address: 11 Don Street,, Grangemouth,, Stirlingshire, FK3 8HD	Discharge Date: 08/02/2018
		Discharge To: Private Residence - Living with Relatives or Friends

Diagnosis/Problem List

K28yv - Other scrotal disease

Additional comment (Progress, Investigations, Procedures, Complications etc)

Dear Doctor,

This 37 year old gentleman was admitted to SAU with right scrotal pain and recent dysuria. This pain was worse on voiding.

O/E: Apyrexial, no tachycardia; both testis normal, no particular testicular tenderness

Recent urine culture negative
CT the previous day negative

Plan:
Home with 7 days of co-amoxiclav 625mg 3x daily

No follow up.

Kind regards
L Fagan
FY1 SAU

Not directly involved in patient care, written from clinical notes

Results Outstanding (Y/N) If yes, give details:	No
--	----

Information to patient/carer (Y/N):	Patient: No Carer (if applicable):
-------------------------------------	---------------------------------------

Follow up arrangements

There are no Reviews planned

Forth Valley Acute Hospitals Acute Division
Medications Discharge Summary

Name: Mr Scott Dowell
Address: 11 Don Street,, Grangemouth,, Stirlingshire, FK3 8HD

Patient's Tel No:
Patient's Tel 474369
Eve:

Admission Date: 08/02/2018

Discharge Date: 08/02/2018

COPY

PATIENT ALERTS

Alert Group	Alert	Alert Comment	When Added	Added By
-------------	-------	---------------	------------	----------

PATIENT DRUG REACTIONS

CURRENT PRESCRIPTION (all medicines currently prescribed)

**e.g. clinical indication for prescription monitoring*

MEDICINES DISCONTINUED

Nurse check on discharge:

Signature 1:

Signature 2:

Name: Mr Scott Dowell

CHI: 2602800570

5679370

14/09/17 (JAN '18)

SE

Department of Orthopaedic Surgery**Consultant: Mr Craig Tinning**

Tel: 01324 566817

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WRDr Sara Else,
Consultant Rheumatologist,
Rheumatology Department,
Forth Valley Royal Hospital.Date Dictated 13 November 2017
Date Typed 16 November 2017
Our Ref CT/SJC/F207472
CHI 2602800570Libby
30/11
18/4

Dear Dr Else

SCOTT DOWELL 26/02/1980**11 DON STREET, GRANGEMOUTH, STIRLINGSHIRE FK3 8ED**

Diagnosis: Ankylosing spondylitis
Advanced secondary osteoarthritis left hip

Management: Waiting list for left total hip replacement (c stem pinnacle ceramic on ceramic)

Thank you for referring this 37 year old gentleman to the orthopaedic clinic. I note your detailed clinic letter from 14.09.2017. Mr Dowell was apparently reviewed by Mr Roche a couple of years ago but the corresponding clinic letter was not available on portal today. I gather that, whilst he was told he had significant left hip osteoarthritis, the advice was to wait as long as possible before proceeding with hip replacement. Mr Dowell's symptoms continue to progress and he complains bitterly of left groin pain. There is clearly associated significant back pain and stiffness and I note Mr Dowell is currently on biologic injections as the main stay of treatment. He is now at a stage where he is unable to walk more than 20 yards at a time without stopping due to hip pain. He uses one crutch in and outdoors. He reports frequent night pain and sleep disturbance.

Examination of the left hip is consistent with advanced osteoarthritis. He has 10-15 degrees of obligate external rotation from where only about 10 degrees of further external rotation is possible. He has passive flexion up to about 80 degrees. His spine is clinically ankylosed. Up to date X rays of the pelvis today confirm advanced secondary osteoarthritis at the left hip. There is quite significant cystic change within the femoral head and there may well be an inflammatory component to his hip arthritis.

From a surgical point of view nothing short of a total hip replacement will help Mr Dowell's symptoms. We discussed the pros and cons in detail in particular we mentioned risks such as infection and Mr Dowell would have to stop his Humira several weeks in advance of surgery. I would be grateful for your specific advice as regards timing. He would also be at risk of dislocation which, given his very stiff spine, would likely be higher than average. Being young eventual loosening and revision surgery would be likely. He would also be at risk of nerve and blood vessel injury and blood clots. Mr Dowell is keen to proceed and feels he has reached a stage where he can no longer continue without addressing his hip pain. He has been

16 NOV 2017

RECEIVED

Chairman: Alex Linkston CBE
Interim Chief Executive: Fiona RamsayForth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SWwww.nhsforthvalley.com Facebook.com/nhsforthvalley @nhsforthvalleyINVESTORS
IN PEOPLE

Silver

added to my waiting list accordingly.

COPY

Yours sincerely

(Dictated and electronically checked by Mr Craig Tinning)

Mr Craig Tinning
Consultant Orthopaedic Surgeon

Cc

Dr Derek Dundas
Westburn Medical Practice
Falkirk Communityhospital
Westburn Ave
Falkirk
FK1 5SU

Gastroenterology Unit
Consultant: Dr Santosh Salunke
Tel: 01324 566841

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Consultants: Dr D Watts, Dr S Paterson, Dr R Burnham, Dr T Heron,
Dr S Siddhi, Dr S Salunke, Dr A Ahmed, Dr C Evans
Specialist Nurses: Ann Muir, Gillian Richardson

Dr Derek Dundas
Westburn Medical Practice
Falkirk Communityhospital
Westburn Ave
Falkirk
FK1 5SU

Date Dictated 30 September 2017
Date Typed 24 October 2017
Our Ref SS/CF/F207472
CHI 2602800570

Dear Dr Dundas

SCOTT DOWELL 26/02/1980
11 DON STREET, GRANGEMOUTH, STIRLINGSHIRE FK3 8HD

Further to review of this gentleman at repeat endoscopy, we repeated the biopsy on an island of suspected Barrett's or irregular Z-line. This showed chronic inflammatory changes at the gastroesophageal junction. This is reassuring.

Although he did not complain of significant symptoms when he came to endoscopy, I have seen a note from my rheumatology colleague Dr Else stating that when he met her at the clinic he had complained of significant indigestion. She therefore added H2 blocker on top of PPI. It would be good to see his response to this combination. I will arrange for him to come to one of the gastroenterology clinics on a routine basis for further assessment.

Yours sincerely

(Dictated and electronically checked by Dr Santosh Salunke)

Dr Santosh Salunke
Consultant Gastroenterologist

Cc: David Ogston, Health Records Officer, RTT Office, FVRH, Larbert
Dr Sara Else, Consultant Rheumatologist, FVRH, Larbert

David: I would be grateful if this gentleman could come to one of the gastro clinics in an RNR slot.



Chairman: Alex Linkston CBE
Interim Chief Executive: Fiona Ramsay

Forth Valley NHS Board is the common name for Forth Valley Health Board.
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SW

www.nhsforthvalley.com Facebook.com/nhsforthvalley @nhsforthvalley

Name : DOWELL, SCOTT
Address : 11 DON STREET
GRANGEMOUTH
STIRLINGSHIRE

Post Code: FK3 8HD

CHI No. : 2602800570
DoB : 26/02/1980

Requested By : Dr Santoshkumar Salunke
Location : Endoscopy
Forth Valley Royal Hospital

COPY

HISTOLOGY REPORT

Clinical Details

Raised area of GOJ.

Oesophageal Biopsy

Two biopsies both 1 mm.

Microscopy

These are biopsies of squamocolumnar mucosa in keeping with the origin from the gastro-oesophageal junction. There is a mild chronic inflammatory cell infiltrate. In areas there is submucosal haemorrhage. There is no evidence of intestinal metaplasia, dysplasia or malignancy.

Summary: Chronic Inflammation at Gastro-oesophageal Junction.

Reported By: Dr Amanda Paton

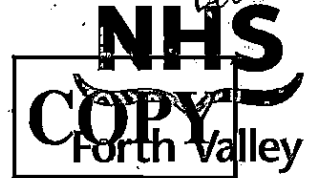


*Lab 1 reported results 150 g 90 in culture
to esophageal 40 g 90. Type that was ok*

See also

Department of Rheumatology
Consultant: Dr Sara Else
Tel: 01324 566336 / 01324 566337

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Dr Derek Dundas
Westburn Medical Practice
Falkirk Community Hospital
Westburn Ave
Falkirk
FK1 5SU

Date Dictated 14 September 2017
Date Typed 14 September 2017
Our Ref SE/WT/F207472
CHI 2602800570

Dear Dr Dundas

SCOTT DOWELL 26/02/1980
11 DON STREET GRANGEMOUTH STIRLINGSHIRE FK3 8HD

Diagnosis:

1. Ankylosing Spondylitis
 - Axial Disease
 - Evidence of complete ankylosis sacroiliac joints on x-ray
 - Post inflammatory corner changes along with extensive ankylosis on MRI
 - Destructive changes to left hip

Current Medications:

1. Humira (April 2017)
2. Esomeprazole 40mg b.d.
3. Dihydrocodeine
4. Ropinirole for restless legs

Previous Treatments:

1. Simponi – problems with suicidal thoughts after first injection
2. Benepali – primary non response
3. Variety of anti-inflammatories – ineffective and problems with indigestion

Management:

1. Continue Humira
2. I am going to refer Mr Scott back to the lower limb orthopaedic surgeons for consideration of left hip replacement
3. Please would you prescribe Ranitidine 150mg b.d. as per my treatment advice note

Follow Up: 6 months

I saw Mr Dowell in the rheumatology clinic today. I was delighted to hear that he does feel that his Humira is really providing some significant benefit for his ankylosing spondylitis. The biggest problem he has at the moment is with pain around the left hip which is related to significant damage. There is no doubt that this is influencing his overall BASDAI score which is still elevated at 7.8 but is a significant improvement from pre treatment score of 9.0. I note that alongside this his CRP has improved from 16 to 5 which is also encouraging.



Chairman: Alex Linkston CBE
Interim Chief Executive: Fiona Ramsay

Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SW

www.nhsforthvalley.com Facebook.com/nhsforthvalley @nhsforthvalley

Scott is getting some problems with alteration of mood which occur about 12 hours after taking Humira injection but resolve within a 12 hours period. We did discuss today about the possibility of trying him on alternate treatment with Secukinumab but because he feels Humira is providing significant improvement with his joints and he and his family are managing his mood alteration he was not at all keen on this. We shall therefore continue with Humira.

Mr Dowell has previously seen by Mr Roche, Consultant Orthopaedic Surgeon. Mr Roche did feel that Scott would need a left hip replacement in the longer term but was trying to delay it as long as possible. Given the severity of his pain we may have reached that point. In light of this I am re-referring him back to orthopaedics.

On a separate note Scott continues to get significant problems with indigestion. He has recently had repeat OGD which does show ongoing evidence of chronic inflammation at the gastro oesophageal junction. He is currently taking Esomeprazole 40mg b.d. In light of this I would suggest that you add in Ranitidine 150mg b.d. although if Dr Salunke feels that something else would be more appropriate then I would be guided by this.

Scott will be reviewed in the nurse biologics clinic in around 6 months.

Yours sincerely

(Dictated and electronically checked by Dr Sara Else)

Dr Sara Else
Consultant Rheumatologist

Cc Dr Salunke, Consultant Gastroenterologist, FVRH

Dear Santosh

I took the liberty of starting Mr Dowell on 150mg b.d. Ranitidine in addition to his Esomeprazole but I did advise him that if you thought that there would be something else that would be more appropriate you would let him know.

Best Wishes

Sara

Cc Lower limb Orthopaedic Consultants, FVRH

Dear Colleagues

This patient was previously seen by Mr Roche. He has got significant destructive changes to his left hip which is probably related to ankylosing spondylitis. Mr Roche was of the view that he would need left hip replacement but was trying to delay this as long as possible. Mr Dowell is now having significant severe pain in his left hip which is affecting his mobility and I wonder if he has reached the point that he does need surgery. I wonder if you could assess this.

Many thanks

Sara

GASTROSCOPY REPORT

Name: **Scott DOWELL (M)**
 Date of birth: **26/02/1980**
 CHI No: **2602800570**
 Case note no.: **S679370**

Address: **11 Don Street,
 Granton, Edinburgh,
 Stirlingshire
 FK3 8HD**

COPY

GP: **Dr DW Dundas
 Westburn Medical Practice
 Falkirk Community Hospital
 Westburn Ave
 Falkirk
 FK1 5SU**

Procedure date: **29th August 2017 (10:10)**
 Priority: **Repeat/Scheduled**
 Status: **Outpatient/NHS**
 Hospital: **FVRH**
 Referring Cons: **Dr Santosh Salunke
 (Referring Consultants)**

Indications

Assessment of raised area at GOJ.

Report

The procedure was completed successfully to D2.

Site a: Anterior lower oesophagus

Specimens: 2x biopsy.

Diagnosis

STOMACH. Normal.
 DUODENUM. Normal.

Advice/comments

Await bx

Follow up

Awaiting pathology results. Return to the GI physician.

Consultant/Endoscopist

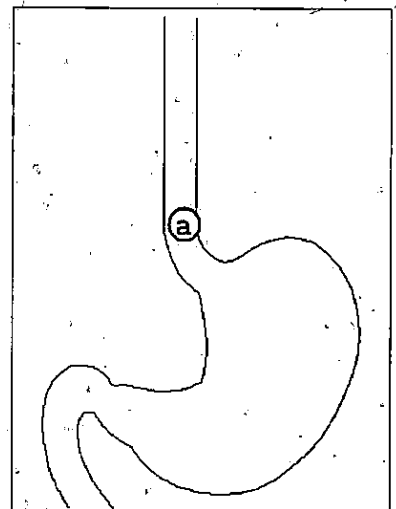
Dr Santosh Salunke
 Nurses: Susan Alexander
 Dianne Hill

Instrument

GIF 260 2243915

Premedication

Buscopan (IV) 10 mg
 Midazolam (IV) 2 mg



**a: Anterior lower oesophagus
 (photographed)**

Dr Santosh Salunke
Consultant Gastroenterologist
 c.c. Dr Santosh Salunke (Referring Consultants)
 Dowell, Scott

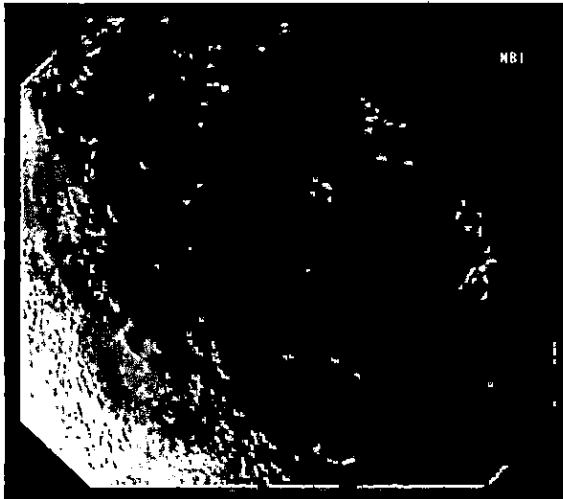
GASTROSCOPY REPORT

Name: **Scott DOWELL (M)**
Date of birth: **26/02/1980**
CHI No: **2602800570**
Case note no.: **S679370**

Address: **11 Don Street,
Grange, Forth
Stirling, FK3 8HD**

COPY

Procedure date: **29th August 2017 (10:10)**



Site a: Anterior lower oesophagus

- (RB/SP/GG)

BIOLOGIC CLINIC REVIEWS



CHI:2602800570

CRN:S679370 26/02/1980

COPY
11 Don Street,
GRANGE MOUTH,
Stirlingshire
FK3 8HD

Date

14/08/17

Phoned for bloods

Weight

BP

Urinalysis

Infections since last review

No

~~Pregnant / using effective contraception~~

Increased shortness of breath?

No SOB

Side effects

None known

Con Med:

1. Humira
2. Dihydrocodeine
3. Esomeprazole
4. Rampidomyl
- 5.
- 6.

Action

Mr Daseel is doing well he feels his movements are much better. Only complaint would be his EMS still last a fair bit. Plan - to continue with Humira at present.

Prescription signed renew in Sept Dr Elze and Biologu.

BSRBR 6 month review form completed Clinic Jan. Aware to

BSRBR 6 month review form posted. Contact advice line should

he need advice prior to this

Stiles
Rheumatology Nurse

Bath Ankylosing Spondylitis Disease Activity BASDAI *Garrett et al.

COPY

CHI 2602800570

CRN:S679370 26/02/1980

DOWELL SCOTT

11 Don Street,
GRANGEMOUTH,
Stirlingshire

FK3 8HD

M

Date 14/08/17

Patient Name

Please place a mark on each line below to indicate your answer to each question, relating to the past week:

1. How would you describe the overall level of fatigue/tiredness you have experienced?

NONE

0

10

VERY SEVERE

8.6

2. How would you describe the overall level of AS neck, back or hip pain you have had?

NONE

0

10

VERY SEVERE

8.5

3. How would you describe the overall level of pain/swelling in joints other than the neck, back or hips you have had?

NONE

0

10

VERY SEVERE

9.2

4. How would you describe the overall level of discomfort you have had from any areas tender to touch or pressure?

NONE

0

10

VERY SEVERE

7

5. How would you describe the overall level of morning stiffness you have had from the time you wake up?

NONE

0

10

VERY SEVERE

9.4

6. How long does your morning stiffness last from the time you wake up?

0hrs

½ hr

1hr

1 ½ hrs

2 or more hours

8.4

3.6

Please add up the scores (take the mean of stiffness questions 5 & 6) to give a score out of 50. Then multiply by 2 and divide by 10 to give a total BASDAI out of 10.

14/09

Department of Rheumatology
Senior Nurse: Susan Guest
Tel: 01324 566336 / 01324 566337

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Dr Derek Dundas
Westburn Medical Practice
Falkirk Community Hospital
Westburn Ave
Falkirk
FK1 5SU

Date Dictated 14 August 2017
Date Typed 22 August 2017

Our Ref SG/EM/F207472
CHI 2602800570

Dear Dr Dundas

SCOTT DOWELL 26/02/1980
11 DON STREET GRANGEMOUTH STIRLINGSHIRE FK3 8HD

Diagnosis:

1. Ankylosing spondylitis
2. Axial disease
3. Evidence of complete ankylosis sacroiliac joints on x-ray
4. Inflammatory corner changes along with extensive ankylosis on MRI spine
5. Destructive changes to left hip

Current Medication:

1. Humira
2. Dihydrocodeine
3. Esomeprazole

Previous Treatment:

1. Simponi – good response to first injection but developed suicidal thoughts so immediately stopped
2. Diclofenac
3. Ibuprofen
4. Naproxen

Plan:

1. Continue current medication, review with Dr Else in September.

Mr Dowell attended the nurse led biologics clinic today. He tells me he has been keeping well. He has had no infections, denies any shortness of breath. He also tells me he has had no side effects from his Humira. He is doing very well. He feels his movements are much better. His only complaint would be his early morning stiffness that still lasts a fair bit of time. However on a whole he definitely feels Humira is doing him good. I have advised Mr Dowell to continue with his Humira at present. He will be reviewed in September by Dr Else and again in the biologics clinic in January. He is aware he can contact the nurse advice line should he need any advice prior to these appointments.

Yours sincerely

(Dictated and electronically checked by Susan Guest)

Susan Guest

Senior Rheumatology Nurse



Chairman: Alex Linkston CBE
Interim Chief Executive: Fiona Ramsay

Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SW

www.nhsforthvalley.com [Facebook.com/nhsforthvalley](https://www.facebook.com/nhsforthvalley) [@nhsforthvalley](https://twitter.com/nhsforthvalley)

Gastroenterology Unit
Consultant: Dr Santosh Salunke
Tel: 01324 566841

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Consultants: Dr D Watts, Dr S Paterson, Dr R Burnham, Dr T Heron, Dr C Evans
Dr T Gordon-Walker, Dr S Siddhi, Dr S Salunke, Dr A Ahmed
Specialist Nurses: Ann Muir, Gillian Richardson

Dr Derek Dundas
Westburn Medical Practice
Falkirk Community Hospital
Westburn Ave
Falkirk
FK1 5SU

Date Dictated 24 July 2017
Date Typed 26 July 2017

Our Ref SS/CB/F207472
CHI 2602800570

Dear Dr Dundas

SCOTT DOWELL 26/02/1980
11 DON STREET GRANGEMOUTH STIRLINGSHIRE FK3 8HD

Mr Dowell attended endoscopy to re-assess the possibility of Barrett's. At endoscopy he was noted to have an irregular Z-line rather than evidence of Barrett's segment. There is a tiny area of mucosa just above the gastroesophageal junction that appeared raised as well. Biopsies were taken from both the z-line as well as the raised area. I am pleased to note that the junctional biopsies just show mild inflammation with no evidence of intestinal metaplasia. The biopsies from the raised area show normal oesophageal mucosa.

Overall this is reassuring but I will bring him back in about 3 months time to repeat his upper GI endoscopy and have a look at this area just above his gastroesophageal junction and perhaps if needed take repeat biopsies. In the interim I would be grateful if he could be given twice daily PPI.

Yours sincerely

(Dictated and electronically checked by Dr Santosh Salunke)

Dr Santosh Salunke
Consultant Gastroenterologist



Chairman: Alex Linkston CBE
Interim Chief Executive: Fiona Ramsay

Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SW

www.nhsforthvalley.com Facebook.com/nhsforthvalley @nhsforthvalley

Name : DOWELL, SCOTT
Address : 11 DON STREET
 GRANGEMOUTH
 STIRLINGSHIRE

CHI No. : 2602800570
DoB : 26/02/1980

Requested By : Dr Santoshkumar Salunke
Location : Endoscopy
 Forth Valley Royal Hospital

COPY

Post Code: FK3 8HD

HISTOLOGY REPORT

Clinical Details

? Barrett's. Irregular Z line. Tiny raised area just proximal to the Z line.

A. Oesophageal Biopsy at Junction

Three biopsies 2-3mm.

Microscopy

These are biopsies of squamocolumnar mucosa with a mild chronic inflammatory cell infiltrate. There is no intestinal metaplasia, dysplasia or malignancy. The features are those of mild chronic inflammation at the gastro-oesophageal junction.

Summary: Gastro-Oesophageal Junction Biopsies – Mild Inflammation. No Intestinal Metaplasia.

B. Raised Area Lower Oesophagus

One biopsy, 2mm plus debris.

Microscopy

These are biopsies of superficial benign squamous oesophageal mucosa. There is no underlying subepithelial connective tissue. Fungi are not identified.

Summary: Normal Oesophageal Biopsies.

Reported By: Dr Amanda Paton

(U) 25/17

GASTROSCOPY REPORT

Name: **Scott DOWELL (M)**
Date of birth: **26/02/1980**
CHI No: **2602800570**
Case note no.: **S679370**

Address: **11 Don Street,
Grangehill,
Stirling FK8 8HD**

COPY

GP: **Dr DW Dundas
Westburn Medical Practice
Falkirk Community Hospital
Westburn Ave
Falkirk
FK1 5SU**

Procedure date: **30th May 2017 (12:42)**
Priority: **Repeat/Scheduled**
Status: **Outpatient/NHS**
Hospital: **FVRH**
Referring Cons: **Dr Santosh Salunke
(Referring Consultants)**

Indications

Clinically important comments: ??Barrett's for reassessment.

Report

The procedure was completed successfully to D2.
Apparent mucosal junction at 40cm from the incisors.

Site a: Posterior lower oesophagus

Specimens: 2x biopsy.

Site b: Lower oesophagus

Specimens: 2x biopsy.

Irregular z-line. But an island of raised area (around 5-6 o'clock).

Diagnoses

OESOPHAGUS. Irregular z line and a small raised area.

Advice/comments

Await bx and decide on further management.

Follow up

Awaiting pathology results. Return to the GI physician.

Consultant/Endoscopist

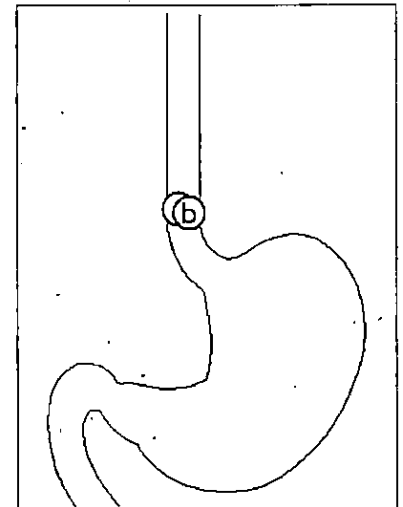
List consultant: Dr Santosh Salunke
Endoscopist No1: Dr Santosh Salunke
Assistant: Stella McNab
Nurses: Jenna Pason
Jaqueline Anderson

Instrument

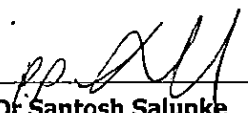
GIF Q260 (S/N 2644206)

Premedication

Xylocaine (Spray) 100 mg



a: Posterior lower oesophagus
b: Lower oesophagus
(photographed)


Dr Santosh Salunke
Consultant Gastroenterologist
c.c. Dr Santosh Salunke (Referring Consultants)

GASTROSCOPY REPORT

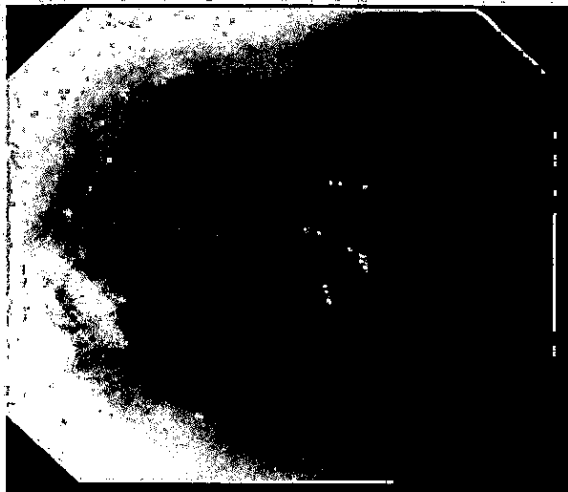
Name: **Scott DOWELL (M)**
Date of birth: **26/02/1980**
CHI No: **2602800570**
Case note no.: **S679370**

Address:

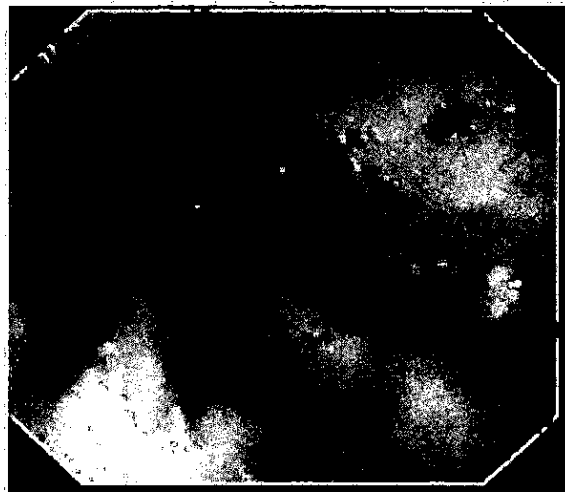
**11 Dow Street
Glasgow G3 7HT
Stirlingshire
FK3 8HT**

COPY

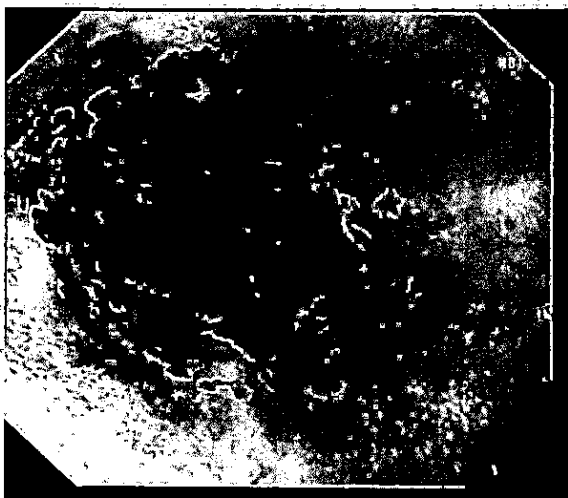
Procedure date: **30th May 2017 (12:42)**



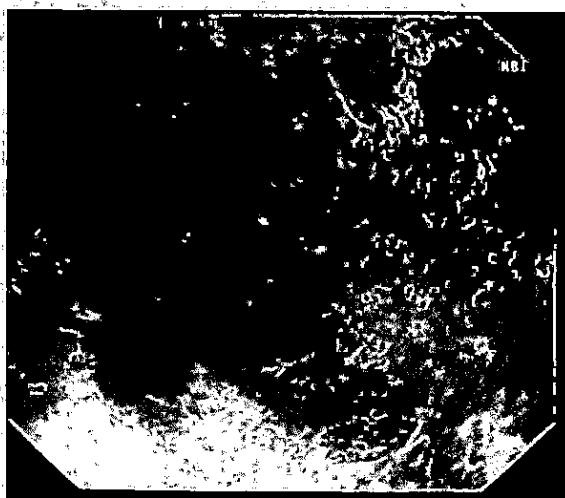
Site b: Lower oesophagus



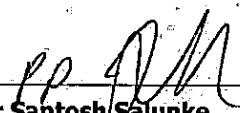
Site b: Lower oesophagus



Site b: Lower oesophagus



Site b: Lower oesophagus


Dr Santosh Salunke
Consultant Gastroenterologist

14/09

Case notes

**Department of Rheumatology
Approval for Biologic Therapy**

COPY

Name: Scott Dowell

CHI: 2602800570

Postcode: FK38HD

The above named patient meets current eligibility criteria for biologic therapy and has been counselled and consented for treatment as follows:

Indication	✓	IPTR Approval (if Required)
Rheumatoid Arthritis		
Ankylosing Spondylitis	X	
Psoriatic Arthritis		
Other (please specify)		

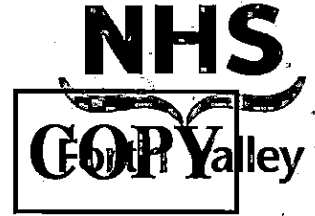
Drug	Route	Treatment			Switched From (if appropriate)
		Initial	2 nd Line	Subsequent	
Orencia (Abatacept)	Subcutaneous				
	Intravenous				
Humira (Adalimumab)	Subcutaneous		X		Switched from Benepali
Cimzia (Certolizumab)	Subcutaneous				
Benepali (Etanercept)	Subcutaneous				
Enbrel (Etanercept)	Subcutaneous				
Simponi (Golimumab)	Subcutaneous				
Remsima (Infliximab)	Intravenous				
Remicade (Infliximab)	Intravenous				
MabThera (Rituximab)	Intravenous				
Cosentyx (Secukinumab)	s/c 150mg				
	s/c 300mg				
RoActemra (Tocilizumab)	Subcutaneous				
	Intravenous				
Stelara (Ustekinumab)	Subcutaneous				
Other (specify)					

Approved By: Dr Else/S Guest

Date: 08/05/17

Department of Rheumatology
Rheumatology Nurse Service
Tel: 01324 566934

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Ref: SG/2602800570

Date: 08/05/17

Scott Dowell
11 Don Street
Grangemouth
FK3 8HD

Dear Scott,

I have completed your prescription to facilitate switching from Benepali to Humira which is your new recommended treatment for management of your ankylosing spondylitis.

The home care company will deliver your injections to your home and provide education on how to give these. A nurse will make arrangements to visit you at home for the first 1-2 injection to make sure you are confident to continue administering your injection independently.

When you receive delivery of your injection/s I would be grateful if you could store these in the fridge.

For this treatment you require to attend for blood monitoring 3 monthly. You may be able to have these checked at your GP practice however if they cannot accommodate this you can attend the phlebotomy service in, Area 3, Out Patient Dept, Forth Valley Royal Hospital. This service is available Mon, Wed, Thurs, Friday from 9:00 to 12:30 and 13:30 to 16:00. If you require to use this service you will need to take a lab request form with you. I have enclosed a form for your convenience.

Should you have any questions you can contact us via the nurse advice service on **01324 566934**.

Yours sincerely

Susan Guest
Rheumatology Nurse
Forth Valley Royal Hospital



INVESTORS
IN PEOPLE | **Bronze**

Chairman: Alex Linkston CBE
Chief Executive: Jane Grant

*Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SW*

www.nhsforthvalley.com Facebook.com/nhsforthvalley @nhsforthvalley

RTN
3

Gastroenterology Unit
Consultant: Dr Santosh Salunke
Tel: 01324 566841

1015

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Consultants: Dr P Bramley, Dr D Watts, Dr S Paterson, Dr R Burnham, Dr T Heron,
Dr T Gordon-Walker, Dr S Siddhi, Dr S Salunke
Specialist Nurses: Ann Muir, Gillian Richardson

Dr Derek Dundas
Westburn Medical Practice
Falkirk Communityhospital
Westburn Ave
Falkirk
FK1 5SU

Date Dictated 24 March 2017
Date Typed 27 March 2017

Our Ref SS/CB/E207472
CHI 2602800570

5679370

Dear Dr Dundas

SCOTT DOWELL 26/02/1980
11 DON STREET GRANGEMOUTH STIRLINGSHIRE FK3 8HD

Apologies for the delay in communication of histopathology results of oesophageal biopsy for Mr Dowell. The oesophageal biopsy simply showed columnar lined oesophagus with mild active chronic inflammation. Whilst looking at the images there may be small islands of Barrett's or the biopsy could simply be a reflection of lower oesophageal mucosa. To reconfirm I shall arrange for him to have a repeat endoscopy before deciding on whether or not he needs to come onto the Barrett's surveillance programme.

In the interim I would be grateful if he could continue on PPI and if there are other modifiable risk factors like high BMI and smoking these could be addressed.

In a different note I notice from his endoscopy report that would have gone to yourself that his urease test was positive and I assume he has been treated for H.Pylori.

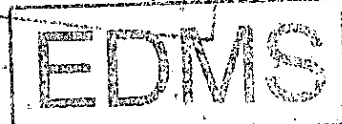
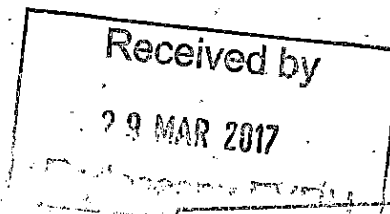
Yours sincerely

(Dictated and electronically checked by Dr Santosh Salunke)

Dr Santosh Salunke
Consultant Gastroenterologist

Cc: ✓ Endoscopy Bookings Team, FVRH, Larbert

Ann/Sharon: I would be grateful if this gentleman could be offered a repeat upper GI endoscopy appointment in the near future.



**INVESTORS
IN PEOPLE** | Silver

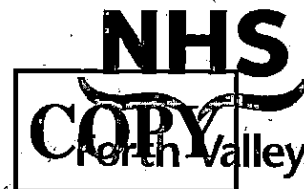
Chairman: Alex Linkston CBE
Chief Executive: Jane Grant

Forth Valley NHS Board is the common name for Forth Valley Health Board.
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SW

www.nhsforthvalley.com Facebook.com/nhsforthvalley @nhsforthvalley

Department of Rheumatology
Consultant: Dr Sara Else
Tel: 01324 566336 / 01324 566337

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Dr Derek Dundas
Westburn Medical Practice
Falkirk Community Hospital
Westburn Ave
Falkirk
FK1 5SU

Date Dictated 20 April 2017 /
Date Typed 20 April 2017
Our Ref SE/WT/F207472
CHI 2602800570

Dear Dr Dundas

SCOTT DOWELL 26/02/1980
11 DON STREET GRANGEMOUTH STIRLINGSHIRE FK3 8HD

Diagnosis:

1. Ankylosing Spondylitis
 - Axial disease
 - Evidence of complete ankylosis sacroiliac joints on x-ray
 - Inflammatory corner changes along with extensive ankylosis on MRI spine
 - Destructive changes to left hip
 - Elevated CRP
2. Indigestion

Current Medications:

1. Benepali – started October 2016
2. Dihydrocodeine
3. Lansoprazole

Previous Treatments:

1. Simponi – good response to first injection but developed suicidal thoughts so immediately stopped
2. Diclofenac
3. Ibuprofen
4. Naproxen

Management:

1. Bloods
2. Intramuscular Depo-Medrone 120mg given today
3. I am going to organise for Mr Dowell to switch to Humira due to non response to Benepali

Follow Up: 4 months

I saw Mr Dowell in the rheumatology clinic today. He initially started on Simponi. He had one injection of this medication. He felt an immediate improvement in his joint disease but unfortunately developed problems with severe suicidal thoughts. In light of this we switched him to Benepali. He started this in October. He does feel that he has had some improvement with this but only gets 3 – 4 days response. This is reflected in the fact his BASDAI score today was 9.0.



Chairman: Alex Linkston CBE
Interim Chief Executive: Fiona Ramsay

Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SW

www.nhsforthvalley.com Facebook.com/nhsforthvalley @nhsforthvalley

I am organising to update bloods. I have given Mr Dowell an intramuscular steroid injection today. Following discussion with him I have elected to switch him to Humira (I did consider Secukinumab but given he had a good response to Simponi further monoclonal antibody seemed to be appropriate and I have had one patient who has had new disturbance with Secukinumab). If he failed to respond to Humira then I think we would look at Secukinumab.

I have arranged to see him back in the clinic in 4 – 5 months.

Results

Plt 130 otherwise FBC ok

U+E, LFTs normal

CRP 5

Yours sincerely

(Dictated and electronically checked by Dr Sara Else)

Dr Sara Else

Consultant Rheumatologist

Cc Carol Ann Davies, Rheumatology Specialist Nurse, FVRH

Department of Rheumatology
Biologics Nurse: Sharon Menzies
Tel: 01324 566336 / 01324 566337

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR



Dr Derek Dundas
Westburn Medical Practice
Falkirk Community Hospital
Westburn Ave
Falkirk
FK1 5SU

Date Dictated 14 February 2017
Date Typed 22 March 2017
Our Ref SM/RN/S679370
CHI 2602800570

Dear Dr Dundas

SCOTT DOWELL 26/02/1980
11 DON STREET GRANGEMOUTH STIRLINGSHIRE FK3 8HD

Out-patient: 14/02/2017 at Rheumatology Biologics Nurse Led Clinic

Diagnosis: Ankylosing spondylitis

- Axial disease
- Evidence of complete ankylosis sacroiliac joints on X-ray
- Post inflammatory corner changes along with extensive ankylosis on MRI spine
- Destructive changes to left hip

Medication: Benepali 50mg weekly (10/16)
Diclofenac
Pantoprazole
Anti-emetic (unsure of name)

Management: Continue Benepali
Discuss with Dr Else re switching biologic therapy

Follow Up: To be arranged following outcome of discussion with Dr Else

I reviewed Scott in the Biologics Clinic this morning. He has been on Benepali for his ankylosing spondylitis approximately four to five months now. He tells me he does not notice much benefit from this. He thinks there may be a slight improvement in his spinal pain; however he still describes his back and hips as feeling 'tight and stiff'. Spinal VAS today was approximately 85/100 and morning stiffness still lasts around 1½ to two hours most days. He also reports feeling generally stiff after periods of inactivity during the day. His neck movement was still fairly restricted; right side 35-45° approximately, left side 20° approximately today. BASDAI score was 9.35 and BASFI score 9.31; both of these still indicate high disease activity. I see Dr Else commented in her clinic letter prior to commencing treatment that he had fairly established disease. However given he had ongoing problems with early morning stiffness and an elevated CRP she wondered if there was still a degree of active disease which might be amenable to therapy. I am not sure today how much of his BASDAI score is reflective of the established disease.

Interestingly prior to commencing Benepali Mr Dowell had one injection of Simponi (Golimumab). This was discontinued as he experienced low mood/tearfulness 24-48 hours after taking this. He does now however report that he had one month's great benefit from this therapy. He is keen to revisit this and try



Chairman: Alex Linkston CBE
Chief Executive: Jane Grant

Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SW

www.nhsforthvalley.com Facebook.com/nhsforthvalley @nhsforthvalley

this. I believe his low mood was fairly severe. His wife reported being quite concerned about him at the time. She was "worried he would do something stupid". I think he may have been suicidal and therefore this was why the therapy was discontinued and the switch to Benepali made. I am not sure if this is something we could consider retrying. I will have to discuss this with Dr Else.

COPY

I think it is unclear whether his symptoms today are due to established disease or if the Benepali has not been effective and he does still have some active disease. I have emailed Dr Else as she is off on annual leave this week for her input. I wonder whether he needs medical review. He has an appointment with her in April. He is keen to discuss his options with her prior to this. Unfortunately I could find nothing any earlier on our computer systems.

I have advised him to continue Benepali meantime as improvement/benefit can still be seen up to six months from commencement of therapy.

Yours sincerely

(Dictated and electronically checked by Sharon Menzies)

Sharon Menzies
Rheumatology Biologics Nurse

PS Routine blood monitoring December 2016 satisfactory.

cc. Biologic notes

S679370

Case note
copy

**Department of Rheumatology
Approval for Biologic Therapy**

COPY

Scott Dowell
11 Don Street, Grangemouth, FK3 8HD
2602800570

The above named patient meets current eligibility criteria for biologic therapy and has been counselled and consented for treatment as follows:

Indication	✓	IPTR Approval (if Required)
Rheumatoid Arthritis		
Ankylosing Spondylitis	x	
Psoriatic Arthritis		
Other (please specify)		

Drug	Route (delete as appropriate)	Treatment			Switched From (if appropriate)
		Initial	2 nd Line	Subsequent	
Orencia (Abatacept)	Subcutaneous Intravenous				
Humira (Adalimumab)	Subcutaneous				
Cimzia (Certolizumab)	Subcutaneous				
Benepali (Etanercept)	Subcutaneous		x		Golimumab – change in mood
Enbrel (Etanercept)	Subcutaneous				
Simponi (Golimumab)	Subcutaneous				
Remsima (Infliximab)	Intravenous				
Remicade (Infliximab)	Intravenous				
MabThera (Rituximab)	Intravenous				
RoActemra (Tocilizumab)	Subcutaneous Intravenous				
Stelara (Ustekinumab)	Subcutaneous				

Approved By: S.Menzies

Date: 07.09.16

Pharmacy Use:

Treatment Date:.....

Review Date:.....

Casenote copy



BIOLOGICAL THERAPY FOR ARTHRITIS

Switching from Golimumab (Simponi) to Etanercept (Benepali) 50mg weekly

Dr Dundas
Westburn Medical Practice
Falkirk Community Hospital
Westburn Ave
FK1 5SU

Date: 07.09.16

Dear Dr Dundas

Re: Scott Dowell 2602800570 11 Don Street, Grangemouth, FK3 8HD

Mr Dowell is switching biologic therapy from Golimumab (Simponi) to Etanercept (Benepali) 50mg weekly. Golimumab has been discontinued after 1 injection as the patient and his wife reported an acute change in mood/mental state shortly after administration.

Etanercept (Benepali) is also a biologic therapy given by weekly s/c injection for management of his Ankylosing Spondylitis. A nurse from the home care company Healthcare at Home will attend Mr Dowell's home to educate the him on the correct storage, administration & disposal of this treatment.

I have enclosed information on Etanercept (Benepali) for your records. The injections will be continue to be delivered to him at home by Healthcare at Home, and repeat prescriptions will be issued by the rheumatology department for the duration of therapy.

This treatment is an Anti TNF therapy and is therefore immunosuppressant in nature. I would be grateful if you could note specifically the section on increased risk of infection whilst on this treatment and the need for prompt intervention and treatment as required.



INVESTOR IN PEOPLE

Chairman Ian Mullen OBE BSc MR PharmS DL
Chief Executive Fiona Mackenzie MA (Hons) MBA MIHM DipHSM

Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SW

www.nhsforthvalley.com

SCOTT DOWELL

Age/Gender:	45Y, Male	Incident Date:	23/11/2025 14:55:00
DOB:	26/02/1980	ePCR Number:	35-2-231125-145511
Address:	11 DON STREET GRANGEMOUTH, FK3 8HD	Incident Number:	CR012676316
CHI Number:	2602800570	Incident Type:	EMG
Ethnicity:	White Scottish	Incident Location:	11 DON STREET GRANGEMOUTH, FK3 8HD

PATIENT INFO**GP And Surgery**

Name:	alba
-------	------

Next Of Kin

Forename:	Diane	Surname:	Dowell
Telephone Number:	01324262719	Relationship To Patient:	Civil Partner / Spouse

ADDITIONAL COMMENTS

Presenting Complaint:	upper abdo pain
-----------------------	-----------------

Timestamp	Additional Comment	Crew Name
23/11/2025 17:43:00	999 call for 45yom c/o abdo pain O/a pt lying on couch, alert, breathing normally, visibly uncomfortable, orientated, pt had gallbladder removed on thursday, has 2 drains in situ due to complication during surgery and pain has slowly got worse since, today being unbearable, pt wife gave pt 2 diazepam and 5mg of oramorph of her own medication, pt wife phoned 111 and spoke to a doctor who referred pt to sau, when awaiting for the ambulance transport, pt wife phoned 999 as pt struggling with the pain. o/e obs as charted, increased rr at 24, chest wheezy on auscultation with crackles in left base, crew administered salbutamol neb which improved the wheeze, ecg shows no acute changes, strong radial pulse present, pt states pain is like an intense throbbing in right upper quadrant of abdo, gurgles on auscultation, pain worse on inspiration and movement, severity 10/10, crew administered paracetamol and a total of 16mg of iv morphine, pain improved to a 7/10, pt usually fit and healthy, smokes around 20 a day, pt conveyed to fvrh sau for further assessment.	

ACVPU

Options:	Alert
----------	-------

CATASTROPHIC HAEMORRHAGE

Catastrophic Haemorrhage:	No
---------------------------	----

AIRWAY

Assessment:	Clear
-------------	-------

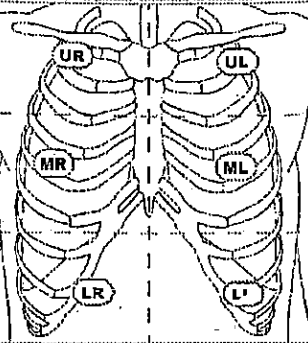
BREATHING

Breathing Adequately:	Yes	Initial Respiratory Rate:	24
Initial SpO2:	96	Initial SpO2 On Air:	Yes
Oxygen Given:	No		

Chest Examination**Anterior**

Wheeze, Normal Air Entry

UR



UL

Wheeze, Normal Air Entry

Wheeze, Normal Air Entry

MR

ML

Wheeze, Normal Air Entry

Wheeze, Normal Air Entry

LR

LL

Crepes/Crackles, Normal Air Entry

Tension Pneumothorax

Tension Pneumothorax Suspected:

No

CIRCULATION

Pulse Rate:	94	Rhythm:	Reg
Most Distal Pulse Found:	Radial	Cap Refill:	<=2 Secs
Central Peripheral:	Peripheral	Arm:	Right
Systolic Pressure:	147	Diastolic Pressure:	84
ECG:	12 Lead		

Skin

Appearance:	Pale	Skin Texture:	Dry
Skin Temperature:	Warm		

IV/IO Access

IV/IO Access:	IV	Left Area:	ACF
---------------	----	------------	-----

PVC

Ensure That A PVC Is Clinically Indicated For This Patient:	Yes	Hand Hygiene Has Been Performed Immediately Before PVC Insertion Procedure:	Yes
Skin Cleansed With A Single-Use Antiseptic Wipe Containing 70% Isopropyl Alcohol & Left To Dry Before Insertion:	Yes	Aseptic Technique Is Maintained Throughout The Insertion Procedure:	Yes
Catheter Site Is Covered With A Sterile Transparent Semi Permeable Dressing, With Time And Date:	Yes		

DISABILITY**Initial GCS:**

Timestamp	Eyes Value	Eyes Score	Voice Value	Voice Score	Motor Value	Motor Score	Final Score
23/11/2025 16:29:00	Spontaneously	4	Orientated	5	Obeys Commands	6	15

Eyes

Left Pupil Size (Mm):	5	Right Pupil Size (Mm):	5
Pupils Equal And Reactive To Light (Pearl):	Yes		

Blood Glucose

Blood Sugar Value (MMOL/L):	6.7
-----------------------------	-----

EXAMINATION**COPY**

Catheter Site Is Covered With A Sterile Transparent Semi Permeable Dressing, With Time And Date: Yes

DISABILITY

Initial GCS:

Timestamp	Eyes Value	Eyes Score	Voice Value	Voice Score	Motor Value	Motor Score	Final Score
23/11/2025 16:29:00	Spontaneously	4	Orientated	5	Obeys Commands	6	15

Eyes

Left Pupil Size (Mm):	5	Right Pupil Size (Mm):	5
-----------------------	---	------------------------	---

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

Blood Glucose

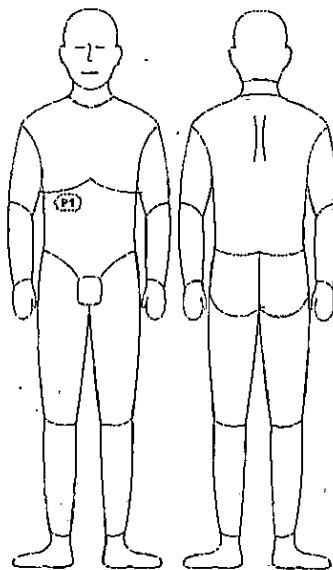
Blood Sugar Value (MMOL/L):	6.7
-----------------------------	-----

EXAMINATION

3/11/2025, 17:49

TerraPACE ePCR - Incident No: 35-2-231125-145511 - Name: SCOTT, DOB: 26/02/1980, Age: 45Y, Gender: M

Assessment Graphic



Pain Table

ID	Pain Scale	Body Part
P1	10	Abdomen

OBSERVATIONS

Observations Assessment

Timestamp	Pulse	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	Temp	BM	ECG	P(L R)	PEF	Crew
23/11/2025 15:35:00	82	22	146/84	99	<=2 Secs	15	Alert		36.7					E9880252

23/11/2025 16:10:00	91	22	100/107	96	<=2 Secs	15	Alert				E9880252
23/11/2025 16:18:00	90	22	147/106	96	<=2 Secs						E9880252
23/11/2025 16:50:00	94	24	147/84	96	<=2 Secs	15	Alert	36.7	6.7	5/5	E9880252

GCS

Timestamp	Eyes Value	Eyes Score	Voice Value	Voice Score	Motor Value	Motor Score	Final Score
23/11/2025 15:35:00	Spontaneously	4	Orientated	5	Obeys Commands	6	15
23/11/2025 16:10:00	Spontaneously	4	Orientated	5	Obeys Commands	6	15
23/11/2025 16:50:00	Spontaneously	4	Orientated	5	Obeys Commands	6	15

NEWS Score

Timestamp	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
23/11/2025 15:35:00	22 (2)	99 (0)	-	0	146 (0)	82 (0)	Alert (0)	36.7 (0)	2
23/11/2025 16:50:00	24 (2)	96 (0)	-	0	147 (0)	94 (1)	Alert (0)	36.7 (0)	3

AMPLE

Allergies:	None
Medication:	See ec's
Other:	Barrets diseaseSpondylitis
Last Eaten:	>4 Hours Ago
Events Prior:	Gallbladder removal on thursday, intensified pain today

SOCIAL HISTORY

23/11/2025, 17:49

TerraPACE ePCR - Incident No: 35-2-231125-145511 - Name: SCOTT, DOB: 26/02/1980, Age: 45Y, Gender: M

Living Arrangement	
Lives Alone:	No
Lives With:	Wife Diane
Mobility	
Patient Mobility:	Fully Mobile
Communication	
Communication Requirements:	No Help Required
Clinical Risks	
Factors:	Smoker
Environmental Risks	
Factors:	None Identified
SOCRATES	
Site	
Site:	Upper right side if abdo
Onset	
Onset:	Gallbladder removal
Character	
Character:	Throbbing
Pattern:	Constant
State:	Worsening
Radiates	
Radiates:	No
Exacerbating Or Relieving Symptoms	
Exacerbating Or Relieving Symptoms:	Worse when breathing and on movement

Communication

Communication Requirements:

No Help Required

Clinical Risks

Factors:

Smoker

Environmental Risks

Factors:

None Identified

COPY

SOCRATES

Site

Site:

Upper right side if abdo

Onset

Onset:

Gallbladder removal

Character

Character:

Throbbing

Pattern:

Constant

State:

Worsening

Radiates

Radiates:

No

Exacerbating Or Relieving Symptoms

Exacerbating Or Relieving Symptoms:

Worse when breathing and on movement

Severity

Severity:

10

DRUGS

Drugs Table

Timestamp	Drug	Expiry	Dosage	Quantity	Route	Pain Before	Pain After	Source	Crew
23/11/2025 15:24:00	Paracetamol	2029-07	1 g	OR	10	10	MANUAL	E9880252	
23/11/2025 15:26:00	Salbutamol Neb	2027-08	5 mg	NEB			MANUAL	E9880252	
23/11/2025 15:35:00	Morphine	2027-11	10 mg	IV	10	7	MANUAL	E9880252	
23/11/2025 16:11:00	Morphine	2027-11	2 mg	IV	7	7	MANUAL	E9880252	
23/11/2025 16:18:00	Morphine	2027-11	2 mg	IV	7	7	MANUAL	E9880252	
23/11/2025 16:30:00	Morphine	2027-11	2 mg	IV			MANUAL	E9880252	

CLOSE REPORT

Clinical Response Feedback

On-Scene Clinical Findings

Non Emergency

CONVEYANCE

Transport To Hospital

Normal Driving

Pre-Alert

No

Destination Hospital

FORTH VALLEY ROYAL
HOSPITAL

Patient Accompanied By

wife

INCIDENT INFORMATION

Dispatch

Dispatch Code

45B02

Dispatch Description

Emergency response
requested (no ILT)

23/11/2025, 17:49

TerraPACE ePCR - Incident No: 35-2-231125-145511 - Name: SCOTT, DOB: 26/02/1980, Age: 45Y, Gender: M

Incident Log

Status Time	Status	Callsign	Reason	Hospital
13:24:00	Call Received Time	FAL3225		

Character									
Character:		Throbbing			Pattern:			Constant	
State:				Worsening					
Radiates									
Radiates:				No					
Exacerbating Or Relieving Symptoms									
Exacerbating Or Relieving Symptoms:				Worse when breathing and on movement					
Severity									
Severity:				10					
DRUGS									
Drugs Table									
Timestamp	Drug	Expiry	Dosage	Quantity	Route	Pain Before	Pain After	Source	Crew
23/11/2025 15:24:00	Paracetamol	2029-07	1 g	OR	10	10	MANUAL	E9880252	
23/11/2025 15:26:00	Salbutamol Neb	2027-08	5 mg	NEB			MANUAL	E9880252	
23/11/2025 15:35:00	Morphine	2027-11	10 mg	IV	10	7	MANUAL	E9880252	
23/11/2025 16:11:00	Morphine	2027-11	2 mg	IV	7	7	MANUAL	E9880252	
23/11/2025 16:18:00	Morphine	2027-11	2 mg	IV	7	7	MANUAL	E9880252	
23/11/2025 16:30:00	Morphine	2027-11	2 mg	IV			MANUAL	E9880252	
CLOSE REPORT									
Clinical Response Feedback									
On-Scene Clinical Findings				Non-Emergency					
CONVEYANCE									
Transport To Hospital		Normal Driving			Pre-Alert			No	
Destination Hospital		FORTH VALLEY ROYAL HOSPITAL			Patient Accompanied By			wife	
INCIDENT INFORMATION									
Dispatch									
Dispatch Code		45B02			Dispatch Description			Emergency response requested (no ILT)	

23/11/2025, 17:49

TerraPACE ePCR - Incident No: 35-2-231125-145511 - Name: SCOTT, DOB: 26/02/1980, Age: 45Y, Gender: M

Incident Log

Status Time:	Status	Callsign	Reason	Hospital
13:24:00	Call Received Time	FAL3225		
14:56:54	Mobile	FAL3225		
16:14:01	Leave Scene	FAL3225		FORTH VALLEY ROYAL HOSPITAL
16:14:01	Leave Scene	FAL3225		FORTH VALLEY ROYAL HOSPITAL
16:30:23	At Hospital	FAL3225		

CREW INFORMATION

Additional Crew

Crew ID
E9880252

Crew Grade
Newly Qualified Paramedic (NQP)

Forth Valley Royal Hospital Assessment Document



Date of arrival 23/11/25 Time of arrival 11:00

Source of referral: GP ED **Other**

GP practice: Aba Medical

C

CHI NO: 2602800570

CRN:

Scott DOWELL

11 DON STREET

COPY

Age 65

N

GRANGEMOUTH
FK3 8HD

Consent for ECS

Yes

No

BM

NEWS score

Tel:

NOK 1 Name: Dianne Dowell

Relationship: Wife

Address:

NOK 2:

07388546682

Presenting complaint

Post op. Complaint

B

Background

A

NEWS 5 or more or other clinical concern

Yes

No

T^o 38°C or more within 14 days of chemotherapy (possible neutropenic sepsis)

Yes

No

Referred with potassium more than 6.4mmol/L or less than 2.8mmol/L

Yes

No

Referred with diabetic ketoacidosis

Yes

No

Reduced GCS

Yes

No

New limb weakness, speech disturbance or numbness for less than 4.5 hours

Yes

No

Abdominal pain: Does referral or patient give history of aortic aneurysm?

Yes

No

Abdominal symptom in female under 55 with possibility of pregnancy

Yes

No

NEWS 2-4

Yes

No

New oxygen requirement (not on home oxygen)

Yes

No

Chest pain at time of triage- Obtain ECG, Clinician to review/ sign within 10 minutes

Yes

No

New limb weakness, speech disturbance or numbness for 4.5 hours or longer

Yes

No

Requires assistance of 1 or more to mobilise

Yes

No

Able to mobilise independently or using own aids/ appliances

Yes

No

R

Very urgent

Urgent

Non-urgent

Ambulant

Actions

U&E/ LFT/ CRP/ FBC/ Glucose

Amylase

Cannula

Cultures

Group and save

ECG- to be signed within 10mins

Troponin 0 hours / 12 hours

Comments

Allergies and alerts

NKDA

Name

Signature

Date

Time

Assessment

Practitioners Name

Date

Patient details

COPY

Grade

Time commenced

GMC/ NMC

Location

Presenting Complaint:

- lap chole. 20/11/12 - op note large cystic duct loop
- LB perforated intra op
- 2 drains

- Returns with 9 pain today
- unable to take lap feed in
- no bsh in drain

Systemic Enquiry:

Height: 5'10

Weight: 176

BMI:

Usual level of activity (please circle)

Bedbound

Dependent
for
personal
care

Requires
minimal
assistance with
ADLs

Slowed.
Assistance with
heavier
household tasks

"Slowed-up"
but not
requiring
assistance

No exercise
beyond
walking.

Occasional
exercise

Regular
exercise

Past medical, surgical and anaesthetic history

Angina	
Hypertension	
COPD	
Stroke /TIA	
Diabetes	
Implement diabetes bundle	

Ankylosing Spondylitis
Barrett's oesophagus.
Fibromyalgia
cholecystectomy

Family History

Travel History

Social History

Smoking: Never Ex smoker (since _____)

Current 20 /day Pack years 20

Alcohol: 0 Units / week

Occupation N/A

Driving license yes/ no

Lives With Wife.

Support/ Carers N/A

PACKAGE OF CARE YES / NO (please circle)

IF YES CARE PROVIDER _____

NUMBER OF TIMES PER DAY 1/ 2/ 3/ 4 (please circle)

Patient details

☐ Relative/Carer

☒ Electronic patient record
ECS (issued in last 6 months?)
IDL (within last month?)

☒ Patient's own medicines

☐ Nursing home prescription

☐ Community pharmacy

COPY

☐ Other

**No Known
Drug 
Allergies**

Drug / Substance	Reaction/ Side effect	Drug / Substance	Reaction/ Side effect

[illegible]

RECENT ANTIBIOTICS/RECENTLY DISCONTINUED MEDICATION (within 6 months)

[illegible]

NON-PRESCRIPTION MEDICATIONS AND HERBAL MEDICATIONS

[illegible]

Are you satisfied this medication history is complete and accurate?

Yes ☒ No ☐

If 'No' please detail what further action is necessary (e.g. contact GP, carer or access ECS)

Medicine reconciliation completed by? Name: L. Bickett Gell

Signature: W. B. Burt

Date: 23/11/25

Time: 17:21

Medicine reconciliation verified by?

Name: _____

Signature:

Date:

Time:

Examination

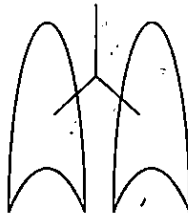
Diabetic patients → foot examination and diabetes bundle
GI Bleeding → PR examination
Age > 65 or confusion → AMT
If cognition or alertness impaired → consider delirium

Patient Details

Cardiovascular

Respiratory

COPY



Abdominal

AMT (If <4/4, complete AMT10)

1. Age
 2. DOB
 3. Year
 4. Location
- /4

Ask patient to remember address: "42 West Street"

5. Time to nearest hour
 6. Current monarch
 7. Date Of WW2
 8. Count 20 → 1
 9. Identify 2 people
 10. Recall address
- /10

PR:

Neurological (remember speech, visual assessment, balance, gait)

Cranial nerves:

	R arm			L arm			R leg			L leg		
Tone												
Power												
Sensation												
Coordination												
Reflexes	B	T	S	B	T	S	K	A	Plantar	K	A	Plantar

Other

hsc N.
CPE 16

Interpretation of results

ECG

CXR

Urine HCG

Other imaging

Urinalysis

Additional comments

	Neg	Trace	+	++	+++	++++
Leucocytes						
Nitrites						
Glucose						
Ketones						
Blood						
Protein						

Differential diagnosis

Patient details

COPY

Management plan

- (will discuss with Mr Emin)

P.R.

Additional investigations required (e.g. cultures) Please initial and date when sent

	Initial/ Date		Initial/ Date
	Initial/ Date		Initial/ Date

Venous thromboembolism (VTE) risk assessment

Medical patient expected to be mobilising as normal within 2 days

Proceed to VTE risk actions

Medical patient with reduced mobility for ≥ 2 days OR Surgical patient

Assess thrombosis and bleeding risk factors

Thrombosis risk factors. ANY thrombosis risk factor(s) should prompt VTE prophylaxis measures unless contraindicated → Assess bleeding risk.

- | | |
|---|--|
| ☒ Mobility reduced for >2 days
☐ Age >60
☐ Dehydration
☐ Obesity BMI $>30 \text{ kg/m}^2$
☐ Significant medical comorbidity (e.g. cardiac, respiratory, endocrine, inflammatory, infectious conditions)
☐ Active cancer or cancer treatment
☐ Thrombophilia
☐ Personal history or first degree relative with history of VTE
☐ Use of hormone replacement therapy or oestrogen containing contraceptive
☐ Pregnancy or $<6/52$ post-partum | ☐ Acute surgical admission with inflammatory or intra-abdominal condition
☐ Surgery with significant reduction in mobility
☐ Critical care admission
☐ Knee or hip replacement
☐ Hip fracture
☐ Total anaesthetic+ surgical time >90 mins
☐ Pelvic or lower-limb surgery with anaesthetic+ surgical time >60 mins
☐ Varicose veins with phlebitis |
|---|--|

Bleeding risk factors. Consider whether sufficient to preclude pharmacological prophylaxis

- ☐
- Active bleeding
-
- ☐
- Acquired bleeding disorder (e.g. acute liver failure)
-
- ☐
- Current use of therapeutic anticoagulation (e.g. warfarin, rivaroxaban, dabigatran)
-
- ☐
- Acute stroke
-
- ☐
- Thrombocytopenia (
- $<75 \times 10^9/\text{L}$
-)
-
- ☐
- Uncontrolled hypertension (
- $>230/120 \text{ mmHg}$
-)
-
- ☐
- Untreated inherited bleeding disorder
-
- ☐
- Neurosurgery, spinal surgery or eye surgery
-
- ☐
- Other procedure with high bleeding risk
-
- ☐
- Lumbar puncture, epidural or spinal anaesthesia expected within the next 12 hours
-
- ☐
- Lumbar puncture, epidural or spinal anaesthesia within the previous 4 hours

VTE risk actions

Information provided

Provide if admission is anticipated
Yes/ No

LMWH

Yes/ No/
Contraindicated

Antiembolism stockings

Consider if thrombosis risk factors present and bleeding risk factors preclude LMWH
Contraindicated in peripheral neuropathy, PVD, ulceration, cellulitis, gross oedema
Yes/ No/ Contraindicated

Name: L. Burt

Signature: L. Burt

Date: 23/11/25

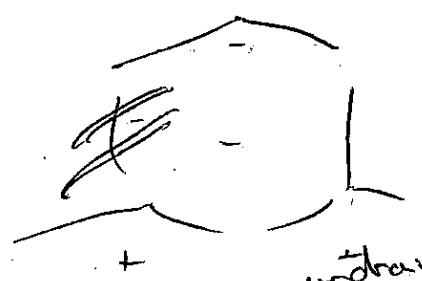
Time complete: 17:27

23/11/25 EMIN (CON)

23:00

- Ha noted.
- admitted this evening.
- LAP CHOLE 20/11 2 drains in situ (150ml of serum this today @ 6.16)
- Pain since today.

o/e



- Soft
- tender RUQ.
- 2 perforators but tender

Imp: Possible ^{undrained} Gallen collection.

- (P) i) Bldh ✓ AST=18, CRP=16, urea (N) 5.7 Hb 164
- ii) NBM → Back to theatre → revision lap possible return to theatre tonight. ^{the} Diagnostic lap tonight would happen with undrained to CRPOD availability. New o. A. B. C. Physiologically well, ∴ FAST from now & if any deterioration ops then theatre.

ECG

CXR/Imaging

Results

IT serum physiologically well then, diagnostic lap tomorrow morning.
 Plan explained to pt + family → who agree with plan.

[Signature]
 EMIN

Consultant Ward Round

Patient details

COPY

Diagnoses and significant comorbidities

Plan

Checklist		Estimated LoS	<24h	24-48h	>48h
Medicine reconciliation		Transfer of Care to:			
VTE assessment					
S _p O ₂ target prescribed					
Fasting	Yes / No	Outstanding criteria for ward transfer/discharge (delete as appropriate):			

Name

Signature

Date

Time

Resuscitation/ Escalation of care/ Anticipatory Care Planning / Advance Directives

Documentation of Discussion with Patient or Family

Treatment options that may help and patient would wish considered (and in what circumstances):-

Treatment options that may not help or patient would not wish:-

Discussed with patient/family: Y /N/Unable

Documentation (circle all that apply): DNACPR ReSPECT AWI

Name

Signature

Date

Time

Date and Time	Daily MDT and Nursing update			
	Consent (care planning)	Yes	☐	
	Name band	Yes	☐	
	NOK details obtained	Yes	☐	
	Vital Signs	Yes	☐	
	Own medication	Yes	☐	No ☐
	Dentures	Yes	☐	No ☐
	Glasses	Yes	☐	No ☐
	Hearing aids	Yes	☐	No ☐
	COPY			
23/11/25	Admitted to SAU			
19.30	EWS as charted.			
	Bloods taken ☒			
	Meds as per hepma.			
	For Senior Review.			
	S/N A. McDermott			
23/11/25	Ruled out STB			
19.45	Discharge with Mr Emir			
	- return to theatre for wash at tonight.			
24/11/25	DSC Ruled out STB			
02.35	Somewhat settled overnight			
	NEWS has remained stable			
	W fluids running via pump			
	W triple antibiotics commenced			
	Analgesia as needed			
	Independently mobile			
	NBm for theatre this morning			
	Medication per Hepma			
	No Drains flushed - 10ml Saline			

ASAW
JW

CHI NO: 2602800570
CRN: 26/02/1980
300th DOWELL
11 DON STREET
GRANGEMOUTH
FK3 8HD

COPY

Daily MDT and Nursing update

24/02/25

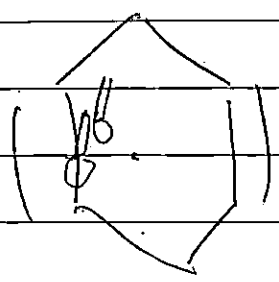
0830

MR WILSON

NEWS / T36.0

Pain persisting

o/g looks unwell, movement restricted by pain



Abdo distended

VL drains - nil output

(P) For heath today

0435
COPY

Patient Label		Age: 45	Post op days:
 CHI NO: 2602800570 26/02/1980 CRN: M Scott DOWELL 11 DON STREET GRANGEMOUTH FK3 8HD		Diagnosis Washout & haematoma PDD: Named Nurse Night Shift: <u>SBROUR</u> Day Shift: <u>SBROUR</u>	
Night Report:		Consultant	MR Emin
Scott had a settled night meds as per hepma. IV Romax given. prn analgesia Obs Charted, news @ 10am independent, eating & drinking Drains unsitu. Drain ① 20mls Drain ② 100mls at midnight on/off ward for cigarettes bent late due to prescription no do nausea no acute concerns		Fluid Balance In: Out: Balance: Cumulative Balance:	
Safety Checklist Ward Round Plan Blood Results checked X-ray check Prophylaxis Antibiotic Review Repeat Bloods tomorrow Y/N Fluid Balance Diabetic Control Resus Status Urinary Catheter Wound Check Discharge planning Signature: <u>[Signature]</u>		Additional Ward Round Notes: 0840 SHAH (SR) D1 post op. Two drains in situ - small volume haemostasis in both. 9C  Soft - mid distension. Plan: Leave drains in for 24h. IVOST obs Position: SR	

COPY
Initials

Daily Nursing Updates	Initials		Additional Charts	Initials
MUST - Dietary intake			Wound Chart	
Braden - Pressure Areas			Stoma Chart	
Falls Risk - mobility			News Chart	
PVC/Cauti/Picline				

Combined Day Report

Initials, Surname and Date of entry

Care taken over at 7:30 2pm

Scot seems settled today

medication given as per hepmae, IV amx ☒ as prescribed.

OBS charted NEWS score = 1

independant eating & drinking

Drains insitu

NO concerns as of writing this

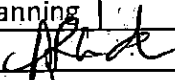
Hannah Butchart STN.

Quinn
8/11/25

Discharge Planning:

Physio		
OT		
Dietetics		
District Nurses		

0210
COPY

Patient Label		Age: 45	Post op days:
 CHI NO: 2602800570 26/02/1980 CRN: M Scott DOWELL 11 DON STREET GRANGEMOUTH FK3 8HD		Diagnosis Biliary collection WASHDOUT PDD:	
		Named Nurse	Night Shift: SBROUEN Day Shift: MANI
Night Report:		Consultant	MR EMIN
Scott had a settled night. meds as per hepma. prn analgesia. obs charted, news 0. independent, eating & drinking. passing urine. NBD few days, prn laxido given. drains insitu, minimal output. on/ward ward. NO QD nausea NO awake concerns		Fluid Balance:	
		In:	
		Out:	
		Balance:	
		Cumulative Balance:	
		SNSBROUEN	
Safety Checklist		Additional Ward Round Notes:	
Ward Round Plan		0840. MR BRENNAN.	
		well.	
Blood Results checked		50ml in both drains yesterday	
X-ray check		Pain controlled.	
Prophylaxis		BNO 3/7	
Antibiotic Review		EWS 0.	
Repeat Bloods tomorrow Y/N		QE serum fluid in both drain bags -	
Fluid Balance		small amount.	
Diabetic Control		Plan: Both drains out. Home later today.	
Resus Status			
Urinary Catheter			
Wound Check			
Discharge planning			
Signature: 		Position: ST8	

COPY
Initials

Daily Nursing Updates	Initials		Additional Charts	Initials
MUST - Dietary intake			Wound Chart	
Braden - Pressure Areas			Stoma Chart	
Falls Risk - mobility			News Chart	
PVC/Cauti/Picline	NR	Removed		

Combined Day Report

Please Sign, date and time all entries

26/11/25 @ 1025 - Patient Scoring 0 on News
 Eating and Drinking Independent
 Patient PVC removed from (L) arm
 X2 Drains Removed on (R) side
 Dressings Changed
 Dressing pack provided
 Medications accepted as per hepma
 Patient recieved TTO medications
 of Dihydrocodeine 30mg, Laxido
 and oral Co-amox 500/125
 Patient Discharged

STN J Reid
 District Nurse referral done
 Patient aware of that
 Paul
 8/11/25

Discharge Planning:

Physio		
OT		
Dietetics		
District Nurses		

CONSENT FORM

Agreement to Operation, Investigation or Treatment



Notes of Guidance for Doctor/Dentist/Healthcare Practitioner

The doctor/dentist/healthcare practitioner must:

- ◆ Be suitably qualified and experienced to explain the procedure to be performed - this should ideally be the operator or consultant.
- ◆ Give the patient sufficient information, in a way he/she can understand, about the proposed procedure, any important risks and the possible alternatives (including no treatment). In broad terms, a significant risk is one which is serious, but uncommon, or one which occurs frequently, even if it is not serious.
- ◆ Give the patient sufficient time to read the form and ask any questions relating to it or their treatment. The patient must be allowed to decide whether he/she will agree to the procedure and they may refuse or withdraw consent at any time.
- ◆ In addition to seeking consent for the procedure, seek written consent from the patient for examination by students.

Children under the age of 16 can give their own consent if the Medical Practitioner attending the child considers the child capable of understanding the nature and possible consequences of the procedure or treatment. If the child is judged capable, the practitioner must seek the consent of the child rather than the parent. This does not mean that the parents must always be excluded from the discussions. Unless there are issues concerning confidentiality, it would be reasonable to involve parents in helping a child to reach a decision. If a child under 16 years of age is giving his/her own consent, the relevant section overleaf, must also be signed.

Writing on the consent form must be legible, unambiguous and contain no abbreviations.

Any alterations to this form must be countersigned by the patient/parent/guardian and the member of the healthcare team taking consent. If the procedure or the information about surgical marking is wrong the form must be re-written.

Surgical Site Marking

- ◆ The site should be marked and documented by the operating surgeon, or nominated deputy, who will be present in the operating theatre at the time of the patient's procedure. If site marking is not applicable, this should be recorded and signed by the person taking consent.
- ◆ The intended site should be ascertained from reliable documentation and/or images.
- ◆ Marking should take place before pre-medication/administration of any sedative.
- ◆ The intended surgical site should, ideally be marked on the ward, day care area or theatre reception prior to the patient transfer to the operating theatre.
- ◆ An indelible marker pen should be used.
- ◆ The mark should be an arrow that extends to, or near, the incision site and remains visible after the application of skin preparation.
- ◆ Where possible the mark should remain visible after the application of theatre drapes.
- ◆ Surgical operations involving side (laterality), should be marked at, or near, the intended incision. For digits on the hand or foot, the mark should extend to the correct specific digit.
- ◆ The process of pre-operative marking of the intended site must involve the patient/parent/guardian wherever possible.

NB. There will be circumstances where marking may not be appropriate i.e. Teeth or Mucous Membranes. Emergency surgery should not be delayed due to lack of pre-operative marking.

PATIENT DETAIL (OR PRE-PRINTED LABEL)

Patient: 

Patient: CHI NO: 2602800570 26/02/1980

Date: CRN: Scott DOWELL M ☐

CHI n: 11 DON STREET

Spec: GRANGEMOUTH FK3 8HD

guage/other communication method):

COPY

STATEMENT FOR DOCTOR/DENTIST/HEALTHCARE PRACTITIONER

(to be completed by a practitioner with appropriate knowledge of proposed procedure. See Notes for Guidance)

Describe proposed operation, investigation or treatment. Where appropriate specify the site or side:

laparoscopy, washout +/- proceed

per, bleeding, infection, need to drain/line

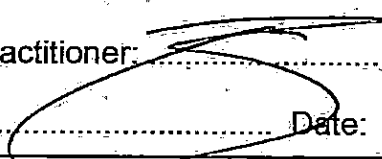
any, have, DVT/PE, Anesthetic risks

I have explained the procedure named on this form to the: (please tick) patient ☒

parent ☐ guardian ☐ Other (please specify):

in terms which, in my judgment, are suited to their understanding. In particular I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure e.g. blood transfusion.

[If you have provided any information leaflet/tape, please tick box ☐ and specify title and version]

Signature of Doctor/Dentist/Healthcare Practitioner: 

Name (PRINT): J. McCauley

Date: dd mm yy
24 11 25

STATEMENT OF INTERPRETER (where appropriate)

I have interpreted the information on this form to the patient/parent/guardian to the best of my ability and in a way in which I believe he/she can understand.

Signature: Date: dd mm yy

Name (PRINT):

SURGICAL SITE MARKING

Site marking not applicable

Correct Patient and Surgical Site verified and marked by:

Signature: Date: dd mm yy

Name (PRINT): Title:

STATEMENT TO BE COMPLETED BY THE PATIENT, PARENT OR GUARDIAN

You should read this form and the notes below and overleaf carefully. If there is anything you do not understand, ask the doctor, Dentist or Healthcare Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

COPY

I am (Please tick)

Patient

☒

Parent

☐

Guardian

☐

I understand:

Yes No

- the procedure, important risks and appropriate alternatives which have been explained to me by the Doctor/Dentist/Healthcare Practitioner named on this form.
- that the procedure might be carried out by a Doctor/Dentist/Healthcare Practitioner other than the Doctor/Dentist/Healthcare Practitioner who has been treating me/the patient so far.
- that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances; in relation to my/the patient's medical treatment, to safeguard or promote my/the patient's physical or mental health.

☒ ☐☒ ☐☐ ☒

I have been told about additional procedures which may become necessary during my/the patient's treatment. I have listed below any procedures which I do not wish to be carried out without further discussion.

I agree:

- to the administration of an anaesthetic or sedation if required.
- to the procedure named on this form.
- that an examination for the purposes of teaching will not be undertaken without my consent.
- that any photographs, video/audio recordings and/or surgical images kept in the records may be used anonymously for research approved by an ethics committee, education and audit to improve the quality of patient care.

If you object to surgical images being used in this way then please tick box ☐

Signature of Patient/Parent/Guardian/Other:

Scott Dowell

Name (PRINT):

Scott Dowell

Date:

dd mm yy
24-11-25

Relationship to child:

Only to be completed by the Medical Practitioner where the form is to be signed by a child under 16 years.

I am of the opinion that the patient is capable of understanding the nature and possible consequences of the proposed treatment/procedure.

Name (PRINT):

Signature:

EXAMINATION FOR THE PURPOSES OF TEACHING

(Please tick) I agree ☐ I do not agree ☐ to an examination by a student during the procedure named on this form under the supervision of the senior doctor undertaking the procedure.

COPY

Signature:

Name (PRINT):

Date:

dd mm yy
[] [] - [] [] - [] []

CONFIRMATION OF CONSENT

(to be completed when patient is admitted for the procedure)

I confirm that I have no further questions and wish the procedure to go ahead.

Patient ☐ Parent ☐ Guardian ☐ Other ☐ (please specify)

dd mm yy
Date: [] [] - [] [] - [] []

Signature of Doctor/Dentist/Healthcare Practitioner:

Signature of Patient:

Notes of Guidance for Patients

The Doctor/Dentist/Healthcare Practitioner is here to help you. He or she will explain the procedure. You are entitled to refuse or withdraw consent at any time. You can ask any questions and ask for more information if you wish.

You may ask for a relative, friend or nurse to be present while the Doctor/Dentist/Healthcare Practitioner explains the procedure and asks you to sign the form.

If an anaesthetic or sedation is to be administered by an anaesthetist, it will be his or her responsibility to discuss details with you before the procedure takes place.

Students need to learn how to examine patients and to see how procedures are done. This is important for the future of the Health Service. You may be asked to give consent to be examined by students during the procedure. It is up to you to decide whether to give your consent or not but, whatever you decide, it will not affect your treatment.

NOTES

CONSENT FORM

Agreement to Operation, Investigation or Treatment



COPY

Notes of Guidance for Doctor/Dentist/Healthcare Practitioner

The doctor/dentist/healthcare practitioner must:

- ◆ Be suitably qualified and experienced to explain the procedure to be performed - this should ideally be the operator or consultant.
- ◆ Give the patient sufficient information, in a way he/she can understand, about the proposed procedure, any important risks and the possible alternatives (including no treatment). In broad terms, a significant risk is one which is serious, but uncommon, or one which occurs frequently, even if it is not serious.
- ◆ Give the patient sufficient time to read the form and ask any questions relating to it or their treatment. The patient must be allowed to decide whether he/she will agree to the procedure and they may refuse or withdraw consent at any time.
- ◆ In addition to seeking consent for the procedure, seek written consent from the patient for examination by students.

Children under the age of 16 can give their own consent if the Medical Practitioner attending the child considers the child capable of understanding the nature and possible consequences of the procedure or treatment. If the child is judged capable, the practitioner must seek the consent of the child rather than the parent. This does not mean that the parents must always be excluded from the discussions. Unless there are issues concerning confidentiality, it would be reasonable to involve parents in helping a child to reach a decision. If a child under 16 years of age is giving his/her own consent, the relevant section overleaf, must also be signed.

Writing on the consent form must be legible, unambiguous and contain no abbreviations.

Any alterations to this form must be countersigned by the patient/parent/guardian and the member of the healthcare team taking consent. If the procedure or the information about surgical marking is wrong the form must be re-written.

Surgical Site Marking

- ◆ The site should be marked and documented by the operating surgeon, or nominated deputy, who will be present in the operating theatre at the time of the patient's procedure. If site marking is not applicable, this should be recorded and signed by the person taking consent.
- ◆ The intended site should be ascertained from reliable documentation and/or images.
- ◆ Marking should take place before pre-medication/administration of any sedative.
- ◆ The intended surgical site should, ideally be marked on the ward, day care area or theatre reception prior to the patient transfer to the operating theatre.
- ◆ An indelible marker pen should be used.
- ◆ The mark should be an arrow that extends to, or near, the incision site and remains visible after the application of skin preparation.
- ◆ Where possible the mark should remain visible after the application of theatre drapes.
- ◆ Surgical operations involving side (laterality), should be marked at, or near, the intended incision. For digits on the hand or foot, the mark should extend to the correct specific digit.
- ◆ The process of pre-operative marking of the intended site must involve the patient/parent/guardian wherever possible.

NB. There will be circumstances where marking may not be appropriate i.e. Teeth or Mucous Membranes. Emergency surgery should not be delayed due to lack of pre-operative marking.

PATIENT DETAIL (OR PRE-PRINTED LABEL)

Patient's surname/family name:

Patient's first name(s):

Date of birth: --

CHI number (or other identifier):

Special requirements (e.g. other language)



CHI NO: 2802800570

CRN:

Scott DOWELL
11 DON STREET

26/02/1980

M

COPY

ORANGEMOUTH
FK3 8HD

STATEMENT FOR DOCTOR/DENTIST/HEALTHCARE PRACTITIONER

(to be completed by a practitioner with appropriate knowledge of proposed procedure. See Notes for Guidance)

Describe proposed operation, investigation or treatment. Where appropriate specify the site or side:

Diagnostic laparoscopy ± wash out
± proceed.

- take back relax laparoscopy vaginal injury pain bleed
infection dit per mi. control illness

I have explained the procedure named on this form to the: (please tick) patient ☐

parent ☐ guardian ☐ Other (please specify)

in terms which, in my judgment, are suited to their understanding. In particular I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure e.g. blood transfusion.

[If you have provided any information leaflet/tape, please tick box ☐ and specify title and version]

Signature of Doctor/Dentist/Healthcare Practitioner: *RO*

Name (PRINT): *ROBERT*

Date: dd mm yy
23 11 25

STATEMENT OF INTERPRETER (where appropriate)

I have interpreted the information on this form to the patient/parent/guardian to the best of my ability and in a way in which I believe he/she can understand.

Signature: Date: dd mm yy

Name (PRINT):

SURGICAL SITE MARKING

Site marking not applicable

Correct Patient and Surgical Site verified and marked by:

Signature: Date: dd mm yy

Name (PRINT): Title:

STATEMENT TO BE COMPLETED BY THE PATIENT, PARENT OR GUARDIAN

You should read this form and the notes below and overleaf carefully. If there is anything you do not understand, ask the doctor, Dentist or Healthcare Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

COPY

I am (Please tick) Patient ☒ Parent ☐ Guardian ☐

I understand:

Yes No

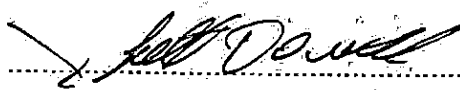
- the procedure, important risks and appropriate alternatives which have been explained to me by the Doctor/Dentist/Healthcare Practitioner named on this form. ☐ ☐
- that the procedure might be carried out by a Doctor/Dentist/Healthcare Practitioner other than the Doctor/Dentist/Healthcare Practitioner who has been treating me/the patient so far. ☐ ☐
- that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to my/the patient's medical treatment, to safeguard or promote my/the patient's physical or mental health. ☐ ☐

I have been told about additional procedures which may become necessary during my/the patient's treatment. I have listed below any procedures which I do not wish to be carried out without further discussion.

I agree:

- to the administration of an anaesthetic or sedation if required.
- to the procedure named on this form.
- that an examination for the purposes of teaching will not be undertaken without my consent.
- that any photographs, video/audio recordings and/or surgical images kept in the records may be used anonymously for research approved by an ethics committee, education and audit to improve the quality of patient care.

If you object to surgical images being used in this way then please tick box ☐

Signature of Patient/Parent/Guardian/Other: 

Name (PRINT):

SCOTT DOWELL

Date:

dd mm yy
25-11-21

Relationship to child:

Only to be completed by the Medical Practitioner where the form is to be signed by a child under 16 years.

I am of the opinion that the patient is capable of understanding the nature and possible consequences of the proposed treatment/procedure.

Name (PRINT): Signature:

EXAMINATION FOR THE PURPOSES OF TEACHING

(Please tick) I agree ☐ I do not agree ☐ to an examination by a student during the procedure named on this form under the supervision of the senior doctor undertaking the procedure.

COPY

Signature:

Name (PRINT):

Date: ^{dd} ^{mm} ^{yy}
 - -

CONFIRMATION OF CONSENT

(to be completed when patient is admitted for the procedure)

I confirm that I have no further questions and wish the procedure to go ahead.

Patient ☐ Parent ☐ Guardian ☐ Other ☐ (please specify)

Date ^{dd} ^{mm} ^{yy}
 - -

Signature of Doctor/Dentist/Healthcare Practitioner:

Signature of Patient:

Notes of Guidance for Patients

The Doctor/Dentist/Healthcare Practitioner is here to help you. He or she will explain the procedure. You are entitled to refuse or withdraw consent at any time. You can ask any questions and ask for more information if you wish.

You may ask for a relative, friend or nurse to be present while the Doctor/Dentist/Healthcare Practitioner explains the procedure and asks you to sign the form.

If an anaesthetic or sedation is to be administered by an anaesthetist, it will be his or her responsibility to discuss details with you before the procedure takes place.

Students need to learn how to examine patients and to see how procedures are done. This is important for the future of the Health Service. You may be asked to give consent to be examined by students during the procedure. It is up to you to decide whether to give your consent or not but, whatever you decide, it will not affect your treatment.

NOTES

Unspecified diagnostic endoscopic examination of peritoneum; Not applicable

COPY

PATIENT DETAILS

AGE: 45 y DOB: 26/02/80 00:00 SEX: Male Height: Weight:

ALLERGIES RISKS

INCIDENTS

PREOP COMMENT
ank spond. large body habitus GA last week from NC

PERSONNEL

PRIMARY	JOB ROLE	NAME	START TIME	END TIME	ADDITIONAL INFO
	Surgeon	John Camilleri-Brennan			
	Supervising Anaesthetist	Nicholas Crutchley, Consultant			
	Recovery Practitioner	Connie Cobain			
	Anaesthetist	Neil Yi Sheng Tan, ST4			
	Anaesthetic Practitioner	Amy Thomson			

STATUS SUMMARY

Anaesthesia techn. ASA
GA ETT 2

29: Nausea score: 0 - None
29: Cough: Absent
29: Respiration: OK
12:29: Pain score: 0 - No pain / Asleep
12:29: D-Sedation score: 1 - Drowsy, easy to rouse by speech
11:51: Wound assessment: 0 - Dry & intact
11:51: Dressing checked: ✓

AIRWAY Local - Regional
10:33 - Endotracheal Tube - 11:42 - Oral / Nasal - 8.0 - 11:18 - Infiltration - 12:56 - n/a - to port sites -
Cuffed - Oral - Primary scope - Macintosh blade - 3 - Inserted by - Surgeon - No immediate complications - ✓
BMV Grade - Moderate - Intubation difficulty - Easy -
Laryngoscopy grade - direct - 2b -
Laryngoscopy view - indirect - Full - Nr of attempts - 1 -
Preoxygenation - ✓ - Oropharyngeal airway required -
Yes - Is awake intubation necessary in the future ? - No

BLOCK EVALUATION

LINES/TUBES/DRAINS

10:28 - Peripheral cannula - 12:56 - Cannula - ACF - Left - 18G Green - Placed prior to admission - ✓ - Asepsis
- Clean Procedure - Dressing - ✓ - Site cleaned with - 70% Isopropyl Alcohol

INTERVENTIONS

10:57, Pneumoperitoneum, 11:14

Unspecified diagnostic endoscopic examination of peritoneum; Not applicable

COPY

FLUID BALANCE

BLOOD OUT	TOTAL IN	1020 mL
URINE OUT	TOTAL OUT	
OTHER OUT	BALANCE	1020 mL

SCORING CHART

SEDATION	NAUSEA	PAIN	WOUND
12:29 - 1 - Drowsy, easy to rouse by speech	12:29 - 0 - None	12:29 - 0 - No pain / Asleep	11:51 - 0 - Dry & intact

NOTES

NOTES		
11:52	Other recovery comment	In recovery, observations stable, BP was high when came to recovery however is now coming down. Dressings checked and are dry and intact. Patient still sleepy. SN Cobain
11:57	Other recovery comment	Patient rouseable to speech. States comfortable at present. Currently back asleep. SN Cobain
12:08	Other recovery comment	Has tolerated sips of water. Still feels comfortable. SN Cobain
12:25	Other recovery comment	Have contacted patients wife as per patients request just to let her know that patient out in recovery. Awaiting bed in B11. Patient still sleepy however easily rouseable. SN Cobain
12:50	Other recovery comment	Have spoken with Nick anaesthetist regarding patients blood pressure as currently 172 systolic. States that he is happy with this as long as patient comfortable which he is. SN Cobain

Unspecified diagnostic endoscopic examination of peritoneum; Not applicable

COPY

POSTOP PLAN

INSTRUCTIONS

Rx goal SpO2 min: 94-98%
Rx Goal BP MAP - Min: 60 mmHg
Postop thromboprophylaxis: Mobilise and keep hydrated
Postop glycaemic control method: Not applicable
Planned postop antimicrobial treatment: Continue as prescribed
Oral Intake: Full diet

DRUGS & FLUIDS

DRUGS & FLUIDS intraop

Dexamethasone 6.6 mg
Levobupivacaine 5 mg/ml 20 mL
Sugammadex 400 mg
Morphine 10 mg
Rocuronium 70 mg
Propofol 200 mg
Fentanyl 100 µg
Ondansetron 4 mg
Hartmanns 0 mL

DRUGS & FLUIDS postop

Hartmanns 1000 mL

Dexamethasone

Recording	Amount	Volume	Rate	Cumulative amount	Cumulative volume	Time	Route	Bag ID	Saved by
Bolus	6.6 mg	0 mL		6.6 mg	0 mL	10:33	IV Bolus		Amy Thomson

any drug	Amount	Volume	Rate	Cumulative amount	Cumulative volume	Time	Route	Bag ID	Saved by
Bolus	100 µg	0 mL		100 µg	0 mL	10:31	IV Bolus		Amy Thomson

Levobupivacaine 5 mg/ml

Recording	Amount	Volume	Rate	Cumulative amount	Cumulative volume	Time	Route	Bag ID	Saved by
Bolus	20 mL	20 mL		20 mL	20 mL	11:18	Perineural		Amy Thomson

Morphine

Recording	Amount	Volume	Rate	Cumulative amount	Cumulative volume	Time	Route	Bag ID	Saved by
Bolus	5 mg	0 mL		10 mg	0 mL	10:47	IV Bolus		Amy Thomson
Bolus	5 mg	0 mL		5 mg	0 mL	10:34	IV Bolus		Amy Thomson

Ondansetron

Recording	Amount	Volume	Rate	Cumulative amount	Cumulative volume	Time	Route	Bag ID	Saved by
Bolus	4 mg	0 mL		4 mg	0 mL	10:33	IV Bolus		Amy Thomson

Propofol

HANDOVER SUMMARY

Name:
CHI#
Procedure Date:

DOWELL, SCOTT
2602800570
24.11.2025

Unspecified diagnostic endoscopic examination of peritoneum; Not applicable

COPY
Amy
Thomson

Recording	Amount	Volume	Rate	Cumulative amount	Cumulative volume	Time	Route	Bag ID	Saved by
Bolus	200 mg	0 mL		200 mg	0 mL	10:33	IV Bolus		
Rocuronium									
Recording	Amount	Volume	Rate	Cumulative amount	Cumulative volume	Time	Route	Bag ID	Saved by
Bolus	70 mg	0 mL		70 mg	0 mL	10:33	IV Bolus		Amy Thomson
Sugammadex									
Recording	Amount	Volume	Rate	Cumulative amount	Cumulative volume	Time	Route	Bag ID	Saved by
Bolus	200 mg	0 mL		400 mg	0 mL	11:29	IV Bolus		Amy Thomson
Bolus	200 mg	0 mL		200 mg	0 mL	11:29	IV Bolus		Amy Thomson

HANDOVER SUMMARY

Name:
CHI#
Procedure Date:

DOWELL, SCOTT
2602800570
24.11.2025

Unspecified diagnostic endoscopic examination of peritoneum; Not applicable.

		24/11/2025										POSTop
		11:45	12:00	12:15	12:30	12:45	13:00	13:15	13:30			
Events	Procedural times	POP in					POP out					
Vitals	SpO2	95	95	95	95	95	95	95	95			
	HR	75	75	75	75	75	75	75	75			
	NIBPsys	150	150	150	150	150	150	150	150			
	NIBPdia	75	75	75	75	75	75	75	75			
Data	Hartmanns	IV infusor					1000 mL					
	RR total	12			14	13						
Status	Temp	37			36.8	36.8						
	Respiration	OK			OK							
	Cough	Absent			Absent							
	Supplemental O2 by	Face mask			Face mask	Nasal cannula						
	Flow O2 set	5			4							
	D- Sedation score	1 - Drowsy, e...			1 - Drowsy, e...							
	Nausea score	0 - None			0 - None							
	Pain score	0 - No pain / ...			0 - No pain / ...							
	Dressing checked											
	Wound assessment	0 - Dry & intact										
BAL by hour	BAL total hourly	0					0					
	IN total hourly	0					0					
	OUT total hourly	0					0					
	OUT blood hourly	0					0					
	OUT urine hourly	0					0					

COPY

Unspecified diagnostic endoscopic examination of peritoneum; Not applicable

		24/11/2025								
		11:45	12:00	12:15	12:30	12:45	13:00	13:15	13:30	POSTop
Block	Lines									
	ACF - Left									
	Infiltration									
	n/a									

COPY

Forth Valley Royal Hospital

CHI Number:

COPY
26/12/2025

Surname, Forename:

Dowen, Scott

Date of Birth:

26 February 1980

Sex:

M

Theatre:

Theatre 11

Date of operation

24 November 2025

Procedures:

Unspecified diagnostic endoscopic examination of peritoneum, Laparoscopic, Not Applicable

procedure	surgeon	localisation	surgical technique
Unspecified diagnostic endoscopic examination of peritoneum	Camilleri-Brennan John	Not Applicable	Laparoscopic

Staff in attendance:

Surgeon: Camilleri-Brennan John

Participants:

participant	participant role	participant type	ref	comment
Camilleri-Brennan John	Surgeon	Consultant Surgeon		N.A.
Cowie Karen	Floor Nurse 1	Healthcare Support Worker		N.A.
Crutchley Nicholas	Supervising Anaesthetist	Anaesthetist		N.A.
McGovern Josh	Surgeon's Assistant 1	Surgeon		N.A.
McKinna Morgan	Scrub Nurse 1	Operating Department Practitioner		N.A.
Stewart Hannah	Floor Nurse 1	Theatre Practitioner		N.A.
Student Nurse 1	Student	Student		Joe
Tan Neil Yi Sheng	Anaesthetist	Anaesthetist		N.A.
Thomson Amy	Anaesthetic Practitioner	Theatre Practitioner		N.A.

ASA Class: ASA 2 Mild Systemic Disease

Anaesthetic: GA ETT

SURGERY REPORT

Management Intent: Inpatient
NCEPOD: E < 24 Hours
Destination after surgery: N.A.
Ward: SAU

COPY

Indication- Lap chole on 20/11. Represented with worsening pain. CRP 14. Minimal from drains. Decision made to return to theatre for laparoscopic washout. Patient consented for theatre and informed of risks.

Findings- Small haematoma on left lobe of liver. No bile, abscess or faecal material.

Procedure- GA. IV Abx. Flowtrons. WHO pause. Prepped and draped. Previous supraumbilical incision re-opened. 10mm port inserted and pneumoperitoneum established. Further 10mm port inserted in virgin area of epigastrium. Inspection of abdomen. Drains in appropriate position. Findings as above. Mr Crumley attended theatre and confirmed no obvious cause for pain. 2L saline lavage clear. Ports removed under vision. Sheath closed with No. 1 Vicryl. 20mls of 0.5% Bupivacaine infiltrated into wound. 3-0 Caprosyn subcuticular to skin. Dressing applied. EBL minimal. Returned to recovery in good condition.

Post-op- Return to ward. Can E+D. Keep drains until surgical team advises otherwise. No further IV Abx.

Sutures/dressings – As above

Any follow up required – TBC

Dictated on: 24 November 2025

Dictated by: McGovern Josh

Surgeon's signature: _____

Date 23/11/25 Ward SPAL		CHI NO: 2802800570 26/02/1980 CRN: M SCOTT DOWELL 11 DON STREET GRANGEMOUTH FK3 8HD		Sex COPY
Procedure and side		Date of Birth		
Surgeon				

CHECKLIST ITEMS	WARD	HANDOVER CHECKS	BASELINE WARD CHECKS & DATA
Verbal Name Check	✓	YD	Pre-assessment Document
ID Band Checked	✓	YD	Present and Checked ☐
Pre-assess/clerking completed	✓	YD	Any Changes?
Pregnant Yes / No LMP date	N/A	NA	
Allergies (see baseline checks Yes / No)	N/A	NO	
Consent / Incapacity completed	✓	YD	Temp Weight (kg)
Operation confirmed with patient	✓	YD	P BP
Consent form corresponds to list		YD	RR SpO2
Operation site marked clearly		NA	BM (Sugar) Height
Nursing notes	✓	YD	Allergies
Case Notes	X	NO	☒ No ☐ Yes
Cross Match - no. of units		NA	Specify reaction
G&S confirmed & 2nd sample (if applicable, yes or no)		7	
Confirm all results available	✓		MRSA +ve / -ve
Addressograph labels	✓	YD	
Fasted for solids / milk from (time)	22/11/25	23/11/25	Hb Na
Fasted for clear fluids from (time)	5pm	24/11/25	WCC K
Bladder emptied (time or No)	19:00	YD	Platelet U
Jewellery removed	✓	none	Clotting Cr
Body piercings taped etc	✓	none	G and S X-Match
Nail Varnish / makeup removed	N/A	none	
Contact lenses removed	N/A	none	
Prosthesis (* or No)	X	NO	
Orthopaedic implants (* or No)	L hip replacement	*	
Pacemaker (Yes or No)	X	NO	
Hearing aid (Yes or No)	X	NO	
Able to move by self on trolley	✓	YD	
Diabetic Yes / No	X	NO	
On Beta Blocker Yes / No	X	NO	
If "YES" Taken Yes / No	X		
If not taken: Administered by Nursing Staff YES (NO)			
Ward sign and designation MR 45 YN			
Handover 1 sign and designation SN			
Handover 2 sign and designation			
Comments* Temp: 35.6 L hip & L arm			Patient Valuables Dentures Full ☐ Partial ☒ None ☐ Glasses ☒ Hearing Aid ☒ Dressing Gown ☒ Slippers ☐ Other _____ Sign 1 MD

RECOVERY CHART

Airway					
O ₂ l/min					
SpO ₂					
Resp Rate					
Temp					
BM					
TIME					
150					
100					
50					
A-line ☐					
Site:-					
CVP ☐ 0					
Sedation Score					
Pain Score					
Nausea Score					
Wound Site					
Drains					
IVI / Ambit Pump					
Spinal / Epidural					
C / S / M					
Urinary Catheter					
Pressure Areas					

Recovery Practitioner.....

HANDOVER CHECKLIST:

- ☐ Patient
☐ Anaesthetic
☐ Surgery
☐ Status
☐ Plan
☐ Cannula flushed
☐ Analgesia & Antimetic on HePMA

COPY

PAEDIATRIC ONLY:

IV Morphine.....mg

IV Fentanyl.....mg

Oxygen - in recovery follow protocol

SpO₂ range.....%

Duration.....

Investigations - in recovery

Transfusion trigger: Hb.....

Anaesthetist Name.....

Signed.....

Page Number.....

Patient discharge

Criteria Met ☐ HePMA ☐ TTA's ☐ Nursing Notes ☒

Op notes ☐ Case notes ☐ Relevant Charts ☐ EWS ☐

Cannula flushed ☐ Valuables ☐

Discharge to (ward).....

Signed..... Recovery

Signed..... Ward

Discharge criteria met, Time.....

Forth Valley Royal Hospital Assessment Document



Date of arrival: _____ Time of arrival: _____
 Source of referral: GP ED Other
 GP practice: _____

CHI: 2602800570
 26/02/1980
 Name: DOWELL Scott
 Address: 11 DON STREET,
 GRANGEMOUTH,
 STIRLINGSHIRE FK3 8HD

**M
COPY**

Time

NEWS score

Tel

NOK 1 Name: Diane
 Relationship: wife
 Address: _____
 Tel: 01324 262719

NOK 2: _____

Presenting complaint

R) testicular pain
 Spondylitis

B Background

A

Probable sepsis- commence Sepsis-6, insert bundle sticker

Yes

No

Diabetic ketoacidosis- commence DKA pathway

Yes

No

Referred with hyperkalaemia ≥ 6.5 mmol/L

Yes

No

Potential stroke, symptoms <3.5 hours → assessment for thrombolysis

Yes

No

Insert bundle sticker for all patients with potential stroke

Abdominal pain and history of aortic aneurysm

Yes

No

Abdominal symptom in female <55 with possibility of pregnancy → urgent urine HCG

Yes

No

Do not delay further assessment waiting for sample

Triggering on NEWS (insert bundle sticker) or other clinical concern

Yes

No

ECG obtained- Clinician to review/ sign/date/ time within 10 minutes if chest/ epigastric pain

Yes

No

Consent for ECS access

Yes

No

Potentially suitable for ambulatory care

Yes

No

R Triage category

1

2

3

Samples sent

Yes/ No

U&E/ LFT/ CRP/ FBC/ Glucose

✓

If triage category 1 or 2 insert cannula

Cultures

No

Site

Amylase

No

Size

Calcium

No

Batch

Group and save

No

Inserted by

Troponin 0 hours / 12 hours (delete as appropriate)

No

Name L McLAY

Signature

L McLAY

Date

21/8/18

Time

16.30

Preliminary Nursing Assessment

PATN

CHI: 2602800570

26/02/1980

M

DOWELL Scott
11 DON STREET,
GRANGEMOUTH,
STIRLINGSHIRE FK10 5DT

COPY

Belongings	With family	☐	☒ With patient	In safe	☐
Own medication	Yes	☐	☒ No		
Name band	☒ Yes	☐	☒ No		
Patient fasted	Yes	☐	☒ No	Food time	Drink time
Relatives with patient	☒ Yes	☐	☒ No	Informed	☐

Preliminary Pressure Ulcer Risk Assessment (PPURA)

Mobility: Patient is fully mobile without equipment/ assistance (Y/N)

Continence: Person is fully continent (Y/N)

Nutrition: Person appears well nourished and able to eat and drink (Y/N)

Record answer in grid below Y=Yes N=No

If the answer is NO to any assessments, complete Braden within 6 hours

Remember

- People who are overweight may not be well nourished
- Please sign after each check

Date	Time	Mobility	Continence	Nutrition	Skin inspected	Braden complete?	Signature/ PRINT
8/2/18	16.30	Y	Y	Y	Y		L MCLAY R MCLAY

Comments if required:

Preliminary falls assessment- if Yes to any, complete falls bundle within 4 hours if being admitted

≥2 falls in last 6 months?	Yes	☐	☒ No
Patient/ Carer/ Referrer anxious about falls?	Yes	☐	☒ No
Tries to walk alone but unsteady/ unsafe?	Yes	☐	☒ No

Additional nursing comments

Name L MCLAY Signature L MCLAY Date 8/2/18 Time complete 16.45

Bundle stickers

Patient details

COPY

Assessment

Practitioner's Name

Date

Patient Detail

Grade

Time commenced

GMC/ NMC

Location

COPY

Presenting Complaint:

Systemic Enquiry:

Height:

Weight:

BMI:

Usual level of activity (please circle)

Bedbound

Dependent
for
personal
care

Requires
minimal
assistance with
ADLs

Slowed.
Assistance with
heavier
household
tasks

"Slowed-up"
but not
requiring
assistance

No exercise
beyond
walking.

Occasional
exercise

Regular
exercise

Past medical, surgical and anaesthetic history

MI

Angina

Hypertension

COPD

Stroke /TIA

Diabetes

Implement diabetes
bundle

Family History

Travel History

Social History

Smoking: Never Ex smoker (since _____)

Current ____/day Pack years _____

Alcohol: ____ Units / week

Occupation

Driving licence yes/ no

Lives With

Support/ Carers

Fatigue details

COPY

- ☐
- Community pharmacy

☐ Other

OR

Reaction/ Side effect

[illegible]

NON-PRESCRIPTION MEDICATIONS AND HERBAL MEDICATIONS

Yes ☐ No ☐

If 'No' please detail what further action is necessary (e.g. contact GP, carer or access ECS)

Time:

Date:

Time:

Examination

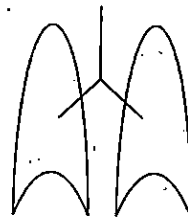
Diabetic patients → foot examination and diabetes bundle
GI Bleeding → PR examination
Age >65 or confusion → AMT
If cognition or alertness impaired → consider delirium

Patient Details

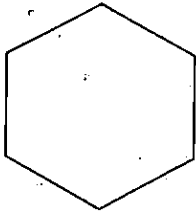
Cardiovascular

Respiratory

COPY



Abdominal



Bowel sounds:

PR:

AMT (If <4/4, complete AMT10)

1. Age
2. DOB
3. Year
4. Location

/4

Ask patient to remember address: "42 West Street"

5. Time to nearest hour
6. Current monarch
7. Date Of WW2
8. Count 20 → 1
9. Identify 2 people
10. Recall address

/10

Neurological (remember speech, visual assessment, balance, gait)

Cranial nerves:

	R arm			L arm			R leg			L leg		
Tone												
Power												
Sensation												
Coordination												
Reflexes												

Other

Interpretation of results

ECG

CXR

Urine HCG

Other imaging

Urinalysis

Additional comments

	Neg	Trace	+	++	+++	++++
Leucocytes						
Nitrites						
Glucose						
Ketones						
Blood						
Protein						

Differential diagnosis

COPY

Management plan

Additional investigations required (e.g. cultures) Please initial and date when sent

Venous thromboembolism (VTE) risk assessment

Medical patient expected to be mobilising as normal within 2 days

Proceed to VTE risk **actions**

Medical patient with reduced mobility for ≥ 2 days OR Surgical patient

Assess **thrombosis and bleeding risk factors**

Thrombosis risk factors. ANY thrombosis risk factor(s) should prompt VTE prophylaxis measures unless contraindicated → Assess bleeding risk.

Bleeding risk factors. Consider whether sufficient to preclude pharmacological prophylaxis

- | | |
|---|--|
| <ul style="list-style-type: none"> ☐ Mobility reduced for >2 days ☐ Age >60 ☐ Dehydration ☐ Obesity BMI >30 kg/ m² ☐ Significant medical comorbidity (e.g. cardiac, respiratory, endocrine, inflammatory, infectious conditions) ☐ Active cancer or cancer treatment ☐ Thrombophilia ☐ Personal history or first degree relative with history of VTE ☐ Use of hormone replacement therapy or oestrogen containing contraceptive ☐ Pregnancy or $<6/52$ post-partum | <ul style="list-style-type: none"> ☐ Acute surgical admission with inflammatory or intra-abdominal condition ☐ Surgery with significant reduction in mobility ☐ Critical care admission ☐ Knee or hip replacement ☐ Hip fracture ☐ Total anaesthetic+ surgical time >90mins ☐ Pelvic or lower-limb surgery with anaesthetic+ surgical time >60mins ☐ Varicose veins with phlebitis |
|---|--|

- ☐ Active bleeding
- ☐ Acquired bleeding disorder (e.g. acute liver failure)
- ☐ Current use of therapeutic anticoagulation (e.g. warfarin, rivaroxaban, dabigatran)
- ☐ Acute stroke
- ☐ Thrombocytopenia ($<75 \times 10^9/L$)
- ☐ Uncontrolled hypertension ($>230/120$ mmHg)
- ☐ Untreated inherited bleeding disorder
- ☐ Neurosurgery, spinal surgery or eye surgery
- ☐ Other procedure with high bleeding risk
- ☐ Lumbar puncture, epidural or spinal anaesthesia expected within the next 12 hours
- ☐ Lumbar puncture, epidural or spinal anaesthesia within the previous 4 hours

VTE risk actions

Information provided

Provide if admission is anticipated
Yes/ No

LMWH

Yes/ No/
Contraindicated

Antiembolism stockings

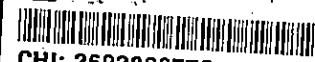
Consider if thrombosis risk factors present and bleeding risk factors preclude LMWH
Contraindicated in peripheral neuropathy, PVD, ulceration, cellulitis, gross oedema
Yes/ No/ Contraindicated

Name

Signature

Date

Time complete



CHI: 2602800570

26/02/1980

M

DOWELL Scott

11 DON STREET

GRANGEMOUTH

STIRLINGSHIRE

COPY
FK3 8HD

08/02/18
1830

N GRUBS

ST4

urology

admitted to severe @ rectal pain
recent dysuria
pain worse on voiding

o/e no pyrexia
no tachycardia
both testis (N)
no particular testicular
tenderness

UKDA

urine culture from yesterday +ve
CT from yesterday -ve

plan: home

7/7 625mg augmentin TDS
no follow-up

NQ
N GRUBS
7271364

ECG

CXR/Imaging

Results

Consultant Ward Round

Page 1 of 1

COPY

Diagnoses and significant comorbidities

Plan

Checklist

Estimated LoS

<24h

24-48h

>48h

Medicine reconciliation

Transfer of Care to:

VTE assessment

Outstanding criteria for ward transfer/discharge (delete as appropriate):

S_pO₂ target prescribed

Fasting

Yes / No

Name

Signature

Date

Time

Resuscitation/ Escalation of care/ Anticipatory Care Planning / Advance Directives

Documentation of Discussion with Patient or Family

Name

Signature

Date

Time

Date and
time

Continuation

Please sign and PRINT NAME and POSITION

CHI: 2602800570

26/02/1980

M

DOWELL Scott

11 DON STREET,

GRANGEMOUTH,

STIRLINGSHIRE FK9 8TB

COPY
2 sided

8/2/18 Arrived in SAU via GP, complaining of
16.35 testicular pain, bloods obtained, vital signs
as charted. Awaiting rlv at present. R. McHugh
18.40 Reviewed by urology, Co-amoxyclov 1g given
on discharge, no follow up. R. McHugh

Forth Valley Royal Hospital Assessment Document



Date of arrival **6/2/18** Time of arrival **2200**
 Source of referral: **(GP)** ED Other
 GP practice:

CHI: 2602800570
 26/02/1980
 DOWELL Scott
 11 DON STREET,
 GRANGEMOUTH,
 STIRLINGSHIRE FK3 8HD

COPY

20 97 14 372 95 11/85

Time **2205** NEWS score ☐

NOK 1 Name **Diane**
 Relationship **wife**
 Address
 Tel **01324 262719**

NOK 2
 Tel

S	Presenting complaint	TESTICULAR PAIN		
B	Background	ALW hip replacement		
A	Probable sepsis- commence Sepsis-6, insert bundle sticker	Yes	☐	No
	Diabetic ketoacidosis- commence DKA pathway	Yes	☐	No
	Referred with hyperkalaemia ≥ 6.5 mmol/L	Yes	☐	No
	Potential stroke, symptoms <3.5 hours → assessment for thrombolysis Insert bundle sticker for all patients with potential stroke	Yes	☐	No
	Abdominal pain and history of aortic aneurysm	Yes	☐	No
	Abdominal symptom in female <55 with possibility of pregnancy → urgent urine HCG Do not delay further assessment waiting for sample	Yes	☐	No
	Triggering on NEWS (insert bundle sticker) or other clinical concern	Yes	☐	No
	ECG obtained- Clinician to review/ sign/date/ time within 10 minutes if chest/ epigastric pain	Yes	☐	No
Consent for ECS access	Yes	☐	No	
Potentially suitable for ambulatory care	Yes	☐	No	

R	Triage category	1	2	3
Samples sent		Yes/ No		
U&E/ LFT/ CRP/ FBC/Glucose		YES		
Cultures		Site		
Amylase		Size		
Calcium		Batch		
Group and save		Inserted by		
Troponin 0 hours / 12 hours (delete as appropriate)				

Name **W. Jones** Signature **[Signature]** Date **6/2/18** Time

Preliminary Nursing Assessment

CHI: 2602800570

26/02/1980

DOWELL Scott

11 DON STREET,

GRANGEMOUTH,

STIRLINGSHIRE

COPY

Belongings	With family		With patient	✓	In safe	
Own medication	Yes		No	✓		
Name band	Yes	✓	No			
Patient fasted	Yes		No	✓	Food time	Drink time
Relatives with patient	Yes	✓	No		Informed	

Preliminary Pressure Ulcer Risk Assessment (PPURA)

Mobility: Patient is fully mobile without equipment/ assistance (Y/N)

Continence: Person is fully continent (Y/N)

Nutrition: Person appears well nourished and able to eat and drink (Y/N)

Record answer in grid below Y=Yes N=No

If the answer is **NO** to any assessments, complete Braden within 6 hours

Remember

- People who are overweight may not be well nourished
- Please sign after each check

Date	Time	Mobility	Continence	Nutrition	Skin inspected	Braden complete?	Signature/ PRINT
6/2/18		Y	Y	Y	patient stable in bed		W

Comments if required:

Preliminary falls assessment- If Yes to any, complete falls bundle within 4 hours if being admitted

≥2 falls in last 6 months?	Yes		No	✓
Patient/ Carer/ Referrer anxious about falls?	Yes		No	✓
Tries to walk alone but unsteady/ unsafe?	Yes		No	✓

Additional nursing comments

Name Signature Date Time complete

W. J. ...

W. J. ...

6/2/18

Bundle stickers



CHI: 2602800570

26/02/1980

M

DOWELL Scott

11 DON STREET,

GRANGEMOUTH

STIRLINGSHIRE

COPY

Assessment

Practitioners Name

Mingman

Date

6/2/18

Grade

Low (ongoing)

Time commenced

2030

GMC/ NMC

6142645

Location

JMU



CHI: 2602800570

26/02/1980

DOWELL Scott

11 DON STREET

GRANGEMOUTH,

STIRLINGSHIRE

COPY

FKS 8HB

Presenting Complaint:

Acute pain HE MI, Sudden onset
Severe

onset @ 1800

last meal @ 1700

No Prodrome

No urinary symptoms

No Discharge

Systemic Enquiry: Downy over

Height:

5ft 9

Weight:

BMI:

Usual level of activity (please circle)

Bedbound

Dependent
for
personal
care

Requires
minimal
assistance with
ADLs

Slowed.
Assistance with
heavier
household
tasks

"Slowed-up"
but not
requiring
assistance

No exercise
beyond
walking.

Occasional
exercise

Regular
exercise

Past medical, surgical and anaesthetic history

MI

Angina

Hypertension

COPD

Stroke /TIA

Diabetes

Implement diabetes
bundle

Angina
Hypertension

Social History

Smoking: Never Ex smoker (since _____)

Current 20 /day Pack years _____

Alcohol: _____ Units / week

Occupation

Driving licence yes/ no

Lives With

Support/ Carers

Family History

Travel History

Medicines Reconciliation At least 2 recent sources, one of which must be patient or carer

CHI: 2602800570

26/02/1980

M

- DOWELL Scott

11 DON STREET,

GRANGEMOUTH

STIRLINGSHIRE

Verba

- ☐ Patient (e.g. verbal recollection or handwritten note) ☐ Relative/Carer ☐ Electronic patient record
ECS (issued in last 6 months?)
IDL (within last month?)
- ☐ Patient's own medicines ☐ Nursing home prescription ☐ Community pharmacy

OR

Drug / Substance	Reaction/ Side effect

[illegible]

RECENT ANTIBIOTICS/RECENTLY DISCONTINUED MEDICATION (within 6 months)

[illegible]

NON-PRESCRIPTION MEDICATIONS AND HERBAL MEDICATIONS

[illegible]

Are you satisfied this medication history is complete and accurate? Yes ☐ No ☐

If 'No' please detail what further action is necessary (e.g. contact GP, carer or access ECS)

Name: _____

Signature:

Date:

Time:

Name: _____

Signature:

Date:

Time:

Examination

Diabetic patients → foot examination and diabetes bundle
GI Bleeding → PR examination
Age >65 or confusion → AMT
If cognition or alertness impaired → consider delirium



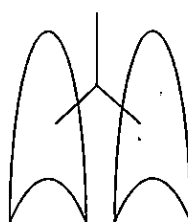
CHI: 2602800570
26/02/1980
DOWELL Scott
11 DON STREET,
GRANGEMOUTH,
STIRLINGSHIRE FK8 3H

M

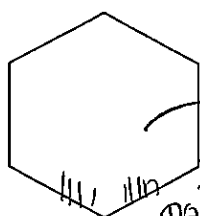
COPY

Cardiovascular

Respiratory



Abdominal



Bowel sounds:

PR:

Soft
Normal
Normal
Normal
Normal

AMT (If <4/4, complete AMT10)

1. Age
2. DOB
3. Year
4. Location

Ask patient to remember address: "42 West Street"

5. Time to nearest hour
6. Current monarch
7. Date Of WW2
8. Count 20 → 1
9. Identify 2 people
10. Recall address

/10

Neurological (remember speech, visual assessment, balance, gait)

Cranial nerves:

	R arm			L arm			R leg			L leg		
Tone												
Power												
Sensation												
Coordination												
Reflexes		T	S	B	T	S	K	A	Plantar	K	A	Plantar

had

Other

Interpretation of results

ECG

CXR

Urine H

Urine K

Leuc	
Nitrit	
Gluc	
Ket	
Blo	
Protein	

GLU Negative
BIL Negative
KET Negative
SG 1.010
BLO Trace-Intact
PH 6.5
PRO Negative
URO 0.2 E.U./dl
NIT Negative
LEU Trace

Not Entered

Test date 07-02-2018
Operator 00:56
Test number 298
Color Not Entered
Clarity Not Entered

Patient:

211756

Serial Number:

Other imaging

al comments

Differential diagnosis

CHI: 2602800570

26/02/1980

DOWELL Scott

11 DON STREET,

GRANGEMOUTH,

STIRLINGSHIRE

COPY

Peritonitis

Acute cholecystitis

Management plan

1) Dilute mouthwash for n/v

2) Monitor

3) Keep fasted for now

4) Bloods only

5) Urine dipstick

Additional investigations required (e.g. cultures) Please initial and date when sent

Venous thromboembolism (VTE) risk assessment

Medical patient expected to be mobilising as normal within 2 days

Proceed to VTE risk actions

Medical patient with reduced mobility for ≥ 2 days OR Surgical patient

Assess thrombosis and bleeding risk factors

Thrombosis risk factors. ANY thrombosis risk factor(s) should prompt VTE prophylaxis measures unless contraindicated → Assess bleeding risk.

Bleeding risk factors. Consider whether sufficient to preclude pharmacological prophylaxis

- ☐ Mobility reduced for >2 days
- ☐ Age >60
- ☐ Dehydration
- ☐ Obesity BMI >30 kg/m²
- ☐ Significant medical comorbidity (e.g. cardiac, respiratory, endocrine, inflammatory, infectious conditions)
- ☐ Active cancer or cancer treatment
- ☐ Thrombophilia
- ☐ Personal history or first degree relative with history of VTE
- ☐ Use of hormone replacement therapy or oestrogen containing contraceptive
- ☐ Pregnancy or $<6/52$ post-partum

- ☐ Acute surgical admission with inflammatory or intra-abdominal condition
- ☐ Surgery with significant reduction in mobility
- ☐ Critical care admission
- ☐ Knee or hip replacement
- ☐ Hip fracture
- ☐ Total anaesthetic+ surgical time >90 mins
- ☐ Pelvic or lower-limb surgery with anaesthetic+ surgical time >60 mins
- ☐ Varicose veins with phlebitis

- ☐ Active bleeding
- ☐ Acquired bleeding disorder (e.g. acute liver failure)
- ☐ Current use of therapeutic anticoagulation (e.g. warfarin, rivaroxaban, dabigatran)
- ☐ Acute stroke
- ☐ Thrombocytopenia ($<75 \times 10^9/L$)
- ☐ Uncontrolled hypertension ($>230/120$ mmHg)
- ☐ Untreated inherited bleeding disorder
- ☐ Neurosurgery, spinal surgery or eye surgery
- ☐ Other procedure with high bleeding risk
- ☐ Lumbar puncture, epidural or spinal anaesthesia expected within the next 12 hours
- ☐ Lumbar puncture, epidural or spinal anaesthesia within the previous 4 hours

VTE risk actions

Information provided

Provide if admission is anticipated
Yes/ No

LMWH

Yes/ No/
Contraindicated

Antiembolism stockings

Consider if thrombosis risk factors present and bleeding risk factors preclude LMWH
Contraindicated in peripheral neuropathy, PVD, ulceration, cellulitis, gross oedema
Yes/ No/ Contraindicated

Name

Signature

Date

Time complete

Date and
time

Continuation

Please sign and PRINT NAME and POSITION

CHI: 2602800570

26/02/1980

M

DOWELL Scott

11 DON STREET,

GRANGEMOUTH,

STIRLINGSHIRE FK9 8DY

COPY

6/2/18

2200

patient admitted to SAU via GP with testicular

pain

tw 1

Cannula & bloods

AKID SONIC VIA

6/2/18

Robertson (JTS) Genl Surg

(37)

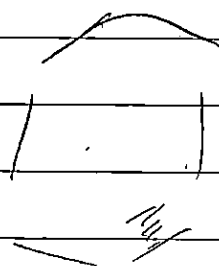
Ask Spand awaiting (L) THR

in biologicals - stopped for surgery

post void severe (R) testicular pain
+ (L) IF pain

opening wounds normally
passing flatus

OF



Refer (L) IF
disturbance

no perh 1
no inguinal / perineal hernia

- Bloods - WCC 11.8
CRP a

- erect CXR+ Lactate - if NAD

Date and
Time

Continuation

Please sign and PRINT NAME and POSITION

CHI: 2602800570
26/02/1980
DOWELL Scott
11 DON STREET,
GRANGEMOUTH,
STIRLINGSHIRE FK10 1PD

M

COPY

vigilant o/n

if does not settle - CT more
lactate 0.8

[Signature]
MOSELEY

7/2/18
06³⁰

Search overnight
fws 0

IV fluids initiated
appears to have slept well
J Wood reported
CT today

[Signature]
W. J. M. S. H.

07/2/18
0810

patient refused to take tramadol this
morning. Enlightenment takes
PRN will mention on ward round to
change prescription or review medication if
IVF ongoing as per
accurate for chat input. Patient seen
CT scan in a common room

07/2/18
0815

need to sort heparin as medications
given on via Kortex - LCA per 7

1200

WCC 45
RCC 1

~~Organism 581~~ urine culture not
complete yet. will probably
be known.
CT - No cause for symptoms identified
Eos & dexam
He has been well since
in error

[Signature]
A. P. B. 3

PRO /

Date and
time

Continuation

Please sign and PRINT NAME and POSITION.



CHI: 2602800570

26/02/1980

M

DOWELL Scott

11 DON STREET,

GRANGEMOUTH,

STIRLINGSHIRE

COPY

7/2/18

let Mr MacDonald

0830

decide TPR next week

presenting acute CRP & testicular pain
although LIF pain on palpation
+ Lennas / no masses.

CRP 122 -

Urine - leucocytes +ve. trace blood

Urine sent

Plan for CT to rule out diverticulitis.

Obtain urine results.

RV later

no need for antibiotic measures
as appropriate

allred
AND/8/8

07/2/18

1100

wife cancelled appointment at the
rehabilitation centre this morning

Shirley will re-schedule send CPP out
to Robert.

await hip replacement in OIP.

IVF continue 60 as PX

ENC 01 - Stroke

CT - HAD

Urine - WCC 45

RBC 1

Organisms 521

no culture as

not, not complete

will probably be
tomorrow

allred

Please tick appropriate box

CLINICAL NOTES

☐

NURSING NOTES

☐

PROGRESS NOTES

☐

Consultant



CHI: 2602800570

26/02/1980

M

DOWELL Scott

11 DON STREET,

GRANGEMOUTH,

STIRLINGSHIRE

FK3 8HD

Label

al No.

COPY

Ward / Dept.

Date and Time

07/2/18

1430

CT scan - normal

? home PM wait MR macdonald to
review later

done on 17

07.02.18

1620

Vent line removed

Discharged home with

family

Dr. (STORMART TEAM LEADER)

Consultant

Write - imprint or Attach Label

Surname..... Hospital No.....

Forenames..... Sex.....

CHI D. of B. COPY

Address.....

Ward / Dept. _____

B COPY

Date and Time

Last: Dowell
First: Scott
ID: 2602800570
DOB: 26-Feb-1980
Age: 45yr
Comment:
Tech:
Ref Phys:

Sex: Male

22-Oct-2025 00:00:16

Vent rate 92 BPM
PR int 159 ms
QRS dur 96 ms
QT/QTc 333/382 ms
P-R-T axes 66 65 43

SINUS RHYTHM
NORMAL ECG
UNCONFIRMED REPORT

1/10/25

COPY

AVR

VI

VI

AVL

VI

VI

AVF

VI

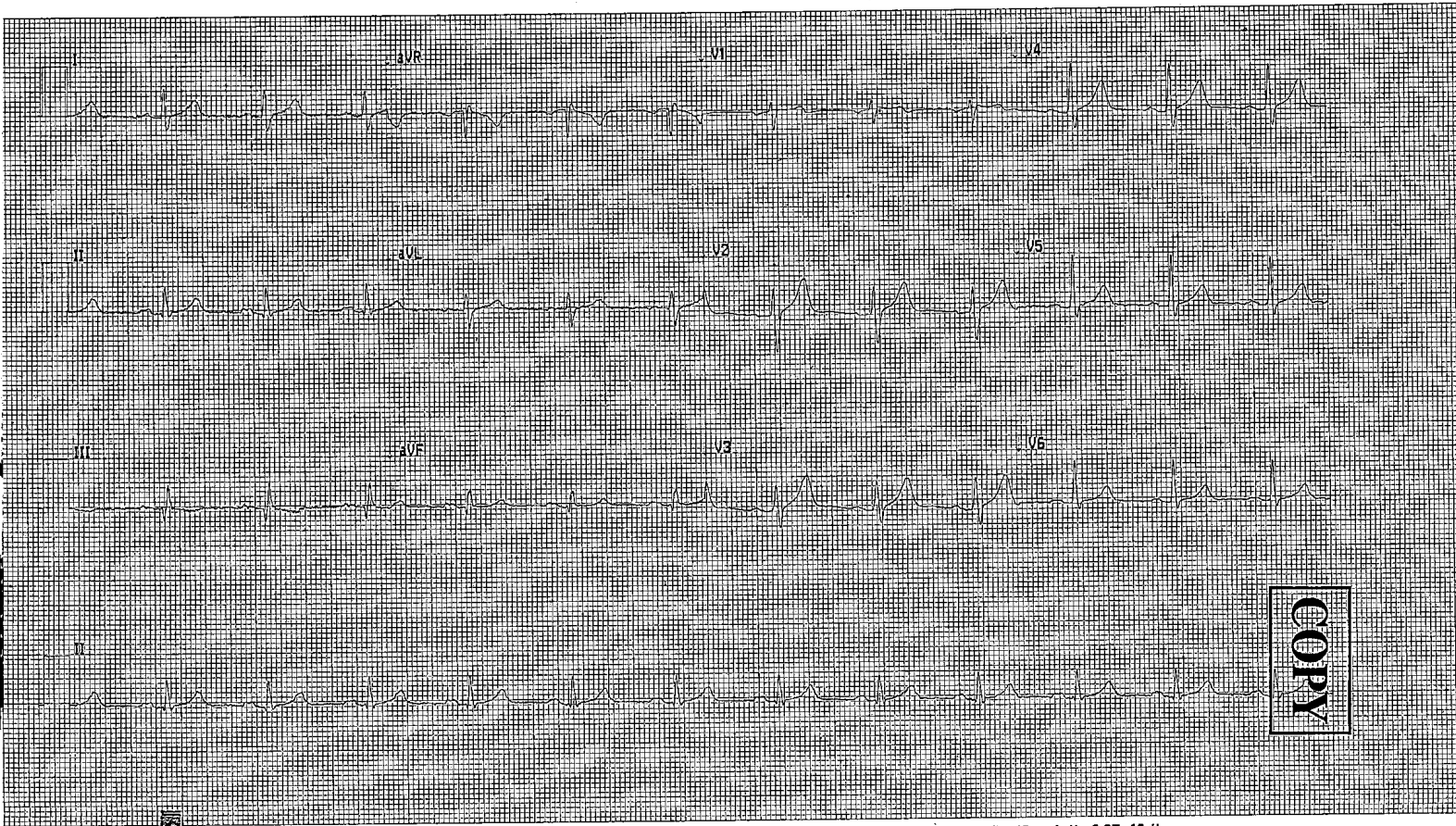
VI

COPY

Last: NO: 2602800570 26/02/1980
First: M
DOB: Scott DOWELL
Age: yr 11 DON STREET
Comment:
Tech: GRANGEMOUTH
Ref Phys: FK3 8HD

24-Feb-2020 10:53:19
Vent rate 14 BPH
PR int 171 ms
QRS dur 56 ms
QT/QTc 367/395 ms
P-R-T axes 61 26 22

SINUS RHYTHM
NORMAL ECG
INTERPRETATION BASED ON A DEFAULT AGE OF 40 YEARS
UNCONFIRMED REPORT



COPY

COPY

Forth Valley Royal Hospital

COPY**Radiology Report**

Patient Name: DOWELL SCOTT
Patient ID: 2602800570
Patient Birth Date: 26-Feb-1980
Referring Physician:

Report Date: 25-Feb-2020 10:49
Accession No.: V213495351201
Report Status: F
Reason For Study:

Clinical Details :

Admitted with generalised abdominal pain, deranged LFTs, recent MRCP, distended abdomen++. On anti-TNF for ank'spond.

Provisional Diagnosis :

?liver pathology

Bleep - 1297

Venous phase CT abdomen and pelvis:
Comparison with prior CT of 07/02/2018.

Minor inflammation surrounding a thin walled gallbladder containing some sludge and small calculi. Prominent local lymph nodes, presumed to be reactive.
No intra or extrahepatic biliary duct dilatation.
Normal pancreas and duodenum.

No free gas. No free fluid.
Normal vermiform appendix.
Normal unprepared bowel.
Normal other abdominal viscera.
Normal lung bases.
Ankylosing spondylitis of the thoracolumbar spine and sacroiliac joints. Left hip replacement.

Opinion: Uncomplicated cholecystitis.

Examination Date: 25/02/2020

Examination: CT Abdomen/Pelvis With Contrast

Date Reported: 25/02/2020

Dictating Radiologist / Clinical Specialist By NIK ARETIS DR CONS R/IST GMC 4500229

Verified by: NIK ARETIS DR CONS R/IST GMC 4500229 on 25/02/2020

Produced by Carestream Health PACS

COPY

Radiology Reports

COPY

Patient Details

Surname	Dowell	Forenames	Scott
Date of Birth	26-Feb-1980	Gender	M
CHI Number	2602800570	Hospital Number	TK2602800570
Address	11 DON STREET	Date Requested	26-Jan-2020 00:00:00
		Location	FV WARD B 11
Examiner1		Examiner2	
Date Report Produced	27-Jan-2020 15:06:00	Attendance Number	6663171

Radiology Report

Clinical Details :

For Monday if possible; Obstructive LFTs (Bi:102) and abdominal pain AUSS: sludge, MRCP for ? ductal stones please as per Mr Crumley

Provisional Diagnosis :

?ductal stone

Bleep - 1295

Report:

MRCP.

Biliary sludge tiny gallstones lying dependently within the otherwise normal gallbladder. No intraductal calculi. Normal calibre biliary tree (CBD 3 mm). No variant anatomy of the cystic duct or right posterior segmental duct insertion.

Diffuse hepatic steatosis. Simple hepatic cysts in segment VI.

Otherwise normal liver, spleen, pancreas, adrenals, and kidneys. Unremarkable partially imaged bowel.

No significantly enlarged lymph nodes.

Opinion:

Biliary sludge tiny gallstones within an otherwise normal gallbladder. No biliary duct abnormality.

Diffuse hepatic steatosis.

Examination Date: 27/01/2020

Examination: MRCP

Date Reported: 27/01/2020

Dictating Radiologist / Clinical Specialist By J FITZPATRICK ST4 R/IST GMC 7440010

Signed by: J FITZPATRICK ST4 R/IST GMC 7440010 on 27/01/2020

Verified by: DR GORDON DEWAR GMC 3330137 on 27/01/2020

COPY

Actions **COPY****Patient**

Patient Name	CHI	Date Of Birth	Age	GP	GP Practice	Consultant Ward/Location
Scott Dowell	2602800570	26/02/1980	39	DUNDAS, DEREK	Westburn Medical Practice	

Name Changed

Report**US**

Clinical Details : Pt admitted with RUQ pain and vomiting. o/e tender RUQ. Bil 102. ? Biliary sepsis ? Obstructed CBD .
Provisional Diagnosis : ? CBD stone ? cholecystitis
Report: The liver is enlarged with a diffusely increased echogenicity in keeping with fatty infiltration. Areas of decreased reflectivity noted adjacent to the gallbladder within the porta hepatis in keeping with focal fatty sparing. Hepatopetal flow was demonstrated within the portal vein

The gallbladder wall is very mildly thickened. Biliary sludge noted but no calculi. No biliary dilatation, the CBD measures 5.1 mm.

The spleen is enlarged measuring 13.6 cm.

Both kidneys appear to outline normally.
Pancreas and abdominal aorta obscured by bowel gas.
No free fluid within the upper abdomen.

Conclusion: Fatty enlarged liver. Areas of focal fatty sparing. Biliary sludge but no calculi. No biliary dilatation.

Patient diffusely tender.

Examination Date: 25/01/2020

Examination: US Abdomen

Date Reported: 25/01/2020

Dictating Radiologist / Clinical Specialist By S HUTCHEON

SONG/R HCPC ID RA62327

Verified by: S HUTCHEON SONG/R HCPC ID RA62327 on 25/01/2020

Case No 94919

Case Active 23/01/2020 22:52

Case Type Attend

COPY

Consultation

Consult By

Bell, Victoria

Consult Start

00:52

Consult End

01:17

PC-Worsening of upper abdo pain

Pain started this morning gnawing type pain in upper abdo and vomited blood stained partially digested food stuffs-has barrets oesphagus and can have blood stained vomit. Pain went away for awhile this afternoon but started worse this evening-feels like crushing type constant pain all across upper abdomen. No pain relief taken but taken medication as per ECS. Vomited again this afternoon blood stained -managed some lasagne this afternoon and this was also through vomit. Normal BO this morning and passing urine normally. No foreign travel-no alcohol intake-not aware of eating or drinking anything that may have caused sx. No fever

Other PMH-ANKYLOSING SPONDYLITIS NKDA -Smoker

Examination Details

Attended with wife-looks unwell warm to touch and well perfused CRT <2-appears to be in pain and discomfort declined meds at this time and anti sickness medication
Abdo distended/ firm and tender in all upper quadrant -? palpable mass in Rt upper upper quadrant ? liver edge- BS active gurgling heard Duller percussion in lower abdo

Clinical Codes

R090, [D]Abdominal pain

ASSESSMENT

Oxygen saturation % 98.0
Systolic BP mmHg 126
Pulse bpm 76
Temperature C 36.6
Diastolic BP mmHg 70

Diagnosis

Abdo pain

Treatment

signs and sx discussed and in view of clinical finding O/E referred to SAU with many thanks

Last: Dowell
First: Scott
ID:
DOB:
Age: yr
Comment:
Tech:
Ref Phys:

Sex: Male

24-Jan-2020 02:32:19

Heart rate
PR int 161 ms
QRS dur 93 ms
QT/QTc 360/390 ms
P-R-T axes 65 64 28

BPM

ms

ms

ms

ms

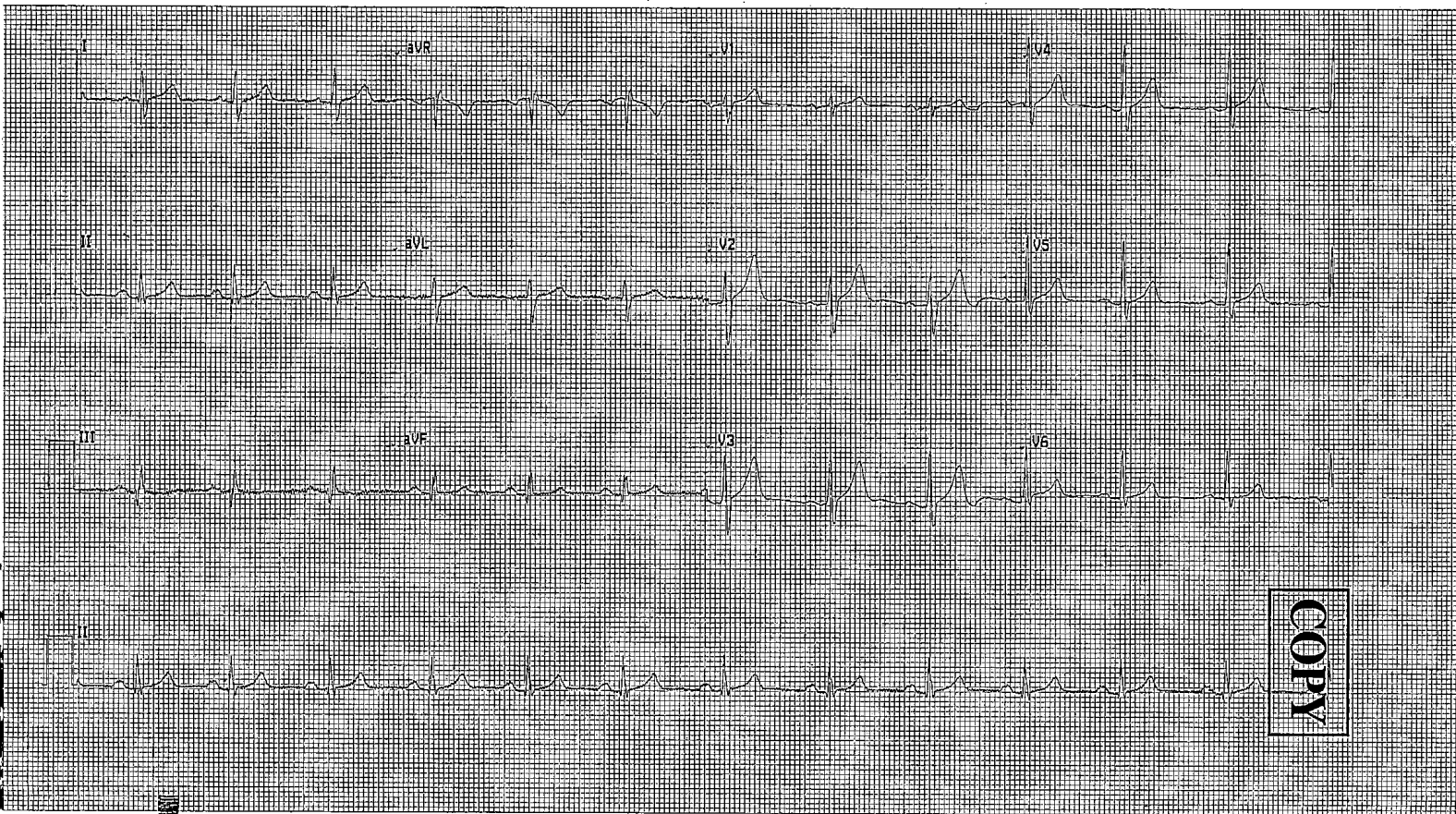
SINUS RHYTHM

NORMAL ECG

INTERPRETATION BASED ON A DEFAULT AGE OF 40 YEARS

UNCONFIRMED REPORT

[Handwritten signature]



COPY

117200569725 SAU

Site # 9 Cart # 0 Version 2.2.1 Sequence #03973 25mm/s .10mm/mV 0.05-150 Hz

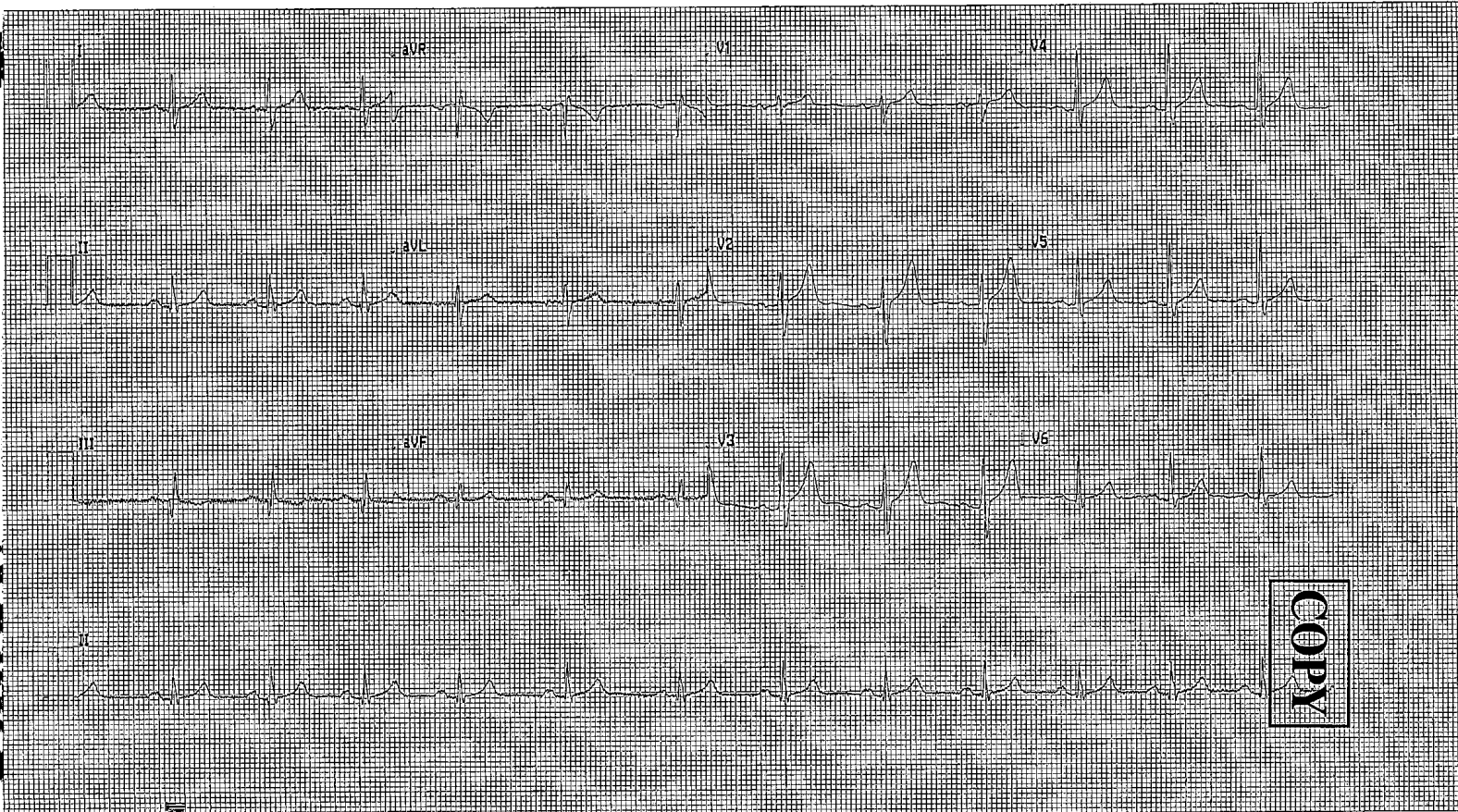
Last: Dowell
First: Scott
ID:
DOB:
Age: yr
Comment:
Tech:
Ref Phys:

Sex: Male

24-Jan-2020 02:31:39

rate 100 bpm
PR int 160 ms
QRS dur 93 ms
QT/QTc 350/380 ms
P-R-T axes 64 21 24

SINUS RHYTHM WITH SINUS ARRHYTHY
NORMAL ECG
INTERPRETATION BASED ON A DEFAULT AGE OF 40 YEARS
UNCONFIRMED REPORT



Radiology Reports

COPY**Patient Details**

Surname	Dowell	Forenames	Scott
Date of Birth	26-Feb-1980	Gender	M
CHI Number	2602800570	Hospital Number	TK2602800570
Address	11 DON STREET	Date Requested	26-Jan-2020 00:00:00
		Location	FV WARD B-11
Examiner1		Examiner2	
Date Report Produced	27-Jan-2020 15:06:00	Attendance Number	6663171

Radiology Report**Clinical Details :**

For Monday if possible; Obstructive LFTs (Bi:102) and abdominal pain AUSS: sludge, MRCP for ? ductal stones please as per Mr Crumley

Provisional Diagnosis :

?ductal stone

Bleep - 1295

Report:

MRCP.

Biliary sludge tiny gallstones lying dependently within the otherwise normal gallbladder. No intraductal calculi. Normal calibre biliary tree (CBD 3 mm). No variant anatomy of the cystic duct or right posterior segmental duct insertion.

Diffuse hepatic steatosis. Simple hepatic cysts in segment VI.

Otherwise normal liver, spleen, pancreas, adrenals, and kidneys. Unremarkable partially imaged bowel.

No significantly enlarged lymph nodes.

Opinion:

Biliary sludge tiny gallstones within an otherwise normal gallbladder. No biliary duct abnormality.

Diffuse hepatic steatosis.

Examination Date: 27/01/2020

Examination: MRCP

Date Reported: 27/01/2020

Dictating Radiologist / Clinical Specialist By J FITZPATRICK ST4 R/IST GMC 7440010

Signed by: J FITZPATRICK ST4 R/IST GMC 7440010 on 27/01/2020

Verified by: DR GORDON DEWAR GMC 3330137 on 27/01/2020

Forth Valley Royal Hospital

COPY**Radiology Report**

Patient Name:	Dowell Scott	Report Date:	06-Jan-2015 11:12
Patient ID:	2602800570	Accession No.:	V213176490101
Patient Birth Date:	26-Feb-1980	Report Status:	F
Referring Physician:	ACUAS2 FV ACUTE ASSESSMENT UNIT 2	Reason For Study:	

Clinical details: Five month history of pain and swelling left groin with on and off discharge. ?Deep collection
Report: L groin: No obvious deep collection. Appearances suggest a collection of thick material just below the
skin surface measuring 35 x 6 x 20 mm..

Examination Date: 06/01/2015

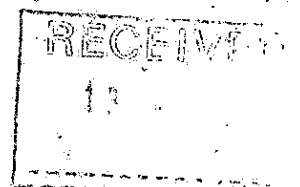
Examination: US Groin Lt

Date Reported: 06/01/2015

Dictating Radiologist / Clinical Specialist By HEATHER MCLEOD

Verified by: HEATHER MCLEOD on 06/01/2015

Produced by Carestream Health PACS

**RADIOLOGY REPORT- FORTH VALLEY ROYAL HOSPITAL****CHI NUMBER: 2602800570 Examination Number: 32326345****Name: Dowell, Scott DOB: 26/02/1980****Address: 11 DON STREET, GRANGEMOUTH, FK3 8HD, -- CC: -****Examination: XR Chest****Examination Date: 25/05/2016 Examination Time: 09:40****Dictating Radiologist: DR MARK ROGER CONS/RIST GMC 4310615****Typed by: None****Referring Consultant: ELSE DR S RHEUMATOLOGY****Referring Department / Location: RHEUMATOLOGY OPD****Clinical History: Ankylosing spondylitis for anti-TNF.****Findings.****The cardiac and mediastinal outlines are normal. Both lungs are clear.****Examination Date: 25/05/2016****Examination: XR Chest****Date Reported: 12/07/2016****Dictating Radiologist / Clinical Specialist By DR MARK ROGER CONS/RIST GMC 4310615****Verified by: DR MARK ROGER CONS/RIST GMC 4310615 on 12/07/2016**

0	1	2	3
---	---	---	---

FULL NAME: Scott Powell
DATE OF BIRTH: 7/6/02/1980

DATE OF BIRTH: 76 / 02 / 1980

DATE 22/10
 TIME 21:15

COPY

COPY

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

NEWS TOTAL					
Monitoring frequency	<	1	0		
Escalation of care Y/N	Y	V	N		
Blood Sugar	-	-	0		
Pain Score 0-3	2	2	0		
Initials	M	ML	M		

National Early Warning Score (NEWS2)



Name:

DOB:

CHI No:

Address:

*** Regardless of NEWS always escalate if concerned about a patient's condition**

Total NEWS	Frequency of Monitoring	Clinical Response
0 *	Minimum 12 hourly	Continue routine NEWS monitoring with every set of observations
1 - 4 *	Minimum 4 - 6 hourly	- Inform registered nurse who must assess the patient - Registered Nurse to decide if increased frequency of monitoring and / or escalation of clinical care is required
5 - 6 * or 3 in one Parameter	Increased frequency to a minimum of 1 hourly	- Registered nurse to urgently inform the medical team caring for the patient - Urgent assessment by a clinician with core competencies to assess acutely ill patients - Ensure structured Response Stickers A & B are completed (<i>Not Applicable in Emergency Dept</i>)
7 * or more	Continuous monitoring of vital signs (3 lead ECG and continuous SpO2 monitoring, 15 minute BP cycling - document observations every 30 minutes)	- Registered nurse to immediately inform the medical team caring for the patient - Emergency assessment by clinical team with core competencies to assess acutely unwell patients - Ensure structured Response Stickers A & B are completed (<i>Not Applicable in Emergency Dept</i>) - Consider transfer of clinical care to ITU

Exclusion Criteria

Anaesthesia and/or sedation may result in reduced conscious levels for a period of time. Scores that are increasing post-procedure and those including "P" or "U" always require escalation. The post-procedure NEWS score and post procedure plan that will include the frequency of observations should be communicated to the ward staff on transfer/handover of the patient.

Target O2 Saturation

Target SpO2 for most patients should be 94-98%.

Selected patients may require target SpO2 88-92% (Appropriate in specific patients with severe chronic respiratory disease who either have established chronic Type 2 respiratory failure, or are felt to be at significantly increased risk of CO2 retention from oxygen therapy). These patients should use the modified (chronic hypercapnia) EWS. Arterial blood gases should be repeated at 30-60 min to check for rising CO2 or H+ after initiation of oxygen in this context.

Acute Respiratory Failure is a life threatening emergency

Severe Hypoxia (Requiring >60% O2 to maintain target SpO2)

Acute Hypercapnia (pCO2 >6 and H+ >45)

Urgent ST3 (or equivalent) review is required to optimise management.

Duty or on call consultant should be contacted if advice required.

Critical care referral and ventilatory support may be needed.

Codes For Recording Oxygen Delivery On NEWS Chart

A = Air (not requiring oxygen or weaning or on PRN oxygen)

N = Nasal Canulae

SM = Simple Mask

V24 = Venturi 24% V28 = Venturi 28% V35 = Venturi 35% V40 = Venturi 40% V60 = Venturi 60%

H28 = Humidified oxygen at 28% (also H35, H40 & H60 = Humidified Oxygen at 35%, 40% & 60%)

RM = Reservoir Mask

TM = Tracheostomy Mask

CP = Patient on CPAP System

NIV = Patient on NIV System

OTH = Other Device: _____ (specify which)

Pain Score

0 = no pain

1 = mild pain

2 = moderate pain

3 = severe pain

Sepsis Screening Tool

NHS

Forth Valley

Patient triggering NEWS ≥ 5 OR Clinical Concern
Neutropenia suspected OR MEWS triggering for obstetric patients

COPY

Is this likely to be due to infection?

Cough/sputum

Abdominal pain/distension/diarrhoea

Line infection

Endocarditis

Dysuria

Cellulitis

Headache with neck stiffness

Wound infection

Obstetric patients (Refer to FV protocol: Sepsis in Maternity Patients)

Perineal trauma

Vaginal discharge

Prolonged SRM

Sore Throat

YES

Escalate to Doctor/ANP with
"suspected sepsis"

Place Sepsis 6 sticker in notes
Prepare giving set/IV fluids

NO

Escalate to Doctor/ANP
Repeat NEWS/MEWS in max 60 mins

**ASSESS FOR OTHER CAUSES OF
TRIGGERING**

Two people work together to deliver the Sepsis 6 within 60 mins of
patient first triggering

- Correct Hypoxia
- Take Blood Cultures
- Give IV antibiotics according to NHS FV Protocol

- Measure whole blood Lactate
- Assess urine output (catheter if obstetric patient)
- Start IV fluids - 20ml/kg, minimum 500mls in the first hour

ASSESS FOR SEVERE SEPSIS

SEVERE SEPSIS

Sepsis with $\geq$ organ dysfunction:

- Hypotension
- Renal
- Respiratory
- Hepatic
- Hematologic
- CNS
- Metabolic acidosis

IF SEVERE SEPSIS

Contact middle grade Doctor (Consultant if obstetric patient)

Catheter mandatory if evidence of AKI

NO EVIDENCE OF SEVERE SEPSIS

Assess response to sepsis 6

Continue regular NEWS

SEPTIC SHOCK

- Hypotension despite fluid resuscitation
- Organ dysfunction

HIGH RISK FACTORS

- Hypotension
- Lactate > 4
- Unexplained INR > 1.5
- APTT > 60 secs
- Bilirubin > 34 (70 if obstetric)
- Platelets < 100

Conscious Level Chart (only as required for head injury observation)

DATE:																			DATE:	
TIME:																			TIME:	
COMA SCALE	Eyes Open	Spontaneously	4																	Eyes closed by swelling = C
		To speech	3																	
		To pain	2																	
		None	1																	
	Best verbal response	Orientated	5																	Endotracheal tube or tracheostomy = T
		Confused	4																	
		Inappropriate words	3																	
		Incomprehensible sounds	2																	
	Best motor response	None	1																	Usually record the best arm response
		Obey commands	6																	
		Localise pain	5																	
		Withdraws to pain	4																	
Flexion to pain		3																		
Extension to pain		2																		
		None	1																	
• • • • • • • 1 2 3 4 5 6 7 8 Pupil Scale (mm)																				
PUPILS	right	Size Reaction																	+ reacts - no reaction c. eye closed	
	left	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																		
	LEGS	No response																		
		Normal power																		
		Mild weakness																		
		Severe weakness																		
		Extension																		
		No response																		

Pain Assessment & Management Guidelines

Pain Score:

- 0 = No pain
- 1 = No pain at rest
Slight pain on movement
- 2 = Intermittent pain at rest
Moderate pain on movement
- 3 = Continuous pain at rest

For Acute and Chronic Pain:

For mild (1), moderate (2) or severe (3) pain refer to Pain Management Guidelines Forth Valley Formulary Appendix 27 & 28. Implement Pain Assessment Chart

For Cancer Related Pain:

For mild (1), moderate (2) or severe (3) pain score, refer Palliative Guidelines.

Supportive and Palliative Care Indicators Tool (SPICT™)

COPY

The SPICT™ is a guide to identifying people at risk of deteriorating and dying. Assessment of unmet supportive and palliative care needs may be appropriate.

Look for two or more general indicators of deteriorating health.

- Performance status poor or deteriorating, with limited reversibility. (needs help with personal care, in bed or chair for 50% or more of the day).
- Two or more unplanned hospital admissions in the past 6 months.
- Weight loss (5 - 10%) over the past 3 - 6 months and/or body mass index < 20.
- Persistent, troublesome symptoms despite optimal treatment of any underlying condition(s).
- Lives in a nursing care home or NHS continuing care unit, or needs care to remain at home.
- Patient requests supportive and palliative care, or treatment withdrawal.

Look for any clinical indicators of advanced conditions

Cancer

Functional ability deteriorating due to progressive metastatic cancer.

Too frail for oncology treatment or treatment is for symptom control.

Dementia / frailty

Unable to dress, walk or eat without help.

Choosing to eat and drink less; difficulty maintaining nutrition.

Urinary and faecal incontinence.

No longer able to communicate using verbal language; little social interaction.

Fractured femur; multiple falls.

Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease

Progressive deterioration in physical and/or cognitive function despite optimal therapy.

Speech problems with increasing difficulty communicating and/or progressive dysphagia.

Recurrent aspiration pneumonia; breathless or respiratory failure.

Heart / vascular disease

NYHA Class III/IV heart failure, or extensive, untreatable coronary artery disease with:

- breathlessness or chest pain at rest or on minimal exertion.

Severe, inoperable peripheral vascular disease.

Respiratory disease

Severe chronic lung disease with:

- breathlessness at rest or on minimal exertion between exacerbations.

Needs long term oxygen therapy.

Has needed ventilation for respiratory failure or ventilation is contraindicated

Kidney disease

Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.

Kidney failure complicating other life limiting conditions or treatments.

Stopping dialysis.

Liver disease

Advanced cirrhosis with one or more complications in past year:

- diuretic resistant ascites
- hepatic encephalopathy
- hepatorenal syndrome
- bacterial peritonitis
- recurrent variceal bleeds

Liver transplant is contraindicated.

Assess and plan supportive & palliative care

- Review current treatment and medication so the patient receives optimal care.
- Consider referral for specialist assessment if symptoms or needs are complex and difficult to manage.
- Agree current and future care goals/plan with the patient and family.
- Plan ahead if the patient is at risk of loss of capacity.
- Handover: care plan, agreed levels of intervention, CPR status.
- Coordinate care (eg. with a primary care register).

Review Date: 2025

Re-order Ref: TF/1013/SS

NEWS2

ACUTE ASSESSMENT UNITS/DAY SURGERY RISK ASSESSMENT and CARE PLAN BOOKLET

COPY

HI NO: 2602800570 26/02/1980
RN: M
COTT DOWELL
1 DON STREET
RANGEMOUTH
K3 8HD

Date of admission: 22-10-25

Time of admission:

Admission Area: SAU

Assessment	Initial assessment to be completed:	Assesment area nurse Initials	Transfer Area nurse Initials
CPE (1 st ward only)	On Admission if required	LU	N/A
Falls Trigger Tool	On Admission	LU	
Bedrail Assessment	On Admission	LU	
Skin, Contenance and Personal Hygiene assessment	On Admission	LU	
Hydration Assessment	On Admission	LU	
4AT	On Admission	LU	
MUST Screening and Care Plan	On Admission	LU	
Oral Care Assessment and Care Plan	On Admission	LU	
Falls history and Falls action plan	On admission if Yes to any factors on Falls Trigger tool		
Braden/Skin Assessment	On admission if at risk or not intact		
Patient Handling and Mobiliy Chart	On admission if not independent		

Daily Assesments to be completed

1. Hydration
2. Skin Assessment
3. Personal Hygiene and continence
4. Bowel Function

Initial Assessments on page 1 must be carried out at time of admission, all other assessments will be reviewed weekly except Daily Assesments

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

COPY

Staff identification This acute assessment and care plan booklet is a legal document. Your signature indicates you have assessed and planned care with your patient/carer and is a true reflection of the care that will be delivered by you or delegated by you.

Name: L. HOTCHKISS	Signature: LH
Name:	Signature:
Name:	Signature:
Name:	Signature:
Name:	Signature:
Name:	Signature:
Name:	Signature:
Name:	Signature:
Name:	Signature:
Name:	Signature:
Name:	Signature:
Name:	Signature:
Name:	Signature:

Valuables Policy

Forth Valley Royal Hospital does not take any responsibility for patients own belongings/ valuables.

Any valuables are encouraged to be taken home or can be logged and kept in the safe. A receipt will require to be provided.

Patient/family aware Yes/No
 Valuables in safe Yes/No
 Valuables kept with patient Yes/No

Details.....

COPY

Nursing Risk Assessments to be completed on Admission

Patients preferred name:

Ward:

Communication Assessment

No concerns - ☒
New receptive/expressive difficulties ☐
Pre-existing ☐

Hydration Risk
Assessment Complete

☐

Falls Risk/Trigger Tool

Circle

History of falls prior to admission?
(Falls(s) since admission?)

Y/N ☒

Additional falls risk factors for this patient?

E.g. Patient tries to walk alone but unsteady/unsafe, learning disabilities, parkinson's, stroke, cognitive impairment, delirium, continence issues, visual impairment, medication (night sedation), surgery, seizures/epilepsy, fear of falling etc.
(if yes to this question, state risk and commence falls prevention action plan)

Y/N ☒

Current Mobility: (walks alone but unsafe, cognitive impairment, drip stand, catheter)

Y/N ☒

Bedrails required Y/N if yes complete bedrails assessment

If answered yes to any of these questions:---complete a falls history on page 6 and commence falls prevention action plan on page 7

☐

Skin, Continence and Personal Hygiene assessment

Skin integrity	Continence Care	Personal Hygiene	Mobility
Independent/no concerns ☒	Continent ☒	Independent ☒	Independent ☒
Skin Checked: Intact ☐	Incontinent ☐	Requires set up ☐	Supervision ☐
Skin Checked: at risk/not intact (please circle)	Continence Aids in use.....	Prompting ☐	Assistance of 1 or 2 or 3 (Please Circle)
Braden +/- wound assessments on admission if within 6 hours of admission	Urinary Catheter ☐ Nephrostomy ☐	Assistance of 1 or 2 (Please Circle)	
	Stoma ☐	Full Assistance ☐	

Name:

LYNLEY HUTCHINGS

Signature:

LU

Date/Time

22-10-25

COPY

Infection Prevention and Control Risk Assessment

All patients admitted must have a Clinical risk assessment (CRA) for Carbapenemase-Producing *Enterobacteriaceae* (CPE) and Methicillin Resistant *Staphylococcus aureus* (MRSA). This is a mandatory requirement.

CPE Clinical Risk Assessment (No patients are excluded from CPE screening).		Response	
Has the patient had any previous history of CPE (check clinical portal)	YES	YES	NO
Has the patient been transferred directly from another hospital out with NHSFV	YES	YES	NO
Has the patient a history of admission to a hospital out with Forth Valley in the last 12 months (including dialysis patients).	YES	YES	NO
Has the patient been in close contact with a person colonised or infected with CPE	YES	YES	NO

A **YES** response to **ANY** of the above questions suggests the patient has an increased risk of CPE and the following actions must be taken:

- Isolated the patient in a single side room, STOP sign on door, contact precautions (PPE)
- The patient is given an information leaflet and consent is obtained for swabbing;
- CPE screen: Rectal swab taken by a registered nurse or stool specimen and, if present, a wound swab. A urine specimen is required if a urinary catheter is present;
- A rectal swab **must not** be used for children under 16 years. A stool specimen should be sent.

MRSA Clinical Risk Assessment (Exclusions from MRSA screening include: Day case patients and admissions to paediatric, obstetric and mental health specialities)		Response	
1	Has the patient a history of MRSA, (check clinical portal)	YES	NO
2	Has the patient been admitted from anywhere other than their own home, e.g. care home, hostel, prison, or transferred from another hospital.	YES	NO
3	Does the patient have any wounds or indwelling medical devices (e.g. PEG, Hickman line, urinary catheter)	YES	NO
4	Will the patient be admitted / transferred to ITU	YES	NO

A **YES** response to questions 1- 3 indicates an increased risk of MRSA colonisation.

The following actions must be taken:

- The patient is isolated in a single side room, STOP sign on door, contact precautions initiated;
- The patient is given an MRSA screening leaflet and consent obtained for swabbing;
- MRSA screen: swab nose, perineum and if present, wounds and insertion sites of invasive devices. A urine specimen is required if a catheter is present.

Note: this is the minimal screen required and additional swabs can be sent if clinically indicated.

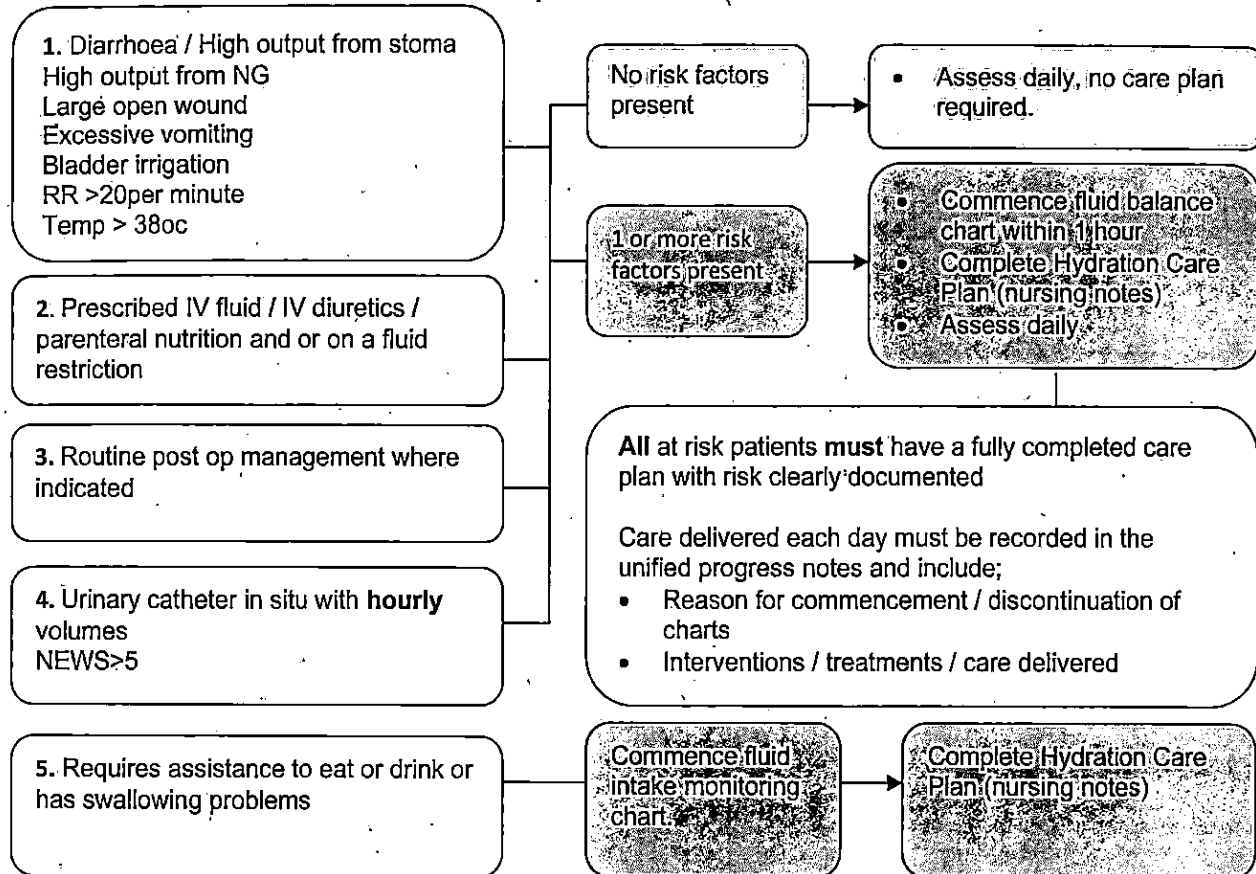
A **YES** response to question 4 confirms admission to a high risk specialty and the following actions must be taken:

- The patient is given an MRSA screening leaflet and consent obtained for swabbing;

Sign <i>LU</i>	Date <i>22-10-25</i>	Swabs sent: Yes / No/NA <i>NA</i>
----------------	----------------------	-----------------------------------

Daily Hydration Risk Assessment

Risk assessment should be carried out within 4 hrs of admission and daily thereafter



Risk Assessment Week 1	Date/time	Date/time	Date/time	Date/time	Date/time	Date/time	Date/time
	22-10-25						
Number of Risks present	0						
Fluid Balance or monitoring indicated Y=Yes N=No	N						
Care Plan commenced/reviewed Y=Yes N=No	Y						
Initials of assessor	LL						

COPY

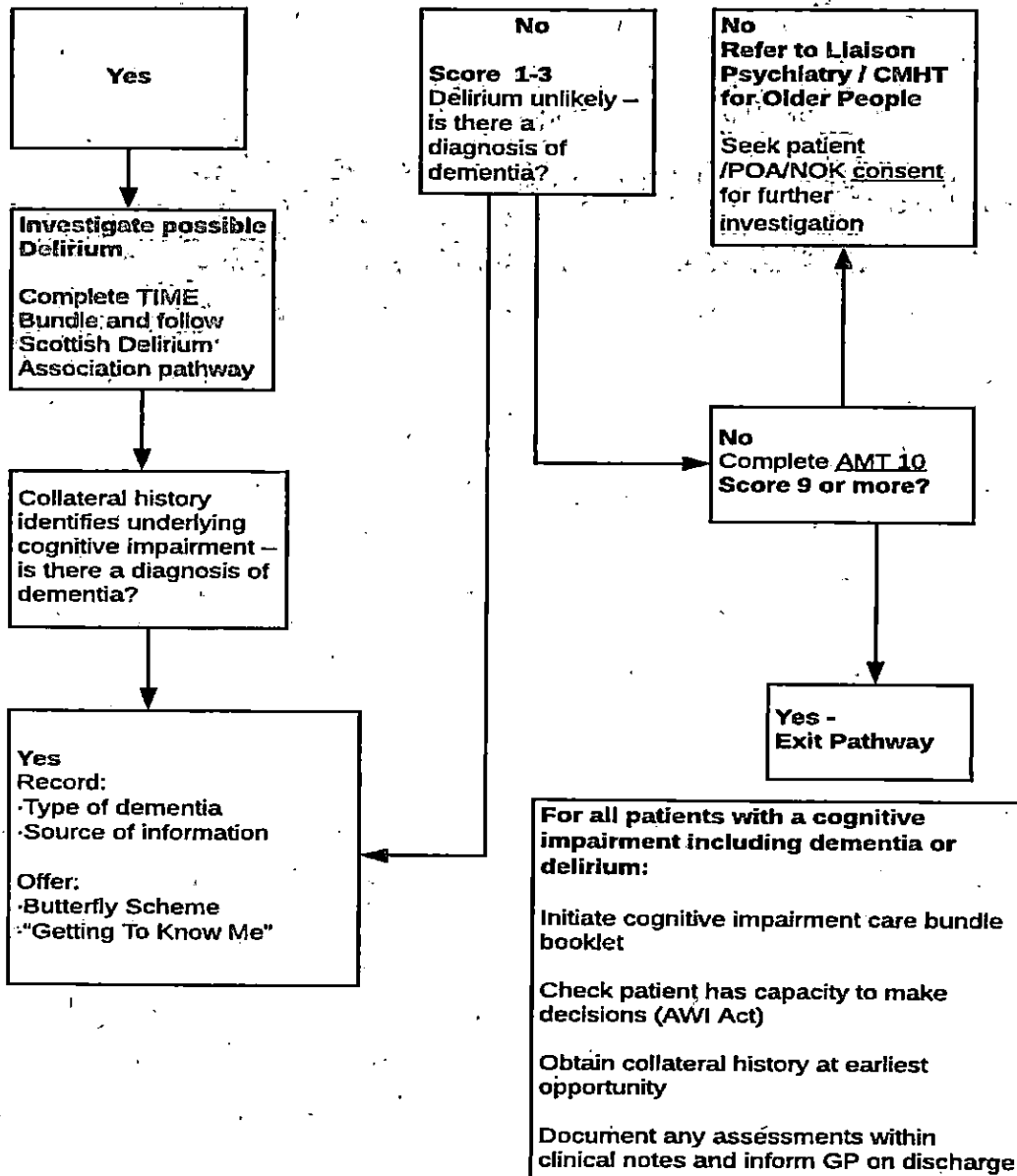
TO BE COMPLETED FOR **ALL** PATIENTS OVER 65 ON ADMISSION AND WHEN A CHANGE IN PRESENTATION IS EVIDENT

* Signed..... Date.....
(ensure documented in clinical notes)

DATE		/ /	/ /	/ /
1. ALERTNESS: <i>This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive.</i> <i>If asleep, attempt to wake and ask the patient to state their name and address to assist rating.</i>	Normal (fully alert, but not agitated throughout assessment)	0	0	0
	Mild sleepiness for <10 seconds after waking, then	0	0	0
	Clearly abnormal (agitated or drowsy)	4	4	4
2. AMT4: <i>Age, sex, date of birth, place (name of hospital or building), current year</i>	No mistakes	0	0	0
	1 mistake	1	1	1
	2 or more mistakes/un-testable	2	2	2
3. ATTENTION: <i>Ask the patient: "Please tell me the months of the year in backwards order, starting at December."</i> <i>To assist initial understanding one prompt of "what is the month before December?" is permitted.</i>	Achieves 7 months or more correctly	0	0	0
	Starts but scores <7 months/refuses to start	1	1	1
	Un-testable (cannot start because unwell, drowsy,	2	2	2
4. ACUTE CHANGE OR FLUCTUATING COURSE: <i>Evidence of significant change or fluctuation in: alertness, cognition (e.g. increased confusion) or other mental function arising over the last 2 weeks and still evident in last 24hrs</i>	No	0	0	0
	Yes	4	4	4
Initials of tester →				
4 or above:	Possible delirium +/- cognitive impairment - score daily until score <4 for 2 consecutive days	Day 1 4ATscore	Day 2 4ATscore	Day 3 4ATscore
1:	Possible cognitive impairment - only rescore if condition changes			
0:	Delirium or cognitive impairment unlikely - only rescore if condition changes			

Cognitive Assessment Pathway

**Assess using 4AT
4 or more?**



Falls History:

To be completed if answered yes to any of the questions on the Falls Risk/Trigger Tool

COPY

Falls history assessment: (Date & time of last fall prior to admission)

Estimated date and time of the last fall? Date Time of Day.....

First fall? Yes ☐ No ☐ Recurrent falls? Yes ☐ No ☐ Number of falls within the last year?

Any warning immediately prior to any falls? Yes ☐ No ☐

Palpitation ☐ Dizziness ☐ Alcohol ☐ Loss of Consciousness ☐
Slip/Trip ☐ Environmental hazards ☐ Associated movement ☐

Explain about fall/previous falls : (where, when, why) Activity at time of fall? (Please describe)
(consider if fall/injury could be non accidental)

Any injury sustained or previous fracture? Yes ☐ No ☐ (if yes, please describe)

Any pain related to fall? Yes ☐ No ☐ (if yes, please describe)

Anxiety regarding further falls/confidence affected? Yes ☐ No ☐ (If yes please describe)

Comments/other information/highlight areas of concern:

Data collected from: Patient ☐ Relative ☐ Carer ☐ Other:

Nurse Signature: _____ Date/Time: _____

COPY

Falls Prevention Action Plan

The following nursing interventions may address some of the falls risk factors. They are however **NOT** exhaustive and staff should use their clinical reasoning/professional judgment when determining falls risk interventions.

Please state all actions taken from the list of interventions below.

Interventions:	Care Plan 1: On Admission
Environmental: - Nurse in most appropriate place on ward for their needs e.g. easily observable area, near toilet etc. - Area hazard free, personal belongings within easy reach - Call system working/within reach at all times - Adequate lighting at all times particularly overnight. - Check infusion stands facilitate mobility. - Use of sound/movement monitors (if available) - Select suitable seating (appropriate height, comfort) - Consider one-way glide sheet for chair - Frequently re-orientate confused patients	
Vision/Hearing - Ensure correct glasses worn/within easy reach and clean. - Determine if patient can recognize objects from the end of the bed - if concerns, refer to medical staff for visual acuity assessment - Consider hearing implications, hearing aid working etc.	
Lying and Standing Blood Pressure: Baseline for all Check and record. If deficit exists, inform medical staff and continue to check twice daily for at least 72 hours. - Advice patient on slow movement from sitting/lying to standing.	Baseline Lying: Standing:
Mobility: - Follow mobility risk assessment/care plan. - Consider referral to Physiotherapy and/or OT - If patient requires walking aid is it within easy reach?	
Medication: Request Medical staff or Pharmaceutical review.	
Delirium (Acute Confusional State) - Complete 4AT risk assessment - Treat causes of delirium, refer to delirium guidelines	
Toileting: - Assess continence. If urine frequency, ward test urine. - Plan routine/frequent toileting. - Consider a commode for night time toileting. - Consider full continence assessment and refer to continence service if indicated.	
Bed and bedrails: - Bed at optimum height and brakes applied. - Assess the need for bedrails - Hi/Low bed assessment and follow pathway	
Footwear/Clothing - Encourage patient to wear shoes not slippers. - Check footwear for secure fit, non-slip sole. Ask relatives to supply safer replacements. - Ensure toenails are in good condition, include plan of care in personal hygiene care plan (Refer to podiatry if infected or neglected) - Suitability and appropriateness of clothing e.g. length	
Inform: - Ensure Medical staff, Physiotherapist, OT, Social Worker etc, are aware of patients falls risk, frequency and nature - Involve/educate patient/relatives in safe practice. - Discuss with patient/relative re specific interventions. - Issue leaflet "How to reduce falls in hospital". - Place patient on care rounds/safety brief	
Additional Falls Risk Management Interventions for Patient:	
Initials of Nurse/Date & Time:	

Falls Care Plan review weekly or post fall

COPY

	Care Plan 2: Review of Interventions Weekly, post fall or changes to the patient's condition Date & Time	Care Plan 3: Review of Interventions Weekly, post fall or changes to the patient's condition Date & Time
Environmental		
Vision and Hearing		
Lying and Standing Blood pressure		
Mobility		
Medication		
Delirium (acute confusion)		
Toileting		
Bedrails		
Footwear and Clothing		
Who did you Inform?		
Additional nformation		
Post Fall	IR1 No..... Falls No..... Care Plan Reviewed and still in use: Y/N New Care Plan required: Y/N Staff Initials/date/time.....	IR1 No..... Falls No..... Care Plan Reviewed and still in use: Y/N New Care Plan required: Y/N Staff Initials/date/time.....

Bedrails Assessment

COPY

Bedrails NOT to be used Code: A. Risk of climbing over and falling from a greater height. B. Patient is independent. C. Risk of entrapment in bedrails outweighs risk of falling D. Do not use with a high/low bed E. Patient with capacity and oriented but refuses bedrails		Bedrails CAN be used Code: F. Patient with capacity and is alert and oriented and requests bedrails. G. Risk of injury from falling from the bed outweighs the risks of not using bed rails. H. Patient is unconscious.	
Assessment to be completed on admission within 6 hours. Review weekly or following a fall and in response to a change in patient condition.			
Date and Time	Codes	Bed rail in use	Initials
		YES/NO	
		YES/NO	
		YES/NO	
		YES/NO	

Bed rails must be used when the bed is moving (ie; transferring patient between areas)

BRADEN RISK ASSESSMENT CHART

Individuals with a total score of 16 or less are considered at risk: 15-16 = low risk, 12-14 = moderate risk, 11 or less = high risk.

Undertake and document risk assessment within 6-8 hours of admission to every ward or department.

Reassess if there is a change in individual's condition and repeat regularly according to local protocol or risk score.

1. Complete skin care plan with BRADEN score included and commence a care and comfort round chart.

2. Consider contributing factors, frailty, diabetes, end of life care.

DATE					On Admission				
TIME									
Sensory Perception – Ability to respond meaningfully to pressure related discomfort	1. Completely Limited Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body surface.	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment that limits the ability to feel pain or discomfort over ½ of body.	3. Slightly Limited Responds to verbal commands but cannot always communicate discomfort or need to be turned. OR has some sensory impairment that limits ability to feel pain or discomfort in 1 or 2 extremities.	4. No Impairment Responds to verbal commands. Has no sensory deficit that would limit ability to feel or voice pain or discomfort.					
Moisture – Degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient/client is moved or turned.	2. Very Moist Skin is often but not always, moist. Linen must be changed at least once a shift.	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day.	4. Rarely Moist Skin is usually dry. Linen only requires changing at routine intervals.					
Activity – Degree of physical activity	1. Bedfast Confined to bed.	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. Walks Occasionally Walks occasionally during day but for very short distance, with or without assistance. Spends majority of each shift in bed or chair.	4. Walks Frequently Walks outside the room at least twice a day and inside the room every 2 hours during waking hours.					
Mobility – Ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance.	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	3. Slightly limited Makes frequent though slight changes in body or extremity position independently.	4. No Limitations Makes major and frequent changes in position without assistance.					
Nutrition – Usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IV's for more than 5 days.	2. Probably Inadequate Rarely eats a complete meal and generally eats only about ¼ of any food offered. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding.	3. Adequate Eats over half of most meals. Occasionally will refuse meal but will usually take a supplement if offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	4. Excellent Eats most of every meal. Never refuses a meal. Occasionally eats between meals. Does not require supplementation.					
Friction and Shear –	1. Problem Requires moderate to maximum assistance in moving.	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.						
Indicate appropriate number and add for total score					TOTAL SCORE:				
					Initials:				

COPY

Consider needs based on score and record in care plan

TOTAL BRADEN SCORE INDICATES THAT THE PATIENT IS:	EQUIPMENT AND ACTION WHICH SHOULD BE CONSIDERED FOR EACH "AT RISK" CATEGORY. DOCUMENT EQUIPMENT TO BE USED AND PLAN OF CARE IN THE SKIN CARE PLAN. GIVE PATIENTS/CARERS AN INFORMATION LEAFLET.	
17+ : NOT AT RISK	Depending on patient's individual requirements an overlay may be required for comfort e.g. Repose/Propad	
15 – 16 : LOW RISK	- Pressure reducing mattress e.g. SOFTFORM/PENTAFLEX - Mattress Overlay e.g. Repose - Daily skin inspection should be documented in nursing notes	
12 – 14 : MODERATE RISK	If skin is intact. - Use pressure reducing mattress e.g. SOFTFORM/PENTAFLEX - Mattress overlay e.g. Repose OR If skin is broken up to a Stage 2 pressure ulcer, - Mattress overlay e.g. Repose or an active pressure relieving mattress overlay e.g. Soft form premiere active Tamora(Community) - Daily Braden risk assessment - Twice daily skin inspection and document in unified progress notes - Implement turning schedule – reposition changes 2-4 hourly and document in unified progress notes	
9 – 11 : HIGH RISK	If skin is broken up to a Stage 3 pressure ulcer - Alternating Dynamic Pressure System, e.g. Softform premiere active Tamora (Community) NIMBUS (Acute) - Daily Braden risk assessment - Implement turning schedule – reposition changes 2-4 hourly and document in unified progress notes - Skin inspection at each reposition change and document in unified progress notes	
6 – 8 : SEVERE RISK	If skin is broken up to a Stage 4 pressure ulcer - Alternating Dynamic Pressure System e.g. NIMBUS, (Community only Softair, Tamora) - Daily Braden risk assessment - Implement turning schedule – reposition changes 2 hourly and document in unified progress notes - Skin inspection at each reposition change and document in unified progress notes	
When an area of redness or discolouration is noted further action is required. Skin inspection, findings and action taken must be documented in unified progress notes.	- If patient is out of bed, a pressure reducing / relieving seating system comparable to the equipment used on the bed should be considered, e.g. Repose, Active Seat Cushion. Patients should be encouraged to reposition at least every 30 minutes and be assisted if unable to do so. - Patients should not be sitting up in a chair for longer than 2 hours if they have a grade 3 or above pressure injury. - Plan should be documented within the skin care plan along with the care and comfort documentation	
Specialised Equipment (Rentals)/TYPE / AID	DATE COMMENCED	DATE DISCONTINUED/Sent back
Tissue Viability Service Please advise TV service of all patients with a grade 3 or above pressure injury. Referral/Advice and Support 01324 673747		

COPY

13

'MUST' - Nutritional Risk Screening

COPY

STEP 1 (BMI) (Complete all 5 steps and transfer results to Initial screening row below).	STEP 2 (Weight Loss)	STEP 3 (Acute Disease Effect)	*If weight not measured please indicate how this was obtained (see key below)	*If height not measured please indicate how this was obtained (see key below)
Weight (Kgs) * = Height (m) * = Method used M,R,C* BMI <u>See BMI charts</u> Greater than 20 score 0 18 20 score 1 Lean 18.5 score 2 (greater than 30=obese)	Pre-illness weight = (Can be obtained from previous notes, GP, patient, carer or clothes size) Total unplanned weight loss over 3-6 months Weight loss (kg) = <u>Complete with weight loss chart</u> Less than 5% score 0 5-10% score 1 Greater than 10% score 2	Acute illness AND there has been or is likely to be no nutritional intake for 5 days No score 0 Yes score 2	M - Measured R - Reported. C - Based solely on clinical impression (See "Ward information pack" for alternative measures)	M - Measured R - Reported C - Based solely on clinical impression (See "Ward information pack" for alternative measures)
STEP 4 (Overall Risk Score) Add scores from steps 1+2+3 to calculate overall risk score SCORE 0 = LOW RISK SCORE 1 = MEDIUM RISK SCORE 2+ = HIGH If risk category arrived at by clinical impression alone, indicate risk category LOW/MEDIUM/HIGH in table below and document rationale in progress notes		STEP 5 (Care Plan) Implement appropriate Nutritional Care Plan 0 = LOW RISK 1 = MEDIUM RISK 2 = HIGH RISK Treat as High Risk - immediate Dietetic Referral • Dysphagia • Decompensated Liver Disease • Enteral Tube Feeding • Multiple Fractures • Pressure Ulcers Grade 3 or more		

Initial screening

Date	Time	Ward	Weight (kg)*	Weight ↑↔↓	Method used (M,R,C)	BMI	Step 1 Score	Step 2 Score	Step 3 Score	Total Score	'MUST' Risk	Initial

'MUST' Nutritional Care Plan

COPY

Low/Medium/High (circle)

Date/Time care plan initiated:

Intervention	Plan of Care	Initials
Has patient been informed of current weight and plan? Discuss the results of the 'MUST' screening/care plan with the patient and family (with agreement and involve them in identifying individualised interventions)	Yes / No (details if no) On admission & on-going	
Weigh patient and rescreen	On Admission then weekly	
Refer high risk patients to Dietitian with 'MUST' score ,BMI and weight loss	Referred Y ☐ NA ☐	
Complete dietary food record charts for med/high risk patients until assessed by dietitian	Y ☐ NA ☐	
Med/High risk :Optimise nutritional intake by offering daily - nourishing milky drinks - regular snacks 3 courses at midday and evening meal Has signifier been added to patient's and kitchen white boards?	Y ☐ NA ☐ Details: Y ☐ NA ☐	

Please ✓ relevant box and where yes is answered, record details of individual requirement below;

Food Allergy- No ☐ Yes ☐ religious, cultural, ethnic requirements - No ☐ Yes ☐ Details:	Initials
Therapeutic diet- No ☐ Yes ☐ Details:	Initials
Assistance required with eating/drinking- No ☐ Yes ☐ Adapted cutlery/aids - No ☐ Yes ☐ Assistance from family - No ☐ Yes ☐ (If yes please monitor fluid intake) Details:	Initials

Oral Health Assessment

Assess within 24 hours of admission to determine if oral care planning is required. Discuss and agree care plan with patient/carer.

[illegible][illegible]

Complete this section to determine frequency of assessment required and document in the care plan.

[illegible]

Oral Health Care Plan

All patients should attain Standard Care 1 for oral hygiene. If any further care is required, this should be carried out in addition to Standard Care 1

COPY

Standard Care 1

Natural teeth	- Brush teeth at least twice per day using fluoride toothpaste and a medium toothbrush. - Spit afterwards – do not rinse.
Dentures	- Remove after each meal and rinse dentures and mouth with water - Brush with toothbrush at least once per day with unperfumed soap and water or denture cream. Repeat this prior to overnight soaking. - Plastic dentures should be brushed then soaked for 20 mins in a fresh solution of hypochlorite (1 part to 80 parts cold water/1/2 a teaspoon) in a patient named individual denture bowl. Then rinse and place in fresh water overnight. Dentures with metal parts should be soaked in chlorhexidine 0.2%. All dentures should be rinsed with cold water before replacing in mouth. - Clean palate, gum ridges and tongue with a soft toothbrush or thoroughly moistened foam stick. - Dentures must be stored in a named denture container when not in mouth.

Standard Care 2

Dry mouth (Xerostomia)	- Follow Care Standard 1 and..... - Review medications that may cause dry mouth 2 hourly mouth care, i.e. water to rinse and water based lubricating gel to dry lips. * see guidelines regarding use of gels. - Foam sticks thoroughly moistened in water to tongue and mucosa if unable to rinse - Frequent sips or sprays of water or crushed ice cubes are as effective and often preferable to artificial products so should be first choice - Saliva replacement products e.g. Biotene gel or mouthwash (ensure these products are prescribed)
------------------------	--

Standard Care 3

Obvious plaque/ swollen or bleeding gums or dry/crusted mouth	- Follow Care Standard 1 and..... - Remove debris with a medium headed tooth brush with a non foaming fluoridated toothpaste or thoroughly moistened foam stick - Using water rinse 4 times daily - Chlorhexidine mouthwash, spray or gel (ensure these products are prescribed and do not use for more than 1 month).
---	---

Standard Care 4

Infection	- Follow Care Standard 1 and..... - Seek medical/dental advice for appropriate treatment
-----------	---

For further advice please contact the Oral Health Department via email for advice from an oral health promoter fv-uhb.enquires@nhs.net

Oral Health Care Plan

[illegible]

Step 1 - BMI score (& BMI)

Height (feet and inches)

BAFER

COPY

Weight (kg)	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																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																					
Height (m)	1.40	1.41	1.42	1.43	1.44	1.45	1.46	1.47	1.48	1.49	1.50	1.51	1.52	1.53	1.54	1.55	1.56	1.57	1.58	1.59	1.60	1.61	1.62	1.63	1.64	1.65	1.66	1.67	1.68	1.69	1.70	1.71	1.72	1.73	1.74	1.75	1.76	1.77	1.78	1.79	1.80	1.81	1.82	1.83	1.84	1.85	1.86	1.87	1.88	1.89	1.90	1.91	1.92	1.93	1.94	1.95	1.96	1.97	1.98	1.99	2.00																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																					
Weight (stones and pounds)	5.7	6.0	6.3	6.6	6.9	7.3	7.7	8.1	8.5	8.9	9.3	9.7	10.1	10.5	10.9	11.3	11.7	12.1	12.5	12.9	13.3	13.7	14.1	14.5	14.9	15.3	15.7	16.1	16.5	16.9	17.3	17.7	18.1	18.5	18.9	19.3	19.7	20.1	20.5	20.9	21.3	21.7	22.1	22.5	22.9	23.3	23.7	24.1	24.5	24.9	25.3	25.7	26.1	26.5	26.9	27.3	27.7	28.1	28.5	28.9	29.3	29.7	30.1	30.5	30.9	31.3	31.7	32.1	32.5	32.9	33.3	33.7	34.1	34.5	34.9	35.3	35.7	36.1	36.5	36.9	37.3	37.7	38.1	38.5	38.9	39.3	39.7	40.1	40.5	40.9	41.3	41.7	42.1	42.5	42.9	43.3	43.7	44.1	44.5	44.9	45.3	45.7	46.1	46.5	46.9	47.3	47.7	48.1	48.5	48.9	49.3	49.7	50.1	50.5	50.9	51.3	51.7	52.1	52.5	52.9	53.3	53.7	54.1	54.5	54.9	55.3	55.7	56.1	56.5	56.9	57.3	57.7	58.1	58.5	58.9	59.3	59.7	60.1	60.5	60.9	61.3	61.7	62.1	62.5	62.9	63.3	63.7	64.1	64.5	64.9	65.3	65.7	66.1	66.5	66.9	67.3	67.7	68.1	68.5	68.9	69.3	69.7	70.1	70.5	70.9	71.3	71.7	72.1	72.5	72.9	73.3	73.7	74.1	74.5	74.9	75.3	75.7	76.1	76.5	76.9	77.3	77.7	78.1	78.5	78.9	79.3	79.7	80.1	80.5	80.9	81.3	81.7	82.1	82.5	82.9	83.3	83.7	84.1	84.5	84.9	85.3	85.7	86.1	86.5	86.9	87.3	87.7	88.1	88.5	88.9	89.3	89.7	90.1	90.5	90.9	91.3	91.7	92.1	92.5	92.9	93.3	93.7	94.1	94.5	94.9	95.3	95.7	96.1	96.5	96.9	97.3	97.7	98.1	98.5	98.9	99.3	99.7	100.1	100.5	100.9	101.3	101.7	102.1	102.5	102.9	103.3	103.7	104.1	104.5	104.9	105.3	105.7	106.1	106.5	106.9	107.3	107.7	108.1	108.5	108.9	109.3	109.7	110.1	110.5	110.9	111.3	111.7	112.1	112.5	112.9	113.3	113.7	114.1	114.5	114.9	115.3	115.7	116.1	116.5	116.9	117.3	117.7	118.1	118.5	118.9	119.3	119.7	120.1	120.5	120.9	121.3	121.7	122.1	122.5	122.9	123.3	123.7	124.1	124.5	124.9	125.3	125.7	126.1	126.5	126.9	127.3	127.7	128.1	128.5	128.9	129.3	129.7	130.1	130.5	130.9	131.3	131.7	132.1	132.5	132.9	133.3	133.7	134.1	134.5	134.9	135.3	135.7	136.1	136.5	136.9	137.3	137.7	138.1	138.5	138.9	139.3	139.7	140.1	140.5	140.9	141.3	141.7	142.1	142.5	142.9	143.3	143.7	144.1	144.5	144.9	145.3	145.7	146.1	146.5	146.9	147.3	147.7	148.1	148.5	148.9	149.3	149.7	150.1	150.5	150.9	151.3	151.7	152.1	152.5	152.9	153.3	153.7	154.1	154.5	154.9	155.3	155.7	156.1	156.5	156.9	157.3	157.7	158.1	158.5	158.9	159.3	159.7	160.1	160.5	160.9	161.3	161.7	162.1	162.5	162.9	163.3	163.7	164.1	164.5	164.9	165.3	165.7	166.1	166.5	166.9	167.3	167.7	168.1	168.5	168.9	169.3	169.7	170.1	170.5	170.9	171.3	171.7	172.1	172.5	172.9	173.3	173.7	174.1	174.5	174.9	175.3	175.7	176.1	176.5	176.9	177.3	177.7	178.1	178.5	178.9	179.3	179.7	180.1	180.5	180.9	181.3	181.7	182.1	182.5	182.9	183.3	183.7	184.1	184.5	184.9	185.3	185.7	186.1	186.5	186.9	187.3	187.7	188.1	188.5	188.9	189.3	189.7	190.1	190.5	190.9	191.3	191.7	192.1	192.5	192.9	193.3	193.7	194.1	194.5	194.9	195.3	195.7	196.1	196.5	196.9	197.3	197.7	198.1	198.5	198.9	199.3	199.7	200.1	200.5	200.9	201.3	201.7	202.1	202.5	202.9	203.3	203.7	204.1	204.5	204.9	205.3	205.7	206.1	206.5	206.9	207.3	207.7	208.1	208.5	208.9	209.3	209.7	210.1	210.5	210.9	211.3	211.7	212.1	212.5	212.9	213.3	213.7	214.1	214.5	214.9	215.3	215.7	216.1	216.5	216.9	217.3	217.7	218.1	218.5	218.9	219.3	219.7	220.1	220.5	220.9	221.3	221.7	222.1	222.5	222.9	223.3	223.7	224.1	224.5	224.9	225.3	225.7	226.1	226.5	226.9	227.3	227.7	228.1	228.5	228.9	229.3	229.7	230.1	230.5	230.9	231.3	231.7	232.1	232.5	232.9	233.3	233.7	234.1	234.5	234.9	235.3	235.7	236.1	236.5	236.9	237.3	237.7	238.1	238.5	238.9	239.3	239.7	240.1	240.5	240.9	241.3	241.7	242.1	242.5	242.9	243.3	243.7	244.1	244.5	244.9	245.3	245.7	246.1	246.5	246.9	247.3	247.7	248.1	248.5	248.9	249.3	249.7	250.1	250.5	250.9	251.3	251.7	252.1	252.5	252.9	253.3	253.7	254.1	254.5	254.9	255.3	255.7	256.1	256.5	256.9	257.3	257.7	258.1	258.5	258.9	259.3	259.7	260.1	260.5	260.9	261.3	261.7	262.1	262.5	262.9	263.3	263.7	264.1	264.5	264.9	265.3	265.7	266.1	266.5	266.9	267.3	267.7	268.1	268.5	268.9	269.3	269.7	270.1	270.5	270.9	271.3	271.7	272.1	272.5	272.9	273.3	273.7	274.1	274.5	274.9	275.3	275.7	276.1	276.5	276.9	277.3	277.7	278.1	278.5	278.9	279.3	279.7	280.1	280.5	280.9	281.3	281.7	282.1	282.5	282.9	283.3	283.7	284.1	284.5	284.9	285.3	285.7	286.1	286.5	286.9	287.3	287.7	288.1	288.5	288.9	289.3	289.7	290.1	290.5	290.9	291.3	291.7	292.1	292.5	292.9	293.3	293.7	294.1	294.5	294.9	295.3	295.7	296.1	296.5	296.9	297.3	297.7	298.1	298.5	298.9	299.3	299.7	300.1	300.5	300.9	301.3	301.7	302.1	302.5	302.9	303.3	303.7	304.1	304.5	304.9	305.3	305.7	306.1	306.5	306.9	307.3	307.7	308.1	308.5	308.9	309.3	309.7	310.1	310.5	310.9	311.3	311.7	312.1	312.5	312.9	313.3	313.7	314.1	314.5	314.9	315.3	315.7	316.1	316.5	316.9	317.3	317.7	318.1	318.5	318.9	319.3	319.7	320.1	320.5	320.9	321.3	321.7	322.1	322.5	322.9	323.3	323.7	324.1	324.5	324.9	325.3	325.7	326.1	326.5	326.9	327.3	327.7	328.1	328.5	328.9	329.3	329.7	330.1	330.5	330.9	331.3	331.7	332.1	332.5	332.9	333.3	333.7	334.1	334.5	334.9	335.3	335.7	336.1	336.5	336.9	337.3	337.7	338.1	338.5	338.9	339.3	339.7	340.1	340.5	340.9	341.3	341.7	342.1	342.5	342.9	343.3	343.7	344.1	344.5	344.9	345.3	345.7	346.1	346.5	346.9	347.3	347.7	348.1	348.5	348.9	349.3	349.7	350.1	350.5	350.9	351.3	351.7	352.1	352.5	352.9	353.3	353.7	354.1	354.5	354.9	355.3	355.7	356.1	356.5	356.9	357.3	357.7	358.1	358.5	358.9	359.3	359.7	360.1	360.5	360.9	361.3	361.7	362.1	362.5	362.9	363.3	363.7	364.1	364.5	364.9	365.3	365.7	366.1	366.5	366.9	367.3	367.7	368.1	368.5	368.9	369.3	369.7	370.1	370.5	370.9	371.3	371.7	372.1	372.5	372.9	373.3	373.7	374.1	374.5	374.9	375.3	375.7	376.1	376.5	376.9	377.3	377.7	378.1	378.5	378.9	379.3	379.7	380.1	380.5	380.9	381.3	381.7	382.1	382.5	382.9	383.3	383.7	384.1	384.5	384.9	385.3	385.7	386.1	386.5	386.9	387.3	387.7	388.1	388.5	388.9	389.3	389.7	390.1	390.5	390.9	391.3	391.7	392.1	392.5	392.9	393.3	393.7	394.1	394.5	394.9	395.3	395.7	396.1	396.5	396.9	397.3	397.7	398.1	398.5	398.9	399.3	399.7	400.1	400.5	400.9	401.3	401.7	402.1	402.5	402.9	403.3	403.7	404.1	404.5	404.9	405.3	405.7	406.1	406.5	406.9	407.3	407.7	408.1	408.5	408.9	409.3	409.7	410.1	410.5	410.9	411.3	411.7	412.1	412.5	412.9	413.3	413.7	414.1	414.5	414.9	415.3	415.7	416.1	416.5	416.9	417.3	417.7	418.1	418.5	418.9	419.3	419.7	420.1	420.5	420.9	421.3	421.7	422.1	422.5	422.9	423.3	423.7	424.1	424.5	424.9	425.3	425.7	426.1	426.5	426.9	427.3	427.7	428.1	428.5	428.9	429.3	429.7	430.1	430.5	430.9	431.3	431.7	432.1	432.5	432.9	433.3	433.7	434.1	434.5	434.9	435.3	435.7	436.1	436.5	436.9	437.3	437.7	438.1	438.5	438.9	439.3	439.7	440.1	440.5	440.9	441.3	441.7	442.1	442.5	442.9	443.3	443.7	444.1	444.5	444.9	445.3	445.7	446.1	446.5	446.9	447.3	447.7	448.1	448.5	448.9	449.3	449.7	450.1	450.5	450.9	451.3	451.7	452.1	452.5	452.9	453.3	453.7	454.1	454.5	454.9	455.3	455.7	456.1	456.5	456.9	457.3	457.7	458.1	458.5	458.9	459.3	459.7	4

COPY



BAPEN
www.bapen.org.uk

Step 2 - Weight loss score

KILOGRAMS		
Score 0 Wt loss < 5%	Score 1 Wt loss 5-10%	Score 2 Wt loss > 10%

Weight loss in last
3 to 6 months

kg	Less than (kg)	Between (kg)	More than (kg)
30	1.6	1.6-3.3	3.3
31	1.6	1.6-3.4	3.4
32	1.7	1.7-3.6	3.6
33	1.7	1.7-3.7	3.7
34	1.8	1.8-3.8	3.8
35	1.8	1.8-3.9	3.9
36	1.9	1.9-4.0	4.0
37	1.9	1.9-4.1	4.1
38	2.0	2.0-4.2	4.2
39	2.1	2.1-4.3	4.3
40	2.1	2.1-4.4	4.4
41	2.2	2.2-4.6	4.6
42	2.2	2.2-4.7	4.7
43	2.3	2.3-4.8	4.8
44	2.3	2.3-4.9	4.9
45	2.4	2.4-5.0	5.0
46	2.4	2.4-5.1	5.1
47	2.5	2.5-5.2	5.2
48	2.5	2.5-5.3	5.3
49	2.6	2.6-5.4	5.4
50	2.6	2.6-5.6	5.6
51	2.7	2.7-5.7	5.7
52	2.7	2.7-5.8	5.8
53	2.8	2.8-5.9	5.9
54	2.8	2.8-6.0	6.0
55	2.9	2.9-6.1	6.1
56	2.9	2.9-6.2	6.2
57	3.0	3.0-6.3	6.3
58	3.1	3.1-6.4	6.4
59	3.1	3.1-6.6	6.6
60	3.2	3.2-6.7	6.7
61	3.2	3.2-6.8	6.8
62	3.3	3.3-6.9	6.9
63	3.3	3.3-7.0	7.0
64	3.4	3.4-7.1	7.1

STONES AND POUNDS		
Score 0 Wt loss < 5%	Score 1 Wt loss 5-10%	Score 2 Wt loss > 10%

Weight loss in last
3 to 6 months

st lb	Less than (st lb)	Between (st lb)	More than (st lb)
4 10	0.3	0.3-0.7	0.7
4 12	0.4	0.4-0.8	0.8
5 1	0.4	0.4-0.8	0.8
5 3	0.4	0.4-0.8	0.8
5 5	0.4	0.4-0.8	0.8
5 7	0.4	0.4-0.9	0.9
5 9	0.4	0.4-0.9	0.9
5 12	0.4	0.4-0.9	0.9
6 0	0.4	0.4-0.9	0.9
6 2	0.5	0.5-0.10	0.10
6 4	0.5	0.5-0.10	0.10
6 6	0.5	0.5-0.10	0.10
6 9	0.5	0.5-0.10	0.10
6 11	0.5	0.5-0.11	0.11
6 13	0.5	0.5-0.11	0.11
7 1	0.5	0.5-0.11	0.11
7 3	0.5	0.5-0.11	0.11
7 6	0.5	0.5-0.12	0.12
7 8	0.6	0.6-0.12	0.12
7 10	0.6	0.6-0.12	0.12
7 12	0.6	0.6-0.12	0.12
8 0	0.6	0.6-0.12	0.12
8 3	0.6	0.6-0.13	0.13
8 5	0.6	0.6-0.13	0.13
8 7	0.6	0.6-0.13	0.13
8 9	0.6	0.6-0.13	0.13
9 11	0.6	0.6-1.0	1.0
9 0	0.7	0.7-1.0	1.0
9 2	0.7	0.7-1.0	1.0
9 4	0.7	0.7-1.0	1.0
9 6	0.7	0.7-1.1	1.1
9 8	0.7	0.7-1.1	1.1
9 11	0.7	0.7-1.1	1.1
9 13	0.7	0.7-1.1	1.1
10 1	0.7	0.7-1.2	1.2

KILOGRAMS		
Score 0 Wt loss < 5%	Score 1 Wt loss 5-10%	Score 2 Wt loss > 10%

Weight loss in last
3 to 6 months

kg	Less than (kg)	Between (kg)	More than (kg)
65	3.4	3.4-7.2	7.2
66	3.5	3.5-7.3	7.3
67	3.5	3.5-7.4	7.4
68	3.6	3.6-7.6	7.6
69	3.6	3.6-7.7	7.7
70	3.7	3.7-7.8	7.8
71	3.7	3.7-7.9	7.9
72	3.8	3.8-8.0	8.0
73	3.8	3.8-8.1	8.1
74	3.9	3.9-8.2	8.2
75	3.9	3.9-8.3	8.3
76	4.0	4.0-8.4	8.4
77	4.1	4.1-8.6	8.6
78	4.1	4.1-8.6	8.6
79	4.2	4.2-8.7	8.8
80	4.2	4.2-8.9	8.9
81	4.3	4.3-9.0	9.0
82	4.3	4.3-9.1	9.1
83	4.4	4.4-9.2	9.2
84	4.4	4.4-9.3	9.3
85	4.5	4.5-9.4	9.4
86	4.5	4.5-9.6	9.6
87	4.6	4.6-9.7	9.7
88	4.6	4.6-9.8	9.8
89	4.7	4.7-9.9	9.9
90	4.7	4.7-10.0	10.0
91	4.8	4.8-10.1	10.1
92	4.8	4.8-10.2	10.2
93	4.9	4.9-10.3	10.3
94	4.9	4.9-10.4	10.4
95	5.0	5.0-10.6	10.6
96	5.1	5.1-10.7	10.7
97	5.1	5.1-10.8	10.8
98	5.2	5.2-10.9	10.9
99	5.2	5.2-11.0	11.0

STONES AND POUNDS		
Score 0 Wt loss < 5%	Score 1 Wt loss 5-10%	Score 2 Wt loss > 10%

Weight loss in last
3 to 6 months

st lb	Less than (st lb)	Between (st lb)	More than (st lb)
10 3	0.8	0.8-1.2	1.2
10 6	0.8	0.8-1.2	1.2
10 8	0.8	0.8-1.2	1.2
10 10	0.8	0.8-1.3	1.3
10 12	0.8	0.8-1.3	1.3
11 0	0.8	0.8-1.3	1.3
11 3	0.8	0.8-1.3	1.3
11 5	0.8	0.8-1.4	1.4
11 7	0.8	0.8-1.4	1.4
11 9	0.9	0.9-1.4	1.4
11 11	0.9	0.9-1.4	1.4
12 0	0.9	0.9-1.5	1.5
12 2	0.9	0.9-1.5	1.5
12 4	0.9	0.9-1.5	1.5
12 6	0.9	0.9-1.5	1.5
12 8	0.9	0.9-1.6	1.6
12 11	0.9	0.9-1.6	1.6
12 13	0.10	0.10-1.6	1.6
13 1	0.10	0.10-1.6	1.6
13 3	0.10	0.10-1.7	1.7
13 5	0.10	0.10-1.7	1.7
13 8	0.10	0.10-1.7	1.7
13 10	0.10	0.10-1.7	1.7
13 12	0.10	0.10-1.8	1.8
14 0	0.10	0.10-1.8	1.8
14 2	0.10	0.10-1.8	1.8
14 5	0.11	0.11-1.8	1.8
14 7	0.11	0.11-1.9	1.9
14 9	0.11	0.11-1.9	1.9
14 11	0.11	0.11-1.9	1.9
14 13	0.11	0.11-1.9	1.9
15 2	0.11	0.11-1.10	1.10
15 4	0.11	0.11-1.10	1.10
15 6	0.11	0.11-1.10	1.10
15 8	0.11	0.11-1.10	1.10

BAPEN

COPY

PATIENT HANDLING ASSESSMENT – 'INITIAL ASSESSMENT'

An assessment of each individual patient must be completed on admission; with the completion of this mobility chart as required.

Ability of patient prior to admission.....

Is the patient independent? YES ☐ NO ☐ (Please tick ✓ as appropriate)

Does the patient have a walking stick or frame on admission? YES ☐ NO ☐

If the patient has been assessed as 'independent' on initial assessment, a mobility chart does **NOT** require to be completed. If this changes, please review; and complete a mobility chart.

If the patient is **not** independent, please complete the mobility chart.

Assessor's Signature:

Date / Time:

PATIENT HANDLING ASSESSMENT – 'MOBILITY CHART'

The form overleaf **must** be completed if the patient is **NOT** independent. Thereafter the mobility chart must be read / reviewed daily; post fall; if patient's condition changes; and on transfer to another area. Document any changes in a new column.

An assessment of the patient should be carried out prior to **every** handling intervention. Any changes should be documented in a new column. Please refer to Manual Handling Guidelines for all manoeuvres. If your patient is 'Plus Size', please refer to the Handling Plus Size Person Guidelines

Areas of concern, risk factors and risk management MUST be documented in the patient record

(Please see below detail of codes)

Codes in Mobility Chart

MC = Mobility Code

HA = Handling Aid / EC = Equipment Code

COPY

	Date / Time Initial Assessment			Review		
	Mobility Codes	Handling Aids	Equipment Codes	Date/Time	Mobility Codes	Handling Aids
Transfers						
Lying to sitting						
Sits up and over the side of the bed						
Sit to stand to sit from bed / chair						
Walking						
Bathing / Showering / Toileting						
Toileting						
Moving up and down the bed						
Turning / Proning						
On / off bed pan						
Lateral transfers						
On / off floor						
Hoist and Sling information		Criteria for referral to Physiotherapist				
Make and model of hoist / stand aid		Chest Infection / difficulty clearing secretions / reduced oxygen saturated level				
Type / size of sling / loop selection (as required)		Reduced mobility compared to normal	Recent fall			
Assessor's Signature		Stair assessment: state reason e.g. injury / acute illness				
Assessor's name (Print)		Major surgery e.g. abdominal / neck dissection / mastectomy				
Review Date		Longer term rehabilitation needs				

MC – Mobility Codes	HA – Handling Aids	EC – Equipment Codes
IND - Independent AST - 1 / 2 / 3 or more	H - Full body hoist BH - Bath hoist	SC - Shower chair ST - Shower trolley
SUP - Supervision BR - Bed Rest	STA - Stand aid Pt T - Patient turner (specify)	Co - Commode W - Wheelchair
FWB - Full weight bearing	GS - Glide sheet ES - Extension straps	C - Crutches (specify)
PWB - Partial weight bearing	HB - Hand blocks HS - Hand sling	S - Stick Z - Zimmer
NWB - Non weight bearing	PAT - Pat slide	HJ - Hover jack HM - Hover matt

Skin Assessment and Care Plan

COPY

Daily Skin Care Assessment

[illegible]

COPY

1. Daily Personal Hygiene Assessment

[illegible]

2. Daily Continence Assessment

[illegible]

1. Daily Personal Hygiene Assessment

[illegible]

2. Daily Continence Assessment

[illegible]

Patients assessed as **yellow** or **red** require a detailed care plan overleaf.
All care given each day **must** be documented in the unified progress notes.

Personal Hygiene & Continence Care Plan

COPY

[illegible]

COPY

[illegible][illegible]

Potential nursing actions

- Please document normal bowel function and/or if the patient has a history of bowel disease
- Document if the patient has a stoma and plan of care, level of assistance required.
- Assess bowel function daily above and document any changes in the unified progress notes
- Review and update care plan below if the patients condition changes.
- Record any bowel pattern change, if patient is on aperients or if a specimen has been sent.
- Identify type of stool using Bristol Stool Form Scale. Record every episode of stool.

[illegible]

Continuation sheet for care plans if require

COPY

[illegible]

Continuation sheet for care plans if require

COPY

[illegible]

PVC INSERTION BUNDLE AND REMOVAL RECORD

PLEASE COMPLETE ALL BOXES

The patients skin is decontaminated and allowed to dry
 Hand hygiene & gloves donned prior to insertion
 Aseptic Non Touch Technique is used to insert PVC
 If not possible, use either **STERILE GLOVES** or **MINI CHLORAPREP**
 Sterile dressing & sticker (date & time) applied after insertion

YES / NO
 YES / NO
 YES / NO
 YES / NO

Scott Pandal
 PATIENT LABEL
 2602800570
COPY

Why is PVC clinically indicated for patient?: (please tick)

IV Fluids
 IV Drugs
 Predicted clinical need

Blood Transfusion
 Diagnostics

Colour:
 Insertion Site:
 Ward/Department:
 Inserted by:
 Date & Time:
 Removed: YES / NO

INVESTIGATIONS

Bloods Required:

FBC U&E GLU LFT CRP AMY CLOTTING G&S ESR PARACETAMOL
 TROP D-DIMER CULTURES VBG* ABG* (*attach to notes) URINALYSIS HCG ECG

Others:

ALUP

BLOODS TAKEN? YES / NO

TIME TAKEN 0010

SIGN

PRINT

Preliminary Pressure Ulcer Risk Assessment (PPURA):

Mobility: Person is fully mobile without equipment/assistance
 Continence: Person is fully continent
 Nutrition: Person appears well nourished and able to eat and drink
 Skin: Skin to pressure points satisfactory/intact

Points to Consider

* People who are overweight may not be well nourished
 * Use of repose mattress or pressure relieving heel protectors.

Record your answer in the grid below Y = Yes or N = No

If the answer is **NO** to any assessments undertake a BRADEN and consider any other assessment

DATE	TIME	MOBILITY	CONTINENCE	NUTRITION	SKIN INSPECTED	SKIN INTACT	BRADEN COMPLETED	SIGNATURE
02-10	0055	Y	Y	Y	N	Y	N	U
SKIN DESCRIPTION: i.e. REDNESS, SKIN BROKEN, BLISTER / ULCER						ACTION TAKEN		

4 AT

ALERTNESS (assess for drowsiness or agitation, if asleep attempt to rouse)

	Tick
Normal	0
Mild sleepiness (easily roused <10 seconds)	0
Clearly abnormal	4

AMT4 (age, date of birth, place, current year)

	Tick
No mistakes	0
1 mistake	1
2 or more mistakes	2

ATTENTION (ask for months of the year backwards)

	Tick
Achieves 7 or more correctly	0
Starts but scores less than 7/Refuses to start	1
Untestable	2

ACUTE CHANGE OR FLUCTUATION (significant change incl. evidence of psychotic symptoms)

	Tick
No	0
Yes	4

Total score (score of 4 or more indicates likely delirium - initiate TIME bundle)

FALLS TRIGGER TOOL: (Complete only if 65 years or over)

2 or more falls in the last 6 months?	YES / NO	Tries to walk alone and is unsteady?	YES / NO
Fall since admission to department?	YES / NO	Patient/relatives anxious about falls	YES / NO
Admitted to department with fall?	YES / NO	4AT more than 4/evidence of confusion	YES / NO
COMPLETED BY			

If you have answered yes to 2 or more questions,

- For patients being admitted please document recommendation that a full care bundle is required to be completed.
- Please add **FALLS RISK IDENTIFIER** to Trakcare (EPR → Patient Alerts → New → Ward Signifiers → Falls risk).

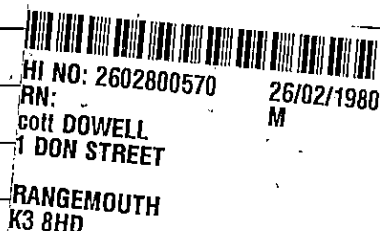
CLINICAL NOTES



Bloods: U+Es NAD Hb 160
 UFTs NAD WCC 8-3
 Any line S3 p1+147
 CRP 9

ECG NSR

CXR



Near Patient Test		Clinitek Status	
Troponin.....Initials.....	Blood Gases	Serial Number:	3600
Time of Trop.....	Arterial/venous	Patient Name:	SCOTT DOWELL
D-dimer.....	Time taken	Patient ID:	26028005
Urine dipstick	FiO2	Multistix® 8 SG	10-22-20
Leucs	pH	Test date	9:40y seen
Nitrite	pCO2	Time	82:le)
Protein	PO2	Operator	Yelliameter.....
Blood	BE	Test number	Cle
Ketones	Lactate	Clarity	
Glucose	Urine Pregna	GLU Negative	t immune (circle)
	HCG positive	KET Negative	Scott DOWELL
		SG 1.010	1 DON STREET
		BLD Negative	RANGEMOUTH
		pH 6.0	TIRLINGSHIRE
		PRO Negative	K3 8HD
		NIT Negative	
		LEU Negative	
Patient/Legal Guardian Permission to release info for:			
Patient Signature..... Print Name			

NEWS TOTAL	3	2	1	2	1	1
Monitoring frequency 4-6	15M	15	10	12	4	
Escalation of care Y/N	N	N	N	N	N	
Blood Sugar	MA	MA	MA	MA	MA	
Pain Score 0-3	0	0	1	0	6	
Initials	12/11/11	12/11/11	12/11/11	12/11/11	12/11/11	

DATE OF ADMISSION:

COPY

DATE
TIME

≥25

21-24

18-20

15-17

12-14

9-11

≤8

≥96

94-95

92-93

≤91

≥97 on O₂

95-96 on O₂

93-94 on O₂

≥93 on air

88-92

86-87

84-85

≤83%

A=Air

O₂ L/min

Device

≥220

201-219

181-200

161-180

141-160

121-140

111-120

101-110

91-100

81-90

71-80

61-70

51-60

≤50

≥131

121-130

111-120

101-110

91-100

81-90

71-80

61-70

51-60

41-50

31-40

≤30

Alert

Confusion

V

P

U

≥39.1°

38.1-39.0°

37.1-38.0°

36.1-37.0°

35.1-36.0°

≤35.0°

TOTAL

Monitoring

Escalation

Blood Sugar

Pain Score 10=3

Initials

National Early Warning Score (NEWS2)

NHS

North Valley

COPY

Name:

CHI NO: 2602800570 26/02/1980

DOB:

CRN: M

CHI No:

Scott DOWELL
11 DON STREET

Address:

GRANGEMOUTH
FK3 8HD

*** Regardless of NEWS always escalate if concerned about a patient's condition**

Total NEWS	Frequency of Monitoring	Clinical Response
0 *	Minimum 12 hourly	Continue routine NEWS monitoring with every set of observations
1 - 4 *	Minimum 4 - 6 hourly	- Inform registered nurse who must assess the patient - Registered Nurse to decide if increased frequency of monitoring and / or escalation of clinical care is required
5 - 6 * or 3 in one Parameter	Increased frequency to a minimum of 1 hourly	- Registered nurse to urgently inform the medical team caring for the patient - Urgent assessment by a clinician with core competencies to assess acutely ill patients - Ensure structured Response Stickers A & B are completed (<i>Not Applicable in Emergency Dept</i>)
7+ or more	Continuous monitoring of vital signs (3 lead ECG and continuous SpO2 monitoring, 15 minute BP cycling - document observations every 30 minutes)	- Registered nurse to immediately inform the medical team caring for the patient - Emergency assessment by clinical team with core competencies to assess acutely unwell patients - Ensure structured Response Stickers A & B are completed (<i>Not Applicable in Emergency Dept</i>) - Consider transfer of clinical care to ITU

Exclusion Criteria

Anaesthesia and/or sedation may result in reduced conscious levels for a period of time. Scores that are increasing post-procedure and those including "P" or "U" always require escalation. The post-procedure NEWS score and post procedure plan that will include the frequency of observations should be communicated to the ward staff on transfer/handover of the patient.

Target O2 Saturation

Target SpO2 for most patients should be 94-98%.

Selected patients may require target SpO2 88-92% (Appropriate in specific patients with severe chronic respiratory disease who either have established chronic Type 2 respiratory failure, or are felt to be at significantly increased risk of CO2 retention from oxygen therapy). These patients should use the modified (chronic hypercapnia) EWS. Arterial blood gases should be repeated at 30-60 min to check for rising CO2 or H+ after initiation of oxygen in this context.

Acute Respiratory Failure is a life threatening emergency

Severe Hypoxia (Requiring >60% O2 to maintain target SpO2)

Acute Hypercapnia (pCO2 >6 and H+ >45)

Urgent ST3 (or equivalent) review is required to optimise management.

Duty or on call consultant should be contacted if advice required.

Critical care referral and ventilatory support may be needed.

Codes For Recording Oxygen Delivery On NEWS Chart

A = Air (not requiring oxygen or weaning or on PRN oxygen)

N = Nasal Canulae

SM = Simple Mask

V24 = Venturi 24% V28 = Venturi 28% V35 = Venturi 35% V40 = Venturi 40% V60 = Venturi 60%

H28 = Humidified oxygen at 28% (also H35, H40 & H60 = Humidified Oxygen at 35%, 40% & 60%)

RM = Reservoir Mask

TM = Tracheostomy Mask

CP = Patient on CPAP System

NIV = Patient on NIV System

OTH = Other Device: _____ (specify which)

Pain Score

0 = no pain

1 = mild pain

2 = moderate pain

3 = severe pain

Sepsis Screening Tool

Patient triggering NEWS ≥ 5 OR Clinical Concern
Neutropenia suspected OR MEWS triggering for obstetric patients

COPY

Is this likely to be due to infection?

Cough/sputum
Abdominal pain/distension/diarrhoea
Line infection
Endocarditis

Dysuria
Cellulitis
Headache with neck stiffness
Wound infection

Obstetric patients (Refer to FV protocol: Sepsis in Maternity Patients)
Perineal trauma Vaginal discharge Prolonged SRM Sore Throat

YES

NO

Escalate to Doctor/ANP with
"suspected sepsis"
Place Sepsis 6 sticker in notes
Prepare giving set/IV fluids

Escalate to Doctor/ANP
Repeat NEWS/MEWS in max 60 mins

ASSESS FOR OTHER CAUSES OF TRIGGERING

Two people work together to deliver the Sepsis 6 within 60 mins of patient first triggering

- Correct Hypoxia
- Take Blood Cultures
- Give IV antibiotics according to NHS FV Protocol

- Measure whole blood Lactate
- Assess urine output (catheter if obstetric patient)
- Start IV fluids - 20ml/kg, minimum 500mls in the first hour

ASSESS FOR SEVERE SEPSIS

SEVERE SEPSIS

Sepsis with $\geq$ organ dysfunction:

- Hypotension
- Renal
- Respiratory
- Hepatic
- Hematologic
- CNS
- Metabolic acidosis

IF SEVERE SEPSIS

Contact middle grade Doctor (Consultant if obstetric patient)

Catheter mandatory if evidence of AKI

NO EVIDENCE OF SEVERE SEPSIS

Assess response to sepsis 6

Continue regular NEWS

SEPTIC SHOCK

- Hypotension despite fluid resuscitation
- Organ dysfunction

HIGH RISK FACTORS

- Hypotension
- Lactate > 4
- Unexplained INR > 1.5
- APTT > 60 secs
- Bilirubin > 34 (70 if obstetric)
- Platelets < 100

Conscious Level Chart (only as required for head injury observation)

DATE:																			DATE:	
TIME:																			TIME:	
COMA SCALE	Eyes Open	Spontaneously	4																	Eyes closed by swelling = C
		To speech	3																	
		To pain	2																	
		None	1																	
	Best verbal response	Orientated	5																	Endotracheal tube or tracheostomy = T
		Confused	4																	
		Inappropriate words	3																	
		Incomprehensible sounds	2																	
		None	1																	
	Best motor response	Obey commands	6																	Usually record the best arm response
		Localise pain	5																	
		Withdraws to pain	4																	
		Flexion to pain	3																	
		Extension to pain	2																	
		None	1																	
1 2 3 4 5 6 7 8 Pupil Scale (mm)																				
PUPILS	right	Size Reaction																	+ reacts - no reaction c. eye closed	
	left	Size Reaction																		
LIMB MOVEMENT	A R M S	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																		
	L E G S	No response																		
		Normal power																		
		Mild weakness																		
		Severe weakness																		
		Extension																		
		No response																		

Pain Assessment & Management Guidelines

Pain Score:

- 0 = No pain
- 1 = No pain at rest
Slight pain on movement
- 2 = Intermittent pain at rest
Moderate pain on movement
- 3 = Continuous pain at rest

For Acute and Chronic Pain:

For mild (1), moderate (2) or severe (3) pain refer to Pain Management Guidelines Forth Valley Formulary Appendix 27 & 28. Implement Pain Assessment Chart

For Cancer Related Pain:

For mild (1), moderate (2) or severe (3) pain score, refer Palliative Guidelines.

Supportive and Palliative Care Indicators Tool (SPICTM)

COPY

The SPICTM is a guide to identifying people at risk of deteriorating and dying. Assessment of unmet supportive and palliative care needs may be appropriate.

Look for two or more general indicators of deteriorating health.

- Performance status poor or deteriorating, with limited reversibility. (needs help with personal care, in bed or chair for 50% or more of the day).
- Two or more unplanned hospital admissions in the past 6 months.
- Weight loss (5 - 10%) over the past 3 - 6 months and/or body mass index < 20.
- Persistent, troublesome symptoms despite optimal treatment of any underlying condition(s).
- Lives in a nursing care home or NHS continuing care unit, or needs care to remain at home.
- Patient requests supportive and palliative care, or treatment withdrawal.

Look for any clinical indicators of advanced conditions

Cancer

Functional ability deteriorating due to progressive metastatic cancer.

Too frail for oncology treatment or treatment is for symptom control.

Dementia / frailty

Unable to dress, walk or eat without help.

Choosing to eat and drink less; difficulty maintaining nutrition.

Urinary and faecal incontinence.

No longer able to communicate using verbal language; little social interaction.

Fractured femur; multiple falls.

Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease

Progressive deterioration in physical and/or cognitive function despite optimal therapy.

Speech problems with increasing difficulty communicating and/or progressive dysphagia.

Recurrent aspiration pneumonia; breathless or respiratory failure.

Heart / vascular disease

NYHA Class III/IV heart failure, or extensive, untreatable coronary artery disease with:

- breathlessness or chest pain at rest or on minimal exertion.

Severe, inoperable peripheral vascular disease.

Respiratory disease

Severe chronic lung disease with:

- breathlessness at rest or on minimal exertion between exacerbations.

Needs long term oxygen therapy.

Has needed ventilation for respiratory failure or ventilation is contraindicated

Kidney disease

Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.

Kidney failure complicating other life limiting conditions or treatments.

Stopping dialysis.

Liver disease

Advanced cirrhosis with one or more complications in past year:

- diuretic resistant ascites
- hepatic encephalopathy
- hepatorenal syndrome
- bacterial peritonitis
- recurrent variceal bleeds

Liver transplant is contraindicated.

Assess and plan supportive & palliative care

- Review current treatment and medication so the patient receives optimal care.
- Consider referral for specialist assessment if symptoms or needs are complex and difficult to manage.
- Agree current and future care goals/plan with the patient and family.
- Plan ahead if the patient is at risk of loss of capacity.
- Handover: care plan, agreed levels of intervention, CPR status.
- Coordinate care (eg. with a primary care register).

Review Date: 2025

Re-order Ref: TF 3/SS

NEW52

Total cholecystectomy NEC; Not applicable

COPY

PATIENT DETAILS

AGE: 45 y DOB: 26/02/80 00:00 SEX: Male Height Weight

ALLERGIES

RISKS

INCIDENTS

PREOP COMMENT
AS prev gd 1 intubation lt htr and arm mw

PERSONNEL

PRIMARY	JOB ROLE	NAME	START TIME	END TIME	ADDITIONAL INFO
	Surgeon	Andrew Crumley			
	Recovery Practitioner	Amelia Wright			
	Recovery Practitioner	Barbara Hill	17:29		
	Anaesthetist	Nicholas Crutchley, Consultant			
	Anaesthetic Practitioner	Tracy Walker			
	Anaesthesia Associate	Cara Jackson, Anaesthesia Associate			

STATUS SUMMARY

Anaesthesia techn. ASA
ETT 2

17:00: Able to void: No
18:00: Nausea score: 0 - None
18:00: D- Sedation score: 1 - Drowsy, easy to rouse by speech
18:00: Wound assessment: 0 - Dry & intact
17:46: Pain score: 0 - No pain / Asleep
17:46: Dressing checked: ✓
17:04: Respiration: OK
17:04: Pressure areas checked - recovery: Yes
17:04: Skin status: Normal: No pressure areas reported on patient handover

AIRWAY: Local - Regional

13:32 - Endotracheal Tube - 15:34 - Oral / Nasal - 8.0 -
Cuffed - Oral - Primary scope - McGrath MAC - 3 -
BMV Grade - Moderate - Intubation difficulty - Easy -
Laryngoscopy view - indirect - Full - Nr of attempts - 1 -
Oropharyngeal airway required - Yes - Inserted by - CJ
- Is awake intubation necessary in the future ? - No

BLOCK EVALUATION

LINES-TUBES-DRAINS

Total cholecystectomy NEC; Not applicable

13:32 - Peripheral cannula - 18:03 - Cannula - Hand - Right - 20G Pink - Asepsis - Clean Procedure - Dressing -
✓ - Site cleaned with - 70% Isopropyl Alcohol

COPY

INTERVENTIONS

FLUID BALANCE

BLOOD OUT
URINE OUT
OTHER OUT

TOTAL IN
TOTAL OUT
BALANCE

1000 mL

1000 mL

SCORING CHART

SEDATION

18:00 -
1 - Drowsy, easy to rouse by
speech

NAUSEA

18:00 - 0 - None

PAIN

17:46 - 0 - No pain / Asleep

WOUND

18:00 - 0 - Dry & intact

NOTES

NOTES

15:57 Other recovery comment
Pt arrived in recovery
Gadel expelled
face mask in situ 6L o2
venflon in situ right hand pink
Fluids running
Two drain in situ left side of stomach
Observations stable
Pt asleep

A Wright SN

16:16 Other recovery comment
Slight drain leakage on site number 1
Padded dressing applied
New gown put on
Pt left comfortable

A Wright SN

16:43 Other recovery comment
Pt has had a few sips of water

A Wright sn

17:07 Other recovery comment
Procedure sights dry.
Drains x 2 in situ, minimal output.
Sedation score 1, patient remains on oxygen via a Hudson mask

17:39 Other recovery comment
Patient sleepy but easily rousable. Asking questions re operation.
Sips H2O given.
Drain 2 :25ml haemoserous fluid
Drain 1: minimal.
Further sips H2O given.

17:47 Other recovery comment
Dentures now in situ at patient request.

Total cholecystectomy NEC; Not applicable

POSTOP PLAN

COPY

INSTRUCTIONS

Postop thromboprophylaxis: Mobilise and keep hydrated
Postop glycaemic control method: Not applicable
Planned postop antimicrobial treatment: Nil
Oral Intake: Full diet

DRUGS & FLUIDS

DRUGS & FLUIDS intraop

Metaraminol 0.5 mg
Dexamethasone 6.6 mg
Gentamicin 240 mg
Sufamamadox 200 mg
Morphine 20 mg
Rocuronium 80 mg
Propofol 300 mg
Metronidazole 500 mg
Fentanyl 100 µg
Ondansetron 4 mg
Hartmanns 0 mL

DRUGS & FLUIDS postop

Hartmanns 1000 mL

Dexamethasone

Recording	Amount	Volume	Rate	Cumulative amount	Cumulative volume	Time	Route	Bag ID	Saved by
Bolus	6.6 mg	0 mL		6.6 mg	0 mL	13:31	IV Bolus		Tracy Walker

Fentanyl

Recording	Amount	Volume	Rate	Cumulative amount	Cumulative volume	Time	Route	Bag ID	Saved by
Bolus	100 µg	0 mL		100 µg	0 mL	13:30	IV Bolus		Tracy Walker

Gentamicin

Recording	Amount	Volume	Rate	Cumulative amount	Cumulative volume	Time	Route	Bag ID	Saved by
Bolus	240 mg	0 mL		240 mg	0 mL	14:25	IV Bolus		Nicholas Crutchley

Metaraminol

Recording	Amount	Volume	Rate	Cumulative amount	Cumulative volume	Time	Route	Bag ID	Saved by
Bolus	0.5 mg	0 mL		0.5 mg	0 mL	14:07	IV Bolus		Nicholas Crutchley

Metronidazole

Recording	Amount	Volume	Rate	Cumulative amount	Cumulative volume	Time	Route	Bag ID	Saved by
Bolus	500 mg	0 mL		500 mg	0 mL	14:25	IV Bolus		Nicholas Crutchley

Morphine

Recording	Amount	Volume	Rate	Cumulative amount	Cumulative volume	Time	Route	Bag ID	Saved by
Bolus	5 mg	0 mL		20 mg	0 mL	14:52	IV Bolus		Nicholas Crutchley

HANDOVER SUMMARY

Name:

CHI#

Procedure Date:

POWELL, SCOTT

2602800570

20/11/2025

Total cholecystectomy NEC; Not applicable

COPY

Recording	Amount	Volume	Rate	Cumulative amount	Cumulative volume	Time	Route	Bag ID	Saved by
Bolus	2 mg	0 mL		15 mg	0 mL	14:26	IV Bolus		Nicholas Crutchley
Bolus	3 mg	0 mL		13 mg	0 mL	14:20	IV Bolus		Nicholas Crutchley
Bolus	5 mg	0 mL		10 mg	0 mL	13:49	IV Bolus		Cara Jackson
Bolus	5 mg	0 mL		5 mg	0 mL	13:35	IV Bolus		Tracy Walker

Ondansetron

Recording	Amount	Volume	Rate	Cumulative amount	Cumulative volume	Time	Route	Bag ID	Saved by
Bolus	4 mg	0 mL		4 mg	0 mL	13:32	IV Bolus		Tracy Walker

Propofol

Recording	Amount	Volume	Rate	Cumulative amount	Cumulative volume	Time	Route	Bag ID	Saved by
Bolus	300 mg	0 mL		300 mg	0 mL	13:30	IV Bolus		Tracy Walker

Rocuronium

Recording	Amount	Volume	Rate	Cumulative amount	Cumulative volume	Time	Route	Bag ID	Saved by
Bolus	80 mg	0 mL		80 mg	0 mL	13:31	IV Bolus		Tracy Walker

Sugammadex

Recording	Amount	Volume	Rate	Cumulative amount	Cumulative volume	Time	Route	Bag ID	Saved by
Bolus	200 mg	0 mL		200 mg	0 mL	15:32	IV Bolus		Nicholas Crutchley

HANDOVER SUMMARY

Name:
CHI#: 2602800570
Procedure Date:

DOWELL, SCOTT
2602800570
20/11/2025

Total cholecystectomy, NEC; Not applicable

		20/11/2025											
		15:45	16:00	16:15	16:30	16:45	17:00	17:15	17:30				
Events	Procedural times	POP in											
Vitals	SpO2 HR NIBPsys NIBPdia RR(ecg)												
D&F all	Sugammadex Hartmanns IV Bolus mg IV Infusion mL/h												
Temp/RR	RR total Temp	15	14	12	11	11				12			
Status	Respiration												
	Supplemental O2 by	Face mask											
	Flow O2 set	6											
	D- Sedation score			1 - Drowsy, e...									
	Nausea score			0 - None									
	Pain score			0 - No pain / ...									
	Dressing checked												
	Wound assessment			0 - Dry & intact									
	Pressure areas checked - recovery												
	Skin status												
BAL by hour	BAL total hourly	ml 0											
	IN total hourly	ml 0											
	OUT total hourly	ml 0											
	OUT blood hourly	ml 0											

COPY

Total cholecystectomy NEC: Not applicable

20/11/2025		15:45	16:00	16:15	16:30	16:45	17:00	17:15	17:30
BAL	OUT urine hourly	ML 0							
Lines	Peripheral cannula								
	Hand - Right								

COPY

HANDOVER SUMMARY

Name:
CHI#
Procedure Date:

DOWELL, SCOTT
2602800570
20.11.2025

Total cholecystectomy NEC; Not applicable

20/11/2025		17:45	18:00	18:15	18:30	18:45	19:00	19:15	19:30	POSTop
Events	Procedural times									
Vitals	- SpO2 - HR V NIBPsys V NIBPdia - RR(ecg)									
D&A	Sugammadex Hartmanns IV Bolus mg IV Infusion mL/h									
Temp/RR	RR total /min Temp °C	14 36.8								
Status	D- Sedation score Nausea score Pain score Dressing checked Wound assessment Able to void	1 - Drowsy, e... 0 - None 0 - No pain / ... ☒ 0 - Dry & intact No	1 - Drowsy, e... 0 - None 0 - Dry & intact No							
Urine	BAL total hourly mL IN total hourly mL Peripheral cannula Hand - Right		1000 1000							

COPY

COPY

REPRINT

Immediate Discharge Letter

Forth Valley Royal Hospital, Larbert

Tel: 01324 566 000

Serial No: 7ee28a35-30b5-48d7-af23-91e44a749f94

Page 1 of 1

*** Non-verified Orders Exist ***

Consultant: DR ANDREW CRUMLEY

NHS

Forth Valley

COPY

Ward: DAY SURGERY

GP Details		Patient Details		Admission Details	
GP Name	A Syeed	CHI No:	2602800570	Admission Date :	20/11/2025
& Address :	Alba Medical Group Forth Firs Entry Bannockburn	Surname :	Dowell	Admission Type :	Planned Admission
		Forename :	Scott	Presenting Complaint :	
		DOB :	26/02/1980		
		Address :	11 Don Street Grangemouth STIR FK3 8HD	Planned Discharge Date :	20/11/2025
				Outpatient Follow Up :	



Patient Tel : 01324 262719

** PLEASE NOTE: DETAILED CLINICAL INFORMATION REGARDING PATIENT EPISODE TO-FOLLOW **

Patient Drug Reactions			
Allergen	Reaction	Allergen	Reaction

Allergy Status not Recorded

Forth Valley Acute Hospitals - Acute Division
Medications Discharge Summary

Medication	Route	Dose & Frequency	Days Supply or POD	GP?	V	Notes
DIHYDROCODEINE 30 mg Tablets	Oral	30 mg FOUR times daily at 8am 12noon 6pm 10pm when required 4-6hourly for PAIN	7 MAX 240mg in 24h	No		

S178

BN 816051

** Last Item **

Dispensed by :

Checked by :

Date :

Discharging Doctor : DR NICHOLAS CRUTCHLEY

Grade :

REPRINT

Forth Valley Royal Hospital, Larbert

Tel: 01324 566 000

Serial No: 7ee28a35-30b5-48d7-af23-91e44a749f94

Page 1 of 1

Consultant: DR ANDREW CRUMLEY

Immediate Discharge Letter

NHS

Forth Valley

COPY

*** Non-verified Orders Exist ***

Ward: DAY SURGERY

GP Details		Patient Details		Admission Details	
GP Name	A Syeed	CHI No:	2602800570	Admission Date :	20/11/2025
& Address :	Alba Medical Group Forth Firs Entry Bannockburn	Surname :	Dowell	Admission Type :	Planned Admission
		Forename :	Scott	Presenting Complaint :	
		DOB :	26/02/1980		
		Address :	11 Don Street Grangemouth STIR FK3 8HD	Planned Discharge Date :	20/11/2025
				Outpatient Follow Up :	



Patient Tel : 01324 262719

** PLEASE NOTE: DETAILED CLINICAL INFORMATION REGARDING PATIENT EPISODE TO-FOLLOW **

Patient Drug Reactions			
Allergen	Reaction	Allergen	Reaction

Allergy Status not Recorded

Forth Valley Acute Hospitals - Acute Division Medications Discharge Summary			
--	--	--	--

Medication	Route	Dose & Frequency	Days Supply or POD	GP?	V	Notes
DIHYDROCODEINE 30 mg Tablets	Oral	30 mg FOUR times daily at 8am 12noon 6pm 10pm when required 4-6hourly for PAIN	7 MAX 240mg in 24h	No		

** Last Item **

Dispensed by :

Checked by :

Date :

Discharging Doctor : DR NICHOLAS CRUTCHLEY

Grade :

REPRINT

Immediate Discharge Letter

Forth Valley Royal Hospital, Larbert

Tel: 01324 566 000

Serial No: 7ee28a35-30b5-48d7-af23-91e44a749f94

Page 1 of 1

*** Non-verified Orders Exist ***

Consultant: DR ANDREW CRUMLEY

Ward: DAY SURGERY



COPY

GP Details		Patient Details		Admission Details	
GP Name	A Syeed	CHI No:	2602800570	Admission Date :	20/11/2025
& Address :	Alba Medical Group Forth Firs Entry Bannockburn	Surname :	Dowell	Admission Type :	Planned Admission
		Forename :	Scott	Presenting Complaint :	
		DOB :	26/02/1980		
		Address :	11 Don Street Grangemouth STIR FK3 8HD	Planned Discharge Date :	20/11/2025
				Outpatient Follow Up :	
					
Patient Tel : 01324 262719					

** PLEASE NOTE: DETAILED CLINICAL INFORMATION REGARDING PATIENT EPISODE TO-FOLLOW **

Patient Drug Reactions			
Allergen	Reaction	Allergen	Reaction

Allergy Status not Recorded

Forth Valley Acute Hospitals - Acute Division	
Medications Discharge Summary	

Medication	Route	Dose & Frequency	Days Supply or POD	GP?	V
DIHYDROCODEINE 30 mg Tablets	Oral	30 mg FOUR times daily at 8am 12noon 6pm 10pm when required 4-6hourly for PAIN	7 MAX 240mg in 24h	No	

** Last Item **

Discharging Doctor : DR NICHOLAS CRUTCHLEY

Grade :

Originally Printed : 20/11/2025 @ 13:47

Patient Copy 2/2

GOING HOME

NAME Mr. CHI:2602800570
 ADDRESS CRN:5679370 26/02/1980
DOWELL SCOTT
11 Don Street
GRANGEMOUTH,
Stirlingshire
 UNIT No. FK3 8HD

ADDRESS TO WHICH DISCHARGED IF DIFFERENT

COPY

G.P. _____

SCHOOL NOW ATTENDED _____

CONSULTANT MR Crumley

HOSPITAL FURIT

WARD ISCU minor ops DATE OF ADMISSION 21/6/16 DATE OF DISCHARGE 21/6/16

DIAGNOSIS _____

TREATMENT IN HOSPITAL (DATE OF OPERATION IF APPLICABLE)

Excision of cystic lesion left neck
Closed with 3-0 ETHILON

TREATMENT REQUIRED FOLLOWING DISCHARGE (DRESSINGS, INJECTIONS, DIET, CATHETER & CATHETER SIZE)

Sutures removed 28/6/16

DRUG	DOSE	FREQUENCY

Services requested – (tick as applicable)

Hospital and Community Nursing Service

District Nursing Sister
 Health Visitor
 Nursing Aids
 Incontinence Aids
 Day Hospital
 Chiropody
 Physiotherapy
 Limb Fitting Centre
 Speech Therapy

Requested via Social Worker

Home Help
 Meals on Wheels
 MECS Alarm
 Sitter Day/Night
 Day Centre
 Welfare Waiting List
 Social Work support

Requested via Occupational Therapist

Personal Aids
 Adaptation to home

Activity on discharge (underline items applicable)

Lives alone – YES/NO

Walks – Unaided – needs help – with frame/stick/tripod

Stairs – Unaided – needs help – cannot manage

Bed – Unaided – needs help – bedfast

Dressing – Unaided – needs help

Toilet – Unaided – needs help – can/cannot manage catheter

Bathing – Unaided – needs help – unable to bath

Special appliances (e.g. commode) _____

Additional Information

O.P.D. Follow-up Appointment _____

Signed E. Mackenzie Sister/Charge/Staff Nurse Date 21/6/16

Top 2 copies to liaison staff – 3rd copy to be retained.

STE 004

DAY SURGERY
LOCAL ANAESTHETIC THEATRE NOTES & CARE PLAN

MAIN THEATRE ☐

TREATMENT ROOM ☐

Admission Date... 21/5/11

COPY

Consultant.....

Planned procedure.....

Waiting List date.....

P
CHI: 2602800570
GRN: S679370 26/02/1980
DOWELL SCOTT
11 Don Street
GRANGEMOUTH,
Stirlingshire
FK3 8HD

THIS SECTION TO BE COMPLETED BY PATIENT

Next of Kin... Diane (wife).....

GP Details... Dr Dundas.....

Tel : - 01324 262719

Westburn H/c

Medical History -

Do you suffer from any of the following :-
(Please delete where appropriate)

Heart Disease / Problems	YES / <u>NO</u>
Angina	YES / <u>NO</u>
High blood pressure	YES / <u>NO</u>
Breathlessness	YES / <u>NO</u>
Asthma	YES / <u>NO</u>
Epilepsy	YES / <u>NO</u>
Bleeding disorders	YES / <u>NO</u>
Are you diabetic?	YES / <u>NO</u>
Do you have any allergies	YES / <u>NO</u>
Please Detail: -	

Drug / Medication Details -

(Please list all your tablets or medicines)

Gabapentin

SECTION BELOW TO BE COMPLETED BY NURSING STAFF

Procedure Details

Local Anaesthetic & Vol:

Suture Type / No.

Removal Date

Dressing Details

Specimen Sent YES / NO

Follow Up

Discharge Criteria Met YES / NO

Discharged by

Surgeon

Scrub Nurse

Needles/ blades

Tracking Labels

NEWS KEY		0 1 2 3				NAME:		DOB:			
Date		08/18									
Time		150									
RESP RATE		≥25									
		21-24									
		12-20		19							
		9-11									
		≤8									
SpO2 Tick if using Patients with Chronic Hypercapnia Sign: ☐		Default		≥96		98					
				94-95							
				92-93							
		Chronic ↑ CO2		≤91							
				≥88							
				86-87							
Inspired O2		Please tick									
O2 Device or Air		Refer to key									
O2 Flow or Rate											
TEMP Mark •		≥39°									
		38°									
		37°									
		36°									
		≤35°									
SYSTOLIC BLOOD PRESSURE Mark ↑↓		220									
		210									
		200									
		190									
		180									
		170									
		160									
		150									
		140									
		130									
		120									
		110									
		100									
		90									
		80									
		70									
		60									
		50									
		HEART RATE Mark •		>140							
130											
120											
110											
100											
90											
80											
70											
60											
50											
40											
30											
CONSCIOUS LEVEL		Alert		✓							
		V/P/U									
Blood Sugar											
TOTAL SCORE		0									
Pain Score (0-3)		1									
Recognition & Response Checklist											
Urine Output Recorded											
Initials		C									

COPY

CHI:

WARD:

Date

COPY

≥25

21-24

12-20

9-11

≤8

≥96

94-95

92-93

≤91

≥88

86-87

≤85

Default

Chronic
↑ CO2☐

Please tick

Refer to key

≥39°

38°

37°

36°

≤35°

220

210

200

190

180

170

160

150

140

130

120

110

100

90

80

70

60

50

>140

130

120

110

100

90

80

70

60

50

40

30

Alert

V/P/U

Blood Sugar

Pain Score (0-3)

Recognition & Response Checklist

Urine Output Recorded

Initials

Score 5-6 (or 3 in one parameter) = 1 hourly

Score 7 or More = Continuous

National Early Warning Score (NEWS)

NHS

Name:

DOB:

CHI No:

Address:



CHI: 2602800570

26/02/1980

DOWELL Scott

11 DON STREET,

GRANGEMOUTH,

STIRLINGSHIRE FK3 8HD

COPY

Forth Valley

* Regardless of NEWS always escalate if concerned about a patient's condition

Total NEWS	Frequency of Monitoring	Clinical Response
0 *	Minimum 12 hourly	Continue routine NEWS monitoring with every set of observations
1 - 4 *	Minimum 4 - 6 hourly	- Inform registered nurse who must assess the patient - Registered Nurse to decide if increased frequency of monitoring and / or escalation of clinical care is required
5 - 6 * or 3 in one Parameter	Increased frequency to a minimum of 1 hourly	- Registered nurse to urgently inform the medical team caring for the patient - Urgent assessment by a clinician with core competencies to assess acutely ill patients - Ensure structured Response Stickers A & B are completed (<i>Not Applicable in Emergency Dept</i>)
7 * or more	Continuous monitoring of vital signs (3 lead ECG and continuous SpO2 monitoring, 15 minute BP cycling - document observations every 30 minutes)	- Registered nurse to immediately inform the medical team caring for the patient - Emergency assessment by clinical team with core competencies to assess acutely unwell patients - Ensure structured Response Stickers A & B are completed (<i>Not Applicable in Emergency Dept</i>) - Consider transfer of clinical care to ITU

Exclusion Criteria

Anaesthesia and/or sedation may result in reduced conscious levels for a period of time. Scores that are increasing post-procedure and those including "P" or "U" always require escalation. The post-procedure NEWS score and post procedure plan that will include the frequency of observations should be communicated to the ward staff on transfer/handover of the patient.

Target O2 Saturation

Target SpO2 for most patients should be 94-98%.

Selected patients may require target SpO2 88-92% (Appropriate in specific patients with severe chronic respiratory disease who either have established chronic Type 2 respiratory failure, or are felt to be at significantly increased risk of CO2 retention from oxygen therapy). These patients should use the modified (chronic hypercapnia) EWS. Arterial blood gases should be repeated at 30-60 min to check for rising CO2 or H+ after initiation of oxygen in this context.

Acute Respiratory Failure is a life threatening emergency.

Severe Hypoxia (Requiring >60% O2 to maintain target SpO2)

Acute Hypercapnia (pCO2 >6 and H+ >45)

Urgent ST3 (or equivalent) review is required to optimise management.

Duty or on call consultant should be contacted if advice required.

Critical care referral and ventilatory support may be needed.

Codes For Recording Oxygen Delivery On NEWS Chart

A = Air (not requiring oxygen or weaning or on PRN oxygen)

N = Nasal Canulae

SM = Simple Mask

V24 = Venturi 24% **V28** = Venturi 28% **V35** = Venturi 35% **V40** = Venturi 40% **V60** = Venturi 60%

H28 = Humidified oxygen at 28% (also H35, H40 & H60 = Humidified Oxygen at 35%, 40% & 60%)

RM = Reservoir Mask

TM = Tracheostomy Mask

CP = Patient on CPAP System

NIV = Patient on NIV System

OTH = Other Device: _____ (specify which)

Pain Score

0 = no pain

1 = mild pain

2 = moderate pain

3 = severe pain

NEWS KEY				NAME:				DOB:			
0	1	2	3								
Date				6/2/18							
Time				02:55							
RESPIRATORY RATE				20, 16, 17, 18							
SpO2				97, 97, 96, 97, 98							
Default				94-95							
Chronic				92-93							
↑ CO2				≤91							
Sign:				≤88							
Inspired O2				86-87							
O2 Device or Air				≤85							
O2 Flow or Rate				A A A A A							
EMP				≥39°							
Mark •				38°							
				37°							
				36°							
				≤35°							
SYSTOLIC				220							
				210							
				200							
				190							
				180							
				170							
				160							
				150							
				140							
				130							
				120							
				110							
				100							
				90							
				80							
				70							
				60							
				50							
				>140							
				130							
				120							
				110							
				100							
				90							
				80							
				70							
				60							
				50							
				40							
				30							
HEART RATE				90							
Mark •				80							
				70							
				60							
				50							
				40							
				30							
CONSCIOUS LEVEL				Alert							
				V/P/U							
				Blood Sugar							
				TOTAL SCORE							
				Pain Score (0-3)							
				Recognition & Response Checklist							
				Urine Output Recorded							
				Initials							

COPY

CHI:

WARD:

Date

COPY

≥25

21-24

12-20

9-11

≤8

≥96

94-95

92-93

≤91

≥88

86-87

≤85

Default

Chronic

↑ CO2

☐

Please tick

Refer to key

≥39°

38°

37°

36°

≤35°

220

210

200

190

180

170

160

150

140

130

120

110

100

90

80

70

60

50

>140

130

120

110

100

90

80

70

60

50

40

30

Alert

V / P / U

Blood Sugar

TOTAL SCORE

Pain Score (0-3)

Recognition & Response Checklist

Urine Output Recorded

Initials

Score 5-6 (or 3 in one parameter) = 1 hourly

Score 7 or More = Continuous

National Early Warning Score (NEWS)



Name: CHI: 2602800570 M
DOB: 26/02/1980
CHI No: DOWELL Scott
 11 DON STREET,
 GRANGEMOUTH,
 STIRLINGSHIRE FK3 8HD
Address:

COPY

*** Regardless of NEWS always escalate if concerned about a patient's condition**

Total NEWS	Frequency of Monitoring	Clinical Response
0 *	Minimum 12 hourly	Continue routine NEWS monitoring with every set of observations
1 - 4 *	Minimum 4 - 6 hourly	- Inform registered nurse who must assess the patient - Registered Nurse to decide if increased frequency of monitoring and / or escalation of clinical care is required.
5 - 6 * or 3 in one Parameter	Increased frequency to a minimum of 1 hourly	- Registered nurse to urgently inform the medical team caring for the patient - Urgent assessment by a clinician with core competencies to assess acutely ill patients - Ensure structured Response Stickers A & B are completed (<i>Not Applicable in Emergency Dept</i>)
7* or more	Continuous monitoring of vital signs (3 lead ECG and continuous SpO2 monitoring, 15 minute BP cycling - document observations every 30 minutes)	- Registered nurse to immediately inform the medical team caring for the patient - Emergency assessment by clinical team with core competencies to assess acutely unwell patients - Ensure structured Response Stickers A & B are completed (<i>Not Applicable in Emergency Dept</i>) - Consider transfer of clinical care to ITU

Exclusion Criteria

Anaesthesia and/or sedation may result in reduced conscious levels for a period of time. Scores that are increasing post-procedure and those including "P" or "U" always require escalation. The post-procedure NEWS score and post procedure plan that will include the frequency of observations should be communicated to the ward staff on transfer/handover of the patient.

Target O2 Saturation

Target SpO2 for most patients should be 94-98%.
 Selected patients may require target SpO2 88-92% (Appropriate in specific patients with severe chronic respiratory disease who either have established chronic Type 2 respiratory failure, or are felt to be at significantly increased risk of CO2 retention from oxygen therapy). These patients should use the modified (chronic hypercapnia) EWS. Arterial blood gases should be repeated at 30-60 min to check for rising CO2 or H+ after initiation of oxygen in this context.

Acute Respiratory Failure is a life threatening emergency

Severe Hypoxia (Requiring >60% O2 to maintain target SpO2)

Acute Hypercapnia (pCO2 >6 and H+ >45)

Urgent ST3 (or equivalent) review is required to optimise management.

Duty or on call consultant should be contacted if advice required.

Critical care referral and ventilatory support may be needed.

Codes For Recording Oxygen Delivery On NEWS Chart

A = Air (not requiring oxygen or weaning or on PRN oxygen)

N = Nasal Canulae

SM = Simple Mask

V24 = Venturi 24% V28 = Venturi 28% V35 = Venturi 35% V40 = Venturi 40% V60 = Venturi 60%

H28 = Humidified oxygen at 28% (also H35, H40 & H60 = Humidified Oxygen at 35%, 40% & 60%)

RM = Reservoir Mask

TM = Tracheostomy Mask

CP = Patient on CPAP System

NIV = Patient on NIV System

OTH = Other Device: _____ (specify which)

Pain Score

- 0 = no pain
- 1 = mild pain
- 2 = moderate pain
- 3 = severe pain

ASSESSMENT & CARE PLAN BOOKLET


CHI: 2602800570
26/02/1980 M
DOWELL Scott
11 DON STREET,
GRANGEMOUTH,
STIRLINGSHIRE FK3 8HD

Date of Admission: 6/2/18
Time of Admission:
Ward admitted to: MSW
Date of transfer:
Ward transferred to:
Booklet number: ①

Assessment	Initial assessment to be completed within:	Initials	Re-assessment code
NEWS	On admission	W	
Hydration	4 hours	W	
MRSA	On admission	W	
Pressure Areas	6 – 8 hours	W	
4AT	6 hours	W	
Falls risk	6 hours	W	
Bed rails	12 hours	W	
MUST	24 hours	W	
Pt handling & mobility	24 hours	W	
Personal hygiene	24 hours	W	
Oral care	24 hours	W	
Continence	24 hours	W	
Elimination	24 hours	W	

	Assess on admission- >24 hours
	Assess daily
	Assess weekly
	Review when condition changes
	Assess 2-4 weekly

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

COPY

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

Staff identification – must be completed by all staff prior to recording in this document

Date	Designation	Print name	Signature	Initials
07/12/18	S/N	W. J. K. W.	W. J.	W

Planning for Discharge.

COPY

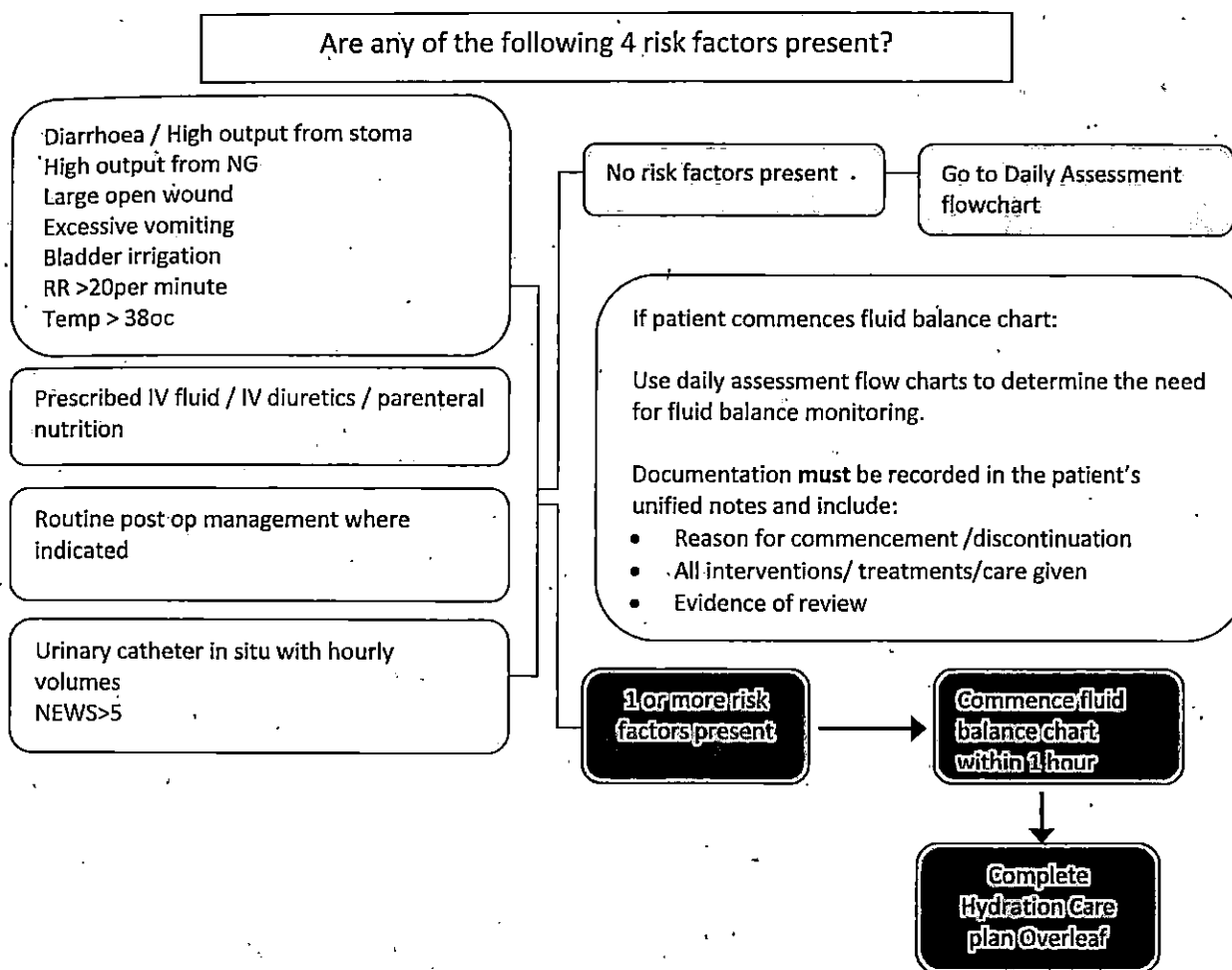
Predicted date for discharge:

Pre-discharge	Date	Comments	Initials
Patient involved in discharge planning			
Is patient homeless or has housing issues?			
Family/carers involved in discharge planning re POC, meds, equipment			
Drug compliance aid			
Controlled drugs			
Referral to community based services i.e. POC, SW ref, confirmed start date			
Catheter for discharge, dressings, equipment etc			
Provide written information to patient/family/carers e.g. what level of POC, meds discussed, Getting To Know Me, D/C leaflet. Contact numbers as appropriate. Follow up appointment			
Key to house available			
Access issues			
Any valuables returned			
Transport method: Booking ref number:			
Outdoor clothing available for discharge			
District nurse involvement and aware of discharge date			
DN letter released			
Day of Discharge			
Discharge prescription checked by nursing staff and available on ward			
Medical discharge letter completed & given to patient/carer			
Compliance aid			
AWI in place and complete			
DNACPR in place and communicated to patient and family			
PVC removed			
Patient experience questionnaire given			

Hydration Assessment

COPY

Risk assessment should be carried out within 4 hrs of admission



Daily Assessment and Review

Risk Assessment	Date/Time	Date	Date	Date	Date	Date	Date
7/2/18							
Number of Risks present	0						
Fluid Balance monitoring indicated Y= Yes N= No	N						
Initials of assessor	W						

PTO

Daily Hydration Care plan

Fluid Preferences on MUST

	Frequency of assessments	Date & Time Assessed with comments	Date & Time Re assessed with comments	Date & Time Re assessed with comments	Date & Time Re assessed with comments	Date & Time Re assessed with comments	Date & Time Re assessed with comments	Date & Time Re assessed with comments
Commence requirement of fluid balance chart if one or more risks are identified	Daily or change in clinical condition	7/12/18 LO						
Set daily fluid balance target with medical team	Daily (At Ward Round)	7/12/18 LO						
Review 24hr fluid balance document in unified notes and discuss with medical team	Daily							
Offer beverages at every Care & Comfort round (if appropriate) and document intake	Continuous	7/12/18 LO						
Encourage patient, family or Carer to be involved with fluid intake and recording (Provide pictorial fluid chart)	Daily	7/12/18 LO						
Describe patient's individual needs	Daily	7/12/18 LO						
Signature		LO						

COPY

Infection Prevention and Control Risk

Assessment **COPY**

On admission, **ALL** patients must be assessed for risk of infection and action taken to minimise the risk.

MRSA Clinical Risk Assessment All questions must be answered

1	Has the patient any history of MRSA (check eward and clinical portal)	YES	☒ NO
2	Has the patient been admitted from anywhere other than their own home (e.g.) care home, prison, hostel or transferred from another hospital	YES	☒ NO
3	Does the patient have any wounds / ulcers or indwelling medical advices (e.g. urinary catheter, PEG, Hickman line, etc)	YES	☒ NO
4	Is the patient being admitted / transferred to ITU, B23 or B31	YES	☒ NO

A **YES** response to questions 1, 2 or 3 indicates there is a risk of MRSA skin carriage. The patient **must be isolated in a single room and swabs taken.**

A **YES** response to question 4 confirms admission to high-risk speciality and the patient must have an **MRSA screen sent.**

MRSA ADMISSION SCREEN – swabs from nose, perineum, wounds and invasive device insertion site. Also send a CSU if urinary catheter is present. NOTE: this is the minimal screen required and additional swabs can be sent if clinically indicated.

Patients with the following presentations also require isolation in a single room.
Multi drug resistant organisms e.g. CPE, VRE (check eward and clinical portal)
Suspected infective diarrhoea e.g., <i>C.diff</i> , food poisoning, Norovirus
Suspected or confirmed Influenza
Suspected or confirmed Pulmonary Tuberculosis (TB)
Fever in a returning traveller
New or unexplained rashes (consider Scabies)
Suspected infective rash e.g. measles, rubella, chickenpox, shingles
Suspected meningitis or encephalitis
Transfers from other hospitals, including community hospitals & care homes
Immunosuppressed patients

Name of nurse completing risk assessment.	Signature	Date
W. J. K. M.	W. J.	7/12/18

If the answer is NO to any statement or there is a notable change in the patient's condition, undertake:

Date	Time	Person is fully competent

Identify risk assessment and consider any other relevant assessment

BRADEN RISK ASSESSMENT CHART

Individuals with a total score of 16 or less are considered at risk; 15-16 = low risk, 12-14 = moderate risk, 11 or less = high risk. Undertake and document risk assessment within 8 hours of admission.

Undertake and document risk assessment with
and repeat regularly according to local protocol
Complete care and comfort around stoma

Consider contributing factors, frailty, diabetes, end of life care.

COPY

Skin Care Plan

COPY

Skin care

Date

7/2/18

Independent, no concerns, check in with patient daily, review if condition changes or concern raised.



Requires supervision/assistance, check skin at least daily, more often if at risk and always at a change in condition

Dependent, will require skin review at every patient interaction (min 2 hrly) and record findings in nursing notes

Goals

- To enable person to maintain intact skin and prevent breakdown.
- Discuss and agree care plan with patient/carer

Potential nursing actions

- Self care, check in with patient daily re any changes, concerns with their skin.
- Whilst supervising your patient, monitor and record skin presentation daily. Record all skin changes and any new care implemented to maintain skin integrity or prevent deterioration if any skin damage is present.
- Dependant, report presentation at each shift change, record all changes and update care plan as well as all actions. Will require assistance to change position – document frequency of positional changes, use of turning chart on care and comfort document.
- Provide patient/family with pressure area care information leaflet

Date/Time

7/2/18

Plan of Care

SA + CMC

Review

Sign

W

THE 4AT TEST: SCREENING INSTRUMENT FOR COGNITIVE IMPAIRMENT AND DELIRIUM

TO BE COMPLETED FOR **ALL** PATIENTS OVER 65 ON ADMISSION AND WHEN A CHANGE IN PRESENTATION IS EVIDENT

*MDT DECIDED INAPPROPRIATE DUE TO CLINICAL PRESENTATION Signed..... Date.....
(ensure documented in clinical notes)

NOT CLINICAL

DATE		1/1	1/2	1/3	1/4	1/5	1/6	1/7	1/8
1. ALERTNESS: <i>This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive.</i> <i>If asleep, attempt to wake and ask the patient to state their name and address to assist rating.</i>		Normal (fully alert, but not agitated throughout assessment)	0	0	0	0	0	0	0
		Mild sleepiness for <10 seconds after waking, then normal	0	0	0	0	0	0	0
		Clearly abnormal (agitated or drowsy)	4	4	4	4	4	4	4
2. AMT4: <i>Age, date of birth, place (name of hospital or building), current year</i>		No mistakes	0	0	0	0	0	0	0
		1 mistake	1	1	1	1	1	1	1
		2 or more mistakes/un-testable	2	2	2	2	2	2	2
3. ATTENTION: <i>Ask the patient: "Please tell me the months of the year in backwards order, starting at December."</i> <i>To assist initial understanding one prompt of "what is the month before December?" is permitted.</i>		Achieves 7 months or more correctly	0	0	0	0	0	0	0
		Starts but scores <7 months/refuses to start	1	1	1	1	1	1	1
		Un-testable (cannot start because unwell, drowsy, inattentive)	2	2	2	2	2	2	2
4. ACUTE CHANGE OR FLUCTUATING COURSE: <i>Evidence of significant change or fluctuation in: alertness, cognition (e.g. increased confusion) or other mental function arising over the last 2 weeks and still evident in last 24hrs</i>		No	0	0	0	0	0	0	0
		Yes	4	4	4	4	4	4	4
Initials of tester →									
4 or above: Possible delirium +/- cognitive impairment - score daily until score <4 for 2 consecutive days		Day 1 4ATscore	Day 2 4ATscore	Day 3 4ATscore	Day 4 4ATscore	Day 5 4ATscore	Day 6 4ATscore	Day 7 4ATscore	Day 8 4ATscore
1-3: Possible cognitive impairment - only rescore if condition changes									
0: Delirium or cognitive impairment unlikely - only rescore if condition changes									
4 or above - initiate TIME bundle and consider need for section 47 of Adults with Incapacity Act.									
1-3 - if no diagnosis of dementia obtain AMT10 and collateral history and refer to Liaison Psychiatry for Older People if any concerns regarding normal level of cognition.									

COPY

Falls Trigger Tool

Age 65 Years or older?	Yes	No	4AT more than 4 or AMT 10 score 8 or less or a confusion?	Yes	No
Has the person fallen in last 6 months?	Yes	No	Based on clinical judgement is this person at risk of falling?	Yes	No
Tries to walk alone but unsteady/safe?	Yes	No	Date:	7/12/18	
If "yes" to more than one question complete Falls Care Plan			Time:	0045	

Falls Care Plan (Complete weekly or if any changes to patients condition)

	Risk Factor	Considerations/Actions	All lines must be completed by circling response	Comments	All lines must be completed by circling response	Comments
F	Footwear	Ensure appropriate footwear available: Walking aid required :	Yes / No Yes / No		Yes / No Yes / No	
	Function	State type of aid:				
	Family	Leaflet given to patient/ relatives falls/falls prevention:	Yes / No		Yes / No	
A	Cognitive Impairment	Walking aid available and within arm's reach at all times: (IF NO PLEASE DOCUMENT REASON WHY)	Yes / No / NA		Yes / No / NA	
		If Physio/OT input required document date of referral				
		If patient has delirium or cognitive impairment, complete 4AT IF >4 INITIATE TIME BUNDLE				
		Can they use the call bell : (IF NO PLEASE DOCUMENT)	Yes / No		Yes / No	
		Consider Individual risk assessment i.e. enhanced observations	Yes / No		Yes / No	
		Increased comfort rounds/ general observations/use strategies to try to reduce stress for patient	Yes / No		Yes / No	
L	Location	Ensure patient is in the most appropriate bed space To minimise risk of falls	Yes / No		Yes / No	
		Ensure patients who have been identified as a higher risk of falls have the RED LEAF protocol initiated	Yes/No		Yes/No	
		HI/LO Bed Required	Yes/No		Yes/No	
		Consider toileting arrangements for patient	Yes/No		Yes/No	
	Medication	Consider increase risk of falls due to medicines, Discuss with medical staff				
L/S	Hypotension	Measure lying and standing blood pressure (if not taken please document why) See NEWS Chart	Yes / No		Yes / No	
S	Sensory	Glasses if required are available:	Yes / No / NA		Yes / No / NA	
		Hearing Aid if required is available	Yes / No / NA		Yes / No / NA	
				Date & Initials:		
				Date & Initials:		

COPY

Bedrails Assessment

COPY

INFORMATION: Use Part 1,2 and 3 below in combination with nursing judgement to inform your decision whether to use or not to use bedrails

- Patients with capacity can make their own decisions about bedrails, however not to be used as a moving and handling aid
- Patients with visual impairment may be more vulnerable to falling from bed
- Patients with involuntary movements (eg spasms) may be more vulnerable to falling from bed and if bedrails are used, may need padded covers

Part 1 – assess mobility & mental state factors		MOBILITY FACTORS		
		Patient is very immobile (bedfast or hoist dependent)	Patient is neither independent nor immobile	Patient can mobilise without help from staff
MENTAL STATE FACTORS	Patient is confused and disorientated	Use bedrails with care	Bedrails NOT recommended	Bedrails NOT recommended
	Patient is drowsy	Bedrails recommended	Use bedrails with care	Bedrails NOT recommended
	Patient is orientated and alert	Bedrails recommended	Bedrails recommended	Bedrails NOT recommended
	Patient is unconscious	Bedrails recommended	N/A	N/A

Part 2 – assess the following additional patient and fitting risks

	Yes	No
1. Is the patient confused and mobile enough to attempt to climb over the bedrail?		✓
2. Is the patient small enough to pass between the bedrails? Eg a child or unusually small adult?		✓
3. Are there any gaps that could cause an entrapment risk to the patients' body or head? <i>Consider each of the following to answer the above question....</i> a. Entrapment gaps between the bars of the bedrail b. Entrapment gaps between bedrail and side of overlay mattress c. Does the mattress compress easily at the edge to increase the gap between the bedrail and the mattress d. Entrapment gaps between footboard and end of side rail e. Entrapment gaps between head board and end of side rail		✓
4. The extra height caused by an overlay mattress <u>must not</u> compromise the safety of the bedrail. The recommended height of the top edge of the bed rail above the mattress (without compression) is to be more than 22cm.220mm . Have you assessed the potential for the person to roll over the bed rail?		✓

NOTE: If answer to Q's 1,2 or 3 is YES then bed rails are NOT APPROPRIATE and alternative methods must be considered.

INFORMATION: the assessment must be reviewed/reassessed if:

- Medical or mental state changes e.g. patient becomes confused, disorientated, agitated, drowsy or unconscious
- Changes are made to bed, mattress or type of bedrails
- The bedrail has been moved out of position

Now complete Part 3 overleaf.....

COPY

[illegible]

'MUST' – Nutritional Risk Screening

COPY
of this form
please

STEP 1 (BMI)	STEP 2 (Weight Loss)	STEP 3 (Acute Disease Effect)	*If weight not measured please indicate how this was obtained (see key below)	*If weight not measured please indicate how this was obtained (see key below)
Weight (Kgs) * = Height (m) * = Method used M,R,C* BMI See BMI charts Greater than 20 score 0 18.5 – 20 score 1 than 18.5 score 2 eater than 30=obese)	Pre-illness weight = Total unplanned weight loss over 3-6 months Weight loss (kg) = Complete with weight loss chart Less than 5% score 0 5-10% score 1 Greater than 10% score 2	Acute illness AND there has been or is likely to be no nutritional intake for 5 days No score 0 Yes score 2	M - Measured R - Reported C - Based solely on clinical impression (See "Ward information pack" for alternative measures)	M - Measured R - Reported C - Based solely on clinical impression (See "Ward information pack" for alternative measures)
STEP 4 (Overall Risk Score) Add scores from steps 1+2+3 to calculate overall risk score SCORE 0 = LOW RISK SCORE 1 = MEDIUM RISK SCORE 2+ = HIGH If risk category arrived at by clinical impression alone, indicate risk category LOW/MEDIUM/HIGH in table below and document rationale in progress notes		STEP 5 (Care Plan) Implement appropriate Nutritional Care Plan 0 = LOW RISK 1 = MEDIUM RISK 2 = HIGH RISK Treat as High Risk - immediate Dietetic Referral •Dysphagia • Decompensated Liver Disease • Enteral Tube Feeding • Multiple Fractures • Pressure Ulcers Grade 3 or more		

'MUST' SCREENING AND RESCREENING

Pre-illness weight

Initial screening

Date	Time	Ward	Weight (kg)*	Weight ↑↔↓	Method used (M,R,C)	BMI	Step 1 Score	Step 2 Score	Step 3 Score	Total Score	MUST Risk	Initial

Rescreening

Date	Time	Ward	Weight (kg)*	Weight ↑↔↓	Method used (M,R,C)	BMI	Step 1 Score	Step 2 Score	Step 3 Score	Total Score	MUST Risk	Initial

'MUST' – Nutritional Risk Screening

COPY

STEP 1 (BMI)	STEP 2 (Weight Loss)	STEP 3 (Acute Disease Effect)	*If weight not measured, please indicate how this was obtained (see key below)	*If weight not measured, please indicate how this was obtained (see key below)
Weight (Kgs) * = Height (m) * = Method used M,R,C* BMI <u>See BMI charts</u> Greater than 20 score 0 18.5 – 20 score 1 Less than 18.5 score 2 (greater than 30=obese)	Pre-illness weight = Total unplanned weight loss over 3-6 months Weight loss (kg) = <u>Complete with weight loss chart</u> Less than 5% score 0 5-10% score 1 Greater than 10% score 2	Acute illness AND there has been or is likely to be no nutritional intake for 5 days No score 0 Yes score 2	M - Measured R - Reported C - Based solely on clinical impression (See "Ward information pack" for alternative measures)	M - Measured R - Reported C - Based solely on clinical impression (See "Ward information pack" for alternative measures)
STEP 4 (Overall Risk Score) Add scores from steps 1+2+3 to calculate overall risk score SCORE 0 = LOW RISK SCORE 1 = MEDIUM RISK SCORE 2+ = HIGH If risk category arrived at by clinical impression alone, indicate risk category LOW/MEDIUM/HIGH in table below and document rationale in progress notes		STEP 5 (Care Plan) Implement appropriate Nutritional Care Plan 0 = LOW RISK 1 = MEDIUM RISK 2 = HIGH RISK Treat as High Risk - immediate Dietetic Referral • Dysphagia • Decompensated Liver Disease • Enteral Tube Feeding • Multiple Fractures • Pressure Ulcers Grade 3 or more		

'MUST' SCREENING AND RESCREENING

Pre-illness weight

Initial screening

Date	Time	Ward	Weight (kg)*	Weight ↑↔↓	Method used (M,R,C)	BMI	Step 1 Score	Step 2 Score	Step 3 Score	Total Score	MUST Risk	Initial

Rescreening

Date	Time	Ward	Weight (kg)*	Weight ↑↔↓	Method used (M,R,C)	BMI	Step 1 Score	Step 2 Score	Step 3 Score	Total Score	MUST Risk	Initial

'MUST': Low Risk Nutrition Care Plan

COPY

Date care plan initiated:

Intervention	Time Frequency	Initial/Date
Has patient been informed of current weight and plan?	Yes/No	
Discuss the results of the 'MUST' screening/care plan with the patient and family (with agreement and involve them in identifying individualised interventions)	On admission & on-going	
Monitor patients weight and rescreen 'MUST' risk weekly or if patient's weight has remained stable for 4 weeks – screen monthly.	On admission	

Please ✓ relevant box and where yes is answered, record details of individual requirement below;

Food Allergy- No ☐ Yes ☐ Religious, cultural, ethnic requirements- No ☐ Yes ☐

Details:	Initial/ Date

Therapeutic diet-No ☐ Yes ☐

Details:	Initial/Date

Assistance required with eating/drinking- No ☐ Yes ☐ Adapted cutlery/aids- No ☐ Yes ☐

Details:	Initial/Date

Specific food preferences (patients unable to make decisions on their food and fluid choices should have a detailed dietary and fluid preference recorded)

Details:	
Is patient able to make own choices?	yes/no
Yes – patient offered daily menu	
No – for patient unable to make choices has food and fluid preferences been recorded on 'my dietary information sheet'	yes/no

CARE PLAN REVIEW

Discuss current weight and plan with patient (initiate new care plan if risk has changed) *Share with relative/carer where appropriate

Initial/Date	Initial/Date	Initial/Date	Initial/Date	Initial/Date
Initial/Date	Initial/Date	Initial/Date	Initial/Date	Initial/Date

'MUST': Medium Risk Nutrition Care Plan

COPY

Date care plan initiated:

Intervention	Time Frequency	Initial/Date
Has patient been informed of current weight and plan?	Yes/No	
Discuss the results of the 'MUST' screening/care plan with the patient and family (with agreement and involve them in identifying individualised interventions)	On admission & on-going	
Monitor patient's weight and rescreen 'MUST' risk weekly or if patient's weight has remained stable for 4 weeks – screen monthly.	On admission	
Optimise nutritional intake by offering - nourishing milky drinks - regular snacks 3 courses at midday and evening meal.	Daily	
Has signifier been added to patient's and kitchen whiteboards?	Yes/no	

Please ✓ relevant box and where yes is answered, record details of individual requirement below;

Food Allergy- No ☐ Yes ☐ Religious, cultural, ethnic requirements- No ☐ Yes ☐

Details:	Initial/Date

Therapeutic diet -No ☐ Yes ☐

Details:	Initial/Date

Assistance required with eating/drinking- No ☐ Yes ☐ Adapted cutlery/aids- No ☐ Yes ☐

Details:	Initial/Date

Specific food preferences (patients unable to make decisions on their food and fluid choices should have a detailed dietary and fluid preference recorded)

Details:	
Is patient able to make own choices?	yes/no
Yes – patient offered daily menu	
No – for patient unable to make choices has food and fluid preferences been recorded on 'my dietary information sheet'	yes/no

CARE PLAN REVIEW

Discuss current weight and plan with patient (initiate new care plan if risk has changed) *Share with relative/carer where appropriate

Initial/Date	Initial/Date	Initial/Date	Initial/Date	Initial/Date
Initial/Date	Initial/Date	Initial/Date	Initial/Date	Initial/Date

'MUST': High Risk Nutrition Care Plan

Date care plan initiated:

COPY

Intervention	Time Frequency	Initial/Date
Has patient been informed of current weight and plan? Discuss the results of the 'MUST' screening/care plan with the patient and family (with agreement and involve them in identifying individualised interventions)	Yes/No On admission & on-going	
Weigh patient and rescreen	Weekly	
Refer to Dietitian with 'MUST' score, BMI and weight loss		
Complete dietary food record charts	Until assessed by dietitian	
Optimise nutritional intake by offering - nourishing milky drinks - regular snacks 3 courses at midday and evening meal	Daily	
Has signifier been added to patient's and kitchen white boards?	Yes/no	

Please ✓ relevant box and where yes is answered, record details of individual requirement below;

Food Allergy- No ☐ Yes ☐

Religious, cultural, ethnic requirements - No ☐ Yes ☐

Details:	Initial/Date

Therapeutic diet- No ☐ Yes ☐

Details:	Initial/Date

Assistance required with eating/drinking- No ☐ Yes ☐

Adapted cutlery/aids - No ☐ Yes ☐

Details:	Initial/Date

Specific food preferences (patients unable to make decisions on their food and fluid choices should have a detailed dietary and fluid preference recorded)

Details:	
Is patient able to make own choices ?	yes/no
Yes – patient offered daily menu	
No – for patient unable to make choices has food and fluid choices been recorded on 'my dietary information sheet'	yes/no

CARE PLAN REVIEW

Discuss current weight and plan with patient (initiate new care plan if risk has changed) *Share with relative/carer where appropriate

Initial/Date	Initial/Date	Initial/Date	Initial/Date	Initial/Date
Initial/Date	Initial/Date	Initial/Date	Initial/Date	Initial/Date

OPEN

Individual Patient Handling Risk Assessment

COPY

If the patient has been assessed as 'independent' on initial assessment, a mobility chart does not require to be completed.
Is the patient independent? YES ☒ NO ☐ (Please tick ✓ as appropriate)

If the patient has been assessed as 'independent' on initial assessment; and this status changes, please review and complete a mobility chart.

If the patient is 'Plus Size', please refer to Bariatric (Plus Size Person) Handling Guidelines.

Please state the patient's ability prior to admission: independent

Please complete the following as to how the patient currently transfers / mobilises (Please tick ✓ as appropriate)

Please sign and date below

Assessor's Name (Print):	<u>W. J. K. W.</u>	Date:	<u>7/12/18</u>
Signature:	<u>W. J. K. W.</u>	Review Date:	
Transfers (including to / from bed; wheelchair; commode; toilet)			
Independent ☒	Supervision ☐	Assistance of 1 ☐ 2 ☐ 3 ☐ More ☐	Standaid ☐ Hoist ☐
If More - please state number			
Moves up and down the bed			
Independent ☒	Supervision ☐	Assistance of 1 ☐ 2 ☐ 3 ☐ More ☐	Glide Sheet ☐ Hoist ☐
If More - please state number			
Sits up and over the side of the bed			
Independent ☒	Supervision ☐	Assistance of 1 ☐ 2 ☐ 3 ☐ More ☐	Bed Rest ☐
If More - please state number			
Bathing (including in and out of the bath / shower)			
Independent ☒	Supervision ☐	Assistance of 1 ☐ 2 ☐ 3 ☐ More ☐	(please specify) Hoist ☐ Other ☐
If More - please state number			
Walking			
Independent ☒	Supervision ☐	Assistance of 1 ☐ 2 ☐ 3 ☐	Walking Aid ☐ No Walking ☐
Did the patient have a walking stick or frame on admission? YES ☐ NO ☒			

This form must be completed for each individual patient, along with a mobility chart, if required.



This form **must** be completed if the patient is **NOT** independent

An assessment of the patient should be carried out prior to every handling intervention. Any changes should be documented in a new column. Please refer to Manual Handling Guidelines for all manoeuvres.

DATE:		AST		AST		AST		AST		AST		AST
Lying to sitting												
Sit to stand to sit												
Walking												
Bathing / Showering / Toileting												
Moving up the bed												
Turning / Proning												
On / off bed pan												
Lateral transfers												
On / off floor*												
State make and model of hoist / stand aid												
State type and size of sling												
Falls assessment (Y / N)												
Signed												

MOBILITY CODES

AST 1 / 2 / 3: Requires assistance of 1 / 2 / 3 or more staff
 SUP: Supervision only IND: Independent

FWB: Full Weight Bearing
 PWB: Partial Weight Bearing
 NWB: Non Weight Bearing
 BR: Bed Rest

HANDLING AIDS / EQUIPMENT CODES

H: Full body lifting hoist (specify hoist type + size of sling)
 STA: Stand aid (specify hoist type + size of sling)
 BH: Bathing hoist (specify hoist type)
 SC: Shower chair ST: Shower Trolley
 Pt T: Pt turner (specify e.g. Etac, Samhall, Cricket,)
 W: Wheelchair or pushchair

GS: Glide sheet(s) ES: (Extension Straps)
 PAT: Pat slide
 HB: Hand blocks HS: Handling Sling
 C: Crutches (specify)
 S: Stick(s) Z: Zimmer
 HM: (HoverMatt) HJ: (HoverJack)

COPY

Manual Handling Service

January 2017

COPY

Complete on admission and review weekly unless condition changes.
Ensure care given is documented daily.

[illegible]

Oral Health Assessment

COPY

All patients should have their mouth assessed within 24 hours of admission to determine if oral care planning is required. Discuss and agree care plan with patient/carer.

Complete this section to determine condition of mouth and the frequency of mouth care required.			Date	Date	Date	Date	Date	Date	Date
			7/2/18						
Condition of mouth Check lips, oral soft tissues and teeth with a good light	Teeth/dentures clean, mucosa pink and moist	Standard Care 1	✓						
	Mucosa/tongue pink and dry	Standard Care 2							
	Obvious plaque/swollen or bleeding gums or dry/crusted mouth	Standard Care 3							
	Possible infection	Standard Care 4							

Complete this section to determine frequency of assessment required			Date	Date	Date	Date	Date	Date	Date
			7/2/18						
Eating ability	Able to eat normal diet	1	1						
	Soft diet/delayed swallow reflex	2							
	Nil by mouth	3							
Physical ability	Requires assistance to access oral hygiene implements	1							
	Requires help with oral hygiene	2							
	Patient not able to carry out any aspect of oral hygiene	3							
Mental ability	Loss of interest/confused	1							
	Memory impaired/confused	2							
	Sedated	3							
Nutritional screening (only score if patient has own teeth)	MUST low	1	1						
	MUST medium	2							
	MUST high	3							
Additional risk factors	Diabetes mellitus	1							
	Medications *	1	1						
	Smoking	1							
	Loose/damaged dentures	1							
	Open mouth breathing	1							
	Oxygen therapy	1							
	Broken or loose teeth	1							
Total score			3						
Initials			W						
Re-assessment risk level: 2-8 = Low (monthly) 9-14 = Medium (every 2 weeks) 15+ = High (daily)									

Oral Health Assessment

COPY

All patients should attain Standard Care 1 for oral hygiene. If any further care is required, this should be carried out **in addition** to Standard Care 1

Standard Care 1	
Natural teeth	1. Brush teeth at least twice per day using fluoride toothpaste and a medium toothbrush. 2. Spit afterwards – do not rinse.
Dentures	1. Remove after each meal and rinse dentures and mouth with water 2. Brush with toothbrush at least once per day with unperfumed soap and water or denture cream. Repeat this prior to overnight soaking. 3. Plastic dentures should be brushed then soaked for 20 mins in a fresh solution of hypochlorite (1 part to 80 parts cold water/1/2 a teaspoon) in a patient named individual denture bowl. Then rinse and place in fresh water overnight. Dentures with metal parts should be soaked in chlorhexidine 0.2%. All dentures should be rinsed with cold water before replacing in mouth. 4. Clean palate, gum ridges and tongue with a soft toothbrush or thoroughly moistened foam stick. 5. Dentures must be stored in a named denture container when not in mouth. NOTE: if unable to carry out the above, clean mouth with foam stick thoroughly moistened in water, twice a day.
Standard Care 2	
Dry mouth (Xerostomia)	• Follow Care Standard 1 and..... • Review medications that may cause dry mouth • 2 hourly mouth care, i.e. water to rinse and water based lubricating gel to dry lips. * see guidelines regarding use of gels. • Foam sticks thoroughly moistened in water to tongue and mucosa if unable to rinse • Frequent sips or sprays of water or crushed ice cubes are as effective and often preferable to artificial products so should be first choice • Saliva replacement products.e.g. Biotene gel or mouthwash
Standard Care 3	
Obvious plaque/ swollen or bleeding gums or dry/crusted mouth	• Follow Care Standard 1 and..... • Remove debris with a medium headed tooth brush with fluoridated toothpaste or thoroughly moistened foam stick • Using water rinse 4 times daily • Chlorhexidine mouthwash, spray or gel (do not use for more than 1 month)
Standard Care 4	
Infection	• Follow Care Standard 1 and..... • Seek medical/dental advice for appropriate treatment

For further advice please contact the Oral Health Department via email for advice from an oral health promoter FV-UHBoralhealthenquiries@nhs.net

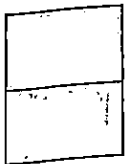
COPY

26 .

COPY

Ensure care given is documented daily.

[illegible]



Stool Chart COPY

Identify type of stool using Bristol Stool Form Scale. Record every episode of stool.

Bristol Stool Scale

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. Entirely liquid

In the boxes below record any bowel pattern change, if patient is on aperients or has a history of bowel disease, or if a specimen has been sent.

Date:	Date:	Date: Action taken:	Date:
Date:	Date:	Date:	Any other comments:

PERIPHERAL VASCULAR CATHETER (PVC) DAILY MAINTENANCE

Label
CHI: 2602800570
26/02/1980
DOWELL Scott
11 DON STREET,
GRANGEMOUTH,
STIRLINGSHIRE FK3 8HD

Reason for insertion:

Testicular pain

COPY

Insertion Date: 6/2/18

Time: 08:15

Colour/batch no:

Position: D ACF

Hand hygiene (HH) performed

Yes No

Skin cleansed for 30 seconds with antiseptic & left to dry prior to insertion

Yes No

Aseptic technique throughout

Yes No

Sterile dressing applied including date and time

Yes No

Inserted by:

SBGO

Ward inserted:

SALU

Ensure that:

Medical staff review the need for intravenous (IV) therapy including antibiotics on a daily basis – switch to oral if possible

An antiseptic containing 70% isopropyl alcohol is used to clean the access hub. Before accessing, rub the access hub for at least 15 seconds ("scrub the hub")

MODIFIED VIP (VISUAL INFUSION PHLEBITIS) SCORE

IV appears healthy	0	No phlebitis:	Observe cannula.
One or the following is evident: Slight pain or redness near site	1	Possible first sign:	Remove & replace cannula. Observe both sites and document. Obtain swab
Two or more of the following are evident: Pain, redness or swelling	2	Early stages of phlebitis:	Remove & replace cannula. Observe both sites and document. Treat if necessary. Obtain swab
All of the following are evident: Pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis	Remove and seek further advice. Obtain swab
Swelling above including palpable venous cord	4		Remove and seek further advice. Obtain swab
Swelling above including pyrexia	5		Seek further advice.

24 hours Date: 7/2/18 Time: 08:15

Is PVC still required	YES	NO
Absence of inflammation/extravasation	YES	NO
VIP score - please circle	0 1 2 3 4 5	
PVC dressing intact	YES	NO
PVC inserted <72 hrs	YES	NO
HH before/after procedure	YES	NO
"Scrub the Hub" (before use)	YES	NO
PVC - please circle	Left in situ	removed

Reason for removal:

Signature: *[Signature]*

48 hours Date: Time:

Is PVC still required	YES	NO
Absence of inflammation/extravasation	YES	NO
VIP score - please circle	0 1 2 3 4 5	
PVC dressing intact	YES	NO
PVC inserted <72 hrs	YES	NO
HH before/after procedure	YES	NO
"Scrub the Hub" (before use)	YES	NO
PVC - please circle	Left in situ	removed

Reason for removal:

Signature:

72 hours Date: Time:

Is PVC still required	YES	NO
Absence of inflammation/extravasation	YES	NO
VIP score - please circle	0 1 2 3 4 5	
PVC dressing intact	YES	NO
PVC inserted <72 hrs	YES	NO
HH before/after procedure	YES	NO
"Scrub the Hub" (before use)	YES	NO
PVC - please circle	Left in situ	removed

Reason left in situ:

Discussed with:

Reason for removal:

Signature:

If PVC to remain in situ for longer than 72 hours this must be documented on a daily basis in notes and discussed with medical staff.

Observe closely for clinical signs and symptoms of Phlebitis.

New sheet to be commenced.

Carbapenemase-Producing *Enterobacteriaceae*

Clinical risk Assessment

COPY

CHI: 2602800570

26/02/1980

M

DOWELL Scott

11 DON STREET,

GRANGEMOUTH,

STIRLINGSHIRE FK3 8HD

Clinical risk assessment (CRA) for Carbapenemase Producing *Enterobacteriaceae* (CPE) for ALL PATIENTS admitted to acute hospital:

CRA allows for the early identification of patients who are at risk of being positive with CPE and will allow for appropriate placement of suspected / confirmed cases.

CRA Questions	Response
Has the patient had any previous history of CPE?	YES ☒ NO
Has the patient been transferred directly from another hospital out with NHS Forth Valley?	YES ☒ NO
Has the patient a history of admission to a hospital outside Scotland in the last 12 months? (including dialysis patients)	YES ☒ NO
Has the patient been in close contact of a person who is colonised or infected with CPE?	YES ☒ NO
Name of Person completing CRA	DATE

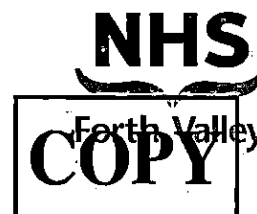
C. J. W. 6/2/17

A **YES** response to **any** of the above questions suggests the patient has an increased risk of CPE and the following actions must be taken:

1. Isolate patient in a single side room and implement contact precautions;
2. Give patient the information leaflet - CPE Screening Information for Patients and obtain consent for screening;
3. Obtain CPE screen: Rectal swab or stool specimen **AND** if present take a wound swab and/or catheter specimen urine;
4. Children under 16 years must **NOT** have rectal swab sent – stool sample to be obtained.

Screen required	Yes/ No	Results	Signature	Date
1 st screen				
2 nd screen				
3 rd screen				

Isolation can be discontinued when there are three negative results taken 48 hours apart



NHS Forth Valley Tobacco Policy

PATIENTS LEAVING HOSPITAL PREMISES TO SMOKE

As smoking is the biggest single cause of ill health in Scotland, NHS Forth Valley does not permit smoking in any of its premises including the grounds and car parks. It is also against the law in Scotland to smoke in any enclosed public place.

What this means for you?

- If you wish to smoke you must leave NHS Forth Valley premises to do so, this includes the grounds. You do this is against medical advice.

How we can help?

- Assistance is available to help you to stop smoking and to alleviate withdrawal symptoms.
- Nicotine Replacement therapy can be prescribed for you during your stay.
- Specialist Stop Smoking support is available from trained nurses who can come to the ward/department to discuss with you how they can help.

I have read and understand that I must leave NHS Forth Valley premises if I wish to smoke.

I understand if I choose to do so this will be at my own risk to my health, safety and well-being and that of others and is against medical advice.

I understand it is illegal to smoke in any enclosed public space.

Name: Scott Donnell

CHI Number: 2602800570

Ward or Department: SAU

Hospital: FVRH

Signature: (patient) Scott Donnell

Date: 07/02/18

☐ If you **DO NOT** wish to speak to a Specialist Stop Smoking Nurse please tick here.

WHITE COPY – FOR PATIENTS NOTES

YELLOW COPY – PATIENT

PINK COPY – STOP SMOKING DEPT, GROUND FLOOR CLINICAL OFFICE, FVRH

FORTH VALLEY ACUTE HOSPITALS
Infusion Fluids / Blood Products Page

WARD	CONSISTANT	PATIENT DETAILS: (Name and Address)
ALLI	CHI: 2602800570 26/02/1980 M	COPY
HEIG (m)	DOWELL Scott 11 DON STREET, GRANGEMOUTH, STIRLINGSHIRE FK3 8HD	
	FACE AREA (m ²)	
		HOSPITAL No:
		HOSPITAL SITE:
		DATE OF BIRTH:
		AGE:

• enter dosage times as 24hour clock

• please write in block capitals in black pen
• IV site MUST be checked prior to and after IV administration

A	APPROVED DRUG NAME	DOSE	ROUTE	START TIME 7/2/18	INFUSION STARTED BY:
	INFUSION FLUID Hydramin	TOTAL VOLUME 500mls		TIME STARTED 0055	W J M
	DOCTORS SIGNATURE K. ROBERTSON	DATE 6/2/18	RATE 60	PUMP NO.	
					BATCH NO. 170674611/19
B	APPROVED DRUG NAME	DOSE	ROUTE	START TIME 7/2/18	INFUSION STARTED BY:
	INFUSION FLUID Opic Water	TOTAL VOLUME 500mls		TIME STARTED 0900	W J M
	DOCTORS SIGNATURE K. ROBERTSON	DATE 6/2/18	RATE 60	PUMP NO.	
					BATCH NO. 170674611/19
C	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
	INFUSION FLUID 5% Dextrose	TOTAL VOLUME 500mls		TIME STARTED	
	DOCTORS SIGNATURE K. ROBERTSON	DATE 6/2/18	RATE 60	PUMP NO.	BATCH NO.
D	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
	INFUSION FLUID	TOTAL VOLUME		TIME STARTED	
	DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.
E	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
	INFUSION FLUID	TOTAL VOLUME		TIME STARTED	
	DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.
F	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
	INFUSION FLUID	TOTAL VOLUME		TIME STARTED	
	DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.
G	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
	INFUSION FLUID	TOTAL VOLUME		TIME STARTED	
	DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.
H	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
	INFUSION FLUID	TOTAL VOLUME		TIME STARTED	
	DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.

ASSESSMENT & CARE PLAN BOOKLET

CHI NO: 2602800570 26/02/1980
CRN: S679370 M
SCOTT DOWELL
11 DON STREET,
GRANGEMOUTH,
STIRLINGSHIRE
FK3 8HD

Date of Admission: 20/7/18
Time of Admission: 084
Ward admitted to: B23
Date of transfer:
Ward transferred to:
Booklet number:

Assessment	Initial assessment to be completed within:	Initials	Re-assessment code
NEWS	On admission		
Hydration	4 hours		
MRSA	On admission		
Pressure Areas	6 – 8 hours		
4AT	6 hours		
Falls risk	6 hours		
Bed rails	12 hours		
MUST	24 hours		
Pt handling & mobility	24 hours		
Personal hygiene	24 hours		
Oral care	24 hours		
Continence	24 hours		
Elimination	24 hours		

	Assess on admission- >24 hours
	Assess daily
	Assess weekly
	Review when condition changes
	Assess 2-4 weekly

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

ASSESSMENT & CARE PLAN BOOKLET

Affix addressograph here

Scott Dave
2602800570

Date of Admission: 20.7.18
Time of Admission:
Ward admitted to: B23
Date of transfer:
Ward transferred to:
Booklet number: ①

Assessment	Initial assessment to be completed within:	Initials	Re-assessment code
NEWS	On admission		
Hydration	4 hours		
MRSA	On admission		
Pressure Areas	6 – 8 hours		
4AT	6 hours		
Falls risk	6 hours		
Bed rails	12 hours		
MUST	24 hours		
Pt handling & mobility	24 hours		
Personal hygiene	24 hours		
Oral care	24 hours		
Continence	24 hours		
Elimination	24 hours		

	Assess on admission- >24 hours
	Assess daily
	Assess weekly
	Review when condition changes
	Assess 2-4 weekly

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

COPY

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

Staff identification – must be completed by all staff prior to recording in this document

Date	Designation	Print name	Signature	Initials
22/7/18	SN	MOCONNOR	McDonnort	MOB

Planning for Discharge

COPY

Predicted date for discharge:

Pre-discharge	Date	Comments	Initials
Patient involved in discharge planning			
Is patient homeless or has housing issues?			
Family/carers involved in discharge planning re POC, meds, equipment			
Drug compliance aid			
Controlled drugs			
Referral to community based services i.e. POC, SW ref; confirmed start date			
Catheter for discharge, dressings, equipment etc			
Provide written information to patient/family/carers e.g. what level of POC, meds discussed, Getting To Know Me, D/C leaflet. Contact numbers as appropriate. Follow up appointment			
Key to house available			
Access issues			
Any valuables returned			
Transport method: Booking ref number:			
Outdoor clothing available for discharge			
District nurse involvement and aware of discharge date			
DN letter released			
Day of Discharge			
Discharge prescription checked by nursing staff and available on ward			
Medical discharge letter completed & given to patient/carer			
Compliance aid			
AWI in place and complete			
DNACPR in place and communicated to patient and family			
PVC removed			
Patient experience questionnaire given			

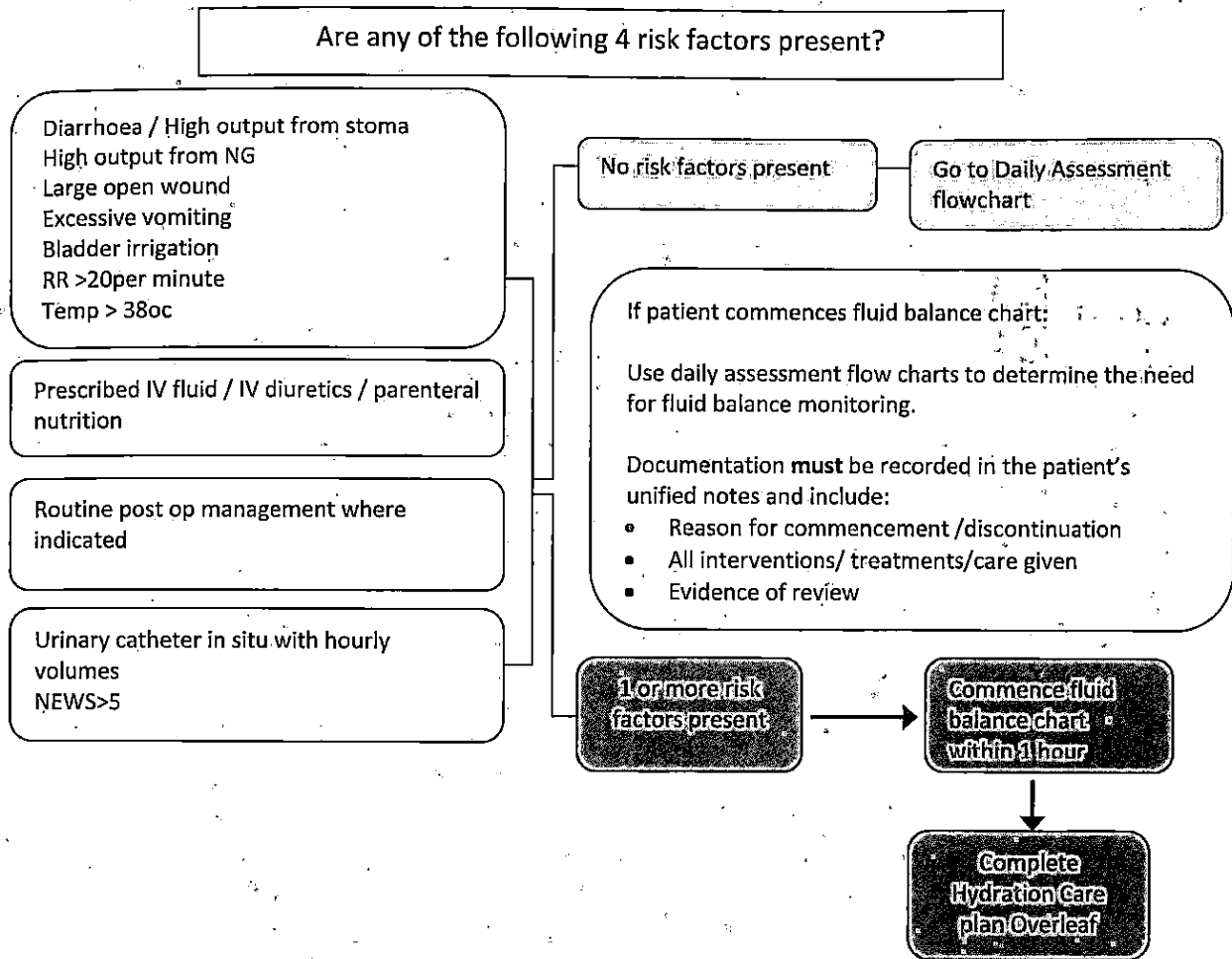
COPY

4

Hydration Assessment

COPY

Risk assessment should be carried out within 4 hrs of admission



Daily Assessment and Review

Risk Assessment	Date/Time	Date	Date	Date	Date	Date	Date
	21.7.18 0235	22/7					
Number of Risks present	2	1					
Fluid Balance monitoring indicated Y= Yes N= No	y	y					
Initials of assessor	MOB	MOB					

PTO

Daily Hydration Care plan

Fluid Preferences on MUST

	Frequency of assessments	Date & Time Assessed with comments	Date & Time Re assessed with comments	Date & Time Re assessed with comments	Date & Time Re assessed with comments	Date & Time Re assessed with comments	Date & Time Re assessed with comments	Date & Time Re assessed with comments
Commence requirement of fluid balance chart if one or more risks are identified	Daily or change in clinical condition	21.7.18 0235 commenced	22/7/18 disc.					
Set daily fluid balance target with medical team.	Daily (At Ward Round)	RV						
Review 24hr fluid balance document in unified notes and discuss with medical team	Daily							
Offer beverages at every Care & Comfort round (if appropriate) and document intake	Continuous	yes						
Encourage patient, family or Carer to be involved with fluid intake and recording (Provide pictorial fluid chart)	Daily	yes						
Describe patient's individual needs	Daily	encourage	Ind.					
Signature		alg	mob					

COPY

Infection Prevention and Control Risk

Assessment
COPY

On admission, **ALL** patients must be assessed for risk of infection and action taken to minimise the risk.

MRSA Clinical Risk Assessment All questions must be answered

pre op?

1	Has the patient any history of MRSA (check ward and clinical portal)	YES	NO
2	Has the patient been admitted from anywhere other than their own home (e.g.) care home, prison, hostel or transferred from another hospital	YES	NO
3	Does the patient have any wounds / ulcers or indwelling medical devices (e.g. urinary catheter, PEG, Hickman line, etc)	YES	NO
4	Is the patient being admitted / transferred to ITU, B23 or B31	YES	NO

A **YES** response to questions 1, 2 or 3 indicates there is a risk of MRSA skin carriage. The patient **must be isolated in a single room and swabs taken.**

A **YES** response to question 4 confirms admission to high risk speciality and the patient must have an **MRSA screen sent.**

MRSA ADMISSION SCREEN – swabs from nose, perineum, wounds and invasive device insertion site. Also send a CSU if urinary catheter is present. **NOTE:** this is the minimal screen required and additional swabs can be sent if clinically indicated.

Patients with the following presentations also require isolation in a single room:
Multi drug resistant organisms e.g. CPE, VRE (check ward and clinical portal)
Suspected infective diarrhoea e.g., <i>C.diff</i> , food poisoning, Norovirus
Suspected or confirmed Influenza
Suspected or confirmed Pulmonary Tuberculosis (TB)
Fever in a returning traveller
New or unexplained rashes (consider Scabies)
Suspected infective rash e.g. measles, rubella, chickenpox, shingles
Suspected meningitis or encephalitis
Transfers from other hospitals, including community hospitals & care homes
Immunosuppressed patients

Name of nurse completing risk assessment.	Signature	Date

Prevention of Pressure Injury Assessment

Record your answer in the grid below Y = Yes N = No

If the answer is NO to any statement or there is a notable change in the patient's condition, undertake a Braden risk assessment and consider any other relevant assessment.

Date	Time	Person is fully mobile without equipment or assistance	Person is fully continent	Person appears well nourished and able to eat /drink	Skin to pressure points satisfactory and intact (observed)	Review these questions every 24 hours if no initial risk identified	Braden requires completion	Signature	Skin description - i.e.: Redness, Skin Broken, Blister/Ulcer	Action Taken:
2/7	0235	n	y	y	y	y	y	AB	labute	

BRADEN RISK ASSESSMENT CHART

Individuals with a total score of 16 or less are considered at risk: 15-16 = low risk, 12-14 = moderate risk, 11 or less = high risk.

Undertake and document risk assessment within 8 hours of admission to every ward or department or on first home visit. Reassess if there is a change in individual's condition and repeat regularly according to local protocol

Complete care and comfort round chart.

Consider contributing factors, frailty, diabetes, end of life care.

Sensory Perception – Ability to respond meaningfully to pressure related discomfort	1. Completely Limited Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body surface.	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment that limits the ability to feel pain or discomfort over ½ of body.	3. Slightly Limited Responds to verbal commands but cannot always communicate discomfort or need to be turned. OR has some sensory impairment that limits ability to feel pain or discomfort in 1 or 2 extremities.	4. No Impairment Responds to verbal commands. Has no sensory deficit that would limit ability to feel or voice pain or discomfort.	3	3					
					3	3					
Moisture – Degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient/client is moved or turned.	2. Very Moist Skin is often but not always, moist. Linen must be changed at least once a shift.	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day.	4. Rarely Moist Skin is usually dry. Linen only requires changing at routine intervals.	3	3					
					3	3					
Activity – Degree of physical activity	1. Bedfast Confined to bed.	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. Walks Occasionally Walks occasionally during day but for very short distance, with or without assistance. Spends majority of each shift in bed or chair.	4. Walks Frequently Walks outside the room at least twice a day and inside the room every 2 hours during waking hours.	1	3					
Mobility – Ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance.	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	3. Slightly limited Makes frequent though slight changes in body or extremity position independently.	4. No Limitations Makes major and frequent changes in position without assistance.	2	3					
Nutrition – Usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IV's for more than 5 days.	2. Probably Inadequate Rarely eats a complete meal and generally eats only about ½ of any food offered. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding.	3. Adequate Eats over half of most meals. Occasionally will refuse meal but will usually take a supplement if offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	4. Excellent Eats most of every meal. Never refuses a meal. Occasionally eats between meals. Does not require supplementation.	3	3					
Friction and Shear –	1. Problem Requires moderate to maximum assistance in moving.	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.			2	2				
Indicate appropriate number and add for total score						TOTAL SCORE:	14	17	COPY		
						SIGNATURE:	AB	mod			

COPY

Prevention of Pressure Injury, Assessment

TOTAL BRADEN SCORE INDICATES THAT THE PATIENT IS:	EQUIPMENT AND ACTION WHICH SHOULD BE <u>CONSIDERED</u> FOR EACH "AT RISK" CATEGORY:	
17+ : NOT AT RISK	Depending on patient's individual requirements an overlay may be required for comfort e.g. Repose/Propad	
15 – 16 : LOW RISK	- Pressure reducing mattress e.g. SOFTFORM/PENTAFLEX - Mattress Overlay e.g. Repose - Daily skin inspection should be documented in care plan or nursing notes	
12 – 14 : MODERATE RISK	- If skin is intact, use pressure reducing mattress e.g. SOFTFORM/PENTAFLEX - Mattress overlay e.g. Repose OR - If skin is broken up to a Stage 2 pressure ulcer, - Mattress overlay e.g. Repose or an active pressure relieving mattress overlay e.g. Soft form premiere active, Tamora (Community) - Daily Braden risk assessment - Twice daily skin inspection and document in care plan or unified notes - Implement turning schedule – reposition changes 2-4 hrly and document in care plan	
9 – 11 : HIGH RISK	- If skin is broken up to a Stage 3 pressure ulcer - Alternating Dynamic Pressure System, e.g. Softform premiere active, Tamora (Community) NIMBUS (Acute) - Daily Braden risk assessment - Implement turning schedule – reposition changes 2-4 hrly and document in care plan - Skin inspection at each reposition change and document in nursing notes	
6 – 8 : SEVERE RISK	- If skin is broken up to a Stage 4 pressure ulcer - Alternating Dynamic Pressure System e.g. NIMBUS, (Community only Softair, Tamora) - Daily Braden risk assessment - Implement turning schedule – reposition changes 2 hrly and document in care plan - Skin inspection at each reposition change and document in nursing notes	
When an area of redness or discolouration is noted further action is required. Skin inspection, findings and action taken must be documented in patient health records	- If patient is out of bed, a pressure reducing / relieving seating system comparable to the equipment used on the bed should be considered, e.g. Repose, Active Seat Cushion. Patients should be encouraged to reposition at least every 30 minutes and be assisted if unable to do so - In community setting this can be advised.	
SPECIALISED EQUIPMENT		
TYPE OF EQUIPMENT / AID	DATE COMMENCED	DATE DISCONTINUED
Contact Tissue Viability Service for advice and support 01324 673747		

COPY

--	--

COPY

10

THE 4AT TEST: SCREENING INSTRUMENT FOR COGNITIVE IMPAIRMENT AND DELIRIUM

TO BE COMPLETED FOR **ALL** PATIENTS OVER 65 ON ADMISSION AND WHEN A CHANGE IN PRESENTATION IS EVIDENT

*MDT DECIDED INAPPROPRIATE DUE TO CLINICAL PRESENTATION Signed..... Date.....
(ensure documented in clinical notes)

DATE		1/1	1/2	1/3	1/4	1/5	1/6	1/7	
1. ALERTNESS: This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. If asleep, attempt to wake and ask the patient to state their name and address to assist rating.		Normal (fully alert, but not agitated throughout assessment)	0	0	0	0	0	0	0
		Mild sleepiness for <10 seconds after waking, then normal	0	0	0	0	0	0	
		Clearly abnormal (agitated or drowsy)	4	4	4	4	4	4	
2. AMT4: Age, date of birth, place (name of hospital or building), current year		No mistakes	0	0	0	0	0	0	
		1 mistake	1	1	1	1	1	1	
		2 or more mistakes/un-testable	2	2	2	2	2	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.		Achieves 7 months or more correctly	0	0	0	0	0	0	
		Starts but scores <7 months/refuses to start	1	1	1	1	1	1	
		Un-testable (cannot start because unwell, drowsy, inattentive)	2	2	2	2	2	2	
4. ACUTE CHANGE OR FLUCTUATING COURSE: Evidence of significant change or fluctuation in: alertness, cognition (e.g. increased confusion) or other mental function arising over the last 2 weeks and still evident in last 24hrs		No	0	0	0	0	0	0	
		Yes	4	4	4	4	4	4	
Initials of tester →									
4 or above:	Possible delirium +/- cognitive impairment - score daily until score <4 for 2 consecutive days	Day 1 4ATscore	Day 2 4ATscore	Day 3 4ATscore	Day 4 4ATscore	Day 5 4ATscore	Day 6 4ATscore	Day 7 4ATscore	
1-3:	Possible cognitive impairment - only rescore if condition changes								
0:	Delirium or cognitive impairment unlikely - only rescore if condition changes								
4 or above - initiate TIME bundle and consider need for section 47 of Adults with Incapacity Act.									
1-3 - if no diagnosis of dementia obtain AMT10 and collateral history and refer to Liaison Psychiatry for Older People if any concerns regarding normal level of cognition.									

COPY

Falls Trigger Tool

Age 65 Years or older?	Yes	☒ No	4AT more than 4 or AMT 10 score 8 or less or acute confusion?	Yes	☒ No
Has the person fallen in last 6 months?	Yes	☒ No	Based on clinical judgement is this person at risk of falling?	Yes	☒ No
Tries to walk alone but unsteady/safe?	Yes	☒ No	Date:	21.7.18	
If "yes" to more than one question complete Falls Care Plan			Time:	0240	

Falls Care Plan. (Complete weekly or if any changes to patients condition)

	Risk Factor	Considerations/Actions	All lines must be completed by circling response	Comments	All lines must be completed by circling response	Comments
F	Footwear	Ensure appropriate footwear available: Walking aid required:	Yes / No Yes / No		Yes / No Yes / No	
	Function	State type of aid:				
	Family	Leaflet given to patient/ relatives falls/falls prevention:	Yes / No		Yes / No	
A	Cognitive Impairment	Walking aid available and within arm's reach at all times: (IF NO PLEASE DOCUMENT REASON WHY) If Physio/OT input required document date of referral	Yes / No / NA		Yes / No / NA	
		If patient has delirium or cognitive impairment, complete 4AT IF >4 INITIATE TIME BUNDLE				
		Can they use the call bell: (IF NO PLEASE DOCUMENT)	Yes / No		Yes / No	
		Consider individual risk assessment i.e. enhanced observations	Yes / No		Yes / No	
		Increased comfort rounds/ general observations/use strategies to try to reduce stress for patient	Yes / No		Yes / No	
		Please consider attachments i.e. (catheters, oxygen tubing, drip stands)				
L	Location	Ensure patient is in the most appropriate bed space To minimise risk of falls	Yes / No		Yes / No	
		Ensure patients who have been identified as a higher risk of falls have the RED LEAF protocol initiated	Yes/No		Yes/No	
		HI/LO Bed Required	Yes/No		Yes/No	
		Consider toileting arrangements for patient	Yes/No		Yes/No	
	Medication	Consider increase risk of falls due to medicines, Discuss with medical staff				
L/S	Hypotension	Measure lying and standing blood pressure (if not taken please document why) See NEWS Chart	Yes / No		Yes / No	
S	Sensory	Glasses if required are available:	Yes / No / NA		Yes / No / NA	
		Hearing Aid if required is available	Yes / No / NA		Yes / No / NA	
				Date & Initials:		
					Date & Initials:	

COPY

	Risk Factor	Circle response	Comments	Circle response	Comments	Circle response	Comments	Circle response	Comments	
F	Footwear	Yes / No Yes / No		Yes / No Yes / No		Yes / No Yes / No		Yes / No Yes / No		
	Function									
	Family	Yes / No		Yes / No		Yes / No		Yes / No		
A	Cognitive Impairment	Yes / No / NA		Yes / No / NA		Yes / No / NA		Yes / No / NA		
		Yes / No		Yes / No		Yes / No		Yes / No		
		Yes / No		Yes / No		Yes / No		Yes / No		
		Yes / No		Yes / No		Yes / No		Yes / No		
L	Location	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		
	Medication									
L/S	Hypotension	Yes / No		Yes / No		Yes / No		Yes / No		
S	Sensory	Yes / No / NA		Yes / No / NA		Yes / No / NA		Yes / No / NA		
		Yes / No / NA		Yes / No / NA		Yes / No / NA		Yes / No / NA		
			Date & Initials:				Date & Initials:			

COPY

Bedrails Assessment

COPY

INFORMATION: Use Part 1,2 and 3 below in combination with nursing judgement to inform your decision whether to use or not to use bedrails

- Patients with capacity can make their own decisions about bedrails, however not to be used as a moving and handling aid
- Patients with visual impairment may be more vulnerable to falling from bed
- Patients with involuntary movements (eg spasms) may be more vulnerable to falling from bed and if bedrails are used, may need padded covers

Part 1 – assess mobility & mental state factors		MOBILITY FACTORS			
		Patient is very immobile (bedfast or hoist dependent)	Patient is neither independent nor immobile	Patient can mobilise without help from staff	
MENTAL STATE FACTORS	Patient is confused and disorientated	Use bedrails with care	Bedrails NOT recommended	Bedrails NOT recommended	
	Patient is drowsy	Bedrails recommended	Use bedrails with care	Bedrails NOT recommended	
	Patient is orientated and alert	Bedrails recommended	Bedrails recommended	Bedrails NOT recommended	
	Patient is unconscious	Bedrails recommended	N/A	N/A	
Part 2 – assess the following additional patient and fitting risks				Yes	No
1. Is the patient confused and mobile enough to attempt to climb over the bedrail?					✓
2. Is the patient small enough to pass between the bedrails? Eg a child or unusually small adult?					✓
3. Are there any gaps that could cause an entrapment risk to the patients' body or head? <i>Consider each of the following to answer the above question....</i>					✓
a. Entrapment gaps between the bars of the bedrail					
b. Entrapment gaps between bedrail and side of overlay mattress					
c. Does the mattress compress easily at the edge to increase the gap between the bedrail and the mattress					
d. Entrapment gaps between footboard and end of side rail					
e. Entrapment gaps between head board and end of side rail					
4. The extra height caused by an overlay mattress <u>must not</u> compromise the safety of the bedrail. The recommended height of the top edge of the bed rail above the mattress (without compression) is to be more than 22cm.220mm . Have you assessed the potential for the person to roll over the bed rail?					✓
NOTE: If answer to Q's 1,2 or 3 is YES then bed rails are NOT APPROPRIATE and alternative methods must be considered.					

INFORMATION: the assessment must be reviewed/reassessed if:

- Medical or mental state changes e.g. patient becomes confused, disorientated, agitated, drowsy or unconscious
- Changes are made to bed, mattress or type of bedrails
- The bedrail has been moved out of position

Now complete Part 3 overleaf.....

Part 3 – outcome/assessment decision

15

'MUST' – Nutritional Risk Screening

STEP 1 (BMI)	STEP 2 (Weight Loss)	STEP 3 (Acute Disease Effect)	*If weight not measured please indicate how this was obtained (see key below)	COPY *If weight not measured please indicate how this was obtained (see key below)
Weight (Kgs) * = <u>58</u> Height (m) * = <u>1.72</u> Method used M,R,C* BMI See BMI charts Greater than 20 score 0 5 – 20 score 1 Less than 18.5 score 2 (greater than 30=obese)	Pre-illness weight = Total unplanned weight loss over 3-6 months Weight loss (kg) = Complete with weight loss chart Less than 5% score 0 5-10% score 1 Greater than 10% score 2	Acute illness AND there has been or is likely to be no nutritional intake for 5 days No score 0 Yes score 2	M - Measured R - Reported C - Based solely on clinical impression (See "Ward information pack" for alternative measures)	M - Measured R - Reported C - Based solely on clinical impression (See "Ward information pack" for alternative measures)
STEP 4 (Overall Risk Score) Add scores from steps 1+2+3 to calculate overall risk score SCORE 0 = LOW RISK SCORE 1 = MEDIUM RISK SCORE 2+ = HIGH If risk category arrived at by clinical impression alone, indicate risk category LOW/MEDIUM/HIGH in table below and document rationale in progress notes		STEP 5 (Care Plan) Implement appropriate Nutritional Care Plan 0 = LOW RISK 1 = MEDIUM RISK 2 = HIGH RISK Treat as High Risk - immediate Dietetic Referral •Dysphagia • Decompensated Liver Disease • Enteral Tube Feeding • Multiple Fractures • Pressure Ulcers Grade 3 or more		

'MUST' SCREENING AND RESCREENING

Pre-illness weight

Initial screening

Date	Time	Ward	Weight (kg)*	Weight ↑↔↓	Method used (M,R,C)	BMI	Step 1 Score	Step 2 Score	Step 3 Score	Total Score	MUST' Risk	Initial
21-7-8	02 ⁴⁰	B23	—	—	reported	29	0	0	0	0	low	gg

Rescreening

Date	Time	Ward	Weight (kg)*	Weight ↑↔↓	Method used (M,R,C)	BMI	Step 1 Score	Step 2 Score	Step 3 Score	Total Score	MUST' Risk	Initial

'MUST': Low Risk Nutrition Care Plan

COPY

Date care plan initiated: 21.7.18

Intervention	Time Frequency	Initial/Date
Has patient been informed of current weight and plan?	Yes/No	J 21.7.18
Discuss the results of the 'MUST' screening/care plan with the patient and family (with agreement and involve them in identifying individualised interventions)	On admission & on-going	
Monitor patients weight and rescreen 'MUST' risk weekly or if patient's weight has remained stable for 4 weeks – screen monthly.	On admission	

Please ✓ relevant box and where yes is answered, record details of individual requirement below;

Food Allergy- No ☒ Yes ☐ Religious, cultural, ethnic requirements- No ☐ Yes ☒

Details:	Initial/Date

Therapeutic diet-No ☒ Yes ☐

Details:	Initial/Date

Assistance required with eating/drinking- No ☒ Yes ☐ Adapted cutlery/aids- No ☒ Yes ☐

Details:	Initial/Date

Specific food preferences (patients unable to make decisions on their food and fluid choices should have a detailed dietary and fluid preference recorded)

Details:

Is patient able to make own choices? yes/no
 Yes – patient offered daily menu
 No – for patient unable to make choices has food and fluid preferences been recorded on 'my dietary information sheet' yes/no

CARE PLAN REVIEW

Discuss current weight and plan with patient (initiate new care plan if risk has changed) *Share with relative/carer where appropriate

Initial/Date	Initial/Date	Initial/Date	Initial/Date	Initial/Date
Initial/Date	Initial/Date	Initial/Date	Initial/Date	Initial/Date

'MUST': Medium Risk Nutrition Care Plan

COPY

Date care plan initiated:

Intervention	Time Frequency	Initial/Date
Has patient been informed of current weight and plan? Discuss the results of the 'MUST' screening/care plan with the patient and family (with agreement and involve them in identifying individualised interventions)	Yes/No On admission & on-going	
Monitor patient's weight and rescreen 'MUST' risk weekly or if patient's weight has remained stable for 4 weeks – screen monthly.	On admission	
Optimise nutritional intake by offering • nourishing milky drinks • regular snacks • 3 courses at midday and evening meal Has signifier been added to patient's and kitchen whiteboards?	Daily Yes/no	

Please ✓ relevant box and where yes is answered, record details of individual requirement below;

Food Allergy- No ☐ Yes ☐ Religious, cultural, ethnic requirements- No ☐ Yes ☐

Details:	Initial/Date

Therapeutic diet -No ☐ Yes ☐

Details:	Initial/Date

Assistance required with eating/drinking- No ☐ Yes ☐ Adapted cutlery/aids- No ☐ Yes ☐

Details:	Initial/Date

Specific food preferences (patients unable to make decisions on their food and fluid choices should have a detailed dietary and fluid preference recorded)

Details:	
Is patient able to make own choices?	yes/no
Yes – patient offered daily menu	
No – for patient unable to make choices has food and fluid preferences been recorded on 'my dietary information sheet'	yes/no

CARE PLAN REVIEW

Discuss current weight and plan with patient (initiate new care plan if risk has changed) *Share with relative/carer where appropriate

Initial/Date	Initial/Date	Initial/Date	Initial/Date	Initial/Date
Initial/Date	Initial/Date	Initial/Date	Initial/Date	Initial/Date

'MUST': High Risk Nutrition Care Plan

Date care plan initiated:

COPY
Initial/Date

Intervention	Time Frequency	Initial/Date
Has patient been informed of current weight and plan?	Yes/No	
Discuss the results of the 'MUST' screening/care plan with the patient and family (with agreement and involve them in identifying individualised interventions)	On admission & on-going	
Weigh patient and rescreen	Weekly	
Refer to Dietitian with 'MUST' score, BMI and weight loss		
Complete dietary food record charts	Until assessed by dietitian	
Optimise nutritional intake by offering - nourishing milky drinks - regular snacks 3 courses at midday and evening meal	Daily	
Has signifier been added to patient's and kitchen white boards?	Yes/no	

Please ✓ relevant box and where yes is answered, record details of individual requirement below;

Food Allergy- No ☐ Yes ☐

Religious, cultural, ethnic requirements - No ☐ Yes ☐

Details:	Initial/Date

Therapeutic diet- No ☐ Yes ☐

Details:	Initial/Date

Assistance required with eating/drinking- No ☐ Yes ☐

Adapted cutlery/aids - No ☐ Yes ☐

Details:	Initial/Date

Specific food preferences (patients unable to make decisions on their food and fluid choices should have a detailed dietary and fluid preference recorded)

Details:	
Is patient able to make own choices ?	yes/no
Yes – patient offered daily menu	
No – for patient unable to make choices has food and fluid choices been recorded on 'my dietary information sheet'	yes/no

CARE PLAN REVIEW

Discuss current weight and plan with patient (initiate new care plan if risk has changed) *Share with relative/carer where appropriate

Initial/Date	Initial/Date	Initial/Date	Initial/Date	Initial/Date
Initial/Date	Initial/Date	Initial/Date	Initial/Date	Initial/Date

Height (feet and inches)

Weight (kg)		Weight (stones and pounds)		Height (ft and inches)	
100	220	14	0	5	0
101	222	14	1	0	0
102	224	14	2	0	0
103	226	14	3	0	0
104	228	14	4	0	0
105	230	14	5	0	0
106	232	14	6	0	0
107	234	14	7	0	0
108	236	14	8	0	0
109	238	14	9	0	0
110	240	14	10	0	0
111	242	14	11	0	0
112	244	14	12	0	0
113	246	15	0	0	0
114	248	15	1	0	0
115	250	15	2	0	0
116	252	15	3	0	0
117	254	15	4	0	0
118	256	15	5	0	0
119	258	15	6	0	0
120	260	15	7	0	0
121	262	15	8	0	0
122	264	15	9	0	0
123	266	15	10	0	0
124	268	15	11	0	0
125	270	15	12	0	0
126	272	16	0	0	0
127	274	16	1	0	0
128	276	16	2	0	0
129	278	16	3	0	0
130	280	16	4	0	0
131	282	16	5	0	0
132	284	16	6	0	0
133	286	16	7	0	0
134	288	16	8	0	0
135	290	16	9	0	0
136	292	16	10	0	0
137	294	16	11	0	0
138	296	17	0	0	0
139	298	17	1	0	0
140	300	17	2	0	0
141	302	17	3	0	0
142	304	17	4	0	0
143	306	17	5	0	0
144	308	17	6	0	0
145	310	17	7	0	0
146	312	17	8	0	0
147	314	17	9	0	0
148	316	17	10	0	0
149	318	17	11	0	0
150	320	18	0	0	0

Notes : The black lines denote the exact cut off points (20,30 and 34,5 kg/m²). Figures on the chart have been rounded to the nearest whole number.

Step 2 - Weight loss score

APEN

BARREN

STONES AND POUNDS

KILOGRAMS

STONES AND POUNDS

Score 0	Score 1	Score 2
HA loss < 5%	HA loss 5-10%	HA loss > 10%

Weight loss in last 3 to 6 months

kg	Less than (kg)	Between (kg)	More than (kg)
30	1.8	1.8-3.3	3.3
31	1.5	1.6-3.4	3.4
32	1.7	1.7-3.6	3.6
33	1.7	1.7-3.7	3.7
34	1.8	1.8-3.8	3.8
35	1.8	1.8-3.9	3.9
36	1.9	1.9-4.0	4.0
37	1.9	1.9-4.1	4.1
38	2.0	2.0-4.2	4.2
39	2.1	2.1-4.3	4.3
40	2.1	2.1-4.4	4.4
41	2.2	2.2-4.5	4.5
42	2.2	2.2-4.7	4.7
43	2.3	2.3-4.8	4.8
44	2.3	2.3-4.9	4.9
45	2.4	2.4-5.0	5.0
46	2.4	2.4-5.1	5.1
47	2.5	2.5-5.2	5.2
48	2.5	2.5-5.3	5.3
49	2.6	2.6-5.4	5.4
50	2.6	2.6-5.6	5.6
51	2.7	2.7-5.7	5.7
52	2.7	2.7-5.8	5.8
53	2.8	2.8-5.9	5.9
54	2.8	2.8-6.0	6.0
55	2.9	2.9-6.1	6.1
56	2.9	2.9-6.2	6.2
57	3.0	3.0-6.3	6.3
58	3.1	3.1-6.4	6.4
59	3.1	3.1-6.6	6.6
60	3.2	3.2-6.7	6.7
61	3.2	3.2-6.8	6.8
62	3.3	3.3-6.9	6.9
63	3.3	3.3-7.0	7.0
64	3.4	3.4-7.1	7.1

Score 0	Score 1	Score 2
HA loss < 5%	HA loss 5-10%	HA loss > 10%

Weight loss in last 3 to 6 months

kg	Less than (kg)	Between (kg)	More than (kg)
40	0.3	0.3-0.7	0.7
41	0.4	0.4-0.8	0.8
42	0.4	0.4-0.8	0.8
43	0.4	0.4-0.8	0.8
44	0.4	0.4-0.8	0.8
45	0.4	0.4-0.8	0.8
46	0.4	0.4-0.8	0.8
47	0.4	0.4-0.8	0.8
48	0.4	0.4-0.8	0.8
49	0.4	0.4-0.8	0.8
50	0.4	0.4-0.8	0.8
51	0.4	0.4-0.8	0.8
52	0.4	0.4-0.8	0.8
53	0.4	0.4-0.8	0.8
54	0.4	0.4-0.8	0.8
55	0.4	0.4-0.8	0.8
56	0.4	0.4-0.8	0.8
57	0.4	0.4-0.8	0.8
58	0.4	0.4-0.8	0.8
59	0.4	0.4-0.8	0.8
60	0.4	0.4-0.8	0.8
61	0.4	0.4-0.8	0.8
62	0.4	0.4-0.8	0.8
63	0.4	0.4-0.8	0.8
64	0.4	0.4-0.8	0.8

Score 0	Score 1	Score 2
HA loss < 5%	HA loss 5-10%	HA loss > 10%

Weight loss in last 3 to 6 months

kg	Less than (kg)	Between (kg)	More than (kg)
65	3.4	3.4-7.2	7.2
66	3.5	3.5-7.3	7.3
67	3.5	3.5-7.4	7.4
68	3.6	3.6-7.6	7.6
69	3.6	3.6-7.7	7.7
70	3.7	3.7-7.8	7.8
71	3.7	3.7-7.9	7.9
72	3.8	3.8-8.0	8.0
73	3.8	3.8-8.1	8.1
74	3.9	3.9-8.2	8.2
75	3.9	3.9-8.3	8.3
76	4.0	4.0-8.4	8.4
77	4.1	4.1-8.6	8.6
78	4.1	4.1-8.8	8.8
79	4.2	4.2-8.7	8.8
80	4.2	4.2-8.9	8.9
81	4.3	4.3-9.0	9.0
82	4.3	4.3-9.1	9.1
83	4.4	4.4-9.2	9.2
84	4.4	4.4-9.3	9.3
85	4.5	4.5-9.4	9.4
86	4.5	4.5-9.6	9.6
87	4.6	4.6-9.7	9.7
88	4.6	4.6-9.8	9.8
89	4.7	4.7-9.9	9.9
90	4.7	4.7-10.0	10.0
91	4.8	4.8-10.1	10.1
92	4.8	4.8-10.2	10.2
93	4.9	4.9-10.3	10.3
94	4.9	4.9-10.4	10.4
95	5.0	5.0-10.6	10.6
96	5.1	5.1-10.7	10.7
97	5.1	5.1-10.8	10.8
98	5.2	5.2-10.9	10.9
99	5.2	5.2-11.0	11.0

BARREN COPY

CLIENT WEIGHT

COPY

Individual Patient Handling Risk Assessment

COPY



If the patient has been assessed as 'independent' on initial assessment, a mobility chart does not require to be completed.

Is the patient independent? YES ☐ NO ☒ (Please tick ✓ as appropriate)

If the patient has been assessed as 'independent' on initial assessment; and this status changes, please review and complete a mobility chart.

If the patient is 'Plus Size', please refer to Bariatric (Plus Size Person) Handling Guidelines.

Please state the patient's ability prior to admission: critched

Please complete the following as to how the patient currently transfers / mobilises (Please tick ✓ as appropriate)

Please sign and date below

Assessor's Name (Print): <u>L SMITH</u>	Date: <u>28/7/18</u>
Signature: <u>Laura Smith</u>	Review Date:
Transfers (including to / from bed; wheelchair; commode; toilet)	
Independent ☐ Supervision ☐ Assistance of 1 ☐ 2 ☒ 3 ☐ More ☐ If More - please state number	Standaid ☐ Hoist ☐
Moves up and down the bed	
Independent ☐ Supervision ☐ Assistance of 1 ☐ 2 ☒ 3 ☐ More ☐ If More - please state number	Glide Sheet ☒ Hoist ☐
Sits up and over the side of the bed	
Independent ☐ Supervision ☐ Assistance of 1 ☐ 2 ☒ 3 ☐ More ☐ If More - please state number	Bed Rest ☐
Bathing (including in and out of the bath / shower)	
Independent ☐ Supervision ☐ Assistance of 1 ☐ 2 ☒ 3 ☐ More ☐ If More - please state number	(please specify) Hoist ☐ Other ☐
Walking	
Independent ☐ Supervision ☐ Assistance of 1 ☐ 2 ☐ 3 ☐ Walking Aid ☐ No Walking ☐	
Did the patient have a walking stick or frame on admission? YES ☐ NO ☐ <u>Q1W PT input</u>	

This form must be completed for each individual patient, along with a mobility chart, if required.



This form **must** be completed if the patient is **NOT** independent

An assessment of the patient should be carried out prior to every handling intervention. Any changes should be documented in a new column. Please refer to Manual Handling Guidelines for all manoeuvres.

DATE:	21.7.18	AST	22/7/18	AST		AST		AST		AST		AST
Lying to sitting	ant x2		Asst x2									
Sit to stand to sit	aiw PT		PT assess									
Walking	aiw PT		↓									
Bathing / Showering / Toileting	ant x2		Asst x1									
Moving up the bed	GS x2		Ind									
Turning / Prone	GS x2		↓									
On / off bed pan	ant x2		N/A									
Lateral transfers	Pat x4		Asst x2									
On / off floor	HOIST 2-4		Hoist x2									
State make and model of hoist / stand aid	nyco		nyco									
State type and size of sling	large		lge									
Falls assessment (Y / N)	n		N									
Signed	AS		mob.									

MOBILITY CODES

AST 1 / 2 / 3: Requires assistance of 1 / 2 / 3 or more staff
SUP: Supervision only IND: Independent

FWB: Full Weight Bearing
PWB: Partial Weight Bearing
NWB: Non Weight Bearing
BR: Bed Rest

HANDLING AIDS / EQUIPMENT CODES

H: Full body lifting hoist (specify hoist type + size of sling)
STA: Stand aid (specify hoist type + size of sling)
BH: Bathing hoist (specify hoist type)
SC: Shower chair ST: Shower Trolley
Pt T: Pt turner (specify e.g. Etac, Samhall, Cricket,.)
W: Wheelchair or pushchair

GS: Glide sheet(s) ES: (Extension Straps)
PAT: Pat slide
HB: Hand blocks HS: Handling Sling
C: Crutches (specify)
S: Stick(s) Z: Zimmer
HM: (HoverMatt) HJ: (HoverJack)

COPY

Manual Handling Service

January 2017

COPY

Complete on admission and review weekly unless condition changes.

Ensure care given is documented daily.

[illegible]

Oral Health Assessment

COPY

All patients should have their mouth assessed within 24 hours of admission to determine if oral care planning is required. Discuss and agree care plan with patient/carer.

Complete this section to determine condition of mouth and the frequency of mouth care required.			Date	Date	Date	Date	Date	Date	Date
Condition of mouth Check lips, oral soft tissues and teeth with a good light	Teeth/dentures clean, mucosa pink and moist	Standard Care 1	21/7 ✓						
	Mucosa/tongue pink and dry	Standard Care 2							
	Obvious plaque/swollen or bleeding gums or dry/crusted mouth	Standard Care 3							
	Possible infection	Standard Care 4							

Complete this section to determine frequency of assessment required			Date	Date	Date	Date	Date	Date	Date
Eating ability	Able to eat normal diet	1	21/7 ✓						
	Soft diet/delayed swallow reflex	2							
	Nil by mouth	3							
Physical ability	Requires assistance to access oral hygiene implements	1	✓						
	Requires help with oral hygiene	2							
	Patient not able to carry out any aspect of oral hygiene	3							
Mental ability	Loss of interest/confused	1							
	Memory impaired/confused	2							
	Sedated	3							
Nutritional screening (only score if patient has own teeth)	MUST low	1	✓						
	MUST medium	2							
	MUST high	3							
Additional risk factors	Diabetes mellitus	1							
	Medications *	1							
	Smoking	1							
	Loose/damaged dentures	1							
	Open mouth breathing	1							
	Oxygen therapy	1	✓						
	Broken or loose teeth	1							
Total score			6						
Initials			DS						

Re-assessment risk level: 2-8 = Low (monthly) 9-14 = Medium (every 2 weeks) 15+ = High (daily)

Oral Health Assessment

COPY

All patients should attain Standard Care 1 for oral hygiene. If any further care is required, this should be carried out **in addition** to Standard Care 1

Standard Care 1

Natural teeth	1. Brush teeth at least twice per day using fluoride toothpaste and a medium toothbrush. 2. Spit afterwards – do not rinse.
Dentures	1. Remove after each meal and rinse dentures and mouth with water 2. Brush with toothbrush at least once per day with unperfumed soap and water or denture cream. Repeat this prior to overnight soaking. 3. Plastic dentures should be brushed then soaked for 20 mins in a fresh solution of hypochlorite (1 part to 80 parts cold water/1/2 a teaspoon) in a patient named individual denture bowl. Then rinse and place in fresh water overnight. Dentures with metal parts should be soaked in chlorhexidine 0.2%. All dentures should be rinsed with cold water before replacing in mouth. 4. Clean palate, gum ridges and tongue with a soft toothbrush or thoroughly moistened foam stick. 5. Dentures must be stored in a named denture container when not in mouth. NOTE: if unable to carry out the above, clean mouth with foam stick thoroughly moistened in water, twice a day.

Standard Care 2

Dry mouth (Xerostomia)	• Follow Care Standard 1 and..... • Review medications that may cause dry mouth • 2 hourly mouth care, i.e. water to rinse and water based lubricating gel to dry lips. * see guidelines regarding use of gels. • Foam sticks thoroughly moistened in water to tongue and mucosa if unable to rinse • Frequent sips or sprays of water or crushed ice cubes are as effective and often preferable to artificial products so should be first choice • Saliva replacement products e.g. Biotene gel or mouthwash
------------------------	---

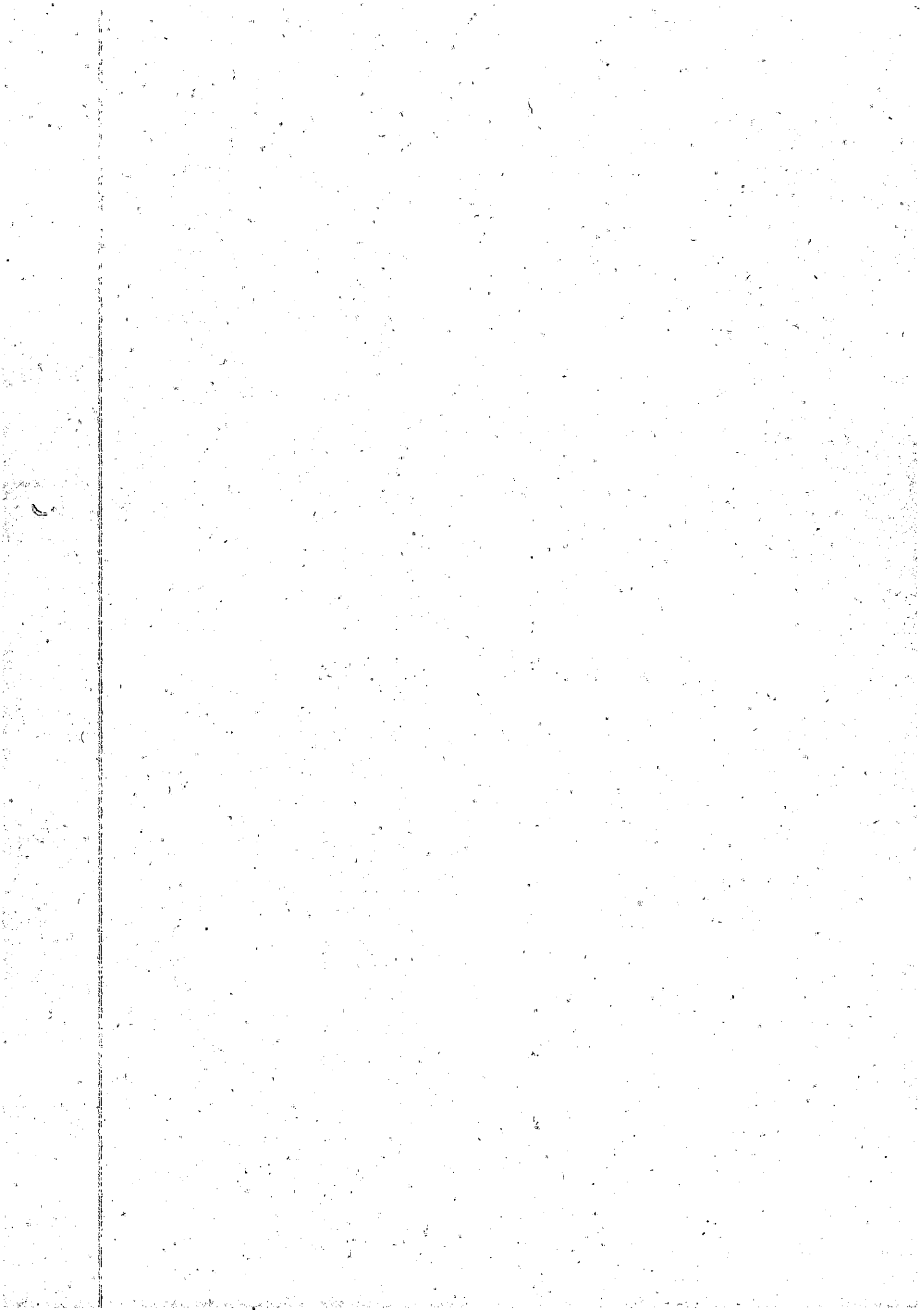
Standard Care 3

Obvious plaque/ swollen or bleeding gums or dry/crusted mouth	• Follow Care Standard 1 and..... • Remove debris with a medium headed tooth brush with fluoridated toothpaste or thoroughly moistened foam stick • Using water rinse 4-times daily • Chlorhexidine mouthwash, spray or gel (do not use for more than 1 month)
---	---

Standard Care 4

Infection	• Follow Care Standard 1 and..... • Seek medical/dental advice for appropriate treatment
-----------	---

For further advice please contact the Oral Health Department via email for advice from an oral health promoter FV-UHBoralhealthenquiries@nhs.net



COPY

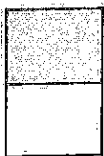
26

COPY

Complete on admission and review weekly unless condition changes.

Ensure care given is documented daily.

[illegible]



Stool Chart COPY

Identify type of stool using Bristol Stool Form Scale. Record every episode of stool.

Bristol Stool Scale

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. Entirely liquid

In the boxes below record any bowel pattern change, if patient is on aperients or has a history of bowel disease, or if a specimen has been sent.

Date: 21/7/18. NBO.	Date:	Date: Action taken:	Date:
Date:	Date:	Date:	Any other comments:

NEWS KEY		0		1		2		3		NAME: Scott Dowell		DOB: 26.2.80	
Date		20/7	20/7	20/7	20/7	20/7	20/7	20/7	20/7	20/7	20/7	20/7	20/7
Time		1300	1330	1345	1400	1415	1430	1445	1500	1515	1530	1545	1600
RESP RATE	≥25												
	21-24												
	12-20	12	15	14	13	13	15	14	14	15	15	17	18
	9-11												
	≤8												
SpO2	Default	≥96	97	98	98	99	99	98	99	98	99	100	98
		94-95											
		92-93											
	Chronic	≤91											
	↑ CO2	≥88											
Sign: ☐		≤85											
Inspired O2		Please tick	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
O2 Device or Air		Refer to key	SM	SM	SM	SM	SM	SM	NC	NC	NC	NS	NS
O2 Flow or Rate			SL	SL	SL	SL	SL	SL	4L	4L	4L	4L	4L
EMP	≥39°												
	38°												
	37°												
	36°												
	≤35°												
SYSTOLIC BLOOD PRESSURE	220												
	210												
	200												
	190												
	180												
HEART RATE	>140												
	130												
	120												
	110												
	100												
CONSCIOUS LEVEL		Alert	A	✓	A	✓	A	✓	A	✓	A	✓	A
Blood Sugar													
TOTAL SCORE			3	2	2	2	3	3	3	3	3	3	0
Pain Score (0-3)			0	0	0	0	0	0	0	0	0	0	0
Recognition & Response Checklist			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Urine Output Recorded			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Initials			W	W	W	W	W	W	W	W	W	W	W

COPY

WARD

1
2
3
3
3
3
3
2
2
1
1
3
3
3

CHI: 2602800570

WARD: 230

Date

COPY

>25

21-24

12-20

9-11

≤8

≥96

94-95

92-93

≤91

≥88

86-87

≤85

Default

Chronic
↑ CO2☐

Please tick

Refer to key

≥39°

38°

37°

36°

≤35°

220

210

200

190

180

170

160

150

140

130

120

110

100

90

80

70

60

50

>140

130

120

110

100

90

80

70

60

50

40

30

Alert

V / P / U

Blood Sugar

TOTAL SCORE

Pain Score (0-3)

Recognition & Response Checklist

Urine Output Recorded

Initials

Score 5-6 (or 3 in one parameter) = 1 hourly

Score 7 or More = Continuous

National Early Warning Score (NEWS)

NHS

Name:

CHI NO: 2602800570 26/02/1980

DOB:

CRN: S679370

CHI No:

SCOTT DOWELL

Address:

11 DON STREET,

GRANGEMOUTH,

STIRLINGSHIRE

FK3 8HD

COPY

Forth Valley

*** Regardless of NEWS always escalate if concerned about a patient's condition**

Total NEWS	Frequency of Monitoring	Clinical Response
0 *	Minimum 12 hourly	Continue routine NEWS monitoring with every set of observations
1 - 4 *	Minimum 4 - 6 hourly	- Inform registered nurse who must assess the patient - Registered Nurse to decide if increased frequency of monitoring and / or escalation of clinical care is required
5 - 6 * or 3 in one Parameter	Increased frequency to a minimum of 1 hourly	- Registered nurse to urgently inform the medical team caring for the patient - Urgent assessment by a clinician with core competencies to assess acutely ill patients - Ensure structured Response Stickers A & B are completed (<i>Not Applicable in Emergency Dept</i>)
7* or more	Continuous monitoring of vital signs (3 lead ECG and continuous SpO2 monitoring, 15 minute BP cycling - document observations every 30 minutes)	- Registered nurse to immediately inform the medical team caring for the patient - Emergency assessment by clinical team with core competencies to assess acutely unwell patients - Ensure structured Response Stickers A & B are completed (<i>Not Applicable in Emergency Dept</i>) - Consider transfer of clinical care to ITU

Exclusion Criteria

Anaesthesia and/or sedation may result in reduced conscious levels for a period of time. Scores that are increasing post-procedure and those including "P" or "U" always require escalation. The post-procedure NEWS score and post procedure plan that will include the frequency of observations should be communicated to the ward staff on transfer/handover of the patient.

Target O2 Saturation

Target SpO2 for most patients should be 94-98%.

Selected patients may require target SpO2 88-92% (Appropriate in specific patients with severe chronic respiratory disease who either have established chronic Type 2 respiratory failure, or are felt to be at significantly increased risk of CO2 retention from oxygen therapy). These patients should use the modified (chronic hypercapnia) EWS. Arterial blood gases should be repeated at 30-60 min to check for rising CO2 or H⁺ after initiation of oxygen in this context.

Acute Respiratory Failure is a life threatening emergency

Severe Hypoxia (Requiring >60% O2 to maintain target SpO2)

Acute Hypercapnia (pCO2 >6 and H⁺ >45)

Urgent ST3 (or equivalent) review is required to optimise management.

Duty or on call consultant should be contacted if advice required.

Critical care referral and ventilatory support may be needed.

Codes For Recording Oxygen Delivery On NEWS Chart

A = Air (not requiring oxygen or weaning or on PRN oxygen)

N = Nasal Canulae

SM = Simple Mask

V24 = Venturi 24% V28 = Venturi 28% V35 = Venturi 35% V40 = Venturi 40% V60 = Venturi 60%

H28 = Humidified oxygen at 28% (also H35, H40 & H60 = Humidified Oxygen at 35%, 40% & 60%)

RM = Reservoir Mask

TM = Tracheostomy Mask

CP = Patient on CPAP System

NIV = Patient on NIV System

OTH = Other Device: _____ (specify which)

Pain Score

0 = no pain

1 = mild pain

2 = moderate pain

3 = severe pain

Sepsis Screening Tool

Patient triggering NEWS ≥ 5 OR Clinical Concern
Neutropenia suspected OR MEWS triggering for obstetric patients

COPY

Is this likely to be due to infection?

Cough/sputum
Abdominal pain/distension/diarrhoea
Line infection
Endocarditis

Dysuria
Cellulitis
Headache with neck stiffness
Wound infection

Obstetric patients (Refer to FV protocol: Sepsis in Maternity Patients)

Perineal trauma Vaginal discharge Prolonged SRM Sore Throat

YES

Escalate to Doctor/ANP with
"suspected sepsis"
Place Sepsis 6 sticker in notes
Prepare giving set/IV fluids

NO

Escalate to Doctor/ANP
Repeat NEWS/MEWS in max 60 mins

**ASSESS FOR OTHER CAUSES OF
TRIGGERING**

**Two people work together to deliver the Sepsis 6 within 60 mins of
patient first triggering**

- Correct Hypoxia
- Take Blood Cultures
- Give IV antibiotics according to
NHS FV Protocol

- Measure whole blood Lactate
- Assess urine output (catheter if
obstetric patient)
- Start IV fluids - 20ml/kg, minimum
500mls in the first hour

ASSESS FOR SEVERE SEPSIS

SEVERE SEPSIS

Sepsis with $\geq$ organ dysfunction:

- Hypotension
- Renal
- Respiratory
- Hepatic
- Hematologic
- CNS
- Metabolic acidosis

IF SEVERE SEPSIS

Contact middle grade Doctor (Consultant
if obstetric patient)

Catheter mandatory if evidence of AKI

NO EVIDENCE OF SEVERE SEPSIS

Assess response to sepsis 6

Continue regular NEWS

SEPTIC SHOCK

- Hypotension despite fluid
resuscitation
- Organ dysfunction

HIGH RISK FACTORS

- Hypotension
- Lactate > 4
- Unexplained INR > 1.5
- APTT > 60 secs
- Bilirubin > 34 (70 if obstetric)
- Platelets < 100

Conscious Level Chart (only as required for head injury observation)

DATE:															DATE:	
TIME:															COPY	
COMA SCALE	Eyes Open	Spontaneously	4													Eyes closed by swelling = C
		To speech	3													
		To pain	2													
		None	1													
	Best verbal response	Orientated	5													Endotracheal tube or tracheostomy = T
		Confused	4													
		Inappropriate words	3													
		Incomprehensible sounds	2													
		None	1													
	Best motor response	Obey commands	6													Usually record the best arm response
		Localise pain	5													
		Withdraws to pain	4													
		Flexion to pain	3													
		Extension to pain	2													
		None	1													
	● 1 ● 2 ● 3 ● 4 ● 5 ● 6 ● 7 ● 8 Pupil Scale (mm)															
	PUPILS	right	Size Reaction													+ reacts - no reaction c. eye closed
		left	Size Reaction													
LIMB MOVEMENT	A R M S	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														
	L E G S	No response														
		Normal power														
		Mild weakness														
		Severe weakness														
		Extension														
		No response														

Pain Assessment & Management Guidelines

Pain Score:

- 0 = No pain
- 1 = No pain at rest
Slight pain on movement
- 2 = Intermittent pain at rest
Moderate pain on movement
- 3 = Continuous pain at rest

For Acute and Chronic Pain:

For mild (1), moderate (2) or severe (3) pain refer to Pain Management Guidelines Forth Valley Formulary Appendix 27 & 28. Implement Pain Assessment Chart

For Cancer Related Pain:

For mild (1), moderate (2) or severe (3) pain score, refer Palliative Guidelines.

Supportive and Palliative Care Indicators Tool (SPICT™)

COPY

The SPICT™ is a guide to identifying people at risk of deteriorating and dying. Assessment of unmet supportive and palliative care needs may be appropriate.

Look for two or more general indicators of deteriorating health.

- Performance status poor or deteriorating, with limited reversibility, (needs help with personal care, in bed or chair for 50% or more of the day).
 - Two or more unplanned hospital admissions in the past 6 months.
 - Weight loss (5 - 10%) over the past 3 - 6 months and/or body mass index < 20.
 - Persistent, troublesome symptoms despite optimal treatment of any underlying condition(s).
 - Lives in a nursing care home or NHS continuing care unit, or needs care to remain at home.
- Patient requests supportive and palliative care, or treatment withdrawal.

Look for any clinical indicators of advanced conditions

Cancer

Functional ability deteriorating due to progressive metastatic cancer.

Too frail for oncology treatment or treatment is for symptom control.

Dementia / frailty

Unable to dress, walk or eat without help.

Choosing to eat and drink less; difficulty maintaining nutrition.

Urinary and faecal incontinence.

No longer able to communicate using verbal language; little social interaction.

Fractured femur; multiple falls.

Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease

Progressive deterioration in physical and/or cognitive function despite optimal therapy.

Speech problems with increasing difficulty communicating and/or progressive dysphagia.

Recurrent aspiration pneumonia; breathless or respiratory failure.

Heart / vascular disease

NYHA Class III/IV heart failure, or extensive, untreatable coronary artery disease with:

- breathlessness or chest pain at rest or on minimal exertion.

Severe, inoperable peripheral vascular disease.

Respiratory disease

Severe chronic lung disease with:

- breathlessness at rest or on minimal exertion between exacerbations.

Needs long term oxygen therapy.

Has needed ventilation for respiratory failure or ventilation is contraindicated

Kidney disease

Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.

Kidney failure complicating other life limiting conditions or treatments.

Stopping dialysis.

Liver disease

Advanced cirrhosis with one or more complications in past year:

- diuretic resistant ascites
- hepatic encephalopathy
- hepatorenal syndrome
- bacterial peritonitis
- recurrent variceal bleeds

Liver transplant is contraindicated.

Assess and plan supportive & palliative care

- Review current treatment and medication so the patient receives optimal care.
- Consider referral for specialist assessment if symptoms or needs are complex and difficult to manage.
- Agree current and future care goals/plan with the patient and family.
- Plan ahead if the patient is at risk of loss of capacity.
- Handover: care plan, agreed levels of intervention, CPR status.
- Coordinate care (eg. with a primary care register).

PERIPHERAL VASCULAR CATHETER (PVC) DAILY MAINTENANCE

Label	Reason for insertion: <i>Theatre</i>	DAY 0
Name: <i>Scott Dawell</i>	Insertion Date: <i>20/7/18</i>	Time: <i>10:00</i>
D.O.B:	Colour/batch no: <i>Green</i>	Position: <i>Left hand</i>
CHI:	Hand hygiene (HH) performed	Yes No
Hospital:	Skin cleansed for 30 seconds with antiseptic & left to dry prior to insertion	Yes No
(Use addressograph label)	Aseptic technique throughout	Yes No
	Sterile dressing applied including date and time	Yes No
	Inserted by:	
	Ward inserted: <i>Theatre</i>	

Ensure that:

Medical staff review the need for intravenous (IV) therapy including antibiotics on a daily basis – switch to oral if possible

An antiseptic containing 70% isopropyl alcohol is used to clean the access hub. Before accessing, rub the access hub for at least 15 seconds ("scrub the hub")

MODIFIED VIP (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 sign: Remove & replace cannula. Observe both sites and document. Obtain swab
Two or more of the following are evident: Pain, redness or swelling	2	Early stages of phlebitis: Remove & replace cannula. Observe both sites and document. Treat if necessary. Obtain swab
All of the following are evident: Pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: Remove and seek further advice. Obtain swab
As above including palpable venous cord	4	Remove and seek further advice. Obtain swab
As above including pyrexia	5	Seek further advice.

24 hours	Date: <i>21/7/18</i>	Time:
Is PVC still required	YES NO	
Absence of inflammation/extravasation	YES NO	
VIP score - please circle	0 1 2 3 4 5	
PVC dressing intact	YES NO	
PVC inserted <72 hrs	YES NO	
HH before/after procedure	YES NO	
"Scrub the Hub" (before use)	YES NO	
PVC - please circle	Left in situ removed	
Reason for removal:		
Signature:	<i>[Signature]</i>	

48 hours	Date: <i>22/7/18</i>	Time:
Is PVC still required	YES NO	
Absence of inflammation/extravasation	YES NO	
VIP score - please circle	0 1 2 3 4 5	
PVC dressing intact	YES NO	
PVC inserted <72 hrs	YES NO	
HH before/after procedure	YES NO	
"Scrub the Hub" (before use)	YES NO	
PVC - please circle	Left in situ removed	
Reason for removal:	<i>? remove a.m.</i>	
Signature:	<i>[Signature]</i>	

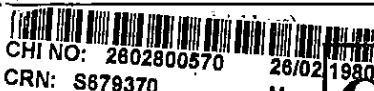
Is PVC still required	YES NO
Absence of inflammation/extravasation	YES NO
VIP score - please circle	0 1 2 3 4 5
PVC dressing intact	YES NO
PVC inserted <72 hrs	YES NO
HH before/after procedure	YES NO
"Scrub the Hub" (before use)	YES NO
PVC - please circle	Left in situ removed
Reason left in situ:	
Discussed with:	
Reason for removal:	
Signature:	

If PVC to remain in situ for longer than 72 hours this must be documented on a daily basis in notes and discussed with medical staff.

Observe closely for clinical signs and symptoms of Phlebitis.

New sheet to be commenced.

FORTH VALLEY ACUTE HOSPITALS
Infusion Fluids / Blood Products Page

WARD 823	CONSULTANT THANING	PAT 	CHI NO: 2802800570 CRN: S879370 SCOTT DOWELL 11 DON STREET, GRANGEMOUTH, STIRLINGSHIRE FK3 8HD		
ALLERGIES - Please use RED INK NKA		COPY			
HEIGHT (m)	WEIGHT (kg)			DATE	SURFACE AREA (m ²)
HC DATE OF BIRTH:					

L SITE:

AGE:

• enter dosage times as 24hour clock

• please write in block capitals in black pen
• IV site MUST be checked prior to and after IV administration

A	APPROVED DRUG NAME	DOSE	ROUTE IV	START TIME	INFUSION STARTED BY:
INFUSION FLUID Hertmanns			TOTAL VOLUME 1000ml	TIME STARTED 1203 20/1/18	
DOCTORS SIGNATURE [Signature]		DATE 20/1/18	RATE 125ml/h	PUMP NO.	BATCH NO. DM/VG
					18F13T3F
B	APPROVED DRUG NAME	DOSE	ROUTE IV	START TIME	INFUSION STARTED BY:
INFUSION FLUID Hertmanns			TOTAL VOLUME 500ml	TIME STARTED	
DOCTORS SIGNATURE		DATE	RATE 125ml/h	PUMP NO.	BATCH NO.
C	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
INFUSION FLUID			TOTAL VOLUME	TIME STARTED	
DOCTORS SIGNATURE		DATE	RATE	PUMP NO.	BATCH NO.
D	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
INFUSION FLUID			TOTAL VOLUME	TIME STARTED	
DOCTORS SIGNATURE		DATE	RATE	PUMP NO.	BATCH NO.
E	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
INFUSION FLUID			TOTAL VOLUME	TIME STARTED	
DOCTORS SIGNATURE		DATE	RATE	PUMP NO.	BATCH NO.
F	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
INFUSION FLUID			TOTAL VOLUME	TIME STARTED	
DOCTORS SIGNATURE		DATE	RATE	PUMP NO.	BATCH NO.
G	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
INFUSION FLUID			TOTAL VOLUME	TIME STARTED	
DOCTORS SIGNATURE		DATE	RATE	PUMP NO.	BATCH NO.
H	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
INFUSION FLUID			TOTAL VOLUME	TIME STARTED	
DOCTORS SIGNATURE		DATE	RATE	PUMP NO.	BATCH NO.

PHYSIOTHERAPY ASSESSMENT

NAME: _____	CHI2602800570	CONS: <u>Tinning</u>	COPY
ADDRESS: _____	CRN:S679370 26/02/1980	GP: <u>Westburn M/px</u>	
POSTCODE: _____	DOWELL SCOTT 11 Don Street, GRANGEMOUTH, Stirlingshire FK3 8HD	WARD: <u>B23</u>	PHONE: <u>07388347406/01324 262719</u>

PC / DIAGNOSIS: (L) TTK 20/7/18

HPC

Admitted for above elective procedure

SH

Lives w/ wife. pt normally cares for wife
- sister helping at present.

Stairs x2 rails

PREVIOUS MOBILITY

Crutches x 2

PMH

PMH

Sebecious cyst
infected cyst
ORUFT @ arm
Bell's Palsy

Restless legs
Ank spondylitis
Reflux

DH

See hepma

OBJECTIVE ASSESSMENT

High typing in bed.

R_x là điện trở biến thiên

2) STS (4)

②) Mobility $\propto \frac{1}{W_2 F} \sim \frac{1}{5 \text{ m. } 180^\circ \text{ turn } 501}$

4) Mobility $\mu_x \times 2 \text{ e/c} \sim 5 \text{ m sO1}$

A- Mobilised well Pissues.

P- Exercises, ~~? progress to crutches~~ 17. Starts prior to d/c.
to error

with
H. Pittman (BSP)

NHS Forth Valley Physiotherapy Service

Patient Name... Scott Donnell ^{1st error} ~~Valerie Kalkin-Smith~~

DOB/CHI... 26/02/80 ⁰⁵⁷⁰

Physiotherapist Name... Valerie Kalkin-Smith (PTA)

Page No... 3

COPY

Date		Signature
21/7/18	③ Consent as per policy ④ Pt just finished washing + dressing. ⑤ mob around room + elbow counter ex: bed ex's: ⑥ THR ext/flex 0-80° abd 20° S&V IRR 5°/leg. } x 10 ⑦ managing well, needing a little support + adduction initially. Given tubi grip to help + this. Once moving able to do ⑧. A, + ⑨ leg on/off of bed. ⑩ cont + bed ex's + stairs Valerie Kalkin-Smith PTA.	
22/7/18	S. Keen for dx home. Mobilising + elc's ⑪ out to front door + back. Consent ✓ ⑫ Mob: + 2 elc's - ⑬, reminded to heel strike. Mobilised to stairs // up/down 7 steps + ⑭ ascending rail + elc - safe + steady. Ding exs ⑮ Reminded not to overdo activities / take analgesics regularly. Advice re: weaning off elc's as able. P. Happy for dx home	Richard

No measurement form

Occupational Therapy

Form

NHS

Forth Valley

COPY

Referral completed by:	Location:	Date: 20/07/2018
	Designation:	
	Phone No.:	

Home Phone: 01324 262719	Mobile:	Forename: Scott	Title: Mr
Marital Status: Single ☐ Married ☒		Surname: Dowell	
Lives: Separated ☐ Widowed ☐		Address: 11 Don Street,, Grangemouth,, Stirlingshire, FK3 8HD	
Alone ☐ with family ☐	with partner ☒ with dependants ☐		
Key Holder:		D.o.B: 26/02/1980 (38yo)	Gender: Male
Occupation:		CHI No.: 2602800570	
Religion:	Ethnicity:	Known risks / alerts:	
SW Number:			
Care Group:			
Communication Issues:	Visual ☐ Auditory ☐	Verbal ☐ Language ☐	AWI ☐ Appropriate adult ☐ Advocacy required ☐

Past Medical History:	Ward: FVRH - Day Surgery Unit	Consultant: Tinning, Dr Craig
Diagnosis: «DIAGNOSES_ACTIVE_LIST»	Date of Admission: 20/07/2018	Admission Reason: Acute - Admission for Treatment
C-Stern	Date of Referral:	Transfer Details:
THR	Date of Discharge: «EPISODE_DISCHARGE_DATE»	
Presenting Problems: Elective Admission	Client aware of referral? Y ☐ N ☐	Consent to Share Yes ☐ No ☐
Cognition / Mood:	Legal Status:	Information Given Yes ☐ No ☐
		Date consent recieved:

Brief reason for referral:	GP: Dr Derek Dundas
	Address: Falkirk Community Hospital, Westburn Avenue, Falkirk, FK1 5SU
	Phone No.: 01324 623577
	Next of kin / representative (please specify) wife
	Name:
	Address: 31A.
	Phone No.:

Patient View of Situation of Condition:	Carer details (if not Next of kin)
	Title:
	Forename:
	Surname:
	Phone No.:
	Family support / significant others

Wife is disabled in a wheelchair - Equipment in situ for herself
 Requires H. Chair - P. Stool, Trolley
 Ramps, BathTift
 Walk in shower
 Shower Chair
 19" nowbray
 ORDERED

Occupational Therapy Initial Assessment and Plan

Patient name SCOTT DOWELL	CHI number 2602800570
----------------------------------	------------------------------

COPY

Contacts: other agencies / services / support networks

DN	SW	Comm. O.T	ReACI
HH	MoW	MECS	Private care
Day hospital	Day care	CPN / CMHT	Other

Accommodation:

LA / HA / Owner / Private rented / NH / SH / RH

HA / Warden

House / flat - GF - 1st 2nd other / bungalow / other

Int stairs straight / curved / stair lift

Banisters R / L / both full / both partial

Ext stairs back rails R / L / both full / both partial

Ext stairs front rails R / L / both full / both partial

Heating Cooking

Financial issues:

Benefits - AA DLA Income support OAP Other

Pension / prescription uplift

Medication compliance **I**

Wheelchair

Pressure equipment: cushion / mattress

Driver Yes / No Socially active Yes / No

automatic car?

heavy plant operator

Toilet upstairs / downstairs / level / both

Bedroom upstairs / downstairs / level / both

Bathroom upstairs / downstairs / level / both bath/toilet upstairs.

Transfers

Chair

Previous **I** - sofa chairs

Bed 24" High

Previous **I**

Toilet - previous **I** with rails

Present - e bath lift

Bath / shower - Previous **I** Walk in shower

Present Shower chair

Domestic ADL

Meal preparation (previous)

Microwave Y / N

Breakfast

Lunch / main meal

Tea

Supper / hot drink

Previous ability **I**

Present ability will have assistance

Housework - previous

Present

Laundry - previous

Present

Shopping - previous

Present

Mobility

Mobility - previous crutches

Present crutches

Stairs adapts + manages

Falls risk - Yes / No

Personal ADL

Washing - previous

Present

Grooming - previous

Present

Continence - previous present

Dressing - previous

Present tricky - needs help

Feeding - previous

Present

Issues / plan

easy reacher ✓ shoe horn ✓
leg lifter

On MiDIS

☒

Discharged

☐

**Joint Loan Equipment Service
Equipment Requisition Form
Hospitals**
All details must be completed

COPY

Joint Loan Equipment Service,
Unit 9, West Mains Industrial
Estate, Grangemouth, FK3
8YE

Tel: 01324 508760/62
Fax: 01324 508761

Requisition Date: 19/07/2018

Requisitioner Details:

Name: Irene Cowie

Contact No: 567436

Requisitioner No: 0958

Designation & Dept: OTA

Title:	Mr	Client ID No (JLES):	
Patient Name:	Mr Scott Dowell	CHI No:	2602800570
Client Address:	11 Don Street,, Grangemouth,, Stirlingshire, FK3 8HD	Previous Address:	
Postcode:	FK3 8HD		
Telephone Number:	01324 262719		
Date of Birth:	26/02/1980	Review in:	

GP Name: Dr Derek Dundas

GP Practice: Westburn Medical Practice

Please indicate with a tick if you are requesting a delivery or uplift:

CODE	Equipment Description	Delivery	Uplift	Priority
YL02 or YL01	High Chair Set to 19" from top of seat to floor	X		2
YM01 x 2	Mowbray toilet frames set to 19" from top of seat to floor. Please place over up and downstairs toilets	X		2

Special Instructions (eg, access): It is ESSENTIAL to phone patients wife for access. ESSENTIAL for Discharge Friday 20/7/2018. High chair is essential to save hip dislocation. Thanks

Signatory Name: Irene Cowie

Designation: OTA

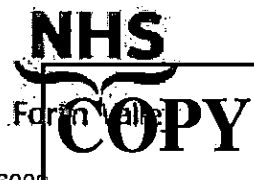
I Cowie
Occupational Therapist

CC:

COPY

4/6 weeks delivery

NHS Forth Valley Nursing Discharge Document



Hospital: Forth Valley Royal Hospital, Larbert
Specialty: Trauma and Orthopaedic Surgery

Telephone Number: 01324 566000
Ward: FVRH - Ward B23

Patient Profile			
Surname: Dowell	Forename: Scott	GP Practice:	Westburn Medical Practice
Address: 11 Don Street,, Grangemouth,, Stirlingshire, FK3 8HD	Day Time Tel:	GP Address:	Falkirk Community Hospital, Westburn Avenue, Falkirk, FK1 5SU
	Evening Tel: 474369	GP Practice Code:	25883
Unit No: F207472	DoB: 26/02/1980	GP Name:	Dr Derek Dundas
CHI No: 2602800570	Sex: Male	Admission Date:	20/07/2018
Presenting Complaint: Elective Admission			

Discharge To: Private Residence - Living with Relatives or Friends	Discharge Date: 22/07/2018
Discharge to comments:	Discharging Consultant: Tinning, Dr Craig
	Next of Kin:
	Address:
	Tel No:

Diagnosis / Treatment

N06ZA - Acute arthritis

Procedures

Results Outstanding / Information to Patient / Carer

Results Outstanding (Y / N): (If Yes, please give details)	No
Information to patient / carer:	Patient: Yes
	Carer: Yes

Reviews

rhthroplasty nuse, Orthopaedic Clinic, 6 Weeks

Nursing Treatment Required (Dressings, Injections, Catheter Type/Size)

Supply of Drugs/Products	Given home with patient
Supply of Drugs/Products	Wound dressings - products supplied
Patients understanding	Good understanding
Follow up	Treatment Room
Wound Review	Assess wound 3rd day post discharge.
Dressing	One day's supply
Dressing	Aquacel Dressing
Dressing	Tegaderm
Frequency of Dressing Change	As required
Date Dressing Last Changed	/ /
Sutures, Clips	Remove remaining sutures: (/ /)

Functional Ability of Discharge

Home Environment	Good family support
Home Environment	Lives with spouse

Services Requested / Equipment Ordered and Supplied

X2 MOWBRAYS ISSUED TO WARD ON 22/7/18

Forth Valley Acute Hospitals Acute Division
Medication Discharge Summary

COPY

Name:	Mr Scott Dowell	Patient's Tel No:	
Address:	11 Don Street,, Grangemouth,, Stirlingshire, FK3 8HD	Patient's Tel Eve:	474369
Admission Date:	20/07/2018	Discharge Date:	22/07/2018

Patient Alerts

Alert Group	Alert	Alert Comment	When Added	Added By
-------------	-------	---------------	------------	----------

Patient Drug Reactions

Current Prescription (all medicines currently prescribed)

Medicines Discontinued

Patient Name: Mr Scott Dowell

CHI Number: 2602800570

National Early Warning Score (NEWS)

NHS



Name:

DOB:

CHI N

Address



CHI: 2602800570 26/02/1980 M

DOWELL
SCOTT
11 DON STREET
STIRLINGSHIRE
FK3 8HD

escalate if concerned about a patient's condition

Total NEWS	Frequency of Monitoring	Clinical Response
0 *	Minimum 12 hourly	Continue routine NEWS monitoring with every set of observations
1 - 4 *	Minimum 4 - 6 hourly	- Inform registered nurse who must assess the patient - Registered Nurse to decide if increased frequency of monitoring and / or escalation of clinical care is required
5 - 6 * or 3 in one Parameter	Increased frequency to a minimum of 1 hourly	- Registered nurse to urgently inform the medical team caring for the patient - Urgent assessment by a clinician with core competencies to assess acutely ill patients - Ensure structured Response Stickers A & B are completed (<i>Not Applicable in Emergency Dept</i>)
7 * or more	Continuous monitoring of vital signs (3 lead ECG and continuous SpO2 monitoring, 15 minute BP cycling - document observations every 30 minutes)	- Registered nurse to immediately inform the medical team caring for the patient - Emergency assessment by clinical team with core competencies to assess acutely unwell patients - Ensure structured Response Stickers A & B are completed (<i>Not Applicable in Emergency Dept</i>) - Consider transfer of clinical care to ITU

Exclusion Criteria

Anaesthesia and/or sedation may result in reduced conscious levels for a period of time. Scores that are increasing post-procedure and those including "P" or "U" always require escalation. The post-procedure NEWS score and post procedure plan that will include the frequency of observations should be communicated to the ward staff on transfer/handover of the patient.

Target O2 Saturation

Target SpO2 for most patients should be 94-98%.

Selected patients may require target SpO2 88-92% (Appropriate in specific patients with severe chronic respiratory disease who either have established chronic Type 2 respiratory failure, or are felt to be at significantly increased risk of CO2 retention from oxygen therapy). These patients should use the modified (chronic hypercapnia) EWS. Arterial blood gases should be repeated at 30-60 min to check for rising CO2 or H+ after initiation of oxygen in this context.

Acute Respiratory Failure is a life threatening emergency

Severe Hypoxia (Requiring >60% O2 to maintain target SpO2)

Acute Hypercapnia (pCO2 >6 and H+ >45)

Urgent ST3 (or equivalent) review is required to optimise management.

Duty or on call consultant should be contacted if advice required.

Critical care referral and ventilatory support may be needed.

Codes For Recording Oxygen Delivery On NEWS Chart

A = Air (not requiring oxygen or weaning or on PRN oxygen)

N = Nasal Canulae

SM = Simple Mask

V24 = Venturi 24% **V28** = Venturi 28% **V35** = Venturi 35% **V40** = Venturi 40% **V60** = Venturi 60%

H28 = Humidified oxygen at 28% (also **H35**, **H40** & **H60** = Humidified Oxygen at 35%, 40% & 60%)

RM = Reservoir Mask

TM = Tracheostomy Mask

CP = Patient on CPAP System

NIV = Patient on NIV System

OTH = Other Device: _____ (specify which)

Pain Score

0 = no pain

1 = mild pain

2 = moderate pain

3 = severe pain

CHI:

WARD:

Date

COPY

≤25

21-24

12-20

9-11

≤8

≥96

94-95

92-93

≤91

≥88

86-87

≤85

Default

Chronic

↑ CO2

☐

Please tick

Refer to key

≥39°

38°

37°

36°

≤35°

220

210

200

190

180

170

160

150

140

130

120

110

100

90

80

70

60

50

>140

130

120

110

100

90

80

70

60

50

40

30

Alert

V / P / U

Blood Sugar

Pain Score (0-3)

Recognition & Response Checklist

Urine Output Recorded

Initials

Score 5-6 (or 3 in one parameter) = 1 hourly

Score 7 or More = Continuous

NEWS KEY		NAME:		DOB:					
0 1 2 3									
Date		1/8/18							
Time		1 08 10 20							
RESP RATE		COPY							
						≥25			
						21-24			
						12-20	20	19	
						9-11			
SpO2 Tick if using Patients with Chronic Hypercapnia		COPY							
						Default	≥96	98	97
							94-95		
							92-93		
							≤91		
Sign: ☐ Inspired O2 O2 Device or Air O2 Flow or Rate		COPY							
						Chronic ↑ CO2	≥88		
							86-87		
							≤85		
TEMP Mark •		COPY							
						≥39°			
						38°			
						37°			
						36°			
SYSTOLIC BLOOD PRESSURE Mark ↔		COPY							
						≤35°			
						220			
						210			
						200			
HEART RATE Mark •		COPY							
						190			
						180			
						170			
						160			
CONSCIOUS LEVEL		COPY							
						150			
						140			
						130			
						120			
TOTAL SCORE		COPY							
						110			
						100			
						90			
						80			
Pain Score (0-3)		COPY							
						70			
						60			
						50			
						40			
Recognition & Response Checklist		COPY							
						30			
						20			
						10			
						0			
Urine Output Recorded		COPY							
						Alert	✓	✓	
						V / P / U			
						Blood Sugar			
						Initials	V	P	A

**SAU Day Patient
Nursing and Medical
Assessment**

Name:



COPY

CHI: 2602800570

26/02/1980

CHI Number

DOWELL Scott

DOB

11 DON STREET,

GRANGEMOUTH,

STIRLINGSHIRE FK3 8HD

Date

Time

Specialty

Consultant

GP

Next of Kin

Relation

Address

Tel.

Tel.

Mobile

son for Admission

abscess on Back 4cm x 6cm cystic
swelling - noticed 2/5 ago painful
discharging small amount of pus discharging

Past Medical History

leg THR 27/7/18 (on Rivaroxaban)
Ankylosing spondylitis Barrett's oesophagus

Allergies

Drug History

NO DM/H/TN

Examination

4x6cm
swelling
cystic
abscess
tender

Oramorph
Rivaroxaban
Paracetamol
PPI Codeine

Urinalysis

B-HCG

Blood Results

Na

AST

CRP

Hb

K

ALT

Amylase

WCC

Urea

Bilirubin

Other

Platelets

Creatinine

ALP

INR

eGFR

Plan

160 under GA
consent
Bare

FBC HE

[Signature]
Abscess
160
HE

Waiting List Referral

NHS
Forth Valley

CHI:2602800570

CRN:S679370 26/02/1980

DOWELL SCOTT

11 Don Street,

GRANGEMOUTH,

Stirlingshire

FK3 8HD

26/2/15

CRN:

COPY

Armed Forces or Veteran: ☐ No ☐ YesArmed Forces Dependant: ☐ No ☐ Yes

Patient's Tel Numbers:

Home:

Mobile:

Work/Other:

Patient's email address:

Specialty:

SURGERY

Consultant:

JCB

Diagnosis:

No adenoids left prior

ended Procedure:

Excision adenoids the left prior

Suitable for pooled list:

☐ No
☒ Yes

If No state reason:

Suitable for Private Sector:

☐ No ☐ Yes If no state reason?

Details for Admission:

Suitable For: ☐ GNM If no state reason?☐ Urgent ☐ Routine☒ Day Case ☐ 23 hrs stay ☐ Inpatient☐ DOSA ☐ DBS☐ May Req HDU Bed ☐ May Req ITU Bed☒ GA ☐ LA

Jehovah Witness:

☐ No ☐ Yes

Will accept short notice app:

☐ No ☐ Yes

Op Assessment Required:

☐ No ☒ Yes☐ High Risk

(if High Risk complete refer

BMI:

Consultant Instructions for WL Dent:

Inc. special requirements and/or equipment

Source of referral if not from clinic:

☐ Ward☐ ED☐ MDT Meeting

Specify Ward or details:

Additional Needs:

☐ Translator

Language:

☐ Impairment Needs

Specify:

☐ Other

Specify:

Clinicians Signature

Date:

26/2/15



CHI 2802800570

Bath Ankylosing Spondylitis Functional Index

CRN: S679370 26/02/1980

BASFI

*Calin et al. J Rheu

DOWELL SCOTT
11 Don Street,
GRANGEMOUTH,
Stirlingshire
FK3 8HD

M

Date 14/08/17

Patient Name

Please draw a mark on each line below to indicate your ability with each of the following activities, during the past week:

1. Putting on your socks or tights without help or aids (e.g. sock aids)?

EASY _____ IMPOSSIBLE
0 10

2. Bending forward from the waist to pick up a pen from the floor without an aid?

EASY _____ IMPOSSIBLE
0 10

3. Reaching up to a high shelf without help or aids (e.g. helping hand)?

EASY _____ IMPOSSIBLE
0 10

4. Getting up out of an armless dining room chair without using your hands or any other help?

EASY _____ IMPOSSIBLE
0 10

5. Getting up off the floor without any help from lying on your back?

EASY _____ IMPOSSIBLE
0 10

6. Standing unsupported for 10 minutes without discomfort?

EASY _____ IMPOSSIBLE
0 10

7. Climbing 12-15 steps without using a handrail or walking aid (one foot on each step)?

EASY _____ IMPOSSIBLE
0 10

8. Looking over your shoulder without turning your body?

EASY _____ IMPOSSIBLE
0 10

9. Doing physically demanding activities (e.g. physiotherapy exercises, gardening or sports)?

EASY _____ IMPOSSIBLE
0 10

10. Doing a full day activities whether it be at home or work?

EASY _____ IMPOSSIBLE
0 10

COPY

COPY

GASTROSCOPY REPORT

Name: **Scott DOWELL (M)**
 Date of birth: **26/02/1980**
 CHI No: **2602800570**
 Case note no.: **S679370**

Address: **11 Don Street,
 Granton, Dunfermline
 Stirling, FK3 8HD**

COPY

GP: **Dr DW Dundas
 Westburn Medical Practice
 Falkirk Community Hospital
 Westburn Ave
 Falkirk
 FK1 5SU**

Procedure date: **29th August 2017 (10:10)**
 Priority: **Repeat/Scheduled**
 Status: **Outpatient/NHS**
 Hospital: **FVRH**
 Referring Cons: **Dr Santosh Salunke
 (Referring Consultants)**

Indications

Assessment of raised area at GOJ.

Report

The procedure was completed successfully to D2.

Site a: Anterior lower oesophagus

Specimens: 2x biopsy.

Diagnosis

STOMACH. Normal.
 DUODENUM. Normal.

Advice/comments

Await bx

Follow up

Awaiting pathology results. Return to the GI physician.

Consultant/Endoscopist

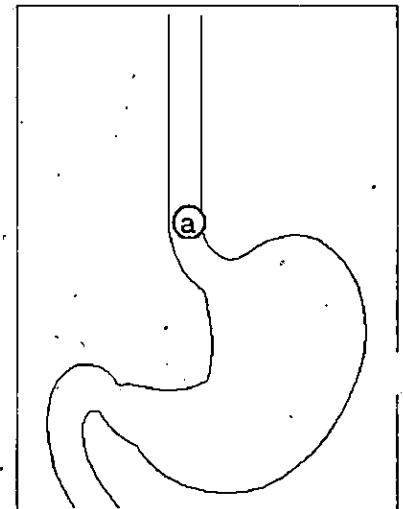
Dr Santosh Salunke
 Nurses: Susan Alexander
 Dianne Hill

Instrument

GIF 260 2243915

Premedication

Buscopan (IV) 10 mg
 Midazolam (IV) 2 mg



**a: Anterior lower oesophagus
 (photographed)**

Dr Santosh Salunke
Consultant Gastroenterologist
 c.c. Dr Santosh Salunke (Referring Consultants)
 Dowell, Scott

GASTROSCOPY REPORT (Patient copy)

Name: **Scott DOWELL (M)**
Date of birth: **26/02/1980**
CHI No: **2602800570**
Case note no.: **S679370**

Address: **11 Don Street,
Grangerouth,
Stirling, FK3 8HD**

COPY

Procedure date: **29th August 2017 (10:10)**

Signed

Name and designation
(Please print)

FORTH VALLEY ACUTE HOSPITALS NHS TRUST

Endoscopy Unit



COPY

Date 28/8/17 Time _____ Ward/Dept Endo Name _____

Presenting Complaint Surveillance Address _____

Procedure UGIE

Is this a repeat procedure? Yes / No

Unit No. _____

Contact Number Sister-in-law Angela

GP Dr. Dundas, Westburn M.P.

CHI NO: 2602800570 26/02/1980
CRN: S679370 M
Scott Dowell
11 Don Street,
GRANGEMOUTH,
Stirlingshire
FK3 8HD

Endoscopy Preparation

Please confirm each check by ticking box or circling item as required. Wards please complete before endoscopy; if not applicable, write N/A in box.

	Ward	Endo
Procedure explained		☒
Written consent		☒
I.D. band checked		☒
Recordings obtained		☒
Premedication given		<u>N/A</u>
Correct casenotes		☒
Correct nursing notes		☒
Referral letter		☒
Relevant X-Rays		<u>PA CS</u>
Blood results obtained		<u>SCI</u>
On warfarin		<u>N/A</u>
INR obtained (If required)		<u>N/A</u>
Date LMPO (X-Ray only)		<u>N/A</u>
Antibiotics given		<u>N/A</u>
I.V. cannula sited	<u>(R) ACF</u>	
I.V. cannula flushed	<u>Na Cl</u>	
I.V. cannula sited by whom	<u>Dianne</u>	

Dentures: Retained / Removed / N/A

TOP Plate Crowns: Loose Teeth N/A

Hearing aid: Retained / Removed / N/A

Contact lenses/ Spectacles: Retained / Removed / N/A

Prosthesis: Yes / No

Orthopaedic implants: Type (L) arm plus a plate Yes / No

Cardiac pacemaker: Yes / No

Heart valve replacement: Yes / No

Jewellery & Valuables: Retained / Removed. In locker / Documented

Time last ate or drank 10pm 28/8/17

Pre scope stool (please circle) loose / bloody / solid	Enteric precautions required: Yes / <u>No</u>
Bowel preparation (if required) type-	
Result	
Any side effects / problems	

History & Medication

Allergies: Yes / No (specify) _____

Heart disease: Yes / No (specify) _____

Chest problems: Yes / No (specify) _____

Rheumatoid arthritis: Yes / No Glaucoma: Yes / No

Epilepsy: Yes / No Diabetes: Yes / No

Other problems Ankylosing spondylitis

Previous surgery: (L) arm
Cyst Neck / Back Surger
Present medication:
Di hydrocodione
Rapinidril
Esomeprazole 40mg BD
Biological Inj - Humira

Discharge

Sedation score, pain score and nausea score must all be 1 or less for safe discharge. Discharge criteria must be met.

Sedation score = 0 Pain score = 0 Nausea Score = 0

Has patient had a drink Yes / No

Has patient had food Yes / No

Has patient been seen by doctor / N.E. Yes / No

Has patient been seen by nurse Yes / No

Advice on discharge sheet given Yes / No

Discharge criteria met Yes / No

If no specify _____

Discharged home (circle as required)

Alone

Accompanied

COPY

By ambulance Yes / No

Transfer to ward Yes / No

Which ward _____

Back to ward _____

Personal effects transferred

Teeth Yes / No

Clothes Yes / No

Glasses Yes / No

Valuables Yes / No

Response to endoscopy

Satisfactory

Unsatisfactory (specify) _____

Patient education

None required / Yes (specify)

After care leaflet given Yes

Signature OK

Condition on leaving endoscopy unit Drowsy / Slightly Drowsy / Awake

Clinic appointment:- Has one for _____ To be made for _____

To be rescoped :- Yes _____ Referral sent:- Yes _____

Other follow up Dr. Salunke to decide

Additional comments _____

Time left
department

11:05 Noon

Signature JK

Recovery Needs

Fast until _____ B.P. Pulse & Resps ¼ hourly until sedation score 1 and stable

Lie in recovery position (circle as required)	Left side	Right side
---	-----------	------------

COPY

Observe for any of the following - Haemorrhage, Perforation, Abdominal pain, Pulse, BP, Change of colour, Change of temperature, Respirations

Oxygen must be administered at 2litres a minute until sedation score 1 or less and oxygen saturation level maintained at pre endoscopy saturation level

Reversal of sedation Yes / No (specify)

Type of recovery Uneventful / Eventful (specify)

Have passed urine Yes No I.V. cannula removed Yes / No / None

I.V. cannula site Satisfactory / Unsatisfactory (specify)

Time	Admission	Theatre and Recovery				
	09:00	10:20	10:35	10:45	10:50	11:00
BP & Pulse	190					
	180					
	170					
	160					
	150					
	140					
	130					
	120					
	110					
	100					
	90					
	80					
	70					
	60					
	50					
	40					
O2 saturation	98	99	98	99	99	99
O2 therapy	NA	2L	N	A	A	A
Respirations	13					
Temperature	—					
BM	—					
Sedation score	—	1/6	1/0	0	0	0
Nausea score	—	0	0	0	0	0
Comfort score	—	1/0	0	0	0	0
Staff Initials	CH	CH	CH	CH	CH	CH

Sedation score

0. Fully aware of self & surroundings
1. Mostly aware of self & surroundings, but sedate
2. Slightly aware of self & surroundings, usually somnolent, arouses easily with stimuli
3. Not aware of self or surroundings; little arousal with stimuli
4. Unconscious, no arousal with painful stimuli

Nausea score

0. None
1. Mild, no treatment required
2. Moderate, helped by treatment
3. Severe, despite treatment

COMFORT SCORE

0. None / minimal
1. Mild
2. Moderate
3. Severe

Endoscopy prescriptions

Date	Medicines	Route	Dose	Time	Dr's Signature	Given By
29	Midazolam	I.V.	2mg	1015	<i>[Signature]</i>	<i>B. Salunkhe</i>
8	Fentanyl	I.V.				
	Pethidine	I.V.				
	Buscopan	I.V.	10mg	1025	<i>[Signature]</i>	<i>B. Salunkhe</i>
	Voltarol	PR				
	Anexate	I.V.				
	Adrenaline	INJ				
	Botox	INJ				
17	Lignocaine	NEB				
	Sodium Chloride	IV				
	Oxygen Therapy	Nasal Inhaler				<i>[Signature]</i>

Comments

Post procedure safety brief carried out _____ Signed *[Signature]*

Endoscope & Equipment decontamination record

Valve No. _____

Please attach all decontamination reports / certificates securely to this page

VRH-ENDOSCOPY BLOCK G/H LV1
BUTTONS & VALVES IN
STRAINER

UC SN04806
ID: 103777000423

VER. 5
CAT.

Packed By	Checked By
Pre-Op	Post-Op

DO NOT USE IF PACKING IS DAMAGED OR
STORE IN A CLEAN DUST FREE ENVIRONMENT

Boston Scientific
Radial Jaw™ 4
2.8mm
GTIN 08714729745488
REF M00513300
LOT 20470791



BUTTONS & VALVES IN
STRAINER



REORDER CODE FPLB 378
Tel: +44 1454 322777

Reprocessor ID: 4
Cycle: 27453
Manual Wash:
28-08-2017 - 12:45
Processed Time:
28-08-2017 - 13:17

Scope Code: 3000004
User Code: 8004A000016
Lot No: 00586
Serial No: 2243915

DO NOT USE IF PACKING IS DAMAGED OR OPEN
STORE IN A CLEAN DUST FREE ENVIRONMENT

NHS-PRN4-Sitting Rd, Letchworth, Herts, AL14 4NN
GASTROSCOPE

Patient safety brief

Procedure Room: 4 Time in 1015

Time out _____

	TICK AS COMPLETED (By Circulating Nurse)	COMMENTS: Please document any comments below (To be completed below by Named Nurse prior to safety brief)
PATIENT DEMOGRAPHICS Name, Address, DOB, GP	☒	Correct
PROCEDURE/INDICATIONS CONSENT completed/checked	☒	Yes
ANTICOAGULANTS Warfarin, Clopidogrel etc	☒	N/A
ALLERGIES To what and effect on patient	☒	N/A
MOBILITY STATUS Hoist, glide sheets etc	☒	N/A
INFECTION CONTROL MRSA, C-Diff, TB etc	☒	N/A
PATIENT ISSUES Same name, confused, fall risk, Pacemakers, Diabetic, Artificial joints etc.	☒	N/A

Sign below on completion of safety brief

Circulating Nurse D. HillEndoscopist S. SalunkoProcedure Performed Gastroscopy - GOS byEndoscope decontaminated, prepared & checked prior to use ☒ Yes / NoThroat spray Yes / ☒ No Time _____Abdominal Pressure Applied Yes ☒ No Where? _____Diathermy plate Yes ☒ No Pad site _____ Skin intact Yes / NoAPC Applied: Yes ☒ No Effect: _____ Watts: _____

Present in Procedure Room (Witnessing Safety Brief)

Name Nurse E. JenkinsCirculating Nurse D. HillTheatre Nurse S. AlexanderEndoscopist Dr. SalunkoTrainee Endoscopist Dr. J. Vermyan

Others _____

Patient Comfort Score: 0 - None ☒ 1 - Mild 2 - Moderate 3 - SevereComments Tolerated well

Mobility Assessment

Complete mobility chart below

Assessment of Potential Problems

COPY

Is	Pre Scope	Post Scope	Discharge
If independently mobile please tick	✓		✓
	Asst Equipment	Asst Equipment	Asst Equipment
Chair to Chair		whilst sedated	independent
Chair to Couch			
Couch to Chair			
Other Specify			
Signature	DNiel	DNiel	✓

Nursing Assessment

Is Sedation Requested

☒ Yes

☐ No

☐ Undecided

Admitted to unit for UGIE
 Procedure explained
 Observations satisfactory
 Discussed at safety brief.
 DNiel

Venflon ☒ Yes / No Size 22G Lot No. 207649361 Expires 03/2020

Sodium Chloride ☒ Yes / No Batch No. 16064013 Expires 07/2018

ASSESSMENT & CARE PLAN BOOKLET

CHI NO: 2602800570 26/02/1980 re
CRN: Scott DOWELL M
11 DON STREET
GRANGEMOUTH
FK3 8HD

Date of Admission:
Time of Admission:
Ward admitted to:
Date of transfer:
Ward transferred to:
Booklet number:

Assessment	Initial assessment to be completed within:	Initials	Re-assessment code
NEWS	On admission		
Hydration	4 hours		
CPE/MRSA	On admission		
Pressure Areas	6 – 8 hours		
4AT	6 hours		
Falls risk	6 hours		
Bed rails	6 hours		
MUST	24 hours		
Pt handling & mobility	24 hours		
Personal hygiene	24 hours		
Oral care	24 hours		
Continence	24 hours		
Elimination	24 hours		

	Assess on admission- >24 hours
	Assess daily
	Assess weekly
	Review when condition changes
	Assess 2-4 weekly

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

COPY

[illegible]

COPY

COPY

NEWS

Date

26
1

NEWS Score 0 ✓

NEWS Score 1-4

News Score greater than 5 or 3 in one parameter

News Score 7 or more

Goals

- To monitor NEWS observations as per FVRH Policy
- Discuss and agree care plan with patient/carer

Potential nursing actions

1. News 0 Minimal 12 hourly observations
2. NEWS 1-4 Minimum 4-6 hourly observations
3. NEWS 5-6 or 3 in one parameter hourly observations (Recognition, Escalation Sticker completed)
4. News 7 or more continuous monitoring of Vital signs Document every 30 minutes.

Date/Time

Plan of Care

Review

Sign

26/1/20

NEWS 0

4-6 hourly obs required

Daily

AMM

Hydration Assessment

Risk assessment should be carried out within 4 hrs of admission

COPY

Are any of the following 4 risk factors present?

Diarrhoea / High output from stoma
High output from NG
Large open wound
Excessive vomiting
Bladder irrigation
RR >20 per minute
Temp > 38°C

Prescribed IV fluid / IV diuretics / parenteral nutrition

Routine post op management where indicated

Urinary catheter in situ with hourly volumes
NEWS > 5

No risk factors present

Go to Daily Assessment flowchart

If patient commences fluid balance chart:

Use daily assessment flow charts to determine the need for fluid balance monitoring.

Documentation **must** be recorded in the patient's unified notes and include:

- Reason for commencement / discontinuation
- All interventions / treatments / care given
- Evidence of review

1 or more risk factors present

Commence fluid balance chart within 1 hour

Complete Hydration Care plan Overleaf

Daily Assessment and Review

Risk Assessment	Date/Time	Date/Time	Date/Time	Date/Time	Date/Time	Date/Time	Date/Time
	24/10						
Number of Risks present	0						
Fluid Balance monitoring Indicated Y= Yes N= No	N						
Initials of assessor	MM						

PTO

Daily Hydration Care plan

Fluid Preferences on MUST

	Frequency of assessments	Date & Time Assessed with comments	Date & Time Re assessed with comments	Date & Time Re assessed with comments	Date & Time Re assessed with comments	Date & Time Re assessed with comments	Date & Time Re assessed with comments	Date & Time Re assessed with comments
Commence requirement of fluid balance chart if one or more risks are identified	Daily or change in clinical condition	24/1/20						
Set daily fluid balance target with medical team	Daily (At Ward Round)							
Review 24hr fluid balance document in unified notes and discuss with medical team	Daily							
Offer beverages at every Care & Comfort round (if appropriate) and document intake	Continuous							
Encourage patient, family or Carer to be involved with fluid intake and recording (Provide pictorial fluid chart)	Daily							
Describe patient's individual needs	Daily							
Signature		HN						

COPY

Infection Prevention and Control Risk Assessment

All patients admitted must have a Clinical risk assessment (CRA) for Carbapenemase producing *Enterobacteriaceae* (CPE) and Meticillin Resistant *Staphylococcus aureus* (MRSA). **COPY**

This is a mandatory requirement.

CPE Clinical Risk Assessment (No patients are excluded from CPE screening).	Response	
Has the patient had any previous history of CPE (check ward / clinical portal)	YES	☒ NO
Has the patient been transferred directly from another hospital outwith NHSFV	YES	☒ NO
Has the patient a history of admission to a hospital outwith Forth Valley in the last 12 months (including dialysis patients)	YES	☒ NO
Has the patient been in close contact with a person colonised or infected with CPE	YES	☒ NO

A **YES** response to **ANY** of the above questions suggests the patient has an increased risk of CPE and the following actions must be taken:

- The patient is isolated in a single side room, STOP sign on door, contact precautions initiated;
- The patient is given an information leaflet and consent is obtained for swabbing;
- CPE screen: Rectal swab taken by a registered nurse or stool specimen and, if present, a wound swab. A urine specimen is required if a urinary catheter is present;
- A rectal swab **must not** be used for children under 16 years. A stool specimen should be sent.

MRSA Clinical Risk Assessment (Exclusions from MRSA screening include: Day case patients and admissions to paediatric, obstetric and mental health specialities)		Response	
1	Has the patient a history of MRSA, (Check ward / clinical portal)	YES	☒ NO
2	Has the patient been admitted from anywhere other than their own home, e.g. care home, hostel, prison, or transferred from another hospital.	YES	☒ NO
3	Does the patient have any wounds or indwelling medical devices (e.g. PEG, Hickman line, urinary catheter)	YES	☒ NO
4	Will the patient be admitted / transferred to ITU, B23 or B31	YES	☒ NO

A **YES** response to questions **1, 2 or 3** indicates an increased risk of MRSA colonisation. The following actions must be taken:

- The patient is isolated in a single side room, STOP sign on door, contact precautions initiated;
- The patient is given an MRSA screening leaflet and consent obtained for swabbing;
- MRSA screen: swab nose, perineum and if present, wounds and insertion sites of invasive devices. A urine specimen is required if a catheter is present.

Note: this is the minimal screen required and additional swabs can be sent if clinically indicated.

A **YES** response to question **4** confirms admission to a high risk specialty and the following actions must be taken:

- The patient is given an MRSA screening leaflet and consent obtained for swabbing;
- MRSA screen: swab nose, perineum and if present, wounds and insertion sites of invasive devices. A urine specimen is required if a catheter is present.

Name of Person completing CRA	Morrison	DATE	24/1/20
-------------------------------	----------	------	---------

Record your answer in the grid below Y = Yes N = No

If the answer is NO to any statement or there is a notable change in the patient's condition, undertake a Braden risk assessment and consider any other relevant assessment

Date	Time	Person is fully mobile without equipment or assistance	Person is fully continent	Person appears well nourished and able to eat /drink	Skin to pressure points satisfactory and intact (observed)	Review these questions every 24 hours if no initial risk identified	Braden requires completion	Signature	Skin description - i.e.: Redness, Skin Broken, Blister/Ulcer	Action Taken:
24/11	06 ¹⁵	Y	Y	Y	Not observed	Y	Y	MMZ	Pt states intact.	Monitor

BRADEN RISK ASSESSMENT CHART

Individuals with a total score of 16 or less are considered at risk: 15-16 = low risk, 12-14 = moderate risk, 11 or less = high risk.

Undertake and document risk assessment within 8 hours of admission to every ward or department or on first home visit. Reassess if there is a change in individual's condition

and repeat regularly according to local protocol

Complete care and comfort round chart.

Consider contributing factors, frailty, diabetes, end of life care.

Sensory Perception – Ability to respond meaningfully to pressure related discomfort	1. Completely Limited Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body surface.	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment that limits the ability to feel pain or discomfort over 1/2 of body.	3. Slightly Limited Responds to verbal commands but cannot always communicate discomfort or need to be turned. OR has some sensory impairment that limits ability to feel pain or discomfort in 1 or 2 extremities.	4. No Impairment Responds to verbal commands. Has no sensory deficit that would limit ability to feel or voice pain or discomfort.	4					
Moisture – Degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient/client is moved or turned.	2. Very Moist Skin is often but not always, moist. Linen must be changed at least once a shift.	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day.	4. Rarely Moist Skin is usually dry. Linen only requires changing at routine intervals.	4					
Activity – Degree of physical activity	1. Bedfast Confined to bed.	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. Walks Occasionally Walks occasionally during day but for very short distance, with or without assistance. Spends majority of each shift in bed or chair.	4. Walks Frequently Walks outside the room at least twice a day and inside the room every 2 hours during waking hours.	4					
Mobility – Ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance.	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	3. Slightly limited Makes frequent though slight changes in body or extremity position independently.	4. No Limitations Makes major and frequent changes in position without assistance.	4					
Nutrition – Usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IV's for more than 5 days.	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding.	3. Adequate Eats over half of most meals. Occasionally will refuse meal but will usually take a supplement if offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	4. Excellent Eats most of every meal. Never refuses a meal. Occasionally eats between meals. Does not require supplementation.	4					
Friction and Shear –	1. Problem Requires moderate to maximum assistance in moving.	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.		3					
Indicate appropriate number and add for total score					TOTAL SCORE:	23				
					SIGNATURE:	MMZ				

COPY

Prevention of Pressure Injury Assessment

Skin Care Plan

COPY

[illegible]

THE 4AT TEST: SCREENING INSTRUMENT FOR COGNITIVE IMPAIRMENT AND DELIRIUM

TO BE COMPLETED FOR ALL PATIENTS OVER 65 ON ADMISSION AND WHEN A CHANGE IN PRESENTATION IS EVIDENT

*MDT DECIDED INAPPROPRIATE DUE TO CLINICAL PRESENTATION Signed..... Date.....
(ensure documented in clinical notes)

Not Required

		DATE	/ /	/ /	/ /	/ /	/ /	/ /
1. ALERTNESS: <i>This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive.</i> <i>If asleep, attempt to wake and ask the patient to state their name and address to assist rating.</i>	Normal (fully alert, but not agitated throughout assessment)	0	0	0	0	0	0	0
	Mild sleepiness for <10 seconds after waking, then normal	0	0	0	0	0	0	0
	Clearly abnormal (agitated or drowsy)	4	4	4	4	4	4	4
2. AMT4: <i>Age, date of birth, place (name of hospital or building), current year</i>	No mistakes	0	0	0	0	0	0	0
	1 mistake	1	1	1	1	1	1	1
	2 or more mistakes/un-testable	2	2	2	2	2	2	2
3. ATTENTION: <i>Ask the patient: "Please tell me the months of the year in backwards order, starting at December."</i> <i>To assist initial understanding one prompt of "what is the month before December?" is permitted.</i>	Achieves 7 months or more correctly	0	0	0	0	0	0	0
	Starts but scores <7 months/refuses to start	-1	1	1	1	1	1	1
	Un-testable (cannot start because unwell, drowsy, inattentive)	2	2	2	2	2	2	2
4. ACUTE CHANGE OR FLUCTUATING COURSE: <i>Evidence of significant change or fluctuation in: alertness, cognition (e.g. increased confusion) or other mental function arising over the last 2 weeks and still evident in last 24hrs</i>	No	0	0	0	0	0	0	0
	Yes	4	4	4	4	4	4	4
Initials of tester →								
4 or above:	Possible delirium +/- cognitive impairment - score daily until score <4 for 2 consecutive days	Day 1 4ATscore	Day 2 4ATscore	Day 3 4ATscore	Day 4 4ATscore	Day 5 4ATscore	Day 6 4ATscore	Day 7 4ATscore
1-3:	Possible cognitive impairment - only rescore if condition changes							
0:	Delirium or cognitive impairment unlikely - only rescore if condition changes							
4 or above - initiate TIME bundle and consider need for section 47 of Adults with Incapacity Act. 1-3 - if no diagnosis of dementia obtain AMT10 and collateral history and refer to Liaison Psychiatry for Older People if any concerns regarding normal level of cognition.								

COPY



Falls trigger tool			
Age 65 Years or older?	Yes	No	4AT more than 4 or AMT 10 score 8 or less or acute confusion?
Has the person fallen in last 6 months?	Yes	No	Based on clinical judgement is this person at risk of falling?
Tries to walk alone but unsteady/safe?	Yes	No	Date: 24/1/20
If "yes" to more than one question complete Falls Care Plan – If High Risk of Falls initiate red leaf protocol + signifier on EWARD			Time: 04 ²⁰ Sign: <i>[Signature]</i>

Risk Factor Contributing to Falls Risk	Document Care to be Undertaken	Review of Interventions Weekly, post fall or changes to the patients condition (If post fall indicate falls number)
Discuss falls risk/history with relatives, engage them in support planning and check contact wishes in event of a fall. Provide a copy of Reducing Falls In Hospital Leaflet	Participation	
State if independent or type of aid used & level of supervision/assistance required. Check that any walking aid is available and within arm's reach at all times (If no please document the reason why) If Physio/OT input required document date of referral	Mobility	
Ensure footwear is appropriate If none available consider hospital stock slippers, slipper socks or if Podiatry referral is required	Footwear	
Is the patient more confused than normal or displaying distressing behaviour – think Delirium – 4 AT if >4 TIME BUNDLE Ensure patient is in the most appropriate bed space, review health needs, for example pain, dehydration, medication Complete Getting to Know me	Cognition	
Consider increase risk of falls due to types and number of medicines e.g. (>4) Discuss with medical staff/pharmacist for a review	Medication	
Record on all patients aged 65+ If a deficit is noted inform medical staff Post fall repeat lying + standing BP	Lying & Standing Blood Pressure	
Ensure the use of the call bell is explained during C&C rounding and in reach. Consider alternatives if unable to use such as: Increased comfort rounds, move closer to nurse's station, 4 bedded room, the use strategies to try to reduce stress for patient e.g. music, film, reading, games etc - involve family.	Call Bell	
Consider seating, flooring, signage, also consider devices e.g. catheter, oxygen tubing, drip stand etc Ensure bed height is at the lowest for the patient. Consider high low bed if does not wander walk	Environment	
Consider toileting arrangements for patient-e.g. closeness, lighting Is a MSU required	Continenence	
Ensure patient's glasses are within easy reach and are clean. Ensure hearing aid is in good working order + batteries changed weekly. Organise immediate repair if necessary and document	Vision Hearing	
	Other risks	
		If post fall review – IR1 NO Falls No.
Date & Time: Sign:		Date & Time: Sign:

COPY

Bedrails Assessment

COPY

Bed Rail Assessment

Bedrails NOT to be used

Code:

- A. Risk of climbing over and falling from a greater height.
- B. Patient is independent.
- C. Risk of entrapment in bedrails outweighs risk of falling
- D. Do not use with a high/low bed
- E. Patient with capacity and oriented but refuses bedrails
- F. Other please state

Bedrails ARE to be used with caution

Code:

- G. Patient with capacity and is alert and oriented and requests bedrails.
- H. Risk of injury from falling from the bed outweighs the risks of not using bed rails.
- I. Patient is unconscious.
- J. Other: please state.

Assessment to be completed on admission within 6 hours, reviewed weekly, following a fall and in response to a change in patient condition.

Date and Time	Code	Comment	Name/Signature
24/1/20. 04 ²⁰	B.		<i>[Signature]</i>

Note Bed rails must be in use when patients are being transported between areas



'MUST' – Nutritional Risk Screening

STEP 1 (BMI)	STEP 2 (Weight Loss)	STEP 3 (Acute Disease Effect)	STEP 4 (Overall Risk Score)	STEP 5 (Care Plan)
Weight (Kgs) * = <u>9.3</u> Height (m) * = <u>1.78</u> Method used <u>M</u> M, R, C* <u>30</u> BMI <u>30</u> See BMI charts Greater than 20 score 0 18.5 - 20 score 1 Less than 18.5 score 2 greater than 30 = obese	Pre-illness weight = Total unplanned weight loss over 3-6 months Weight loss (kg) = <u>Complete with weight loss chart</u> Less than 5% score 0 5-10% score 1 Greater than 10% score 2	Acute illness AND there has been or is likely to be no nutritional intake for 5 days No score 0 Yes score 2	Add scores from steps 1+2+3 to calculate overall risk score SCORE 0 = LOW RISK SCORE 1 = MEDIUM RISK SCORE 2+ = HIGH If risk category arrived at by clinical impression alone, indicate risk category LOW/MEDIUM/HIGH in table below and document rationale in progress notes	Implement appropriate Nutritional Care Plan 0 = LOW RISK 1 = MEDIUM RISK 2 = HIGH RISK Treat as High Risk - immediate Dietetic Referral • Dysphagia • Enteral Tube Feeding • Multiple Fractures • Pressure Ulcers Grade 3 or more • Decompensated Liver Disease

'MUST' SCREENING AND RESCREENING

Pre-illness weight

Initial screening

Date	Time	Ward	Weight (kg)*	Weight ↑↔↓	Method used (M,R,C)	BMI	Step 1 Score	Step 2 Score	Step 3 Score	Total Score	'MUST' Risk	Initial
24/1	04 ³⁰	SAU	93	↔	M	30	0	0	0	0	Low	MM.

Rescreening

[illegible]

'MUST': Low Risk Nutrition Care Plan

Date care plan initiated: 26/1/20

COPY

Intervention	Time Frequency	Initial/Date
Has patient been informed of current weight and plan?	☒ Yes ☐ No	26/1/20 HME
Discuss the results of the 'MUST' screening/care plan with the patient and family (with agreement and involve them in identifying individualised interventions)	On admission & on-going	
Monitor patients weight and rescreen 'MUST' risk weekly or if patient's weight has remained stable for 4 weeks – screen monthly.	On admission	26/1/20 HME

Please ☒ relevant box and where yes is answered, record details of individual requirement below;

Food Allergy- No ☒ Yes ☐

Religious, cultural, ethnic requirements- No ☒ Yes ☐

Details:	Initial/Date
	HM 26/1/20

Therapeutic diet- No ☒ Yes ☐

Details:	Initial/Date
	HM 26/1/20

Assistance required with eating/drinking- No ☒ Yes ☐

Adapted cutlery/aids- No ☒ Yes ☐

Details:	Initial/Date
	HM 26/1/20

Specific food preferences (patients unable to make decisions on their food and fluid choices should have a detailed dietary and fluid preference recorded)

Details:

Is patient able to make own choices?

Yes – patient offered daily menu

No – for patient unable to make choices has food and fluid preferences been recorded on 'my dietary information sheet'

yes/no

CARE PLAN REVIEW

Discuss current weight and plan with patient (initiate new care plan if risk has changed) *Share with relative/carer where appropriate Sign and date on review of care plan.

Initial/Date	Initial/Date	Initial/Date	Initial/Date	Initial/Date
Initial/Date	Initial/Date	Initial/Date	Initial/Date	Initial/Date

Individual Patient Handling Risk Assessment

COPY

If the patient has been assessed as 'independent' on initial assessment, a mobility chart does not require to be completed.

Is the patient independent? YES ☒ NO ☐ (Please tick ✓ as appropriate)

If the patient has been assessed as 'independent' on initial assessment; and this status changes, please review and complete a mobility chart.

If the patient is 'Plus Size', please refer to Bariatric (Plus Size Person) Handling Guidelines.

Please state the patient's ability prior to admission: Independent

Please complete the following as to how the patient currently transfers / mobilises (Please tick ✓ as appropriate)

Please sign and date below

Assessor's Name (Print): <u>HMORRISON</u>		Date: <u>24/1/20</u>	
Signature: <u>[Signature]</u>		Review Date:	
Transfers (including to / from bed; wheelchair; commode; toilet)			
Independent ☒	Supervision ☐	Assistance of 1 ☐ 2 ☐ 3 ☐ More ☐ If More - please state number	Standaid ☐ Hoist ☐
Moves up and down the bed			
Independent ☒	Supervision ☐	Assistance of 1 ☐ 2 ☐ 3 ☐ More ☐ If More - please state number	Glide Sheet ☐ Hoist ☐
Sits up and over the side of the bed			
Independent ☒	Supervision ☐	Assistance of 1 ☐ 2 ☐ 3 ☐ More ☐ If More - please state number	Bed Rest ☐
Bathing (including in and out of the bath / shower)			
Independent ☒	Supervision ☐	Assistance of 1 ☐ 2 ☐ 3 ☐ More ☐ If More - please state number	(please specify) Hoist ☐ Other ☐
Walking			
Independent ☒	Supervision ☐	Assistance of 1 ☐ 2 ☐ 3 ☐	Walking Aid ☐ No Walking ☐
Did the patient have a walking stick or frame on admission? YES ☐ NO ☐			

This form must be completed for each individual patient, along with a mobility chart, if required.

The figure consists of two square panels, labeled (a) and (b). Panel (a) shows a square lattice with a central square highlighted. Panel (b) shows a similar lattice with a different central square highlighted. The diagram is labeled with 'a' and 'b' to indicate dimensions.

COPY

[illegible]

COPY

[illegible]





CHI NO: 260280057
SRN:
COLL DOWELL
VDC

DOB:

COPY

Mark ○

SYSTOLIC
BLOOD
PRESSURE

Mark

HEART
RATE

Mark •

CONSCIOUS
LEVEL

Blood Sugar

TOTAL SCORE

Pain Score (0-3)

Recognition & Response Checklist

Urine Output Recorded

Initials

≥ 39°
38°
37°
36°
≤ 35°

220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30

Alert

V/P/U

0 1 1 1 0 1 1 1 3 1

2 2 1 6 0 1 0 0 0 0

0 0 1 1

0 0 -

19 5 1 1 1 1 1 1 1 1

12

NEWS Recording Frequency:

Score 0 = Routinely

Score 1-4 = Minimum 4-6 hourly

CHI:

WARD:

Date

COPY

≥25

21-24

12-20

9-11

≤8

≥96

94-95

92-93

≤91

≥88

86-87

≤85

Default

Chronic
↑ CO2

Please tick

Refer to key

≥39°

38°

37°

36°

≤35°

220

210

200

190

180

170

160

150

140

130

120

110

100

90

80

70

60

50

>140

130

120

110

100

90

80

70

60

50

40

30

Alert

V / P / U

Blood Sugar

Respiratory

Pain Score (0-3)

Recognition & Response Checklist

Urine Output Recorded

Initials

Score 5-6 (or 3 in one parameter) = 1 hourly

Score 7 or More = Continuous

National Early Warning Score (NEWS)

NHS

North Valley

COPY

Name:

DOB:

CHI No:

Address:

Regardless of NEWS always escalate if concerned about a patient's condition

Total NEWS	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	Continue routine NEWS monitoring with every set of observations
1-4	Minimum 4 - 6 hourly	- Inform registered nurse who must assess the patient - Registered Nurse to decide if increased frequency of monitoring and / or escalation of clinical care is required
5-6 or 3 in one Parameter	Increased frequency to a minimum of 1 hourly	- Registered nurse to urgently inform the medical team caring for the patient - Urgent assessment by a clinician with core competencies to assess acutely ill patients - Ensure structured Response Stickers A & B are completed (<i>Not Applicable in Emergency Dept</i>)
7 or more	Continuous monitoring of vital signs (3 lead ECG and continuous SpO2 monitoring, 15 minute BP cycling - document observations every 30 minutes)	- Registered nurse to immediately inform the medical team caring for the patient - Emergency assessment by clinical team with core competencies to assess acutely unwell patients - Ensure structured Response Stickers A & B are completed (<i>Not Applicable in Emergency Dept</i>) - Consider transfer of clinical care to ITU

Exclusion Criteria

Anaesthesia and/or sedation may result in reduced conscious levels for a period of time. Scores that are increasing post-procedure and those including "P" or "U" always require escalation. The post-procedure NEWS score and post-procedure plan that will include the frequency of observations should be communicated to the ward staff on transfer/handover of the patient.

Target O2 Saturation

Target SpO2 for most patients should be 94-98%.

Selected patients may require target SpO2 88-92% (Appropriate in specific patients with severe chronic respiratory disease who either have established chronic Type 2 respiratory failure, or are felt to be at significantly increased risk of CO2 retention from oxygen therapy). These patients should use the modified (chronic hypercapnia) EWS. Arterial blood gases should be repeated at 30-60 min to check for rising CO2 or H+ after initiation of oxygen in this context.

Acute Respiratory Failure is a life threatening emergency

Severe Hypoxia (Requiring >60% O2 to maintain target SpO2)

Acute Hypercapnia (pCO2 >6 and H+ >45)

Urgent ST3 (or equivalent) review is required to optimise management.

Duty or on call consultant should be contacted if advice required.

Critical care referral and ventilatory support may be needed.

Codes For Recording Oxygen Delivery On NEWS Chart

A = Air (not requiring oxygen or weaning or on PRN oxygen)

N = Nasal Canulae

SM = Simple Mask

V24 = Venturi 24% V28 = Venturi 28% V35 = Venturi 35% V40 = Venturi 40% V60 = Venturi 60%

H28 = Humidified oxygen at 28% (also H35, H40 & H60 = Humidified Oxygen at 35%, 40% & 60%)

RM = Reservoir Mask

TM = Tracheostomy Mask

CP = Patient on CPAP System

NIV = Patient on NIV System

OTH = Other Device:

(specify which)

Pain Score

0 = no pain

1 = mild pain

2 = moderate pain

3 = severe pain

ault

nic
02
1

Checklist

ed

S

Sepsis Screening Tool

NHS
Forth Valley

Patient triggering NEWS ≥ 5 OR Clinical Concern
Neutropenia suspected OR MEWS triggering for obstetric patients

COPY

Is this likely to be due to infection?

Cough/sputum
Abdominal pain/distension/diarrhoea
Line infection
Endocarditis

Dysuria
Cellulitis
Headache with neck stiffness
Wound infection

Obstetric patients (Refer to FV protocol: Sepsis in Maternity Patients)
Perineal trauma Vaginal discharge Prolonged SRM Sore Throat

YES

Escalate to Doctor/ANP with
"suspected sepsis"
Place Sepsis 6 sticker in notes
Prepare giving set/IV fluids

NO

Escalate to Doctor/ANP
Repeat NEWS/MEWS in max 60 mins

**ASSESS FOR OTHER CAUSES OF
TRIGGERING**

Two people work together to deliver the Sepsis 6 within 60 mins of
patient first triggering

- Correct Hypoxia
- Take Blood Cultures
- Give IV antibiotics according to
NHS FV Protocol

- Measure whole blood Lactate
- Assess urine output (catheter if
obstetric patient)
- Start IV fluids - 20ml/kg, minimum
500mls in the first hour

ASSESS FOR SEVERE SEPSIS

SEVERE SEPSIS

Sepsis with $\geq$ organ dysfunction:

- Hypotension
- Renal
- Respiratory
- Hepatic
- Hematologic
- CNS
- Metabolic acidosis

IF SEVERE SEPSIS

Contact middle grade Doctor (Consultant
if obstetric patient)

Catheter mandatory if evidence of AKI

NO EVIDENCE OF SEVERE SEPSIS

Assess response to sepsis 6

Continue regular NEWS

SEPTIC SHOCK

- Hypotension despite fluid
resuscitation
- Organ dysfunction

HIGH RISK FACTORS

- Hypotension
- Lactate > 4
- Unexplained INR > 1.5
- APTT > 60 secs
- Bilirubin > 34 (70 if obstetric)
- Platelets < 100

Conscious Level Chart (only as required for head injury observation)

DATE:																			DATE:	
TIME:																				
C O M A S C A L E	Eyes Open	Spontaneously	4																	Eyes closed by swelling = C
		To speech	3																	
		To pain	2																	
		None	1																	
	Best verbal response	Orientated	5																	Endotracheal tube or tracheostomy = T
		Confused	4																	
		Inappropriate words	3																	
		Incomprehensible sounds	2																	
		None	1																	
	Best motor response	Obey commands	6																	Usually record the best arm response
		Localise pain	5																	
		Withdraws to pain	4																	
		Flexion to pain	3																	
		Extension to pain	2																	
		None	1																	
• 1 • 2 • 3 • 4 • 5 • 6 • 7 • 8 Pupil Scale (mm)																				
PUPILS	right	Size Reaction																	+ reacts - no reaction c. eye closed	
	left	Size Reaction																		
L I M B M O V E M E N T	A R M S	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																		
	L E G S	No response																		
		Normal power																		
		Mild weakness																		
		Severe weakness																		
		Extension																		
		No response																		

Pain Assessment & Management Guidelines

Pain Score:

- 0 = No pain
- 1 = No pain at rest
Slight pain on movement
- 2 = Intermittent pain at rest
Moderate pain on movement
- 3 = Continuous pain at rest

For Acute and Chronic Pain:

For mild (1), moderate (2) or severe (3) pain refer to Pain Management Guidelines Forth Valley Formulary Appendix 27 & 28. Implement Pain Assessment Chart

For Cancer Related Pain:

For mild (1), moderate (2) or severe (3) pain score, refer Palliative Guidelines.

Supportive and Palliative Care Indicators Tool (SPICT™)

COPY

The SPICT™ is a guide to identifying people at risk of deteriorating and dying. Assessment of unmet supportive and palliative care needs may be appropriate.

Look for two or more general indicators of deteriorating health.

- Performance status poor or deteriorating, with limited reversibility. (needs help with personal care, in bed or chair for 50% or more of the day).
- Two or more unplanned hospital admissions in the past 6 months.
- Weight loss (5 - 10%) over the past 3 - 6 months and/or body mass index < 20.
- Persistent, troublesome symptoms despite optimal treatment of any underlying condition(s).
- Lives in a nursing care home or NHS continuing care unit, or needs care to remain at home.
- Patient requests supportive and palliative care, or treatment withdrawal.

Look for any clinical indicators of advanced conditions

Cancer

Functional ability deteriorating due to progressive metastatic cancer.

Too frail for oncology treatment or treatment is for symptom control.

Dementia / frailty

Unable to dress, walk or eat without help.

Choosing to eat and drink less; difficulty maintaining nutrition.

Urinary and faecal incontinence.

No longer able to communicate using verbal language; little social interaction.

Fractured femur; multiple falls.

Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease

Progressive deterioration in physical and/or cognitive function despite optimal therapy.

Speech problems with increasing difficulty communicating and/or progressive dysphagia.

Recurrent aspiration pneumonia; breathless or respiratory failure.

Heart / vascular disease

NYHA Class III/IV heart failure, or extensive, untreatable coronary artery disease with:

- breathlessness or chest pain at rest or on minimal exertion.

Severe, inoperable peripheral vascular disease.

Respiratory disease

Severe chronic lung disease with:

- breathlessness at rest or on minimal exertion between exacerbations.

Needs long term oxygen therapy.

Has needed ventilation for respiratory failure or ventilation is contraindicated

Kidney disease

Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.

Kidney failure complicating other life limiting conditions or treatments.

Stopping dialysis.

Liver disease

Advanced cirrhosis with one or more complications in past year:

- diuretic resistant ascites
- hepatic encephalopathy
- hepatorenal syndrome
- bacterial peritonitis
- recurrent variceal bleeds

Liver transplant is contraindicated.

Assess and plan supportive & palliative care

- Review current treatment and medication so the patient receives optimal care.
- Consider referral for specialist assessment if symptoms or needs are complex and difficult to manage.
- Agree current and future care goals/plan with the patient and family.
- Plan ahead if the patient is at risk of loss of capacity.
- Handover: care plan, agreed levels of intervention, CPR status.
- Coordinate care (eg. with a primary care register).

PERIPHERAL VASCULAR CATHETER (PVC) DAILY MAINTENANCE

Label	Reason for insertion:	DAY 0
Name: 	Insertion Date: <u>24/01/20</u> Time: <u>17:30</u>	COPY
D.O.B: <u>CHI NO: 2602800570</u> <u>26/02/1980</u>	Colour/batch no: <u>PINK</u> Position: <u>(1) arm</u>	
CHI: <u>CRN:</u>	Hand hygiene (HH) performed	Yes ☒ No ☐
Hospital: <u>Scott DOWELL</u>	Skin cleansed for 30 seconds with antiseptic & left to dry prior to insertion	Yes ☒ No ☐
(Use address) <u>11 DON STREET</u>	Aseptic technique throughout	Yes ☒ No ☐
GRANGEMOUTH	Sterile dressing applied including date and time	Yes ☒ No ☐
FK3 8HD	Inserted by: <u>ELP</u>	
	Ward inserted: <u>SPN</u>	

Ensure that:

Medical staff review the need for intravenous (IV) therapy including antibiotics on a daily basis – switch to oral if possible

An antiseptic containing 70% isopropyl alcohol is used to clean the access hub. Before accessing, rub the access hub for at least 15 seconds ("scrub the hub")

Removed at 5PM

MODIFIED VIP (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 sign:	Remove & replace cannula. Observe both sites and document. Obtain swab
Two or more of the following are evident: Pain, redness or swelling	2	Early stages of phlebitis:	Remove & replace cannula. Observe both sites and document. Treat if necessary. Obtain swab
All of the following are evident: Pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis	Remove and seek further advice. Obtain swab
As above including palpable venous cord	4		Remove and seek further advice. Obtain swab
As above including pyrexia	5		Seek further advice.

24 hours	Date:	Time:
Is PVC still required	YES	NO
Absence of inflammation/extravasation	YES	NO
VIP score - please circle	0 1 2 3 4 5	
PVC dressing intact	YES	NO
PVC inserted <72 hrs	YES	NO
HH before/after procedure	YES	NO
"Scrub the Hub" (before use)	YES	NO
PVC - please circle	Left in situ	removed
Reason for removal:		
Signature:		

48 hours	Date:	Time:
Is PVC still required	YES	NO
Absence of inflammation/extravasation	YES	NO
VIP score - please circle	0 1 2 3 4 5	
PVC dressing intact	YES	NO
PVC inserted <72 hrs	YES	NO
HH before/after procedure	YES	NO
"Scrub the Hub" (before use)	YES	NO
PVC - please circle	Left in situ	removed
Reason for removal:		
Signature:		

72 hours	Date:	Time:
Is PVC still required	YES	NO
Absence of inflammation/extravasation	YES	NO
VIP score - please circle	0 1 2 3 4 5	
PVC dressing intact	YES	NO
PVC inserted <72 hrs	YES	NO
HH before/after procedure	YES	NO
"Scrub the Hub" (before use)	YES	NO
PVC - please circle	Left in situ	removed
Reason left in situ:		
Discussed with:		
Reason for removal:		
Signature:		

If PVC to remain in situ for longer than 72 hours this must be documented on a daily basis in notes and discussed with medical staff.

Observe closely for clinical signs and symptoms of Phlebitis.

New sheet to be commenced.

PERIPHERAL VASCULAR CATHETER (PVC) DAILY MAINTENANCE

CHI NO: 2602800570 CRN: Scott DOWELL 11 DON STREET GRANGEMOUTH FK3 8HD 26/02/1980 LOT 9167802P02 2019-07-01 2022-06-30	Reason for insertion: <i>IV Access</i>	DAY 0
	Insertion Date: <i>25/1/20</i>	Time: <i>08:15</i>
	Colour/batch no: <i>PVC</i>	Position: <i>R ACE</i>
	Hand hygiene (HH) performed	☒ Yes ☐ No
	Skin cleansed for 30 seconds with antiseptic & left to dry prior to insertion	☒ Yes ☐ No
	Aseptic technique throughout	☒ Yes ☐ No
Sterile dressing applied including date and time		☒ Yes ☐ No
Inserted by: <i>[Signature]</i>		
Ward inserted: <i>[Signature]</i>		

eed for intravenous (IV) therapy including antibiotics on a daily basis – switch to oral if

0% isopropyl alcohol is used to clean the access hub. Before accessing, rub the access ds ("scrub the hub")

MODIFIED VIP (VISUAL INFUSION PHLEBITIS) SCORE

IV site	0	No phlebitis:	Observe cannula.
One of the following: Slight pain or redness near site	1	Possible first sign:	Remove & replace cannula. Observe both sites and document. Obtain swab
Two or more of the following are evident: Pain, redness or swelling	2	Early stages of phlebitis:	Remove & replace cannula. Observe both sites and document. Treat if necessary. Obtain swab
All of the following are evident: Pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis	Remove and seek further advice. Obtain swab
As above including palpable venous cord	4		Remove and seek further advice. Obtain swab
As above including pyrexia	5		Seek further advice.

24 hours	Date: <i>25/1/20</i>	Time: <i>08:15</i>
Is PVC still required	<i>WAB</i>	YES NO
Absence of inflammation/extravasation		YES NO
VIP score - please circle		0 1 2 3 4 5
PVC dressing intact		YES NO
PVC inserted <72 hrs		YES NO
HH before/after procedure		YES NO
"Scrub the Hub" (before use)		YES NO
PVC - please circle		Left in situ removed
Reason for removal:		
Signature: <i>[Signature]</i>		

48 hours	Date:	Time:
Is PVC still required	YES NO	
Absence of inflammation/extravasation	YES NO	
VIP score - please circle	0 1 2 3 4 5	
PVC dressing intact	YES NO	
PVC inserted <72 hrs	YES NO	
HH before/after procedure	YES NO	
"Scrub the Hub" (before use)	YES NO	
PVC - please circle	Left in situ removed	
Reason for removal:		
Signature:		

72 hours	Date:	Time:
Is PVC still required	YES NO	
Absence of inflammation/extravasation	YES NO	
VIP score - please circle	0 1 2 3 4 5	
PVC dressing intact	YES NO	
PVC inserted <72 hrs	YES NO	
HH before/after procedure	YES NO	
"Scrub the Hub" (before use)	YES NO	
PVC - please circle	Left in situ removed	
Reason left in situ:		
Discussed with:		
Reason for removal:		
Signature:		

If PVC to remain in situ for longer than 72 hours this must be documented on a daily basis in notes and discussed with medical staff.

Observe closely for clinical signs and symptoms of Phlebitis.

New sheet to be commenced

Removed as leaking
[Signature]
27/01/20

PERIPHERAL VASCULAR CATHETER (PVC) DAILY MAINTENANCE

Label	Reason for insertion: <i>in AIOX</i>	DAY 0
Name: 	Insertion Date: <i>27.1.20</i> Time: <i>10:30</i>	COPY
D.O.B: <i>CHI NO: 2602800570</i> <i>26/02/1980</i>	Colour/batch no: <i>Pink</i> Position: <i>(R) In N</i>	
CHI: <i>CRN:</i>	Hand hygiene (HH) performed	☒ Yes ☐ No
Hospit: <i>Scott DOWELL</i>	Skin cleansed for 30 seconds with antiseptic & left to dry prior to insertion	☒ Yes ☐ No
(Use at: <i>11 DON STREET</i>	Aseptic technique throughout	☒ Yes ☐ No
GRANGEMOUTH	Sterile dressing applied including date and time	☒ Yes ☐ No
FK3 8HD	Inserted by: <i>E. C.</i>	
	Ward inserted: <i>B11</i>	

Ensure that:

Medical staff review the need for intravenous (IV) therapy including antibiotics on a daily basis – switch to oral if possible

An antiseptic containing 70% isopropyl alcohol is used to clean the access hub. Before accessing, rub the access hub for at least 15 seconds ("scrub the hub")

MODIFIED VIP (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 sign:	Remove & replace cannula. Observe both sites and document. Obtain swab
Two or more of the following are evident: Pain, redness or swelling	2	Early stages of phlebitis:	Remove & replace cannula. Observe both sites and document. Treat if necessary. Obtain swab
All of the following are evident: Pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis	Remove and seek further advice. Obtain swab
As above including palpable venous cord	4		Remove and seek further advice. Obtain swab
As above including pyrexia	5		Seek further advice.

24 hours	Date:	Time:
Is PVC still required	YES	NO
Absence of inflammation/extravasation	YES	NO
VIP score - please circle	0 1 2 3 4 5	
PVC dressing intact	YES	NO
PVC inserted <72 hrs	YES	NO
HH before/after procedure	YES	NO
"Scrub the Hub" (before use)	YES	NO
PVC - please circle	Left in situ	removed
Reason for removal:		
Signature:		

48 hours	Date:	Time:
Is PVC still required	YES	NO
Absence of inflammation/extravasation	YES	NO
VIP score - please circle	0 1 2 3 4 5	
PVC dressing intact	YES	NO
PVC inserted <72 hrs	YES	NO
HH before/after procedure	YES	NO
"Scrub the Hub" (before use)	YES	NO
PVC - please circle	Left in situ	removed
Reason for removal:		
Signature:		

72 hours	Date:	Time:
Is PVC still required	YES	NO
Absence of inflammation/extravasation	YES	NO
VIP score - please circle	0 1 2 3 4 5	
PVC dressing intact	YES	NO
PVC inserted <72 hrs	YES	NO
HH before/after procedure	YES	NO
"Scrub the Hub" (before use)	YES	NO
PVC - please circle	Left in situ	removed
Reason left in situ:		
Discussed with:		
Reason for removal:		
Signature:		

If PVC to remain in situ for longer than 72 hours this must be documented on a daily basis in notes and discussed with medical staff.

Observe closely for clinical signs and symptoms of Phlebitis.

New sheet to be commenced.

Removed for home

ADULT PARENTERAL GENTAMICIN (), PRESCRIBING, ADMINISTRATION & MONITORING CHART

Use for patients prescribed intravenous gentamicin as per the GGC dosing guidance. Not for prophylactic indication or where synergistic doses (usually in endocarditis) are being used.
Refer to full guidance for information on EXCLUSIONS and Cautions / Contra-indications to gentamicin.

Patient n
CHI NO: 2602800570 26/02/1980
CRN:
Date of b Scott DOWELL
11 DON STREET
CHI no.: GRANGEMOUTH
FK3 8HD

Age 39 Sex: (M) / F
Weight: 145.8 Height: 5'9"
Creatinine: 82 on 15/1/20

Initial Gentamicin Dose* 400mg
Predicted Frequency* 24h
*this is not a prescription and may change. Doses must be prescribed individually below.

Source of first dose: Online calculator (preferred method) ☒ Manual calculation ☐ Weight-based, creatinine not known ☐

Step 1: Calculate and prescribe the first dose of gentamicin (see overleaf for more details)

- If creatinine is known - use the online gentamicin dose calculator
- If creatinine is not known - give 5 mg/kg gentamicin (maximum 400 mg) or, if CKD 5, give 2.5 mg/kg (maximum 180 mg) on advice of senior medical staff
- Prescribe gentamicin 'as per chart' on the medication chart (kardex). AVOID specifying dose or administration time on the kardex
- Prescribe individual doses in the prescription record section below, specifying the date and time the dose should be given

Step 2: Monitor creatinine and gentamicin concentration and reassess the dosage regimen

- Check gentamicin concentration after the first dose and then at least every 2 days (see overleaf for more details)
- Monitor creatinine daily. Seek advice if renal function is unstable (e.g. a change in creatinine of >15-20%)

Step 3: Assess daily: the ongoing need for gentamicin; signs of toxicity

- Consider an alternative agent if creatinine is increasing or the patient becomes oliguric
- If gentamicin continues for >7 days, suggest referral to audiology for assessment
- Refer to guidelines or clinical pharmacist for further advice on prescribing, monitoring and administration

PROMPT ADMINISTRATION
within 1 hour of recognition of sepsis reduces mortality

SIGNS OF GENTAMICIN TOXICITY

RENAL: ↓ urine output/oliguria or ↑ creatinine

OTO/ NEW tinnitus, dizziness, poor balance

VESTIBULAR: hearing loss, oscillating vision

Toxicities may occur irrespective of gentamicin concentration

TOXICITY	Gentamicin Prescription Record				Administration Record			Monitoring Record				
Before prescribing each dose check:	Complete each time a dose is to be given (ensuring gentamicin is prescribed 'as per chart' on the kardex)				Complete each time gentamicin is administered (in addition to the kardex)			Record ALL sample dates/times accurately below - See overleaf for monitoring advice				
Renal & Oto-vestibular function	Date to be given	Time to be given 24h clock	Gentamicin Dose (mg)	Prescriber's signature, PRINTED name and STATUS	*infuse over 30 mins*		Given by	Date of sample	Time of sample 24h clock	Gent level (mg/L)	Action/Comments (please initial action to be taken)	
					Date given	Time started 24h clock						
Cr = 82 micromol/L	25/01	02:45	400mg	Ben Nune	25/01	02:45	AK	25/01	06:20	2.0	24 hourly ☒ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other:	
Cr = 74 micromol/L	25/01	02:13	400	TFOLEY PV	26/01	02:15	AMC/PV			2.0	24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other:	
Discuss with an infection specialist or microbiology and document in the notes if treatment continues beyond 3 to 4 days												
Risks of prolonged treatment must be considered and treatment options discussed with microbiology or infection specialist												
Cr = 74 micromol/L	27/01	02:15	400	SCONNOR AMP	27/01	20:15	IN				24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other:	
Cr = micromol/L											24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other:	
Discuss with an infection specialist before continuing onto a second sheet												

Discuss with an infection specialist before continuing onto a second sheet

COPY

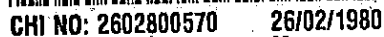
FORTH VALLEY ACUTE HOSPITALS
Infusion Fluids / Blood Products Page



WARD		CONSULTANT		PATIENT DETAILS		 CHI NO: 2602800570 CRN: Scott DOWELL 11 DON STREET	
ALLERGIES - Please use RED INK				HOSPITAL No: GRANGEMOUTH FK3 8HD DATE OF BIRTH: _____ AGE: _____		26/02/1980 COPY	
HEIGHT (m)	WEIGHT (kg)	DATE	SURFACE AREA (m ²)				

- enter dosage times as 24hour clock.
- please write in block capitals in black pen
- IV site MUST be checked prior to and after IV administration

A	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
	INFUSION FLUID	TOTAL VOLUME		TIME STARTED	
	Hartmanns	500		0845	1x500 - 19J125
	DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.
		25/1/20	125ml/hr		8
B	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
	INFUSION FLUID	TOTAL VOLUME		TIME STARTED	
	Hartmanns	500		1600	AC
	DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.
		25/1/20	125ml/hr		19J13T2C 09/21
C	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
	INFUSION FLUID	TOTAL VOLUME		TIME STARTED	
	Hartmanns	1000ml		04:30	Amorhead
	DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.
		25/1/20	125ml/hr		19J25T3E 05/22
D	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
	INFUSION FLUID	TOTAL VOLUME		TIME STARTED	
	Hartmanns	1000ml		0730	19J25T3E
	DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.
		25/1/20	125ml/hr		19J25T3E 05/22
E	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
	INFUSION FLUID	TOTAL VOLUME		TIME STARTED	
	DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.
F	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
	INFUSION FLUID	TOTAL VOLUME		TIME STARTED	
	DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.
G	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
	INFUSION FLUID	TOTAL VOLUME		TIME STARTED	
	DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.
H	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
	INFUSION FLUID	TOTAL VOLUME		TIME STARTED	
	DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.



GRANGEMOUTH
FK3 8HD

Ward:

Date _____

COPY

Weight: _____ kgs

Fluid Target (M= 2L / F= 1.6L avg)

Negative/ Restrict ☐ Neutral ☐ Positive ☐ _____ mls target

Previous 24hrs fluid balance

Reason commenced (✓ risk factors present) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

Discontinued by (name) _____

Clinical team aware: Yes ☐ No ☐

[illegible]

Total Intake: 200 mls

Total Output: _____ mls

Insensible Losses: _____ mls

(Total intake — total output + insensible loss) **24 hr Balance:** _____ ml



NHS Forth Valley No Smoking Policy

PATIENTS LEAVING HOSPITAL PREMISES TO SMOKE

As smoking is the biggest single cause of ill health in Scotland, NHS Forth Valley does not permit smoking in any of its premises including the grounds and car parks. It is also against the law in Scotland to smoke in any enclosed public place.

What this means for you?

- If you wish to smoke you must leave NHS Forth Valley premises to do so, this includes the grounds. You do this against medical advice.

How we can help?

- Assistance is available to help you to stop smoking and to alleviate withdrawal symptoms.
- Nicotine Replacement therapy can be prescribed for you during your stay.
- Specialist Stop Smoking support is available from trained staff who can come to the ward/department to discuss with you how they can help.

I have read and understand that I must leave NHS Forth Valley premises if I wish to smoke. **I understand if I choose to do so this will be at my own risk to my health, safety and well-being and that of others and is against medical advice.** I understand it is illegal to smoke in any enclosed public space.

Name: _____

CHI Number: _____



CHI NO: 2602800570 26/02/1980

CRN: M

Scott DOWELL

Ward or Department: _____

11 DON STREET

Hospital: _____

GRANGEMOUTH

FK3 8HD

Signature: (patient) Scott Dowell

Date: 25-1-20

☒ If you **DO NOT** wish to speak to a Specialist Stop Smoking Nurse please tick here.

ACTION REQUIRED

NOW - call Ext **66367** if box **NOT** ticked to refer patient

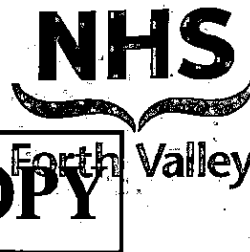
WHITE COPY - FOR PATIENTS NOTES

YELLOW COPY - PATIENT

PINK COPY - STOP SMOKING DEPT, GROUND FLOOR CLINICAL OFFICE, FVRH

NEWS KEY		0		1		2		3		NAME:		DOB:	
Date		24/2/20		24/2/20		24/2/20		24/2/20		24/2/20		24/2/20	
Time		12:50		13:10		13:45		14:00		14:55		15:00	
Time		15:20		15:45		16:00		16:15		16:30		16:45	
Time		17:00		17:15		17:30		17:45		18:00		18:15	
Time		18:30		18:45		19:00		19:15		19:30		19:45	
Time		20:00		20:15		20:30		20:45		21:00		21:15	
Time		21:30		21:45		22:00		22:15		22:30		22:45	
Time		23:00		23:15		23:30		23:45		24:00		24:15	
Time		24:30		24:45		25:00		25:15		25:30		25:45	
Time		26:00		26:15		26:30		26:45		27:00		27:15	
Time		27:30		27:45		28:00		28:15		28:30		28:45	
Time		29:00		29:15		29:30		29:45		30:00		30:15	
Time		30:30		30:45		31:00		31:15		31:30		31:45	
Time		32:00		32:15		32:30		32:45		33:00		33:15	
Time		33:30		33:45		34:00		34:15		34:30		34:45	
Time		35:00		35:15		35:30		35:45		36:00		36:15	
Time		36:30		36:45		37:00		37:15		37:30		37:45	
Time		38:00		38:15		38:30		38:45		39:00		39:15	
Time		39:30		39:45		40:00		40:15		40:30		40:45	
Time		41:00		41:15		41:30		41:45		42:00		42:15	
Time		42:30		42:45		43:00		43:15		43:30		43:45	
Time		44:00		44:15		44:30		44:45		45:00		45:15	
Time		45:30		45:45		46:00		46:15		46:30		46:45	
Time		47:00		47:15		47:30		47:45		48:00		48:15	
Time		48:30		48:45		49:00		49:15		49:30		49:45	
Time		50:00		50:15		50:30		50:45		51:00		51:15	
Time		51:30		51:45		52:00		52:15		52:30		52:45	
Time		53:00		53:15		53:30		53:45		54:00		54:15	
Time		54:30		54:45		55:00		55:15		55:30		55:45	
Time		56:00		56:15		56:30		56:45		57:00		57:15	
Time		57:30		57:45		58:00		58:15		58:30		58:45	
Time		59:00		59:15		59:30		59:45		60:00		60:15	
Time		60:30		60:45		61:00		61:15		61:30		61:45	
Time		62:00		62:15		62:30		62:45		63:00		63:15	
Time		63:30		63:45		64:00		64:15		64:30		64:45	
Time		65:00		65:15		65:30		65:45		66:00		66:15	
Time		66:30		66:45		67:00		67:15		67:30		67:45	
Time		68:00		68:15		68:30		68:45		69:00		69:15	
Time		69:30		69:45		70:00		70:15		70:30		70:45	
Time		71:00		71:15		71:30		71:45		72:00		72:15	
Time		72:30		72:45		73:00		73:15		73:30		73:45	
Time		74:00		74:15		74:30		74:45		75:00		75:15	
Time		75:30		75:45		76:00		76:15		76:30		76:45	
Time		77:00		77:15		77:30		77:45		78:00		78:15	
Time		78:30		78:45		79:00		79:15		79:30		79:45	
Time		80:00		80:15		80:30		80:45		81:00		81:15	
Time		81:30		81:45		82:00		82:15		82:30		82:45	
Time		83:00		83:15		83:30		83:45		84:00		84:15	
Time		84:30		84:45		85:00		85:15		85:30		85:45	
Time		86:00		86:15		86:30		86:45		87:00		87:15	
Time		87:30		87:45		88:00		88:15		88:30		88:45	
Time		89:00		89:15		89:30		89:45		90:00		90:15	
Time		90:30		90:45		91:00		91:15		91:30		91:45	
Time		92:00		92:15		92:30		92:45		93:00		93:15	
Time		93:30		93:45		94:00		94:15		94:30		94:45	
Time		95:00		95:15		95:30		95:45		96:00		96:15	
Time		96:30		96:45		97:00		97:15		97:30		97:45	
Time		98:00		98:15		98:30		98:45		99:00		99:15	
Time		99:30		99:45		100:00		100:15		100:30		100:45	
Time		101:00		101:15		101:30		101:45		102:00		102:15	
Time		102:30		102:45		103:00		103:15		103:30		103:45	
Time		104:00		104:15		104:30		104:45		105:00		105:15	
Time		105:30		105:45		106:00		106:15		106:30		106:45	
Time		107:00		107:15		107:30		107:45		108:00		108:15	
Time		108:30		108:45		109:00		109:15		109:30		109:45	
Time		110:00		110:15		110:30		110:45		111:00		111:15	
Time		111:30		111:45		112:00		112:15		112:30		112:45	
Time		113:00		113:15		113:30		113:45		114:00		114:15	
Time		114:30		114:45		115:00		115:15		115:30		115:45	
Time		116:00		116:15		116:30		116:45		117:00		117:15	
Time		117:30		117:45		118:00		118:15		118:30		118:45	
Time		119:00		119:15		119:30		119:45		120:00		120:15	
Time		120:30		120:45		121:00		121:15		121:30		121:45	
Time		122:00		122:15		122:30		122:45		123:00		123:15	
Time		123:30		123:45		124:00		124:15		124:30		124:45	
Time		125:00		125:15		125:30		125:45		126:00		126:15	
Time		126:30		126:45		127:00		127:15		127:30		127:45	
Time		128:00		128:15		128:30		128:45		129:00		129:15	
Time		129:30		129:45		130:00		130:15		130:30		130:45	
Time		131:00		131:15		131:30		131:45		132:00		132:15	
Time		132:30		132:45		133:00		133:15		133:30		133:45	
Time		134:00		134:15		134:30		134:45		135:00		135:15	
Time		135:30		135:45		136:00		136:15		136:30		136:45	
Time		137:00		137:15		137:30		137:45		138:00		138:15	
Time		138:30		138:45		139:00		139:15		139:30		139:45	
Time		140:00		140:15		140:30		140:45		141:00		141:15	
Time		141:30		141:45		142:00		142:15		142:30		142:45	
Time		143:00		143:15		143:30		143:45		144:00		144:15	
Time		144:30		144:45		145:00		145:15		145:30		145:45	
Time		146:00		146:15		146:30		146:45		147:00		147:15	
Time		147:30		147:45		148:00		148:15		148:30		148:45	
Time		149:00		149:15		149:30		149:45		150:00		150:15	
Time		150:30		150:45		151:00		151:15		151:30		151:45	
Time		152:00		152:15		152:30		152:45		153:00		153:15	
Time		153:30		153:45		154:00		154:15		154:30		154:45	
Time		155:00		155:15		155:30		155:45		156:00		156:15	
Time		156:30		156:45		157:00		157:15		157:30		157:45	
Time		158:00		158:15		158:30		158:45		159:00		159:15	
Time		159:30		159:45		160:00		160:15		160:30		160:45	
Time		161:00		161:15		161:30		161:45		162:00		162:15	
Time		162:30		162:45		163:00		163:15		163:30		163:45	
Time		164:00		164:15		164:30		164:45		165:00		165:15	
Time		165:30		165:45		166:00		166:15		166:30		166:45	
Time		167:00		167:15		167:30		167:45		168:00		168:15	
Time		168:30		168:45		169:00		169:15		169:30		169:45	
Time		170:00		170:15		170:30		170:45		171:00		171:15	
Time		171:30		171:45		172:00		172:15		172:30		172:45	
Time		173:00		173:15		173:30		173:45		174:00		174:15	
Time		174:30		174:45		175:00		175:15		175:30		175:45	
Time		176:00		176:15		176:30		176:45		177:00		177:15	
Time		177:30		177:45		178:00		178:15		178:30		178:45	
Time		179:00		179:15		179:30		179:45		180:00		180:15	
Time		180:30		180:45		181:00		181:15		181:30		181:45	
Time		182:00		182:15		182:30		182:45		183:00		183:15	
Time		183:30		183:45		184:00		184:15		184:30		184:45	
Time		185:00		185:15		185:30		185:45		186:00		186:15	
Time		186:30		186:45		187:00		187:15		187:30		187:45	
Time		188:00		188:15		188:30		188:45		189:00			

National Early Warning Score (NEWS)



Name:

CHI NO: 2602800570 26/02/1980
CRN: M

DOB:

Scott DOWELL
11 DON STREET

CHI No:

Address:

GRANGEMOUTH
FK3 8HD

*** Regardless of NEWS always escalate if concerned about a patient's condition**

Total NEWS	Frequency of Monitoring	Clinical Response
0 *	Minimum 12 hourly	Continue routine NEWS monitoring with every set of observations
1 - 4 *	Minimum 4 - 6 hourly	- Inform registered nurse who must assess the patient - Registered Nurse to decide if increased frequency of monitoring and / or escalation of clinical care is required
5 - 6 * or 3 in one Parameter	Increased frequency to a minimum of 1 hourly	- Registered nurse to urgently inform the medical team caring for the patient - Urgent assessment by a clinician with core competencies to assess acutely ill patients - Ensure structured Response Stickers A & B are completed (Not Applicable in Emergency Dept)
7 * or more	Continuous monitoring of vital signs (3 lead ECG and continuous SpO2 monitoring, 15 minute BP cycling - document observations every 30 minutes)	- Registered nurse to immediately inform the medical team caring for the patient - Emergency assessment by clinical team with core competencies to assess acutely unwell patients - Ensure structured Response Stickers A & B are completed (Not Applicable in Emergency Dept) - Consider transfer of clinical care to ITU

Exclusion Criteria

Anaesthesia and/or sedation may result in reduced conscious levels for a period of time. Scores that are increasing post-procedure and those including "P" or "U" always require escalation. The post-procedure NEWS score and post procedure plan that will include the frequency of observations should be communicated to the ward staff on transfer/handover of the patient.

Target O2 Saturation

Target SpO2 for most patients should be 94-98%.

Selected patients may require target SpO2 88-92% (Appropriate in specific patients with severe chronic respiratory disease who either have established chronic Type 2 respiratory failure, or are felt to be at significantly increased risk of CO2 retention from oxygen therapy). These patients should use the modified (chronic hypercapnia) EWS. Arterial blood gases should be repeated at 30-60 min to check for rising CO2 or H+ after initiation of oxygen in this context.

Acute Respiratory Failure is a life threatening emergency

Severe Hypoxia (Requiring >60% O2 to maintain target SpO2).

Acute Hypercapnia (pCO2 >6 and H+ >45)

Urgent ST3 (or equivalent) review is required to optimise management.

Duty or on call consultant should be contacted if advice required.

Critical care referral and ventilatory support may be needed.

Codes For Recording Oxygen Delivery On NEWS Chart

A = Air (not requiring oxygen or weaning or on PRN oxygen)

N = Nasal Canulae

SM = Simple Mask

V24 = Venturi 24% V28 = Venturi 28% V35 = Venturi 35% V40 = Venturi 40% V60 = Venturi 60%

H28 = Humidified oxygen at 28% (also H35, H40 & H60 = Humidified Oxygen at 35%, 40% & 60%)

RM = Reservoir Mask

TM = Tracheostomy Mask

CP = Patient on CPAP System

NIV = Patient on NIV System

OTH = Other Device: _____ (specify which)

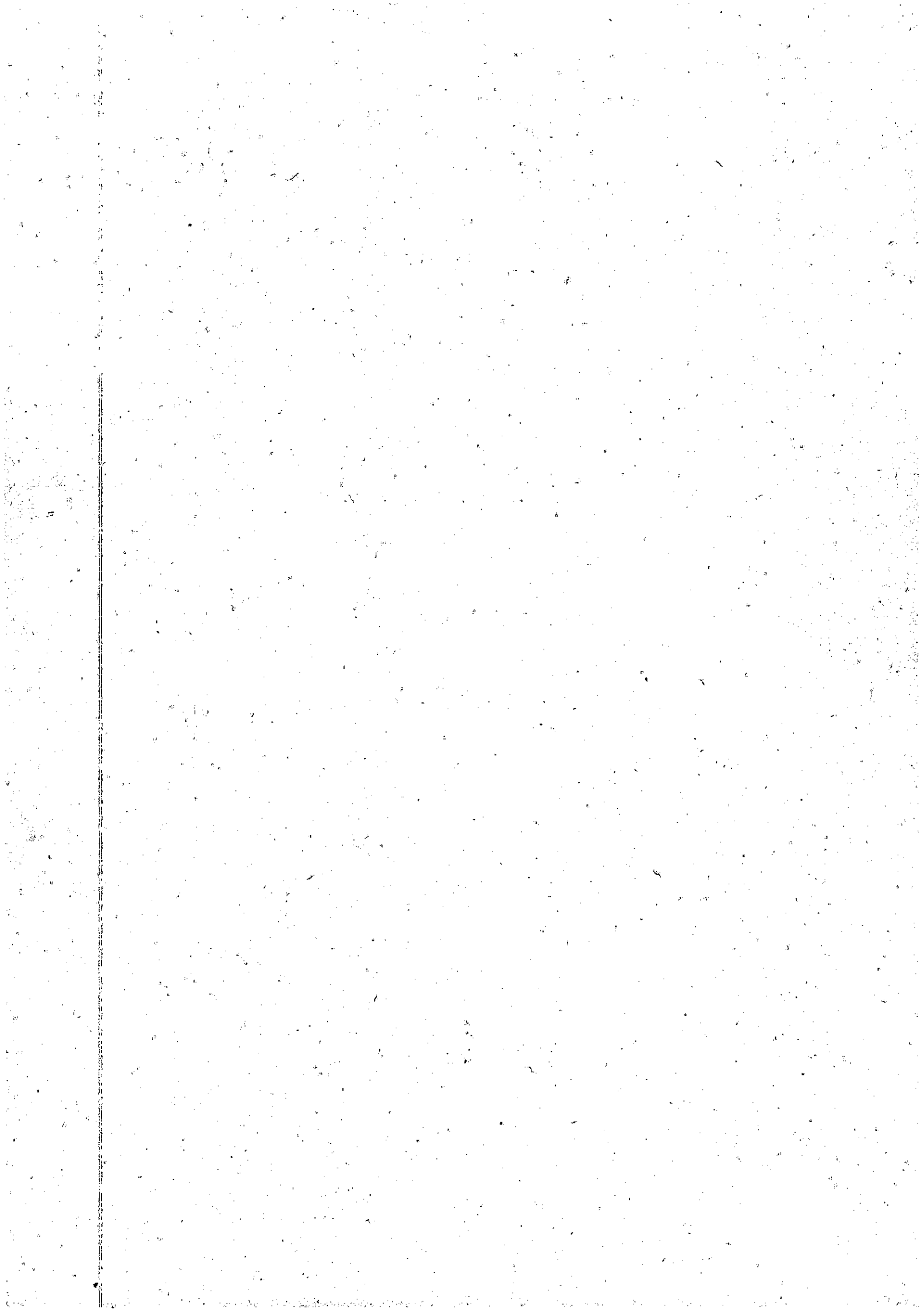
Pain Score

0 = no pain

1 = mild pain

2 = moderate pain

3 = severe pain



Sepsis Screening Tool

Patient triggering NEWS ≥ 5 OR Clinical Concern
Neutropenia suspected OR MEWS triggering for obstetric patients

COPY

Is this likely to be due to infection?

Cough/sputum
Abdominal pain/distension/diarrhoea
Line infection
Endocarditis

Dysuria
Cellulitis
Headache with neck stiffness
Wound infection

Obstetric patients (Refer to FV protocol: Sepsis in Maternity Patients)
Perineal trauma Vaginal discharge Prolonged SRM Sore Throat

YES

NO

Escalate to Doctor/ANP with
"suspected sepsis"
Place Sepsis 6 sticker in notes
Prepare giving set/IV fluids

Escalate to Doctor/ANP
Repeat NEWS/MEWS in max 60 mins

**ASSESS FOR OTHER CAUSES OF
TRIGGERING**

**Two people work together to deliver the Sepsis 6 within 60 mins of
patient first triggering**

- Correct Hypoxia
- Take Blood Cultures
- Give IV antibiotics according to
NHS FV Protocol

- Measure whole blood Lactate
- Assess urine output (catheter if
obstetric patient)
- Start IV fluids - 20ml/kg, minimum
500mls in the first hour

ASSESS FOR SEVERE SEPSIS

SEVERE SEPSIS

Sepsis with $\geq$ organ dysfunction:

- Hypotension
- Renal
- Respiratory
- Hepatic
- Hematologic
- CNS
- Metabolic acidosis

IF SEVERE SEPSIS

Contact middle grade Doctor (Consultant
if obstetric patient)

Catheter mandatory if evidence of AKI

NO EVIDENCE OF SEVERE SEPSIS

Assess response to sepsis 6

Continue regular NEWS

SEPTIC SHOCK

- Hypotension despite fluid
resuscitation
- Organ dysfunction

HIGH RISK FACTORS

- Hypotension
- Lactate > 4
- Unexplained INR > 1.5
- APTT > 60 secs
- Bilirubin > 34 (70 if obstetric)
- Platelets < 100

Conscious Level Chart (only as required for head injury observation)

DATE:																				DATE:				
TIME:																				TIME:				
C O M A S C A L E	Eyes Open	Spontaneously	4																	Eyes closed by swelling = C				
		To speech	3																					
		To pain	2																					
		None	1																					
	Best verbal response	Orientated	5																	Endotracheal tube or tracheostomy = T				
		Confused	4																					
		Inappropriate words	3																					
		Incomprehensible sounds	2																					
		None	1																					
	Best motor response	Obey commands	6																	Usually record the best arm response				
		Localise pain	5																					
		Withdraws to pain	4																					
		Flexion to pain	3																					
		Extension to pain	2																					
		None	1																					
					• • • • • • • • 1 2 3 4 5 6 7 8 Pupil Scale (mm)																			
	PUPILS	right	Size Reaction																	+ reacts - no reaction c. eye closed				
		left	Size Reaction																					
	L I M B M O V E M E N T	A R M S	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																					
L E G S		Normal power																						
		Mild weakness																						
		Severe weakness																						
		Extension																						
		No response																						

Pain Assessment & Management Guidelines

Pain Score:

- 0 = No pain
- 1 = No pain at rest
Slight pain on movement
- 2 = Intermittent pain at rest
Moderate pain on movement
- 3 = Continuous pain at rest

For Acute and Chronic Pain:

For mild (1), moderate (2) or severe (3) pain refer to Pain Management Guidelines Forth Valley Formulary Appendix 27 & 28. Implement Pain Assessment Chart

For Cancer Related Pain:

For mild (1), moderate (2) or severe (3) pain score, refer Palliative Guidelines.

Supportive and Palliative Care Indicators Tool (SPICT™)

COPY

The SPICT™ is a guide to identifying people at risk of deteriorating and dying. Assessment of unmet supportive and palliative care needs may be appropriate.

Look for two or more general indicators of deteriorating health.

- Performance status poor or deteriorating, with limited reversibility. (needs help with personal care, in bed or chair for 50% or more of the day).
- Two or more unplanned hospital admissions in the past 6 months.
- Weight loss (5 - 10%) over the past 3 - 6 months and/or body mass index < 20.
- Persistent, troublesome symptoms despite optimal treatment of any underlying condition(s).
- Lives in a nursing care home or NHS continuing care unit, or needs care to remain at home.
- Patient requests supportive and palliative care, or treatment withdrawal.

Look for any clinical indicators of advanced conditions

Cancer

Functional ability deteriorating due to progressive metastatic cancer.

Too frail for oncology treatment or treatment is for symptom control.

Dementia / frailty

Unable to dress, walk or eat without help.

Choosing to eat and drink less; difficulty maintaining nutrition.

Urinary and faecal incontinence.

No longer able to communicate using verbal language; little social interaction.

Fractured femur; multiple falls.

Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease

Progressive deterioration in physical and/or cognitive function despite optimal therapy.

Speech problems with increasing difficulty communicating and/or progressive dysphagia.

Recurrent aspiration pneumonia; breathless or respiratory failure.

Heart / vascular disease

NYHA Class III/IV heart failure, or extensive, untreatable coronary artery disease with:

- breathlessness or chest pain at rest or on minimal exertion.

Severe, inoperable peripheral vascular disease.

Respiratory disease

Severe chronic lung disease with:

- breathlessness at rest or on minimal exertion between exacerbations.

Needs long term oxygen therapy.

Has needed ventilation for respiratory failure or ventilation is contraindicated

Kidney disease

Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.

Kidney failure complicating other life limiting conditions or treatments.

Stopping dialysis.

Liver disease

Advanced cirrhosis with one or more complications in past year:

- diuretic resistant ascites
- hepatic encephalopathy
- hepatorenal syndrome
- bacterial peritonitis
- recurrent variceal bleeds

Liver transplant is contraindicated.

Assess and plan supportive & palliative care

- Review current treatment and medication so the patient receives optimal care.
- Consider referral for specialist assessment if symptoms or needs are complex and difficult to manage.
- Agree current and future care goals/plan with the patient and family.
- Plan ahead if the patient is at risk of loss of capacity.
- Handover: care plan, agreed levels of intervention, CPR status.
- Coordinate care (eg. with a primary care register).

PERIPHERAL VASCULAR CATHETER (PVC) DAILY MAINTENANCE

Label	Reason for insertion: <i>Clinical need</i>	DAY 0
Name: CHI NO: 2602800570	Insertion Date: <i>24/2/20</i>	Time: <i>14:00</i>
D.O.B: CRN: <i>26/02/1980</i>	Colour/batch no: <i>Pink</i>	Position: <i>Left IJ</i>
CHI: Scott DOWELL	Hand hygiene (HH) performed	Yes No
Hospital: 11 DON STREET	Skin cleansed for 30 seconds with antiseptic & left to dry prior to insertion	Yes No
(Use address) GRANGEMOUTH FK3 8HD	Aseptic technique throughout	Yes No
	Sterile dressing applied including date and time	Yes No
	Inserted by: <i>E. Matgale</i>	
	Ward inserted: <i>Jay</i>	

Ensure that:

Medical staff review the need for intravenous (IV) therapy including antibiotics on a daily basis – switch to oral if possible

An antiseptic containing 70% isopropyl alcohol is used to clean the access hub. Before accessing, rub the access hub for at least 15 seconds ("scrub the hub")

MODIFIED VIP (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 sign:	Remove & replace cannula. Observe both sites and document. Obtain swab
Two or more of the following are evident: Pain, redness or swelling	2	Early stages of phlebitis:	Remove & replace cannula. Observe both sites and document. Treat if necessary. Obtain swab
All of the following are evident: Pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis	Remove and seek further advice. Obtain swab
As above including palpable venous cord	4		Remove and seek further advice. Obtain swab
As above including pyrexia	5		Seek further advice.

24 hours	Date: <i>25/2/20</i>	Time: <i>12:00</i>
Is PVC still required	<i>YES</i>	NO
Absence of inflammation/extravasation	<i>YES</i>	NO
VIP score - please circle	<i>0</i> 1 2 3 4 5	
PVC dressing intact	<i>YES</i>	NO
PVC inserted <72 hrs	<i>YES</i>	NO
HH before/after procedure	<i>YES</i>	NO
"Scrub the Hub" (before use)	<i>YES</i>	NO
PVC - please circle	<i>Left in situ</i>	removed
Reason for removal:		
Signature: <i>Carl Wood</i>		

48 hours	Date: <i>26/2/20</i>	Time: <i>14:00</i>
Is PVC still required	<i>YES</i>	NO
Absence of inflammation/extravasation	<i>YES</i>	NO
VIP score - please circle	<i>0</i> 1 2 3 4 5	
PVC dressing intact	<i>YES</i>	NO
PVC inserted <72 hrs	<i>YES</i>	NO
HH before/after procedure	<i>YES</i>	NO
"Scrub the Hub" (before use)	<i>YES</i>	NO
PVC - please circle	<i>Left in situ</i>	removed
Reason for removal:		
Signature: <i>Amull</i>		

72 hours	Date: <i>28/2/20</i>	Time: <i>14:00</i>
Is PVC still required	<i>YES</i>	NO
Absence of inflammation/extravasation	<i>YES</i>	NO
VIP score - please circle	<i>0</i> 1 2 3 4 5	
PVC dressing intact	<i>YES</i>	NO
PVC inserted <72 hrs	<i>YES</i>	NO
HH before/after procedure	<i>YES</i>	NO
"Scrub the Hub" (before use)	<i>YES</i>	NO
PVC - please circle	<i>Left in situ</i>	removed
Reason left in situ: <i>Final</i>		
Discussed with:		
Reason for removal:		
Signature: <i>Carl Wood</i>		

If PVC to remain in situ for longer than 72 hours this must be documented on a daily basis in notes and discussed with medical staff.

Observe closely for clinical signs and symptoms of Phlebitis.

New sheet to be commenced.

28/2/20 - Removed Amull

ADULT PARENTERAL GENTAMICIN (GGC): PRESCRIBING, ADMINISTRATION & MONITORING CHART

Use for patients prescribed intravenous gentamicin at or above the GGC dosing guidance. Not for prophylactic indication or where synergistic doses (usually in endocarditis) are being used.

For information on EXCLUSIONS and Cautions / Contra-indications to gentamicin:

Use for patients prescribed intravenous gentamicin and/or oral gentamicin tablets. For further dosing guidance, refer to appropriate guidelines for appropriate use of gentamicin. For information on EXCLUSIONS and Cautions / Contra-indications to gentamicin:

CHI NO: 2602800570 26/02/1980
 CRN: M

Patient name: Scott DOWELL
 11 DON STREET

Date of birth: GRANGEMOUTH
 FK3 8HD

CHI no.: Affix patient label

Age: 39 Sex: M/F
 Weight: 154.28 Height: 5'6" 9
 Creatinine: 75 on: 25/12/20

Initial Gentamicin Dose*: 400 mg
 Predicted Frequency*: 24hr

*this is not a prescription and may change. Doses must be prescribed individually below.

Source of first dose: Online calculator (preferred method) ☐ Manual calculation ☐ Weight based, creatinine not known ☐

Step 1: Calculate and prescribe the first dose of gentamicin (see overleaf for more details)

- If creatinine is known - use the online gentamicin dose calculator.
- If creatinine is not known - give 5 mg/kg gentamicin (maximum 400 mg) or, if CKD 5, give 2.5 mg/kg (maximum 180 mg) on advice of senior medical staff.
- Prescribe gentamicin 'as per chart' on the medication chart (kardex). AVOID specifying dose or administration time on the kardex.
- Prescribe individual doses in the prescription record section below, specifying the date and time the dose should be given.

Step 2: Monitor creatinine and gentamicin concentration and reassess the dosage regimen

- Check gentamicin concentration after the first dose and then at least every 2 days (see overleaf for more details).
- Monitor creatinine daily. Seek advice if renal function is unstable (e.g. a change in creatinine of >15-20%).

Step 3: Assess daily: the ongoing need for gentamicin; signs of toxicity

- Consider an alternative agent if creatinine is increasing or the patient becomes oliguric.
- If gentamicin continues for >7 days, suggest referral to audiology for assessment.
- Refer to guidelines or clinical pharmacist for further advice on prescribing, monitoring and administration.

PROMPT ADMINISTRATION
 within 1 hour of recognition of sepsis reduces mortality

SIGNS OF GENTAMICIN TOXICITY
 RENAL: ↓ urine output/oliguria or ↑ creatinine
 OTO/ NEW tinnitus, dizziness, poor balance,
 VESTIBULAR: hearing loss, oscillating vision
 Toxicities may occur irrespective of gentamicin concentration

TOXICITY		Gentamicin Prescription Record			Administration Record			Monitoring Record			
Before prescribing each dose check:		Complete each time a dose is to be given (ensuring gentamicin is prescribed 'as per chart' on the kardex)			Complete each time gentamicin is administered (in addition to the kardex)			Record ALL sample dates/times accurately below. See overleaf for monitoring advice.			
Renal & Oto-vestibular function	Date to be given	Time to be given 24 h clock	Gentamicin Dose (mg)	Prescriber's signature, PRINTED name and STATUS.	*Infuse over 30 mins*		Given by	Date of sample	Time of sample 24 h clock	Gent level (mg/L)	Action/ Comments (please initial action to be taken)
					Date given	Time started 24 h clock					
Cr = 70 micromol/L	25/2	1130	400mg	McKee	25/2	11:40	JB	25/2	1700	5.6	24 hourly ☒ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other: /
Cr = 26 micromol/L	26/2	1130	400mg	McKee	26/2	14:40	JB	26/02	1916	3.1	24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other: /
*Discuss with an infection specialist or microbiology and document in the notes if treatment continues beyond 3 to 4 days * Risks of prolonged treatment must be considered and treatment options discussed with microbiology or infection specialist											
Cr = 84 micromol/L	27/02	1130	400mg	McKee	27/2	15:00	Am, NK				24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other: /
Cr = micromol/L											24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other: /

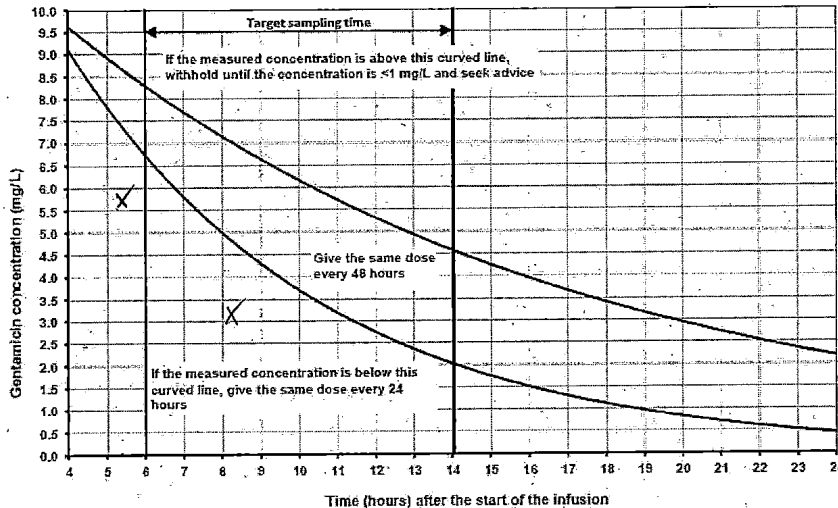
Discuss with an infection specialist before continuing onto a second sheet

Patient name:

CHI no.:

ADULT PARENTERAL GENTAMICIN (GGC): PRESCRIBING, ADMINISTRATION & MONITORING CHART

Prescribing, monitoring, interpreting and re-prescribing advice



If the measured concentration is unexpectedly HIGH or LOW

- Were dose and sample times recorded accurately?
- Was the correct dose administered?
- Was the sample taken from the line used to administer the drug?
- Was the sample taken during drug administration?
- Has renal function declined or improved?
- Does the patient have oedema or ascites?

If in doubt, take another sample before re-prescribing and/or contact pharmacy for advice.

Calculating the first dose of gentamicin

- If creatinine is known - use the online gentamicin dose calculator.
- If creatinine is not known - give 5 mg/kg gentamicin (maximum 400 mg) or, if CKD 5, give 2.5 mg/kg (maximum 180 mg) on advice of senior medical staff.
- Calculate the dosage regimen once creatinine is available.
- If the online calculator is not available, manually calculate the dose referring to xxxxx.

Checking the patient's gentamicin concentration

- Take a blood sample 6-14 hours after the start of the first gentamicin infusion (or after 24 hours if CrCl <21 ml/min).
- Thereafter, sample at least every 2 days.
- Record the exact time of all gentamicin samples overleaf AND on the sample request form.

Interpreting gentamicin results and re-prescribing

- Record the measured concentration overleaf.
- If creatinine clearance is ≥ 21 ml/min and therapy is to continue, plot the gentamicin concentration on the graph opposite & reassess the dose/dosing interval as indicated.
- If creatinine clearance is <21 ml/min and therapy is to continue, give a further dose once the measured concentration is <1 mg/L.
- Document the action taken in the medical notes and overleaf. Prescribe the next dose overleaf as appropriate.
- Contact pharmacy for further advice as necessary (e.g. if renal function is changing, the gentamicin concentration is unexpectedly high or low or the concentration is on the line between dosage intervals).
- Check microbiology sensitivities and refer to IV to Oral switch policy.

Approved by: Forth Valley AMG July 2013
Date of Review: July 2015

copy

CHI NO: 2602800570 26/02/1980
 CRN: M
 Scott DOWELL
 11 DON STREET
 GRANGEMOUTH
 FK3 8HD

COPY

Gentamicin (GGC) dosage regimen

Dose (mg)

400

Duration of infusion

30 mins

Interval (hours)

24

MONITORING - TAKE NOTE

Take sample 6-14 hours after the first dose then refer to the gentamicin plot

REVIEW ANTIMICROBIAL THERAPY DAILY

Seek advice from microbiology if gentamicin is required beyond 3-4 days

Ideal Body Weight (kg)

66

Height (cm)

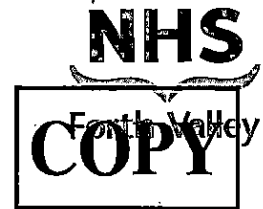
175

Weight for creatinine clearance (kg)

79.2

Creatinine Cl ml/min

110.9



NHS Forth Valley Tobacco Policy

PATIENTS LEAVING CLINICAL AREA TO SMOKE

As smoking is biggest single cause of ill health in Scotland NHS Forth Valley does not permit smoking in any of premises including the grounds and car parks. It is also against the law in Scotland to smoke in any enclosed public place.

Assistance is available from NHS Forth Valley with helping you stop smoking, including Nicotine Replacement Therapy which is a free service. We also can offer you one to one help from nurses whose role is to help / aid / offer advice to people to stop smoking. These nurses will be informed that you are in the ward / department, if you do not wish this support please indicate below.

However should you wish to smoke, you will have to leave NHS Forth Valley premises to do so this includes the grounds of the hospital. Please use the bins provided at the gates to the hospital to extinguish your cigarettes to keep our entrances clear of tobacco.

I have read the above and understand that I must leave NHS Forth Valley premises if I wish to smoke. I understand if I choose to do so that this will be at my own risk to my health, safety and well-being and that of others. I understand that it is illegal to smoke in any enclosed public space.

Name: Scott Dowell

CHI Number: 2602800570

Ward or Department: B11

Hospital: FVRH

Signature: (patient) [Signature]

Date: 25/2/2020

☒ Please tick this box if you **do not** wish to speak to a smoking cessation nurse.

TOP COPY - FOR PATIENTS NOTES

SECOND COPY - PATIENT

THIRD COPY - SMOKING CESSATION NURSE, HUT 5, FALKIRK ROYAL INFIRMARY

ASSESSMENT & CARE PLAN BOOKLET

CHI NO: 2602800570 26/02/1980
CRN: M
Scott DOWELL
11 DON STREET
GRANGEMOUTH
FK3 8HD

Date of Admission: 24/12/20
Time of Admission:
Ward admitted to: SW
Date of transfer:
Ward transferred to:
Booklet number: ①

Assessment	Initial assessment to be completed within:	Initials	Re-assessment code
NEWS	On admission	W	
Hydration	4 hours	W	
CPE/MRSA	On admission	W	
Pressure Areas	6 – 8 hours	W	
4AT	6 hours	W	
Falls risk	6 hours	W	
Bed rails	6 hours	W	
MUST	24 hours	W	
Pt handling & mobility	24 hours	W	
Personal hygiene	24 hours	W	
Oral care	24 hours	W	
Continence	24 hours	W	
Elimination	24 hours	W	

	Assess on admission - >24 hours
	Assess daily
	Assess weekly
	Review when condition changes
	Assess 2-4 weekly

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

COPY

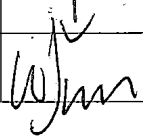
[illegible]

COPY

[illegible]

Daily Hydration Care plan

Fluid Preferences on MUST

	Frequency of assessments	Date & Time Assessed with comments	Date & Time Re assessed with comments	Date & Time Re assessed with comments	Date & Time Re assessed with comments	Date & Time Re assessed with comments	Date & Time Re assessed with comments	Date & Time Re assessed with comments
Commence requirement of fluid balance chart if one or more risks are identified	Daily or change in clinical condition	24/12/20 W						
Set daily fluid balance target with medical team	Daily (At Ward Round)							
Review 24hr fluid balance document in unified notes and discuss with medical team	Daily							
Offer beverages at every Care & Comfort round (if appropriate) and document intake	Continuous							
Encourage patient, family or Carer to be involved with fluid intake and recording (Provide pictorial fluid chart)	Daily							
Describe patient's individual needs	Daily							
Signature								

COPY

Infection Prevention and Control Risk Assessment

All patients admitted must have a Clinical risk assessment (CRA) for Carbapenemase Producing *Enterobacteriaceae* (CPE) and Methicillin Resistant *Staphylococcus aureus* (MRSA).

COPY

This is a mandatory requirement.

CPE Clinical Risk Assessment (No patients are excluded from CPE screening).	Response
Has the patient had any previous history of CPE (check eward / clinical portal)	YES ☒ NO
Has the patient been transferred directly from another hospital outwith NHSFV	YES ☒ NO
Has the patient a history of admission to a hospital outwith Forth Valley in the last 12 months (including dialysis patients)	YES ☒ NO
Has the patient been in close contact with a person colonised or infected with CPE	YES ☒ NO

A **YES** response to **ANY** of the above questions suggests the patient has an increased risk of CPE and the following actions must be taken:

- The patient is isolated in a single side room, STOP sign on door, contact precautions initiated;
- The patient is given an information leaflet and consent is obtained for swabbing;
- CPE screen: Rectal swab taken by a registered nurse or stool specimen and, if present, a wound swab. A urine specimen is required if a urinary catheter is present;
- A rectal swab **must not** be used for children under 16 years. A stool specimen should be sent.

MRSA Clinical Risk Assessment (Exclusions from MRSA screening include: Day case patients and admissions to paediatric, obstetric and mental health specialities)	Response
1 Has the patient a history of MRSA, (Check eward / clinical portal)	YES ☒ NO
2 Has the patient been admitted from anywhere other than their own home, e.g. care home, hostel, prison, or transferred from another hospital.	YES ☒ NO
3 Does the patient have any wounds or indwelling medical devices (e.g. PEG, Hickman line, urinary catheter)	YES ☒ NO
4 Will the patient be admitted / transferred to ITU, B23 or B31	YES ☒ NO

A **YES** response to questions **1, 2 or 3** indicates an increased risk of MRSA colonisation. The following actions must be taken:

- The patient is isolated in a single side room, STOP sign on door, contact precautions initiated;
- The patient is given an MRSA screening leaflet and consent obtained for swabbing;
- MRSA screen: swab nose, perineum and if present, wounds and insertion sites of invasive devices. A urine specimen is required if a catheter is present.

Note: this is the minimal screen required and additional swabs can be sent if clinically indicated.

A **YES** response to question **4** confirms admission to a high risk specialty and the following actions must be taken:

- The patient is given an MRSA screening leaflet and consent obtained for swabbing;
- MRSA screen: swab nose, perineum and if present, wounds and insertion sites of invasive devices. A urine specimen is required if a catheter is present.

Name of Person completing CRA	<i>W. Jenkins</i>	DATE	24/12/20
-------------------------------	-------------------	------	----------

Prevention of Pressure Injury Assessment

Record your answer in the grid below Y = Yes N = No

If the answer is NO to any statement or there is a notable change in the patient's condition, undertake a Braden risk assessment and consider any other relevant assessment

Date	Time	Person is fully mobile without equipment or assistance	Person is fully continent	Person appears well nourished and able to eat /drink	Skin to pressure points satisfactory and intact (observed)	Review these questions every 24 hours if no initial risk identified	Braden requires completion	Signature	Skin description - i.e.: Redness, Skin Broken, Blister/Ulcer	Action Taken:
24/2/20		Y	Y	Y	Y	Y	Y	WJmm	11/10/15	mm

BRADEN RISK ASSESSMENT CHART

Individuals with a total score of 16 or less are considered at risk: 15-16 = low risk, 12-14 = moderate risk, 11 or less = high risk.

Undertake and document risk assessment within 8 hours of admission to every ward or department or on first home visit. Reassess if there is a change in individual's condition and repeat regularly according to local protocol

Complete care and comfort round chart.

Consider contributing factors, frailty, diabetes, end of life care.

Sensory Perception – Ability to respond meaningfully to pressure related discomfort	1. Completely Limited Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body surface.	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment that limits the ability to feel pain or discomfort over ½ of body.	3. Slightly Limited Responds to verbal commands but cannot always communicate discomfort or need to be turned. OR has some sensory impairment that limits ability to feel pain or discomfort in 1 or 2 extremities.	4. No Impairment Responds to verbal commands. Has no sensory deficit that would limit ability to feel or voice pain or discomfort.	4														
Moisture – Degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient/client is moved or turned.	2. Very Moist Skin is often but not always, moist. Linen must be changed at least once a shift.	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day.	4. Rarely Moist Skin is usually dry. Linen only requires changing at routine intervals.	3														
Activity – Degree of physical activity	1. Bedfast Confined to bed.	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. Walks Occasionally Walks occasionally during day but for very short distance, with or without assistance. Spends majority of each shift in bed or chair.	4. Walks Frequently Walks outside the room at least twice a day and inside the room every 2 hours during waking hours.	4														
Mobility – Ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance.	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	3. Slightly limited Makes frequent though slight changes in body or extremity position independently.	4. No Limitations Makes major and frequent changes in position without assistance.	4														
Nutrition – Usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IV's for more than 5 days.	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding.	3. Adequate Eats over half of most meals. Occasionally will refuse meal but will usually take a supplement if offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	4. Excellent Eats most of every meal. Never refuses a meal. Occasionally eats between meals. Does not require supplementation.	3														
Friction and Shear –	1. Problem Requires moderate to maximum assistance in moving.	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.		3														
Indicate appropriate number and add for total score					TOTAL SCORE:	13													
					SIGNATURE:														

COPY

Skin Care Plan

COPY

[illegible]

Bedrails Assessment

Bed Rail Assessment

COPY

Bedrails NOT to be used

Code:

- A. Risk of climbing over and falling from a greater height.
- B. Patient is independent.
- C. Risk of entrapment in bedrails outweighs risk of falling
- D. Do not use with a high/low bed
- E. Patient with capacity and oriented but refuses bedrails
- F. Other please state

Bedrails ARE to be used with caution

Code:

- G. Patient with capacity and is alert and oriented and requests bedrails.
- H. Risk of injury from falling from the bed outweighs the risks of not using bed rails.
- I. Patient is unconscious.
- J. Other: please state.

Assessment to be completed on admission within 6 hours, reviewed weekly, following a fall and in response to a change in patient condition.

Date and Time	Code	Comment	Name/Signature
24/2/20	(B)	/	WJm

Note Bed rails must be in use when patients are being transported between areas

CO

'MUST' SCREENING AND RESCREENING

Initial screening

Rescreening

[illegible]

'MUST': Low Risk Nutrition Care Plan

Date care plan initiated: 24/12/20

COPY

Intervention	Time Frequency	Initial/Date
Has patient been informed of current weight and plan?	Yes/No	W 24/12/20
Discuss the results of the 'MUST' screening/care plan with the patient and family (with agreement and involve them in identifying individualised interventions)	On admission & on-going	↓
Monitor patients weight and rescreen 'MUST' risk weekly or if patient's weight has remained stable for 4 weeks – screen monthly.	On admission	↓

Please ✓ relevant box and where yes is answered, record details of individual requirement below;

Food Allergy- No ☒ Yes ☐ Religious, cultural, ethnic requirements- No ☒ Yes ☐

Details:	Initial/Date
	W 24/12/20

Therapeutic diet-No ☒ Yes ☐

Details:	Initial/Date
	W 24/12/20

Assistance required with eating/drinking- No ☒ Yes ☐ Adapted cutlery/aids- No ☒ Yes ☐

Details:	Initial/Date
	W 24/12/20

Specific food preferences (patients unable to make decisions on their food and fluid choices should have a detailed dietary and fluid preference recorded)

Details:	
Is patient able to make own choices?	yes/no
Yes – patient offered daily menu	
No – for patient unable to make choices has food and fluid preferences been recorded on 'my dietary information sheet'	yes/no

CARE PLAN REVIEW

Discuss current weight and plan with patient (initiate new care plan if risk has changed) *Share with relative/carer where appropriate Sign and date on review of care plan.

Initial/Date	Initial/Date	Initial/Date	Initial/Date	Initial/Date
Initial/Date	Initial/Date	Initial/Date	Initial/Date	Initial/Date

Individual Patient Handling Risk Assessment

COPY

If the patient has been assessed as 'independent' on initial assessment, a mobility chart does **not** require to be completed.

Is the patient independent? YES ☒ NO ☐ (Please tick ✓ as appropriate)

If the patient has been assessed as 'independent' on initial assessment; and this status changes, please review and complete a mobility chart.

If the patient is 'Plus Size', please refer to Bariatric (Plus Size Person) Handling Guidelines.

Please state the patient's ability prior to admission: INDEPENDENT

Please complete the following as to how the patient currently transfers / mobilises (Please tick ✓ as appropriate)

Please sign and date below

Assessor's Name (Print): <u>WJr mly</u>	Date: <u>24/2/20</u>
Signature: <u>WJr mly</u>	Review Date:
Transfers (including to / from bed; wheelchair; commode; toilet)	
Independent ☒ Supervision ☐ Assistance of 1 ☐ 2 ☐ 3 ☐ More ☐ If More - please state number	Standard ☐ Hoist ☐
Moves up and down the bed	
Independent ☒ Supervision ☐ Assistance of 1 ☐ 2 ☐ 3 ☐ More ☐ If More - please state number	Glide Sheet ☐ Hoist ☐
Sits up and over the side of the bed	
Independent ☒ Supervision ☐ Assistance of 1 ☐ 2 ☐ 3 ☐ More ☐ If More - please state number	Bed Rest ☐
Bathing (including in and out of the bath / shower)	
Independent ☒ Supervision ☐ Assistance of 1 ☐ 2 ☐ 3 ☐ More ☐ If More - please state number	(please specify) Hoist ☐ Other ☐
Walking	
Independent ☒ Supervision ☐ Assistance of 1 ☐ 2 ☐ 3 ☐ Did the patient have a walking stick or frame on admission? YES ☐ NO ☒	Walking Aid ☐ No Walking ☐

This form **must** be completed for each individual patient, along with a mobility chart, if required.

This form **must** be completed if the patient is **NOT** independent

An assessment of the patient should be carried out prior to every handling intervention. Any changes should be documented in a new column. Please refer to Manual Handling Guidelines for all manoeuvres.

DATE:	AST	AST	AST	AST	AST	AST
Lying to sitting						
Sit to stand to sit						
Walking						
Bathing / Showering / Toileting						
Moving up the bed						
Turning / Proning						
On / off bed pan						
Lateral transfers						
On / off floor						
State make and model of hoist / stand aid						
State type and size of sling						
Falls assessment (Y / N)						
Signed						

MOBILITY CODES

AST 1 / 2 / 3: Requires assistance of 1 / 2 / 3 or more staff
 SUP: Supervision only IND: Independent
 FWB: Full Weight Bearing
 PWB: Partial Weight Bearing
 NWB: Non Weight Bearing
 BR: Bed Rest

HANDLING AIDS / EQUIPMENT CODES

H: Full body lifting hoist (specify hoist type + size of sling)
 STA: Stand aid (specify hoist type + size of sling)
 BH: Bathing hoist (specify hoist type)
 SC: Shower chair ST: Shower Trolley
 Pt T: Pt turner (specify e.g. Etac, Samhall, Cricket,)
 W: Wheelchair or pushchair

GS: Glide sheet(s) ES: (Extension Straps)
 PAT: Pat slide
 HB: Hand blocks HS: Handling Sling
 C: Crutches (specify)
 S: Stick(s) Z: Zimmer
 HM: (HoverMatt) HJ: (HoverJack)

COPY

COPY

[illegible]

Oral Health Assessment

COPY

patients should have their mouth assessed within 24 hours of admission to determine if oral care planning is required. Discuss and agree care plan with patient/carer.

Complete this section to determine condition of mouth and the frequency of mouth care required.			Date	Date	Date	Date	Date	Date	Date
Condition of mouth Check lips, oral soft tissues and teeth with a good light	Teeth/dentures clean, mucosa pink and moist	Standard Care 1	24/12/20	✓					
	Mucosa/tongue pink and dry	Standard Care 2							
	Obvious plaque/swollen or bleeding gums or dry/crusted mouth	Standard Care 3							
	Possible infection	Standard Care 4							

Complete this section to determine frequency of assessment required			Date	Date	Date	Date	Date	Date	Date
Eating ability	Able to eat normal diet	1	24/12/20	1					
	Soft diet/delayed swallow reflex	2							
	Nil by mouth	3							
Physical ability	Requires assistance to access oral hygiene implements	1							
	Requires help with oral hygiene	2							
	Patient not able to carry out any aspect of oral hygiene	3							
Mental ability	Loss of interest/confused	1							
	Memory impaired/confused	2							
	Sedated	3							
Nutritional screening (only score if patient has own teeth)	MUST low	1	24/12/20	1					
	MUST medium	2							
	MUST high	3							
Additional risk factors	Diabetes mellitus	1							
	Medications *	1							
	Smoking	1							
	Loose/damaged dentures	1							
	Open mouth breathing	1							
	Oxygen therapy	1							
	Broken or loose teeth	1							
Total score		2							
Initials		W							

Re-assessment risk level: 2-8 = Low (monthly) 9-14 = Medium (every 2 weeks) 15+ = High (daily)

Continence Assessment

COPY

Continence

Date _____

24/2/20

Independent, no concerns, review regularly for change

✓

Uses continence products, continue to support whilst in hospital with prescribed products

New continence issue, requires assessment

Goals

Potential nursing actions

- To enable person to remain continent
- Maintain continence level using prescribed products
- Be fully assessed and create care plan to support
- Discuss and agree care plan with patient/carer

1. Self care
2. Offer ,Basin/shower/bed bath, after episodes of incontinence, as required
3. Provide and document agreed continence product for use in ward. This may include skin cleansers and barrier creams. Carer or family may bring same into ward for use
4. Undertake full continence assessment and patient education.

Date/Time

Plan of Care

Review

Sign

24/2/20

SELA CARAT

W

Elimination Assessment

Complete on admission and review weekly unless condition changes
Ensure care given is documented daily.

COPY

[illegible]

REPRINT

Immediate Discharge Letter

Forth Valley Royal Hospital, Larbert

Tel: 01324 566 000



Page 1 of 3

*** Non-verified Orders Exist ***

Consultant: DR CHRISTOPHER SHEARER

COPY

Ward: B11

GP Details

GP Name DW Dundas
& Address : Westburn Medical
Practice
Falkirk Community
Hospital
Westburn Avenue

Patient Details

CHI No: 2602800570

Surname : Dowell

Forename : Scott

DOB : 26/02/1980

Address : 11 DON STREET
Grangemouth
Stirlingshire
STIR
FK3 8HD

Admission Details

Admission Date : 24/02/2020

Admission Type : Planned Admission

Presenting
Complaint :

Planned

Discharge Date : 29/02/2020

Outpatient
Follow Up :

Patient Tel : 01324262719

** PLEASE NOTE: DETAILED CLINICAL INFORMATION REGARDING PATIENT EPISODE TO-FOLLOW **

Patient Drug Reactions

Allergen	Reaction	Allergen	Reaction
dihydrocodeine	Unknown		

Forth Valley Acute Hospitals - Acute Division
Medications Discharge Summary

Medication	Route	Dose & Frequency	Days Supply or POD	GP?	V
ESOMEPRAZOLE 40 mg Tablets ADMIT ON	Oral	40 mg TWICE daily at 8am and 8pm	Patient's Own	Yes	✓JR
RANITIDINE 150 mg Tablets ADMIT ON	Oral	150 mg TWICE daily at 8am and 8pm	Patient's Own	Yes	✓JR
ROPINIROLE 500 micrograms Tablets ADMIT ON	Oral	1000 microgram ONCE daily at 10pm	Patient's Own	Yes	✓JR
LAXIDO Sachets	Oral	2 Sachet TWICE daily at 8am and 12 midday	7	Yes	✓JR
AMOXICILLIN 500 mg Capsules	Oral	500 mg THREE times daily at 8am, 12 midday and 6pm	5	No	
RONIDAZOLE 400 mg Tablets	Oral	400 mg THREE times daily at 8am, 12 midday and 6pm	5	No	
CIPROFLOXACIN 500 mg Tablets	Oral	500 mg TWICE daily at 8am and 6pm	5	No	

** Last Item **

Discharging Doctor : DR RACHAEL ROBERTSON

Grade : Foundation Year 1

Originally Printed : 29/02/2020 @ 11:39

Revised : 29/02/2020 @ 11:45

Patient Copy 2/2

Immediate Discharge Letter

Page 3 of 3

*** Non-verified Orders Exist ***

Consultant: DR CHRISTOPHER SHEARER

COPY

Ward: B11

GP Details

GP Name DW Dundas
& Address : Westburn Medical
Practice
Falkirk Community
Hospital
Westburn Avenue

Patient Details

CHI No: 2602800570

Surname : Dowell

Forename : Scott

DOB : 26/02/1980

Address : 11 DON STREET
Grangemouth
Stirlingshire
STIR
FK3 8HD

Patient Tel : 01324262719

Admission Details

Admission Date : 24/02/2020

Admission Type : Planned Admission

Presenting
Complaint :

Planned
Discharge Date : 29/02/2020

Outpatient
Follow Up :



** PLEASE NOTE: DETAILED CLINICAL INFORMATION REGARDING PATIENT EPISODE TO-FOLLOW **

Discharge Comments and Follow up arrangements**GP Communication**

Changes made to Medication _Yes_ Short Stay Patient _No_

DISCONTINUED MEDICATION

None

MODIFIED MEDICATION

None

SUSPENDED MEDICATION

None

CLINICAL SUMMARY

No changes to regular medication. To complete 5 days oral antibiotics

DR RACHAEL ROBERTSON 29/02/2020 11:45

** End of Discharge Notes **

Dispensed by :

Checked by :

Date :

Discharging Doctor : DR RACHAEL ROBERTSON

Grade : Foundation Year 1

Immediate Discharge Letter

Forth Valley Royal Hospital, Larbert
Tel 01324 566 000

Page 2 of 3

*** Non-verified Orders Exist ***

Consultant: DR CHRISTOPHER SHEARER

COPY

Ward: B11

GP Details	Patient Details	Admission Details
GP Name DW Dundas & Address : Westburn Medical Practice Falkirk Community Hospital Westburn Avenue	CHI No: 2602800570 Surname : Dowell Forename : Scott DOB : 26/02/1980 Address : 11 DON STREET Grangemouth Stirlingshire STIR FK3 8HD	Admission Date : 24/02/2020 Admission Type : Planned Admission Presenting Complaint : Planned Discharge Date : 29/02/2020 Outpatient Follow Up :
		
Patient Tel : 01324262719		

** PLEASE NOTE: DETAILED CLINICAL INFORMATION REGARDING PATIENT EPISODE TO-FOLLOW **

Notes Transferred from the Inpatient Chart

Patient Note

Pt has admitted on/reg meds at home

Ms Charlene Murphy 26/02/2020 11:55

** End of Transferred Notes **

Discharging Doctor : DR RACHAEL ROBERTSON

Grade : Foundation Year 1

REPRINT

Immediate Discharge Letter



Forth Valley Royal Hospital, Larbert
Tel 01324 566 000

Page 3 of 3

*** Non-verified Orders Exist ***

Consultant: DR CHRISTOPHER SHEARER

COPY

Ward: B11

GP Details	Patient Details	Admission Details
GP Name : DW Dundas & Address : Westburn Medical Practice Falkirk Community Hospital Westburn Avenue	CHI No: 2602800570 Surname : Dowell Forename : Scott DOB : 26/02/1980 Address : 11 DON STREET Grangemouth Stirlingshire STIR FK3 8HD Patient Tel : 01324262719	Admission Date : 24/02/2020 Admission Type : Planned Admission Presenting Complaint : Planned Discharge Date : 29/02/2020 Outpatient Follow Up :



** PLEASE NOTE: DETAILED CLINICAL INFORMATION REGARDING PATIENT EPISODE TO-FOLLOW **

Discharge Comments and Follow up arrangements	
GP Communication	Changes made to Medication _Yes_ Short Stay Patient _No_ _DISCONTINUED MEDICATION_ None _MODIFIED MEDICATION_ None _SUSPENDED MEDICATION_ None _CLINICAL SUMMARY_ No changes to regular medication. To complete 5 days oral antibiotics

DR RACHAEL ROBERTSON 29/02/2020 11:45

** End of Discharge Notes **

Discharging Doctor : DR RACHAEL ROBERTSON

Grade : Foundation Year 1

Originally Printed : 29/02/2020 @ 11:39

Revised : 29/02/2020 @ 11:45

Patient Copy 2/2

ACUTE HOSPITAL ASSESSMENT & CARE PLAN BOOKLET

COPY

Affix addressograph here

CHI NO: 2602800570 26/02/1980
CRN: M
Scott DOWELL
11 DON STREET
GRANGEMOUTH
FK3 8HD

Date of admission:
Time of admission:
Ward admitted to: B1
Date/Time of transfer: 24/11/28
Ward transferred to:
Date/Time of transfer:
Ward transferred to:
Booklet number:

Assessment	Initial assessment to be completed within:	Admitting Area Initials	Transfer Area Initials
CPE (1 st ward only)	On admission	LE	N/A
Hydration Assessment	4 hours	LE	
BRADEN/Skin Assessment	6 – 8 hours	LE	
Falls Trigger Tool/Care Plan	6 hours	LE	
Bed Rails Assessment	6 hours	LE	
4AT	24 hours	LE	
Personal Hygiene and Continence	24 hours	LE	
Oral Care Assessment and Care Plan	24 hours	LE	
MUST Screening and Care Plan	24 hours	LE	
Patient Handling and Mobility Chart	24 hours	LE	
Bowel Function assessment and Care Plan	24 hours	LE	

Daily assessments

1. Hydration
2. Skin assessment
3. Personal hygiene & continence
4. Bowel function

Assessments must be carried out by the required time **on admission or transfer.**

Apart from daily assessment, all other assessments will be reviewed weekly

If patients conditions changes, assessments must be stepped up to appropriate level of monitoring immediately

Patient/Carer consented to or participated in care plan process:

Staff Initials.....

Communication Assessment

No concerns ☐
New expressive difficulties (inability to name 3 objects clearly or slurred speech evident) ☐
New receptive difficulties (not understanding or following commands i.e. close eyes, make fist) ☐
Pre-existing. (Not new to this admission) ☐ (Document details in progress notes).
Check for any communication support materials being used at home, please document in the unified progress notes.

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

COPY

[illegible]

Infection Prevention and Control Risk Assessment

COPY

All patients admitted must have a Clinical risk assessment (CRA) for Carbapenemase-Producing *Enterobacteriaceae* (CPE) and Methicillin Resistant *Staphylococcus aureus* (MRSA). This is a mandatory requirement.

CPE Clinical Risk Assessment (No patients are excluded from CPE screening).		Response
Has the patient had any previous history of CPE (check clinical portal)	YES	☒ NO
Has the patient been transferred directly from another hospital out with NHSFV	YES	☒ NO
Has the patient a history of admission to a hospital out with Forth Valley in the last 12 months (including dialysis patients)	YES	☒ NO
Has the patient been in close contact with a person colonised or infected with CPE	YES	☒ NO

A **YES** response to **ANY** of the above questions suggests the patient has an increased risk of CPE and the following actions must be taken:

- Isolated the patient in a single side room, STOP sign on door, contact precautions (PPE)
- The patient is given an information leaflet and consent is obtained for swabbing;
- CPE screen: Rectal swab taken by a registered nurse or stool specimen and, if present, a wound swab. A urine specimen is required if a urinary catheter is present;
- A rectal swab **must not** be used for children under 16 years. A stool specimen should be sent.

MRSA Clinical Risk Assessment (Exclusions from MRSA screening include: Day case patients and admissions to paediatric, obstetric and mental health specialities)		Response
1	Has the patient a history of MRSA, (check clinical portal)	YES ☒ NO
2	Has the patient been admitted from anywhere other than their own home, e.g. care home, hostel, prison, or transferred from another hospital.	YES ☒ NO
3	Does the patient have any wounds or indwelling medical devices (e.g. PEG, Hickman line, urinary catheter)	YES ☒ NO
4	Will the patient be admitted / transferred to ITU, B23 or B31	YES ☒ NO

A **YES** response to questions 1- 3 indicates an increased risk of MRSA colonisation. The following actions must be taken:

- The patient is isolated in a single side room, STOP sign on door, contact precautions initiated;
- The patient is given an MRSA screening leaflet and consent obtained for swabbing;
- MRSA screen: swab nose, perineum and if present, wounds and insertion sites of invasive devices. A urine specimen is required if a catheter is present.

Note: this is the minimal screen required and additional swabs can be sent if clinically indicated.

A **YES** response to question 4 confirms admission to a high risk specialty and the following actions must be taken:

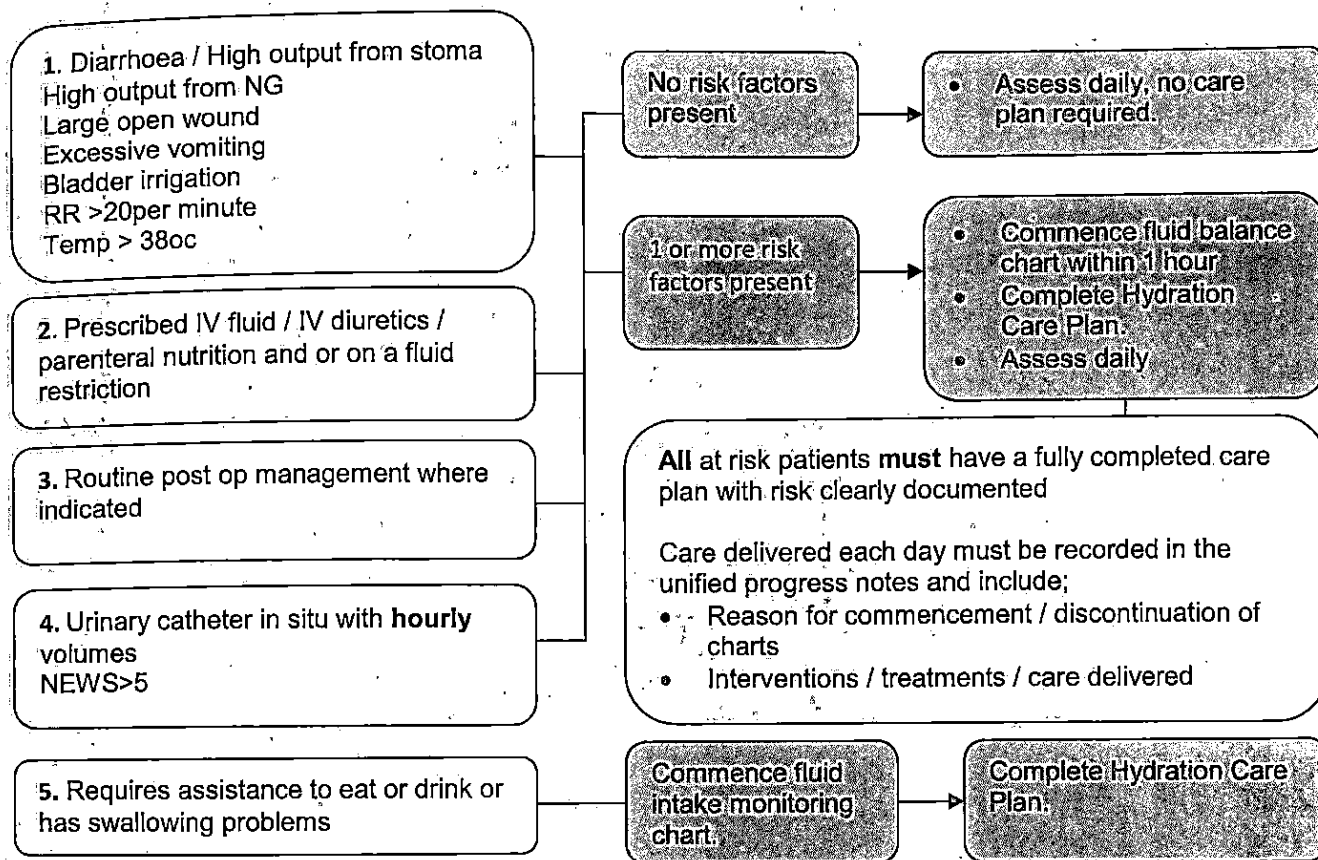
- The patient is given an MRSA screening leaflet and consent obtained for swabbing;
- MRSA screen: swab nose, perineum and if present, wounds and insertion sites of invasive devices. A urine specimen is required if a catheter is present.

Sign	Date 24/11/25	Swabs sent: Yes / No / ☒ NA
------	---------------	--

Daily Hydration Risk Assessment

Risk assessment should be carried out within 4 hrs of admission and daily thereafter

COPY



Daily Assessment

Care plan to be completed for all patients assessed as 'at risk'

Risk Assessment Week 1	Date/ Time	Date	Date	Date	Date	Date	Date
	24/11/25	25/11/25	26/11/26				
Number of Risks present	1	2	1				
Fluid Balance or monitoring indicated Y= Yes N= No	N	Y	Y				
Care Plan commenced/reviewed Y=Yes N=No	N	Y	Y				
Initials of assessor	LC	SB	SB				

Hydration Care plan

Potential nursing actions

(Please include all that apply in the care plan below)

COPY

- Commence fluid balance chart (Risk1-4). Clearly document the risk/reason.
- Commence fluid intake monitoring chart (Risk 5) for at least 3days to establish that the patient is adequately hydrated.
- Set daily fluid balance/intake target with medical team.
- Review 24hr fluid balance at midnight and document in unified progress notes for medical team.
- Offer drinks at each care and comfort round (If appropriate) and document preferences for drinks.
- Encourage patient /carers to be involved with fluid intake and documentation on pictorial fluid chart.
- Describe individual patients care needs.

[illegible]

BRADEN RISK ASSESSMENT CHART

Individuals with a total score of 16 or less are considered at risk: 15-16 = low risk, 12-14 = moderate risk, 11 or less = high risk.
 Undertake and document risk assessment within 6-8 hours of admission to every ward or department. Reassess if there is a change in individual's condition and repeat regularly according to local protocol or risk score.
 1. Complete skin care plan with BRADEN score included and commence a care and comfort round chart.

2. Consider contributing factors, frailty, diabetes, end of life care.

DATE					24	11	25													
TIME					18	44														
Sensory Perception – Ability to respond meaningfully to pressure related discomfort	1. Completely Limited Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body surface.	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment that limits the ability to feel pain or discomfort over ½ of body.	3. Slightly Limited Responds to verbal commands but cannot always communicate discomfort or need to be turned. OR has some sensory impairment that limits ability to feel pain or discomfort in 1 or 2 extremities.	4. No Impairment Responds to verbal commands. Has no sensory deficit that would limit ability to feel or voice pain or discomfort.	4															
Moisture – Degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient/client is moved or turned.	2. Very Moist Skin is often but not always, moist. Linen must be changed at least once a shift.	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day.	4. Rarely Moist Skin is usually dry. Linen only requires changing at routine intervals.	4															
Activity – Degree of physical activity	1. Bedfast Confined to bed.	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. Walks Occasionally Walks occasionally during day but for very short distance, with or without assistance. Spends majority of each shift in bed or chair.	4. Walks Frequently Walks outside the room at least twice a day and inside the room every 2 hours during waking hours.	4															
Mobility – Ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance.	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	3. Slightly limited Makes frequent though slight changes in body or extremity position independently.	4. No Limitations Makes major and frequent changes in position without assistance.	4															
Nutrition – Usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IV's for more than 5 days.	2. Probably Inadequate Rarely eats a complete meal and generally eats only about ½ of any food offered. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding.	3. Adequate Eats over half of most meals. Occasionally will refuse meal but will usually take a supplement if offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	4. Excellent Eats most of every meal. Never refuses a meal. Occasionally eats between meals. Does not require supplementation.	4															
Friction and Shear –	1. Problem Requires moderate to maximum assistance in moving.	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.		3															
Indicate appropriate number and add for total score					TOTAL SCORE: 23															
					Initials: LC															

COPY

Skin Assessment and Care Plan

COPY

Daily Skin Care Assessment

[illegible]

Falls Risk Assessment

COPY

The following 3 questions must be completed with **ALL** patients, within **6 hours** of admission.
Re-assessment required if patient falls or condition changes.

(Please document Yes/No below)

1	History of falls prior to admission? (if yes, complete falls history & falls prevention action plan)	N						
2	Falls(s) since admission? (if yes, complete falls prevention action plan)	N						
3	Additional falls risk factors for this patient? E.g. Patient tries to walk alone but unsteady/unsafe, learning disabilities, parkinson's, Stroke, cognitive impairment, acute confusional state, continence issues, visual impairment, medication (night sedation), surgery, seizures/epilepsy, fear of falling etc. (if yes, complete falls prevention action plan) Please state: (walks alone but unsafe, cognitive impairment).....	Hip replace ment						
Date		24/11						
Time		1845						
Initial		LC						

Falls History: (to be completed within 6 hours of admission)

Falls history assessment:(Date & time of last fall prior to admission)

Estimated date and time of the last fall? Date Time of Day.....

First fall? Yes ☐ No ☐ Recurrent falls? Yes ☐ No ☐ Number of falls within the last year?

Any warning immediately prior to any falls? Yes ☐ No ☐

Palpitation ☐ Dizziness ☐ Alcohol ☐ Loss of Consciousness ☐
 Slip/Trip ☐ Environmental hazards ☐ Associated movement ☐

Explaination about fall/previous falls :(where, when, why) Activity at time of fall? (Please describe)
 (Consider if fall/injury could be non accidental)

Any injury sustained or previous fracture? Yes ☐ No ☐ (if yes, please describe)

Any pain related to fall? Yes ☐ No ☐ (if yes, please describe)

Any anxiety regarding further falls/confidence affected? Yes ☐ No ☐ (If yes please describe)

Comments/other information/highlight areas of concern:

Data collected from: Patient ☐ Relative ☐ Carer ☐ Other:

Initials of Nurse: _____

Date/Time: _____

Falls Prevention Action Plan

The following nursing interventions may address some of the falls risk factors. They are however NOT exhaustive and staff should use their clinical reasoning/professional judgment when determining falls risk interventions.

COPY

Please state all actions taken from the list of interventions below.

Interventions:	Care Plan 1: On Admission
Environmental: - Nurse in most appropriate place on ward for their needs e.g. easily observable area, near toilet etc. - Area hazard free, personal belongings within easy reach - Call system working/within reach at all times - Adequate lighting at all times particularly overnight. - Check infusion stands facilitate mobility. - Use of sound/movement monitors (if available) - Select suitable seating (appropriate height, comfort) - Consider one-way glide sheet for chair - Frequently re-orientate confused patients	Call system within reach.
Vision/Hearing - Ensure correct glasses worn/within easy reach and clean. - Determine if patient can recognize objects from the end of the bed - if concerns, refer to medical staff for visual acuity assessment - Consider hearing implications, hearing aid working etc.	N/A.
Lying and Standing Blood Pressure: - Check and record. If deficit exists, inform medical staff and continue to check twice daily for at least 72 hours. - Advise patient on slow movement from sitting/lying to standing.	N/A.
Mobility: - Follow mobility risk assessment/care plan. - Consider referral to Physiotherapy and/or OT - If patient requires walking aid is it within easy reach?	Crutches at home. States does not use them.
Medication: Request Medical staff or Pharmaceutical review.	HEPMA
Delirium (Acute Confusional State) - Complete 4AT risk assessment - Treat causes of delirium, refer to delirium guidelines	N/A.
Toileting: - Assess continence. If urine frequency, ward test urine. - Plan routine/frequent toileting. - Consider a commode for night time toileting. - Consider full continence assessment and refer to continence service if indicated.	Independent
Bed and bedrails: - Bed at optimum height and brakes applied. - Assess the need for bedrails - Hi/Low bed assessment and follow pathway	Independent
Footwear/Clothing - Encourage patient to wear shoes not slippers. - Check footwear for secure fit, non-slip sole. Ask relatives to supply safer replacements. - Ensure toenails are in good condition, include plan of care in personal hygiene care plan (Refer to podiatry if infected or neglected) - Suitability and appropriateness of clothing e.g. length	Slippers.
Inform: - Ensure Medical staff, Physiotherapist, OT, Social Worker etc, are aware of patients falls risk, frequency and nature - Involve/educate patient/relatives in safe practice. - Discuss with patient/relative re specific interventions. - Issue leaflet "How to reduce falls in hospital". - Place patient on care rounds/safety brief	PT.
Additional Falls Risk Management Interventions for Patient:	
Initials of Nurse/Date & Time:	LC 24/11/25 1845

Bedrails Assessment

COPY

Bedrails NOT to be used Code: A. Risk of climbing over and falling from a greater height. B. Patient is independent. C. Risk of entrapment in bedrails outweighs risk of falling D. Do not use with a high/low bed E. Patient with capacity and oriented but refuses bedrails	Bedrails CAN be used Code: F. Patient with capacity and is alert and oriented and requests bedrails. G. Risk of injury from falling from the bed outweighs the risks of not using bed rails. H. Patient is unconscious.
---	---

Assessment to be completed on admission within 6 hours. Review weekly or following a fall and in response to a change in patient condition.

Date and Time	Codes	Bed rail in use	Initials
24/11/25	E	YES/NO	LC
		YES/NO	
		YES/NO	
		YES/NO	
		YES/NO	
		YES/NO	
		YES/NO	

Bed rails must be used when the bed is moving (ie; transferring patient between areas)

THE 4AT TEST: Screening instrument for cognitive impairment and delirium

To be completed on **ALL** patients on admission/transfer to clinical area and when a change in presentation is evident

		On admission	On transfer to ward	If condition changes	
DATE			25/11/25		
TIME			0000		
1. ALERTNESS: <i>This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or more agitated/hyperactive than normal.</i> <i>If asleep, attempt to wake and ask the patient to state their name and address to assist rating.</i>	Normal (fully alert, but not agitated throughout assessment)	0	0	0	0
	Mild sleepiness for <10 seconds after waking, then normal	0	0	0	0
	Clearly abnormal (drowsy or more agitated/hyperactive than normal)	4	4	4	4
2. AMT4: Age, date of birth, place (name of hospital or building), current year	No mistakes	0	0	0	0
	1 mistake	1	1	1	1
	2 or more mistakes/untestable as unwell or too drowsy	2	2	2	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.	Achieves 7 months or more correctly	0	0	0	0
	Scores <7 months/refuses to start/unable due to cognitive impairment	1	1	1	1
	Unable to start as unwell/drowsy	2	2	2	2
4. ACUTE CHANGE OR FLUCTUATING COURSE: Evidence of significant change or fluctuation in: alertness, cognition (e.g. increased confusion) or other mental function arising over the last 2 weeks and still evident in last 24hrs	No	0	0	0	0
	Yes	4	4	4	4
4 or above: Possible delirium +/- cognitive impairment – ensure TIME bundle completed 1 – 3: Possible cognitive impairment – only rescore if condition changes 0: Delirium or cognitive impairment unlikely – rescore if condition changes		Score	Score	Score	Score
If 4 or more initiate TIME bundle (only one required per episode of delirium) TIME bundle commenced?		YES NO	YES NO	YES NO	YES NO
Initials of tester →		SB			

COPY

*MDT decided rescreening inappropriate due to clinical presentation (ensure documented in clinical notes) Sign Date.....
 (eg end of life, stroke, where fluctuation is part of normal presentation)

Daily Personal Hygiene & Continence Assessment

COPY

1. Daily Personal Hygiene Assessment

Date/ Time	24 11	25 11	26 11																
Independent with hygiene (no care plan required)	✓	✓	✓																
Requires supervision/assistance with hygiene (detailed care plan required)																			
Dependent with hygiene (detailed care plan required)																			

2. Daily Continence Assessment

Independent with continence, no concerns, review regularly for change	✓	✓	✓																
Uses continence products, continue to support whilst in hospital with prescribed products. Requires supervision/assistance (detail added to care plan)																			
Dependent or new continence issue, patient requires full assessment.																			
Initials	SB	SB																	

1. Daily Personal Hygiene Assessment

Date/ Time																			
Independent with hygiene (no care plan required)																			
Requires supervision/assistance with hygiene (detailed care plan required)																			
Dependent with hygiene (detailed care plan required)																			

2. Daily Continence Assessment

Independent with continence, no concerns, review regularly for change																			
Uses continence products, continue to support whilst in hospital with prescribed products. Requires supervision/assistance (detail added to care plan)																			
Dependent or new continence issue, requires full assessment.																			
Initials																			

Patients assessed as **yellow** or **red** require a detailed care plan overleaf.
All care given each day **must** be documented in the unified progress notes.

COPY

[illegible]

COPY

COPY

Complete this section to determine condition of mouth and the frequency of mouth care required. Document in the care plan and commence '2 Hourly' oral care record for Standard 2-4.

[illegible]

Complete this section to determine frequency of assessment required and document in the care plan.

[illegible]

COPY

[illegible]

COPY

Initial screening

Date	Time	Ward	Weight (kg)*	Weight ↑↔↓	Method used (M,R,C)	BMI	Step 1 Score	Step 2 Score	Step 3 Score	Total Score	'MUST' Risk	Initial
24/11	1853	BN	97.65	—	C	32	0	0	0	0	Low	LC

Pre-illness weight =

[illegible]

'MUST': Low Risk Nutrition Care Plan

COPY

Date/Time care plan initiated: 24/11/25

Intervention	Time Frequency	Initials
Has patient been informed of current weight and plan?	Yes/No	LC
Discuss the results of the 'MUST' screening/care plan with the patient and family (with agreement and involve them in identifying individualised interventions)	On admission & on-going	LC
Monitor patients weight and rescreen 'MUST' risk weekly or if patient's weight has remained stable for 4 weeks – screen monthly.	On admission and weekly	LC

base ✓ relevant box and where yes is answered, record details of individual requirement below;

Food Allergy- No ☒ Yes ☐	Religious, cultural, ethnic requirements- No ☒ Yes ☐	Initials
Details:		LC

Therapeutic diet required - No ☒ Yes ☐	Initials
Details:	LC

Assistance required with eating/drinking- No ☒ Yes ☐	Initials
Adapted cutlery/aids- No ☒ Yes ☐	LC
Assistance from family - No ☒ Yes ☐ (If yes please monitor fluid intake)	
Details:	

Specific food preferences (patients unable to make decisions on their food and fluid choices should have a detailed dietary and fluid preference recorded)	
Details:	
Is patient able to make own choices? No ☐ Yes ☒	
Yes – patient offered daily menu	
No – for patient unable to make choices has food and fluid preferences been recorded on 'my dietary information sheet' or offer and utilise 'Getting to Know Me' document No ☐ Yes ☐	

CARE PLAN REVIEW (SIGN & DATE AT EACH REVIEW)

Discuss current weight and plan with patient (initiate new care plan if risk has changed)

*Share with relative/carer where appropriate

Init/Date	Init/Date	Init/Date	Init/Date
24/11/25 LC			

PATIENT HANDLING ASSESSMENT – 'MOBILITY CHART'

Independent Y/N Dependent Y/N Ability prior to admission.....
 This mobility chart must be completed on admission for all patients. On transfer if the patients condition has changed and thereafter should be read/reviewed daily, post fall or if patient condition changes. Document any changes in a new column.
 Please refer to Manual Handling Guidelines for all manoeuvres. If your patient is 'Plus Size', please refer to the Bariatric Handling Guidelines

CODES	MC	HA/EC	MC	HA/EC	MC	HA/EC	MC	HA/EC	MC	HA/EC	MC	HA/EC
Lying to sitting	IND											
Sit to stand to sit												
Walking												
Bathing / Showering / Toileting												
Moving up the bed												
Turning / Proning												
On / off bed pan												
Lateral transfers												
On / off floor	✓											
State make and model of hoist / stand aid	N/A											
State type and size of sling	N/A											
Falls assessment (Y / N)	N/A											
Sign / Date / Time	24/11/25 JEC											

MC – Mobility Codes	HA – Handling Aids	EC – Equipment Codes
IND - Independent AST - 1/2/3	H - Full body hoist BH - Bath hoist	SC - Shower chair ST - Shower trolley
SUP - Supervision BR - Bed Rest	STA - Stand aid Pt T - Patient turner (specify)	W - Wheelchair
FWB - Full weight bearing	GS - Glide sheet ES - Extension straps	C - Crutches (specify)
PWB - Partial weight bearing	HB - Hand blocks HS - Handling sling	S - Stick Z - Zimmer
NWB - Non weight bearing	PAT - Pat slide	HJ - Hover Jack HM - Hover Jack

COPY

COPY

Date/
Time

$\frac{24}{11}$	$\frac{25}{11}$	$\frac{26}{11}$
-----------------	-----------------	-----------------

Daily Bowel Assessment

Date/
Time

Bowel Function Care plan

Potential nursing actions

(Please include all that apply in the care plan below)

- Please document normal bowel function and/or if the patient has a history of bowel disease
- Document if the patient has a stoma and plan of care, level of assistance required.
- Assess bowel function daily above and document any changes in the unified progress notes
- Review and update care plan below if the patients condition changes.
- Record any bowel pattern change, if patient is on aperients or if a specimen has been sent.
- Identify type of stool using Bristol Stool Form Scale. Record every episode of stool.

[illegible]

CHI NO: 2602800570
CRN:
Scott DOWELL
11 DON STREET
BRANDEMOUTH
FK3 8HD

26/02/1980
M

FULL NAME:

DATE OF BIRTH:

24/12/25
23/11 16:50 20:30 10 03 12:56 24/11 24/11/25 11 08:30 14:20 15/11 16/11 20:50 20:50 20:50

COPY

Respirations
Breaths/min

SpO₂ Scale 1
Oxygen saturation (%)

SpO₂ Scale 2
Oxygen saturation (%)
Tick if using Scale 2 ☐
Signed
ONLY use Scale 2 under the
direction of a qualified clinician

Air or
oxygen?

A=Air
O₂ L/min
Device

Pulse
Beats/min

Use •

Consciousness
Score for NEW onset of
confusion
(no score if chronic)

Temperature
°C

NEWS TOTAL

Monitoring frequency
Escalation of care Y/N
Blood Sugar
Pain Score 0-3
Initials

1 6 2 1 1 3 1 1 0 1 0 0 0
4-6 4-6 4-6 4-6 5 4-6 12 12 12
N N N N N N N N N N
/ / / / / / / / / /
/ / / / / / / / / /
N N N N N N N N N N

DATE OF ADMISSION:

COPY

DATE
TIME

≥25

21-24

18-20

15-17

12-14

9-11

≤8

≥96

94-95

92-93

≤91

≥97 on O₂

95-96 on O₂

93-94 on O₂

≥93 on air

88-92

86-87

84-85

≤83%

A=Air

O₂ L/min

Device

≥220

201-219

181-200

161-180

141-160

121-140

111-120

101-110

91-100

81-90

71-80

61-70

51-60

≤50

≥131

121-130

111-120

101-110

91-100

81-90

71-80

61-70

51-60

41-50

31-40

≤30

Alert

Confusion

V

P

U

≥39.1°

38.1-39.0°

37.1-38.0°

36.1-37.0°

35.1-36.0°

≤35.0°

TOTAL

Monitoring

Escalation

Blood Sugar

Pain Score 0-3

Initials

National Early Warning Score (NEWS2)

NHS

York Valley

COPY

Name:

DOB:

CHI No:

Address:

*** Regardless of NEWS always escalate if concerned about a patient's condition**

Total NEWS	Frequency of Monitoring	Clinical Response
0*	Minimum 12 hourly	Continue routine NEWS monitoring with every set of observations
1 - 4*	Minimum 4 - 6 hourly	- Inform registered nurse who must assess the patient - Registered Nurse to decide if increased frequency of monitoring and / or escalation of clinical care is required
5 - 6* or 3 in one Parameter	Increased frequency to a minimum of 1 hourly	- Registered nurse to urgently inform the medical team caring for the patient - Urgent assessment by a clinician with core competencies to assess acutely ill patients - Ensure structured Response Stickers A & B are completed (Not Applicable in Emergency Dept)
7* or more	Continuous monitoring of vital signs (3 lead ECG and continuous SpO2 monitoring, 15 minute BP cycling - document observations every 30 minutes)	- Registered nurse to immediately inform the medical team caring for the patient - Emergency assessment by clinical team with core competencies to assess acutely unwell patients - Ensure structured Response Stickers A & B are completed (Not Applicable in Emergency Dept) - Consider transfer of clinical care to ITU

Exclusion Criteria

Anaesthesia and/or sedation may result in reduced conscious levels for a period of time. Scores that are increasing post-procedure and those including "P" or "U" always require escalation. The post-procedure NEWS score and post procedure plan that will include the frequency of observations should be communicated to the ward staff on transfer/handover of the patient.

Target O2 Saturation

Target SpO2 for most patients should be 94-98%.

Selected patients may require target SpO2 88-92% (Appropriate in specific patients with severe chronic respiratory disease who either have established chronic Type 2 respiratory failure, or are felt to be at significantly increased risk of CO2 retention from oxygen therapy). These patients should use the modified (chronic hypercapnia) EWS. Arterial blood gases should be repeated at 30-60 min to check for rising CO2 or H+ after initiation of oxygen in this context.

Acute Respiratory Failure is a life threatening emergency

Severe Hypoxia (Requiring >60% O2 to maintain target SpO2)

Acute Hypercapnia (pCO2 >6 and H+ >45)

Urgent ST3 (or equivalent) review is required to optimise management.

Duty or on call consultant should be contacted if advice required.

Critical care referral and ventilatory support may be needed.

Codes For Recording Oxygen Delivery On NEWS Chart

A = Air (not requiring oxygen or weaning or on PRN oxygen)

N = Nasal Canulae

SM = Simple Mask

V24 = Venturi 24% **V28** = Venturi 28% **V35** = Venturi 35% **V40** = Venturi 40% **V60** = Venturi 60%

H28 = Humidified oxygen at 28% (also H35, H40 & H60 = Humidified Oxygen at 35%, 40% & 60%)

RM = Reservoir Mask

TM = Tracheostomy Mask

CP = Patient on CPAP System

NIV = Patient on NIV System

OTH = Other Device: _____ (specify which)

Pain Score

- 0 = no pain
- 1 = mild pain
- 2 = moderate pain
- 3 = severe pain

PERIPHERAL VASCULAR CATHETER (PVC) DAILY MAINTENANCE

Label Name: D.O.B: CHI: Hospital: (Use addressograph label)	Reason for insertion:		COPY DAY 0
	Insertion Date: _____ Time: _____		
	Colour/batch no: _____ Position: _____		
	Hand hygiene (HH) performed		Yes No
	Skin cleansed for 30 seconds with antiseptic & left to dry prior to insertion		Yes No
	Aseptic technique throughout		Yes No
	Sterile dressing applied including date and time		Yes No
	Inserted by: _____		
Ward inserted: _____			

Ensure that:

Medical staff review the need for intravenous (IV) therapy **including antibiotics on a daily basis – switch to oral if possible**

An antiseptic containing 70% isopropyl alcohol is used to clean the access hub. **Before accessing, rub the access hub for at least 15 seconds ("scrub the hub")**

MODIFIED VIP (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 sign:	Remove & replace cannula. Observe both sites and document. Obtain swab
Two or more of the following are evident: Pain, redness or swelling	2	Early stages of phlebitis:	Remove & replace cannula. Observe both sites and document. Treat if necessary. Obtain swab
All of the following are evident: Pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis	Remove and seek further advice. Obtain swab
As above including palpable venous cord	4		Remove and seek further advice. Obtain swab
As above including pyrexia	5		Seek further advice.

24 hours		Date: <u>21/06/2024</u>	Time: <u>09:00</u>
Is PVC still required	YES	<u>NO</u>	
Absence of inflammation/extravasation	YES	<u>NO</u>	
VIP score - please circle	<u>0</u> 1 2 3 4 5		
PVC dressing intact	YES	<u>NO</u>	
PVC inserted <72 hrs	YES	<u>NO</u>	
HH before/after procedure	YES	<u>NO</u>	
"Scrub the Hub" (before use)	YES	<u>NO</u>	
PVC - please circle	Left in situ	<u>removed</u>	
Reason for removal: <u>Discharged</u>			
Signature: <u>STNJK</u>			

48 hours		Date: _____	Time: _____
Is PVC still required	YES	NO	
Absence of inflammation/extravasation	YES	NO	
VIP score - please circle	0 1 2 3 4 5		
PVC dressing intact	YES	NO	
PVC inserted <72 hrs	YES	NO	
HH before/after procedure	YES	NO	
"Scrub the Hub" (before use)	YES	NO	
PVC - please circle	Left in situ	removed	
Reason for removal: _____			
Signature: _____			

72 hours		Date: _____	Time: _____
Is PVC still required	YES	NO	
Absence of inflammation/extravasation	YES	NO	
VIP score - please circle	0 1 2 3 4 5		
PVC dressing intact	YES	NO	
PVC inserted <72 hrs	YES	NO	
HH before/after procedure	YES	NO	
"Scrub the Hub" (before use)	YES	NO	
PVC - please circle	Left in situ	removed	
Reason left in situ: _____			
Discussed with: _____			
Reason for removal: _____			
Signature: _____			

If PVC to remain in situ for longer than 72 hours this must be documented on a daily basis in notes and discussed with medical staff.

Observe closely for clinical signs and symptoms of Phlebitis.

New sheet to be commenced.

PERIPHERAL VASCULAR CATHETER (PVC) DAILY MAINTENANCE

Label	Reason for insertion:	DAY 0
Name:	Insertion Date: 23/11/25	Time: 14:00
D.O.B:	Colour/batch no: green	Position: LACP
CHI:	Hand hygiene (HH) performed	Yes No
Hospital:	Skin cleansed for 30 seconds with antiseptic & left to dry prior to insertion	Yes No
(Use addressograph label)	Aseptic technique throughout	Yes No
	Sterile dressing applied including date and time	Yes No
	Inserted by:	
	Ward inserted:	

Ensure that:

Medical staff review the need for intravenous (IV) therapy including antibiotics on a daily basis – switch to oral if possible

An antiseptic containing 70% isopropyl alcohol is used to clean the access hub. Before accessing, rub the access hub for at least 15 seconds ("scrub the hub")

MODIFIED VIP (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 sign:	Remove & replace cannula. Observe both sites and document. Obtain swab
Two or more of the following are evident: Pain, redness or swelling	2	Early stages of phlebitis:	Remove & replace cannula. Observe both sites and document. Treat if necessary. Obtain swab
All of the following are evident: Pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis	Remove and seek further advice. Obtain swab
As above including palpable venous cord	4		Remove and seek further advice. Obtain swab
As above including pyrexia	5		Seek further advice.

24 hours	Date: 24/11/25	Time: 14:00
Is PVC still required	YES	NO
Absence of inflammation/extravasation	YES	NO
VIP score - please circle	0 1 2 3 4 5	
PVC dressing intact	YES	NO
PVC inserted <72 hrs	YES	NO
HH before/after procedure	YES	NO
"Scrub the Hub" (before use)	YES	NO
PVC - please circle	Left in situ	removed
Reason for removal:		
Signature:		

48 hours	Date: 25/11/25	Time: 14:00
Is PVC still required	YES	NO
Absence of inflammation/extravasation	YES	NO
VIP score - please circle	0 1 2 3 4 5	
PVC dressing intact	YES	NO
PVC inserted <72 hrs	YES	NO
HH before/after procedure	YES	NO
"Scrub the Hub" (before use)	YES	NO
PVC - please circle	Left in situ	removed
Reason for removal:		
Signature:		

72 hours	Date: 26/11/25	Time: 14:00
Is PVC still required	YES	NO
Absence of inflammation/extravasation	YES	NO
VIP score - please circle	0 1 2 3 4 5	
PVC dressing intact	YES	NO
PVC inserted <72 hrs	YES	NO
HH before/after procedure	YES	NO
"Scrub the Hub" (before use)	YES	NO
PVC - please circle	Left in situ	removed
Reason left in situ:		
Discussed with:		
Reason for removal:		
Signature:		

If PVC to remain in situ for longer than 72 hours this must be documented on a daily basis in notes and discussed with medical staff.

Observe closely for clinical signs and symptoms of Phlebitis.

New sheet to be commenced.

ADULT PARENTERAL GENTAMICIN (GGC): PRESCRIBING, ADMINISTRATION & MONITORING CHART

Use for patients prescribed intravenous gentamicin as per the GGC dosing guidance. Not for prophylactic indication or where synergistic doses (usually in endocarditis) are being used. Refer to full guidance for information on EXCLUSIONS and Cautions / Contra-indications to gentamicin.

Pa: 
CHI NO: 2602800570 26/02/1980
Da: CRN: M
Scott DOWELL
11 DON STREET
CHI ORANGEMOUTH
FK3 8HD

Age: 45 Sex: M / F
Weight: 108 kg Height: 178 cm
Creatinine: 66 on: 23 / 11 / 25

Initial Gentamicin Dose*: 400mg
Predicted Frequency*: 24h
*this is not a prescription and may change. Doses must be prescribed individually below.

Source of first dose: Online calculator (preferred method) ☒ Manual calculation ☐ Weight based, creatinine not known ☐

Step 1: Calculate and prescribe the first dose of gentamicin (see overleaf for more details)

- If creatinine is known - use the online gentamicin dose calculator.
- If creatinine is not known - give 5 mg/kg gentamicin (maximum 400 mg) or, if CKD 5, give 2.5 mg/kg (maximum 180 mg) on advice of senior medical staff.
- Prescribe gentamicin 'as per chart' on the medication chart (kardex). AVOID specifying dose or administration time on the kardex.
- Prescribe individual doses in the prescription record section below, specifying the date and time the dose should be given.

Step 2: Monitor creatinine and gentamicin concentration and reassess the dosage regimen

- Check gentamicin concentration after the first dose and then at least every 2 days (see overleaf for more details).
- Monitor creatinine daily. Seek advice if renal function is unstable (e.g. a change in creatinine of >15-20%).

Step 3: Assess daily: the ongoing need for gentamicin; signs of toxicity

- Consider an alternative agent if creatinine is increasing or the patient becomes oliguric.
- If gentamicin continues for >7 days, suggest referral to audiology for assessment.
- Refer to guidelines or clinical pharmacist for further advice on prescribing, monitoring and administration.

PROMPT ADMINISTRATION
within 1 hour of recognition of sepsis reduces mortality

SIGNS OF GENTAMICIN TOXICITY
RENAL: ↓ urine output/oliguria or ↑ creatinine

OTO/ NEW tinnitus, dizziness, poor balance,
VESTIBULAR: hearing loss, oscillating vision

Toxicities may occur irrespective of gentamicin concentration.

TOXICITY Before prescribing each dose check: Renal & Oto-vestibular function	Gentamicin Prescription Record				Administration Record			Monitoring Record			
	Complete each time a dose is to be given (ensuring gentamicin is prescribed 'as per chart' on the kardex)				Complete each time gentamicin is administered (in addition to the kardex)			Record ALL sample dates/times accurately below. See overleaf for monitoring advice.			
	Date to be given	Time to be given 24 h clock	Gentamicin Dose (mg)	Prescriber's signature, PRINTED name and STATUS	*Infuse over 30 mins*		Given by	Date of sample	Time of sample 24 h clock	Gent level (mg/L)	Action/ Comments (please initial action to be taken)
					Date given	Time started 24 h clock					
Cr = micromol/L	23/11	2330	400mg	M. WALKER Miche F	23/11/25	23:20	CG, AS				24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other:
Cr = micromol/L	25/11	0630	400mg	Miche F	25/11/25	0630	SB, MQ				24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other:
*Discuss with an infection specialist or microbiology and document in the notes if treatment continues beyond 3 to 4 days *											
Risks of prolonged treatment must be considered and treatment options discussed with microbiology or infection specialist											
Cr = micromol/L											24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other:
Cr = micromol/L											24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other:

Discuss with an infection specialist before continuing onto a second sheet

COPY



NHS Forth Valley No Smoking Policy

PATIENTS LEAVING HOSPITAL PREMISES TO SMOKE

As smoking is the biggest single cause of ill health in Scotland, NHS Forth Valley does not permit smoking in any of its premises including the grounds and car parks. It is also against the law in Scotland to smoke in any enclosed public place.

What this means for you?

- If you wish to smoke you must leave NHS Forth Valley premises to do so, this includes the grounds. You do this against medical advice.

How we can help?

- Assistance is available to help you to stop smoking and to alleviate withdrawal symptoms.
- Nicotine Replacement therapy can be prescribed for you during your stay.
- Ongoing support can be provided for you after discharge to help you stay stopped.

I have read and understand that I must leave NHS Forth Valley premises if I wish to smoke. **I understand if I choose to do so this will be at my own risk to my health, safety and well-being and that of others and is against medical advice.** I understand it is illegal to smoke in any enclosed public space.

Name:

SCOTT DOWELL

CHI Number:

2602800570

Ward or Department:

WARD B11

Hospital:

FVHM

Signature: (patient)

Scott Dowell

Date:

25/11/25

☒ If you **DO NOT** wish to speak to a Specialist Stop Smoking Advisor please tick here.

ACTION REQUIRED

NOW - call 01786 433293 if box **NOT** ticked to refer patient

WHITE COPY - FOR PATIENTS NOTES

YELLOW COPY - PATIENT

PINK COPY - STOP SMOKING SERVICE, HEALTH PROMOTION, CSD, COLQUHOUN ST, STIRLING

Immediate Discharge Letter

NHS
Forth Valley

Forth Valley Royal Hospital, Larbert

Tel: 01324 566 000

Serial No: bba19a17-10f8-43a6-9817-c8ec304bc339

Page 1 of 3

*** Non-verified Orders Exist ***

Consultant: DR AKAN EMIN

Ward: B11

GP Details

Patient Details

Admission Details

GP Name: A Syeed
& Address: Alba Medical Group
Forth
Firs Entry
Bannockburn

CHI No: 2602800570

Surname: Dowell

Forename: Scott

DOB: 26/02/1980

Address: 11 Don Street
Grangemouth
STIR
FK3 8HD

Admission Date: 23/11/2025

Admission Type: Planned Admission

Presenting
Complaint:

Planned
Discharge Date: 26/11/2025

Outpatient
Follow Up:



Patient Tel: 01324 262719

** PLEASE NOTE: DETAILED CLINICAL INFORMATION REGARDING PATIENT EPISODE TO-FOLLOW **

Patient Drug Reactions

Allergen	Reaction	Allergen	Reaction

Allergy Status not Recorded

Forth Valley Acute Hospitals - Acute Division
Medications Discharge Summary

Medication	Route	Dose & Frequency	Days Supply or POD	GP?	V	Notes
DIHYDROCODEINE 30 mg Tablets	Oral	60 mg FOUR times daily at 8am 12noon 6pm 10pm when required 4-6 hourly for PAIN	7 MAX 240mg in 24h	No		
LAXIDO Sachets	Oral	1 Sachet when required for constipation	7 as required	No		
CO-AMOXICLAV 500/125 Tablets	Oral	1 Tablet THREE times daily at 8am, 2pm and 10pm for 5 day(s)	5	No		

** Last Item **

Dispensed by:

E Grant

Checked by:

Heidi Hook

Date:

26/11/25

Discharging Doctor: DR HANNAH DIAMOND

Grade:

Immediate Discharge Letter

Forth Valley Royal Hospital, Larbert

Tel: 01324 566 000

NHS

Forth Valley

COPY

Serial No: bba19a17-10f8-43a6-9817-c6ec304bc339

Page 2 of 3

*** Non-verified Orders Exist ***

Consultant: DR AKAN EMIN

Ward: B11

GP Details

Patient Details

Admission Details

GP Name : A Syeed

CHI No: 2602800570

Admission Date : 23/11/2025

& Address : Alba Medical Group

Surname: Dowell

Admission Type : Planned Admission

Forth

Firs Entry

Bannockburn

Forename : Scott

Presenting

Complaint :

DOB : 26/02/1980

Address : 11 Don Street

Grangemouth

STIR

FK3 8HD

Planned

Discharge Date : 26/11/2025

Outpatient

Follow Up :



Patient Tel : 01324 262719

Discharge Comments and Follow up arrangements

GP Communication

TTO- Co-Amoxiclav, 5 days remain to complete course, laxido and dihydrocodine.

GP- No changes have been made to medication during this admission

DR HANNAH DIAMOND 26/11/2025 9:42

** End of Discharge Notes **

Dispensed by :

Checked by :

Date :

Discharging Doctor : DR HANNAH DIAMOND

Grade :

Printed: 26/11/2025 @ 09:42:50

Immediate Discharge Letter

Forth Valley Royal Hospital, Larbert
Tel: 01324 566 000

NHS
Forth Valley

COPY

Serial No: bba9a17-10f8-43a6-9817-c6ec304bc339

Page 3 of 3

*** Non-verified Orders Exist ***

Consultant: DR AKAN EMIN

Ward: B11

GP Details

Patient Details

Admission Details

GP Name: A Syeed

CHI No: 2602800570

Admission Date: 23/11/2025

& Address: Alba Medical Group

Surname: Dowell

Admission Type: Planned Admission

Forth

Forename: Scott

Presenting
Complaint:

Firs Entry

Bannockburn

DOB: 26/02/1980

Address: 11 Don Street
Grangemouth

Planned
Discharge Date: 26/11/2025

STIR

FK3 8HD

Outpatient
Follow Up:

Patient Tel: 01324 262719

Medicines Changed in this Admission

Medicine	Modification / Statement
DOXYCYCLINE 100 mg Capsules	Discontinued - Therapeutic switch
COLECALCIFEROL 800 units Tablets	Not prescribed on TTA
ESOMEPRAZOLE 40 mg Tablets	Not prescribed on TTA
ROPINIROLE 250 micrograms Tablets	Not prescribed on TTA
PREGABALIN 300 mg Capsules	Not prescribed on TTA
TADALAFIL 5 mg Tablets	Not prescribed on TTA
DULOXETINE 60 mg Capsules	Not prescribed on TTA
LIDOCAINE 5 % Medicated plaster	Not prescribed on TTA

Dispensed by :

Checked by :

Date :

Discharging Doctor : DR HANNAH DIAMOND

Grade :

Originally Printed : 26/11/2025 @ 09:42

Pharmacy Copy 1/2

