Clyde SAR Team
Level E
Inverclyde Royal Hospital
Larkfield Road
Greenock
PA16 0XN

NHS
Greater Glasgow and Clyde

PRIVATE

Date: 17.07.2026
Your Ref: 100299

MMA Legal Ltd
23 Goodlass road
Building B
Speke Liverpool
L24 9HJ

Our Ref: LAT/JM/AK/2208793218
Enquiries to: Aileen Kane
Direct Line: 01475 504761

E-mail: aileen.kane2@nhs.scot

Dear Sir/Madam

Subject Access Request under the General Data Protection Regulation

Patient: HENRY BURGESS DOB: 22.08.1979

Thank you for your request received on 24TH June 2026 in which you seek a copy of your client's personal information.

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

INVERCLYDE ROYAL & ROYAL ALEXANDRA HOSPITAL MEDICAL RECORDS

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

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

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

- patient health records, photographs or Radiology images.
- video/telephone recordings, including CCTV images.
- Witness Statements.

- Incident reports
- Complaints files
- Emails

The source of our data includes patients, General Practitioners, healthcare, social and welfare organisations, legal representatives and police forces.
We sometimes need to share the personal information we process with the individual themselves and with other organizations as listed above. Where this is necessary, we are required to comply with all aspects of the General Data Protection Regulation.

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

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

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

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

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

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

Yours sincerely

A Kane

Legal Aspects Team

LM PART 1

ELECTRONIC PATIENT RECORDS

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

Including:

BADGERNET	☐		
CAREVUE	☐		
MEDICAL ILLUSTRATION	☐		
METAVISION	☐		
PHYSIOTHERAPY	☐		
RADIOLOGY	☑		
WEST MARC	☐		
LABS	☐		
OPEN EYES	☐		
PODIATRY	☐		
ORTHOTICS	☐		

BURGESS, Henry
BORN 22-Aug-1979 (46y) GENDER Male
CHI 2208793218

Information Record; Occupational Therapy and Physiotherapy

Last updated by Amanda GILLESPIE (Amanda Gillespie) 6 years ago (v. 1) Show History

Sensitivity

Content Restricted	No	Sensitivity	Sensitive
If the information on this form merits further restriction than that of Highly Sensitive, please select **Yes** to apply a Privacy Seal		The information on this form **will** be viewable by health and care providers with the appropriate access permissions	

Admission Information

Hospital	Royal Alexandra Hospital
Ward	Ward 24
Specialty	General Surgery
Consultant	MacGoey
Assessment completed by	Occupational Therapist

Personal Details

Consents to assessment	Yes	Details	—
Does the patient have an appointed welfare guardian or power of attorney	No		

Medical History

Relevant past medical history	EMBOLISM AND THROMBOSIS OF OTHER SPECIFIED VEINS (I82.8) Diagnosis 01 May 2018 CHEST PAIN ON BREATHING (R07.1) Diagnosis 10 Dec 2017 PERSON WITH FEARED COMPLAINT IN WHOM NO DIAGNOSIS IS MADE (Z71.1) Diagnosis 13 Sep 2017 ACC POISONING BY NARCOTICS/PSYCHODYSLEPTICS NEC IN UNSPECIFIED PLACE (X42.9) Diagnosis 21 Apr 2017 MENTAL/BEHAVIOUR DIS DUE TO OPIOIDS,ACUTE	Reason for referral / management instructions	OT Assessment
		Risks / precautions / contraindications / allergies / red flags	—

BURGESS, Henry
BORN 22-Aug-1979 (46) GENDER Male
CHI 2208793218

INTOX,UNCOMPLICATED (F11.00)
Diagnosis 23 Mar 2017 PERSON WITH FEARED COMPLAINT IN WHOM NO DIAGNOSIS IS MADE (Z71.1)
Diagnosis 11 Aug 2016 INTENT SELF-POISON BY ANTIEPILEP/ANTIPARK/PSYCHOTROP DRUG IN OTH INSTITUT (X61.2)
Diagnosis 11 Aug 2016 OBSERVATION FOR SUSPECTED TOXIC EFFECT FROM INGESTED SUBSTANCE (Z03.6)
Diagnosis 11 Aug 2016 POISONING BY BENZODIAZEPINES (T42.4)
Diagnosis 11 Aug 2016 POISONING BY OTHER ANTIEPILEPTIC AND SEDATIVE-HYPNOTIC DRUGS (T42.6)
Diagnosis 07 Jul 2016 CELLULITIS OF OTHER PARTS OF LIMB (L03.1)
Diagnosis 07 Jul 2016 CHRONIC VIRAL HEPATITIS C (B18.2)
Diagnosis 07 Jul 2016 INSULIN-DEPENDENT DIABETES MELLITUS WITHOUT COMPLICATIONS (E10.9)
Diagnosis 07 Jul 2016 PHLEBITIS AND THROMBOPHLEBITIS OF OTHER DEEP VESSELS OF LOWER EXTREMITIES (I80.2)
Diagnosis 28 Jun 2016 OTHER SPECIFIED SOFT TISSUE DISORDERS (PELVIC/THIGH) (M79.85)
Diagnosis 23 Feb 2015 CLOSED FRACTURE OF OTHER FINGER (S62.60)

Present complaint / history of present complaint	abscess spleen removed
Current / pending investigations	No
Relevant drug history on admission	As per drug prescription chart (Kardex)
Smoker	—

Personal and Social Circumstances

Personal and social circumstances	Details

Obtained from	Patient		
Living arrangements	Spouse / Partner	Details	girlfriend

BURGESS, Henry
BORN 22-Aug-1979 (46y) GENDER Male

Accommodation

Accommodation	Details
Type	House
Number of floors	2

Home Information

Home information	Details		
Ownership	Local authority / housing association	Detail	—
Door Entry System	No	Key Safe	No
Telecare	No	Community Alarm	No
Heating	Gas		
Bedroom location	Upstairs	Bath/ Shower room location	Upstairs
Internal stairs	Yes	External stairs	Yes
Number	10	Number	5
Handrail Ascending	Bilateral	Handrail Ascending	Right
Type	Straight flight		
Ability to negotiate stairs or steps	Independent	Stair lift	—
Further home information	—		

Previous Level of Mobility

Previous mobility	Details		
Indoor	Independent	Further details	—
Outdoor	Independent	Further details	—

Previous Transfers

Previous transfers	Details		
Bed	Yes	Details and Equipment	DOUBLE BED
Toilet or Commode	Yes	Details and Equipment	NIL AID
Bath	Yes	Details and Equipment	OBS
Shower	No		
Chair or Wheelchair	Yes	Details and Equipment	NIL ISSUES
Other Transfer	—		
Additional information	—		

Falls

Falls Details

BURGESS, Henry
BORN 22-Aug-1979 (46y) GENDER Male
CHI 2208793218

How many falls in the last year	0	Any sustained injury	—
		Further Information	—
Mechanism of fall	—		

Sensory Function

Sensory function	Not completed at this time

Self Care

Self care	Details		
Washing / bathing	Independent	Further details	—
Personal grooming	Independent	Further details	—
Toileting / continence	Independent	Further details	—
Night toileting	Independent	Further details	—
Dressing	Independent	Further details	—
Eating and drinking	Independent	Further details	—
Medication	Independent	Further details	—
Additional information	No		

Domestic Life

Domestic life	Details		
Shopping	Independent	Further details	girlfriend
Laundry	Independent	Further details	girlfriend
Housework	Independent	Further details	girlfriend
Meal preparation	Independent	Further details	girlfriend shares
Driving	—	Further details	—
Childcare	Not Applicable		
Additional information	—		

Social Support

Social support	Not completed at this time

Lifestyle and Leisure

Lifestyle and leisure	—

Physical Activity

Physical activity	—

Employment

Employment	—

Finance

Finance **BURGESS, Henry**

BORN 22-Aug-1979 (46y) GENDER Male

CHI 2208793218

Form completed by a student No

Amend

Fluid Balance Chart

NI 2208793218
BURGESS
Henry M
96A ALICE STREET 22/08/1979
Paisley, Renfrewshire
PA2 6EA

Hospital: RAH

Ward: 20

Date: 08/12/20

Reason for Fluid Balance Chart _____

Is patient fluid restricted? Yes ☐ No ☐

If yes how many mls in 24 hours? _____

Fluid balance from previous 24hrs
+/- _____

Does patient require thickened fluids?
Yes ☐ No ☐ Stage _____

Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3

Signature: _____ Designation: _____

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input								Running Total INPUT	Output						Running Total OUTPUT	Initials
	Oral Fluids		Enteral		IV / Other					Urine	Gastric / Vomit	Bowel	Type	Type	Type		
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00										1000ml		CBE				1000	N.M
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
08:00																	
09:00																	
10:00																	
11:00																	
12:00																	
13:00																	
14:00																	
15:00																	
16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
								*Total Intake							*Total Output		

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

*24 hr Fluid Balance +/-

220665

Patient name

Patient CHI

2208793218
BURGESS M
Henry 22/08/1979
96A ALICE STREET
Paisley, Renfrewshire
PA2 6EA

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Greater Glasgow and Clyde

Emergency Care Nursing Documentation

Presenting complaint - and relevant past medical history including allergies

Date and Time		Name/Signature
1615	Stand by.	

Nursing notes - on admission

Date and Time		Name/Signature
	A- maintained	
	B- HR. 129	
	C- bp 99/50	
	D- AVPU	
	E- Temp. 37.1 BM- 26.8 keto 0.8 Ward to	
	ECG ✓ ABG ✓	
	central line inserted by ED	
	consultant.	

Triage

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

Communication

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

Risk Assessments and Screening Tools

SEPSIS	Y	N	GMAWS	Y	N
FAST	Y	N	Adult Support and Protection	Y	N
Swallow Testing	Y	N	Mental Health Triage Assessment	Y	N
Falls Risk (clinical judgeument)	Y	N	Child Protection Concerns	Y	N

Signature:

Patient nam
Patient CHI

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Greater Glasgow and Clyde

Care Rounds Checklist

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

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Use the following Codes:
Y = Yes **N** = No **NA** = Not Applicable **NT** = No Thanks **S** = Sleeping **O** = Off the ward **I** - Independent

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

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

Patient name

Patient CHI

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Greater Glasgow and Clyde

Nursing notes - ongoing care

Date and Time		Name/Signature
1700	Urinary catheter inserted by ED consultant.	
	given 1mg metaraminol	
1730	patient remains hypotensive - to be maintained with boluses of metaraminol. ——	
	Both surg + ITU in attendance	
1825	Central line (R) femoral	
	Arterial line (L) wrist -	
	Catheter in situ ——	
	2x NaCl 1000mls given stat.	
	1x Haemaccel 1000mls in progress	
	Noradrenaline infusion commenced	
	titrated by ITU consultant —	
	seen by Surgery for IVBG +	
	CT chest/abdo/pelvis with contrast	
	attending for CT at present	
	with ITU consultant + nurse	
	escort. IV Metronidazole	
	commenced ——	
19.20.	Return CT. For	
	surgical team	
	checklist ✓.	D Campbell RN.
	For surgery Surgical	
	team informed.	
	Partner given update.	
	Give 2g co-amox	
	given.	
	40mg IV omeprazole	
	running	

Patient name .....

Patient CHI .....

or use sticker

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Greater Glasgow and Clyde

4AT assessment - for delirium and cognitive impairment

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

4 or more possible delirium + /- cognitive impairment
1-3 possible cognitive impairment
0 delirium or severe cognitive impairment unlikey (but delirium still possibe if (4) information incomplete

TOTAL

Frailty Assessment Tool (Healthcare Improvement Scotland)

Step 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?			circle Y or N	
F	**Functional impairment**	(new or worsening) eg difficulty with self care	**Y**	**N**
R	**Resident**	in a care home	**Y**	**N**
A	**Altered mental state**	such as delirium or dementia (**4AT Assessment**)	**Y**	**N**
I	**Immobility/Instability**	decline in mobility, difficulty mobilising without help, fall leading to presentation	**Y**	**N**
L	**Living at home with support**	on a daily basis (homecare, one visit or more per day)	**Y**	**N**

If YES to any of the criteria in Step 1 move to Step 2

Step 2 Would this person be better managed by another speciality team at present?	circle Y or N	
Clear need for other specialty input eg exacerbation of known long-term condition such as COPD	**Y**	**N**
Need for HDU/ITU (including non-invasive ventilation)	**Y**	**N**
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit	**Y**	**N**
Head injury with loss of consciousness	**Y**	**N**
Acute abdominal pain/ surgical presentation	**Y**	**N**
Upper GI Bleed	**Y**	**N**
Chest pain with suspected acute coronary syndrome	**Y**	**N**
Trauma with suspected fracture	**Y**	**N**

Are any of the criteria met?
If YES to any criteria in Step 2: Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.
If YES to any criteria in Step 1 and NO to ALL criteria in STEP 2: Prioritise transfer of care to specialist geriatric assessment service.

Patient nam
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Hospital:

Ward:

Points to consider:

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

NHS
Greater Glasgow and Clyde

PUDRA

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

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

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

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

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

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

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

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

Patient name

Patient CHI

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Nursing notes - discharge plannning

Date and Time		Name/Signature

Outcomes and outstanding issues

Date and Time		Name/Signature

Pause for Discharge or Transfer

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

Contact with relatives

Signature:

My Admission Record

NHS Greater Glasgow and Clyde

Name: _____
Addre
2208793218
BURGESS
Henry M
DoB: 96A ALICE STREET 22/08/1979
CHI: Paisley, Renfrewshire
Affix PA2 6EA

Hospital: RAH Ward: ICU2
Date of Admission: Time:
Information obtained from: Name:
Patient ☑ Relative ☐ Other ☐ _____
Preferred Name:
Age: 41 Telephone Number:
Consultant: Dr O'Neil

Communication

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

Preferred first contact	Preferred second contact
Name: Lorna Relationship: Sister Address: Telephone: 07914528461 Is this person aware of your admission? Yes ☑ No ☐ Can we share information with this person? Yes ☑ No ☐	Name: Fiona Relationship: Partner Address: Telephone: 07435910104 Is this person aware of your admission? Yes ☑ No ☐ Can we share information with this person? Yes ☐ No ☑ Discuss with Henry first

Presenting Complaint / Diagnosis

General decline (3stone weight loss) Severe sepsis
CT-pneumoperitoneum → theatre.
Explained to the patient? Yes ☑ No ☐ Not Applicable ☐
Do you understand the reason for your admission? Yes ☐ No ☐

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

No known allergies ☑

Relevant past medical history

Type 1 DM
Prev IVDU - Treated HCV

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

Power of Attorney / Guardianship / Adult with Incapacity

Name: _____
Address: _____
_____
_____
DoB: _____
CHI: _____
Affix patient ID label

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

Yes ☐ No ☑

OR

Does someone have Guardianship?

Yes ☐ No ☑

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

Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

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

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:	Yes	No
1. Been an inpatient in a hospital outside Scotland?	☐	☑
2. Received holiday dialysis outside Scotland?	☐	☑
3. Been told that you have CPE?	☐	☑
4. Been in close contact with a person with CPE?	☐	☑

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

- Isolate the patient in a side room ☐
- Obtain Rectal swab marked 'for CPE' ☐
- If patient refuses rectal swab, obtain a stool specimen marked 'for CPE' ☐
- **and inform the IPCT** ☐

MRSA Screening

	Yes	No	Unsure
Will the patient be an inpatient for more than 23 hours	☐	☐	☑
If **YES** complete the following section			
1. Have you ever been told that you have MRSA?	☐	☐	☐
2. Have you been admitted from another hospital/ residential setting or care home?	☐	☑	
3. Do you have a wound / skin ulcer or invasive device which you had before admission?	☐	☑	☐

If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabs

Nasal ☑ Perineum ☑ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

	Yes	No	Unsure
Have you ever been informed that you are at increased risk of CJD or vCJD?	☐	☑	☐

If **YES inform the IPCT** ☐

Name: _____
Address: _____
_____
_____
DoB: _____
CHI: _____
Affix patient ID label

Lifestyle

Smoking

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

Never smoked ☐

Do you use eCigarettes? Yes ☐ No ☐

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

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

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

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

Drugs

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

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

Alcohol

Do you drink alcohol? Yes ☑ No ☐

How often do you have more than 6 units of alcohol on one occasion: 1L vodka per day.

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

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

Name (Please PRINT): R. BURNS Signature: [signature]

Designation: SN. Date: 2/12/20.

Updated when info available as patient sedated + ventilated on admission.

My Assessment Record

Name: _____
Address: _____
_____
_____
DoB: _____
CHI: _____
Affix patient ID label

1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems			
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			

Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems			
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

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

Name: _____
Address: _____
_____
_____
DoB: _____
CHI: _____
Affix patient ID label

3. Senses

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

Can you describe where and what the pain is like?

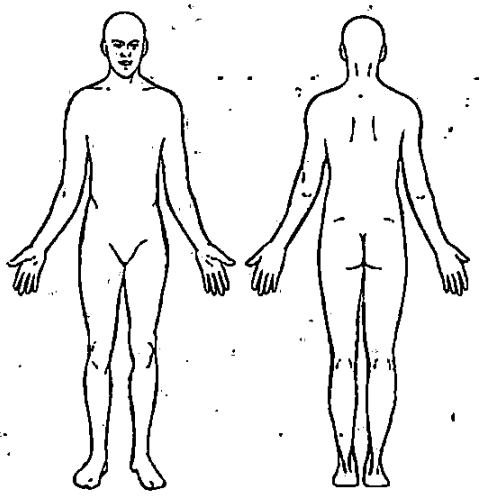
Have you had treatment / intervention for the pain?

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

Can you describe any chronic pain that you have?

What makes the pain better?

Mark current pain on body chart



Name: _____
Address: _____
_____
_____
DoB: _____
CHI: _____
Affix patient ID label

4. Cognitive Status THINK DELIRIUM

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

N.B. Think Delirium

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

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

and follow the guidance

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

What do you like to eat and drink?

What do you not like to eat and drink?

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

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓
Normal diet and fluids		
Therapeutic diet		
Cultural, ethnic or religious diet		
Texture Modified Diet Please state _____		
Thickened Fluid Please state _____		
Oral Nutritional supplements Preferred flavour _____		
Enteral Nutrition		
Parenteral Nutrition		
Nil by Mouth		

Name: _____
Address: _____
_____
_____
DoB: _____
CHI: _____
Affix patient ID label

Assessment of the patient's hydration and nutrition needs

N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharngeal Swallow Symptoms (STOPSS) within 4 hours of admission.

Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓
Independent (Green)		
Prompting / encouragement / opening packets/cutting up food (Amber)		
Full assistance with eating and drinking (Red)		

Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?

6. Elimination

Bladder	Admission Presentation ✓	Normal for the patient ✓
Pass urine with no problems		
Frequently pass urine during the day		
Frequently pass urine overnight		
Sense of urgency when need to pass urine		
Urine retention		

Assessment of the patient's elimination needs

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓
Haematuria		
Incontinent		

Name: _____
Address: _____
_____
_____
DoB: _____
CHI: _____
Affix patient ID label

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

What products do you normally use for this continence issue?

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

Date urinary catheter last changed ___/___/___

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

Bowels

When did your bowels last move?

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

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

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

What products do you normally use for this continence issue?

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

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

Name: _____
Address: _____
_____
_____
DoB: _____
CHI: _____
Affix patient ID label

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

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

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

Pressure ulcer identified on admission: Yes ☐ No ☐

Pressure Ulcer Grade: _____

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

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

Wound Care	Yes ✓	No ✓	Name: _____ Address: _____ _____ _____ DoB: _____ CHI: _____ Affix patient ID label
Do you have any wounds? **N.B. If yes, complete an assessment chart for wound management**			

8. Mobility

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

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

9. Maintaining a Safe Environment

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

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

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

10. Sleep and Rest

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

Name: _____
Address: _____
_____
_____
DoB: _____
CHI: _____
Affix patient ID label

11. Social Circumstances

Do you:

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

Other please specify _____ ☐

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

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

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

12. Emotional and Spiritual Care

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

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

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

Healthcare Chaplain informed Yes ☐ N/A ☑

Name: _____
Address: _____
_____
_____
DoB: _____
CHI: _____
Affix patient ID label

13. Person Centred Care

What matters and is important to you whilst you are in hospital?
This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care:

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

Informal Support

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

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

Name: .....
Contact Details: .....
.....
.....

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

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

Yes ☐ No ☐

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

Name: _____
Address: _____
_____
_____
DoB: _____
CHI: _____
Affix patient ID label

Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?
Yes ☐ No ☐
Referrals can be made via the central phone number: 0141 452 2387

Has the carer been advised of the Carers Information Line?
Yes ☐ No ☐ Not appropriate at this time ☐
Carers Information Line: 0141 353 6504
Carers Information Leaflet provided?
Yes ☐ No ☐

Are you:
Employed ☐ Unemployed ☐
Self-employed ☐ Retired ☐
Full time education ☐

Has your health had an impact on your ability to carry out your day to day activities at work?
Yes ☐ No ☐ Not applicable ☐

Do you have any money worries?
Yes ☐ No ☐ Not appropriate to ask at this time ☐
If yes would you like referred to a money advice service that can offer confidential advice/ support?
Yes ☐ No ☐ If yes when was patient referred ___ /___/___

Would you like a referral to a service that can support you with employment / education/ training/ skills volunteering?
Yes ☐ No ☐ Not applicable ☐ Not appropriate to ask at this time ☐
If yes when was patient referred ___ /___/___

Name: _____
Address: _____
_____
_____
DoB: _____
CHI: _____
Affix patient ID label

Risk Assessments/Other Documentation

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

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
2/12/20020	Please see carevue for details of ICU admission.	R. BURNS SN

My Admission Record

NHS Greater Glasgow and Clyde

Name: _____
Address: 2208793218
BURGESS
Henry M
96A ALICE STREET 22/08/1979
Paisley, Renfrewshire.
DoB: _____
CHI: _____ PA2 8EA
Affix patient ID label

Hospital: RAH Ward: HDU
Date of Admission: 08/12/20 Time: 1730
Information obtained from: Name:
Patient ☑ Relative ☐ Other ☐ _____
Preferred Name:
Age: 41. Telephone Number:
Consultant: Gray

Communication

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

Preferred first contact	**Preferred second contact**
Name: Lorna Thomson	Name: Fiona
Relationship: Sister	Relationship: Partner
Address:	Address:
Telephone: 07914528461	Telephone: 07435910104
Is this person aware of your admission? Yes ☑ No ☐	Is this person aware of your admission? Yes ☑ No ☐
Can we share information with this person? Yes ☐ No ☐	Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

Laparotomy + washout ~~splenectomy~~ ?? pancreatitis pneumoperitoneum
Explained to the patient? ICU staff Yes ☑ No ☐ Not Applicable ☐
Do you understand the reason for your admission? Yes ☑ No ☐

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

No known allergies ☑

Relevant past medical history

prev DVT
prev HDU
ex smoker
T2 on insulin

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

Power of Attorney / Guardianship / Adult with Incapacity

Name: _____
Address: 2208793218
BURGESS
Henry M
96A ALICE STREET 22/08/1979
Paisley, Renfrewshire
DoB: __ PA2 6EA
CHI: __
Affix patient ID label

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

Yes ☐ No ☑

OR

Does someone have Guardianship?

Yes ☐ No ☐

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

Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

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

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:	Yes	No
1. Been an inpatient in a hospital outside Scotland?	☐	☑
2. Received holiday dialysis outside Scotland?	☐	☑
3. Been told that you have CPE?	☐	☑
4. Been in close contact with a person with CPE?	☐	☑

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

- Isolate the patient in a side room ☐
- Obtain Rectal swab marked 'for CPE' ☐
- If patient refuses rectal swab, obtain a stool specimen marked 'for CPE' ☐
- **and inform the IPCT** ☐

MRSA Screening

	Yes	No	Unsure
Will the patient be an inpatient for more than 23 hours	☑	☐	☐
If **YES** complete the following section			
1. Have you ever been told that you have MRSA?	☐	☑	☐
2. Have you been admitted from another hospital/ residential setting or care home?	☑	☐	
3. Do you have a wound / skin ulcer or invasive device which you had before admission?	☑	☐	☐

If YES to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabs

Nasal ☑ Perineum ☐ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

	Yes	No	Unsure
Have you ever been informed that you are at increased risk of CJD or vCJD?	☐	☑	☐

If **YES inform the IPCT** ☐

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Henry M
96A ALICE STREET 22/08/1979
Paisley, Renfrewshire
PA2 6EA
Affix patient ID label

Lifestyle

Smoking

Are you a: smoker ☐ ex- smoker ☑ when did you stop? 2 years ago

Never smoked ☐

Do you use eCigarettes? Yes ☐ No ☐

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

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

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

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

Drugs

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

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

methedene

Alcohol

Do you drink alcohol? Yes ☑ No ☐ last drank 4/52 ago

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

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

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

Name (Please PRINT): C. WILLIAMS Signature:

Designation: SN Date: 28/11/20

My Assessment Record

Name: _____
Address:
2208793218
DoB BURGESS 22/08/1979 M
CHI: Henry 96A ALICE STREET PA2 6EA
Affix | Paisley, Renfrewshire

1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems			3L O2 on admission
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy	✓		
Do you have any other symptoms?			

Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems			prev DVT
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

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

Name:
Address:
2208793218
DoB: BURGESS Henry M 22/08/1979
CHI: 96A ALICE STREET Paisley, Renfrewshire
Affix PA2 6EA

3. Senses

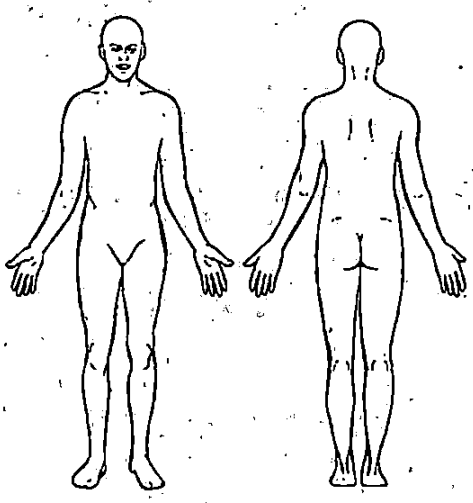
Vision	**Yes** ✓	**No** ✓	Assessment of the patient's vision
Do you have any problems with your vision?		✓	
Do you wear glasses?		✓	Distance ☐ Reading ☐ Both ☐
Do you have your glasses with you?			
Do you wear contact lenses?			
Do you have your lenses with you?			
Do you wear a prosthesis?			

Hearing	**Yes** ✓	**No** ✓	Assessment of the patient's hearing
Do you have any problems with your hearing?		✓	
Do you have any hearing loss?			
Do you use a hearing aid?			
Do you have your hearing aid(s) with you?			

Pain	**Yes** ✓	**No** ✓	Assessment of the patient's pain
Do you have pain?		✓	

Can you describe where and what the pain is like?

Mark current pain on body chart



Have you had treatment / intervention for the pain?

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

Can you describe any chronic pain that you have?

What makes the pain better?

2208793218
BURGESS
Henry
96A ALICE STREET
Paisley, Renfrewshire
PA2 6EA
M
22/08/1979

4. Cognitive Status — THINK DELIRIUM

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

N.B. Think Delirium

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

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

and follow the guidance

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

NO allergies

What do you like to eat and drink?

prefers cake / Irn Bru

What do you not like to eat and drink?

No preference

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

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓
Normal diet and fluids	✓	✓
Therapeutic diet		
Cultural, ethnic or religious diet		
Texture Modified Diet Please state _____		
Thickened Fluid Please state _____		
Oral Nutritional supplements Preferred flavour No preference	✓	
Enteral Nutrition	✓	
Parenteral Nutrition		
Nil by Mouth		

Name: _____
Addre
2208793218
BURGESS M
DoB: Henry 22/08/1979
CHI: 96A ALICE STREET
Affix Paisley, Renfrewshire
PA2 6EA

Assessment of the patient's hydration and nutrition needs

NG feed running 25sms centres can have diet also. Requires dietician input.

N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharnygeal Swallow Symptoms (STOPSS) within 4 hours of admission

Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓
Independent (Green)	✓	✓
Prompting / encouragement / opening packets/cutting up food (Amber)	✓	
Full assistance with eating and drinking (Red)		

Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?

6. Elimination

Bladder	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Pass urine with no problems	✓		catheterised
Frequently pass urine during the day			
Frequently pass urine overnight			
Sense of urgency when need to pass urine			
Urine retention			

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓
Haematuria		
Incontinent		

Name: _____

Add...

2208793218 M

BURGESS 22/08/1979

Do Henry

CH 96A ALICE STREET

Affi Paisley, Renfrewshire PA2 6EA

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

What products do you normally use for this continence issue?

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

Date urinary catheter last changed ___/___/___

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

Bowels

When did your bowels last move?

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

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

Bowel Habit	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Regular			faecal collector in place 2o samples sent
Constipated			
Diarrhoea / loose stools	✓		
Blood in stools			
Incontinent			

What products do you normally use for this continence issue?

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

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

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

N 2208793218
A BURGESS
Henry M
22/08/1979
Affix patient ID label

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

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

Pressure ulcer identified on admission: Yes ☐ No ☑

Pressure Ulcer Grade: _____

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

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

Wound Care	Yes ✓	No ✓
Do you have any wounds? **N.B. If yes, complete an assessment chart for wound management**	✓	

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8. Mobility

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

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

9. Maintaining a Safe Environment

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

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

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

10. Sleep and Rest

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

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11. Social Circumstances

Do you:

Live alone	☐	Live with family/ friend/ other	☑
Live in a nursing home	☐	Live in a care home	☐
Live in residential supported care	☐	Live in student accommodation	☐
Live in 'homeless' accommodation	☐	Have no fixed abode	☐

Other please specify_____ ☐

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

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

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

12. Emotional and Spiritual Care

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

NC

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

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

Healthcare Chaplain informed Yes ☐ N/A ☐

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13. Person Centred Care

What matters and is important to you whilst you are in hospital?
This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

~~on~~ family 2x sister / 2 Brothers / mother

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

Informal Support

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

family

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

Name: .....

Contact Details: .....

.....

.....

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

to keep family updated

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

Yes ☐ No ☑

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

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Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?
Yes ☐ No ☑
Referrals can be made via the central phone number: 0141 452 2387

Has the carer been advised of the Carers Information Line?
Yes ☐ No ☐ Not appropriate at this time ☐
Carers Information Line: 0141 353 6504
Carers Information Leaflet provided?
Yes ☐ No ☐

Are you:
Employed ☐ Unemployed ☑
Self-employed ☐ Retired ☐
Full time education ☐

Has your health had an impact on your ability to carry out your day to day activities at work?
Yes ☐ No ☑ Not applicable ☐

Do you have any money worries?
Yes ☐ No ☑ Not appropriate to ask at this time ☐
If yes would you like referred to a money advice service that can offer confidential advice/ support?
Yes ☐ No ☐ If yes when was patient referred ___/___/___

Would you like a referral to a service that can support you with employment / education/ training/ skills volunteering?
Yes ☐ No ☐ Not applicable ☐ Not appropriate to ask at this time ☐
If yes when was patient referred ___/___/___

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Risk Assessments/Other Documentation

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

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
03/12/20 @ 1830 – 1930	Patient admitted to HDU from ICU 2 – laparotomy, washout and splenectomy. Having base stocks. Nursed in side room. 2 l O2 Sp2 95% RR 18	

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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
03/12/20 1930	Contwd: BP stable, ST 90-100 Apyrexial. Catheter insitu NG feed capped off N/insulin wds running from T/F. BM @ 3.2 Insulin stopped. NG feed re-commenced @ 55 mls/hr. 2x Glucojuice given and ensure BM 4-6. FY2 contacted re: VRI to be prescribed. VRI not yet started as unable to source flush for VRI. have paged FY2 to re-prescribed last BM 10.3. Will require Dietician Review for NG Feed. then diabetic review regarding insulin regime. Blexseal replaced as dislodged - x1 sample required after midnight tonight	

15

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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
03/12/20 1935	contacted: Requires Bloods tonight via CVC – have booked ace to nightshift.	
4/12/20 03:30	Remains on 3-4 litres O2 via nasal cannula to achieve sats ≥94%. RR 12-20 breaths/min. Coughing & clearing chest under. Breathing unlabored. Monitoring sinus rhythm to tachy 90-110bpm. Normotensive, MAP ≥65mmHg. Urine output ≥30mls/hr via urinary catheter, clear in colour. Peripherally warm to touch however mildly oedematous to extremities. (A)VBLL & orientated to time & place. 4AT score 0. CBG 15.4, ketones 0.6. c/o UBIII as per prescription chart. Meds given as per drug Kardex. No c/o pain or nausea expressed. Pyrexic @ 38.1 CVC + peripheral blood cultures obtained, settled with window open therefore no paracetamol req. Pressure areas intact on inspection. Lap. & prev. drain site dressings dry & intact. Passed STOPPS, tolerating	CURES

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CLINICAL NOTES - MEDICAL ☐
NURSING ☑

Please tick ✔ appropriate directorate

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Created on 04 Dec 2020 06:39 by N

Date & Time		Signature, Print Name & Designation
4/12/20	oral fluids well however declined	
03:30	any diet. c/o food record chart	
	as MUST score 4, note partner states	
	approx. 3 stone unintentional weight	
	loss over 6/12. Remains on continuous	
	enteral feeding regimen 55mls/hr	
	as per TCU via NG tube, 72cms	
	external length @ nostril x with	
	bridle in place. Aspirates minimal,	
	appears to be absorbing well.	
	Referred to dietician re. above. faecal	
	collection device in situ, nil further	
	stool passed currently. Routine	
	bloods obtained via CVC. F/U	
	aware of same & will review	S/N
	results.	Signature Signature
4.12.2020	ward round MacGoey:	
1200	- infected infarcted spleen/	
	peritonitis	
	- continue total. 2152 (meropenem)	
	- CT CAP if septic this weekend	
	- vaccinate next week.	
	- IV insulin - DW diabetic team re insulin S/C.	
	- Nutrition - NBM feed currently if	
	stopping feed restart S/C insulin regime.	
	- diarrhoea - obtain further samples.	
	- dalteparin to continue.	
	- methadone 70mg daily	

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Date & Time		Signature, Print Name & Designation
4/12/2	Dietician reviews:	
12?	- feed changed to 12hour feed,	
	83ml/hr 6pm - 6AM.	
	- ensure x3 day.	
	- food chart	
	- weigh ☒	M
	- review on Monday	K. LOKE (SN)
4/12/202	(A) Maintaining our airway.	
850	(B) RR 20-28, currently on 4L%.	
	VM / was on 4Litres nasal Cannula	
	had desaturated to 88%,	
	Spo2 now 97% On once &	
	to review. Coughing &	
	expectorating (Green Sputum).	
	(C) Blood press normotensive,	
	MAP >65mmHg. Monitoring 4.	
	Sinus tachycardia	
	rate 110 - 125bpm.	
	STAT 1Lto 250mls given,	
	then 4% 1L fluids. 1L nexperan	
	Continues. Catheter patent +	
	draining >30ml/hr. VRIII	
	Stopped as per medics,	
	await diabetic review to	
	determine what insulin Hendy	
	needs before going back	
	on feed. Apyexial. Faecal	
	Collector remain intact. for	
	3rd sample tonight after midnight.	
	(D) Alert + orientated. BM, 9 - 14mmol.	
	(E) Sacrum red but intact - Laparotomy	
	wound has moderate staining.	
	NG tube remain intact. up to 5cm	

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Date & Time		Signature, Print Name & Designation
4.12.20	in chair, assistance of 2	
1500	with zimmer (seen by physio)	
	Reviewed by F42 re desaturation	
	- likely mucous plug	
	- CXR ☑ (looks slightly better)	
	- monitor oxygen levels	
	+ contact if deteriorates	K. Lee (SN)
4.12.20	Reg informed by F2 re desaturation	
1600	PRN saline nebs, PRN Salbutamol	
	nebs. Chest PT. Continue to monitor	
	Sputum sent ☑. Seen by diabetic	
	team, plan for insuli in medical	
	notes. BM 15.1mmols Ketone 0.2 @1600hrs	
	4 units novorapid given ☑.	
	For Novomix 30 at start of feed	
	& termin cut end of feed.	
	Insuli IV prescribed. weaned to	
	4 ltrs nasal cannula Sp$_2$ 94%	
14.12.20	Taken over patient care @ 16^{30} due	
	to staff illness.	
	S/B Mr McGoey - Discontinue IVF.	
	See medical notes - Stepdown	
	permissable if ward staffing levels	
	permit in stepdown area.	
18^{00}	BM 12.9mmols - 30 u Novomix given.	
	NG Aspirate 4.5 - c/o feed as	
	per dietician instruction 53mls/hr	
	12 hrs.	
	Sedation score 2 - Unable to	

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Date & Time		
	stay awake to complete full sentences. Will delay diazepam meantime. NIC informed. observations stable as charted.	Mcnek SN
07/12/20 0130	patient day 2 in HDU following theatre on (24/11/2020) for laparotomy splenectomy low stepdown.	
	(A) maintaining own airway	
	(B) r/e stable. coughing and expectorating	
	(C) Spo2 >94% (on >94%) on 4-5L NC Normotensive map>80. sinus Rythem 80-90bpm Apyrexial nil iv fluids has Ng feed running @ 83ml/hr due discontinued at 0000. passing >50ml/hr. via catheter	
	(D) AVPU orientated. drowsy at times, quick to fall asleep following nursing intervention meds as per Kardex diazepam not given at present due to drowsyness no nausea issues. BM's stable 11.1 - 12.9mmol continue to monitor.	
	(E) skin on pressure areas intact. faecal collector insitu bypassed at beginning of shift given full assistance with personal care	
	no other issues or concerns at present	
	Family - no communication overnight	
	lines- central line insitu (inserted 28/11/20) clean + dressing intact.	HAZELBALLER HBall staff
07/12/20 0600	patient remained settled observations stable BM ↑ 21.2 witness at med rec nurse continue to monitor insulin given as prescribed feed discontinued + flushed	HAZELBALLER.
	no other issues or concerns	HBall staff

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Date & Time		Signature, Print Name & Designation
5.12.20	Taken over patient care @ 0715	
	BM @ 0800 14.2 mmols - small amount	
	of breakfast tolerated.	
	Refused to sit out of bed.	
	Bed bath given. Pressure areas	
	intact.	
	Laparotomy wound redressed.	
	3 x staples removed from umbilical	
	area. ooze noted c same swabbed	
	for culture.	M CLARK S/N
W/R	SLB Ms Gray - wound swab, c/w chest	
	physio, encourage mobilisation c c/w	
	abx therapy.	M CLARK S/N
1445	Continues on 4L O2 therapy via	
	nlc. RR 19-24 sats 95%.	
	Coughing & expectorating++.	
	Normotensive via cuff. HR SR-ST 95-105bpm	
	Apyrexial. Meropenum given via (L) cline.	
	BM's 7.2 - 14.2 mmols	
	Tolerating small volumes diet &	
	fluid. Diuresing good volumes via	
	catheter. Faecal collector remains	
	in place - 200mls emptied.	
	Stool for culture & wound swab	
	sent. No bloods sent this a.m.	
	Henry alert & orientated to time	
	& place. Continues on abx.	
	Pain managed.	M CLARK S/N.

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Date & Time		
5/12/20	For transfer to ward 20 tonight.	
20:30	Remains on 3-4 ltrs O². Sats >92%.	
	RR 15-25. Coughing intermittently.	
	BP 130-140 systolic. map >65.	
	Heart rate sinus tachy 110 bpm.	
	Apyrexial. U/O >30mls/hr.	
	NG feed continues 83mls/hr.	
	BMs stable. Flexiseal remains	
	in place. Awaiting bed onward. —	Agarett agarett SIN
2345	Pt arrived on ward 20 via	
	HDU. Pt present - vitals taken.	
	Slightly sore. - awaiting	
	pump for feed. - Nevs = 4	SIN.
0300	Pt has started feeling very	
	warm + clammy. - temp	
	37.9 / cold compress given	
	News = (5) due to O²	
	requirement, tachy @	
	105 - 110, RR @ 22. Reg	
	aware and reviewed	
	pt. for ? Post pneumonectomy -	
	? CT d Thorax Cultures &	
	spike 4 38.00. ? chest sepsis.	SIN.
0600	Pt News = (7) RR - 23, Sats 95%	
	on 2L. tachy @ 127. —	
	Vitals aware, Reg aware	SIN
	Both in attendance. —	Bedmaker flood
0710	Central line is no longer	
	working - cannot get	
	access anywhere. Awaiting	
	new line.	SIN

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CLINICAL NOTES - MEDICAL ☐
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Date & Time		Signature, Print Name & Designation
6/12/20	Patient seen on w/R by Ms	
1315	Gray.	
	- Chase repeat bloods	
	- update CT AP with contrast	
	- wean O_2 as able	
	- continue IVABX	
	- continue IVF.	
	- Chest PT	
	- Rx dose dalteparin w/h	
	- new central line insertion	
	Seen by chest PT sputum sample sent. Weaned O_2 therapy to 4L via mask. News score 3 for Oxygen requirement and pulse 96bpm.	
	Feed completed at 1100hrs and insulin given as BM 18.5mmol	
	Catheter patent and draining good volumes. IVF as charted.	
	IVABX as per Kardex. Miss Gray taken patient to theatre for new central line insertion. At time of writing sleeping however rousable.	G Moore, S/N G Moore
6/12/20	Patient attended for new central	
1920	line insertion in Xgram currently	
	has Vancomycin running at	
	micro aduse. Bowels moving,	
	passing urine. Now wearing a	
	2 for 2 litre O_2 therapy - feed	

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Date & Time		Signature, Print Name & Designation
6/11/20 1920	Not commenced as awaiting contact from on call hospital pharmacy re. Naomix 50 pen availability. Seen on WR tonight by Miss Gray, - consider picc line for long term antibiotic therapy. - chase Hb a1hrs	Gillcare S/N Gillcare
2330	Pt News = (3) due to being on 2L of Oxygen + being tachy @ 92. feeling a lot better. Had ABX, IVF in situ.	[illegible] S/N.
0630	News = (3) due to O^2 requirement and being tachy @ 96. flexi seal bag burst and 3 urine off. Pad awake and have had abdominal getting up to commode. WHBX recurrica at present Cath pt patients and running.	[illegible] S/N.
0715	BM = 12.3.	[illegible] S/N.
7/11/2020	Addiction liaison - Reviewed today and remain on Methadone 7.0mls sugar free. Will update Ren from Drug Service on progress.	DENNIS JOHNSON Addiction RGN
09.00	Morning meds given as prescribed on kardex. IV abx running. Pt seems well at present. BM - 12.3 insulin given as prescribed. Seen on ward round for picc line tomorrow. News 4 - 95% 2L + 99 HK.	[illegible] S/N

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22/08/197

Date & Time	Dietitian	Signature, Print Name & Designation
7/12/20	Pt ↑v. See EPR for full entry.	
13.15	Plan ① Encourage oral intake ② Full Cream mix ③ Ensure compact bd ④ overnight NGT feed - 1000mls peptamen HN @ 83ml/hr x 12hrs ⑤ 50ml H2O flush pre + post meds ⑥ food chart + weekly wt. ↑v 3/7	Renata RD
13.15	Ordered lunch meal given as prescribed on kardex. Managed ensure.	Stephanie SHN
15.15	Ordered mattress. Skin inspection small PU on right buttock and small PU inbetween buttocks	Stephanie SHN
18.00	Evening meds given as prescribed News 3 - 2L O^2 + HR - 98. Catheter out put charted. Not given evening insulin as BM - 5.9. Pt not got appetite. Given glass of milk and ensure compact. given.	Stephanie SHN
22.00	BM 7.7 - insulin adjusted as per chart and Registar notified. Catheters in & on therapy - feed cables. IV Antibiotics cable. Patient transfered to air mattress. Catheter plate used dressings intact. Sputum sample sent for OCes. Managing oral pills and ensure drink.	Stephanie SHN
8/12/20 06.45	BM 13.8 - feed completed. News ③ Resp rate 96 BM - SATS 96% on O2 therapy. Catheter plate. IV Antibiotics	Stephanie SHN

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Date & Time		Signature, Print Name & Designation
8/12/20 0640	⇒ active, assisted + assisted to	
	bed pan - Bowel movement	
	noted. Sputum sample sent.	
9am	R/V Miss Gray: to get up to sit	
	today	
	Will be for pic line insertion	
	IV antibiotics continue	
	Insulin given as prescribed.	S Robots SRobots
6pm	Remains settled.	
	Pic line inserted as planned	
	NEWS 2 - BM 7.9 mmol/L evening insulin given	
	NJ feed to commence this evening	
	Urine output good via catheter	S Robots SRobots
22:45	Robot appears more settled	
	this evening - no complaints of	
	pain. BM 5.6 - feed	
	commenced - Continues on IV	
	Antibiotics. Merging of PICC	
	PICC line robot catheter	
	start of draining good volumes.	
	Assisted to bed pan - Bowels	
	opened. Nebuliser given to	
	robot as per kardex. Await	
	sputum result.	
9/12/20 02:00	Robot appears settled - catheter start	
	- Repositioned 2 hourly - Moving from	
	one side of the bed independently.	
	PICC line robot, IV antibiotics	
	continue. O2 therapy continues 2 litres.	
06:45	robot settled. NEWS (4) SATS 96 on	
	2 litres of O2 therapy - pulse 96BPM -	
	Await physio and dietician review	
	today, and sputum sample result: BM 12.9	

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CLINICAL NOTES - MEDICAL ☐
NURSING ☑

Please tick ✔ appropriate directorate

Henry Burgess
CHI: 2208793218

Date & Time		Signature, Print Name & Designation
9/12/20 06.45	Catheter patent. IV Abtx ceftriax	
9am	RIB Miss Gray Femoral line to be removed	
	Catheter to be removed	
	To encourage mobility	SPeters SGlasgow
12.30	Femoral Line removed by FY1	
17^{00}	BM 4.9 prescribed insulin given	
	Ward referred with Mepore	
	Has passed urine since catheter removed	
	NEWS 3	
	For transfer to Ward 24	SPeters Glasgow CV
10/12/20	Passing urine using	
04.45	bottles. Unable to	
	give NG feed as	
	prescribed feed not	
	available. 2° PUDRA.	
	BM - 3.4. at 22^{00}.	
	Resolved with glucose	
	drinks. IV Dextrose	
	prescribed. —	R Coddan
	IV Vancomycin was	
	due at 20.00.	
	Unable to give as	
	no level taken.	
	Spoke with 2nd on	
	who advised to	
	give vanc & for abxs	
	level dose to be taken	
	today. —	R Coddan

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Date & Time		Signature, Print Name & Designation
	RB Miss Cray patient to stop NBM & commence feed.	
	Commence intolerance chart to ~~start~~ enteric 2nd NIL	K Cleary
	Patient given methadone.	
	Given diazepam as prescribed.	
	Patient NEWS = 9.	
	Seen by doctors	
	?? due to methadone +	
	diazepam dropping sats + patient asleep	K Conway K Cleary.
1	Patient much improved.	
	BM @ 12. given glucogel	
	now up to 4.4	
	refusing feed to start.	K Cleary
	RB Mr McCoy fed	
	to commence. he has	
	told patient. this	
	to recheck BM in	
	1hr a bit then given	K Cleary.
	& feed insulin	K Cleary
	morning insulin/ was	
	not given on time	
	as chug round but	
	caught up	K Cleary
11/12/20	Unable to tolerate	
0435	nasal cannula. Desaturating	
	to 86% on 4L. Venturi	
	mask used at 4L	R Cockburn.
	& Sats ↑ 94%. IV abx (cont-)	

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CLINICAL NOTES - MEDICAL ☐
NURSING ☑

Please tick ✔ appropriate directorate

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Date & Time		Signature, Print Name & Designation
11/12/20	(Cont..) administered via	
0435	PICC line. Brand 3. RC.	
	Insulin administered	
	at 2230 as pt's	
	BM ↓2.2 when NG	
	feed commenced.	
	BM ↑6.2 at time	
	of insulin administration.	
	BM then ↓3.9.	
	Glucose drink given	
	to pt & BM RC	
	BM returned within	
	normal parameters.	
	NG feed continues.	
	Patient accepting some	
	positional changes	
	overnight. Vancomycin	
	administered at 21.30	
	as per pharmacy.	RCockburn
11/12/20	Ward round seen by Mr Gray	
0810	Tpy watching, D/W micro regarding cont/	NBREMNER RN
	equivalent	WB
1220	Dose Vancomycin reduced to 1750 and given	
	to give at 2130 tonight please.	WB NBREMNER RN
1330	Physiotherapy reviewing mobility safety.	WB NBREMNER RN
1430	Transfer with walking frame and NAD	WB NBREMNER RN
1600	BM 2.7 round - given Bens sugar & should	
	commenced on enteral feed - no cognitive	NBREMNER RN
	concerns noted.	WB

83949 GGC0072

Date & Time		Signature, Print Name & Designation
12/12/20	Settled night. Meds	
0140	administered as px.	
	NEWS - 4 BM - 6.3.	
	NG feed running to	
	time. IV vancomycin	
	administered at 21.30.	
	Nil new issues.	R Cockburn
17/12/20	Ward round – wound examination – to	
1000	remove wound staples and advise	NBRENNAN S/N
	and wean off oxygen.	N.B
1300	Most of staples removed – wound gaping	
	straightened and aquared staples pulling	
	noted though and some fluid leaking	
	at time of wound care.	NBRENNAN S/N
	IV antibiotic given as chart/Kardex	N.B
	MRSA screen sample taken of nose	
	perineum and vulnerable.	NBRENNAN S/N N.B
1900	Registra (Ben) review of wound opened	
	up wound – repacked – wound chart	
	to be completed	N.B NBRENNAN S/N
13/12/20	Patient settled mostly during	
03.35	evening. Medication given as	
	per Kardex. Current NEWS: 4	
	- slight tachycardia (99),	
	Temp 35.9°C and 4L O2.	
	Patient SATS at >97% on 4L.	
	Commenced O2 titration - to	
	monitor SATS during this.	
	NG feed continues to run.	
	BM's stable. I.V antibiotics	
	continue to run. I.V Vancomycin	
	administered at 22:20 hrs.	Rmyczko S.N
	Patient sleeping at present.	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐ NURSING ☑

Please tick ✔ appropriate directorate

2208793218
BURGESS
Henry
96A ALICE STREET
Paisley, Renfrewshire
PA2 6EA
M
22/08/1971

Date & Time		Signature, Print Name & Designation
13/12/20	Ward round seen by Ms Chisholm	
1100	Check weight happy for [illegible]	
	- wound reviewed	
1900	Very reluctant to mobilise today, [illegible]	
	get up to [illegible] - has been	
	done given encouragement. NG positive	
	and running and [illegible]	
	given. Has continued to want [illegible]	
	nebuliser to try to [illegible] off.	
	Has slept/napped for periods today	
	SETTLED NIGHT DNF FEED	
	RUNNING TO DISTANCE	
	IV MEDICATION GIVEN	
	ASSESSMENTED. NEWS 2	
	DIETITIAN OF THERAPY	
	PASSING URINE.	
	OBSERVED WELL.	ORI/JPorter
14/12/20	Dietitian	
15:45	Pt rev. Please see EPR for full entry.	
	Plan ① Encourage high energy diet little + often - additional yoghurts as snacks ② full Cream milk as able ③ Ensure compact bd ④ New NGT feeding regimen to commence from pm 15/12/20 ⑤ f/c chart + update Weight r/v 4-5/7	RKnowles

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Date & Time		Signature, Print Name & Designation
14/12/20. 1400	Seen on ward round - continue OT/PT - Sats 92% + above. - NG feed as per dietician. wound redressed with ribbon + mepore OB dietician - new NG regime to start tomorrow night. Insulin doses will need ~~ass~~ adjustment. Can eat + drink as able - food chart in place. NEWS = 2 due to sats.	ANCW surgeons
1830	NG feed commenced insulin given pre-feed. BM 9.3 mmol	ANCW surgeons
15/12/20 0830	~~OE~~ Spo2 ± 77 on air 2L o2 Morphy put on place Spo2 92% with is normal for tachy 102. NG feed Resumes. IV abx given. ODT morphine given. Medication as per Kodex. Wound intake earthed to mattress.	(SN) N. Kimoto NK

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☑

Please tick ✔ appropriate directorate

Henry Burgess
220879 3218

Date & Time		Signature, Print Name & Designation
15/12/20	No changes made @ ward	
1600	round. IV abx continue.	
	NG feed as per dietician	
	Insulin dose to be	
	altered. Declined assistance	
	with personal care.	
	Bowels active. using	
	bottles to pass urine.	
	Hb 78 - not for transfusion	cNIEWIS
	at present. NEWS = (3)	dmyleus
1612	Settled night.	
0855	Medication as per	
	Kardex observation	
	Stable. 20 PUREA	
	Using bottles over	
	night. NG feed	
	Running. BM	
	Stable. PRN oral	
	morph given.	(SN)
	No other issues	N. Kinnaird
	at present.	NK
16/12	No changes @ ward	
1400	round - continue	
	PT for mobility + chest.	
	NG feed will be	
	reviewed on Friday.	
	Oral intake encouraged.	
	NEWS = (3)	cNIEWIS
	IV abx given as prescribed.	dmyleus

83949 GCC0072

Date & Time		Signature, Print Name & Designation

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☑

Please tick ✔ appropriate directorate

HENRY BURGESS
2208793218

Date & Time		Signature, Print Name & Designation
18/12/20 0330	Patient settled; NEWS = (1) Sats 94 1· O/A· BM 2·6 mmols around 9pm, increased to 6·4 mmols NG feed running overnight. Patient mobile to toilet· IV abx continue Wound intact· Nil issues @ present	CCarle (CCarle (SN))
18/12/20 11·45	Dietitian Pt r/v· Please see EPR for full entry. Plan (1) Encourage high energy diet little + often - may prefer meals from additional choices menu eg tomato soup, ham sw[illegible], Sausages, chips, beans, spaghetti, soups, yoghurts (2) full Cream milk as able (3) Ensure Compact ~~bd~~ qds (4) ~~NGT feed - 500mls Ensure plus 1 (1 unit/hr x 12hrs overnight~~ (5) ~~5cm tap flush pre/post feed~~ (4) Keep NG in flush daily. (6) Please keep accurate food chart + update Weight (7) close BM monitoring r/v 4/1	PKnowles (RD)
11·50	~~Patient settled; assessed; dietetic needs = to comply with all nutritional requirements; as per doctor; continue on NGT; as feed to continue over 24hr; Encourage snacks; Patients medication NAD; acceptable in co, discussed with~~ Patient agreeing to work with Dietetics	[illegible] SJD
1220	~~Re-assessed by Dietitian & Feedback as to remain patient to have Ensure as per prescription~~	[illegible] SJD

83949 GGC0072

Date & Time		Signature, Print Name & Designation
19/12/20	Patient settled ; News = (3) due to	
0500	2L O2 therapy + slight hypotension.	
	Meds as per kardex ; IV abx contine	
	PICC line in situ, NG to remain	
	in situ, bm 5.5 mmols , had hypo	
	around 23:00 18/12/20 2.7 mmols	
	- correction given - ? for diabetic	
	review. Skin intact - 2 hourly PUDRA	
	Maintained on mattress. Patient	
	had fall at around 4 am using	
	zimmer, (L) knee causing pain	
	- assisted to toilet + back to	
	bed - Nil issues at present	
	Wound dry + intact , refused	(SN)
	dressing change last night. —	C.Care / Care
1930	Settled day.	
	SB mr whalen no change	
	to patients care.	
	Wound renewed.	
	Iv antibiotics given via	
	picc line.	
	News 2 . Spo2 93% on Air:-	
	neds administered -	
	managing small amount	
	of diet as per food chart.	
	bm prior to dinner 8.2 mmol.	
	insulin administered	
	—	SBUACEY (SN)
20/12/20	dressing renewed - no leaking or pus	
1730	noted. continues with W.O. —	R. Sw

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☑

Please tick ✔ appropriate directorate

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Paisley, Renfrewshire
PA2 6EA
M
22/08/197

Date & Time		Signature, Print Name & Designation
21/12/20	Patients BM 2.6mmol at	
0315	beginning of shift. glyco Juice	
	and gel administered. BM ↑ 8.8mmol.	
	Spo2 88% on room air 3 litres	
	via nasal cannula given spo2 96%	
	IV antibiotics given as per	SBLACEY (N)
	Kardex.	RGN
21/12/20	Patient settled at Present, Observations	
	satisfactory. Medication given as	
	per kardex seen on ward round	
	and clarified spo2 of 92%.	
	Was seen on ward round to	
	remove NG commence on	
	oral Antibiotics encourage mobilising	
	and improve on diet and fluid	
	intake. Went to cardiology for echo	
	await results. Has mobilised well	
	to bathroom Pt has change aid	
	to walking stick, doing well	Sarah Hannigan
	with this. no new issues noted.	S. Hannigan S/N
22/12	Patient Deeload bed	
0445	time Nebs give	
	@ 2am due spo2 88%	
	BM low Glucose	
	Juice given x2.	
	Medication as per	
	Kardex. Mobilising to	S/N
	the bathroom. NO	N. Kennedy
	Commplant of Pain.	N

83949 GGC0072

Date & Time		Signature, Print Name & Designation
22/12/20	Dietician Pt Nil. Please see EPR for fun eating. Plan ① Encourage high energy diet as able with regular carbohydrates ② additional yoghurts as snacks ③ fun Gram mix as able ④ fresh compact gas ⑤ accurate food chart + weekly weight rl/ 9/1	(Brownlee RD)
1540	Patient settled: observations satisfactory NEWS = 0 : compliant with all medications as per Kardex, Sony Lozapem on reducing dose : Awaiting results of ? Echo : VS Needs assessment of Systemic and pelvic pain - ct ...	Pongsena SN
23/12 0710	Settled night. Medications as per Kardex. Observations and BM Stable. Mobilising to and from bathroom.	NIL NIL
1920	Patient discharged: IOL ☑ Medication ☑ DD's ☑ Shelter ☑ Dressings ☑	Pongsena SN

DATE: 5/12/20

Patient ID Label:

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Henry
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Paisley, Renfrewshire
PA2 6EA

M
22/08/1979

VALUABLES ON ADMISSION TO HDU

List:- mobile phone
toiletries
Bag with clothing

Checked by: A [illegible]

Witnessed by: M Clark

Patient signature as responsible person: _____

With patients consent N.O.K given valuables:
Please List

N.O.K signature if taking valuables

Patients own drugs entered into register YES NO

If patient unable to take responsibility for own valuables then deposited into hospital cashier/night safe as per NHS GGC policy

Receipt obtained YES NO

Receipt filed in patient case record YES NO

VALUABLES ON TRANSFER FROM HDU

As listed above? YES NO
If NO then list items on transfer with patent

Pt's own meds transferred with patient? YES. NO N/A

Signed and dated
Witnessed by: _____

Record of Communication with Relatives / Carers

NHS Greater Glasgow and Clyde

This form should be stored at the front of the patient's nursing notes during the period of admission and then filed on discharge.

Hospital:	Ward:

2208793218
BURGESS
Henry
96A ALICE STREET
Paisley, Renfrewshire
PA2 6EA
M
22/08/1979

Support and Care Arrangements	No Carer identified ✓ If NO following section N/A	
IDENTIFYING	Yes ✓	No ✓
Have support and care arrangements been confirmed with relative / carer? N.B. record details below including details of any existing support plans		
INVOLVING	Yes ✓	No ✓
Have progress and on-going support needs been discussed with relative / carer?		
Have the carer's views / opinions / requests on discharge plan been noted?		
Has the carer given consent to share their views with the patient?		
SUPPORTING	Yes ✓	No ✓
Has the carer been advised of what support is available to them?		
Has the "Are you looking after someone?" flyer been given to the carer?		
Have you referred to a support service?		
Has the offer of support been declined by the carer?		

Record Name of who discussed with; details of discussion; action agreed.

Date	Record of Communication	Print and Sign Name	Staff Code
4.12.20	Call from patients porter. Updated		
15.00	her that he remains in HDU.		
	Remains on oxygen, NG feed		
	& Abx (for a few weeks).	UCN	
	Happy with update. Henry informed	IC-NOLE	(N)
5.12.20	Partner phoned for update. S/N		
	McBride informed her that Henry		
	was stable. Doctor felt that he		
	would be able to continue care		
	in ward (general) area. Happy		
	with information given.	M Cunek	S/N.
18.00	Sister Lona phoned Henry consented		
	for information sharing. Happy to		

Staff Codes: **N** – Nursing. **M** – Medical. **P** – Physiotherapist. **OT** – Occupational Therapist. **SW** – Social Worker. **SLT** – Speech and Language Therapist. **D** – Dietician. **O** – Other.

Carers Information Line: 0141 353 6504
NHSGGC Support & Information Services: 0141 452 2387

Record Name of who discussed with; details of discussion; action agreed.			
Date	**Record of Communication**	**Print and Sign Name**	**Staff Code**
	hear that he is ward fit. Asked		
	me to ensure he had belongings		
	delivered to Give & Go service.		
	Belongings checked in by Angela		
	Coldwell. Happy with		

Staff Codes: **N** – Nursing. **M** – Medical. **P** – Physiotherapist. **OT** – Occupational Therapist. **SW** – Social Worker. **SLT** – Speech and Language Therapist. **D** – Dietician. **O** – Other.

Carers Information Line: 0141 353 6504
NHSGGC Support & Information Services: 0141 452 2387

NHS Greater Glasgow and Clyde

NATVNS SCOTLAND

ASSESSMENT CHART FOR WOUND MANAGEMENT

For multiple wounds complete formal wound assessment for each wound. Add inserts as needed.

Affix label if available

Name: 2208793218

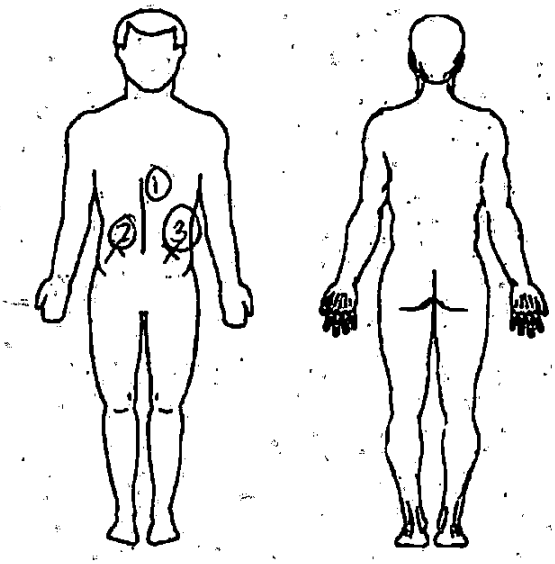
CHI N: BURGESS Henry M 22/08/1979

Locati: 96A ALICE STREET Paisley, Renfrewshire PA2 6EA

Consultant / GP

Body Diagram

Anterior view | Posterior view



Mark location with 'X' and number each wound

Factors that could delay healing:

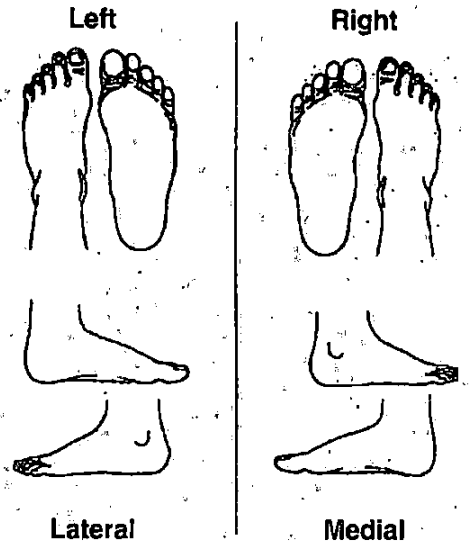
(Please tick relevant boxes)

- Immobility ☑
- Poor Nutrition ☑
- Diabetes ☑
- Incontinence ☐
- Respiratory/Circulatory Disease ☐
- Anaemia ☐
- Wound Infection ☐
- Medication ☐
- Inotropes ☐
- Anti-coagulants ☐
- Oedema ☐
- Steroids ☐
- Chemotherapy ☐

Other .....

Allergies & Sensitivities NKDA

Feet Diagram



Mark location with 'X' and number each wound

Type of Wound	Total number & duration of each type of wound
Leg Ulcer	
Surgical Wound	1+2+3
Diabetic Ulcer	
Pressure Ulcer	
Other, specify	

Date referred to:

TVN _____ Physiotherapist 21/11/20

Podiatrist _____ Dietician 02/12/20

Other (please specify) _____

Assessors signature: _____

Date: 2/12/20

83928 GGC0068

FORMAL WOUND ASSESSMENT

Complete on initial assessment and thereafter complete at every dressing change

Date of Assessment								
Number of wound								
Analgesia required *(Refer to local pain assessment tool)*	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Regular/ongoing analgesia								
Pre-dressing only								
Wound Dimensions (enter size)								
Length (cm/mm)								
Width (cm/mm)								
Depth (cm/mm)								
Or tract wound circumference								
Is wound tracking/undermining								
Photography obtained								
Tissue type on wound bed (enter percentages)								
Necrotic (Black)								
Sloughy (Yellow/Green)								
Granulating (Red)								
Epithelialising (Pink)								
Hypergranulating (Red)								
Haematoma								
Bone/tendon visible								
Wound exudate levels/type (tick all relevant boxes)								
Low								
Moderate								
High *								
Serous (Straw)								
Haemoserous (Red/Straw)								
Purulent (Green/Brown/Yellow)*								
Peri-wound skin (tick relevant boxes)								
Macerated (White)								
Oedematous *								
Erythema (Red)*								
Excoriated (Red)								
Fragile								
Dry/scaly								
Healthy/intact								
Signs of Infection * 1 or more of these signs may indicate possible infection								
Heat *								
New slough/necrosis (deteriorating wound bed)*								
Increasing pain*								
Increasing exudate*								
Increasing odour*								
Friable granulation tissue*								
Treatment objectives (tick relevant box)								
Debridement								
Absorption								
Hydration								
Protection								
Palliative / conservative								
Reduce bacterial load								
Assessors Print Initials								
Dressing Renewed (planned or unplanned dressing change)								
Re-assessment date								

FORMAL WOUND ASSESSMENT

Complete on initial assessment and thereafter complete at every dressing change

Date of Assessment								
Number of wound								
Analgesia required *(Refer to local pain assessment tool)*	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Regular/ongoing analgesia								
Pre-dressing only								
Wound Dimensions (enter size)								
Length (cm/mm)								
Width (cm/mm)								
Depth (cm/mm)								
Or tract wound circumference								
Is wound tracking/undermining								
Photography obtained								
Tissue type on wound bed (enter percentages)								
Necrotic (Black)								
Sloughy (Yellow/Green)								
Granulating (Red)								
Epithelialising (Pink)								
Hypergranulating (Red)								
Haematoma								
Bone/tendon visible								
Wound exudate levels/type (tick all relevant boxes)								
Low								
Moderate								
High *								
Serous (Straw)								
Haemoserous (Red/Straw)								
Purulent (Green/Brown/Yellow)*								
Peri-wound skin (tick relevant boxes)								
Macerated (White)								
Oedematous *								
Erythema (Red)*								
Excoriated (Red)								
Fragile								
Dry/scaly								
Healthy/intact								
Signs of Infection * 1 or more of these signs may indicate possible infection								
Heat *								
New slough/necrosis (deteriorating wound bed)*								
Increasing pain*								
Increasing exudate*								
Increasing odour*								
Friable granulation tissue*								
Treatment objectives (tick relevant box)								
Debridement								
Absorption								
Hydration								
Protection								
Palliative / conservative								
Reduce bacterial load								
Assessors Print Initials								
Dressing Renewed (planned or unplanned dressing change)								
Re-assessment date								

WOUND TREATMENT PLAN AND EVALUATION OF CARE

To be completed when treatment or dressing type / regime altered
NB print information (write clearly)

Date	Wound Number	Cleansing Method, Dressing Choice & Rationale	Frequency	Evaluation & Rationale for changing dressing type	Signature

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FALLS RISK ASSESSMENT

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

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

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

	Ward: ICU Date: 2/12/20 Time: 02:00	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	Not mobilising yet. NA				
2. Check walking aid (if required) is in reach and in use.	NA				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	Y				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	NA				
5. If glasses are worn, check they are available and in use.	NA				
6. If hearing aid/s are worn, check they are working and in use.	NA				

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).
Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.
ALL patients in older people's wards must have an interventional plan in place (overleaf)

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

Highlight risk of fall at the ward safety brief.

Patient Details

FALLS INTERVENTION CHECKLIST

NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----
BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)					
Assess if a low bed is required (Patient care plan 9)					
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)					
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)					
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.					
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)					
Document continence problems and link to care rounding (Patient care plan 6)					
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)					
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.					
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)					
Update the ward team of the patient's mobility status. (Patient care plan 8)					
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)					
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)					
Signature of nurse completing interventional plan / or update					

*****If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team*****

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

2208793218
BURGESS
Henry
22/08/197

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date 2/12/20 time 0200 of initial height and weight on admission to hospital		Actual	*Patient reported	*If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height	177 cm	☐	☐	estimated
Admission Weight	70 Kg	☐	☐	

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

Patients reported normal weight _____ Unable to Recall ☐

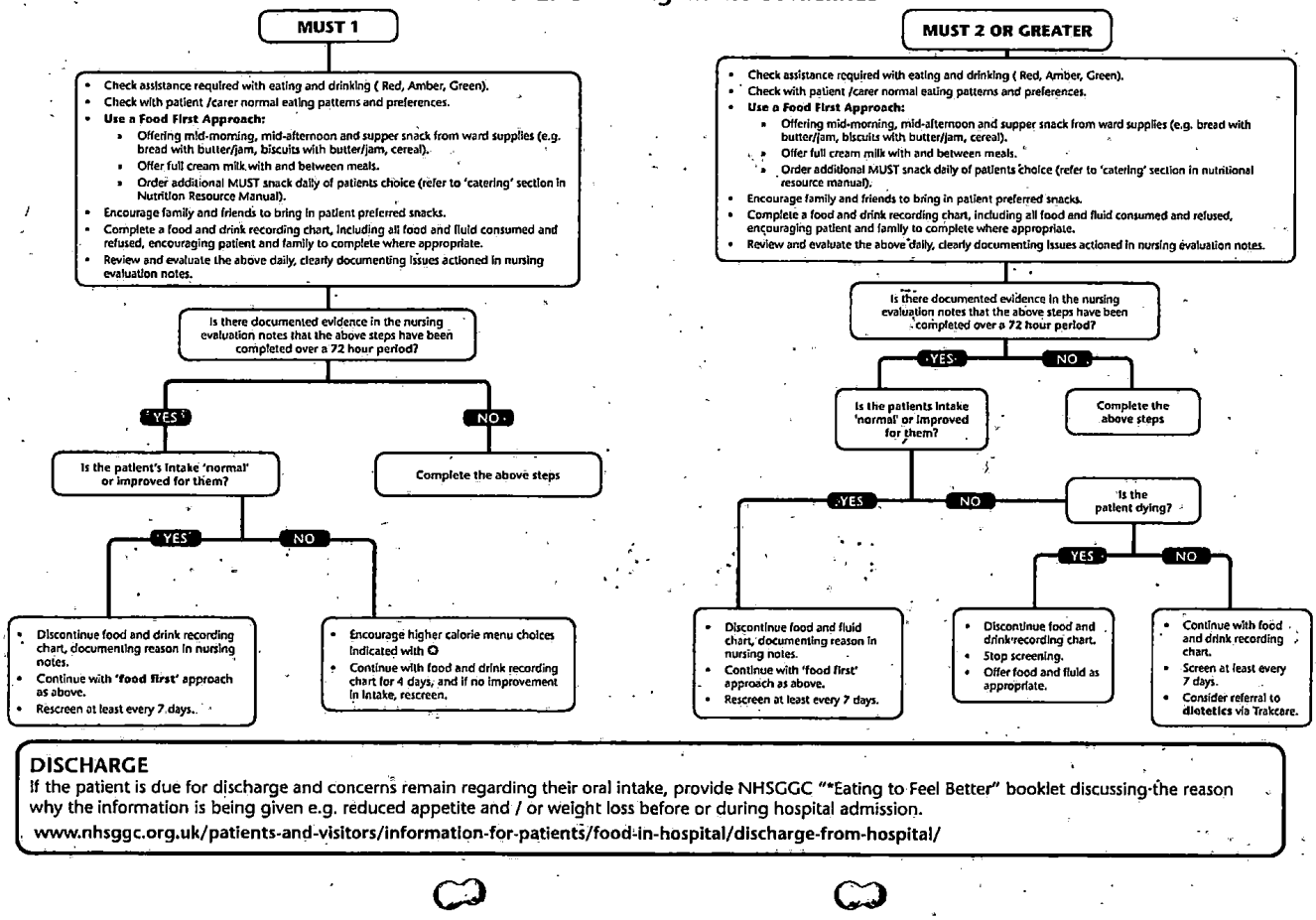
Any unplanned weight loss in the last 6 months Yes ☑ how much 3stone No ☐ Don't Know ☐

Date	2/12/20							
Time	0200							
Ward	ICU							
Oedema/ Ascities present Y/N	N							
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes	UW							
Weight (kgs)	70							
BMI	22							
Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days								
Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	0							
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	2							
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	2							
Step 4 Overall Risk of Malnutrition TOTAL	4							
Rescreen on	daily							
Signature	[signature]							

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

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

MUST STEP 5 Management Guidelines



DISCHARGE

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

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

mi • 285884 v3.0 • GGC0250

2206793218
BURGESS M
Henry 22/08/1979

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date 3/12/20 Time 21:00 of initial height and weight on admission to hospital		Actual	*Patient reported	*If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height	173 cm	☐	☑	
Admission Weight	87 Kg	☐	☑	

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

Patients reported normal weight 13 Stone. Unable to Recall ☐

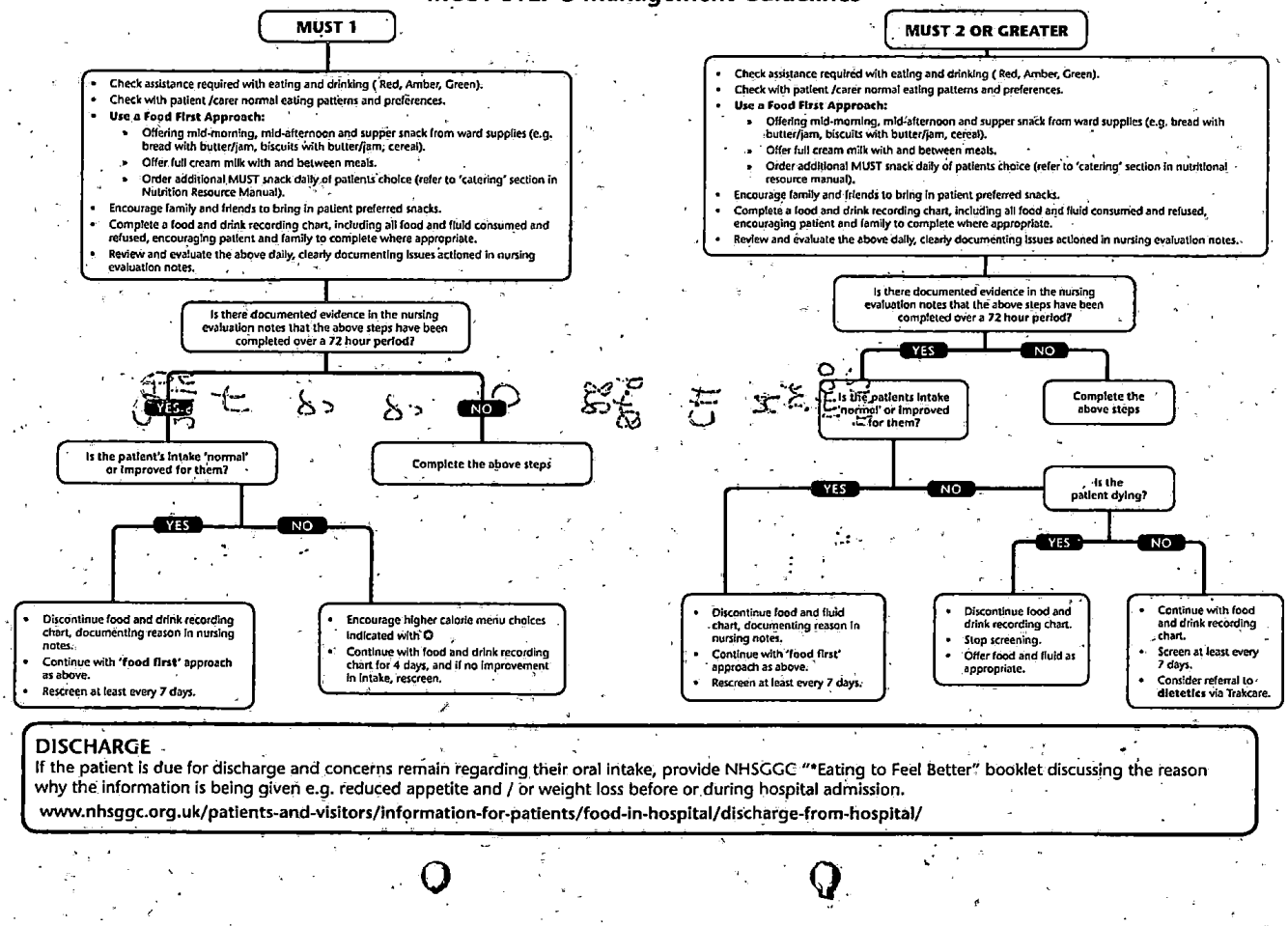
Any unplanned weight loss in the last 6 months Yes ☑ how much? 3 Stone No ☐ Don't Know ☐

Date	3/12/20	4/12/20	14/12	22.12				
Time	21:00	1400	1400	1250				
Ward	HDU	HDU	24	26				
Oedema/ Ascities present Y/N	Y	Y	N	N				
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes	UW	CH	CH	CH				
Weight (kgs)	87	86.7	84.9	76.2				
BMI	29	29	28					
Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days								
Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	0	0	0	0				
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	?2	2	2	2				
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	2	2	2	2				
Step 4 Overall Risk of Malnutrition TOTAL	?4	4	4	4				
Rescreen on	when able	1 week	21/12	29/12				
Signature	CW	W						

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

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

MUST STEP 5 Management Guidelines



DISCHARGE

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

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

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NHSGGC Bedrail Risk Assessment

2208793218
BURGESS
Henry
96A ALICE STREET
Paisley, Renfrewshire
PA2 6EA
M
22/08/1979
Patient N
CHI Num

NHS Greater Glasgow and Clyde

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

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

	Use guidance on the reverse of this document when completing this Risk Assessment	DATE	2/12/20						
		TIME	0200						
		WARD	ICU						
		HOSPITAL	RAH						
	SECTION ONE – GENERAL		Y	N	Y	N	Y	N	Y	N
1	Is the patient likely to fall, roll, slip or slide from the bed?		✓							
2	Has the patient requested the use of bedrails?		✓							
	IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED									
	SECTION TWO – COGNITIVE AND PHYSICAL STATUS									
3	Is the patient at risk of climbing out of bed?			✓						
4	Is the patient stressed, delirious or restless?			✓						
5	Is the patient small in stature?			✓						
6	Does the patient have an unusually large or small head that might present an entrapment issue?			✓						
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?			✓						
	IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
	SECTION THREE – COMMUNICATION									
8	Has the patient been consulted regarding the use of bedrails?		✓							
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition		✓							
10	Has the use of bedrails been discussed with relatives/carers?			✓						
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?			✓						
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?		✓							
	IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
	SECTION FOUR – DECISION MAKING		Y	N	Y	N	Y	N	Y	N
13	Will bedrails be used for this patient at the present time?		✓							
14	Rationale for use of bedrails: (Please insert code in the box on the right)									
	A – Risk of falling from the bed		✓							
	B – Risk of rolling from the bed									
	C – Risk of slipping from the bed									
	D – Risk of sliding from the bed									
	E – Patient request									
15	Bedrail risk assessment completed by:		R. BURNS							
16	Bedrails checked by:		R. BURNS							
17	Date		2/12/20							

Any issues relating to the use of bedrails including discussion with family/relatives/carers should be recorded here

A. Alternatives to bed rails:-

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

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

Is patient:-

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

C. Safe use and application of bedrails:-

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

D. Record keeping:-

All of the following should be recorded:-

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

Bedrail risk assessments should be made as follows:-

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

NHSGGC Bedrail Risk Assessment

2208793218
BURGESS
Henry
96A ALICE STREET
Paisley, Renfrewshire
PA2 6EA
M
22/08/1979
NHS Greater Glasgow and Clyde

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

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

Patient Name

CHI Number

Use guidance on the reverse of this document when completing this Risk Assessment								
	DATE	3/12/20	14/12/20					
	TIME	22:00	14:00					
	WARD	HCU	3H					
	HOSPITAL	RAH	RAH					
SECTION ONE – GENERAL		**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**
1	Is the patient likely to fall, roll, slip or slide from the bed?		✓		✓				
2	Has the patient requested the use of bedrails?	✓			✓				
IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED									
SECTION TWO – COGNITIVE AND PHYSICAL STATUS									
3	Is the patient at risk of climbing out of bed?		✓						
4	Is the patient stressed, delirious or restless?		✓						
5	Is the patient small in stature?		✓						
6	Does the patient have an unusually large or small head that might present an entrapment issue?		✓						
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?		✓						
IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
SECTION THREE – COMMUNICATION									
8	Has the patient been consulted regarding the use of bedrails?	✓							
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition	✓							
10	Has the use of bedrails been discussed with relatives/carers?		✓						
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?		✓						
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?	✓							
IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
SECTION FOUR – DECISION MAKING		**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**
13	Will bedrails be used for this patient at the present time?	✓		✓					
14	Rationale for use of bedrails: (Please insert code in the box on the right)								
	A – Risk of falling from the bed								
	B – Risk of rolling from the bed								
	C – Risk of slipping from the bed								
	D – Risk of sliding from the bed								
	E – Patient request	✓							
15	Bedrail risk assessment completed by: (Signature)			JL					
16	Bedrails checked by: (Signature)								
17	Date	3/12/20		14/12					

Any issues relating to the use of bedrails including discussion with family/relatives/carers should be recorded here

A. Alternatives to bed rails:-

- Move the patient to a more observable area
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- Ensure the bed is returned to the lowest height appropriate to the patient needs, after care delivery
- Ensure patient needs are anticipated e.g. drinks are accessible, regular toileting, call bell to hand
- Nursing patient on mattress on the floor should be the last resort, and safety checks should be made for hot pipes, trailing wires, electrical sockets etc
- A generic moving and handling assessment must be carried out for staff caring for patients nursed on mattress on the floor.
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- If the gap between the bedrail and the footboard is between 6cm and 25cm then a bedrail should not be used
- If the bedrail has not been fitted correctly then the bedrail should not be used
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- Care planning should be reviewed and updated as per record keeping standards

Bedrail risk assessments should be made as follows:-

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

Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)

NHS Greater Glasgow and Clyde

Name: 2208793218 BURGESS Henry
Address: 96A ALICE STREET Paisley, Renfrewshire PA2 6EA
DoB: 22/08/1979 M
CHI number:
Affix patient data label

(Do not repeat STOPSS if inpatient Speech and Language Therapy management is ongoing)

Part 1: Is the patient fit for screening? (Patients with a tracheostomy follow the STOPSS for tracheostomy form.)

Can the patient:

- Maintain an upright sitting position in a bed or chair **AND**
- Stay awake and alert for 15 minutes while seated upright

N.B. Consider waiting 24-48 hrs post extubation if intubated for >24hrs

No ✓

Keep Nil By Mouth and alert medical staff.
- Implement and maintain full oral hygiene.
- Document plan for patient's medication route, hydration and nutritional status.
- **Recommence STOPSS** (new form) when oral intake is being reconsidered.

Sign: _____ Print: _____ Grade: _____
Date: _____ Time: _____

Yes – Proceed to Part 2 ✓

Part 2: If the patient meets any of the criteria below DO NOT water swallow test

	✓
Weak or absent voice post extubation	
Recurrent unexplained chest infections or documented aspiration on formal investigation	
Poorly controlled respiration plus **new** swallowing difficulties	
Patient is reporting previously unsuspected swallowing difficulties	
Patient has a known swallowing problem (e.g. on a texture modified diet) and is experiencing **new** difficulties	

NB: Exclude aspiration resulting from vomiting, seizures, oesophageal stricture

Yes – Alert medical staff. Refer to Speech and Language Therapy through trakcare. (Part 3 **NOT** required)

Sign: _____ Print: _____ Grade: _____
Date: _____ Time: _____

No – Proceed to Part 3 ✓

Part 3: Water Swallow Test (Patients already on modified fluids should be tested with their usual fluid recommendation)

PART A:
Can the patient take 3 x 5ml teaspoons of water **WITHOUT** coughing **OR** choking **OR** becoming breathless **OR** hoarse **OR** gurgly?

No

1st Attempt – FAIL – Keep nil by mouth and **alert medical staff**. Repeat Part A within 3-12 hours. ✓
Sign [signature] Print: R. BURNS Grade: SN
Date: 4/12/20 Time: 0800

2nd Attempt – FAIL – Keep nil by mouth and **alert medical staff**. Refer to Speech and Language Therapy. ✓
Sign _____ Print: _____ Grade: _____
Date: _____ Time: _____

Yes ✓

PART B:
Can the patient drink 50 ml of water from a glass at a comfortable pace **WITHOUT** coughing **OR** choking **OR** becoming breathless **OR** hoarse **OR** gurgly?

No

1st Attempt – FAIL – Keep nil by mouth and **alert medical staff**. Repeat Part B within 3-12 hours. ✓
Sign _____ Print: _____ Grade: _____
Date: _____ Time: _____

2nd Attempt – FAIL – Keep nil by mouth and **alert medical staff**. Refer to Speech and Language Therapy. ✓
Sign _____ Print: _____ Grade: _____
Date: _____ Time: _____

Yes - PASS ✓

Commence normal fluids and Level 7- Easy to Chew or pre-admission modified diet+fluids. (local protocol applies for initial intake post head and neck cancer surgery and in Spinal units)
- Supervise the first mealtime and note any problems.
- If no problems observed proceed to previous oral intake
- If problems develop e.g. cough, gurgly voice, moist chest or chest infection consider nil by mouth, alert medical staff and refer to Speech and Language Therapy

Sign: _____ Print: _____ Grade: _____ Date: _____ Time: _____

Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)

NHS Greater Glasgow and Clyde

Name: ... 2208793218 .....
Address:. BURGESS M .....
..... Henry 22/08/1979 .....
DoB:..... 96A ALICE STREET .....
CHI num Paisley, Renfrewshire
PA2 6EA .....

(Do not repeat STOPSS if inpatient Speech and Language Therapy management is ongoing)

Part 1: Is the patient fit for screening? (Patients with a tracheostomy follow the STOPSS for tracheostomy form.)

Can the patient:

- Maintain an upright sitting position in a bed or chair **AND**
- Stay awake and alert for 15 minutes while seated upright

N.B. Consider waiting 24-48 hrs post extubation if intubated for >24hrs

No ✓

Keep Nil By Mouth and alert medical staff.

- Implement and maintain full oral hygiene.
- Document plan for patient's medication route, hydration and nutritional status.
- **Recommence STOPSS** (new form) when oral intake is being reconsidered.

Sign: _____ Print: _____ Grade: _____
Date: _____ Time: _____

Yes – Proceed to Part 2 ✓

Part 2: If the patient meets any of the criteria below DO NOT water swallow test ✓

Weak or absent voice post extubation	
Recurrent unexplained chest infections or documented aspiration on formal investigation	
Poorly controlled respiration plus **new** swallowing difficulties	
Patient is reporting previously unsuspected swallowing difficulties	
Patient has a known swallowing problem (e.g. on a texture modified diet) and is experiencing **new** difficulties	

NB: Exclude aspiration resulting from vomiting, seizures, oesophageal stricture

No – Proceed to Part 3 ✓

Yes – Alert medical staff. Refer to Speech and Language Therapy through trakcare. (Part 3 **NOT** required)

Sign: _____ Print: _____ Grade: _____
Date: _____ Time: _____

Part 3: Water Swallow Test (Patients already on modified fluids should be tested with their usual fluid recommendation)

PART A:
Can the patient take 3 x 5ml teaspoons of water **WITHOUT** coughing **OR** choking **OR** becoming breathless **OR** hoarse **OR** gurgly?

No →

1st Attempt – FAIL – Keep nil by mouth and **alert medical staff.** Repeat Part A within 3-12 hours. ✓
Sign Print: _____ Grade: _____
Date: _____ Time: _____

2nd Attempt – FAIL – Keep nil by mouth and **alert medical staff.** Refer to Speech and Language Therapy. ✓
Sign _____ Print: _____ Grade: _____
Date: _____ Time: _____

Yes ✓

PART B:
Can the patient drink 50 ml of water from a glass at a comfortable pace **WITHOUT** coughing **OR** choking **OR** becoming breathless **OR** hoarse **OR** gurgly?

No →

1st Attempt – FAIL – Keep nil by mouth and **alert medical staff.** Repeat Part B within 3-12 hours. ✓
Sign _____ Print: _____ Grade: _____
Date: _____ Time: _____

2nd Attempt – FAIL – Keep nil by mouth and **alert medical staff.** Refer to Speech and Language Therapy. ✓
Sign _____ Print: _____ Grade: _____
Date: _____ Time: _____

Yes - PASS ✓

Commence normal fluids and Level 7- Easy to Chew or pre-admission modified diet+fluids. (local protocol applies for initial intake post head and neck cancer surgery and in Spinal units)

- Supervise the first mealtime and note any problems.
- If no problems observed proceed to previous oral intake
- If problems develop e.g. cough, gurgly voice, moist chest or chest infection consider nil by mouth, alert medical staff and refer to Speech and Language Therapy

Sign: CMcGuire Print: C M Guire Grade: S/N Date: 3/12/20 Time: 20:00

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

attach addressograph	Hospital: RAH Ward: ICU2	**Points to consider:** • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

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

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

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

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
2/12/2002	00	N	Y	N	Y	Y	Y	4 hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	

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

Prevention of Pressure Ulcer Interventional Plan

NHS Greater Glasgow and Clyde

2208793218
BURGESS
Henry
96A ALICE STREET
Paisley, Renfrewshire
PA2 6EA
M
22/08/1975

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

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

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan: 2/12/20	Check: • Pressure areas 4 hourly. • Skin under medical devices 4 hourly. • Specify medical devices used: ICU devices	Specify: • Mattress: Totalcare • Cushion: • Detail additional pressure redistributing equipment:	• Reposition 4 hourly in bed and chair. • Overnight patient / carer has agreed to repositioning 4 hourly • Specify any manual handling equipment used:	• Skin care to be carried out 4 hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree plan with patient / family/ carer YES ☑ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☑	R. BURNS SN Date discontinued:
Date Reviewed:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition ____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out ____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued:
Date Reviewed:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition ____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out ____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued:

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

2208793218 BURGESS M Henry 22/08/197 96A ALICE STREET Paisley, Renfrewshire PA2 6EA	Hospital: RAH Ward: 24	Points to consider: • Use within 6 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

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

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

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

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
18/12/20	03:30	N	N	N	Y	N	N	2 hrly	C Care
19/12/20	05:00	N	N	N	Y	N	N	2 hrly	C Care
20/12/20	01:50	N	N	N	Y	N	N	2 hrly	C Care
21/12/20	08:30	N	N	N	Y	Y	Y	2 hrly	SQA
22/12/20	08:00	✓	✓	✓	✓	✓	✓	2 hrly	NK
23/12/20	07:15	✓	✓	✓	✓	✓	✓	2 hrly	NK
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	

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

Prevention of Pressure Ulcer Interventional Plan

NHS Greater Glasgow and Clyde

Attach Addressograph

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

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

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCONTINENCE / MOISTURE	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of initial plan:	Check: • Pressure areas 2 hourly. • Skin under medical devices 2 hourly. • Specify medical devices used:	Specify: • Mattress: Air • Cushion: ✓ • Detail additional pressure redistributing equipment:	• Reposition 2 hourly in bed and chair. • Overnight patient / carer has agreed to repositioning 2 hourly • Specify any manual handling equipment used:	• Skin care to be carried out 2 hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST ✓	• Discuss and agree plan with patient / family/ carer YES ☑ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☑ NO ☐	Karen Date discontinued:
Date Reviewed:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition ____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out ____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐	Date discontinued:
Date Reviewed:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition ____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out ____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐	Date discontinued:

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

2208793218 BURGESS M Henry 22/08/1979 98A ALICE STREET Paisley, Renfrewshire PA2 6EA	Hospital: RAH Ward: HDU/20	**Points to consider:** • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

1	Pressure Damage No	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan overleaf.

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

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

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
3/12/2020	00	N	Y	Y	N	Y	Y	4 hrly	
4/12/2020	15	N	Y	Y	N	Y	Y	4 hrly	
05/12/20	00:10	N	Y	Y	N	Y	Y	4 hrly	
6/12/20	08:00	N	Y	Y	N	N	Y	4 hrly	
7/12/20	16:06	N	Y	Y	N	N	Y	2 hrly	
8/12/20	00:00	N	Y	Y	N	Y	Y	2 hrly	
9/12/20	00:00	Y	Y	Y	N	Y	Y	2 hrly	
10/12/20	04:55	Y	Y	Y	N	Y	Y	2 hrly	
11/12/20	10:00	Y	Y	Y	N	Y	Y	2 hrly	
12/12/20	01:40	Y	Y	Y	N	Y	Y	2 hrly	
13/12/20	0:00	Y	Y	Y	N	Y	Y	2 hrly	
14/12/20	0400	Y	Y	Y	N	Y	Y	2 hrly	
15/12/20	08:30	Y	Y	Y	Y	Y	Y	2 hrly	
16/12/20	08:16	Y	Y	Y	Y	Y	Y	2 hrly	

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

Prevention of Pressure Ulcer Interventional Plan

NHS Greater Glasgow and Clyde

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

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

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan: 3/12/20	Check: • Pressure areas 4 hourly. • Skin under medical devices 4 hourly. • Specify medical devices used: HDU. monitoring equipment, urinary catheter, NG tube, faecal collector, rectal canula	Specify: • Mattress: • Cushion: Soft foam • Detail additional pressure redistributing equipment:	• Reposition 4 hourly in bed and chair. • Overnight patient / carer has agreed to repositioning 4 hourly • Specify any manual handling equipment used:	• Skin care to be carried out 4 hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree plan with patient / family/ carer YES ☑ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Emgicure Date discontinued:
Date Reviewed:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition ____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out ____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued:
Date Reviewed:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition ____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out ____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued:

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22/08/1979

Food and Drink Recording Chart

NHS Greater Glasgow and Clyde

Reason for recording intake: Unexplained weight loss

Guidance:

If the patient is at risk of dehydration please record drinks on a Fluid Balance Chart.

Record **ALL** food, drink and supplements that the patient eats and drinks.

Make sure the type and amount of the food, drink or supplement is accurate e.g. 3 spoonfuls of lentil soup, 1 cup of full fat milk.

It is important to record if the patient refuses food, drink or supplement and the reason why e.g. no appetite, didn't like, feeling sick.

Patients, friends, relatives, volunteers can write on this chart.

The information documented on this chart should be reviewed and evaluated daily by a Registered Nurse. Any changes should be noted in the patients care plan.

Date: 3/12/20	Day Number: 1
Food and Drink Intake	
Breakfast:	
Snack:	
Lunch:	
Snack:	
Evening Meal: Ensure compact	
Supper: Declined	
Overnight:	
Is the patients intake 'normal' or improved for them? Yes ☐ No ☐ Unsure ☑	
Continue: ☑ **Discontinue:** ☐	
Rationale: As above	
Signed: [signature] **Print:** C. McGuire	

Date: 4/12/20	Day Number: 2
Food and Drink Intake	
Breakfast: x3 spoonfuls weetabix to ensure	
Snack:	
Lunch: ensure compact	
Snack:	
Evening Meal: Declined.	
Supper:	
Overnight:	
Is the patients intake 'normal' or improved for them? Yes ☐ No ☐ Unsure ☐	
Continue: ☐ **Discontinue:** ☐	
Rationale:	
Signed: **Print:**	

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Food and Drink Recording Chart

Reason for recording intake: _____

NHS Greater Glasgow and Clyde

Guidance:

If the patient is at risk of dehydration please record drinks on a Fluid Balance Chart.

Record **ALL** food, drink and supplements that the patient eats and drinks.

Make sure the type and amount of the food, drink or supplement is accurate e.g. 3 spoonfuls of lentil soup, 1 cup of full fat milk.

It is important to record if the patient refuses food, drink or supplement and the reason why e.g. no appetite, didn't like, feeling sick.

Patients, friends, relatives, volunteers can write on this chart.

The information documented on this chart should be reviewed and evaluated daily by a Registered Nurse. Any changes should be noted in the patients care plan.

Date: 5·12·20	Day Number: 3
Food and Drink Intake	
Breakfast: Refused	
Snack: ORANGE JUICE / MILK	
Lunch: Yoghurt ENSURE	
Snack:	
Evening Meal: couple spoons custard.	
Supper:	
Overnight:	
Is the patients intake 'normal' or improved for them? Yes ☐ No ☐ Unsure ☐	
Continue: ☐ **Discontinue:** ☐	
Rationale: _____	
Signed: _____ **Print:** _____	

Date:	Day Number:
Food and Drink Intake	
Breakfast:	
Snack:	
Lunch:	
Snack:	
Evening Meal:	
Supper:	
Overnight:	
Is the patients intake 'normal' or improved for them? Yes ☐ No ☐ Unsure ☐	
Continue: ☐ **Discontinue:** ☐	
Rationale: _____	
Signed: _____ **Print:** _____	

Henry Burtgess

Patient Address Label

Food and Drink Recording Chart

NHS Greater Glasgow and Clyde

Reason for recording intake: poor intake

Guidance:

If the patient is at risk of dehydration please record drinks on a Fluid Balance Chart.

Record **ALL** food, drink and supplements that the patient eats and drinks.

Make sure the type and amount of the food, drink or supplement is accurate e.g. 3 spoonfuls of lentil soup, 1 cup of full fat milk.

It is important to record if the patient refuses food, drink or supplement and the reason why e.g. no appetite, didn't like, feeling sick.

Patients, friends, relatives, volunteers can write on this chart.

The information documented on this chart should be reviewed and evaluated daily by a Registered Nurse. Any changes should be noted in the patients care plan.

Date: 14/12/20	Day Number: 1
Food and Drink Intake	
Breakfast: Milk	
Snack:	
Lunch: Milk	
Snack:	
Evening Meal: Milk	
Supper:	
Overnight:	
Is the patients intake 'normal' or improved for them? Yes ☐ No ☑ Unsure ☐	
Continue: ☑ **Discontinue:** ☐ **Rationale:** ↓ intake **Signed:** dl **Print:** Amy Lewis	

Date: 15/12/20	Day Number: 2
Food and Drink Intake	
Breakfast: 1 x yoghurt 1 x milk, orange juice	
Snack: ensure compact	
Lunch: 1 x yoghurt cup of milk	
Snack:	
Evening Meal: 1 x yoghurt cup of milk, orange	
Supper:	
Overnight:	
Is the patients intake 'normal' or improved for them? Yes ☐ No ☑ Unsure ☐	
Continue: ☑ **Discontinue:** ☐ **Rationale:** ↓ intake **Signed:** dl **Print:** Amy Lewis	

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22/08/197[illegible]el

Food and Drink Recording Chart

Reason for recording intake: [illegible]

NHS
Greater Glasgow and Clyde

Guidance:

If the patient is at risk of dehydration please record drinks on a Fluid Balance Chart.

Record ALL food, drink and supplements that the patient eats and drinks.

Make sure the type and amount of the food, drink or supplement is accurate e.g. 3 spoonfuls of lentil soup, 1 cup of full fat milk.

It is important to record if the patient refuses food, drink or supplement and the reason why e.g. no appetite, didn't like, feeling sick.

Patients, friends, relatives, volunteers can write on this chart.

The information documented on this chart should be reviewed and evaluated daily by a Registered Nurse. Any changes should be noted in the patients care plan.

Date:	Day Number:
Food and Drink Intake	
Breakfast:	
Snack:	
Lunch:	
Snack:	
Evening Meal:	
Supper:	
Overnight:	
Is the patients intake 'normal' or improved for them?	
Yes ☐ No ☐ Unsure ☐	
Continue: ☐ Discontinue: ☐	
Rationale:	
Signed: Print:	

Date: [illegible]	Day Number:
Food and Drink Intake	
Breakfast:	Ensure x1 3x Yogurt
Snack:	
Lunch:	Ensure Sandwich x2 2x Yogurt
Snack:	
Evening Meal:	Ensure + 2x Yogurt
Supper:	
Overnight:	
Is the patients intake 'normal' or improved for them?	
Yes ☐ No ☐ Unsure ☐	
Continue: ☐ Discontinue: ☐	
Rationale:	
Signed: Print:	

Food and Drink Recording Chart

Reason for recording intake: _____

NHS Greater Glasgow and Clyde

Patient Address Label

Guidance:

If the patient is at risk of dehydration please record drinks on a Fluid Balance Chart.

Record **ALL** food, drink and supplements that the patient eats and drinks.

Make sure the type and amount of the food, drink or supplement is accurate e.g. 3 spoonfuls of lentil soup, 1 cup of full fat milk.

It is important to record if the patient refuses food, drink or supplement and the reason why e.g. no appetite, didn't like, feeling sick.

Patients, friends, relatives, volunteers can write on this chart.

The information documented on this chart should be reviewed and evaluated daily by a Registered Nurse. Any changes should be noted in the patients care plan.

Date: 19/12/20	Day Number: (4)
Food and Drink Intake	
Breakfast: ½ yoghurt	
Snack:	
Lunch: Jelly	
Snack:	
Evening Meal:	
Supper:	
Overnight:	
Is the patients intake 'normal' or improved for them? Yes ☐ No ☐ Unsure ☐	
Continue: ☐ **Discontinue:** ☐	
Rationale: _____	
Signed: _____ **Print:** _____	

Date: 20/12/20	Day Number:
Food and Drink Intake	
Breakfast: Roll butter/Jam 1	
Snack:	
Lunch: few mouthfuls of roast beef potato	
Snack:	
Evening Meal:	
Supper:	
Overnight:	
Is the patients intake 'normal' or improved for them? Yes ☐ No ☐ Unsure ☐	
Continue: ☐ **Discontinue:** ☐	
Rationale: _____	
Signed: _____ **Print:** _____	

Patient Address Label

Food and Drink Recording Chart

NHS Greater Glasgow and Clyde

Reason for recording intake: _____

Guidance:

If the patient is at risk of dehydration please record drinks on a Fluid Balance Chart.

Record **ALL** food, drink and supplements that the patient eats and drinks.

Make sure the type and amount of the food, drink or supplement is accurate e.g. 3 spoonfuls of lentil soup, 1 cup of full fat milk.

It is important to record if the patient refuses food, drink or supplement and the reason why e.g. no appetite, didn't like, feeling sick.

Patients, friends, relatives, volunteers can write on this chart.

The information documented on this chart should be reviewed and evaluated daily by a Registered Nurse. Any changes should be noted in the patients care plan.

Date: 22-12-20	Day Number:
Food and Drink Intake	
Breakfast: Milk + Weetabix	
Snack:	
Lunch: Small pasta bake. Milk	
Snack: Refused.	
Evening Meal: 1 Ensure	
Supper:	
Overnight:	
Is the patients intake 'normal' or improved for them? Yes ☐ No ☐ Unsure ☐	
Continue: ☐ **Discontinue:** ☐	
Rationale: _____	
Signed: _____ **Print:** _____	

Date:	Day Number:
Food and Drink Intake	
Breakfast:	
Snack:	
Lunch:	
Snack:	
Evening Meal:	
Supper:	
Overnight:	
Is the patients intake 'normal' or improved for them? Yes ☐ No ☐ Unsure ☐	
Continue: ☐ **Discontinue:** ☐	
Rationale: _____	
Signed: _____ **Print:** _____	

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LINE CHANGE CHART

DEVICE	DAY 1 3/12/20	DAY 2 04/02/12	DAY 3 / /	DAY 4 / /	DAY 5 / /	DAY 6 / /	DAY 7 / /
Respiflo, Face mask, N/C **DAILY**	3/12/20	04/02/12					
Nebuliser **DAILY**	X	x					
In use Suction **DAILY**	X	x					
SC Line **3DAYS**	X	x					
CVC Line **7 DAYS**	28/11/20	28/11/20					
CVCTransducer **3 DAYS**	X	x					
Arterial Line **7 DAYS**	X	x					
Arterial Line Transducer **3 DAYS**	X	x					
Needlefree Connectors **7 DAYS**	28/12/20	x					
Urinary Catheter **4 WEEKS**	24/12/20	24/12/20					
Urinary catheter bag **7 DAYS**	?	?					
Widebore NG tube **7 DAYS**	X	x					
Finebore NG Tube **6 WEEKS**	?	?					
NG Feeding Set **DAILY**	3/12/20	04/12/20					
Bipap/CPAP Circuit. HFNO **CHECK DAILY**	X	x					
PICC line Dressings **7 DAYS**	X	y					
Continuous IV infusion **3 DAYS**	3/12/20	x					
Intermittent IV infusions On **DISCONNECT** or **DAILY**	Discard after each use	Discard after each use					
CHANGED BY (INITIAL)	CM	HS					

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22/08/1979

MICROBIOLOGY CHART

DATE OBTAINED	SPECIMEN	TEST ORDERED	SIGNATURE	DATE RESULT REPORTED	SIGNATURE
3/12/20	Nasal Swab	MRSA	Mcguire		
3/12/20	CVC	Cultures	Mcguire		
3/12/20	Peripheral	Cultures	Mcguire		
4/12/20	Stool	Culture	Mcguire		
5/12/20	WOUND	O,C+S	MCLARK		
5/12/20	FAECES	(3RD) CULTURE	MCLARK		

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Adult Wound Assessment and Management Chart

NHS Greater Glasgow and Clyde

Hospital/Healthcentre: RAH

Ward/Department: HDU

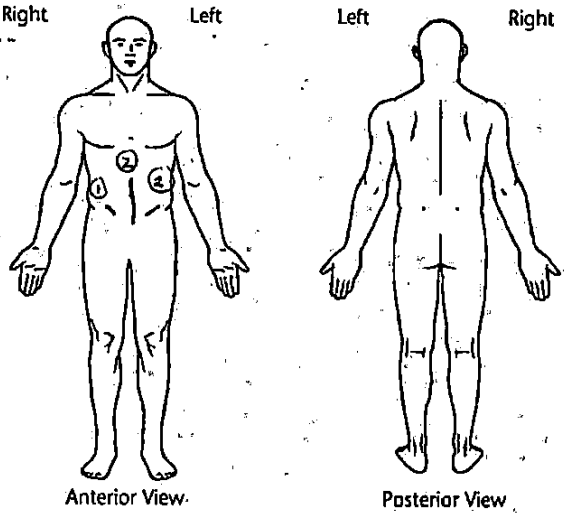
Factors present that could delay healing:			
Anaemia		Medication	
Anti-coagulants		Oedema	
Chemotherapy		Poor Nutrition	
Diabetes	✓	Radiotherapy	
Incontinence		Respiratory/Circulatory Disease	
Immobility		Steroids	
Inotropes		Wound Infection	

Allergies & Sensitivities (please state):

Nil Known

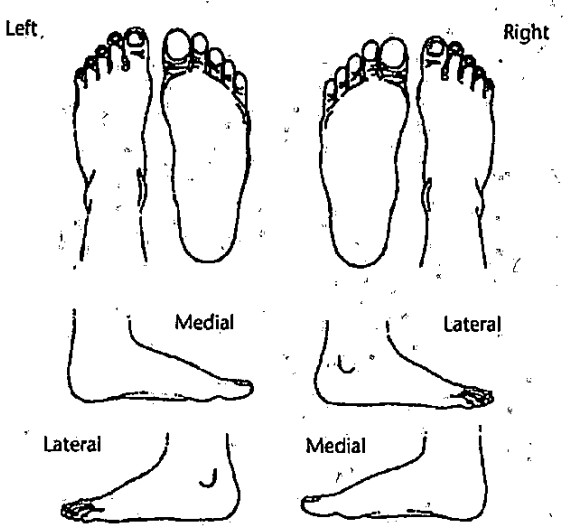
Other (please state):

Body Diagram



Mark location with 'x' and number each wound

Feet Diagram



Mark location with 'x' and number each wound

Type of Wound

Wound Number on body chart	Type of Wound	Duration
1 + 3	DRAIN SITE	24.11.20
2	LAPAROTOMY WOUND	24.11.20

Assessor Details

Name: MCLEAR Signature: M Clear

Designation: CSW Date: 5.12.20 Time: 1200

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Adult Wound Assessment and Management Chart

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Formal Wound Assessment (see guideline notes before completion)

It is mandatory to complete the formal wound assessment for every wound requiring treatment / intervention:

- At least every 7 days
- If treatment is being changed
- If there is any significant change in the wound

Wound number	1	2	3					
Date of Assessment	5.12.20	5.12.20	5.12.20					
Time of Assessment	1180	11:30	11:30					
Pre-dressing analgesia required	YES / (NO)	YES / (NO)	YES / (NO)	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
Wound Dimensions (enter size)								
Length/Width/Depth(cm)	L: 3cm W: D:	L: 24cm W: D:	L: 3cm W: D:	L: W: D:	L: W: D:	L: W: D:	L: W: D:	L: W: D:
Is wound: Tracking Undermining	YES / (NO)	YES / (NO)	YES / (NO)	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
Photography obtained	YES / (NO)	YES / (NO)	YES / (NO)	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
Tissue Type on Wound Bed (percentage total must = 100%)								
Necrotic (black)	%	%	%	%	%	%	%	%
Sloughy (yellow/green)	%	10 %	%	%	%	%	%	%
Granulating (red)	100 %	90 %	100 %	%	%	%	%	%
Epithelialiasing (pink)	%	%	%	%	%	%	%	%
Hypergranulating (red)	%	%	%	%	%	%	%	%
Blister	%	%	%	%	%	%	%	%
Haematoma	%	%	%	%	%	%	%	%
Bone/tendon visible	%	%	%	%	%	%	%	%
Other e.g. metal work _____	%	%	%	%	%	%	%	%
Wound Exudate Levels/Type (tick all that apply)								
None								
Low								
Medium								
High								
Serous (straw)								
Haemoserous (red/straw)								
Purulent (green/brown)								
Skin Surrounding Wound (tick relevant boxes)								
Healthy/intact	✓	✓	✓					
Dry/scaly								
Erythema (red)								
Excoriated (red)								
Fragile								
Macerated (white)								
Oedematous								
Signs of Infection - two or more of these signs may indicate possible infection								
Friable granulation tissue								
Heat								
Increasing exudate		✓						
Increasing odour/malodour								
Increasing pain								
Deteriorating wound bed								
Treatment Objectives (tick relevant boxes)								
Absorption		✓						
Hydration								
Debridement								
Palliative/Conservative								
Protection/promote healing	✓	✓	✓					
Reduce bacterial load								
ASSESSOR INITIAL/DESIGNATION	MC SN	MC SN	MC SN					

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Adult Wound Assessment and Management Chart

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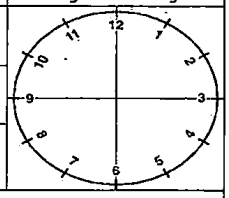
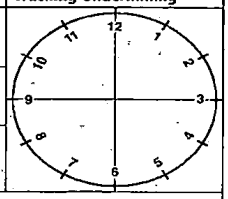
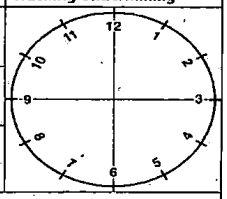
This Treatment Plan and Evaluation of Care refers to Wound Number: _____
To be completed on inital assessment, thereafter, complete when the dressing type and/or regimen is altered following changes identified at the wound assessment.
For advice: Please contact relevant speciality.

Dressing Plan (1)	Dressing Choice	Rationale for Treatment plan including any new allergies or sensitivities	Tracking Undermining
Cleansing Method (if applicable)	CLEANSED SALINE		
Primary Dressing please state: • Dressing • Size • Number of dressings used i.e. fibre dressing, 2.5cmx40cm, x3	STERISTRIP PREMIPORE	**Frequency of dressing change** PRN	
Secondary Dressing (if applicable)		**Has care plan been discussed with patient/carer?** (YES) / NO Comments:	
Retention Dressing (e.g. Bandage, Tape)			
Treatment to surrounding skin (if appropriate, e.g. skin barrier film)		**Treatment Plan completed by:** MCLARK **Designation:** S/N **Date:** 5·12·20	

Dressing Plan (2)	Dressing Choice	Rationale for Treatment plan including any new allergies or sensitivities	Tracking Undermining
Cleansing Method (if applicable)	CLEANSED SALINE		
Primary Dressing please state: • Dressing • Size • Number of dressings used i.e. fibre dressing, 2.5cmx40cm, x3	WOUND SWAB MEPORE TO COVER	**Frequency of dressing change** PRN	
Secondary Dressing (if applicable)		**Has care plan been discussed with patient/carer?** (YES) / NO Comments: 3 x staples removed	
Retention Dressing (e.g. Bandage, Tape)			
Treatment to surrounding skin (if appropriate, e.g. skin barrier film)	WOUND SWAB SENT 5/12/20	**Treatment Plan completed by:** MCLARK **Designation:** S/N **Date:** 5·12·20	

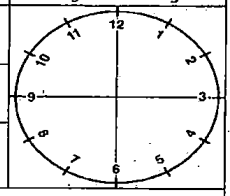
Dressing Plan (3)	Dressing Choice	Rationale for Treatment plan including any new allergies or sensitivities	Tracking Undermining
Cleansing Method (if applicable)	CLEANSED WITH SALINE		
Primary Dressing please state: • Dressing • Size • Number of dressings used i.e. fibre dressing, 2.5cmx40cm, x3	STERISTRIP PREMIPORE	**Frequency of dressing change** PRN	
Secondary Dressing (if applicable)		**Has care plan been discussed with patient/carer?** (YES) / NO Comments:	
Retention Dressing (e.g. Bandage, Tape)			
Treatment to surrounding skin (if appropriate, e.g. skin barrier film)		**Treatment Plan completed by:** MCLARK **Designation:** S/N **Date:** 5·12·20	

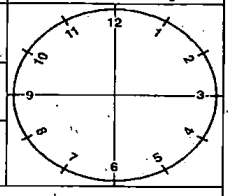
m • 296236 v2.1 • CGC00068

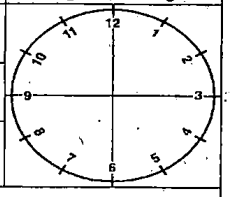
Adult Wound Assessment and Management Chart

This Treatment Plan and Evaluation of Care refers to Wound Number: _____
To be completed on inital assessment, thereafter, complete when the dressing type and/or regimen is altered following changes identified at the wound assessment.
For advice: Please contact relevant speciality.

Patient ID label

Dressing Plan	Dressing Choice	Rationale for Treatment plan including any new allergies or sensitivities	Tracking Undermining
Cleansing Method (if applicable)			
Primary Dressing please state: • Dressing • Size • Number of dressings used i.e. fibre dressing, 2.5cmx40cm, x3		**Frequency of dressing change**	
Secondary Dressing (if applicable)		**Has care plan been discussed with patient/carer?** **YES / NO** Comments:	
Retention Dressing (e.g. Bandage, Tape)			
Treatment to surrounding skin (if appropriate, e.g. skin barrier film)		**Treatment Plan completed by:** _____ **Designation:** _____ **Date:** _____	

Dressing Plan	Dressing Choice	Rationale for Treatment plan including any new allergies or sensitivities	Tracking Undermining
Cleansing Method (if applicable)			
Primary Dressing please state: • Dressing • Size • Number of dressings used i.e. fibre dressing, 2.5cmx40cm, x3		**Frequency of dressing change**	
Secondary Dressing (if applicable)		**Has care plan been discussed with patient/carer?** **YES / NO** Comments:	
Retention Dressing (e.g. Bandage, Tape)			
Treatment to surrounding skin (if appropriate, e.g. skin barrier film)		**Treatment Plan completed by:** _____ **Designation:** _____ **Date:** _____	

Dressing Plan	Dressing Choice	Rationale for Treatment plan including any new allergies or sensitivities	Tracking Undermining
Cleansing Method (if applicable)			
Primary Dressing please state: • Dressing • Size • Number of dressings used i.e. fibre dressing, 2.5cmx40cm, x3		**Frequency of dressing change**	
Secondary Dressing (if applicable)		**Has care plan been discussed with patient/carer?** **YES / NO** Comments:	
Retention Dressing (e.g. Bandage, Tape)			
Treatment to surrounding skin (if appropriate, e.g. skin barrier film)		**Treatment Plan completed by:** _____ **Designation:** _____ **Date:** _____	

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Wound dressing change log

To be completed at EVERY dressing change

Patient ID label

Date	Time	Wound Number	Number of sheets/ribbons removed from wound	If dressing change is unplanned please state the reason e.g. swab taken, dressing adhering or dressing saturated	Additional Comments e.g. swab obtained, reason or investigation requested, wound photographed,	Sign, Print , Designation

Wound dressing change log

To be completed at EVERY dressing change

Patient ID label

Date	Time	Wound Number	Number of sheets/ribbons removed from wound	If dressing change is unplanned please state the reason e.g. swab taken, dressing adhering or dressing saturated	Additional Comments e.g. swab obtained, reason or investigation requested, wound photographed,	Sign, Print , Designation

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Pati
2208793218
BURGESS
Henry
22/08/197

Adult Wound Assessment and Management Chart

NHS Greater Glasgow and Clyde

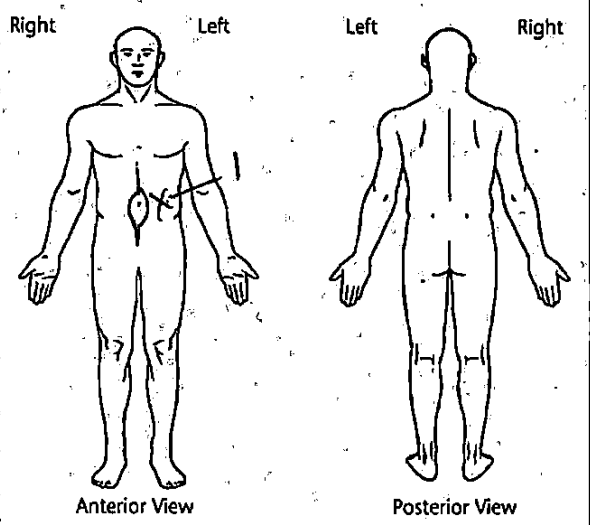
Hospital/Healthcentre: _____

Ward/Department: _____

Factors present that could delay healing:			
Anaemia		Medication	
Anti-coagulants		Oedema	
Chemotherapy		Poor Nutrition	✓
Diabetes		Radiotherapy	
Incontinence		Respiratory/Circulatory Disease	
Immobility	✓	Steroids	
Inotropes		Wound Infection	

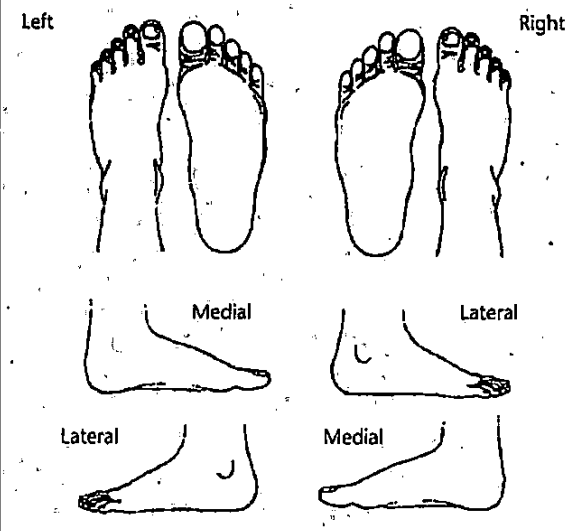
Allergies & Sensitivities (please state):	Other (please state):

Body Diagram



Mark location with 'x' and number each wound

Feet Diagram



Mark location with 'x' and number each wound

Type of Wound

Wound Number on body chart	Type of Wound	Duration
1.	Surgical	

Assessor Details

Name: NORMAN BRENNER Signature: N.B

Designation: STAFF NURSE Date: 13/12/10 Time: 1150

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Adult Wound Assessment and Management Chart

Formal Wound Assessment (see guideline notes before completion)

It is mandatory to complete the formal wound assessment for every wound requiring treatment / intervention:

- At least every 7 days
- If treatment is being changed
- If there is any significant change in the wound

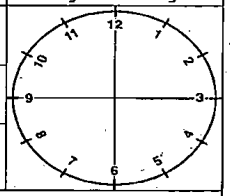
Patient ID label

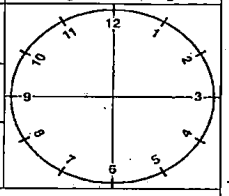
Wound number	~~1~~ 1	2						
Date of Assessment	13/12/20	21/12/20						
Time of Assessment	1145	1845						
Pre-dressing analgesia required	YES / (NO)	YES / (NO)	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
Wound Dimensions (enter size)								
Length/Width/Depth(cm)	L: 14 W: 2.5 D: 7.5	L: 14 W: 2.5 D: 2.5	L: W: D:	L: W: D:	L: W: D:	L: W: D:	L: W: D:	L: W: D:
Is wound: Tracking Undermining	YES / (NO)	YES / (NO)	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
Photography obtained	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
Tissue Type on Wound Bed (percentage total must = 100%)								
Necrotic (black)	%	%	%	%	%	%	%	%
Sloughy (yellow/green)	10 %	5 %	%	%	%	%	%	%
Granulating (red)	80 %	75 %	%	%	%	%	%	%
Epithelialiasing (pink)	10 %	20 %	%	%	%	%	%	%
Hypergranulating (red)	%	%	%	%	%	%	%	%
Blister	%	%	%	%	%	%	%	%
Haematoma	%	%	%	%	%	%	%	%
Bone/tendon visible	%	%	%	%	%	%	%	%
Other e.g. metal work _____	%	%	%	%	%	%	%	%
Wound Exudate Levels/Type (tick all that apply)								
None								
Low	✓	✓						
Medium								
High								
Serous (straw)								
Haemoserous (red/straw)								
Purulent (green/brown)								
Skin Surrounding Wound (tick relevant boxes)								
Healthy/intact	✓	✓						
Dry/scaly								
Erythema (red)								
Excoriated (red)								
Fragile								
Macerated (white)								
Oedematous								
Signs of Infection - two or more of these signs may indicate possible infection								
Friable granulation tissue								
Heat								
Increasing exudate								
Increasing odour/malodour								
Increasing pain								
Deteriorating wound bed								
Treatment Objectives (tick relevant boxes)								
Absorption	✓	✓						
Hydration								
Debridement	✓	✓						
Palliative/Conservative								
Protection/promote healing	✓	✓						
Reduce bacterial load		✓						
ASSESSOR INITIAL/DESIGNATION	MB RGN	LCS RN						

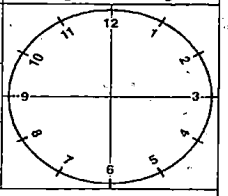
Adult Wound Assessment and Management Chart

Patient ID label

This Treatment Plan and Evaluation of Care refers to Wound Number: _____
To be completed on inital assessment, thereafter, complete when the dressing type and/or regimen is altered following changes identified at the wound assessment.
For advice: Please contact relevant speciality.

Dressing Plan	Dressing Choice	Rationale for Treatment plan including any new allergies or sensitivities	Tracking Undermining
Cleansing Method (if applicable)	Aquacel ribbon 4x30cm Island Dressing 10x25cm	Absorption Healing	
Primary Dressing please state: • Dressing • Size • Number of dressings used i.e. fibre dressing, 2.5cmx40cm, x3		**Frequency of dressing change** Daily	
Secondary Dressing (if applicable)		**Has care plan been discussed with patient/carer?** YES / NO Comments:	
Retention Dressing (e.g. Bandage, Tape)			
Treatment to surrounding skin (if appropriate, e.g. skin barrier film)		**Treatment Plan completed by:** [illegible] **Designation:** S/N **Date:** 18/12/20	

Dressing Plan	Dressing Choice	Rationale for Treatment plan including any new allergies or sensitivities	Tracking Undermining
Cleansing Method (if applicable)			
Primary Dressing please state: • Dressing • Size • Number of dressings used i.e. fibre dressing, 2.5cmx40cm, x3		**Frequency of dressing change**	
Secondary Dressing (if applicable)		**Has care plan been discussed with patient/carer?** YES / NO Comments:	
Retention Dressing (e.g. Bandage, Tape)			
Treatment to surrounding skin (if appropriate, e.g. skin barrier film)		**Treatment Plan completed by:** _____ **Designation:** _____ **Date:** _____	

Dressing Plan	Dressing Choice	Rationale for Treatment plan including any new allergies or sensitivities	Tracking Undermining
Cleansing Method (if applicable)			
Primary Dressing please state: • Dressing • Size • Number of dressings used i.e. fibre dressing, 2.5cmx40cm, x3		**Frequency of dressing change**	
Secondary Dressing (if applicable)		**Has care plan been discussed with patient/carer?** YES / NO Comments:	
Retention Dressing (e.g. Bandage, Tape)			
Treatment to surrounding skin (if appropriate, e.g. skin barrier film)		**Treatment Plan completed by:** _____ **Designation:** _____ **Date:** _____	

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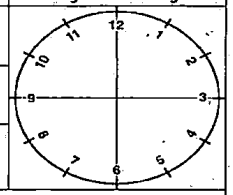
Adult Wound Assessment and Management Chart

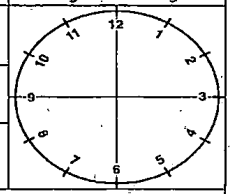
Patient ID label

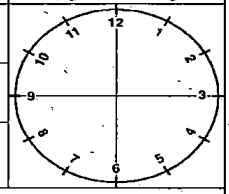
This Treatment Plan and Evaluation of Care refers to Wound Number: _____

To be completed on inital assessment, thereafter, complete when the dressing type and/or regimen is altered following changes identified at the wound assessment.

For advice: Please contact relevant speciality.

Dressing Plan	Dressing Choice	Rationale for Treatment plan including any new allergies or sensitivities	Tracking Undermining
Cleansing Method (if applicable)			
Primary Dressing please state: • Dressing • Size • Number of dressings used i.e. fibre dressing, 2.5cmx40cm, x3		**Frequency of dressing change**	
Secondary Dressing (if applicable)		**Has care plan been discussed with patient/carer?** **YES / NO** Comments:	
Retention Dressing (e.g. Bandage, Tape)			
Treatment to surrounding skin (if appropriate, e.g. skin barrier film)		**Treatment Plan completed by:** _____ **Designation:** _____ **Date:** _____	

Dressing Plan	Dressing Choice	Rationale for Treatment plan including any new allergies or sensitivities	Tracking Undermining
Cleansing Method (if applicable)			
Primary Dressing please state: • Dressing • Size • Number of dressings used i.e. fibre dressing, 2.5cmx40cm, x3		**Frequency of dressing change**	
Secondary Dressing (if applicable)		**Has care plan been discussed with patient/carer?** **YES / NO** Comments:	
Retention Dressing (e.g. Bandage, Tape)			
Treatment to surrounding skin (if appropriate, e.g. skin barrier film)		**Treatment Plan completed by:** _____ **Designation:** _____ **Date:** _____	

Dressing Plan	Dressing Choice	Rationale for Treatment plan including any new allergies or sensitivities	Tracking Undermining
Cleansing Method (if applicable)			
Primary Dressing please state: • Dressing • Size • Number of dressings used i.e. fibre dressing, 2.5cmx40cm, x3		**Frequency of dressing change**	
Secondary Dressing (if applicable)		**Has care plan been discussed with patient/carer?** **YES / NO** Comments:	
Retention Dressing (e.g. Bandage, Tape)			
Treatment to surrounding skin (if appropriate, e.g. skin barrier film)		**Treatment Plan completed by:** _____ **Designation:** _____ **Date:** _____	

m • 292936 v2.1 • GCC0068

Wound dressing change log

To be completed at EVERY dressing change

Patient ID label

Date	Time	Wound Number	Number of sheets/ribbons removed from wound	If dressing change is unplanned please state the reason e.g. swab taken, dressing adhering or dressing saturated	Additional Comments e.g. swab obtained, reason or investigation requested, wound photographed,	Sign, Print, Designation
2.12.20	1845	1.	1x ribbon removed	n/a	Daily dressing change	[illegible] SRN

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Wound dressing change log

To be completed at EVERY dressing change

Patient ID label

Date	Time	Wound Number	Number of sheets/ribbons removed from wound	If dressing change is unplanned please state the reason e.g. swab taken, dressing adhering or dressing saturated	Additional Comments e.g. swab obtained, reason or investigation requested, wound photographed,	Sign, Print , Designation

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Patient ID label

Adult Wound Assessment and Management Chart

NHS Greater Glasgow and Clyde

Wound Assessment Chart Guidelines

PLEASE READ GUIDELINE PRIOR TO COMPLETING FORM

Completion of the wound assessment chart assists in the holistic assessment and management of patients requiring ongoing treatment of their wound(s), enhances communication and helps improve continuity of care. It is **mandatory** to complete wound chart for all wounds requiring ongoing intervention.

Page 1 - to be completed on initial assessment

- Record ward/department and the site (hospital or health centre)
- Attach patient label
- Identify all factors present which could delay wound healing
- Record any known allergies or sensitivities including those to dressing products
- Identify the location of each wound on body diagram. Number each wound (maximum of 2 per wound chart)
- Record wound type and duration of wound to corresponding number - these factors will influence wound management plan
- Assessor's details- print name and sign, record designation and date assessment completed

Page 2 - wound assessment information must be completed for every wound on the initial assessment, when changes noted in the condition of the wound or surrounding area or at least once every 7 days

- Record wound number, date and time of assessment
- Ensure effective pain control identify if analgesia required prior to dressing change
- Wound dimensions – measure wound in cm/mm. Use disposable tape measure e.g. in wound dressing packs or measuring scales on some wound dressing product packaging. DO NOT USE multiple use measuring tools
  - » Length is from head to toe
  - » Width is from right to left
  - » Depth of wound should be measured
- Record if tracking or undermining is present to help identify full extent of wound and possibility of sinus/fistula
- Record direction of undermining/ tracking on clock face diagram in treatment plan (pages 3&4)
- Record if photographic record is obtained-NB. Patient consent is required and photographs can only be taken by authorised camera users and stored within a secure system as per policy link below http://www.staffnet.ggc.scot.nhs.uk/Acute/Diagnostics/Medical%20Illustration%20Services/Pages/OtherLinks.aspx
- Identify tissue types on wound bed in %
- The type of tissues present will help identify stage of healing and treatment objectives.
- Record % of each tissue type to obtain 100%, will identify if treatment objectives being achieved.
- Wound Exudate - identify exudate levels and record type of exudate

Descriptor	Description
None	Wound tissues dry
Low	Wound tissues wet, moisture evenly distributed in wound <25% of dressing soiled
Medium	Wound tissues saturated, drainage may or may not be evenly distributed in wound, 25%-75% of dressing soiled
High	Wound tissues bathed in fluid, drainage freely expressed, may or not be evenly distributed in the wound, >75% of dressing soiled
Serous	Clear, light colour, Thin, watery
Haemoserous	Light red to pink, Thin, watery
Purulent / Pus	Yellow, tan to green, Thick, opaque

- Monitor for signs of infection and obtain wound swab if infection suspected
- Record the skin condition around the wound -

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Patient ID label

Adult Wound Assessment and Management Chart

NHS Greater Glasgow and Clyde

- Treatment objectives - determine treatment objectives to guide dressing choice and plan care
- Record assessors details in line with requirement for record keeping

Page 3 - treatment plan and evaluation of care

- To be completed on inital assessment, thereafter, complete when the dressing type and/ or regimen is altered following changes identified at the wound assessment. Keep the bit that says For advice please contact relevant speciality.
- Complete information in the dressing choice section as indicated for
  - » Method of cleansing if require (refer to wound cleansing guidelines)
  - » Primary dressing including size and number of dressing pieces used.
- **When inserting dressing product into a cavity wound, ensure end of every dressing piece is left above skin surface and number of pieces of dressing used recorded on application/removal to ensure there is no risk of dressing products being retained in wound**
- Secondary dressing used if applicable
- Any retention dressing required such as bandages
- Record if any product is to be applied to surrounding skin e.g. for protection
- Record frequency for each dressing change
- Rationale for treatment plan – record objective of treatment to allow effectiveness and appropriateness of treatment to be evaluated
- Draw line to indicate direction of tracking undermining on clock face diagram with 12 o'clock referring to head, 3 o'clock to patient's left side, add corresponding dimension
- Record whether wound care has been discussed with the patient to ensure care is patient centred
- Record assessors details
- If change in care plan discontinue previous care plan by one score through, initial and date

Page 4 - wound dressing change log

- Complete at EVERY dressing change
- Record date and time
- Record number for corresponding wound as noted on the wound assessment chart
- Record the number of dressing pieces removed from the wound, refer to number of pieces applied from previous dressing application (as per treatment plan) to ensure no dressing products are retained within the wound
- Record reason for any unplanned wound dressing changes
- Provide additional comments as required such as when wound photographed, investigations requested or feedback from patient.
- Sign your record of care and print name and designation
- Record if wound swab obtained for culture and sensitivity

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Care Rounds Checklist

Date: 3/12/20

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

1. Signed CMcguire Name C McGuire Designation S/N
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach Addr 2208793218
BURGESS M
Henry 22/08/1979
96A ALICE STREET
Paisley, Renfrewshire
Ward: PA2 6EA

NHS Greater Glasgow and Clyde

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

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

			Times 2030																		
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N																		
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N																		
S	3	**SKIN INSPECTION** Pressure areas checked:	Y																		
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	NT																		
K	4	**KEEP MOVING** Has the patient moved or walked?	Y																		
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B																		
		Chair Assist to walk or stand (W/ST)																			
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	V																		
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N																		
		Drink taken?	Y																		
		Food, snack, or supplement taken?	NT																		
		Has oral hygiene been carried out as per care plan?	I																		
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y																		
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT																		
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA																		
		Care provider / role	N																		

Care Rounds Variance Sheet

2208793218
Attach ABURGESS M
Henry 22/08/1979
96A ALICE STREET
Paisley, Renfrewshire
PA2 6EA

Ward:

NHS
Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name
3/12/20	20:30	5.	Urinary catheter & faecal collection device in situ.	
		6.	Passed STOPPS & on continuous enteral nutrition via NG tube as per dietician recommended regimen.	AMcguire CMcGuire

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Care Rounds Checklist

Date: 4/12/20

2208793218
BURGESS
Henry M
96A ALICE STREET 22/08/1979
Paisley, Renfrewshire
PA2 6EA

NHS Greater Glasgow and Clyde

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

1. Signed [signature] Name C T Figure Designation S/N
2. Signed [signature] Name [illegible] Designation [illegible]
3. Signed _____ Name _____ Designation _____

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

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

		Times	0000	0800	1200	1600	2000																		
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	~	~	~	~	~																
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	~	~	~	~	~																
S	3	**SKIN INSPECTION** Pressure areas checked:	N	Y	4	4	4	4	4																
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	~	INT	~	INT	INT	INT	INT																
K	4	**KEEP MOVING** Has the patient moved or walked?	R	Y	4	4	4	4	4																
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	L	R	B	B	B	B	L																
		Chair Assist to walk or stand (W/ST)	~	~	~	~	ST	ST	I																
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	V	V	V	V	V	V	V																
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	~	~	~	~	~																
		Drink taken?	Y	Y	4	4	4	4	4																
		Food, snack, or supplement taken?	NT	NT	M	M	NT	M	NG																
		Has oral hygiene been carried out as per care plan?	I	I	I	I	I	I	I																
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	4	4	4	4	4																
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	M	M	NT	M	Y																
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA	NA	NA																
		Care provider / role	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	HR SW																

Care Rounds Variance Sheet

2208793218
Attach BURGESS M
Henry 22/08/1979
96A ALICE STREET
Paisley, Renfrewshire
PA2 6EA
Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name
4/12/20	00:15	5.	Urinary catheter & faecal collection device in situ.	
		6.	Passed STOPPS & on continuous enteral nutrition via NG tube as per dietician recommended regimen.	Procedure error

Care Rounds Checklist

Date: 05/11/2020

Attach Addre [redacted]
2208793218
BURGESS
Henry
96A ALICE STREET
Paisley, Renfrewshire
PA2 6EA
M
22/08/1979

NHS Greater Glasgow and Clyde

Ward: HA

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

1. Signed HBeale Name HAZEL BAUER Designation Staff Nurse
2. Signed aganett Name A. Garnett Designation S/N
3. Signed _____ Name _____ Designation _____

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

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

		Times	2000	2400	0900				0800											
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N				N											
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N				N											
S	3	**SKIN INSPECTION** Pressure areas checked:	Y	Y	Y				Y											
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	INT	INT	INT				INT											
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y				Y											
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B	L	R				B											
		Chair Assist to walk or stand (W/ST)	T	T	T															
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	Call	Call	Call				V											
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N				N											
		Drink taken?	Y	N	Y				Y											
		Food, snack, or supplement taken?	NA	NA	Y				V											
		Has oral hygiene been carried out as per care plan?	I	I	I				Y											
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y				Y											
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	Y	Y	Y				Y											
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA				NA											
		Care provider / role	HB SN	HB SN	AC				AG SN											

Care Rounds Variance Sheet

Attach Addr.

2208793218
BURGESS
Henry
96A ALICE STREET
Paisley, Renfrewshire
PA2 6EA

M
22/08/1979

Ward: HDU

NHS
Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name
05/12/20	0000	2	nil pain issues.	
		3	skin on pressure areas intact	
		4	Aor to mobilise in bed.	
		5	faecal collector + catheter insit.	HAZELBALLEN.
		6	can eat + drink on own good running 23ml/h.	HGrade staffs

Care Rounds Checklist

Date: 6-12-20

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

1. Signed MC Name MARCUS Designation RN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach Addressograph Label

2208793218
BURGESS M
Henry 22/08/1979
96A ALICE STREET
Paisley, Renfrewshire
PA2 6EA

Ward: SARU

NHS Greater Glasgow and Clyde

'Must dos' fo... is anything they want specifically done today.

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

		Times	01 00	05 00	09 00	13 00	17 00	20 00												
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N												
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N/A	Y												
S	3	**SKIN INSPECTION** Pressure areas checked:	Y	N	N		Y	Y												
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	INT	/	/		INT	INT												
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y	Y												
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	self	self	I	I	B	B												
		Chair Assist to walk or stand (W/ST)	/	/	/	/	/	-												
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	cath	cath	cath	cath	cath	CATH												
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N												
		Drink taken?	Y	S	Y	Y	Y	Y												
		Food, snack, or supplement taken?		S	Y	Y	Y	Y												
		Has oral hygiene been carried out as per care plan?	I	S	N	N	Y	N												
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y Y	Y Y	Y Y	Y Y												
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	N	NT	NT	NT	NT												
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	N	NA	NA	NA	NA												
		Care provider / role	AP	AP	MW	MW	GCA	EC SW												

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 7/12/20

Attach Addressograph Label
2208793218
HENRY BURGESS
22/08/1979.
Ward: SARU

NHS Greater Glasgow and Clyde

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

1. Signed _____ Name Bethany Gleeson Designation S/N
2. Signed _____ Name Kate Finlayson Designation S/N
3. Signed _____ Name _____ Designation _____

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

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

		Times	06/07	08/09	10/11	08 00	12 00	15 00	17 00	20:00	22:00									
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N.	N	N	N	N	N	N									
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	Y	Y	Y	N	N	N	N	Y	Y									
S	3	**SKIN INSPECTION** Pressure areas checked:	Y	N	Y	Y	Y	Y	Y	Y	Y									
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	I	I	R.	K	R	PU	PU	PU	PU									
K	4	**KEEP MOVING.** Has the patient moved or walked?	Y	Y	Y.	Y	Y	Y	Y	Y										
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B	R	B.	B	B	R	L	R	L									
		Chair Assist to walk or stand (W/ST)	T	T	T	/	/	/	/	T	T									
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	I	I/C	cath	cath	cath	cath	I/C	I/C									
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N	N	N	N									
		Drink taken?	sip	sip	sip	sip	sip	sip	sip	Y	Y									
		Food, snack, or supplement taken?	Y	Y	Y	N	Y	Y	Y	Y	Y									
		Has oral hygiene been carried out as per care plan?	Y	Y	Y	/	N	N	N	N	Y									
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y Y	Y	Y Y	Y Y	Y	Y									
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	N	Y	N	NT	NT	NT	NT	N	N									
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA	NA	NA	NA	NA									
		Care provider / role	BF	BF	SF	CO	SY	CO	CO	SY	N									

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name
7/12/20	12.00	3	Small pressure ulcer on ® buttock area & second	
			small sore between buttocks (mattress ordered	Cfullerton SLN

[redacted]nds Checklist

Date: 08/12/20

Attach Ad

2208793218
BURGESS M
Henry 22/08/1979
95A ALICE STREET
Paisley, Renfrewshire
PA2 6EA

Ward: 20

NHS Greater Glasgow and Clyde

[redacted]valuated and deemed that the frequency of care delivery over the next work shift, based on the patient's [redacted]t critical need should be every (please circle) 1hr **2hr** 3hr 4hr

1. Signed [redacted] Name [redacted] Designation SP
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

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

USE FOLLOWING CODES:
Y = Yes **N** = No **NA** = Not applicable **NT** = No Thanks **S** = Sleeping **O** = Off the ward **I** = Independent

		Times	02 00	05 00	08 00	08 30	13 30	16 30	20 00	24 00										
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	S	N	N	N										
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	S	N	N	N										
S	3	**SKIN INSPECTION** Pressure areas checked:	✓	✓	✓	–	–	–	M	M										
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	PU	PU	PU	PU	PU	PU	PU	PU										
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	–	Y	M	M										
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	R	L	R	BL	–	BL	B	L										
		Chair Assist to walk or stand (W/ST)	–	–	–	–	–	–												
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	cath	cath	cath	cath	cath	cath	C	C										
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	NG	N	N										
		Drink taken?	Y	N	N	N	S	N												
		Food, snack, or supplement taken?	✓	✓	✓	N	S	N												
		Has oral hygiene been carried out as per care plan?	N	N	N	I	S	I												
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y Y	Y	Y	Y	M	M										
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	NT	NT	NT	NT	NT	NT										
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	Y	NA	NA	NA	NA										
		Care provider / role	MT SM	MT SM	SM EM	SB SM	SB SM	SB SM	M	M										

Care Rounds Variance Sheet

Attach Addressograph Label

Ward: 20

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name
8/12/20	00.00	6	NJ feed cautwes	

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Care Rounds Checklist

Date: 9/12/20

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

1. Signed _____ Name _____ Designation CRN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach Addressograph Label

Henry Burgess

Ward: 20

NHS Greater Glasgow and Clyde

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

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

		Times	10	20	00	04 00	08 00	10am 60	12											
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N	N											
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N	N											
S	3	**SKIN INSPECTION** Pressure areas checked:	Y	Y	Y	Y	Y	Y	N											
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	R	R	R	PU	PU													
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y	Y	Y											
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	R	R	L	R	/													
		Chair Assist to walk or stand (W/ST)				/	C	✓	OH											
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	N	N	N	NT	A	A	N											
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N			N	N	N	N											
		Drink taken?				Y	N	Y	Y											
		Food, snack, or supplement taken?				N	N	N	N											
		Has oral hygiene been carried out as per care plan?	Y			Y	N		Y											
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y Y	Y	Y	Y											
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	NT	NT	NT	N	N											
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA	N	N											
		Care provider / role	NB	NB	NB	MB	SB	DC	DC											

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 10/12/20

Attach Addressograph Label
HENRY
BURGESS
Ward: 24

NHS Greater Glasgow and Clyde

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

1. Signed _____ Name _____ Designation _____
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

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

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

			Times	1:15	0800	0600	0800	1000	1200	1400	1600	1800										
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		N	N	N	W	W	W	W	W	W										
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.		N	N	N	W	W	W	N	N	W										
S	3	**SKIN INSPECTION** Pressure areas checked:		Y	N	N	W	W	R	R	R	W										
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		R	R	/	/	/	R	R	R	R										
K	4	**KEEP MOVING** Has the patient moved or walked?		Y	N	N	Y	Y	Y	Y	Y	Y										
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		R	R	B	B	B	E	E	O	R										
		Chair Assist to walk or stand (W/ST)		/	T	R	/	/	/	/	/	/										
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		N	A	N	N	A	A	A	/	IC										
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?		N	N	N	W	N	N	N	N	W										
		Drink taken?			N	N	Y	Y	Y	Y	Y	Y										
		Food, snack, or supplement taken?			N	N	Y	Y	Y	Y	Y	W										
		Has oral hygiene been carried out as per care plan?			N	N	W	W	N	N	N	W										
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		Y	N	N	Y	Y	Y	Y	Y	Y										
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.		N	N	N	NA	NA	NA	NA	NA	NA										
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.		NA	NA	N	NA	NA	NA	NA	NA	NA										
		Care provider / role		AHA	RGN	RGN	EW	EW	EW	EW	EW	EW										

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 22/12/20

Attach Addressograph Label
Henry Burgess

Ward: 24

NHS Greater Glasgow and Clyde

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

1. Signed [signature] Name N. Kimmett Designation SIN
2. Signed _____ Name _____ Designation _____
3. Signed M·mcf Name M·mcf Designation N/A

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

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

		Times	MN	4AM	8	12	4	8
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N
S	3	**SKIN INSPECTION** Pressure areas checked:	✓	✓	✓	✓	✓	✓
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	Int	Int	Int	Int	Int	Int
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y	Y
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	R	R	B	B	B	B
		Chair Assist to walk or stand (W/ST)	W	W	C	C	C	
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	I	I	I	I	I
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N
		Drink taken?	Y	Y	Y	Y	Y	Y
		Food, snack, or supplement taken?	Y	–	Y	Y	Y	NT
		Has oral hygiene been carried out as per care plan?	✓	–	✓	✓	✓	✓
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y Y	Y Y	Y Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	NT	NT	NT	NT
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	N/A	N/A	N/A	N/A	N/A	N/A
		Care provider / role	MW	MW	RN	RN	RN	RN

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 10/12/20

Attach Addressograph Label

Henry Burgess

Ward: 24

NHS Greater Glasgow and Clyde

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

1. Signed lpark Name lpark Designation STN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

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

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

			Times	00 45	01 30	04 30	05 15	05 30	12 30	15 30	15 00										
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		N	N	N	N	N	N	N	N										
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.		N	N	N	N	N	N	N	N										
S	3	**SKIN INSPECTION** Pressure areas checked:		Y	Y	Y	Y	Y	Y	Y	Y										
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		R	R	R	R	R	R	R	R										
K	4	**KEEP MOVING** Has the patient moved or walked?		Y	Y	Y	Y	Y	Y	Y	Y										
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		B	B	B	B	B	B	B	B										
		Chair Assist to walk or stand (W/ST)		/			/	—	—	/	/										
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		BTHR	BTHR	BTHR	BTHR	A	A	A	A										
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?		N	N	N	N	N	N	N	N										
		Drink taken?		N	/	Y	Y	Y	Y	Y	Y										
		Food, snack, or supplement taken?		N	/	Y	Y	Y	N	Y	Y										
		Has oral hygiene been carried out as per care plan?		N	/	Y	N	N	N	N	N										
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		Y	Y	Y	Y	Y	Y	Y	Y										
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.		NT	NT	NT	NT	NT	NT	NT	NT										
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.		NA	NA	NA	NA	NA	NA	NA	NA										
		Care provider / role		MK	MK	MK	MK	MK	MK	MK	MK										

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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3/6

Care ...nds Checklist — Date: 12/12/20

Attach Addressograph Label

Henry Bulgeo

Ward:

NHS Greater Glasgow and Clyde

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

1. Signed [signature] Name Rumyszko Designation SN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

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

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

			Times	01:45	03:45	05:45	07:30	11:30	13:30	15:30	17:30	19:00	21:00	23:00							
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		N	N	N	N	N	N	N	N	N	N	N							
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.		N	N	N	N	N	N	N	N	N	N	N							
S	3	SKIN INSPECTION Pressure areas checked:		N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y							
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		-	R	R	N	N	N	N	N	Int	INT	INT							
K	4	KEEP MOVING Has the patient moved or walked?		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y							
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		B	R	B	B	B	B	B	B	B	R	B							
		Chair Assist to walk or stand (W/ST)		T	T	/	-	-	-	-	-	-	T	-							
I	5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		A	A	A	A	A	A	A	A	/	A	A							
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?		N	N	N	N	N	N	N	N	N	N	N							
		Drink taken?		S	Y	N	Y	Y	Y	Y	Y	Y	Y	N							
		Food, snack, or supplement taken?		S	N	N	N	Y	Y	Y	Y	N	N	N							
		Has oral hygiene been carried out as per care plan?		S	I	I	I	I	I	I	I	I	I	I							
	7	ENVIRONMENT Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		Y	Y	Y	Y	Y	Y	Y	Y	Y Y	N	N							
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.		NT	NT	NT	NT	NT	NT	NT	NT	N	N	N							
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.		NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA							
		Care provider / role		RG	RG	RG	MK	ML	NK	ML	ML	RG	EM	EM							

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 13/12/20

3/6

Attach Addressograph Label
Henry Burgess

Ward:

NHS Greater Glasgow and Clyde

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

1. Signed [signature] Name Rmy cr ko Designation SN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

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

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

			Times	01	03	05	07	09 30	11 30	13 30	15 30										
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		N	N	N	N	N	N	N	N										
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.		N	N	N	N	N	N	N	N										
S	3	SKIN INSPECTION Pressure areas checked:		Y	Y	Y	Y	Y	Y	Y	Y										
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		INT	INT	INT	INT	INT	NT	NT	NT										
K	4	KEEP MOVING Has the patient moved or walked?		Y	Y	Y	Y	Y	Y	Y	Y										
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		B	B	B	B	B	B	B	B										
		Chair Assist to walk or stand (W/ST)		—	—	—	—	—	—	—	—										
I	5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		—	—	—	A	A	A	A	A										
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?		N	N	N	N	N	N	N	N										
		Drink taken?		N	N	N	N	N	Y	Y	Y										
		Food, snack, or supplement taken?		N	N	N	N	N	N	N	N										
		Has oral hygiene been carried out as per care plan?		N	N	N	N	N	N	N	Y										
	7	ENVIRONMENT Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		Y	Y	Y	Y	Y	Y	Y	Y										
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.		N	N	N	N	NT	NT	NT	NT										
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.		N	N	N	N	NA	NA	NA	NA										
			Care provider / role	EM	EM	EM	EM	MH	MH	MH	EM										

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care kounds Checklist

Date: 14-12-20

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

1. Signed [signature] Name [signature] Designation CN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach

2208793218
BURGESS M
Henry 22/08/1979
86A ALICE STREET
Ward: Paisley, Renfrewshire
PA2 6EA

NHS Greater Glasgow and Clyde

3.6.

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

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

		Times	01[30]	03[30]	05[40]	8	10	12	2	4	6	20[00]	22[00]
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	U	N	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	U	N	N
S	3	**SKIN INSPECTION** Pressure areas checked:	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	R	R	R	R	R	R	R	R	R	R	R
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	L	R	B	L	R	B	L	R	B	B	R
		Chair Assist to walk or stand (W/ST)				T	T	T	T	T	~~I~~	~~X~~	-
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	CATH	CATH	CATH	C	C	C	C	C	C	C	C
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	NG	NG	NG	N	N	N	N	N	U	N	N
		Drink taken?	—	—	—	Y	Y	Y	Y	Y	Y	Y	Y
		Food, snack, or supplement taken?	—	—	—	Y	Y	Y	Y	Y	Y	Y	N
		Has oral hygiene been carried out as per care plan?	N	N	N	Y	Y	Y	I	I	I	I	I
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	N/A	N/A	N/A	NT	NT	NT	NT	NT	NT	NT	NT
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	N/A	N/A	N/A	NA	NA	NA	NA	NA	NA	NA	NA
		Care provider / role	SW	SW	SW	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	SW	ST	ST

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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316.

[redacted]nds Checklist

Date: 15/12/20

Attach Addressograph Label
Henry Burgess

Ward: 24

NHS Greater Glasgow and Clyde

[redacted]ted and deemed that the frequency of care delivery over the next work shift, based on the patient's [redacted]l need should be every (please circle) 1hr **2hr** 3hr 4hr

1. Signed [redacted] Name N. Kimmett Designation SIN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

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

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

			Times	8	10	12	2	4	6	8	10	12
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	N	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	N	N
S	3	**SKIN INSPECTION** Pressure areas checked:	Y	Y	Y	Y	Y	Y	Y	N	N	N
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	R	R	R	R	RR	R	—	R	R	
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y	Y	Y	Y	Refused No	NO
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	L	B	L	R	L	B	B	B	B	B
		Chair Assist to walk or stand (W/ST)	T	T	T	T	T	T	ST	—	—	—
!	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	V	~~A~~ A	~~A~~ A	A	A	A	A	N	—	N
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N	N	N	N	N
		Drink taken?	Y	Y	Y	Y	Y	Y	Y	Y	N	N
		Food, snack, or supplement taken?	NT	NT	NT	NT	NT	NT	Y	N	N	N
		Has oral hygiene been carried out as per care plan?	I	—	—	—	—	—	NT	I	N	N
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	NT	NT	NT	NT	NT	NT	N	N
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA	NA	NA	NA	N	N
		Care provider / role	MK	dd	dd	dd	dd	dd	N	[redacted]	[redacted]	EN

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

Care Rounds Checklist

Date: 17/12/20

3/6

Attach Addressograph Label

B Henry Burgess

Ward: 24

NHS Greater Glasgow and Clyde

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

1. Signed [signature] Name N. Kinnaird Designation SN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

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

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

		Times	0003	04	08	10	12	14	16	18	21	23							
			05	10	30	0	00	00	00	00	00	00							
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	N	N							
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	N	N							
S	3	SKIN INSPECTION Pressure areas checked:	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y							
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	Int	Int	Int	Int	I	I	I	I	Int	Int							
K	4	KEEP MOVING Has the patient moved or walked?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y							
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	L	R	B/B	C	B	C	C	B	B	B							
		Chair Assist to walk or stand (W/ST)	—	—	—			S/B			NO								
I	5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	I	I	I	I	I	I	I	A	/							
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?	N	N	N	N	N	N	N	N	N	N							
		Drink taken?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y							
		Food, snack, or supplement taken?	N	N	N	N	Int	Int	Int	Int	Y	N							
		Has oral hygiene been carried out as per care plan?	I	I	I	I	I	I	I	I	I	I							
	7	ENVIRONMENT Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	X	Y Y	Y	Y	Y	Y	Y	Y Y							
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	NT	N T	Y	NT	NT	NT	NT	N T							
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA							
		Care provider / role	NK	NK	NK	PK	PK	PK	PK	PK	PK	PK							

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 18.9.20

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

1. Signed C Clarke Name C.CARLE Designation SN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach Addressograph Label

Henry Burgess

Ward: 24

NHS Greater Glasgow and Clyde

3/G

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

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

			Times	8:00	8:00	10:00	10:00	12:30													
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		N	N	N	N	N													
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.		N	N	N	N	N													
S	3	**SKIN INSPECTION** Pressure areas checked:		Y	N	Y	Y	Y													
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		Int	Int	I	I	I													
K	4	**KEEP MOVING** Has the patient moved or walked?		Y	Y	Y	Y	Y													
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		B	B	C	C	B													
		Chair Assist to walk or stand (W/ST)		W	/	W	W	W													
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		A	/	I	I	I													
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?		N	N	N	N	N													
		Drink taken?		Y	Y	Y	Y	Y													
		Food, snack, or supplement taken?		N	N	Y	Y	N													
		Has oral hygiene been carried out as per care plan?		I	I	I	I	I													
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		Y	Y	Y	Y	Y													
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.		NT	NT	NT	NT	NT													
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.		NA	NA	NA	NA	NA													
		Care provider / role		RN	RN	HCA	HCA	RN													

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 19.12.25

Attach Addressograph Label

Henry Burgess

Ward: 24

NHS Greater Glasgow and Clyde

3/6

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

1. Signed Sandra Inches Name SANDRA INCHES Designation SIN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

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

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

		Times	9:00	9:45	9:00	03:00	11:00	13:00	17:00	19:30	21:00	23:00
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N		N	N	N	N	N	N	N
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.	N	N		N	N	N	N	N	N	N
S	3	SKIN INSPECTION Pressure areas checked:	Y	Y		NT	/	NT	/	N	Y	Y
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	R/M	R/M			/		/	/	R	R
K	4	KEEP MOVING Has the patient moved or walked?	Y	Y		Y	Y	Y	Y	I	I	I
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	L	R		C	N	C	L	HB	/	/
		Chair Assist to walk or stand (W/ST)	T	T						/	/	/
I	5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	IC	IC		/	I	I	I	I	I	I
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?	N	N		N	N	N	N	N	N	N
		Drink taken?	Y	Y		Y	Y	Y	Y	Y	Y	Y
		Food, snack, or supplement taken?	N	N		Y	Y	Y	Y	Y	NT	/
		Has oral hygiene been carried out as per care plan?	I	I						NT	I	/
	7	ENVIRONMENT Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y Y	Y Y		Y	Y	Y	Y	Y	Y	Y
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.	N T	N T		N	N	N	N	NT	NT	NT
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.	NA	NA		Y	N	N	N	NA	NA	NA
		Care provider / role	RN	RN						CA	CA SN	CA SN

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 29/12/20

2208793218
BURGESS M
Henry 22/08/197
96A ALICE STREET
Paisley, Renfrewshire
PA2 6EA

36

NHS Greater Glasgow and Clyde

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

1. Signed CCarle Name CCARLE Designation SN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

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

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

		Times	0130	0330	0600	08	10	12	16	18	22
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	N
S	3	**SKIN INSPECTION** Pressure areas checked:	NT	NT	NT	NT	I	I	M	M	N
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	–	–	int						–
K	4	**KEEP MOVING** Has the patient moved or walked?	I	I	I	I	I	I	I	I	I
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	–	–	–	L	L	L	BC	B	R
		Chair Assist to walk or stand (W/ST)	–	–	–	C	C	BC			–
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	I	I	I	–	–	I	I	I
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N	N	N	N
		Drink taken?	Y	Y	Y	Y	Y	Y	Y	Y	Y
		Food, snack, or supplement taken?	NT	NT	NT	Y	Y	Y	Y	Y	N
		Has oral hygiene been carried out as per care plan?	–	–	–						I
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	NT	N	N	N	N	N	N
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	N					NA
		Care provider / role	SN	SN	SN						SN

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

ml • 278936 v2.1 • GGC0098

3/6

Care Rounds Checklist

Date: 21/12/20

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

1. Signed [signature] Name SHANELLE Designation CN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach Addressograph Label
Henry Burgess
Ward: 24

NHS Greater Glasgow and Clyde

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

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

			Times	00	04	08	12	16	20														
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		S	S	N	N	O	N														
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.		S	S	N	N	O	N														
S	3	**SKIN INSPECTION** Pressure areas checked:		N	N	NT	NT	O	NT														
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		—	—				—														
K	4	**KEEP MOVING** Has the patient moved or walked?		Y	Y	Y	Y	O	Y														
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		B	L	R	L	O	B														
		Chair Assist to walk or stand (W/ST)		—	—	W	W	O	W														
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		S	S	—	—	O	I														
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?		N	N	N	N	O	N														
		Drink taken?		S	S	Y	Y	O	Y														
		Food, snack, or supplement taken?		S	S	Y	Y	O	Y														
		Has oral hygiene been carried out as per care plan?		S	S	/	/	O	I														
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		Y	Y	Y	Y	O	Y														
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.		S	S	N	N	O	N														
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.		NA	NA	N	N		N														
		Care provider / role		[signature]																			

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 23.12.20

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

1. Signed [signature] Name N. Kimmett Designation SIN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach Addressograph Label

Henry Burgess

Ward: 24

NHS Greater Glasgow and Clyde

316

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

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

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

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

CONTINUED

Maintenance – When maintaining an inserted CVC and acc g the insertion site and line ensure that: CHI:

If the patient has a Haemodialysis catheter and outwith Renal service, do not use unless an emergency and contact the Renal on call team as soon as possible for advice.

1. The requirement for the CVC in situ is reviewed and recorded on a daily basis.
2. The CVC dressing is intact. (If not intact , the dressing must be changed)
3. The CVC dressing has been changed in the last 7 days.
4. Chlorhexidine gluconate 2% in 70% isopropyl alcohol is used for cleaning the insertion site during dressing changes.
5. Hand hygiene is performed immediately before accessing the site or line
6. An antiseptic containing Chlorhexidine gluconate 2% in 70% isopropyl alcohol is used to clean the access hub (needle free device) for at least 15 seconds [Scrub the Hub]. Allow to dry completely before accessing line.

Signs and symptoms of CVC infection

Local infection	Systemic infection
• Erythema / inflammation /exudate • Hot to touch • Pain tenderness	• Hypotension • Tachycardia • Pyrexia • Rigors when using the line

If lumen blocked: seek medical advice as soon as possible as this could potentiate complications.

Maintenance – To be completed daily (Observe for signs and symptoms of local or systemic infection) please record any variances in section below

Day & Date	Has the need for CVC been reviewed today?	Any sign of CVC infection?	The CVC dressing is intact?	Hand hygiene performed?	Exit site, line and hubs cleaned with 2% Chlorhexidine in 70% IPA	Aseptic non touch technique used?	CVC is locked/ flushed as per local guidelines	What has been done?	Date dressing due changed	Initials
Day 1 ~~28~~ 11.20	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day 2 ~~29~~ 11.20	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day 3 ~~30~~ 12.20	Yes ☐ No ☐	Yes ☐ No ☐ documented on careviewe	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day 4 1.12.20	Yes ☑ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Left in situ ☑ Removed ☐ Redressed ☐	5/12/20	RB
Day 5 2.12.20	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day 6 __/__/__	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day 7 __/__/__	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		

If CVC remains in situ for greater than 7 days - please use a continuation sheet to record daily maintenance

Variance recording:

Reason for removal	Exit site infection ☐	Bacteraemia ☐	Poor flow/ dysfunction ☐	Leak/bleed ☐	End of treatment ☐	Other:

If infection suspected, the catheter tip should be sent to Microbiology for culture & sensitivity

Write or
Name: M 2208793218 BURGESS
Address: 9 Henry 22/08/197

CHI:
DOB:
Hospital & Ward:

Adult Central Venous Cannula (CVC) Insertion & Maintenance – General wards*

NHS Greater Glasgow and Clyde

Please complete insertion details for each CVC inserted
Care & maintenance to be undertaken & documentation completed each day.
(If CVC in longer than 7 days please use a further CVC Insertion & maintenance document as continuation to evidence maintenance)
*critical care areas will have existing insertion & maintenance bundles in use

Insertion – When inserting a CVC ensure that:

1. Surgical scrub is performed before application of maximal sterile barrier precautions.
2. Sterile barrier precautions are used: hat, mask, sterile gown & sterile gloves (Operator & Assistant).
3. Sterile drape used to cover whole patient.
4. Aseptic technique maintained throughout insertion procedure.
5. Skin prepared by decontamination of the insertion site using 2% Chlorhexidine gluconate in 70% isopropyl alcohol and allowed to dry completely.
6. The Subclavian site is used if possible or internal jugular* vein. (The femoral site should be avoided whenever possible- if used record in variance section). [*IJ vein is the preferred site for CVC insertion by NHSGGC clinicians. This is in alignment with NHSGGC policy.]
7. A sterile, transparent semi-permeable dressing is used to cover the catheter site.

Good practice includes the documenting of the date & time of CVC insertion. This provides a baseline for ongoing catheter maintenance and to enable timely line removal when clinically no longer required.

CVC insertion details – please record any variances in section below

Where inserted: ED ☐ Theatre ☐ ITU/HDU ☑ Interventional Radiology ☐ Ward/other	Date/time inserted	Insertion site	☐ Emergency ☑ Elective	Inserted by (Name & Designation)
	28/11/20	LIJ	☑ Elective	C. McGovern

Clinical indication	IV Fluids/IV Medication ☑	Chemotherapy ☐	Urgent access ☐	Total Parenteral Nutrition ☐	Haemodialysis ☐	Other Please state:

Insertion Criteria (If no: please explain in variance section below)	1. Surgical scrub Yes ☑ No ☐	2. & 3. Maximal sterile barrier precautions Yes ☑ No ☐	4. Aseptic technique Yes ☑ No ☐	5. Skin prep Yes ☑ No ☐	6. Subclavian or IJ vein used Yes ☑ No ☐	7. Sterile transparent semi-permeable dressing affixed Yes ☑ No ☐

Type of CVC (Tunnelled/Non-tunnelled) please record	Real time Ultrasound Guidance Yes ☑ No ☐	If used: Guidewire removed & intact Yes ☑ No ☐ N/A ☐	Position tip confirmed by Chest X-ray (if applicable) Yes ☐ No ☐ N/A ☐
Needle free device placed on end port(s) (As per GGC protocol) Yes ☑ No ☐ N/A ☐			
Has there been more than one puncture attempt? Yes ☐ No ☑ If yes			

Info copied from carevue.

Variance recording:	

Not completed on insertion

Write or affix 2208793218
Name: BURGESS M
Address: Henry 22/08/1979

CHI:
DOB:
Hospital &

Adult Central Venous Cannula (CVC) Insertion & Maintenance – General wards*

NHS Greater Glasgow and Clyde

Please complete insertion details for each CVC inserted
Care & maintenance to be undertaken & documentation completed each day.
(If CVC in longer than 7 days please use a further CVC insertion & maintenance document as continuation to evidence maintenance)
*critical care areas will have existing insertion & maintenance bundles in use

Insertion – When inserting a CVC ensure that:

1. Surgical scrub is performed before application of maximal sterile barrier precautions.
2. Sterile barrier precautions are used: hat, mask, sterile gown & sterile gloves (Operator & Assistant).
3. Sterile drape used to cover whole patient.
4. Aseptic technique maintained throughout insertion procedure.
5. Skin prepared by decontamination of the insertion site using 2% Chlorhexidine gluconate in 70% isopropyl alcohol and allowed to dry completely.
6. The Subclavian site is used if possible or internal jugular* vein. (The femoral site should be avoided whenever possible- if used record in variance section). [*IJ vein is the preferred site for CVC insertion by NHSGGC clinicians. This is in alignment with NHSGGC policy.]
7. A sterile, transparent semi-permeable dressing is used to cover the catheter site.

Good practice includes the documenting of the date & time of CVC insertion. This provides a baseline for ongoing catheter maintenance and to enable timely line removal when clinically no longer required.

CVC insertion details – please record any variances in section below

Where inserted: ED ☐ Theatre ☐ ITU/HDU ☑ Interventional Radiology ☐ Ward/other			Date/time inserted 28/12/20	Insertion site LIJ	☐ Emergency ☐ Elective	Inserted by (Name & Designation)
Clinical indication	IV Fluids/IV Medication ☐	Chemotherapy ☐	Urgent access ☐	Total Parenteral Nutrition ☐	Haemodialysis ☐	Other Please state:
Insertion Criteria (If no: please explain in variance section below)	1.Surgical scrub Yes ☐ No ☐	2. & 3. Maximal sterile barrier precautions Yes ☐ No ☐	4. Aseptic technique Yes ☐ No ☐	5. Skin prep Yes ☐ No ☐	6.Subclavian or IJ vein used Yes ☐ No ☐	7. Sterile transparent semi-permeable dressing affixed Yes ☐ No ☐

Type of CVC (Tunnelled/Non-tunnelled) please record	Real time Ultrasound Guidance Yes ☐ No ☐	If used: Guidewire removed & intact Yes ☐ No ☐ N/A ☐	Position tip confirmed by Chest X-ray (if applicable) Yes ☐ No ☐ N/A ☐
Needle free device placed on end port(s) Yes ☐ No ☐ N/A ☐ (As per GGC protocol)			
Has there been more than one puncture attempt? Yes ☐ No ☐ If yes			
Variance recording:			

Maintenance – When maintaining an inserted CVC and accessing the insertion site and line ensure that: CHI:
If the patient has a Haemodialysis catheter and outwith Renal service, do not use unless an emergency and contact the Renal on call team as soon as possible for advice.

1. The requirement for the CVC in situ is reviewed and recorded on a daily basis.
2. The CVC dressing is intact. (If not intact , the dressing must be changed)
3. The CVC dressing has been changed in the last 7 days.
4. Chlorhexidine gluconate 2% in 70% isopropyl alcohol is used for cleaning the insertion site during dressing changes.
5. Hand hygiene is performed immediately before accessing the site or line
6. An antiseptic containing Chlorhexidine gluconate 2% in 70% isopropyl alcohol is used to clean the access hub (needle free device) for at least 15 seconds [Scrub the Hub]. Allow to dry completely before accessing line.

Signs and symptoms of CVC Infection

Local infection	Systemic infection
• Erythema / inflammation /exudate • Hot to touch • Pain tenderness	• Hypotension • Tachycardia • Pyrexia • Rigors when using the line

If lumen blocked: seek medical advice as soon as possible as this could potentiate complications.

Maintenance – To be completed daily (Observe for signs and symptoms of local or systemic infection)
please record any variances in section below

Day & Date	Has the need for CVC been reviewed today?	Any sign of CVC infection?	The CVC dressing is intact?	Hand hygiene performed?	Exit site, line and hubs cleaned with 2% Chlorhexidine in 70% IPA	Aseptic non touch technique used?	CVC is locked/ flushed as per local guidelines	What has been done?	Date dressing due changed	Initials
Day 1 __/__/__	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day 2 __/__/__	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day 3 __/__/__	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day 4 __/__/__	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day 5 __/__/__	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day ~~5~~ 3/12/20	Yes ☑ No ☐	Yes ☐ No ☑	Yes ☑ No ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Left in situ ☑ Removed ☐ Redressed ☐	4/12/20 pm	
Day ~~6~~ 4/12/20	Yes ☑ No ☐	Yes ☐ No ☑	Yes ☑ No ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Left in situ ☑ Removed ☐ Redressed ☐	Today ☐ pm	

If CVC remains in situ for greater than 7 days - please use a continuation sheet to record daily maintenance

Variance recording: 6/12/20

Reason for removal | Exit site infection ☐ | Bacteraemia ☐ | Poor flow/ dysfunction ☐ | Leak/bleed ☐ | End of treatment ☐ | Other: over 7 days

If infection suspected, the catheter tip should be sent to Microbiology for culture & sensitivity

2208793218
BURGESS
Henry
96A ALICE STREET
Paisley, Renfrewshire
PA2 6EA
M
22/08/1979

NHS Greater Glasgow and Clyde

Adult Central Venous Cannula (CVC)
Maintenance Bundle continuation sheet– General wards cont. . .
This document should be used in conjunction with an insertion & maintenance bundle for days 1 to 7
If the patient has a Haemodialysis catheter and outwith Renal service, do not use unless an emergency and contact the Renal on call team as s
When maintaining an inserted CVC and accessing the insertion site and line ensure that:

1. The requirement for the CVC in situ is reviewed and recorded on a daily basis.
2. The CVC dressing is intact. (If not intact , the dressing must be changed)
3. The CVC dressing has been changed in the last 7 days.
4. Chlorhexidine gluconate 2% in 70% isopropyl alcohol is used for cleaning the insertion site during dressing changes.
5. Hand hygiene is performed immediately before accessing the site or line
6. An antiseptic containing Chlorhexidine gluconate 2% in 70% isopropyl alcohol is used to clean the access hub (needle free device) for at least 15 seconds [Scrub the Hub]. Allow to dry completely before accessing line.

Signs and sy

Local infection	Systemic infection
• Erythema / inflammation /exudate • Hot to touch • Pain tenderness	• Hypotension • Tachycardia • Pyrexia • Rigors when using the line

If lumen blocked: seek medical advice as soon as possible as this could potentiate complications.

CHI:

Maintenance – To be completed daily (Observe for signs and symptoms of local or systemic infection)
please record any variances in section below

Day (8,9 etc.) & Date	Has the need for CVC been reviewed today?	Any sign of CVC infection?	The CVC dressing is intact?	Hand hygiene performed?	Exit site, line and hubs cleaned with 2% Chlorhexidine in 70% IPA	Aseptic non touch technique used?	CVC is locked/ flushed as per local guidelines	What has been done?	Date dressing due changed	Initials
Day 7 05/12/20	Yes ☑ No ☐	Yes ☐ No ☑	Yes ☑ No ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Left in situ ☑ Removed ☐ Redressed ☐	Today as required	HB
Day __/__/__	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day 7/12/20	Yes ☑ No ☐	Yes ☐ No ☑	Yes ☑ No ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Left in situ ☑ Removed ☐ Redressed ☐		SH
Day 8/12/20	Yes ☐ No ☐	Yes ☐ No ☑	Yes ☑ No ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Left in situ ☑ Removed ☐ Redressed ☐		SH
Day __/__/__	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day __/__/__	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day __/__/__	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day __/__/__	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		

Maintenance – To be completed daily (Observe for signs and symptoms of local or systemic infection) please record any variances in section below

CHI:

Day (16, 17 etc.) & Date	Has the need for CVC been reviewed today?	Any sign of CVC infection?	The CVC dressing is intact?	Hand hygiene performed?	Exit site, line and hubs cleaned with 2% Chlorhexidine in 70% IPA	Aseptic non touch technique used?	CVC is locked/ flushed as per local guidelines	What has been done?*	Date dressing due changed	Initials
Day __/__/____	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day __/__/____	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day __/__/____	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day __/__/____	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day __/__/____	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day __/__/____	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day __/__/____	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day __/__/____	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day __/__/____	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day __/__/____	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day __/__/____	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day __/__/____	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Variance recording:										
Reason for removal	Exit site infection ☐	Bacteraemia ☐	Poor flow/ dysfunction ☐	Leak/bleed ☐	End of treatment ☐	Other:				

If infection suspected, the catheter tip should be sent to Microbiology for culture & sensitivity

2208793218
BURGESS M
Henry 22/08/1979
96A ALICE STREET
Paisley, Renfrewshire
PA2 6EA

BIOPATCH® Protective Disk with CHG
QUERIES and SUPPORT: Stacey Amatt 07881 518 026 Samatt@its.jnj.com
Replace dressing after 7 days
CHG antimicrobial sponge dressing applied, replace every 7 days. Scan QR code for instructions.
Order stock of BioPatch 44150 from PECOS - NDC code 185160
NHS Greater Glasgow and Clyde

2206793218
BURGESS M
Henry 22/08/1975
96A ALICE STREET
Paisley, Renfrewshire
PA2 6EA

Adult Central Venous Cannula (CVC) Insertion & Maintenance – General wards*

Please complete insertion details for each CVC inserted
Care & maintenance to be undertaken & documentation completed each day.
(if CVC in longer than 7 days please use a further CVC Insertion & maintenance document as continuation to evidence maintenance)
*critical care areas will have existing insertion & maintenance bundles in use

[illegible] ensure that:

1. Surgical scrub is performed before application of maximal sterile barrier precautions.
2. Sterile barrier precautions are used: hat, mask, sterile gown & sterile gloves (Operator & Assistant).
3. Sterile drape used to cover whole patient.
4. Aseptic technique maintained throughout insertion procedure.
5. Skin prepared by decontamination of the insertion site using 2% Chlorhexidine gluconate in 70% isopropyl alcohol and allowed to dry completely.
6. The Subclavian site is used if possible or internal jugular* vein. (The femoral site should be avoided whenever possible- if used record in variance section). [*IJ vein is the preferred site for CVC insertion by NHSGGC clinicians. This is in alignment with NHSGGC policy.]
7. A sterile, transparent semi-permeable dressing is used to cover the catheter site.

Good practice includes the documenting of the date & time of CVC insertion. This provides a baseline for ongoing catheter maintenance and to enable timely line removal when clinically no longer required.

CVC insertion details – please record any variances in section below

Where inserted: ED ☐ Theatre ☐ ITU/HDU ☐ Interventional Radiology ☑ Ward/other_____			Date/time inserted 8/12/20	Insertion site RAH Left Arm	☐ Emergency ☐ ~~Elective~~	Inserted by (Name & Designation) Dr Mayan (con)
Clinical indication	IV Fluids/IV Medication ☐	Chemotherapy ☐	Urgent access ☐	Total Parenteral Nutrition ☐	Haemodialysis ☐	Other Please state:
Insertion Criteria (If no: please explain in variance section below)	1.Surgical scrub Yes ☑ No ☐	2. & 3. Maximal sterile barrier precautions Yes ☑ No ☐	4. Aseptic technique Yes ☑ No ☐	5. Skin prep Yes ☑ No ☐	6.Subclavian or IJ vein used Yes ☐ No ☐	7. Sterile transparent semi-permeable dressing affixed Yes ☑ No ☐

Type of CVC (Tunnelled/Non-tunnelled) please record 5fr Single Lumen	Real time Ultrasound Guidance Yes ☑ No ☐	If used: Guidewire removed & intact Yes ☐ No ☐ N/A ☐	Position tip confirmed by Chest X-ray (if applicable) Yes ☐ No ☐ N/A ☐
Needle free device placed on end port(s) Yes ☐ ~~No~~ ☐ N/A ☐ (As per GGC protocol)			
Has there been more than one puncture attempt? Yes ☐ No ☑ If yes			
Variance recording:			

Maintenance – When maintaining an inserted CVC and accessing the insertion site and line ensure that:
If the patient has a Haemodialysis catheter and outwith Renal service, do not use unless an emergency and contact the Renal on call team as soon as possible for advice.

CHI:

1. The requirement for the CVC in situ is reviewed and recorded on a daily basis.
2. The CVC dressing is intact. (If not intact, the dressing must be changed)
3. The CVC dressing has been changed in the last 7 days.
4. Chlorhexidine gluconate 2% in 70% isopropyl alcohol is used for cleaning the insertion site during dressing changes.
5. Hand hygiene is performed immediately before accessing the site or line
6. An antiseptic containing Chlorhexidine gluconate 2% in 70% isopropyl alcohol is used to clean the access hub (needle free device) for at least 15 seconds [Scrub the Hub]. Allow to dry completely before accessing line.

Signs and symptoms of CVC infection

Local infection	Systemic infection
• Erythema / inflammation /exudate • Hot to touch • Pain tenderness	• Hypotension • Tachycardia • Pyrexia • Rigors when using the line

If lumen blocked: seek medical advice as soon as possible as this could potentiate complications.

Maintenance – To be completed daily (Observe for signs and symptoms of local or systemic infection)
please record any variances in section below

Day & Date	Has the need for CVC been reviewed today?	Any sign of CVC infection?	The CVC dressing is intact?	Hand hygiene performed?	Exit site, line and hubs cleaned with 2% Chlorhexidine in 70% IPA	Aseptic non touch technique used?	CVC is locked/ flushed as per local guidelines	What has been done?	Date dressing due changed	Initials
Day 1 9/__/__	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day 2 10/__/__	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day 3 11/12/20	Yes ☑ No ☐	Yes ☐ No ☑	Yes ☑ No ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Left in situ ☑ Removed ☐ Redressed ☐		NR
Day 4 12/12/20	Yes ☑ No ☐	Yes ☐ No ☑	Yes ☑ No ☐	Yes ☑ No ☐ NA ☐	Yes ☐ No ☑ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Left in situ ☑ Removed ☐ Redressed ☐		MY
Day 5 13/12/20	Yes ☐ No ☐	Yes ☐ No ☑	Yes ☑ No ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☑ Removed ☐ Redressed ☐		MY
Day 6 14/12/20	Yes ☑ No ☐	Yes ☐ No ☑	Yes ☑ No ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☑ Removed ☐ Redressed ☐		
Day 7 __/__/__	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		

If CVC remains in situ for greater than 7 days - please use a continuation sheet to record daily maintenance

Variance recording:						
Reason for removal	Exit site infection ☐	Bacteraemia ☐	Poor flow/ dysfunction ☐	Leak/bleed ☐	End of treatment ☐	Other:

If infection suspected, the catheter tip should be sent to Microbiology for culture & sensitivity

Adult Central Venous Cannula (CVC)
Maintenance Bundle continuation sheet– General wards
This document should be used in conjunction with an insertion & maintenance bundle for days 1 to 7
If the patient has a Haemodialysis catheter and outwith Renal service, do not use unless an emergency and contact the Renal on call team as soon as possible for advice.
When maintaining an inserted CVC and accessing the insertion site and line ensure that:

NHS Greater Glasgow and Clyde

1. The requirement for the CVC in situ is reviewed and recorded on a daily basis.
2. The CVC dressing is intact. (If not intact , the dressing must be changed)
3. The CVC dressing has been changed in the last 7 days.
4. Chlorhexidine gluconate 2% in 70% isopropyl alcohol is used for cleaning the insertion site during dressing changes.
5. Hand hygiene is performed immediately before accessing the site or line
6. An antiseptic containing Chlorhexidine gluconate 2% in 70% isopropyl alcohol is used to clean the access hub (needle free device) for at least 15 seconds [Scrub the Hub]. Allow to dry completely before accessing line.

Signs and symptoms of CVC infection

Local infection	Systemic infection
• Erythema / inflammation /exudate • Hot to touch • Pain tenderness	• Hypotension • Tachycardia • Pyrexia • Rigors when using the line

If lumen blocked: seek medical advice as soon as possible as this could potentiate complications.

CHI:

Maintenance – To be completed daily (Observe for signs and symptoms of local or systemic infection)
please record any variances in section below

Day (8,9 etc.) & Date	Has the need for CVC been reviewed today?	Any sign of CVC infection?	The CVC dressing is intact?	Hand hygiene performed?	Exit site, line and hubs cleaned with 2% Chlorhexidine in 70% IPA	Aseptic non touch technique used?	CVC is locked/ flushed as per local guidelines	What has been done?	Date dressing due changed	Initials
Day 8 16/12/20	Yes ☑ No ☐	Yes ☐ No ☑	Yes ☑ No ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Left in situ ☑ Removed ☐ Redressed ☐		AA
Day 17/12/20	Yes ☑ No ☐	Yes ☐ No ☑	Yes ☑ No ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day 18/12/20	Yes ☑ No ☐	Yes ☐ No ☑	Yes ☑ No ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Left in situ ☑ Removed ☐ Redressed ☐		CC SC
Day 19/12/20	Yes ☑ No ☐	Yes ☐ No ☑	Yes ☑ No ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Left in situ ☑ Removed ☐ Redressed ☐		CC
Day __/__/__	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day __/__/__	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day 22/12/20	Yes ☑ No ☐	Yes ☐ No ☑	Yes ☑ No ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Yes ☑ No ☐ NA ☐	Left in situ ☑ Removed ☐ Redressed ☐	23/12	
Day __/__/__	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		

Maintenance – To be completed daily (Observe for signs and symptoms of local or systemic infection) please record any variances in section below | **CHI:**

Day (16, 17 etc.) & Date	Has the need for CVC been reviewed today?	Any sign of CVC infection?	The CVC dressing is intact?	Hand hygiene performed?	Exit site, line and hubs cleaned with 2% Chlorhexidine in 70% IPA	Aseptic non touch technique used?	CVC is locked/ flushed as per local guidelines	What has been done?	Date dressing due changed	Initials
Day __/__/____	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day __/__/____	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day __/__/____	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day __/__/____	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day __/__/____	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day __/__/____	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day __/__/____	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day __/__/____	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day __/__/____	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day __/__/____	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day __/__/____	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		
Day __/__/____	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Yes ☐ No ☐ NA ☐	Left in situ ☐ Removed ☐ Redressed ☐		

Variance recording:						
Reason for removal	Exit site infection ☐	Bacteraemia ☐	Poor flow/ dysfunction ☐	Leak/bleed ☐	End of treatment ☐	Other:

If infection suspected, the catheter tip should be sent to Microbiology for culture & sensitivity

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Affix Patient ID

2208793218
BURGESS
Henry
96A ALICE STREET
Paisley, Renfrewshire
PA2 6EA
M
22/08/1975

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

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

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

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

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed.....

Medical: .....

Date: .....

| | | |

NEWS 2 Key | 1 | 2 | 3

given Ventolin
L
Return CT

| | | |

Glasgow Coma Scale

| | | |

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

2208793218 N
BURGESS 22/08/197
Henry
96A ALICE STREET
Paisley, Renfrewshire PA2 6EA

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

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

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

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

Document all actions and interventions

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

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

Discontinuation of NEWS
Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations
Signed.....
Medical: .....
Date: .....

		41-50	1
		31-40	3
		≤30	3

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

E Temperature		≥39	2
		38.1-39.0	1
		37.1-38.0	0
	●	36.1-37.0	0
		35.1-36.0	1
		≤35.0	3

NEWS Total	0

Blood glucose	7.0
Pain / function score	OA
Time Pt last passed urine	10.20
Fluid balance chart indicated Y/N	N
GCS indicated Y/N	N
Time NEWS due	23.00
Escalation of care Y/N	N
Initials	AB

Affix Patient ID

ELEVATED NEWS2 ≥ 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

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

Think ACE

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

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

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

NEWS 2 Key | 1 | 2 | 3

Date	1/11	
Time	11.00	

Affix Patient ID

A + B Respirations Breaths/min	●	≥25 = 3; 21-24 = 2; 12-20 = 0; 9-11 = 1; ≤8 = 3
A + B SpO2 Scale 1 Oxygen saturation (%)	97	≥96 = 0; 94-95 = 1; 92-93 = 2; ≤91 = 3
SpO2 Scale 2 Oxygen saturation (%) Use Scale 2 if target range is 88-92% e.g. in chronic hypercapnic respiratory failure. Only use scale 2 under direction of qualified clinician		≥97 on O2 = 3; 95-96% on O2 = 2; 93-94% on O2 = 1; ≥93 on air = 0; 88-92 = 0; 86-87 = 1; 84-85 = 2; ≤83 = 3
Air or oxygen?	A	Air (A) or O2 device* = 0; O2 L/min 2 = 2
C Blood Pressure mmHg (Score uses systolic BP only)	↑ ↓	≥220 = 3; 201-219 = 0; 181-200 = 0; 161-180 = 0; 141-160 = 0; 121-140 = 0; 111-120 = 0; 101-110 = 1; 91-100 = 2; 81-90 = 3; 71-80 = 3; 61-70 = 3; 51-60 = 3; ≤50 = 3
C Pulse Beats / min	●	≥131 = 3; 121-130 = 2; 111-120 = 2; 101-110 = 1; 91-100 = 1; 81-90 = 0; 71-80 = 0; 61-70 = 0; 51-60 = 0

Abbreviations for recording oxygen device

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

Glasgow Coma Scale

| | | |

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

2208793218
BURGESS M
Henry 22/08/1979
98A ALICE STREET
Paisley, Renfrewshire
PA2 6EA

	Date	Ward	Time
Admitted	3/12/20	HOU	
Transferred			
Transferred			
Transferred			
Transferred			

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

Document all actions and interventions

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

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

Discontinuation of NEWS

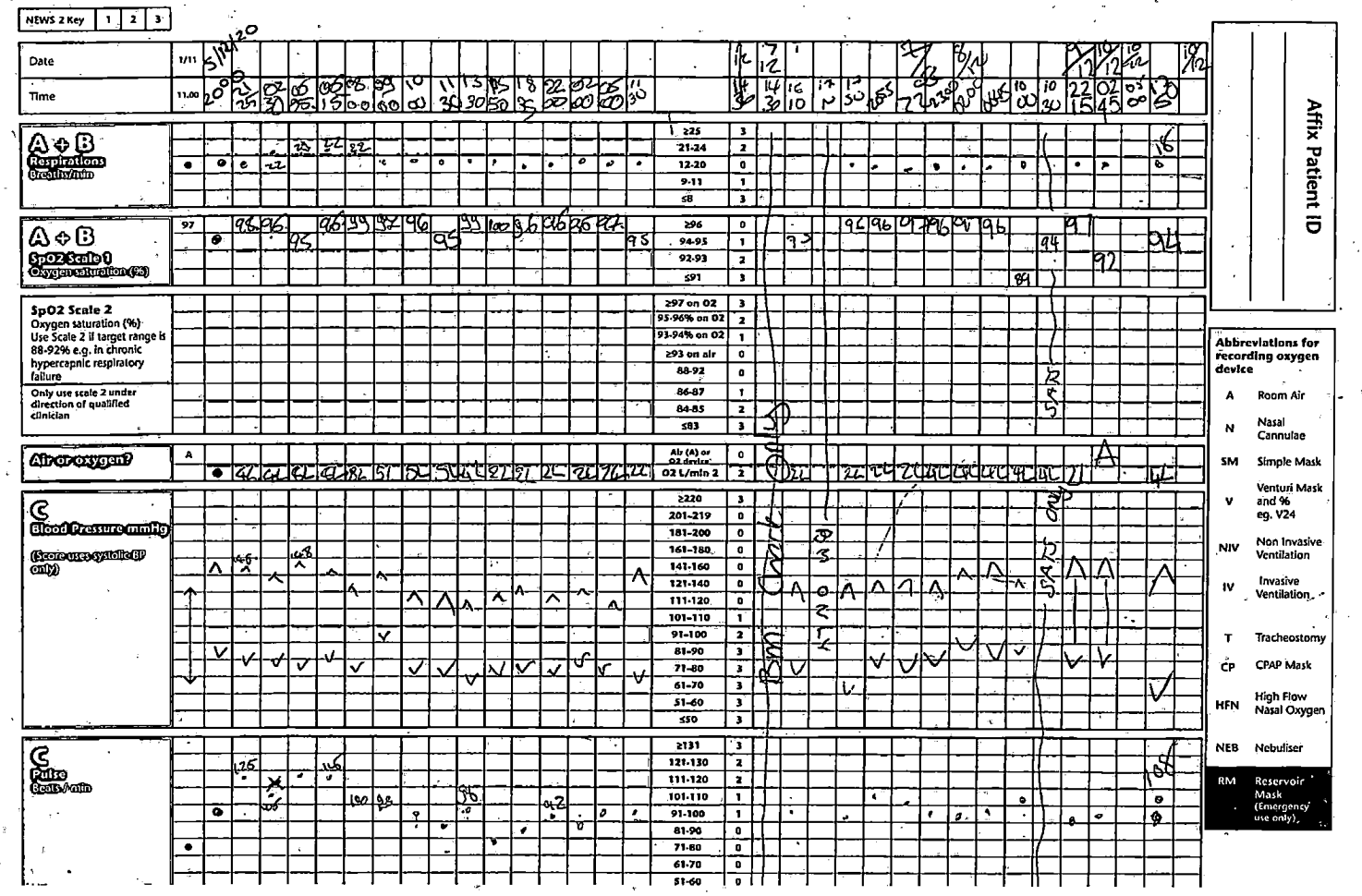
Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed.....

Medical: .....

Date: .....

| | | |


NEWS 2 Key 1 2 3
Date
Time
A ⇕ B
Respirations
Breaths/min
A ⇕ B
SpO2 Scale 1
Oxygen saturation (%)
SpO2 Scale 2
Oxygen saturation (%)
Use Scale 2 if target range is 88-92% e.g. in chronic hypercapnic respiratory failure
Only use scale 2 under direction of qualified clinician
Air or oxygen?
C
Blood Pressure mmHg
(Score uses systolic BP only)
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Pulse
Beats/min
Affix Patient ID
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Glasgow Coma Scale

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NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

2208793218	
BURGESS	M
Henry	22/08/1979

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

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

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

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

Document all actions and interventions

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

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

Discontinuation of NEWS
Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations
Signed.....
Medical: .....
Date: .....

Affix Patient ID

| | | |

NEWS 2 Key | 1 | 2 | 3

Affix Patient ID

| | | |

Glasgow Coma Scale

| | | |

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

2208793218 M
BURGESS 22/08/1979
Henry
96A ALICE STREET PA2 6EA
Paisley, Renfrewshire

	Date	Ward	Time
Admitted		24	
Transferred			
Transferred			
Transferred			
Transferred			

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

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

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

Sats target 92%
FM2
21/12/20

Document all actions and interventions

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

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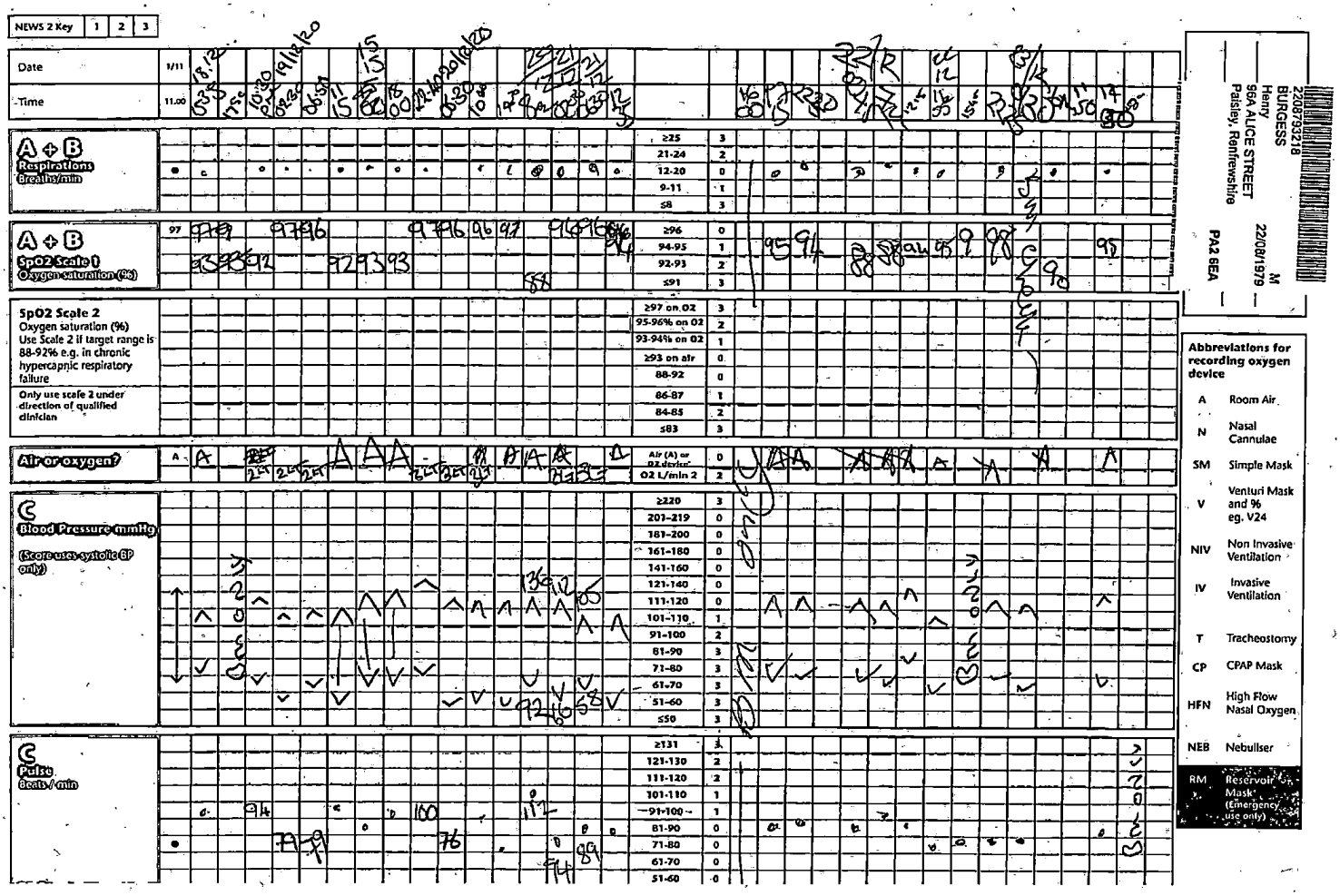
Signed.....

Medical: .....

Date: .....

| | | |



2208793218
BURGESS
Henry
96A ALICE STREET
Paisley, Renfrewshire
PA2 6EA
M
22/08/1979

Glasgow Coma Scale

| | | |

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Affix Patient ID
Henry Burgess

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

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

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

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

Document all actions and interventions

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

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

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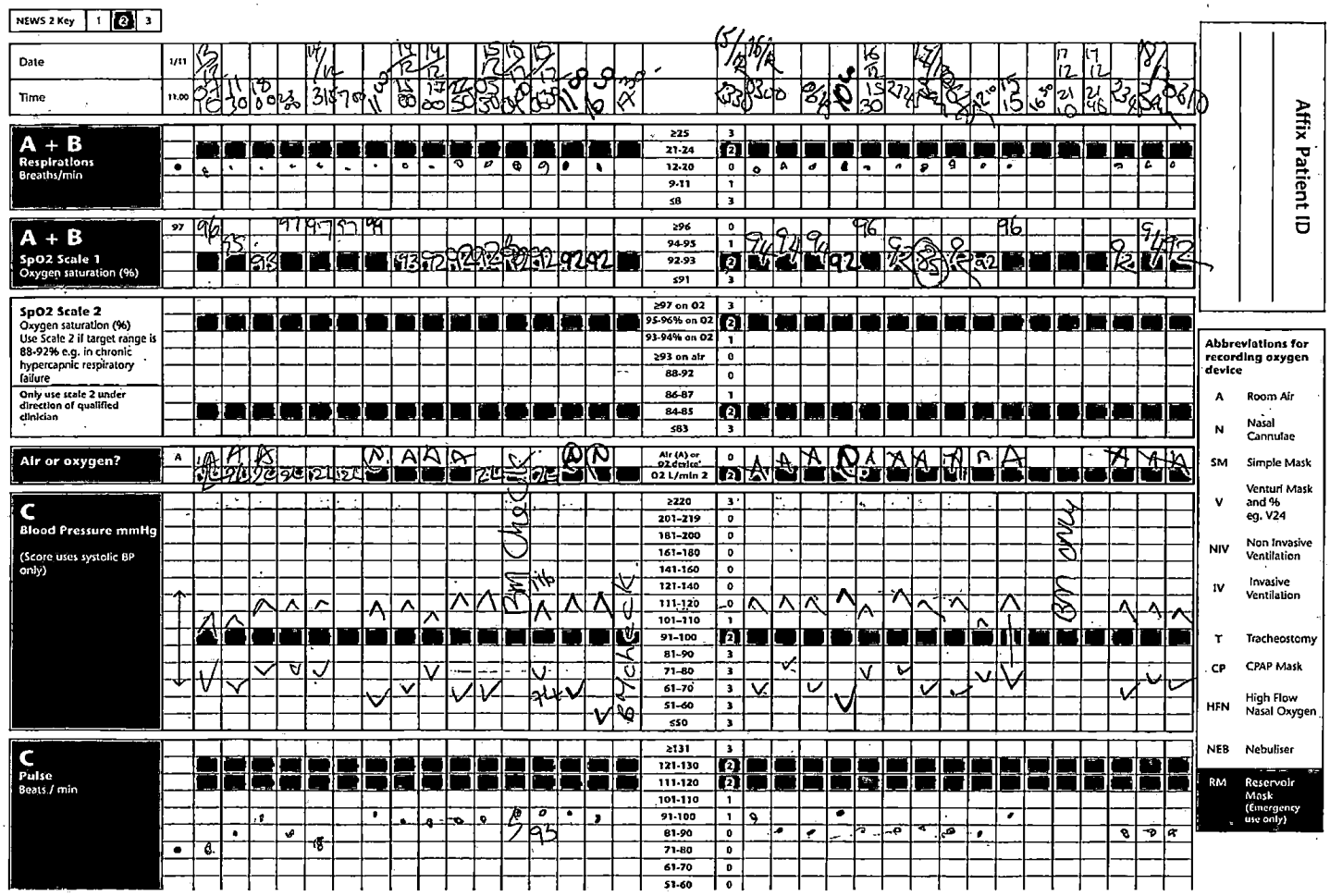
Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed .....

Medical: .....

Date: .....

| | | |


NEWS 2 Key 1 2 3
Date
Time
A + B
Respirations
Breaths/min
A + B
SpO2 Scale 1
Oxygen saturation (%)
SpO2 Scale 2
Oxygen saturation (%)
Use Scale 2 if target range is 88-92% e.g. in chronic hypercapnic respiratory failure
Only use scale 2 under direction of qualified clinician
Air or oxygen?
C
Blood Pressure mmHg
(Score uses systolic BP only)
C
Pulse
Beats / min
Affix Patient ID
Abbreviations for recording oxygen device
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N Nasal Cannulae
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V Venturi Mask and % eg. V24
NIV Non Invasive Ventilation
IV Invasive Ventilation
T Tracheostomy
CP CPAP Mask
HFN High Flow Nasal Oxygen
NEB Nebuliser
RM Reservoir Mask (Emergency use only)

Glasgow Coma Scale

| | | |

Nasogastric Feeding Tube Care Plan

Nasogastric tube placement bedside checklist

NHS Greater Glasgow and Clyde

This bedside checklist should be completed for all patients requiring nasogastric tube placement, on insertion and on all subsequent insertions, before administration of artificial nutrition/hydration or medication via the nasogastric tube.

Patient Name:

NHS Number / Hospital Number:

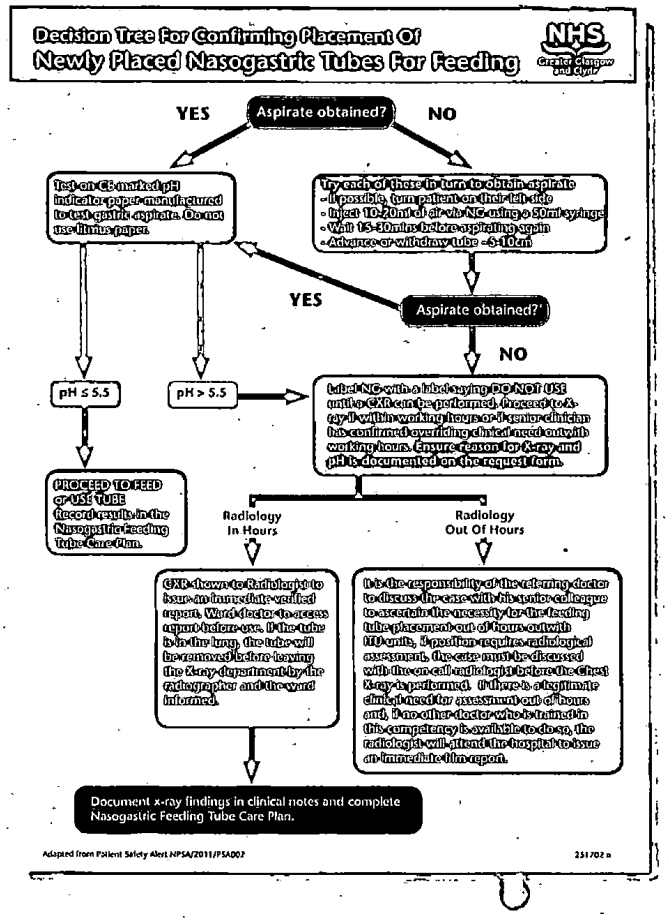
DOB:

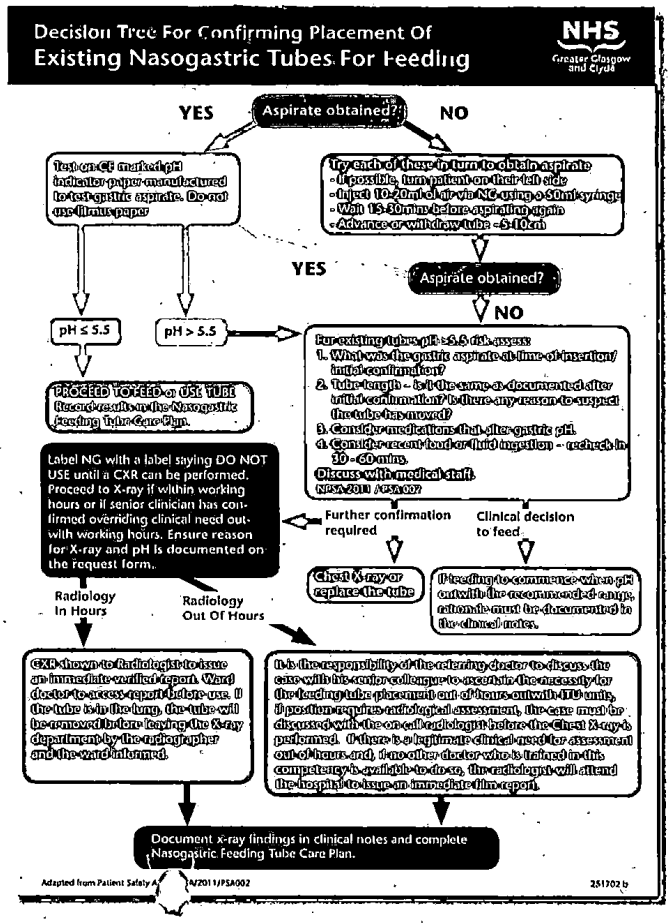
Ward:

2208793218
BURGESS M
Henry 22/08/1979
96A ALICE STREET
Paisley, Renfrewshire PA2 6EA

Nasogastric tube insertion / reinsertion / X-ray confirmation of position

Consent Obtained	Date & time of • insertion • reinsertion • X-ray confirmation of position	Tube make/ size	NEX measurement	External cm marking at the nostril	Nostril used on insertion / reinsertion L / R	Aspirate obtain Y/N	Ph of aspirate (if obtained)	X-ray required Y/N	Inserted by:	Date & time of X-ray interpretation	Is this the most current X-ray Y / N	Is the X-ray for the correct patient Y/ N	X-ray results e.g. *"NG has passed down midline past level of diaphragm and deviates to left. It is safe to feed via the NGT"*	X - ray interpreted by / Designation:
Yes ☐ No ☐ Verbal ☐ AWI ☐ POA ☐														
Yes ☐ No ☐ Verbal ☐ AWI ☐ POA ☐														
Yes ☐ No ☐ Verbal ☐ AWI ☐ POA ☐														
Yes ☐ No ☐ Verbal ☐ AWI ☐ POA ☐														
Yes ☐ No ☐ Verbal ☐ AWI ☐ POA ☐														
Yes ☐ No ☐ Verbal ☐ AWI ☐ POA ☐														
Yes ☐ No ☐ Verbal ☐ AWI ☐ POA ☐														
Yes ☐ No ☐ Verbal ☐ AWI ☐ POA ☐														
Yes ☐ No ☐ Verbal ☐ AWI ☐ POA ☐														


Decision Tree For Confirming Placement Of
Newly Placed Nasogastric Tubes For Feeding
NHS
Greater Glasgow and Clyde
Aspirate obtained?
YES
NO
Test on CE marked pH indicator paper manufactured to test gastric aspirate. Do not use litmus paper.
Try each of these in turn to obtain aspirate
- If possible, turn patient on their left side
- Inject 10-20ml of air via NG using a 50ml syringe
- Wait 15-30mins before aspirating again
- Advance or withdraw tube ~5-10cm
Aspirate obtained?
YES
NO
pH ≤ 5.5
pH > 5.5
PROCEED TO FEED or USE TUBE
Record results in the Nasogastric Feeding Tube Care Plan.
Label NG with a label saying DO NOT USE until a CXR can be performed. Proceed to X-ray if within working hours or if senior clinician has confirmed overriding clinical need out with working hours. Ensure reason for X-ray and pH is documented on the request form.
Radiology In Hours
Radiology Out Of Hours
CXR shown to Radiologist to issue an immediate verified report. Ward doctor to access report before use. If the tube is in the lung, the tube will be removed before leaving the X-ray department by the radiographer and the ward informed.
It is the responsibility of the referring doctor to discuss the case with his senior colleague to ascertain the necessity for the feeding tube placement out of hours out with ITU units. If position requires radiological assessment, the case must be discussed with the on call radiologist before the Chest X-ray is performed. If there is a legitimate clinical need for assessment out of hours and, if no other doctor who is trained in this competency is available to do so, the radiologist will attend the hospital to issue an immediate film report.
Document x-ray findings in clinical notes and complete Nasogastric Feeding Tube Care Plan.
Adapted from Patient Safety Alert NPSA/2011/PSA002
251702 a


Decision Tree For Confirming Placement Of
Existing Nasogastric Tubes For Feeding
NHS
Greater Glasgow and Clyde
Aspirate obtained?
YES
NO
Test on CE marked pH indicator paper manufactured to test gastric aspirate. Do not use litmus paper
Try each of these in turn to obtain aspirate
- If possible, turn patient on their left side
- Inject 10-20ml of air via NG using a 50ml syringe
- Wait 15-30mins before aspirating again
- Advance or withdraw tube ~5-10cm
Aspirate obtained?
YES
NO
pH ≤ 5.5
pH > 5.5
PROCEED TO FEED or USE TUBE
Record results in the Nasogastric Feeding Tube Care Plan.
For existing tubes, pH ≤ 5.5 do not assess
1. What was the gastric aspirate at time of insertion/ initial confirmation?
2. Tube length – is it the same as documented after initial confirmation? Is there any reason to suspect the tube has moved?
3. Consider medications that alter gastric pH.
4. Consider recent food or fluid ingestion – recheck in 30 - 60 mins.
Discuss with medical staff.
NPSA 2011 / PSA 002
Label NG with a label saying DO NOT USE until a CXR can be performed. Proceed to X-ray if within working hours or if senior clinician has confirmed overriding clinical need out-with working hours. Ensure reason for X-ray and pH is documented on the request form.
Further confirmation required
Clinical decision to feed
Chest X-ray or replace the tube
If feeding to commence when pH out with the recommended range, rationale must be documented in the clinical notes.
Radiology In Hours
Radiology Out Of Hours
CXR shown to Radiologist to issue an immediate verified report. Ward doctor to access report before use. If the tube is in the lung, the tube will be removed before leaving the X-ray department by the radiographer and the ward informed.
It is the responsibility of the referring doctor to discuss the case with his senior colleague to ascertain the necessity for the feeding tube placement out of hours out with ITU units. If position requires radiological assessment, the case must be discussed with the on call radiologist before the Chest X-ray is performed. If there is a legitimate clinical need for assessment out of hours and, if no other doctor who is trained in this competency is available to do so, the radiologist will attend the hospital to issue an immediate film report.
Document x-ray findings in clinical notes and complete Nasogastric Feeding Tube Care Plan.
Adapted from Patient Safety A /2011/PSA002
251702 b

Nasogastric tube position confirmation record

NHS Greater Glasgow and Clyde

The position of the nasogastric tube should be checked:

- Following initial insertion (please use placement checklist to record this).
- Before administering each feed.
- Before giving medications.
- Any new or unexplained respiratory symptoms or if oxygen saturations decrease.
- At least once daily during continuous feeds.
- Following episodes of vomiting, retching or coughing spasms.
- When there is suggestion of tube displacement.

Date	Time	pH	External cm marking at the nostril	Checked by / designation
3/12/20	20:00	Continuous feed	72cms	Mcguire S/N
4/12/20	0800	continuous feed	72cm	U.H SN
4.12.20	1800	4.5	73cm	MCLARK S/N
04/12/2020	2000	continuous feed	73cm	HBAKER S/N
05/12/20	1800	4.5	73cm	MCLARK S/N
8/12/20	21.30	4.5	73cm	[illegible] S/N
~~9/12/20~~	~~18.0~~			~~[illegible]~~
10/12/20	1900	4.5	73cm.	OK [illegible]
11/12/20	1800	4.5	73 cm	NAD
12/12/20	1830	5.5	73cms	M H N
14/12/20	1880	5.5	73cm	[illegible]
15/12/20	1830	5.5	73cm	[illegible]
16/12/20	18.15	4.5	73 cm	[illegible]
17/12/20	18.35	5.5.	73cm	[illegible]

If any new or unexplained respiratory symptoms, stop feed immediately and contact medical team.

Date	Time	pH	External cm marking at the nostril	Checked by / designation

Enteral Feeding Regimen

NHS Greater Glasgow and Clyde

Name: ....
Address:..
.....
DoB:.....
Chi numb

2208793218
BURGESS M
Henry 22/08/197
96A ALICE STREET
Paisley, Renfrewshire
PA2 6EA

- Before enteral nutrition is commenced it should be confirmed with medical staff that this is an appropriate treatment plan, the route is patent and nutritional bloods have been checked.
- Stated below is the recommended regimen to meet patients nutritional requirements please see instructions overleaf if this has to be introduced in a step wise process, following an approved starter regimen or dietetic assessment.

Recommended Regimen
based on (please tick box)

☐ Established feeding regimen commenced in previous care setting or from home reported by
Name: _____ Designation: _____ on date ___/___/___

☑ Nutritional assessment by dietitian
Name: Rachel Knowles on date 14 / 12 / 2020

Route (please circle) Nasogastric/Orogastric/Nasojejunal/Stomagastric/Gastrostomy/Jejunostomy/Other

Comments: * Provides 78g Carbohydrates *

Type/Name of feed:	Volume (ml) per 24 hours	Rate ml/hr or Bolus	No. of hours to run	Comments: (if in depth instructions required to administer regimen they should be documented in the Nursing/ Clinical Evaluation Notes)
~~Peptamen 1cal~~ EK				
Peptamen HN Trial Stopping 15/12/20.	500ml	41ml/hr	x 12hrs overnight (7pm-7am)	* TO Commence 15/12/2020 PM *
Water:				

This regimen provides 665 Kcal 33 g Protein 20 mmol Na 23 mmol K _____ ml Fluid

Please tick box: ☐ Feed is sole source of nutrition e.g. patient NBM ☑ Feed is in addition to oral intake as tolerated / parenteral nutrition

The person completing this regimen should sign below (NB. any health care professional, dietitian, doctor, nurse can document an enteral feeding regimen)

Print name and sign: Rachel Knowles Designation: Dietitian Date/Time: 14/12/20

- Enteral feeding regimen must be used in conjunction with the NHSGGC Nutrition Resource Manual
- Gastric aspirate pH (naso/oro/stomogastric only) should be tested and recorded prior to feed being commenced.
- The tube should be flushed with sterile water prior to commencing feed or medication and between individual medications.
- A new giving set should be used every 24hours and any feed that has been hanging for 24 hours should be discarded.
- For steps to achieve recommended regimen using an approved starter regimen (refer to local protocol) or a graduated introduction regimen (advised by the dietitian) see over leaf.
- All patients on enteral feeding should be referred to the dietitian for assessment.

For further advice please contact the Dietitian ext _____ page _____ or Nutrition Nurse Specialist / Nutrition Team _____

If patient is receiving 'recommended regimen' (see overleaf) this area of this chart is not required and a score should be put through it.

Steps to achieve recommended regimen (see overleaf)

To be completed by Nursing Staff / Medical Staff following an approved starter regimen or Dietitian following assessment.

Date regimen to commence	Type / Name	Volume in 24hrs (record on fluid balance chart once administered)	Rate ml/hr (or bolus)	No. of hrs feed to administered	Route e.g. NG	**Comments** (If in depth instructions required to administer regimen they should be documented in the Nursing/ Clinical Evaluation Notes)	**Feed discontinued** please sign and date by whom and give rationale
Day 1 ___/___/___	Feed:						
	Water:						
Recommended by (Print name and sign):		Designation:		Date/Time:			
Day 2 ___/___/___	Feed:						
	Water:						
Recommended by (Print name and sign):		Designation:		Date/Time:			
Day 3 ___/___/___	Feed:						
	Water:						
Recommended by (Print name and sign):		Designation:		Date/Time:			
Day 4 ___/___/___	Feed:						
	Water:						
Recommended by (Print name and sign):		Desi		Date/Time:			

ENTERAL FEEDING RECORD

NHS Greater Glasgow and Clyde

All patients receiving enteral feeding must have a fluid balance chart.

All feed and water administered via the feeding tube should be recorded on the 'enteral' section of the Fluid Balance Chart to enable accurate calculation of fluids and nutrition provided in 24 hour period. The volume of feed documented on the fluid balance chart should be the actual amount received by the patient.

If patient does not receive recommended volume of feed to be administered please document why in the comments box. All fields on the Enteral Feeding Record must be completed.

Date started	Time started	Type/name of feed	Volume (ml) to be administered	Rate (ml/hr)	Pack Size	Lot No.	Expiry Date	Sign & print	Comments
15/12/20	1830	Peptamen HN	500ml	41ml/hr	1000ml	006527	01/21		
16/12/20	18.15	Peptamen	500ml	41 ml/hr	1000ml	0914428 2200	08/01 21		
17/12/20	18:35	peptamen	500ml	41ml/hr	1000ml	08012021 0914428200	08/01/ 21		

All fields on the Enteral Feeding Record must be completed.

Date started	Time started	Type/name of feed	Volume (ml) to be administered	Rate (ml/hr)	Pack Size	Lot No.	Expiry Date	Sign & print	Comments

ENTERAL FEEDING RECORD

NHS Greater Glasgow and Clyde

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All fields on the Enteral Feeding Record must be completed.

Date started	Time started	Type/name of feed	Volume (ml) to be administered	Rate (ml/hr)	Pack Size	Lot No.	Expiry Date	Sign & print	Comments
4/12/20	1800	PEPTAMEN HN	1000mL	83mls	1000mls	00144282 00	08/01/21	MCLAEK	c/o 1800 @ 83ml/hr
5/12/20	1810	PEPTAMEN HN	1000mL	83mls	1000mls			MCLAEK	
6/12/20	2030	Peptamen HN.	1000mls	83mls	1000mls	00144282 00	05/01/21	B.Flood.	
7/12/20	19.00	Peptamen HN	1000ml	83 mls	1000ml	00144282 00	8/1/20	Upclose	
8/12/20	19.40	Peptamen HN	1000ml	83mls/hr	1000ml	00144282 00	8/1/21	[illegible]	
10/12/20	1900	Peptamen HN	1000mls	83mls	1000mls	-	8/1/21	[illegible]	
11/12/20		Peptamen HN	1000 mls	83mls	1000mls	00144282 00	8/1/21	N-R	
12/12/20	1830	Peptamen HN	1000 mls	83 mls	1000 mls	00144282 00	8/1/21	MH	
13/12/20		Peptamen HN	1000 mls	83mls	1000 mls	00144282 00		MH	
14/12	1830	Peptamen HN	1000ml	83ml	1000ml	00144282 00	8/21	[illegible]	

All fields on the Enteral Feeding Record must be completed.

Date started	Time started	Type/name of feed	Volume (ml) to be administered	Rate (ml/hr)	Pack Size	Lot No.	Expiry Date	Sign & print	Comments

If patient is receiving 'recommended regimen' (see overleaf) this area of this chart is not required and a score should be put through it.

Steps to achieve recommended regimen (see overleaf)

To be completed by Nursing Staff / Medical Staff following an approved starter regimen or Dietitian following assessment.

Date regimen to commence	Type / Name	Volume in 24hrs (record on fluid balance chart once administered)	Rate ml/hr (or bolus)	No. of hrs feed to administered	Route e.g. NG	**Comments** (If in depth instructions required to administer regimen they should be documented in the Nursing/ Clinical Evaluation Notes)	**Feed discontinued** please sign and date by whom and give rationale
Day 1 ___/___/___	Feed:						
	Water:						
Recommended by (Print name and sign):		Designation:		Date/Time:			
Day 2 ___/___/___	Feed:						
	Water:						
Recommended by (Print name and sign):		Designation:		Date/Time:			
Day 3 ___/___/___	Feed:						
	Water:						
Recommended by (Print name and sign):		Designation:		Date/Time:			
Day 4 ___/___/___	Feed:						
	Water:						
Recommended by (Print name and sign):		Des[redacted]		Date/Time:			

Enteral Feeding Regimen

NHS Greater Glasgow and Clyde

Nam 2208793218
Addr BURGESS M
Henry 22/08/1979
36A ALICE STREET
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- Before enteral nutrition is commenced it should be confirmed with medical staff that this is an appropriate treatment plan, the route is patent and nutritional bloods have been checked.
- Stated below is the recommended regimen to meet patients nutritional requirements please see instructions overleaf if this has to be introduced in a step wise process, following an approved starter regimen or dietetic assessment.

Recommended Regimen

based on (please tick box)

☐ Established feeding regimen commenced in previous care setting or from home reported by
Name: _____ Designation: _____ on date ___/___/___

☑ Nutritional assessment by dietitian
Name: Jenny Gregg on date 04 / 12 / 20.

Route (please circle): Nasogastric/Orogastric/Nasojejunal/Stomagastric/Gastrostomy/Jejunostomy/Other

Comments:

Type/Name of feed:	Volume (ml) per 24 hours	Rate ml/hr or Bolus	No. of hours to run	Comments: (if in depth instructions required to administer regimen they should be documented in the Nursing/ Clinical Evaluation Notes)
Peptamen HN	1000	83	12 hrs	6pm → 6am.
Water: 50ml pre + post feed + meds.				

This regimen provides 1300 Kcal 66 g Protein _____ mmol Na _____ mmol K _____ ml Fluid

Please tick box: ☐ Feed is sole source of nutrition e.g. patient NBM ☑ Feed is in addition to oral intake as tolerated ~~/ parenteral nutrition~~

The person completing this regimen should sign below (NB. any health care professional, dietitian, doctor, nurse can document an enteral feeding regimen)

Print name and sign: Jenny Gregg J.GREGG Designation: Dietitian Date/Time: 04/12/20

- Enteral feeding regimen must be used in conjunction with the NHSGGC Nutrition Resource Manual
- Gastric aspirate pH (naso/oro/stomogastric only) should be tested and recorded prior to feed being commenced.
- The tube should be flushed with sterile water prior to commencing feed or medication and between individual medications.
- A new giving set should be used every 24hours and any feed that has been hanging for 24 hours should be discarded.
- For steps to achieve recommended regimen using an approved starter regimen (refer to local protocol) or a graduated introduction regimen (advised by the dietitian) see over leaf.
- All patients on enteral feeding should be referred to the dietitian for assessment.

Peptamen Contains 160g CHO!
Ensure compact 36g CHO per bottle.

For further advice please contact the Dietitian ext 06808 page 56381 or Nutrition Nurse Specialist / Nutrition Team

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

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

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

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NHS Greater Glasgow and Clyde

4AT	Ward HIU Date & Time 3/12/20 20:30	Ward 24 Date & Time 10/12/20 1825	Ward 24 Date & Time 14/12	Ward ____ Date & Time	Ward ____ Date & Time
(1) Alertness This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep attempt to wake with speech or gentle touch on shoulder. **Ask the patient to state their name and address to assist rating**					
Normal (fully alert, but not agitated, throughout the assessment)	(0)	(0)	(0)	0	0
Mild sleepiness for <10 seconds after waking, then normal	0	0	0	0	0
Clearly abnormal	4	4	4	4	4
(2) AMT4 Ask the patient their **Age, Date of Birth, Place** (name of hospital) **Current Year**					
No mistakes	(0)	(0)	(0)	0	0
1 mistake	1	1	1	1	1
2 or more mistakes	2	2	2	2	2
(3) Attention Ask the patient **"Please tell me the months of the year in backward order, starting at December".** To assist, one prompt of **"What is the month before December"** is permitted.					
Achieves 7 months or more correctly	(0)	(0)	(0)	0	0
Starts but scores < 7 months or refuses to start	1	1	1	1	1
Untestable (cannot participate because too drowsy or inattentive)	2	2	2	2	2
(4) Acute change or fluctuating course Evidence of significant change of fluctuation in: alertness, cognition, other mental function (e.g. hallucinations, paranoia) over the past 2 weeks and still present in preceding 24 hrs.					
No	(0)	(0)	(0)	0	0
Yes	4	4	4	4	4
4AT TOTAL SCORE	0	0	0		
Print initials of assessor	PM	MM	AL		

Score >4 This is a possible DELIRIUM +/- COGNITIVE IMPAIRMENT, start 'T' and 'I' of TIME and escalate to medical staff to confirm diagnosis	**Score 1-3** This is a possible COGNITIVE IMPAIRMENT, and requires further assessment	**Score 0** DELIRIUM or SEVERE COGNITIVE impairment unlikely

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

TIME checklist to guide Delirium risk reduction, Identification and Management

The TIME checklist is a joint medical and nursing responsibility.

Affix ID Label

NHS Greater Glasgow and Clyde

	Triggers, Investigate, Manage and Engage	Date	Date	Date	Date	Date
Triggers	**Think possible triggers for delirium**	Tick box	Tick box	Tick box	Tick box	Tick box
	Is the patient in pain? Start pain chart, review analgesia and consider need for an aperient					
	Is the patient constipated or at risk of constipation? Commence bowel chart and review daily to assess for constipation, especially if on analgesia. Consider rectal examination					
	Is the patient in urinary retention? Palpate bladder/scan					
	Is the patients oral intake sufficient to prevent dehydration? Encourage hourly fluids, start fluid balance chart					
	Could any drugs trigger delirium? Doctor to review medication					
	Blood sugar, high or low?					
	Is there a history of alcohol intake/drug abuse? Intoxication or withdrawal, start GMAWS/drug misuse guidelines					
	Does the patient have sensory impairment? Ensure patient is wearing their glasses/hearing aid(s)					
	Is the patient immobile? Promote early mobilisation in order to prevent delirium					
	Document 4AT score					
	Does the patient have Delirium? (Yes/No/Unsure) Please Circle	Y N U	Y N U	Y N U	Y N U	Y N U
Investigate	**Investigate**					
	Record NEWS					
	Screen for infection					
	Take bloods and ensure ECG/appropriate imaging					
Manage	**Management: Diagnose causes & initiate treatment**					
	Document diagnosis of delirium					
	Document potential causes of delirium			1015		
	Document treatment plan					
Engage	**Engage and Explore**					
	If appropriate, explain diagnosis of delirium to patient/ family/ carers and provide delirium leaflet					
	Engage with patient/ family/ carers. Complete "What matters to me"/"Getting to know me" document					
	Does the patient have capacity to consent to care? (Yes/No/Ongoing Assessment)	Y N O	Y N O	Y N O	Y N O	Y N O
	If no, complete AWI document					
	Print initials of assessor					

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FALLS RISK ASSESSMENT

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

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

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

	Ward: HDU Date: 3/12/20 Time: 22:00	Ward: 20 Date: 04/12/20 Time: 01:00	Ward: 24 Date: 14/12 Time: 1445	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	✓	✓	✓		
2. Check walking aid (if required) is in reach and in use.	N/A	WCA.	NA		
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	✓	✓	✓		
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	✓	✓	✓		
5. If glasses are worn, check they are available and in use.	N/A	WCA.	NA		
6. If hearing aid/s are worn, check they are working and in use.	N/A	WCA.	NA		

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).
Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.
ALL patients in older people's wards must have an interventional plan in place (overleaf).

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

Highlight risk of fall at the ward safety brief.

Patient Details

FALLS INTERVENTION CHECKLIST

NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----
BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)					
Assess if a low bed is required (Patient care plan 9)					
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)					
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)					
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.					
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)					
Document continence problems and link to care rounding (Patient care plan 6)					
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)					
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.					
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)					
Update the ward team of the patient's mobility status. (Patient care plan 8)					
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)					
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)					
Signature of nurse completing interventional plan / or update					

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

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raph label

Ward: 24

Discharge destination: Home

Estimated Discharge Date (1) / /

Estimated Discharge Date (2) / /

Final date of discharge : 23/12/20

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓			
Relative/carer informed	✓			
Others informed: Care Home		✓		
Transport arranged				
Own transport (preferred option)	✓			
Ambulance-1 man/ 2 man am/pm		✓		
Other: Flight, Air ambulance etc.		✓		
Discharge medication				
Discharge prescription completed	✓			
Compliance aids e.g. Dossette Box (involve pharmacist)		✓		
Medication received	✓			
Medication explained to patient and/or relative/carer	✓			
Own medication returned to patient		✓		
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)	✓			4 DN's
Informed of discharge				
Social work/ Other agencies/Home help	✓			
Physiotherapist		✓		
Occupational Therapist		✓		
Dietician		✓		
Speech and Language Therapist		✓		
Clinical Nurse specialist e.g. Care Home Liaison		✓		
Liaison/ District Nurse/Practice Nurse	✓			Wounds
Other discharge items				
Access arrangements (e.g. keys, door entry)	✓			Patient to collect
Patients clothing available for day of discharge	✓			
Valuables e.g. cashier		✓		
Intravenous cannula removed	✓			
Equipment ordered (inc. walking aids) in place for discharge	✓			
Part 2 Discharge letter - Required	✓			
- Completed	✓			
Out patient clinic appointment e.g. Anticoagulation clinic				
Arranged / To follow	✓			
If unknown at time of discharge state reason		✓		
Additional information / leaflets / factsheets		✓		
Time of Discharge:				
Nurse's signature:			Designation: SN	Date: 23/12/20

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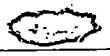
BOWEL MOVEMENT RECORD

..... CHI: ..... Date Commenced: 3/12/20

Date	Time	Comments i.e. volume, blood, mucous S – small M – medium L – large	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 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) 	Staff Initials
04/12/20	2000	L							✓	HK
5/12/20	1500								200mls ~~faeces collector~~ emptied	MC

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

Write 2208793218 M
Name BURGESS
Addre Henry 22/08/1979

CHI:
DOB:

Adult Urethral Urinary Catheter(UUC)

Insertion & Maintenance Care Plan

Catheter Batch Label
NOT completed on insertion

NHS Greater Glasgow and Clyde

Insertion – Complete all sections				
Date and time inserted 24/11/20	Urethral Urinary Catheter inserted Hospital RAH ED ☑ Theatre ☐ ITU/HDU ☐ Ward ____	Gauge	____ mls in balloon	Inserted by (Print name & designation [if known])
Clinical indication for urethral urinary catheterisation	Long term urethral urinary catheter ☐ (> 28 days)	Short term urethral urinary catheter ☐ (≤ 28 days)		
Patient had urethral urinary catheter inserted in the community/out with NHS GGC	Yes ☐	No ☐	Date UUC inserted (if known) ____	

Insertion Criteria		Comments
Alternatives to urethral urinary catheterisation considered	Yes ☐ No ☐	
Hand hygiene is performed immediately before urethral urinary catheter insertion	Yes ☐ No ☐	
Aseptic technique performed at insertion	Yes ☐ No ☐	
Urethral Urinary catheter of smallest gauge used and balloon filled to recommended level	Yes ☐ No ☐	
Urethral meatus cleaned with sterile saline and sterile lubricant used	Yes ☐ No ☐	
Aseptic technique maintained when connecting urethral urinary catheter to closed drainage system	Yes ☐ No ☐	

DAILY MAINTENANCE: FOR ALL PATIENTS WITH A URETHRAL URINARY CATHETER:

- Staff must wear gloves and apron and perform hand hygiene before and after urinary catheter procedures
- The drainage bag must be emptied when clinically indicated using a clean disposable container for each patient. Please refer to Insertion and maintenance of adult indwelling urethral urinary catheter SOP.

Maintenance – To be completed daily (observe for signs and symptoms of infection)						
Please regard Day 1 as day of insertion or the day patient is admitted to hospital with Urethral Urinary Catheter.	Ward	Does the patient still require a urethral urinary catheter?	Is the urethral urinary catheter connected to a closed drainage system and changed in line with manufacturer's instructions?	Daily meatal hygiene has been carried out? (soap and water)	Urine drainage bag is situated below the level of the bladder and not in contact with any surface e.g. floor?	Signature and Print Name
Day 1 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 2 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 3 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	

Date removed: ____ Time removed: ____ Reason for Urethral Urinary Catheter removal: ____ Removed by: ____

?? removed

CHI Number: _____

Maintenance – To be completed daily (observe for signs and symptoms of infection)						
	Ward	Does the patient still require a urethral urinary catheter?	Is the urethral urinary catheter connected to a closed drainage system and changed in line with manufacturer's instructions?	Daily meatal hygiene has been carried out?	Urine drainage bag is situated below the level of the bladder and not in contact with any surface e.g. floor?	Signature and Print Name
Day 4 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 5 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 6 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 7 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 8 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 9 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 10 3/12/20	HDU	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Signature CF Figure
Day 11 4/12/20	HDU	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Signature CF Figure
Day 12 05/12/20	HDU	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	HDU MAZEIKAITE
Day 13 6/12/20	20	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Signature SN
Day 14 7/12/20	20	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Sue smith
Day 15 8/12/20	20	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Sue smith
Day 16 9/12/20	20	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Sue smith
Day 17 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 18 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 19 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 20 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 21 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 22 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 23 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 24 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 25 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 26 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 27 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 28 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	

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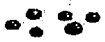
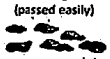
NHS Greater Glasgow and Clyde

BOWEL MOVEMENT RECORD

CHI: .....

Date Commenced: 01/12/20

Date	Time	Comments i.e. volume, blood, mucous S – small M – medium L – large	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 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)	Staff Initials
1/12/20	1600	L							✓	

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

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Infection Control Care Plan for a patient with Loose Stools of unknown origin / Gastroenteritis

This Care checklist should be used with patients who have loose stools of unknown origin OR Gastroenteritis. This Care Plan should be followed to reduce the risk of transmitting faecal organisms to other patients, staff, carers and visitors, while the patient is considered infectious and then signed off at end of the isolation period / discharge. Each criteria should be ticked √if in place or X if not, the checklist should be then initialled after completion, daily.

Date Isolation commenced: 3/12/20

		Date: 3/12	4/12					
	Patient Placement/ Assessment of Risk	Daily check (√/x)						
Patient Placement /Assessment of risk	Patient isolated in a single room with *en suite* facilities / own commode until 48 hours asymptomatic. If a single room is not available, an IPCT risk assessment is completed (see Appendix 1)	✓	✓					
	Place yellow isolation sign on the door to the isolation room	✓	✓					
	Door to isolation room is closed when not in use. If for any reason this is not appropriate then an IPCT risk assessment is completed	✓	✓					
	A Bristol stool chart is in use and is up to date	✓	✓					
Standard Infection Control & Transmission Based Precautions	**Hand Hygiene (HH)**							
	All staff must use correct 6 step technique for hand hygiene at 5 key moments	✓	✓					
	HH facilities are offered to patient after using the toilet and prior to mealtimes etc. (clinical wash hand basic/ wipes where applicable)	✓	✓					
	Personal Protective Clothing (PPE)							
	Disposable gloves and yellow apron are worn for all direct contact with the patient and their equipment/environment, removed before leaving the isolation area and discarded as clinical waste. **HH must follow removal of PPE.**	✓	✓					
	Safe Management of Care Equipment							
	Single-use items are used where possible OR equipment is dedicated to patient while in isolation.	✓	✓					
	There are no non-essential items in room. (eg. Excessive patient belongings)	✓	✓					
	Twice daily decontamination of the patient equipment by HCW is in place using 1,000 ppm solution of chlorine based detergent	✓	✓					
	Safe Management of Care Environment							
	Twice daily clean of isolation room is completed by Domestic services, using a solution of 1,000 ppm chlorine based detergent. A terminal clean will be arranged on day of discharge/ end of isolation.	✓	✓					
	Remove any uncovered food from patient lockers.	✓	✓					
	Laundry and Clinical/Healthcare waste							
	All laundry is placed in a water soluble bag, then into a clear plastic bag (brown bag in mental health areas) then into a laundry bag.	✓	✓					
	Clean linen must not be stored in the isolation room.	✓	✓					
	All waste should be disposed of in the isolation room as clinical/ Healthcare waste	✓	✓					
Information for patients/carers	**Information for patients and their carers**							
	The patient has been given information on their infection/ isolation and provided with a patient information leaflet (PIL) if available.	✓	✓					
	If taking soiled clothing home, carers have been issued with a Washing Clothes at Home PIL. (NB. Personal laundry is placed into a water soluble bag and then into a patient clothing bag before being given to carer to take home)	✓	✓					
	HCW Daily Initial	JMcM						

Date Isolation ceased/ Terminal Clean completed: ..... Signature: ..... Date: .....

Date Specimens Obtained: Please note there should be 24hours between each sample for culture & c diff testing

Culture & C Diff	Virology
1.	1.
2.	
3.	

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Adult Urethral Urinary Catheter(UUC)

Insertion & Maintenance Care Plan

Catheter Batch Label

NHS Greater Glasgow and Clyde

Insertion – Complete all sections				
Date and time inserted: 24/11/20	Urethral Urinary Catheter inserted Hospital RAH ED ☐ Theatre ☐ ITU/HDU ☐ Ward ?ED	Gauge: ?	?10 mls in balloon	Inserted by (Print name & designation [if known]): unknown
Clinical indication for urethral urinary catheterisation: Critical illness	Long term urethral urinary catheter ☐ (> 28 days)	Short term urethral urinary catheter ☑ (≤ 28 days)		
Patient had urethral urinary catheter inserted in the community/out with NHS GGC: Yes ☐ No ☑	Date UUC inserted (if known) _____			

Insertion Criteria		Comments
Alternatives to urethral urinary catheterisation considered	Yes ☐ No ☐	Unable to complete as catheter inserted prior to ICU admission
Hand hygiene is performed immediately before urethral urinary catheter insertion	Yes ☐ No ☐	
Aseptic technique performed at insertion	Yes ☐ No ☐	
Urethral Urinary catheter of smallest gauge used and balloon filled to recommended level	Yes ☐ No ☐	
Urethral meatus cleaned with sterile saline and sterile lubricant used	Yes ☐ No ☐	
Aseptic technique maintained when connecting urethral urinary catheter to closed drainage system	Yes ☐ No ☐	

DAILY MAINTENANCE: FOR ALL PATIENTS WITH A URETHRAL URINARY CATHETER:

- Staff must wear gloves and apron and perform hand hygiene before and after urinary catheter procedures
- The drainage bag must be emptied when clinically indicated using a clean disposable container for each patient. Please refer to Insertion and maintenance of adult indwelling urethral urinary catheter SOP.

Maintenance – To be completed daily (observe for signs and symptoms of infection)						
Please regard Day 1 as day of insertion or the day patient is admitted to hospital with Urethral Urinary Catheter.	Ward	Does the patient still require a urethral urinary catheter?	Is the urethral urinary catheter connected to a closed drainage system and changed in line with manufacturer's instructions?	Daily meatal hygiene has been carried out? (soap and water)	Urine drainage bag is situated below the level of the bladder and not in contact with any surface e.g. floor?	Signature and Print Name
Day 1 24/11/20		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 2 25/11/20		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 3 26/11/20		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	

Date removed: _____ Time removed: _____ Reason for Urethral Urinary Catheter removal: _____ Removed by: _____

CHI Number: _____

Maintenance – To be completed daily (observe for signs and symptoms of infection)						
	Ward	Does the patient still require a urethral urinary catheter?	Is the urethral urinary catheter connected to a closed drainage system and changed in line with manufacturer's instructions?	Daily meatal hygiene has been carried out?	Urine drainage bag is situated below the level of the bladder and not in contact with any surface e.g. floor?	Signature and Print Name
Day 4 27/11/20		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 5 28/11/20		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 6 29/11/20		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 7 30/11/20		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 8 1/12/20		documented on careviewYes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 9 2/12/20	ICM	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	R. BURNSON
Day 10 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 11 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 12 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 13 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 14 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 15 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 16 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 17 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 18 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 19 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 20 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 21 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 22 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 23 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 24 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 25 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 26 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 27 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 28 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	

Fluid Balance Chart

Name: Henry Hughes
DoB: 22/04/79
Chi number: 2208793248
Affix patient data label

Hospital: RAH
Ward: 20
Date: 9/12/20

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids?
Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input								Running Total	Output						Running Total	Initials
	Oral Fluids		Enteral		IV / Other				INPUT	Urine	Gastric / Vomit	Bowel				OUTPUT	
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00			Nisdrink	500	IV ABX	300 mls			800	1400							
01:00																	
02:00																	
03:00																	
04:00										1400							
05:00																	
06:00					IV ABX	100mls			900	110						990	
07:00																	
08:00	180ml								1050								
09:00																	
10:00																	
11:00										320mls		catheter removed 710					
12:00																	
13:00					NACL	500			1650								
14:00																	
15:00																	
16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00					NACL	250			1900	400						1110	
23:00																	
								*Total Intake	[illegible]						*Total Output	[illegible]	

*24 hr Fluid Balance +/- +800

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

220665

Fluid Balance Chart

Name: Henry
DoB: Burgess
Chi number:
Affix patient data label

Hospital: RAH
Ward: 24
Date: 10/12/20

Reason for Fluid Balance Chart
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours?
Fluid balance from previous 24hrs +/- +800

Does patient require thickened fluids?
Yes ☐ No ☐ Stage
NHS Greater Glasgow and Clyde
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type circle how many daily 1 2 3
2. Type circle how many daily 1 2 3
Signature: Designation:

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00					NaCl	300											
01:00																	
02:00										500							
03:00					IVF	500			800								
04:00																	
05:00																	
06:00																	
07:00		200															
08:00					IVF	500			1300								
09:00																	
10:00																	
11:00																	
12:00		200															
13:00		400															
14:00																	
15:00																	
16:00					IV Vanc	500			1800								
17:00					IV	100			1900								
18:00		200															
19:00			Ashfood	100					1960								
20:00																	
21:00																	
22:00																	
23:00																	
							*Total Intake								*Total Output		

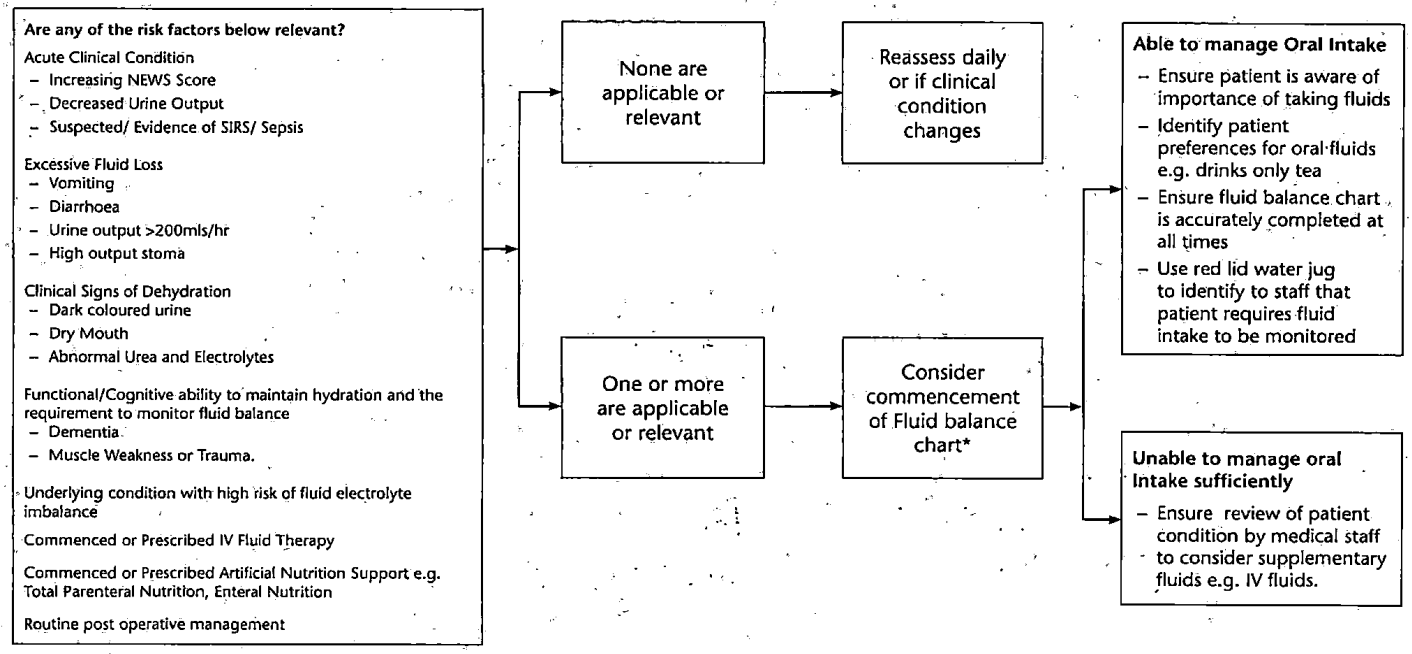
*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

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Fluid Balance Chart

Name: Henry
DoB: Burgess
Chi number:
Affix patient data label

Hospital: RAH
Ward: 24
Date: 11/12/20

Reason for Fluid Balance Chart
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours?
Fluid balance from previous 24hrs +/-

Does patient require thickened fluids? Yes ☐ No ☐ Stage
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type circle how many daily 1 2 3
2. Type circle how many daily 1 2 3
Signature: Designation:

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00										700						700	JW
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
08:00																	
09:00																	
10:00																	
11:00																	
12:00																	
13:00																	
14:00																	
15:00					IV Hal	500											
16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00										600 (x3 bottles)							
23:00																	
							*Total Intake	[redacted]							*Total Output	[redacted]	

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

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

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Are any of the risk factors below relevant?

Acute Clinical Condition
- Increasing NEWS Score
- Decreased Urine Output
- Suspected/ Evidence of SIRS/ Sepsis

Excessive Fluid Loss
- Vomiting
- Diarrhoea
- Urine output >200mls/hr
- High output stoma

Clinical Signs of Dehydration
- Dark coloured urine
- Dry Mouth
- Abnormal Urea and Electrolytes

Functional/Cognitive ability to maintain hydration and the requirement to monitor fluid balance
- Dementia
- Muscle Weakness or Trauma.

Underlying condition with high risk of fluid electrolyte imbalance

Commenced or Prescribed IV Fluid Therapy

Commenced or Prescribed Artificial Nutrition Support e.g. Total Parenteral Nutrition, Enteral Nutrition

Routine post operative management

None are applicable or relevant → Reassess daily or if clinical condition changes

One or more are applicable or relevant → Consider commencement of Fluid balance chart*

Able to manage Oral Intake
- Ensure patient is aware of importance of taking fluids
- Identify patient preferences for oral fluids e.g. drinks only tea
- Ensure fluid balance chart is accurately completed at all times
- Use red lid water jug to identify to staff that patient requires fluid intake to be monitored

Unable to manage oral Intake sufficiently
- Ensure review of patient condition by medical staff to consider supplementary fluids e.g. IV fluids.

Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

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Flui[illegible] Chart

2208793218
BURGESS
Henry
M
22/08/197[illegible]

Hospital: RPH
Ward: 60-
Date: 24/4/20

Reason for Fluid Balance Chart: Sepsis
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids?
Yes ☐ No ☒ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

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ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume	INPUT							OUTPUT	
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
08:00																	
09:00																	
10:00																	
11:00																	
12:00																	
13:00																	
14:00																	
15:00																	
16:00																	
17:00					Nacl	1000											
18:00					Nacl	000											
19:00					Normal	1000			3000			Catheter					
20:00										100						100	OS
21:00																	
22:00																	
23:00																	
								*Total Intake	[redacted]						*Total Output	[redacted]	

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

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

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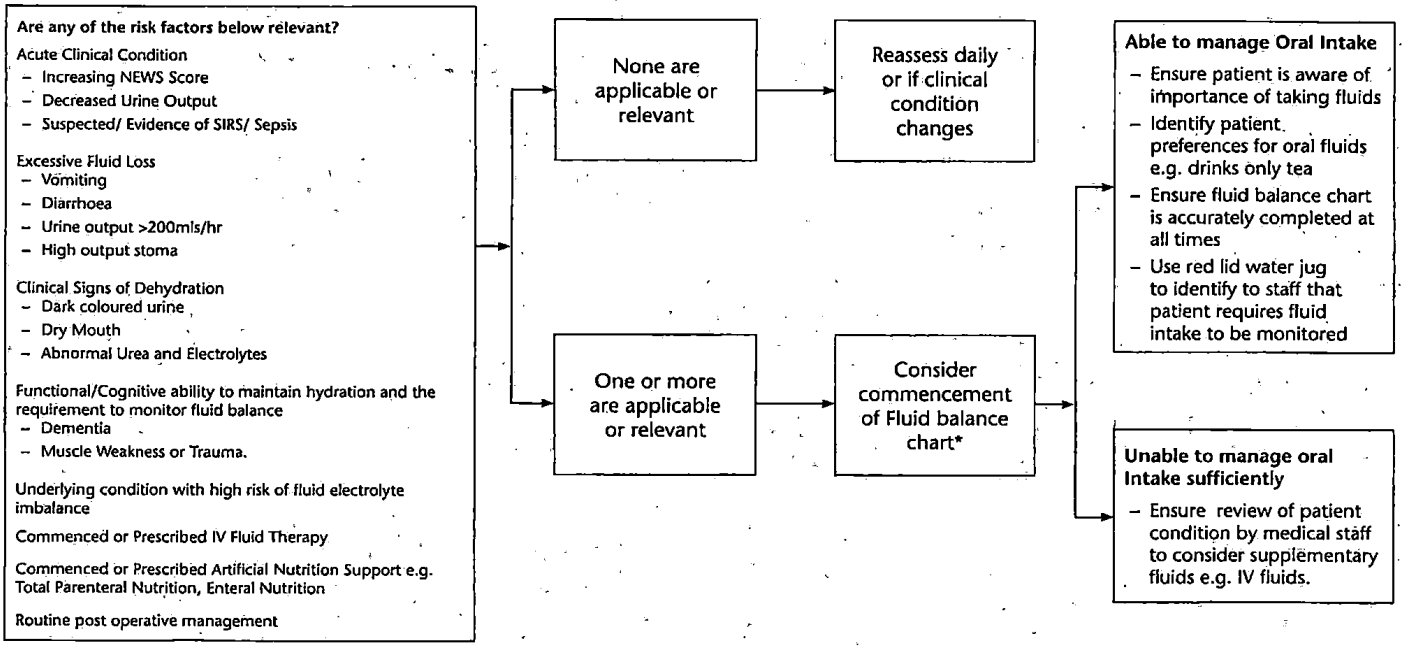

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Fluid Balance Chart

2208793218 M .....
BURGESS 22/08/1979 .....
Henry
96A ALICE STREET
Paisley, Renfrewshire PA2 6EA .....

Hospital: RAH
Ward: HDU
Date: 5/12/20

Reason for Fluid Balance Chart: monitor input output
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids? Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
08:00																	
09:00																	
10:00																	
11:00																	
12:00																	
13:00																	
14:00																	
15:00																	
16:00																	
17:00																	
18:00																	
19:00	Transferred from HDU chart								816	Transferred from HDU chart						1335	AG
20:00			NG Feed	83					899	260						1595	AG
21:00																	
22:00																	
23:00																	
							*Total Intake		[redacted]						*Total Output	[redacted]	

*24 hr Fluid Balance +/-

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

220665

Guide to commencing fluid balance charts

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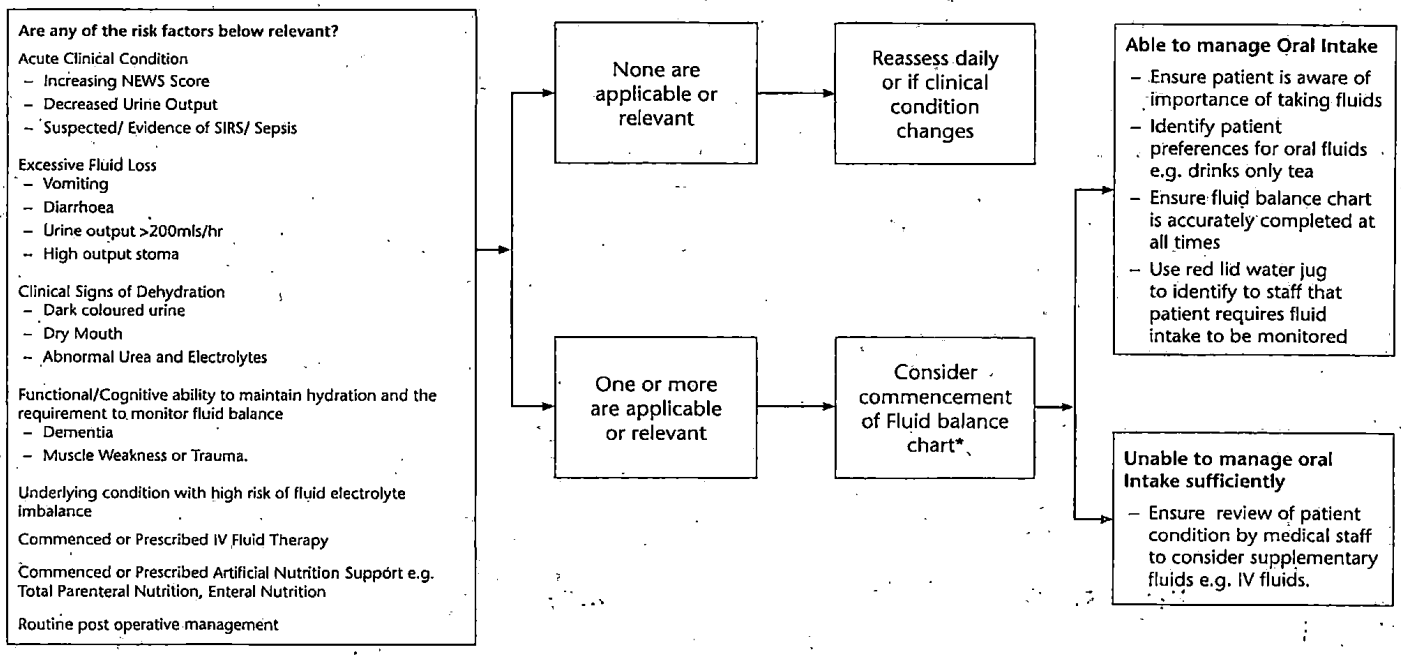

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Fluid Balance Chart

N 2208793218
BURGESS M
D Henry 22/08/1979
96A ALICE STREET
CPaisley, Renfrewshire
PA2 6EA
Af

Hospital: RAH
Ward: SARU
Date: 6.12.20

Reason for Fluid Balance Chart: monitor input/output
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids? Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume	INPUT							OUTPUT	
00:00																	
01:00																	
02:00	water	100ml															
03:00																	
04:00																	
05:00																	
06:00										500ml							
07:00																	
08:00	water	200			Nacl	0.9%	500		800								
09:00																	
10:00										109						609	
11:00					Nacl	0.9%	500		1300	460						1069	
12:00										80						1149	
13:00																	
14:00																	
15:00																	
16:00																	
17:00										600						1749	
18:00										180						1929	
19:00					Vanc	500											
20:00																	
21:00																	
22:00																	
23:00																	
							*Total Intake								*Total Output		

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

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

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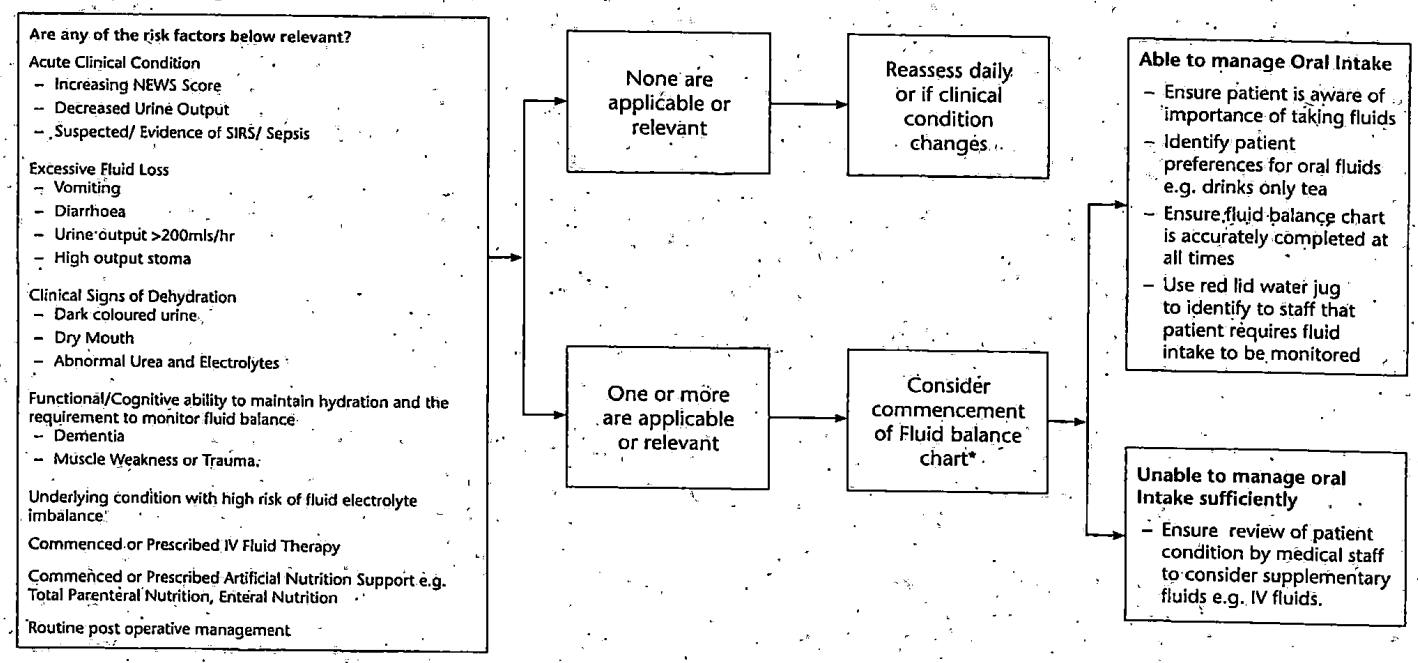

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Fluid Balance Chart

Name: Reuna Burgess
DoB: 27/08/20
Chi number:
Affix patient data label

Hospital: RAH
Ward: 20
Date: 07/12/20

Reason for Fluid Balance Chart
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours?
Fluid balance from previous 24hrs +/-

Does patient require thickened fluids? Yes ☐ No ☐ Stage
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type ____ circle how many daily 1 2 3
2. Type ____ circle how many daily 1 2 3
Signature: ____ Designation: ____

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume	INPUT							OUTPUT	
00:00																	
01:00																	
02:00					Wtr	500			500								
03:00																	
04:00																	
05:00																	
06:00										550						580	
07:00																	
08:00																	
09:00										500						1050	
10:00					500	Na Solm	ABX		1006								
11:00																	
12:00																	
13:00										500						1550	
14:00					100	Abx			1100	180	CBF					1730	
15:00																	
16:00					500	(N) Saline			1600	260						1990	
17:00																	
18:00										400						2390	
19:00					1000	ng feed			2600								
20:00			Venogrin		500mls				3100								
21:00										500						2890	
22:00																	
23:00										600						3490	
							*Total Intake								*Total Output		

*24 hr Fluid Balance +/-

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

220665

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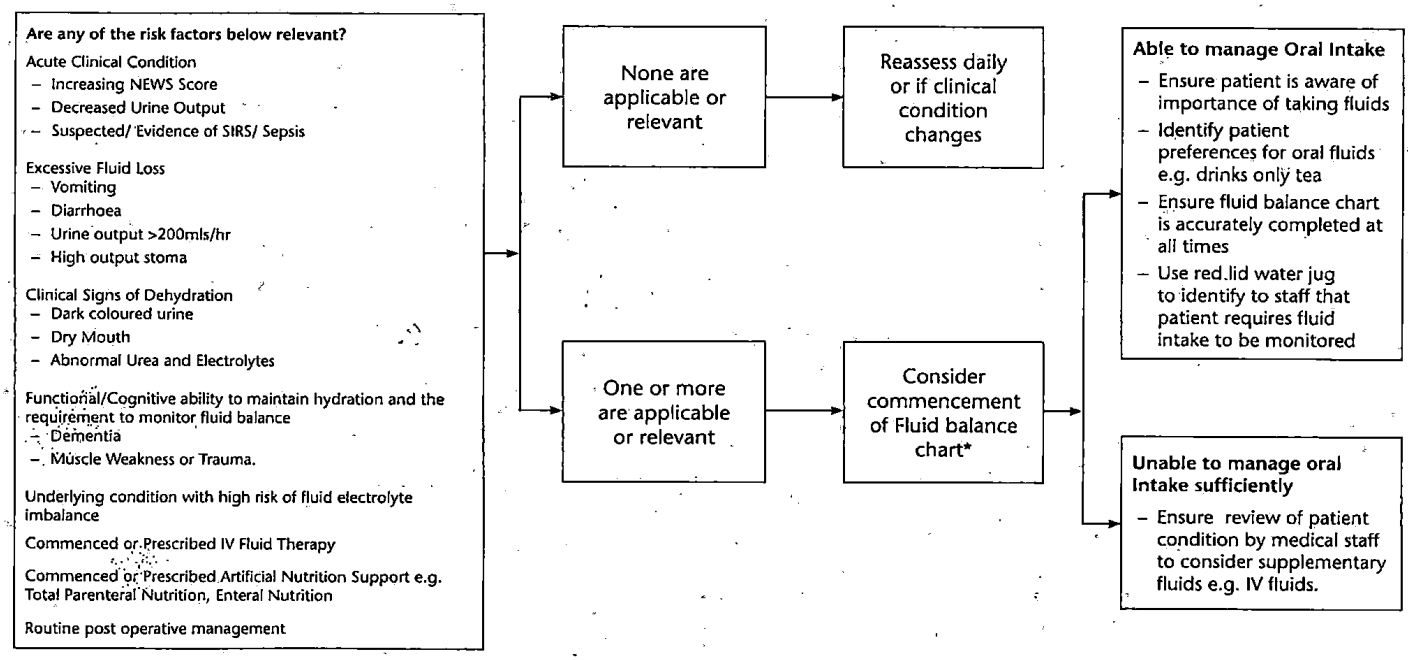

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Fluid Balance Chart

Na 2208793218
Dq BURGESS M
Henry 22/08/197
Cl 98A ALICE STREET
Paisley, Renfrewshire
Alt PA2 6EA

Hospital: RAH
Ward: 20
Date: 8/12/20

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids? Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume	INPUT							OUTPUT	
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
08:00																	
09:00																	
10:00																	
11:00																	
12:00																	
13:00																	
14:00																	
15:00																	
16:00																	
17:00																	
18:00																	
19:00			2 Flush 50		NJ Feed 1000mls				1050								SM
20:00					Vancomycin 500ml				1550								SM
21:00																	
22:00										500						500	MS
23:00																	
									*Total Intake							*Total Output	

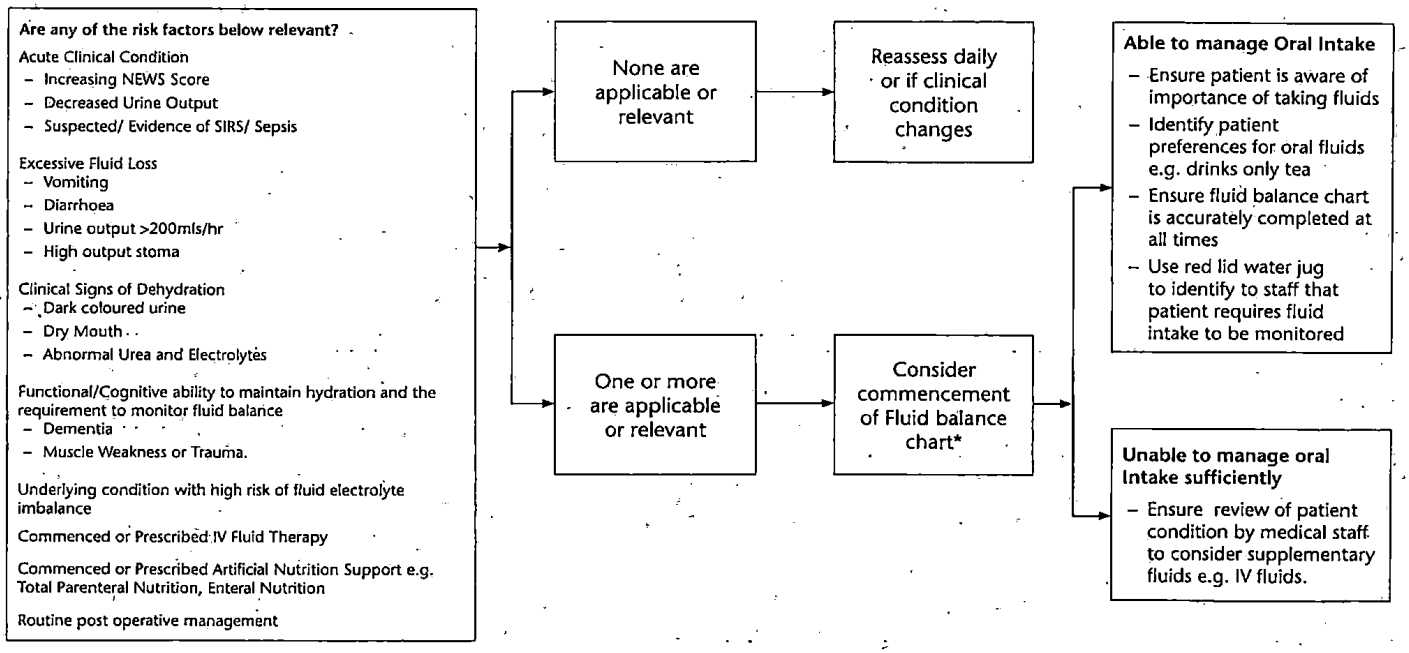
*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2

Fluid Balance Chart

Name: Henry
DoB: Burgess
Chi number:
Affix patient data label

Hospital: RAH
Ward: 24
Date: 12/12/20

Reason for Fluid Balance Chart: NG Feed
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours?
Fluid balance from previous 24hrs +/-

Does patient require thickened fluids? Yes ☐ No ☐ Stage
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type ____ circle how many daily 1 2 3
2. Type ____ circle how many daily 1 2 3
Signature: Designation: SN

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
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13:00																	
14:00																	
15:00																	
16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00					Meds 200ml												
23:00																	
								*Total Intake							*Total Output		

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

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.

Are any of the risk factors below relevant?

Acute Clinical Condition
- Increasing NEWS Score
- Decreased Urine Output
- Suspected/ Evidence of SIRS/ Sepsis

Excessive Fluid Loss
- Vomiting
- Diarrhoea
- Urine output >200mls/hr
- High output stoma

Clinical Signs of Dehydration
- Dark coloured urine
- Dry Mouth
- Abnormal Urea and Electrolytes

Functional/Cognitive ability to maintain hydration and the requirement to monitor fluid balance
- Dementia
- Muscle Weakness or Trauma.

Underlying condition with high risk of fluid electrolyte imbalance

Commenced or Prescribed IV Fluid Therapy

Commenced or Prescribed Artificial Nutrition Support e.g. Total Parenteral Nutrition, Enteral Nutrition

Routine post operative management

None are applicable or relevant → Reassess daily or if clinical condition changes

One or more are applicable or relevant → Consider commencement of Fluid balance chart*

Able to manage Oral Intake
- Ensure patient is aware of importance of taking fluids
- Identify patient preferences for oral fluids e.g. drinks only tea
- Ensure fluid balance chart is accurately completed at all times
- Use red lid water jug to identify to staff that patient requires fluid intake to be monitored

Unable to manage oral Intake sufficiently
- Ensure review of patient condition by medical staff to consider supplementary fluids e.g. IV fluids.

Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2

Fluid Balance Chart

Name: Henry Burgos
DoB: .....
Chi number: .....
Affix patient data label

Hospital: RAH
Ward: 24
Date: 13.12.21

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids?
Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume	INPUT							OUTPUT	
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
08:00	Milk	150								200							
09:00	tea	200															
10:00	Juice	250								200							
11:00																	
12:00										200		NCT					
13:00																	
14:00	Water	Sip															
15:00																	
16:00																	
17:00	Dalla	Sip															
18:00										500							
19:00										200							
20:00																	
21:00																	
22:00																	
23:00																	
								*Total Intake	[redacted]						*Total Output	[redacted]	

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

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

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- Decreased Urine Output
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- Diarrhoea
- Urine output >200mls/hr
- High output stoma

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- Dark coloured urine
- Dry Mouth
- Abnormal Urea and Electrolytes

Functional/Cognitive ability to maintain hydration and the requirement to monitor fluid balance
- Dementia
- Muscle Weakness or Trauma.

Underlying condition with high risk of fluid electrolyte imbalance

Commenced or Prescribed IV Fluid Therapy

Commenced or Prescribed Artificial Nutrition Support e.g. Total Parenteral Nutrition, Enteral Nutrition

Routine post operative management

None are applicable or relevant → Reassess daily or if clinical condition changes

One or more are applicable or relevant → Consider commencement of Fluid balance chart*

Able to manage Oral Intake
- Ensure patient is aware of importance of taking fluids
- Identify patient preferences for oral fluids e.g. drinks only tea
- Ensure fluid balance chart is accurately completed at all times
- Use red lid water jug to identify to staff that patient requires fluid intake to be monitored

Unable to manage oral Intake sufficiently
- Ensure review of patient condition by medical staff to consider supplementary fluids e.g. IV fluids.

Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

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Fluid Balance Chart

Name: Henry Burgess
DoB: .....
Chi number: .....
Affix patient data label

Hospital: RAH
Ward: 24
Date: 16/12/20

Reason for Fluid Balance Chart: NG Feed
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids? Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00										300						300	EM
07:00																	
08:00					Ann	100			100								
09:00										250						550	AA
10:00																	
11:00																	
12:00																	
13:00																	
14:00																	
15:00																	
16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
								*Total Intake	[redacted]						*Total Output	[redacted]	

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

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

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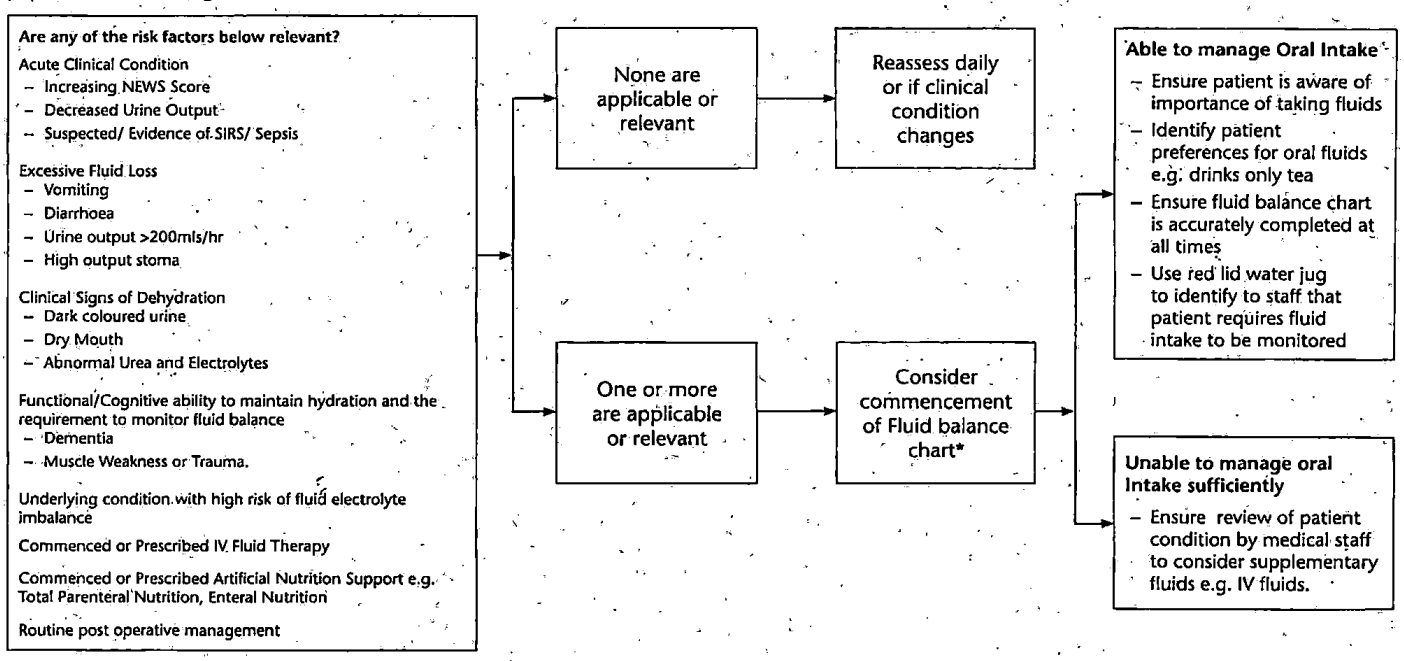

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316.

lance Chart

Henry Burgess

DoB: .....

Chi number: .....

Affix patient data label

Hospital: RAH

Ward: 24

Date: 15/12/20

Reason for Fluid Balance Chart: NG feed

Is patient fluid restricted? Yes ☐ No ~~☐~~ IV ~~Stop~~

If yes how many mls in 24 hours? _____

Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids? Yes ☐ No ☑ ~~Stage~~ _____

NHS Greater Glasgow and Clyde

Is the patient on an oral supplement? Yes ☐ No ~~☐~~ ~~If YES please indicate:~~

1. Type _____ circle how many daily 1 2 3

2. Type _____ circle how many daily 1 2 3

Signature: [redacted] Designation: SIN

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00			1000ml FEED						1000ml								
07:00			50ml FLUSH						1050ml								
08:00																	
09:00																	
10:00																	
11:00																	
12:00																	
13:00																	
14:00																	
15:00	HCa	100							1150								
16:00																	
17:00																	
18:00																	
19:00										200							
20:00																	
21:00																	
22:00										800							
23:00																	
								*Total Intake	[redacted]						*Total Output	[redacted]	

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*24 hr Fluid Balance +/-

220665

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Commenced or Prescribed Artificial Nutrition Support e.g. Total Parenteral Nutrition, Enteral Nutrition

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MIS • EDU • 237971-2

Fluid Balance Chart

316.

Name: Henry Biggs
DoB: .....
Chi number: .....
Affix patient data label

Hospital: RAH
Ward: 26
Date: 17/12/20

Reason for Fluid Balance Chart: NG
Is patient fluid restricted? Yes ☐ No ☑
If yes how many mls in 24 hours? N/A
Fluid balance from previous 24hrs +/- Bal not accurate

Does patient require thickened fluids? Yes ☐ No ☑ Stage ____
Is the patient on an oral supplement? Yes ☐ No ☑ If YES please indicate:
1. Type ____ circle how many daily 1 2 3
2. Type ____ circle how many daily 1 2 3
Signature: ____ Designation: SIN

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input: Oral Fluids Type	Oral Fluids Volume	Enteral Type	Enteral Volume	IV / Other Type	IV / Other Volume	Type	Volume	Running Total INPUT	Output: Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
00:00																	
01:00																	
02:00																	
03:00										200ml						200ml	NK
04:00																	
05:00																	
06:00																	
07:00																	
08:00																	
09:00	WCHO	150															
10:00	Milk	150								300							
11:00	DRINK	220															
12:00	WATER	300															
13:00	tea	150															
14:00	mix	200														700	
15:00	DRINK	220								200							
16:00	WCHO	150															
17:00	Milk	150															
18:00	tea	150							1540								
19:00																	
20:00																	
21:00	Int	100							1650	Pu							
22:00	Choc																
23:00																	
								*Total Intake	[redacted]						*Total Output	700	

*24 hr Fluid Balance +/-

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

220665

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MIS • EDU • 237971-2

Fluid Balance Chart

Name: Henry Burgess
DoB: .....
Chi number: .....
Affix patient data label

Hospital: RAH
Ward: 24
Date: 18.12.20

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids? Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume	INPUT							OUTPUT	
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
08:00	Milk	200	Fibo	500													
09:00	tea	200															
10:00	Milk	150															
11:00																	
12:00	tea	150															
13:00	Milk	150															
14:00																	
15:00	Orange	150															
16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00	Hotcho	200							1700								
22:00										Pu.							
23:00																	
								*Total Intake							*Total Output		

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

*24 hr Fluid Balance +/-

220665

Fluid Balance Chart

Name: Henry Burgess
DoB: .....
Chi number: .....
Affix patient data label

Hospital: RAH
Ward: 24
Date: 19-12-20

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids? Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
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Signature: _____ Designation: _____

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input								Running Total	Output						Running Total	Initials
	Oral Fluids		Enteral		IV / Other					Urine	Gastric / Vomit	Bowel	Type	Type	Type		
	Type	Volume	Type	Volume	Type	Volume	Type	Volume	INPUT							OUTPUT	
00:00																	
01:00																	
02:00	Juice	2ps								PU							
03:00																	
04:00																	
05:00										PU		Blk Small Soft					
06:00																	
07:00																	
08:00																	
09:00										800							
10:00																	
11:00										PU							
12:00		500															
13:00		800															
14:00																	
15:00																	
16:00																	
17:00		200								800							
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
									*Total Intake							*Total Output	

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*24 hr Fluid Balance +/-

220665

2208793218
BURGESS M
Henry 22/08/1979

ROYAL ALEXANDRA HOSPITAL * HIGH DEPENDENCY UNIT * PATIENT CARE PLAN

Tasha Parker

RESPIRATORY

	NURSING CARE/TREATMENT	DS	NS
	Explain treatment to the patient		✓
	Administer O2 via FM/NP/TM/HFNO		✓
A. Room Air	Titrate O2 as clinically indicated		✓
	Enhance patient position to maximise oxygen		
B. Oxygen Therapy <60%	Encourage deep breathing exercises		✓
	Chest physio review		
C. Oxygen Therapy >60%	Record respirations 1 (2) 4 hrly		✓
	Record arterial blood gas 1 2 4 hrly		
D. CPAP/BIPAP	Nasal airway Inserted :		
	Nasal airway removed		
E. Tracheostomy	Care of nasal airway insertion site		
	Tracheostomy as per careplan		
ASSESS	Administer O2 via trachy mask or Tpiece		
Day Shift / Night Shift	Perform suction as per guidelines		
/ B	Chest drain insitu Y/ N Oscillating Y/N		
GOAL	Care of chest drain as per guidelines		
Day Shift / Night Shift	Chest drain removed Y / N Xray Y/ N		
/ A			
OUTCOME			
Day Shift / Night Shift			
/ B			

CARDIOVASCULAR

	NURSING CARE/TREATMENT	DS	NS
A. STABLE with no intervention	Monitor alarms set, safety checks complete		✓
	Transducer lines zeroed		
	Record HR/Rhythm/BP 1 (2) 4 hourly		✓
B. STABLE with oral drug intervention	Correct hyper / hypo thermia		
	Fluid challenge as prescribed		
	Inotropes administered as prescribed		
	Blood available if required		
C. STABLE with IV fluid, blood, drug intervention	Administer blood as per transfusion guidelines		
	12 lead ECG		
	Arterial line in situ		
D. UNSTABLE with IV fluid, blood, drug intervention	Date of insertion:		
	Care of arterial line as per protocol		✓
ASSESS	Care of central line a as per bundle		✓
Day Shift / Night Shift	Care of PVC as per cabundle		
/ A	Thrombo prophylaxis prescribed (Y) N		✓
GOAL	TED stockings in situ Y / N		
Day Shift / Night Shift	Flotron therapy in situ Y / N		
/ A			
OUTCOME			
Day Shift / Night Shift			
/ A			

HYDRATION/NUTRITION

	NURSING CARE/TREATMENT	DS	NS
	Monitor/record fluid intake 1 (2) 4 hourly		✓
	Crystalloids given as prescribed		
A. IVI +/- NBM, 30-60s Orally	Nutritional Careplan updated		✓
	Dietician referral Y / N		
B. Free oral fluids +/- diet	Dietician review Y / N		✓
	Food chart in situ (Y) N		✓
C. Enteral Nutrition	NG Careplan updated		
	Prescribed NG feed, titrate as per protocol		
D. Parenteral Nutrition +/- IV	Administer TPN as prescribed		
	Record BM stix 1 2 (4) hourly, BD		✓
	STOPSS completed Y /N Date:		
	SALT referral Y/ N Date:		
ASSESS	SALT review Y / N Date:		
Day Shift / Night Shift	SALT recommendations identifiable Y /N		
/ C+B	NG feed patient info leaflet given Y N		
GOAL	ERAS documentation updated Y N		
Day Shift / Night Shift	DKA bundle in use Y N		
/ C+B			
OUTCOME			
Day Shift / Night Shift			
/ C+B			

ELIMINATION

	NURSING CARE/TREATMENT	DS	NS
A. Normal Renal Function +/- Maintenance Fluids/IV Fluids	Monitor/record fluid output 1 (2) 4 hrly		✓
	Ketones present Y / N		
	Care of catheter as per CAUTI bundle		✓
B. Abnormal U & E's +/- Treatment	Catheter lavaged as per guidelines		
	Bowels last moved Date:		
C. Normal Bowel Function	Bowel Movement Record chart (Y) N		✓
	Stoma care as per guidelines		
D. Abnormal Bowel Function +/- treatment	Stoma Nurse Referral Date:		
	Stoma Nurse Review Date:		
	Care of drains		
E. Other Fluid Losses	Aspirate NGT 1 2 4 hourly		
ASSESS			
Day Shift / Night Shift			
/ A+D			
GOAL			
Day Shift / Night Shift			
/ A+C			
OUTCOME			
Day Shift / Night Shift			
/ A+D			

PAIN

	NURSING CARE/TREATMENT	DS	NS
A. No Pain	Pain Assessment 1 (2) 4 hrly		✓
	Abbey Pain Scale in use for non verbalising pts		
B. PAIN controlled with oral analgesia	Reassurance + comfort measures given		✓
	Pain team referral/input		
C. PAIN controlled with SC IV analgesia	SC cannula inserted. Date:		
	Care of SC cannula as per protocol		
	PCA, standard / modified protocol		
D. PAIN controlled with PCA	Epidural Care as per guidelines		
	Epidural catheter removed. Date:		
E. PAIN controlled with epidu	Administer analgesia as prescribed		✓
ASSESS			
Day Shift / Night Shift			
/ A			
GOAL			
Day Shift / Night Shift			
/ A			
OUTCOME			
Day Shift / Night Shift			
/ A			

PERSONAL HYGIENE

	NURSING CARE/TREATMENT	DS	NS
A. Self Caring	Independent with personal hygiene Y/N		
	Bedside wash +/- assist daily, BD, other		
	Bedbath with full assist daily, BD, other		
	Shave offered Y / N		
B. Minimal Assistance	Shave declined Y / N		
	Oral Hygiene offered Y / N		
	Times		
C. Maximum Assistance	Signed		
	Eye care as per guidelines		
	Podiatry Referral. Date:		
	Podiatry Review Y / N		
ASSESS			
Day Shift / Night Shift			
/ C			
GOAL			
Day Shift / Night Shift			
/ B			
OUTCOME			
Day Shift / Night Shift			
/ C			

DAY SHIFT: DATE SIGN J

NIGHT SHIFT: DATE 05/12/20 00:00 SIGN ABell Staff N.

MOBILITY

NURSING CARE/TREATMENT			DS	NS
A. Independent		Patient independent and requires no assistance		
		Mobility assessed by nurses/physio		✓
B. Mobile with MIN/MOD/FU assistance		Moves in bed with assist of 1 (2) staff		✓
		Transfers with assist of 1 2 staff		
		Low Bed required Y / N		
C. Bedrest		Out of bed Y / (N)		✓
		Use of walking aids		
		Requires Moving and Handling equipment		
		Specifics of equipment:		
		Falls Risk Assessment document updated		
ASSESS		Bed rails in use Y / N		
Day Shift	Night Shift	Bed rails risk assessment completed Y / N		
	C	Is falls alarm in use Y/N		
GOAL		Reason for falls alarm:		
Day Shift	Night Shift	Falls alarms checked and working Y/N		
	C	Log roll as per guidelines		
OUTCOME		Hard/spinal collar in situ		
Day Shift	Night Shift	Care of collar as per guidelines		
		Nurse call buzzer within patient reach		✓
		Increased supervision required Y / N		
		Close obs. required when using toilet/ commode Y / N		

INFECTION CONTROL

NURSING CARE/TREATMENT			DS	NS
A. No risk identified		Damp dust bedspace		✓
		MRSA admission screen		
		MRSA orange sticker completed		
		Adhere to all infection control policies		
B. Suspected risk		Provide isolation facilities as per policy		
		Risk assessment if unable to isolate		
		Appropriate Care plan in situ, reviewed		
C. Confirmed risk		Patient and NOK informed of suspected/confirmed infection		
		Relevant info/leaflets to patient/NOK		
ASSESS		Update line chart		✓
Day Shift	Night Shift	Update Microbiology chart		✓
	R			
GOAL				
Day Shift	Night Shift			
	R			
OUTCOME				
Day Shift	Night Shift			
	R			

COMMUNICATION

NURSING CARE/TREATMENT			DS	NS
A. Communicates Verbally				
B. Communicates Non-Verbal		Reassurance/explanation of care to pts & relatives		✓
		Calm and quiet environment encouraged		✓
		Communication sheet updated		
C. Identified Communication		Communication aids in use		
Barriers/Cognitive Impairmen		Interpreter/signer requested		
		Cultural/spiritual needs identified		
		Nursing care and interventionsdiscussed		✓
ASSESS		and agreed with pt and family		
Day Shift	Night Shift	HDU info leaflets to patient/family		
	A	(Leaflets given to :)		
GOAL		NOK details accurate and documented		
Day Shift	Night Shift	If NOK unavailabe, details of contact person		
	A	for information sharing		
OUTCOME		Does patient has designated Carer ?		
Day Shift	Night Shift	(Carer :)		
	A	Carer visiting information & leaflet given		
		Valuables form completed		
		Valuables given to family		
		Indemnity form signed		
		Valuables given to cashier		
		Receipt given to patient/relative		
		Feedback Form given -Date:		

SEDATION/NEUROLOGICAL

NURSING CARE/TREATMENT			DS	NS
A. Patient alert				
B. Altered Conscious Level due to anaesthesia				
C. Altered Conscious Level due to prescribed analgesia		Reassurance/explanation of care given		
		Family involvement Y / N		
D. Intermittent Confusion uncertain cause		Incapacity documentation in place Y / N		
		Sedation administered as prescribed		
E. New Acute Confusion/ Altered Conscious Level with likely cause		Sedation level assessed 1 (2) 4 hourly		✓
		Neuro obs needed Y / N 1 2 4 hourly		
		GMAWS insitu Y / N		
F. Known Confusion/Altered Perception with known cause		Alcohol Liason Service Referral Y / N Date:		
		Alcohol Liason Review Y / N Date:		
G. Acute Agitation/Withdrawal Symptoms requiring Intervention		Psychiatric referral/review		
		Para suicidal precautions in place Y / N		
		Constant observation required		
ASSESS		Cognitive Assessment (4AT) completed		
Day Shift	Night Shift	Getting To Know Me form Y N N/A		
	A			
GOAL		Behavioural disturbance care plan.		
Day Shift	Night Shift	in use Y N N/A		
	A			
OUTCOME				
Day Shift	Night Shift			
	A			

TISSUE VIABILITY

NURSING CARE/TREATMENT			DS	NS
		Skin integrity assessed on PUDRA		✓
A. Skin Intact/ No pressure Ulcer Evident		PUDRA reviewed and update every 24 hours		✓
		EPUAP ulcer graded Y / N		
		PUDRA Inteventional care plan up to date		
B. Pressure Areas At Risk		Wound chart completed Y / N		
		Wound chart updated Y / N		
C. Surgical Wound +/- Drain Site/Sites		Skin integrity check re lines/drains/leads etc		
		Wound/drain site redressed Y / N		
		Specimen/Swab for OC + S		
D. Tissue Damage Evident		Tissue Viability referral Y / N Date:		
		Tissue Viability review Y / N		
ASSESS		Care Rounding updated in relation to pt risk		
Day Shift	Night Shift	Pressure ulcer prevention explained pt/carer		
	A+B	and info leaflet given		
GOAL		(leaflet given to:)		
Day Shift	Night Shift			
	A			
OUTCOME				
Day Shift	Night Shift			
	AHS			

OTHER DAILY ACTIVITIES

NURSING CARE/TREATMENT	DS	NS
Urea and Electrolyte Daily BD Other Time		
Full Blood Count		
Group and Save		
Gent / Vanc Level due @ hrs		
Gentamicin / Vancomycin Level Obtained		
Gentamicin / Vancomycin Prescribed		

DAY SHIFT: DATE SIGN NIGHT SHIFT: DATE 05/12/20 0100 SIGN

GREATER GLASGOW & CLYDE HIGH DEPENDENCY UNIT

DATE: 08/12/20 DAY No: 1
DATE OF ADMISSION 08/12/20

SURNAME: BURGESS
FIRST NAME: Henry
2208793218
M
22/08/1979
96A ALICE STREET
Paisley, Renfrewshire
PA2 6EA
LHB 781 (Rev)

DOB:
UNIT No.:

CONSULTANT:

NASAL AIRWAY Size:
TRACHEOSTOMY:
TUBE TYPE: Size:
TUBE LAST CHANGED

	DATE INSERTED	DATE CHANGED	TRANSDUCER CHANGED
CENTRAL LINE SITE:	4J		
PERIPHERAL LINES - SITE: (1)			
(2)			
ARTERIAL LINE SITE:			
URINARY CATHETER SIZE:			

INVESTIGATIONS

HAEMATOLOGY	BIOCHEMISTRY	BACTERIOLOGY	DRUG LEVELS	X-RAY	ECG	OTHER
FBC ☐	GLUCOSE ☐		Gent ☐			
COAG ☐	U & Es ☐		Vanc ☐			
INR ☐	LFTs ☐		Dig ☐			
	Ca ☐					
	PO4 ☐					
	CK ☐					
	Thyroid funct ☐					
	CRP ☐					
	Mg ☐					
	Other:					

DAILY PLAN / WARD ROUND

RESPIRATORY	CVS	INTAKE / OUTPUT / NUTRITION	DRUGS	INITIALS

GENERAL CARE / COMMENTS

	INITIALS

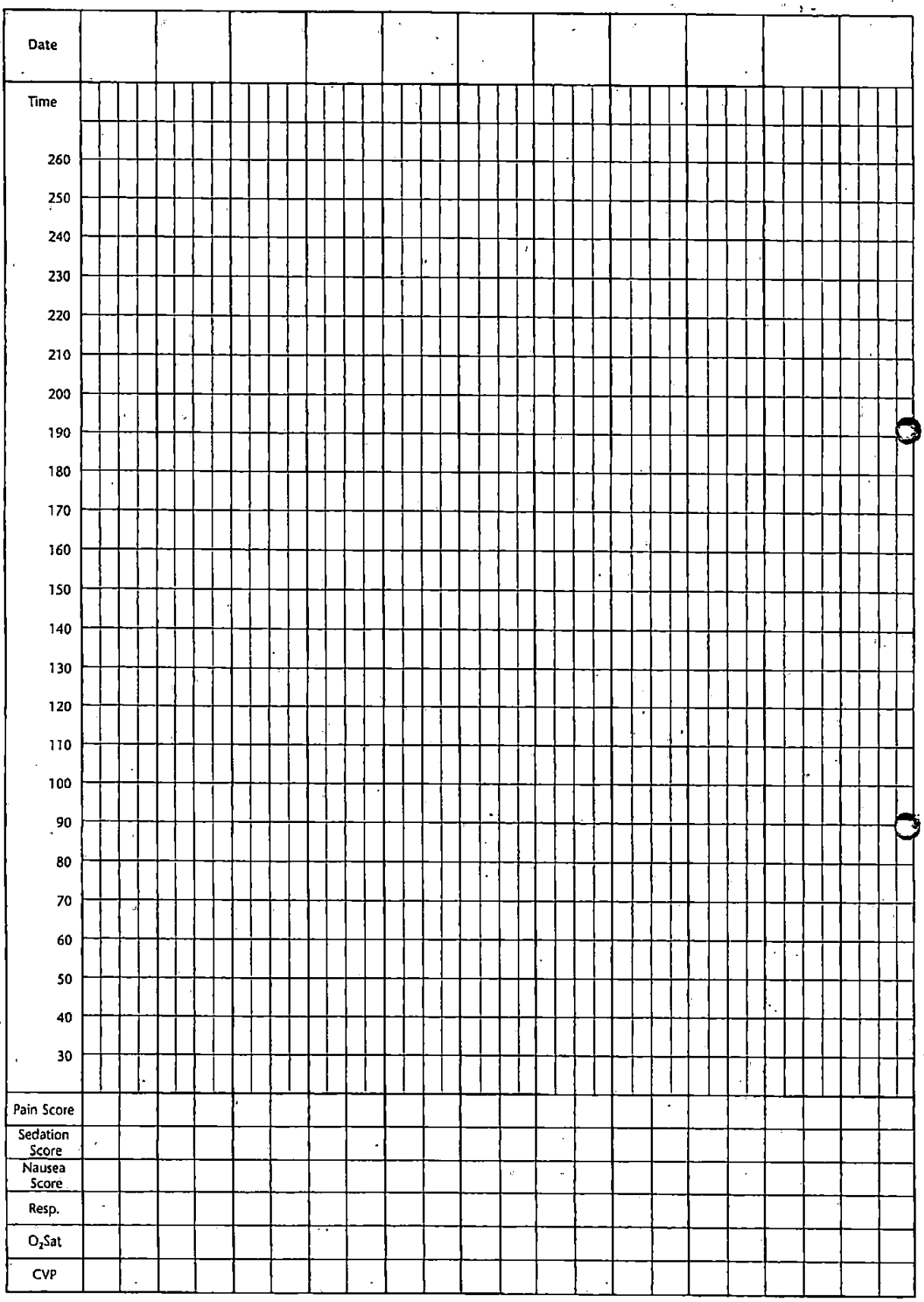
STY5217N

HDU

	8	9	10	11	12	13	14	15	16	17	18	19	2
RESP MODE										NC	NC	NC	
NASAL AIRWAY													
F_iO_2										3L	3L	3L	
PEEP													
RESP. RATE										18	16	17	
AIR ENTRY													
SUCTION													
OXYGEN SAT										99	95	95	
PO_2													
PCO_2													
H^+													
HCO_3													
BE													
PAIN SCORE										0	0	0	
SEDATION SCORE										0	0	0	
NAUSEA SCORE										0	0	0	
ALARM CHECK													
CVS 40 / 180										ST	ST	ST	
39 / 160													
TEMP °C 38 / 140													
•PERIPH (Black) 37 / 120										A	A	A	
•TYMP (Green)													
•PULSE (Red) 36 / 100													
35 / 80										X	X	X	
BP ▲ cuff													
^ artline 34 / 60													
X mean 33 / 40													
CVP													
RHYTHM										ST	ST	ST	
Ketones WOUND CHECK													
BM										5.8	6.8	10.2	
DRUGS										Bm 3.2			
Actrapid										Bm 6.4			
FLUID INTAKE CRYST													
BLOOD													
COLLOID													
TPN													
DRUGS													
ORAL										180	30	20	
NG											55	55	
CUMULATIVE TOTAL										180	765	840	
FLUID OUTPUT URINE										110	110	40 50	50 20
DRAINAGE GASTRIC													
BOWELS										~~100~~			
DRAIN													
OTHER													
CUMULATIVE TOTAL										310	150	700	
	8	9	10	11	12	13	14	15	16	17 CN	18 CN	19	

	21	22	23	24	01	02	03	04	05	06	07	08
	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
	3L	3L	14L	4L	4L	4L	4L	4L	4L	4L	4L	
	17	19	18	16	17	17	18	17	20.	21	17	
	94%	94%	95%	96%	99%	98%	99%	98%	95%	99%	98%	
		192%										
	O	O	O	O	O	O	O	O	O	S	O	
	O	O	O	O	O	O	O	O	O	S	O	
	O	O	O	O	O	O	O	O	O	S	O	
	37.9	38.1	36.7			35.8	36.4		35.9		36.2	

GREATER GLASGOW & CLYDE
Blood Pressure, Pulse & Pain Assessment Chart



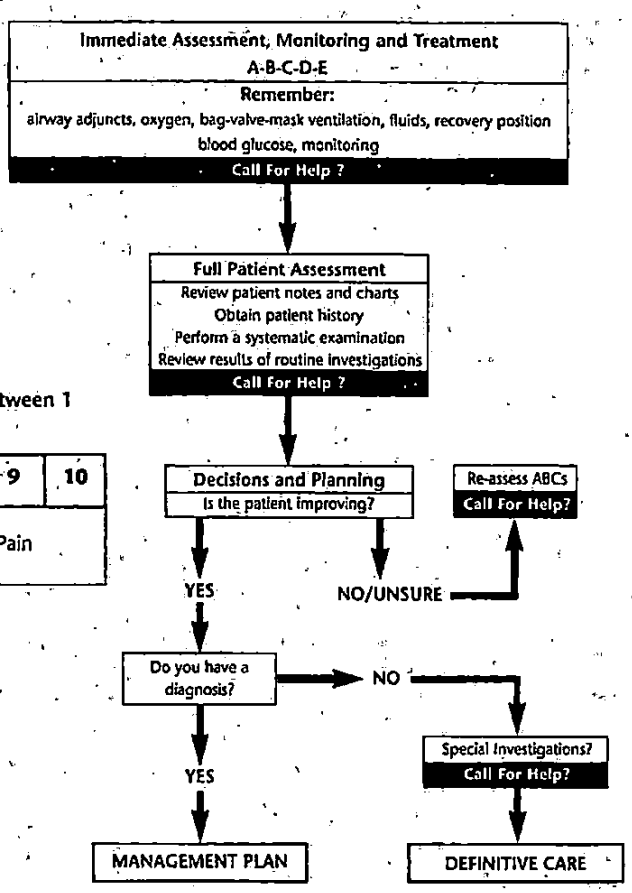
FLUID ADMINISTRATION

FLUID	VOL (ml)	ADDITIVE / AMT	RATE	PRESC SIGN	START TIME	GIVEN BY	CHECKED BY	BATCH NO

Air Entry

✔	Present
H	Harsh
Q	Quiet
D	Dull
↓	Dull to base
W	Wheeze

ALERT™ Plan of Assessment



Ask the patient to rate his/her pain by choosing a number between 1 and 10. Use the diagram below to assist the patient

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

Sedation Score

0	None (pt. alert)
1	Mild (occasionally drowsy - easy to rouse)
2	Moderate (frequently drowsy - easy to rouse)
3	Severe (somnolent - difficult to rouse)
S	Sleep (normal sleep - easy to rouse)

Nausea Score

0	None
1	Mild (not distressing - no retching / vomiting)
2	Moderate (troublesome - occasional retching / vomiting)
3	Severe (distressing - frequent retching / vomiting)

GREATER GLASGOW & CLYDE HIGH DEPENDENCY UNIT

2208793218
BURGESS Henry M 22/08/1979

DOB:

UNIT No.:

DATE: 4/12/20 DAY No: 2
DATE OF ADMISSION 3/12/20

ICU stepdown, Laparotomy Splenectomy + wash out

CONSULTANT: Mr Mac Geoy

NASAL AIRWAY ✓ Size:

TRACHEOSTOMY:

TUBE TYPE: Size:

TUBE LAST CHANGED

	DATE INSERTED	DATE CHANGED	TRANSDUCER CHANGED
CENTRAL LINE SITE: RIJ	28/11/20		
PERIPHERAL LINES - SITE: (1)			
(2)			
ARTERIAL LINE SITE:			
URINARY CATHETER SIZE: See CALTI			

INVESTIGATIONS

HAEMATOLOGY	BIOCHEMISTRY	BACTERIOLOGY	DRUG LEVELS	X-RAY	ECG	OTHER
FBC ☐	GLUCOSE ☐		Gent ☐			
COAG ☐	U & Es ☐		Vanc ☐			
INR ☐	LFTs ☐		Dig ☐			
	Ca ☐					
	PO4 ☐					
	CK ☐					
	Thyroid funct ☐					
	CRP ☐					
	Mg ☐					
	Other:					

DAILY PLAN / WARD ROUND

RESPIRATORY	CVS	INTAKE / OUTPUT / NUTRITION	DRUGS	INITIALS

GENERAL CARE / COMMENTS

	INITIALS

		8	9	10	11	12	13	14	15	16	17	18	19	2
RESP	MODE	NC	NC	NC	NC	NC	NC	NC	VM	NC	NC	NC		
	NASAL AIRWAY								3L/					
	FiO_2	4L	4L	4L	4L	4L	4L	↑6L	~~4L~~	4L	4L	4L		
	PEEP							14cm						
Aim 4-25	RESP. RATE	20	19	19	22	25	22	28	23	17	17	17		
	AIR ENTRY													
	SUCTION													
Aim 94%	OXYGEN SAT	95%	94%	96%	95%	94%	91%	92%	94%	98%	95%	95%		
	PO_2							86%						
	PCO_2													
	H													
	HCO_3													
	BE													
	PAIN SCORE	0	0	0	0	0	0	Yes	0	0	N	No		
	SEDATION SCORE	0	0	0	0	0	0	0	0	0	2	2		
	NAUSEA SCORE	0	0	0	0	0	?	?	0	0	0	0		
	ALARM CHECK	✓VM												
CVS.	40	~~36.9~~		36.8	36.2	36.1		36.1		~~35.9~~	36.7	36.5		
	39													
Aim MAP 65 mmHg	38													
TEMP °C	37													
•PERIPH (Black)	36													
•TYMP (Green)	35													
•PULSE (Red)	34													
BP ^ cuff	33													
^ artline														
X mean														
	180													
	160													
	140													
	120													
	100													
	80													
	60													
	40													
	CVP													
	RHYTHM	ST	ST	ST	ST	ST	ST	ST	ST	ST	SR	SR		
Keto	~~WOUND CHECK~~									0.2				
	BM		10.0		9.5	14.1		14.6		15.1	12.9	11.1		
DRUGS	Aceraplin	3	3	3 //										
FLUID INTAKE	CRYST			100/				250	~~125~~ 83	83	OFF			
	BLOOD													
	COLLOID													
	TPN													
	DRUGS							~~280~~						
	ORAL	325			50	100	100			50		50		
	NG	55	55/	55//								↑83	83	
	CUMULATIVE TOTAL	~~383~~ 383	~~438~~ 441	596	646	596	646	896	979	1029		1162	1245	
FLUID OUTPUT DRAINAGE	URINE	220	220	60	280	240	320	45	385	285	180	960	185	1145
		85	125	105	135									
	GASTRIC													
	BOWELS													
	DRAIN													
	OTHER													
	CUMULATIVE TOTAL	VM		520	520	VM		VM		1145				
		8	VM 9	RM 10	11	12	VM 13	14	VM 15	16	17	18	19	

2 hourly

	21	22	23	24	01	02	03	04	05	06	07	08
	NC	NC	NC	NC		NC		NC		NC		
	4L	4L	4L	4L		4L		5L		5L		
	19	16	18	15		15		16		16		
	96%	98%	95%	94%		95%		94%		95%		
	0	0	0	0		0		0		0		
	0	0	0	0		0		0		0		
	0	0	0	0		0		0		0		
	HB											
	36.5			37.0						35.5		
	SR	SR	SR	SR		ST						
	11.1			12.9						21.2		
			100									
	83	83	83	83	83	83	83	83	83	83	OFF	
	1378	1461	1644	1727	1810	1893	1976	2059	2142	2225		
	120/55	140/95	110/85		120/55		140/75		160/35		180/115	
	1145	149										

10 HB. 21 HB 22 HB 23 24 HB 01 02 03 04 05 06 07 08

40 180 39 160 38 140 37 120 36 100 35 80 34 60 33 40

TRACHEAL SUCTION / SPUTUM

1=Scanty M=Mucoid
2=Moderate B=Blood Stained
3=Profuse P=Purulent

CARE, POSITION & INTERVENTION

E=Eye M=Mouth N=Nebuliser P=Physio

Rt=Right tilt Lt=Left tilt B=Back

8	20
9	21
10	22
11	23
12	24
13	01
14	02
15 CXR	03
16	04
17	05
18	06
19	07

14 Or cuff deflation

FLUID BALANCE

INTAKE	
BLOOD	
COLLOID	
TPN	
DRUGS	
ORAL/NG	
TOTAL	2225

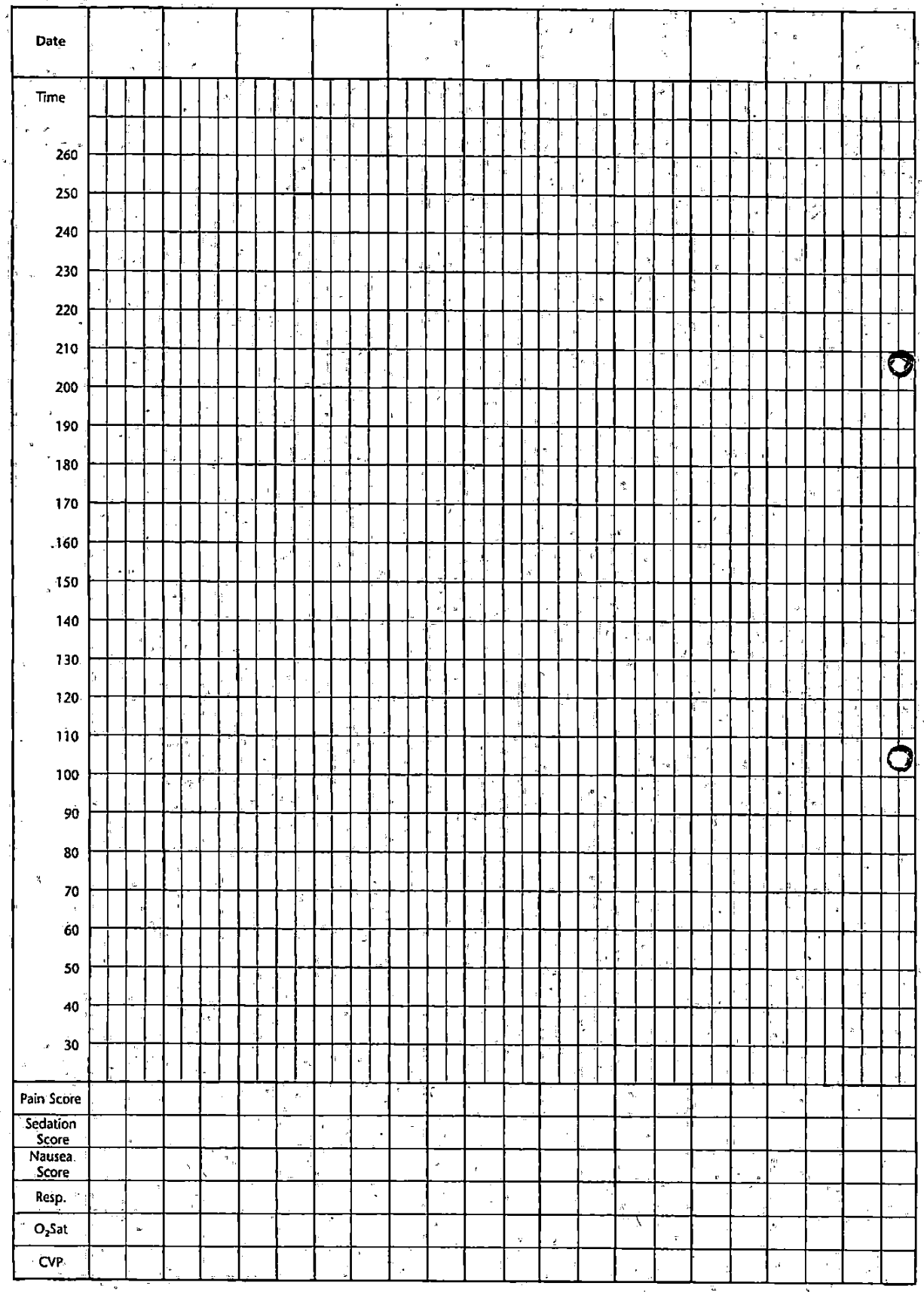
OUTPUT	
URINE	
GASTRIC	
DRAIN/S	
OTHER	
TOTAL	1515

BALANCE

PREV 24hr BALANCE

GREATER GLASGOW & CLYDE

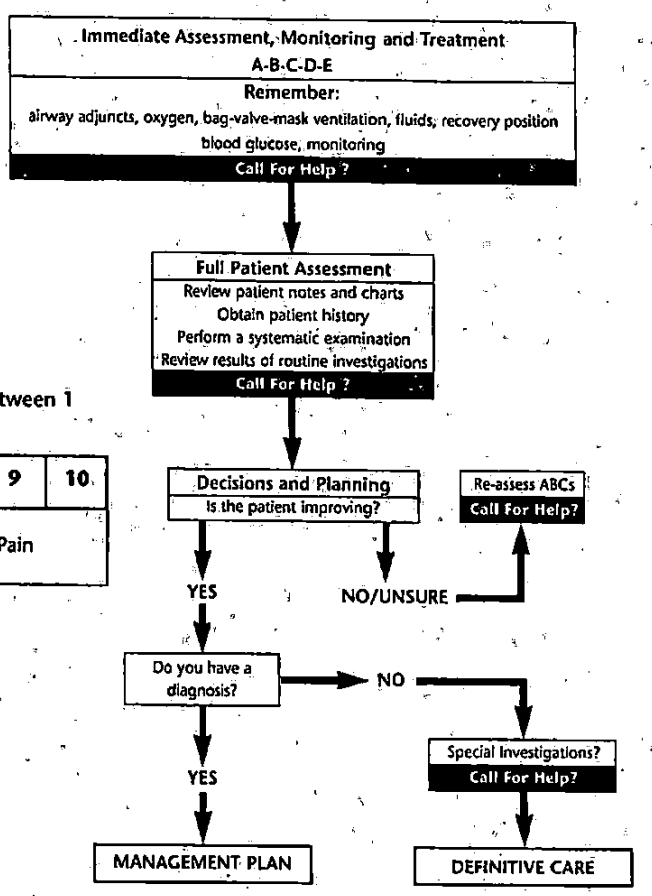
Blood Pressure, Pulse & Pain Assessment Chart



Air Entry

✔	Present
H	Harsh
Q	Quiet
D	Dull
↓	Dull to base
W	Wheeze

ALERT™ Plan of Assessment



Ask the patient to rate his/her pain by choosing a number between 1 and 10. Use the diagram below to assist the patient

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

Sedation Score

0	None (pt. alert)
1	Mild (occasionally drowsy - easy to rouse)
2	Moderate (frequently drowsy - easy to rouse)
3	Severe (somnolent - difficult to rouse)
S	Sleep (normal sleep - easy to rouse)

Nausea Score

0	None
1	Mild (not distressing - no retching / vomiting)
2	Moderate (troublesome - occasional retching / vomiting)
3	Severe (distressing - frequent retching / vomiting)

FLUID ADMINISTRATION

FLUID	VOL (ml)	ADDITIVE / AMT	RATE	PRESC SIGN	START TIME	GIVEN BY	CHECKED BY	BATCH NO
0.9% NaCl	250	—	STAT	JE	1620	VMK	✓	
0.9% NaCl	500	—	6°	JE	1640	VMK	✓	
0.9% NaCl	500	—	8°	JE				

ADDITIONAL REQUIREMENTS / INSTRUCTIONS

NUTRITION

PARENTERAL	ENTERAL
VOL /24 HRS	TYPE VOL /20 HRS
PRESCRIPTION SIGNATURE	PRESCRIPTION SIGNATURE

BATCH NO.	GIVEN BY	CHECKED BY	START TIME	BATCH NO.	GIVEN BY	CHECKED BY	START TIME

GREATER GLASGOW & CLYDE HIGH DEPENDENCY UNIT

S 2208793218
BURGESS M
F Henry 22/08/1979
96A ALICE STREET
Paisley, Renfrewshire
PA2 6EA

DOB:
UNIT No.:

DATE: 5/12/20 DAY No: (3)
DATE OF ADMISSION 03/12/2020
ICU stepdown, laparotomy
Splenectomy + wash out

CONSULTANT: Mr Macgeoy

NASAL AIRWAY Size:
TRACHEOSTOMY:
TUBE TYPE: Size:
TUBE LAST CHANGED

	DATE INSERTED	DATE CHANGED	TRANSDUCER CHANGED
CENTRAL LINE SITE: LIJ	28/11/20		
PERIPHERAL LINES - SITE: (1)	see pve		
(2)			
ARTERIAL LINE SITE:	✓		
URINARY CATHETER SIZE:	see ocw		

INVESTIGATIONS

HAEMATOLOGY	BIOCHEMISTRY	BACTERIOLOGY	DRUG LEVELS	X-RAY	ECG	OTHER
FBC ☐	GLUCOSE ☐		Gent ☐			
COAG ☐	U & Es ☐		Vanc ☐			
INR ☐	LFTs ☐		Dig ☐			
	Ca ☐					
	PO4 ☐					
	CK ☐					
	Thyroid funct ☐					
	CRP ☐					
	Mg ☐					
	Other:					

DAILY PLAN / WARD ROUND

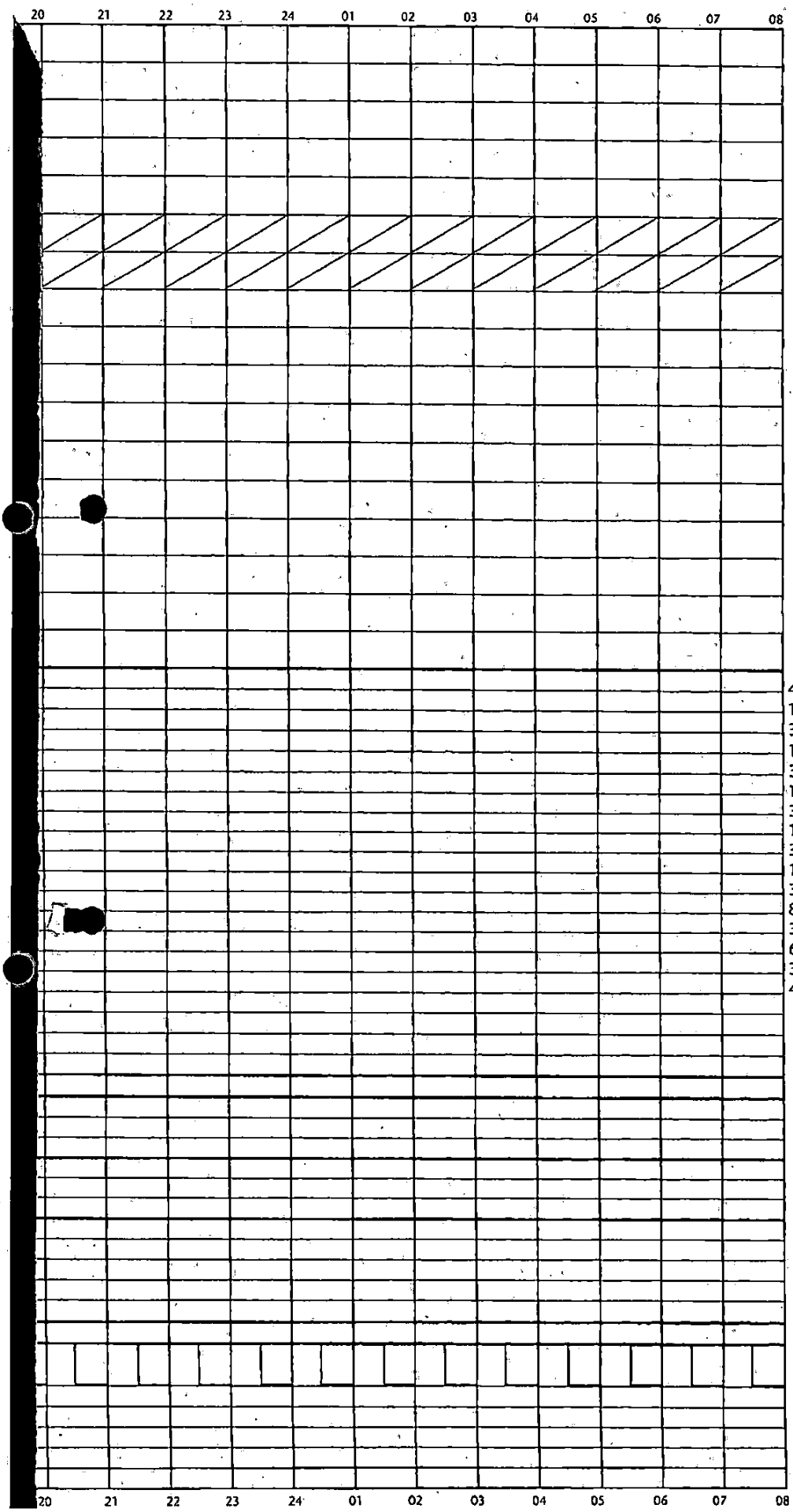
RESPIRATORY	CVS	INTAKE / OUTPUT / NUTRITION	DRUGS	INITIALS

GENERAL CARE / COMMENTS

	INITIALS

STY5217N

		8	9	10	11	12	13	14	15	16	17	18	19
RESP	MODE	NC		NC			NC			NC		NC	
	NASAL AIRWAY												
	F_iO_2	4L		4L			4L			3L		4L	
	PEEP									↑4L			
	RESP. RATE	21		24			19			28		19	
	AIR ENTRY												
	SUCTION												
	OXYGEN SAT	95%		99%			96%			92%		93%	
	PO_2									195%			
	PCO_2												
	H^+												
	HCO_3												
	BE												
	PAIN SCORE	0		0			0			0		0	
	SEDATION SCORE	0		0			0			0		0	
	NAUSEA SCORE	0		0			0			0		0	
	ALARM CHECK	✓											
CVS	40	36.1c		36.8			36.3c			36.1c		36c	
	180												
	39												
	160												
TEMP °C	38												
•PERIPH (Black)	140												
•TYMP (Green)	37												
•PULSE (Red)	120												
	36												
	100												
	35												
BP ▲ cuff	80												
^ artline	34												
X mean	60												
	33												
	40												
	CVP												
	RHYTHM	ST		SR			SR			SR		SR	
	WOUND CHECK	✓											
	BM	14.2		10.1			7.2			6.2		6.7	
DRUGS													
FLUID INTAKE	CRYST												
	BLOOD												
	COLLOID												
	TPN												
	DRUGS						100						
	ORAL	200		50			150			100		150	
	NG											183	83
	CUMULATIVE TOTAL	200		250			400			500		733	816
FLUID OUTPUT DRAINAGE	URINE	275 375		285 560			275 835			285 1120		215 1335	
	GASTRIC												
	BOWELS									200			
	DRAIN												
	OTHER												
	CUMULATIVE TOTAL												
		8	9	10	11	12	13	14	15	16	17	18	19



TRACHEAL SUCTION / SPUTUM

1=Scanty M=Mucoid
2=Moderate B=Blood Stained
3=Profuse P=Purulent

CARE, POSITION & INTERVENTION

E=Eye M=Mouth N=Nebuliser P=Physio

Rt=Right tilt Lt=Left tilt B=Back

8	20
9	21
10	22
11	23
12	24
13	01
14	02
15	03
16	04
17	05
18	06
19	07

FLUID BALANCE

INTAKE

BLOOD _____
COLLOID _____
TPN _____
DRUGS _____
ORAL/NG _____
TOTAL _____

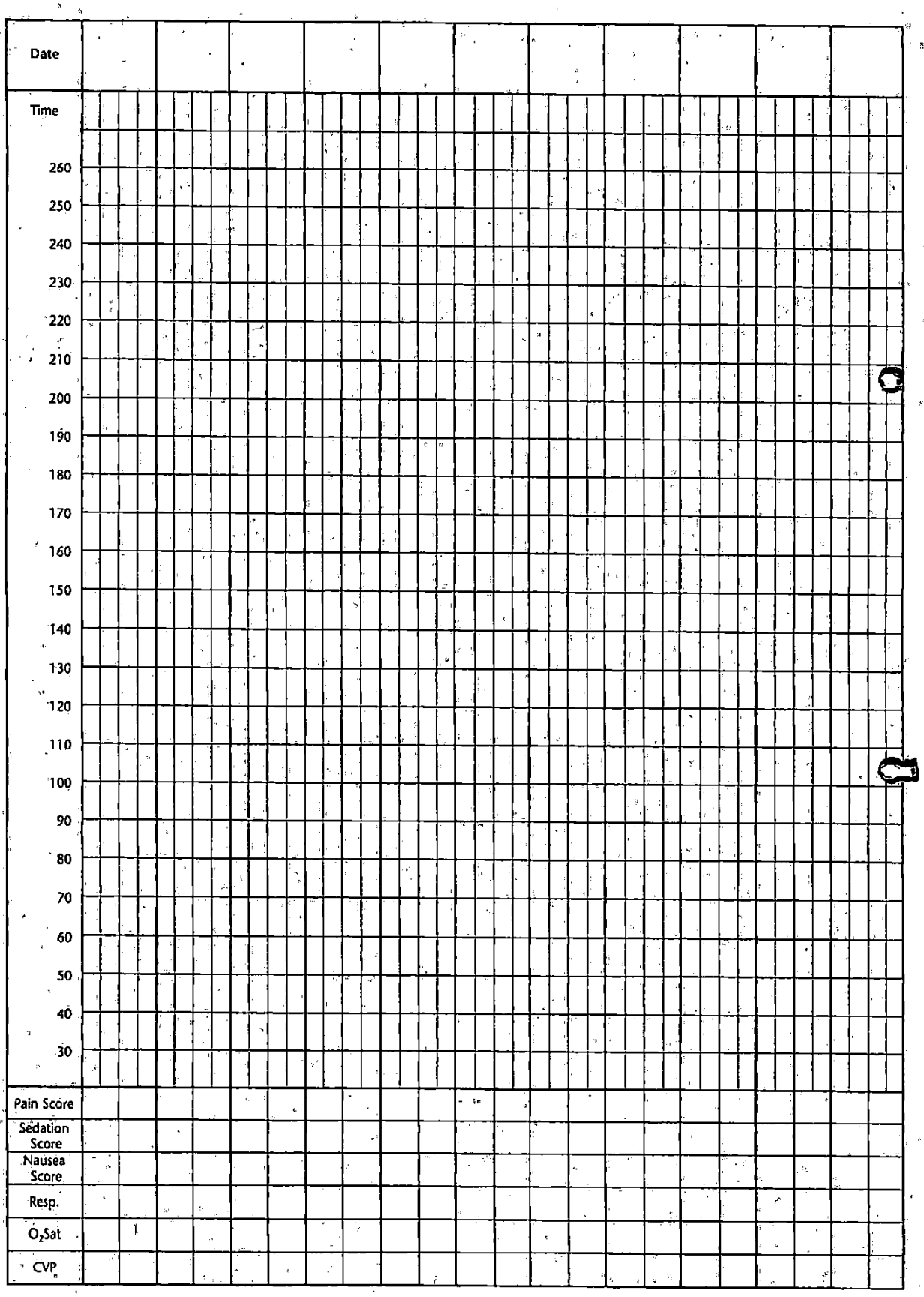
OUTPUT

URINE _____
GASTRIC _____
DRAIN/S _____
OTHER _____
TOTAL _____

BALANCE

PREV 24hr
BALANCE

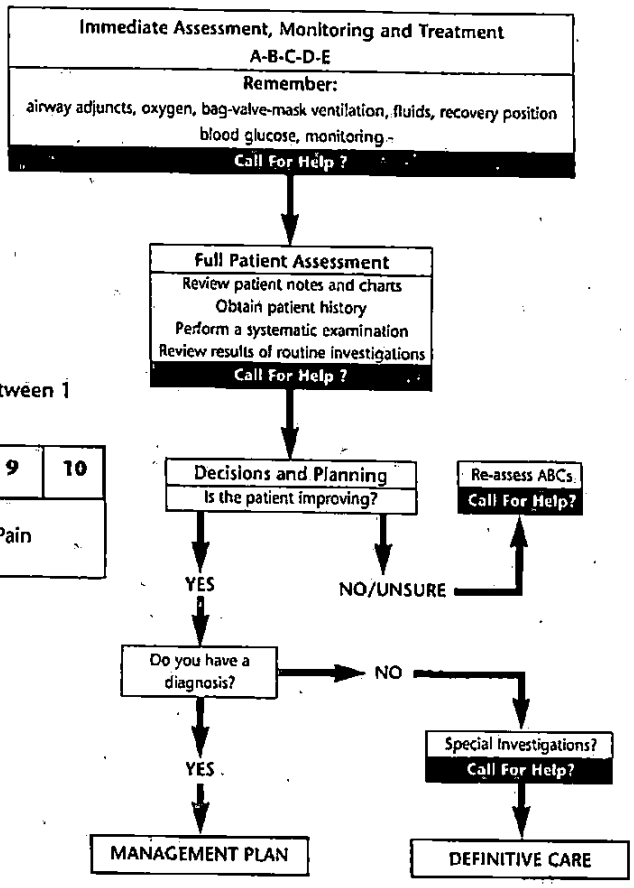
GREATER GLASGOW & CLYDE
Blood Pressure, Pulse & Pain Assessment Chart



Air Entry

✔	Present
H	Harsh
Q	Quiet
D	Dull
↓	Dull to base
W	Wheeze

ALERT™ Plan of Assessment



Ask the patient to rate his/her pain by choosing a number between 1 and 10. Use the diagram below to assist the patient

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

Sedation Score

0	None (pt. alert)
1	Mild (occasionally drowsy - easy to rouse)
2	Moderate (frequently drowsy - easy to rouse)
3	Severe (somnolent - difficult to rouse)
S	Sleep (normal sleep - easy to rouse)

Nausea Score

0	None
1	Mild (not distressing - no retching / vomiting)
2	Moderate (troublesome - occasional retching / vomiting)
3	Severe (distressing - frequent retching / vomiting)

FLUID ADMINISTRATION

FLUID	VOL (ml)	ADDITIVE / AMT	RATE	PRESC SIGN	START TIME	GIVEN BY	CHECKED BY	BATCH NO

ADDITIONAL REQUIREMENTS / INSTRUCTIONS

2208793218
BURGESS
Henry
M
22/08/1979

NUTRITION

PARENTERAL	ENTERAL
VOL /24 HRS	TYPE VOL /20 HRS
PRESCRIPTION SIGNATURE	PRESCRIPTION SIGNATURE

BATCH NO.	GIVEN BY	CHECKED BY	START TIME	BATCH NO.	GIVEN BY	CHECKED BY	START TIME

My Admission Record

NHS Greater Glasgow and Clyde

Name: [redacted]
2208793218
Address: [redacted] BURGESS M
[redacted] Henry 22/08/1979
[redacted] FLAT 0/1
[redacted] 128 NEILSTON ROAD
DoB: [redacted] Paisley, Renfrewshire
CHI: [redacted] PA2 6EP
Affix patient ID label

Hospital: RNH Ward: Rowan
Date of Admission: 26/4/22 Time: 2245
Information obtained from: Name:
Patient ☐ Relative ☐ Other ☐ _____
Preferred Name: Harry
Age: 42 Telephone Number:
Consultant:

Communication

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

Preferred first contact	**Preferred second contact**
Name: Fiona Garrett.	Name:
Relationship: partner	Relationship:
Address:	Address:
Telephone: 07868 392152	Telephone:
Is this person aware of your admission? Yes ☑ No ☐	Is this person aware of your admission? Yes ☐ No ☐
Can we share information with this person? Yes ☑ No ☐	Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

Confusion.

Explained to the patient? Yes ☑ No ☐ Not Applicable ☐
Do you understand the reason for your admission? Yes ☑ No ☐

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

No known allergies ☑

Relevant past medical history

T1DM
Ex IVDU.
Hepatitis
Suicide attempt March 22.
Splenectomy.

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

Power of Attorney / Guardianship / Adult with Incapacity

Name: _
Address: _
_____
_____
DoB: ___
CHI: ___
Affix patient ID label

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BURGESS M
Henry 22/08/197
FLAT 0/1
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Paisley, Renfrewshire
PA2 6EF

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

Yes ☐ No ☑

OR

Does someone have Guardianship?

Yes ☐ No ☑

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

Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

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

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:	Yes	No
1. Been an inpatient in a hospital outside Scotland?	☑	☐
2. Received holiday dialysis outside Scotland?	☐	☑
3. Been told that you have CPE?	☐	☑
4. Been in close contact with a person with CPE?	☐	☑

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

- Isolate the patient in a side room ☐
- Obtain Rectal swab marked 'for CPE' ☐
- If patient refuses rectal swab, obtain a stool specimen marked 'for CPE' ☐
- **and inform the IPCT** ☐

MRSA Screening

	Yes	No	Unsure
Will the patient be an inpatient for more than 23 hours	☑	☐	☐
If **YES** complete the following section			
1. Have you ever been told that you have MRSA?	☐	☑	☐
2. Have you been admitted from another hospital/ residential setting or care home?	☐	☑	
3. Do you have a wound / skin ulcer or invasive device which you had before admission?	☐	☑	☐

If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabs

Nasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

	Yes	No	Unsure
Have you ever been informed that you are at increased risk of CJD or vCJD?	☐	☑	☐

If **YES Inform the IPCT** ☐

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Henry 22/08/1979
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Paisley, Renfrewshire
PA2 6EP
DoB: ____
CHI: ____
Affix patient ID label

Lifestyle

Smoking

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

Never smoked ☐ vape.

Do you use eCigarettes? Yes ☐ No ☐

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

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

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

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

Drugs

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

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

Alcohol

Do you drink alcohol? Yes ☑ No ☐ 4 cans of dragon soup per day

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

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

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

Name (Please PRINT): JMCWILLIAMS Signature: JMcW

Designation: SN. Date: 26/4/22

My Assessment Record

Name: _____
Address 2208793218
BURGESS
Henry 22/08/1976
FLAT 0/1
128 NEILSTON ROAD
DoB: __ Paisley, Renfrewshire
CHI: __ PA2 6EF
Affix patient ID label

1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems	✓	✓	
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			

Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems	✓	✓	
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

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

Name: ___
Address: ___
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Henry 22/08/1978
FLAT 0/1
DoB: ___ 128 NEILSTON ROAD
CHI: ___ Paisley, Renfrewshire
PA2 6EF
Affix patient ID label

3. Senses

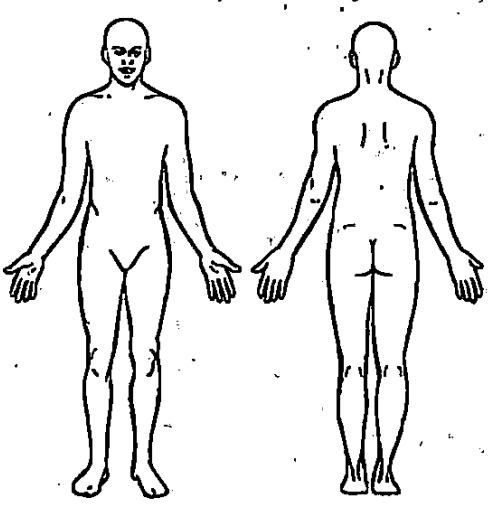
Vision	Yes ✓	No ✓	Assessment of the patient's vision
Do you have any problems with your vision?		✓	
Do you wear glasses?			Distance ☐ Reading ☐ Both ☐
Do you have your glasses with you?			
Do you wear contact lenses?			
Do you have your lenses with you?			
Do you wear a prosthesis?			

Hearing	Yes ✓	No ✓	Assessment of the patient's hearing
Do you have any problems with your hearing?		✓	
Do you have any hearing loss?			
Do you use a hearing aid?			
Do you have your hearing aid(s) with you?			

Pain	Yes ✓	No ✓	Assessment of the patient's pain
Do you have pain?		✓	

Can you describe where and what the pain is like?

Mark current pain on body chart



Have you had treatment / intervention for the pain?

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

Can you describe any chronic pain that you have?

What makes the pain better?

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M
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DoB: __
CHI: __
Affix patient ID label

4. Cognitive Status — THINK DELIRIUM

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

N.B. Think Delirium

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

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

and follow the guidance

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

MSUR.

What do you like to eat and drink?

What do you not like to eat and drink?

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

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓
Normal diet and fluids	✓	✓
Therapeutic diet		
Cultural, ethnic or religious diet		
Texture Modified Diet Please state _____		
Thickened Fluid Please state _____		
Oral Nutritional supplements Preferred flavour _____		
Enteral Nutrition		
Parenteral Nutrition		
Nil by Mouth		

Name: _____
Address: _____
_____
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DoB: ____
CHI: ____
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Henry
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PA2 6EI
22/08/197

Assessment of the patient's hydration and nutrition needs

N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharnygeal Swallow Symptoms (STOPSS) within 4 hours of admission

Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓
Independent (Green)	✓	✓
Prompting / encouragement / opening packets/cutting up food (Amber)		
Full assistance with eating and drinking (Red)		

Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?

6. Elimination

Bladder	Admission Presentation ✓	Normal for the patient ✓
Pass urine with no problems	✓	✓
Frequently pass urine during the day		
Frequently pass urine overnight		
Sense of urgency when need to pass urine		
Urine retention		

Assessment of the patient's elimination needs

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓
Haematuria		
Incontinent		

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

What products do you normally use for this continence issue?

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

Date urinary catheter last changed ___/___/___

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

Bowels

When did your bowels last move? unsure

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

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

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

What products do you normally use for this continence issue?

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

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

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3 Henry
FLAT 0/1
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PA2 6EF
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CHI:
Affix patient ID label

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

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

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

Pressure ulcer identified on admission: Yes ☐ No ☐

Pressure Ulcer Grade: _____

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

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

Wound Care	Yes ✓	No ✓
Do you have any wounds? **N.B. If yes, complete an assessment chart for wound management**		

Name: [redacted]
Address: 2208793218
BURGESS
Henry 22/08/197[illegible]
FLAT 0/1
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 8EI
DoB: [redacted]
CHI: [redacted]
Affix patient ID label

8. Mobility

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

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

9. Maintaining a Safe Environment

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

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

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

10. Sleep and Rest

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

Name:
Address:
DoB:
CHI:
Affix patient ID label

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PA2 6EF
22/08/197

11. Social Circumstances

Do you:

Live alone	☑	Live with family/ friend/ other	☐
Live in a nursing home	☐	Live in a care home	☐
Live in residential supported care	☐	Live in student accommodation	☐
Live in 'homeless' accommodation	☐	Have no fixed abode	☐

Other please specify_____ ☐

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

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

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

12. Emotional and Spiritual Care

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

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

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

Healthcare Chaplain informed Yes ☐ N/A ☑

Name: ___
Address: _
_____
_____
DoB: ____
CHI: ____
Affix patient ID label

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M
22/08/1979

13. Person Centred Care

What matters and is important to you whilst you are in hospital?
This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

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

Informal Support

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

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

Name: .....

Contact Details: .....

.....

.....

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

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

Yes ☐ No ☑

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

Name: _
Address: 2208793218
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Henry 22/08/1971
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CHI: ___ PA2 6EF
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Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?
Yes ☐ No ☑
Referrals can be made via the central phone number: 0141 452 2387

Has the carer been advised of the Carers Information Line?
Yes ☐ No ☑ Not appropriate at this time ☐
Carers Information Line: 0141 353 6504
Carers Information Leaflet provided?
Yes ☐ No ☑

Are you:
Employed ☐ Unemployed ☑
Self-employed ☐ Retired ☐
Full time education ☐

Has your health had an impact on your ability to carry out your day to day activities at work?
Yes ☐ No ☑ Not applicable ☐

Do you have any money worries?
Yes ☐ No ☑ Not appropriate to ask at this time ☐
If yes would you like referred to a money advice service that can offer confidential advice/ support?
Yes ☐ No ☑ If yes when was patient referred ___/___/___

Would you like a referral to a service that can support you with employment / education/ training/ skills volunteering?
Yes ☐ No ☑ Not applicable ☐ Not appropriate to ask at this time ☐
If yes when was patient referred ___/___/___

Name: _____
Address: 2208793218
BURGESS
Henry 22/08/197
FLAT 0/1
128 NEILSTON ROAD
DoB: ___ Paisley, Renfrewshire
CHI: ___ PA2 6E
Affix patient ID label

Risk Assessments/Other Documentation

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

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
26/6/22 2265	Patient attended with convulsions	
	Seizures, febrile. Had 2 seizures	
	last night + convulsed afterwards	
	fell down 6 stairs after 2nd	
	Seizure. Recent ETOH Binge	
	stopped over weekend - nil	
	alcohol. Usually drinks 4 cans	

Name: _
Address: _
_____
_____
DoB: ___
CHI: ___
Affix patient ID label

2208793218
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Henry
FLAT 0/1
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6EF
M
22/08/197[illegible]

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
26/4/22 22:55	Dr dragan saw per Jay. Self	
	discharged early this am	
	went home & smoked heroin	
	~11am. Had further seizure	
	~12noon, much more confused	
	after this. very confused	
	speech, repeating words	
	+ blessing himself during	
	assessment. very vacant	
	history from partner. Fiona	
	pt too confused to answer	
	questions temp 38.7°. Has	
	had ~3 seizures. In the last	
	year Fiona more what caused	
	this Bloods ☑ inc cultures.	
	CTH ☑. NILacute. CKD.	
	Urine cultures + urinalysis ☑	
	Imp! Seizures	
	- Infection ? CNS ? other source	
	- ? Intracranial bleed	
	Plan: CT H ☑.	
	- Antibiotics.	
	- IV aciclovir	
	- MRI ☐	
	- LP. ☑	
	1g Amoxicillin IV @ 2160	
	360mg Gentamycin @ 2160	

Name: ___
Address: ___
2208793218
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Henry 22/08/1979
DoB: ___
CHI: ___
Affix patie... ... ...

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
26/4/22 2245 Ct	On arrival to AMU patient	
	independant from mally	
	to bed. Observations recorded	
	NEWS (4) sats 96% on air	
	new cannula BM 10.1 mmol/l	
	Anairs medical review	
	Tolerating diet + fluids	
	No new complaints offered	
	ACS 14/15 E4 V4 M6	
27/4/22 N/S	Sam Pt was on the phone talking loudly & disruptively within the ward. Pt was asked several times to lower his tones as he argued loudly on the phone. Medics came to review him and he continued to argue with them. Finally I asked him to leave and stop shouting. He was maintaining he wanted to leave & was being very disruptive. Medics encouraged him to stay but did not replace the cannula the left lady pulled out. Pt then decided to go and thirty minutes later during a ward emergency.	

16

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Patient na

Patient CHI

2208793218 M
BURGESS 22/08/1979
Henry
FLAT 0/1
128 NEILSTON ROAD
Paisley, Renfrewshire PA2 6EP

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Emergency Care Nursing Documentation

Presenting complaint - and relevant past medical history including allergies

Date and Time		Name/Signature
26/4/22 19:10	High temp - seizures confusion	MMartinSN.

Nursing notes - on admission

Date and Time		Name/Signature
26/4/22 19:10	ED doctor in attendance Mumira ✓ Roache ✓	MMartinSN

Triage

tient prepared for exam - clothing bagged Y N

NEWS Chart	Y	N	X-rays	Y	N
ID band	Y	N	CXR + CT Head		
Peak Flow	Y	N	Please specify		
12-lead ECG	Y	N	Urinalysis	Y	N
IV access	Y	N			
Blood samples	Y	N	Positive findings		
Blood Gas	Y	N	B-HCG	Y	N

Communication

GGC Red Bag with Patient (nursing home resident)	Y	N
Language or hearing difficulty	Y	N
Interpreter required	Y	N
what arrangements have been made?		
Relatives / Carer / Next of Kin present	Y	N

Partner.

name,relationship,location,particular concerns

Risk Assessments and Screening Tools

SEPSIS	Y	N	GMAWS	Y	N
FAST	Y	N	Adult Support and Protection	Y	N
Swallow Testing	Y	N	Mental Health Triage Assessment	Y	N
Falls Risk (clinical judgeument)	Y	N	Child Protection Concerns	Y	N

Signature: MMartinSN.

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Care Rounds Checklist

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

Signed [signature] Name [illegible] Designation SN

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Use the following Codes:
Y = Yes **N** = No **NA** = Not Applicable **NT** = No Thanks **S** = Sleeping **O** = Off the ward **I** - Independent

			Times	6	22										
	1	**THINK DELIRIUM** Is the patient more confused/drowsy than normal?If yes inform registered nurse.		Y	Y										
	2	**PAIN: ASSESS AND ADDRESS.** Is the patient distressed or in pain?If yes inform registered nurse.		N	N										
S	3	**SKIN INSPECTION** Pressure areas checked?		I	N										
		R = RED D = Discloured PU - Pressure Ulcer INT = Intact M= Moisture		I	I										
K	4	**KEEP MOVING** Has the patient moved or walked?		Y	Y										
		Bed **R** =Right side (30°) tilt **L** =Left side (30°) tilt **B** =Back Chair **W/ST** = Assist to walk / stand		B	B										
		ELIMINATION. Does the patient need the toilet?		I	N										
I	5	**I** = Independent **A** - Assistance given **IC** = Incontinent (urine/faeces)		I	I										
N	6	**FOOD FLUIDS AND NUTRITIO.** Is the patient nil by mouth?		N	N										
		Drink taken?		N	Y										
		Food, snack, or supplements taken?		N/	N										
		Has oral hygiene been carried out as per care plan?		/	NA										
	7	**ENVIRONMENT CHECK** Is the patient's call buzzer to hand? Is the area clutter free clean and safe? Does the patient have everything they require in safe reach? Is the bed in the lowest position?		Y	NA Y										
	8	**INFORMATION** Is there anything else I can help you with? Inform the patient of the time of return		NT	NT										
	9	**ESCALATION** Is there anything else I can help you with? Inform the patient of the time of return		NT	NA										
		Care provider		[illegible]	[illegible]										
		Role		SN	SN										

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

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sticker

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

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PUDRA

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

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

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

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

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

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

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

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

Patient nam

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Nursing notes - discharge plannning

Date and Time		Name/Signature

Outcomes and outstanding issues

Date and Time 19:15		Name/Signature
26/4/22	Pouche · negative	MMansfield SN

Pause for Discharge or Transfer

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

Contact with relatives

Signature:

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4AT assessment - for delirium and cognitive impairment

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

4 or more possible delirium + /- cognitive impairment
1-3 possible cognitive impairment
0 delirium or severe cognitive impairment unlikey (but delirium still possibe if (4) information incomplete

TOTAL

Frailty Assessment Tool (Healthcare Improvement Scotland)

Step 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)? circle Y or N

F	**Functional impairment**	(new or worsening) eg difficulty with self care	**Y**	**N**
R	**Resident**	in a care home	**Y**	**N**
A	**Altered mental state**	such as delirium or dementia **(4AT Assessment)**	**Y**	**N**
I	**Immobility/instability**	decline in mobility, difficulty mobilising without help, fall leading to presentation	**Y**	**N**
L	**Living at home with support**	on a daily basis (homecare, one visit or more per day)	**Y**	**N**

If YES to any of the criteria in Step 1 move to Step 2

Step 2 Would this person be better managed by another speciality team at present? circle Y or N

Clear need for other specialty input eg exacerbation of known long-term condition such as COPD	**Y**	**N**
Need for HDU/ITU (including non-invasive ventilation)	**Y**	**N**
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit	**Y**	**N**
Head injury with loss of consciousness	**Y**	**N**
Acute abdominal pain/ surgical presentation	**Y**	**N**
Upper GI Bleed	**Y**	**N**
Chest pain with suspected acute coronary syndrome	**Y**	**N**
Trauma with suspected fracture	**Y**	**N**

Are any of the criteria met?

If YES to any criteria in Step 2: Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.

If YES to any criteria in Step 1 and NO to ALL criteria in STEP 2: Prioritise transfer of care to specialist geriatric assessment service.

Patient nar

Patient CH

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Henry ..... M
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Nursing notes - ongoing care

Date and Time		Name/Signature
	RR 16/min	
	HR 77/min	
	SpO_2 94%	
	BP 158/84 mmHg	
19:45	T 38.2°C NEWS 2	P
21:20	Attended for CT head + CXR.	DDunne
21:40.	Given 1g amoxicillin I.V Commenced 240mg gentamicin for admission to AMU.	DDunne
22:00	Patient remains agitated Attempting to self d/c. Re-assured patient ~~eng~~ and encouraged to stay.	DDunne
22:15.	Bed ready in AMU. For Aciclovir. Unable to locate in ED or wards at present.	DDunne
22:30.	Called bed manager who is Sourcing Abx. Called AMU happy to start it when Sourced	DDunne

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Care Plan

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Care discussed with patient Unable	☐ Yes	☐ No	☐ If unable, give reason:
Care discussed with family Unable	☐ Yes	☐ No	☐ If unable, give reason:

Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
26/4/22	Nil of note				
MHelme					
	Obs as per news				
			26/4/22	5. Hydration and Nutrition	
			MHelme	Normal diet + fluids	
26/4/22	2, 3. Communication and senses				
MHelme	Wears glasses				
			26/4/22	6. Elimination	
26/4/22	4. Cognitive status		MHelme	Independant.	
MHelme	Normally alert				
	however confused at				
	present				

2208793218
1 BURGESS
3 Henry [illegible] 22/08/1976
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Care Plan

NHS Greater Glasgow and Clyde

Date Commenced and Signature	7. Personal Hygiene, oral care, skin care and wound care	Date Discontinued and Signature	Date Commenced and Signature	9. Maintaining a safe environment, Technical Care	Date Discontinued and Signature
26/6/22	Independant with		26/6/22	Ensure bells to hand	
[signature]	all aspects of personal		[signature]		
	care				
			26/6/22	10. Sleep and Rest	
			[signature]	Promote rest + sleep	
26/6/22	8. Mobility				
[signature]	Independant		26/6/22	12. Privacy, dignity and sexuality	
			[signature]	Ensure curtains	
				are drawn during	
				nursing interventions	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

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FALLS RISK ASSESSMENT

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

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS
TO BE UNDERTAKEN FOR ALL PATIENTS

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

	Ward: AMU Date: 26/4 Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	✓				
2. Check walking aid (if required) is in reach and in use.	✓				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	✓				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	✓				
5. If glasses are worn, check they are available and in use.	✓				
6. If hearing aid/s are worn, check they are working and in use.	✓				

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).
Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.
ALL patients in older people's wards must have an interventional plan in place (overleaf)

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

Highlight risk of fall at the ward safety brief.

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FALLS INTERVENTION CHECKLIST

NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----
BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)					
Assess if a low bed is required (Patient care plan 9)					
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)					
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)					
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.					
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)					
Document continence problems and link to care rounding (Patient care plan 6)					
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)					
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.					
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)					
Update the ward team of the patient's mobility status. (Patient care plan 8)					
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)					
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)					
Signature of nurse completing interventional plan / or update					

If a fall has occurred, refer to the Post Fall Poster and ---ort in Datix. Share post fall lessons learned w[illegible] the team

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

attach label 2208793218 BURGESS M Henry 22/08/1978 FLAT 0/1 128 NEILSTON ROAD Paisley, Renfrewshire PA2 6EP	Hospital: RAH Ward: MMW	Points to consider: • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

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

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

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

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
26/4/22	2265	N	N	N	N	N	N	4 hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	

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

Prevention of Pressure Ulcer Interventional Plan

NHS Greater Glasgow and Clyde

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

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

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

Care Rounds Checklist

Date: 26/4/22

Attach Addr

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Ward:

NHS Greater Glasgow and Clyde

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

1. Signed Mene Name JMcWilliams Designation SN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

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

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

			Times 22Fri																	
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	Y																	
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N																	
S	3	**SKIN INSPECTION** Pressure areas checked:	Y																	
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	INT																	
K	4	**KEEP MOVING** Has the patient moved or walked?	Y																	
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B																	
		Chair Assist to walk or stand (W/ST)	W																	
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	NT																	
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N																	
		Drink taken?	Y																	
		Food, snack, or supplement taken?	Y																	
		Has oral hygiene been carried out as per care plan?	N																	
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y																	
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT																	
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	N/A																	
		Care provider / role	✓																	

Care Rounds Variance Sheet

Attach Addres

2208783218
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Ward:

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Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Pa[illegible]ient) Moving and Handling Assessment Form

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Paisley, Renfrewshire
PA2 6EP

Person's Name:

Named Nurse: JMacMillan

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

1. Ge

Body Build

Weight	Height
Kg	cm
BMI	ft

Problems with comprehension, behaviour, co-operation (specify):

Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):

Risk of Falls: Yes ☐ No ☐

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N/A
See No 2 Sit to Stand Transfers for details	Roll patient ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information:	
	Monkey pole ☐			
	Independent bridging ☐			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information:	
	Monkey pole ☐			
	Rope ladder ☐			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify) ☐			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley ☐			
Bed bath	Bathing hoist (eg Akmi) ☐			

9. Walking

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

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:	26/4/22		
Assessor's signature:	JMacMillan		
Proposed Review date:			

Continuation Sheet

1. General Information (Only complete this section if changed from over page)

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

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist ☐	Standaid ☐	Walking Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
Model		Aid Type	People: 1 ☐ 2 ☐ >3 ☐	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

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

4. Move on / off bed pan

Hoist ☐	Manoeuvre ☐	Assistance ☐	Supervision ☐	N/A ☐
See No 2 Sit to Stand Transfers for details	Roll patient ☐	People: 1 ☐ 2 ☐ >3 ☐	Additional Information:	
	Monkey pole ☐			
	Person bridges ☐			

5. Move up / down bed

Hoist ☐	Handling Aids ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details	Sliding sheets ☐	People: 1 ☐ 2 ☐ >3 ☐	Additional Information:	
	Monkey pole ☐			
	Rope ladder ☐			

6. Lateral Transfer to / from trolley / bed

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

7. Sit up over side of bed

Bed Rest ☐	Assistance ☐	Supervision ☐	Independent ☐
	People: 1 ☐ 2 ☐ >3 ☐	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

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

9. Walking

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

10. Other Instructions / Observations / Equipment Used

	4th Assessment	5th Assessment	6th Assessment
Recording Symbol:	☐ / Forward slash	☐ X Where a forward slash exists, add a back slash to make a cross	☐ * Where a slash or cross exists add slashes to make a star
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

2208793218
BURGESS M
Henry 22/08/197
FLAT 0/1
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6EP

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date_____ Time_____ of initial height and weight on admission to hospital		Actual	*Patient reported	*If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height	_____ cm	☐	☐	
Admission Weight	_____ Kg	☐	☐	

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

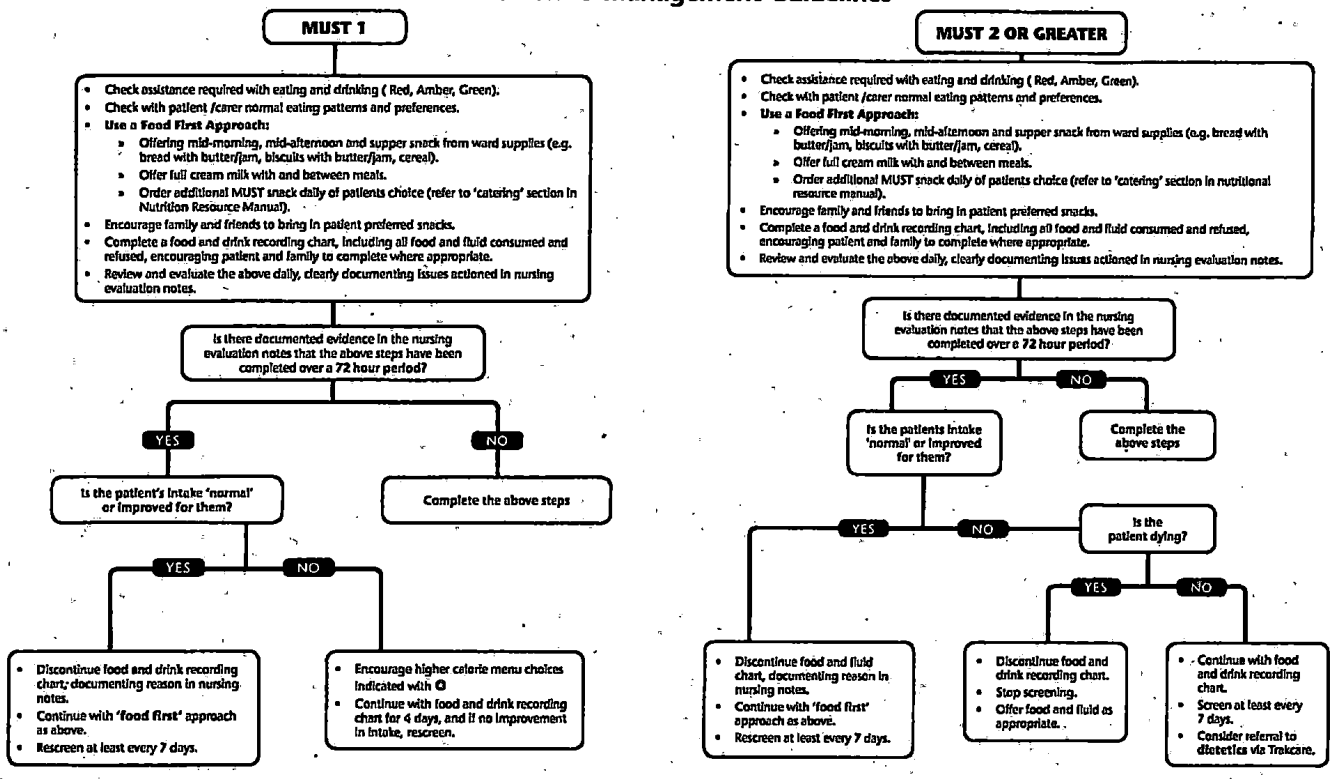
Patients reported normal weight _____ Unable to Recall ☐

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

Date								
Time								
Ward								
Oedema/ Ascities present Y/N								
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes								
Weight (kgs)								
BMI								
Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days								
Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2								
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2								
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0								
Step 4 Overall Risk of Malnutrition TOTAL								
Rescreen on								
Signature								

Step 5 Management Guidelines (excludes patients who are Nil by Mouth)	
Overall Risk of Malnutrition	Ensure plan of care for specific nutritional requirements, MUST score and plans to improve / increase nutritional intake are documented in the patients care plan
0	**LOW RISK** - Repeat screening every 7 days
1	**MEDIUM RISK** - Follow the flowchart for MUST 1 overleaf
2 or greater	**HIGH RISK** - Follow the flowchart for MUST 2 or greater overleaf

MUST STEP 5 Management Guidelines



DISCHARGE

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

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

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Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patient's name:	Ward:
2208793218	
CHI number: A BURGESS M	Discharge destination:
3. Henry 22/08/1978	
FLAT 0/1	Estimated Discharge Date (1) / /
Apply addre 128 NEILSTON ROAD	Estimated Discharge Date (2) / /
Paisley, Renfrewshire	Final date of discharge : / /
PA2 6EP	

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

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Patient ID
2258783218 22/08/1975
BURGESS
Henry

	Date	Ward	Time
Admitted	26/4/22	ED	1720
Transferred			
Transferred			
Transferred			
Transferred			

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

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed.....

Medical: .....

Date: .....

Glasgow Coma Scale

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

Pain Score

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

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

Pain Function Score

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

Patient ID
2258783218 22/08/1975
BURGESS
Henry

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NEWS 2 Key | 1 | 2 | 3

| | | |

My Admission Record

NHS Greater Glasgow and Clyde

Name: [redacted]
Addres 2208783218
BURGESS - - M
Henry 22/08/1979
88a Alice Street
DoB: _ Paisley, Renfrewshire
CHI: _ - - - PA2 6EA
Affix patient ID label

Hospital: RAH Ward: Ann
Date of Admission: 28/04/22 Time: 1530
Information obtained from: Name: cm Blake
Patient ☑ Relative ☐ Other ☐ _____
Preferred Name: Hamy
Age: 42 · Telephone Number:
Consultant: Cenve

Lumiro Neg 28/4/22 ✗ detained A

Communication

What is your first language? Estonian.
Do you require an interpreter? Yes ☐ No ☑
If yes, provide details of arrangements made_____
Do you use British Sign Language (BSL)? Yes ☐ No ☑
Do you need someone to help you to communicate? Yes ☐ No ☑ If yes, who_____

Preferred first contact	**Preferred second contact**
Name: Fiona Gallacks.	Name:
Relationship: Partner.	Relationship:
Address:	Address:
Telephone: 07868 392152.	Telephone:
Is this person aware of your admission? Yes ☑ No ☐.	Is this person aware of your admission? Yes ☐ No ☐
Can we share information with this person? Yes ☑ No ☐	Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

* AWI * *EDOA*

Seizures.

Explained to the patient? Yes ☐ No ☑ Not Applicable ☐
Do you understand the reason for your admission? Yes ☑ No ☐

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

No known allergies ☑

Relevant past medical history

T1DM Splenectomy.
Ex IVDU. Suicide Attempt.
Hepatitis.

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

Power of Attorney / Guardianship / Adult with Incapacity

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

Yes ☐ No ☑

OR

Does someone have Guardianship?

Yes ☐ No ☑

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

Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

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

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Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:	Yes	No
1. Been an inpatient in a hospital outside Scotland?	☑	☐
2. Received holiday dialysis outside Scotland?	☐	☑
3. Been told that you have CPE?	☐	☑
4. Been in close contact with a person with CPE?	☐	☑

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

- Isolate the patient in a side room ☐
- Obtain Rectal swab marked 'for CPE' ☐
- If patient refuses rectal swab, obtain a stool specimen marked 'for CPE' ☐
- **and inform the IPCT** ☐

MRSA Screening

	Yes	No	Unsure
Will the patient be an inpatient for more than 23 hours	☑	☐	☐
If **YES** complete the following section			
1. Have you ever been told that you have MRSA?	☐	☑	☐
2. Have you been admitted from another hospital/ residential setting or care home?	☐	☑	
3. Do you have a wound / skin ulcer or invasive device which you had before admission?	☐	☑	☐

If YES to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabs

Nasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

	Yes	No	Unsure
Have you ever been informed that you are at increased risk of CJD or vCJD?	☐	☐	☐

If **YES inform the IPCT** ☐

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Lifestyle

Smoking

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

Never smoked ☐

Do you use eCigarettes? Yes ☐ No ☐

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

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why:_____

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

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

Drugs

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

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

Alcohol

Do you drink alcohol? Yes ☑ No ☐ NONE in last week.

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

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

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

Name (Please PRINT): CMPAKE Signature: CMPooke

Designation: SCN Date: 28/4/22

My Assessment Record

Nam
Addr
2208793218
BURGESS
Henry
M
DoB 96a Alice Street 22/08/1979
Paisley, Renfrewshire
CHI:
PA2 6EA
Affix

1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems	✓	✓	
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			

Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems	✓	✓	
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

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

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Henry
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Paisley, Renfrewshire
DoB: 22/08/1979 M
CHI:
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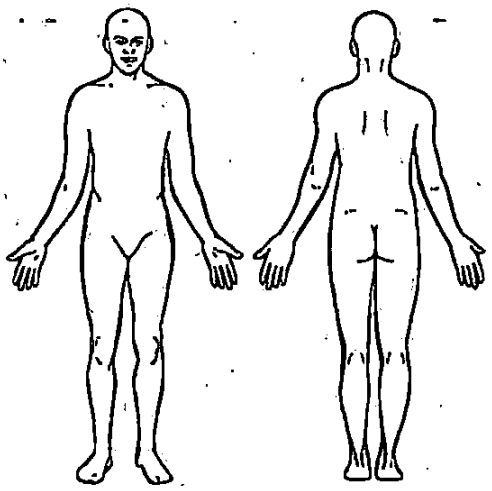
3. Senses

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

Can you describe where and what the pain is like?

Mark current pain on body chart



Have you had treatment / intervention for the pain?

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

Can you describe any chronic pain that you have?

What makes the pain better?

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4. Cognitive Status THINK DELIRIUM

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

N.B. Think Delirium

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

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

and follow the guidance

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

Diabetic

What do you like to eat and drink?

What do you not like to eat and drink?

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

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓
Normal diet and fluids	✓	✓
Therapeutic diet		
Cultural, ethnic or religious diet		
Texture Modified Diet Please state _____		
Thickened Fluid Please state _____		
Oral Nutritional supplements Preferred flavour _____		
Enteral Nutrition		
Parenteral Nutrition		
Nil by Mouth		

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Assessment of the patient's hydration and nutrition needs

N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharnygeal Swallow Symptoms (STOPSS) within 4 hours of admission

Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓
Independent (Green)	✓	✓
Prompting / encouragement / opening packets/cutting up food (Amber)		
Full assistance with eating and drinking (Red)		

Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?

6. Elimination

Bladder	Admission Presentation ✓	Normal for the patient ✓
Pass urine with no problems	✓	✓
Frequently pass urine during the day		
Frequently pass urine overnight		
Sense of urgency when need to pass urine		
Urine retention		

Assessment of the patient's elimination needs

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓
Haematuria		
Incontinent		

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

What products do you normally use for this continence issue?

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

Date urinary catheter last changed ___/___/___

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

Bowels

When did your bowels last move? 9

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

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

Bowel Habit	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Regular			9
Constipated			
Diarrhoea / loose stools			
Blood in stools			
Incontinent			

What products do you normally use for this continence issue?

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

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

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

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

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

Pressure ulcer identified on admission: Yes ☐ No ☑

Pressure Ulcer Grade: _____

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

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

Wound Care	Yes ✓	No ✓
Do you have any wounds? **N.B. If yes, complete an assessment chart for wound management**		

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CHI.
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8. Mobility

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

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

9. Maintaining a Safe Environment

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

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

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

10. Sleep and Rest

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

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Add
DoB
CHI
Affix patient ID label

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22/08/1979

11. Social Circumstances

Do you:

Live alone	☐	Live with family/ friend/ other	☑
Live in a nursing home	☐	Live in a care home	☐
Live in residential supported care	☐	Live in student accommodation	☐
Live in 'homeless' accommodation	☐	Have no fixed abode	☐

Other please specify_____ ☐

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

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

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

12. Emotional and Spiritual Care

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

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

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

Healthcare Chaplain informed Yes ☐ N/A ☑

Nar
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CHI:
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Henry
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Paisley, Renfrewshire
PA2 6EA
M
22/08/1979

13. Person Centred Care

What matters and is important to you whilst you are in hospital?
This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

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

Informal Support

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

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

Name: .....

Contact Details: .....

.....

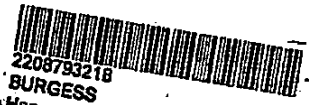
.....

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

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

Yes ☐ No ☑

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



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Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?
Yes ☐ No ☑
Referrals can be made via the central phone number: 0141 452 2387

Has the carer been advised of the Carers Information Line?
Yes ☐ No ☑ Not appropriate at this time ☐
Carers Information Line: 0141 353 6504
Carers Information Leaflet provided?
Yes ☐ No ☑

Are you:
Employed ☐ Unemployed ☐
Self-employed ☐ Retired ☐
Full time education ☐

Has your health had an impact on your ability to carry out your day to day activities at work?
Yes ☐ No ☑ Not applicable ☐

Do you have any money worries?
Yes ☐ No ☑ Not appropriate to ask at this time ☐
If yes would you like referred to a money advice service that can offer confidential advice/ support?
Yes ☐ No ☑ If yes when was patient referred ___/___/___

Would you like a referral to a service that can support you with employment / education/ training/ skills volunteering?
Yes ☐ No ☑ Not applicable ☐ Not appropriate to ask at this time ☐
If yes when was patient referred ___/___/___

Risk Assessments/Other Documentation

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

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
28/4/22	Emergency admission via	
15³⁰	A&E follow up 999 call	
	No history from patient as	
	confused but partner says	
	he had been in hospital	
	& "signed the book" a	
	couple of days ago. Is	

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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
	confused & head ∅ seizure	
	overnight so called	
	ambulance	
	Whilst in ED given IV	
	Ceftriaxone, Aciclovir, paracetamol	
	lorazepam 3mg	
	- Notes say he had taken	
	110 Subutex (buprenorphine)	
	that we brought in street	
	- CT not repeated (had one	
	18hrs ago). Needs LP	
	WCC ↑ 16.7 PG 18.1	
	ALKP 163 AST 172. CRP 23	
	O/A to AMU confused NEWS 3	
	due to ETOH	CM PAICE SCN
	Bery reviewed by Dr Pinter	CM Peake
29/4/22 14.06	BM 17 mmol/L. Insulin given	
	as prescribed. IV abx given	
	as prescribed. Patient remains	
	very agitated. Medics unable	
	to perform LP as so agitated.	
29/4/22 0000	News 4 confusion sp02 95% on air.	
	BM 19.6 mmol/L before 0.6 mmol.	
	IV abx given, IV paracetamol given	
	as prescribed. Encourage oral intake.	
	Meds given and taken well.	
	Patient still unsettled, shouting →	

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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
29/4/22	demanding things.	
→ cont.	Still very ↓ ↓ ↓

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CLINICAL NOTES - MEDICAL ☐
NURSING ☑

Please tick ✔ appropriate directorate

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Date & Time	29/4/22	Signature, Print Name & Designation
Cont.	Patient left hospital.	
0855	Medics asked to phoned police to bring patient back.	
	Police phone back.	
	Patient back and getting r/v by medics. Patient doesn't have capacity. For EDC.	
	Awaiting further plan.	Iswangolata CN.
1550	Seen by Dr Sullivan (MO3)	
	Imp: Lacks capacity to make decisions. For welfare.	
	Risk. to self - seizure / death.	
	↑ potential untreated Encephalitis.	
	Plan: Detain / EDC - in place ✓	
	AWI in place ✓	
	D/w/b MHO - not available.	
	Details taken by Gillian (MHO) will r/v tomorrow.	Iswangolata CN.
0750	Patient tried to leave the ward patient directed back to the ward. Was getting verbally aggressive towards staffs.	
	Directed back to the room.	
	NO observation or Bm / ketone check, as patient was getting aggressive / aggitated and patient refused. Patient was asking for razor this morning, spoke to patient about but refused to listen	→ cont. Iswangolata

83949 GGC0072

Date & Time	29/4/22.	Signature, Print Name & Designation
0730 → con.	Was getting aggitated again. Patient left theware. Staff phoned police for assistance. Awaiting for police to phone back. Medics aware patient of this and suggested to phone police. Still No access. No IV abx given this morning as still no access.	Iverangelista. Iverangelista cc.
29042 1930	Very unsettled day. News (3) due to PCV ev. BM 11.8 at present. Absconded from ward 2x today - brought back by police both times - pt getting physically aggressive with staff. Police remained in attendance. R/V by Dr Grieve this AM:— Imp: . likely not CNS infec . likely drug related plan: . L.P.☐ — . Give ½ dose methadone — . Gmaus / pabrinex. — — . Ψr/v ☐ — — . Continue ceph etc until — L.P proved -ve. Unable to gain IV access all day. - no abx, pabrinex given. Had morning insulin, requiring evening. Sedation plan now in place as per medical notes.	continue → vrayton

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☑

Please tick ✔ appropriate directorate

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Date & Time		Signature, Print Name & Designation
290422 1930	~~Street~~. Short stay detention order now in place. Police have now left. Continue current plan. Aim to gain access and give Abx. ——	
	Was given 2x 0.5mg IM haloperidol by Gerry McLaughlin - not signed on kepma as not prescribed by medics at time. Settled at present. RMN in attendence. ——	Victoria Cavers VCrayfan
30/4/22 0100	Given 10mg Diazepam: meds given and taken well - tolerated. RMN present in the room. spoke to medics, new access inserted IV abx / IV Paracetamol given as prescribe. Given haloperidol but taken oral instead. Medics aware of this, sadly in kepma IM is sign off. No pain voiced. Nursed.	sign off. Ian Laughlin GN.
0745	Patient had a settled night. IV abx given as per prescribe. No pain voiced. Observation taken. Light will last night.	IV angelaki

83949 CGC0072

Date & Time		Signature, Print Name & Designation
30/4/22	Fairly settled day. News 0	
19[10]	at present. Orientated to time +	
	place. today. BM 19.3 ketones 0.7	
	Evening insulin APC. All medications	
	as per Chepma. Independent all	
	ADLs. Tolerating oral diet +	
	fluids. Rlv by Dr Kiyani: —	
	plan: • continue current mgmt	
	— • await L.P + further	
	— Ψ input on Monday	
	Not requiring 1:1 observation	
	today. Given full dose	
	methadone as per Dr Kiyani	
	Nil complaints. Partner in	VICTORIA CANN
	attendance throughout day. —	VCann
2340	Alert & Orientated. Medication	
	as per MEPMA. Independent	
	with ADLs. Tolerating Diet &	
	fluid. No Complaints ——	SN
01/5/22	Patient Slept well. overnight.	
0630	Independent to bathroom.	
	I.V Abx waiting to attach as PVC	
	dislodged, medics aware. No	
	Complaints offered ——	SN
01/05/22	Settled day. News 0. BM 23.9.	
20[00]	Evening insulin APC. Alert +	
	orientated. No IV access throughout	
	day - medics aware + unable to gain access.	
	Tolerating oral diet + fluids. Continues	
	to await further Ψ rlv re:	
	detention. Nil issues throughout	
	day. Given 75mls methadone AMU	VICTORIA CANN
	Stock + 35mls Ward 27 stock.	VCann

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CLINICAL NOTES - MEDICAL ☐
NURSING ☑

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Date & Time		Signature, Print Name & Designation
01/05/22	Patient alert & Orientated. Observations	
2320	stable tolerating Oral fluid Oral	
	Medication given NO IV ACCESS	
	Medics aware.	SN
02/05/22	Patient slept well overnight. Independent	
0610	to bathroom. Remains NO IV Access	
	Medics aware await update	SN
	patient independent with	
	personal care needs	
	Fluid and diet taken well	
	BM 9.1 mmols.	
	Reviewed by SHO Green	
	Plan - LP to take art.	JBlair
	CNS informed.	JL
	+patient still has NO	
	IV access, unable to administer	
	IV antibiotics Medical Staff	
	aware	
	NEWS 0 -	
	patient commenced on	
	Income patch. ☑	
	LP carried out ☑ await	
	result.	
	Detention order remains	
	in situ @ present. awaiting	JBlair
	further input from DRHH.	JL
	patient advised to lie	
	flat after LP.	
	thereafter obs's level fine	

83949 CGC0072

Date & Time		Signature, Print Name & Designation
	Medical Staff aware —	
1830	BM 22.5 mmols KT 0.1	
	patient advised has ate	
	same carbs. —	
	16 units of NOVOMIX 30	Blair.
	administered —	
1920	Telephone call from labs:	
	LP samples not received	
	Medical Staff that sent	Blair.
	sample off duty —	
1926	Contacted ATE Reception.	JBlair
	NO samples at reception.	
2320	Patient independent with personal care	
	this evening. Samples ~~phoned~~ found	
	at ~~Royal~~ Glasgow Royal Infirmary:	
	CSF protein → 0.54	
	CSF Glucose → 6.3	
	BM recheck 7.8 mmols, patient settled at	
	present. No concerns to note	
0215	Patient for transfer to ward 27. Verbal	
	handover given as no access to SBAR	
3/5/22	Patient transferred at 2pm.	
04:30	OBS stable as charted	
	patient fell back to sleep	
	been settled. Inap has	
	detention + AWI in place.	
	can only be removed by	Debbie Knight
	mental health nurse.	D. Knight
DS	comparable BM stable highest 18.1 ketones	
	of 0.2 insulin administered as per HEPMA	
	Shared family involved care continues as	
	per plans.	Nelson Gongora

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Date & Time		Signature, Print Name & Designation
	Alert, Orientated, Novamix given,	
4/5/22	Normal diet and fluids, IV Pabrinex	
0245	written up but meant to be	
	discharged. to query if switch to	
	thiamine. Independent. Mobile, Settled	Rcoordner one
4/5/22	Addiction Liaison: Reports drug use over a	
08:35	bottle of Jack Daniels daily, always requiring	
	morning relief drink. Also reports occasional	
	Xanax use, but states these kept him awake at	
	night. Strongly encouraged to stop all illicit	
	drug use. Open to Renfrewshire ADRS who	Kcoordinator
	prescribe his Methadone.	A ALS
4/5/22	Assessment Independent with personal	
1224	care. Medications given as per	
	kepma. Methadone given.	
	Breakfast taken and insulin self	
	administered.	
	Reviewed by medical staff.	
	For discharge home today.	
	Patient discharged.. Discharge drugs	
	explained and given to patient.	AMorton SCN
	Partner collected.	L C

83949 CGC0072

Date & Time		Signature, Print Name & Designation

Patient name ..

Patient CHI ..

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Emergency Care Nursing Documentation

Presenting complaint - and relevant past medical history including allergies

Date and Time		Name/Signature
28/04/22 07:15	Seizures lasting 2 minute COPD. NKDA	AM. RGN (ST)

Nursing notes - on admission

Date and Time		Name/Signature
28/04/22 08:20	patient confused post seizure. taken to a room and prepared for exam. News of 3. ROC, CPIP. ECG.	

Triage

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

Communication

GGC Red Bag with Patient (nursing home resident)	Y	N
Language or hearing difficulty	Y	N
Interpreter required	Y	N
what arrangements have been made?		
Relatives / Carer / Next of Kin present	Y	N
07928883,		
name,relationship,location,particular concerns		

Risk Assessments and Screening Tools

SEPSIS	Y	N	GMAWS	Y	N
FAST	Y	N	Adult Support and Protection	Y	N
Swallow Testing	Y	N	Mental Health Triage Assessment	Y	N
Falls Risk (clinical judgeument)	Y	N	Child Protection Concerns	Y	N

Signature:

Patient
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e sticker

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are Rounds Checklist

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

Signed [signature] Name Alan M. Designation Student

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Use the following Codes:
Y = Yes **N** = No **NA** = Not Applicable **NT** = No Thanks **S** = Sleeping **O** = Off the ward **I** - Independent

			Times	08:00	11:00								
	1	**THINK DELIRIUM** Is the patient more confused/drowsy than normal? If yes inform registered nurse.	Y	Y	Y								
	2	**PAIN: ASSESS AND ADDRESS.** Is the patient distressed or in pain? If yes inform registered nurse.	N	N	N								
S	3	**SKIN INSPECTION** Pressure areas checked?	N	N	N								
		R = RED **D** = Discloured **PU** - Pressure Ulcer **INT** = Intact **M**= Moisture	I	I	I								
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y								
		Bed **R** =Right side (30°) tilt **L** =Left side (30°) tilt **B** =Back Chair **W/ST** = Assist to walk / stand	B	B	B								
		ELIMINATION. Does the patient need the toilet?	N	N	N								
I	5	**I** = Independent **A** - Assistance given **IC** = Incontinent (urine/faeces)	I	(I)	I								
N	6	**FOOD FLUIDS AND NUTRITIO.** Is the patient nil by mouth?	N	N	N								
		Drink taken?	N	N	N								
		Food, snack, or supplements taken?	N	N	N								
		Has oral hygiene been carried out as per care plan?	N	N	N								
	7	**ENVIRONMENT CHECK** Is the patient's call buzzer to hand? Is the area clutter free clean and safe? Does the patient have everything they require in safe reach? Is the bed in the lowest position?	Y	Y	Y								
	8	**INFORMATION** Is there anything else I can help you with? Inform the patient of the time of return	NR	NR	NR								
	9	**ESCALATION** Is there anything else I can help you with? Inform the patient of the time of return	NR	NR	NR								
		Care provider	AM	AM	AM								
		Role	SN	SN	SN								

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

Patient name .....

Patient CHI .....

or use sticker

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

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PUDRA

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

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

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

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

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

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

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

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

Patient nam
Patient CH

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Nursing notes - discharge plannning

Date and Time		Name/Signature

Outcomes and outstanding issues

Date and Time		Name/Signature
26/4/22	LUMIRAGGC R BURGESS Henry 22/08/1979 Nasal OR Nasopharyngeal 26/04/22 07:31 RAHAE negcare	JS

Pause for Discharge or Transfer

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

Signature: CRes

Contact with relatives

Signature:

Patient name .....

Patient CHI .....

or use sticker

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4AT assessment - for delirium and cognitive impairment

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

4 or more possible delirium + /- cognitive impairment
1-3 possible cognitive impairment
0 delirium or severe cognitive impairment unlikey (but delirium still possibe if (4) information incomplete

TOTAL

Frailty Assessment Tool (Healthcare Improvement Scotland)

Step 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?			circle Y or N	
F	**Functional impairment**	(new or worsening) eg difficulty with self care	**Y**	**N**
R	**Resident**	in a care home	**Y**	**N**
A	**Altered mental state**	such as delirium or dementia **(4AT Assessment)**	**Y**	**N**
I	**Immobility/instability**	decline in mobility, difficulty mobilising without help, fall leading to presentation	**Y**	**N**
L	**Living at home with support**	on a daily basis (homecare, one visit or more per day)	**Y**	**N**

If YES to any of the criteria in Step 1 move to Step 2

Step 2 Would this person be better managed by another speciality team at present?	circle Y or N	
Clear need for other specialty input eg exacerbation of known long-term condition such as COPD	**Y**	**N**
Need for HDU/ITU (including non-invasive ventilation)	**Y**	**N**
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit	**Y**	**N**
Head injury with loss of consciousness	**Y**	**N**
Acute abdominal pain/ surgical presentation	**Y**	**N**
Upper GI Bleed	**Y**	**N**
Chest pain with suspected acute coronary syndrome	**Y**	**N**
Trauma with suspected fracture	**Y**	**N**

Are any of the criteria met?
If YES to any criteria in Step 2: Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.
If YES to any criteria in Step 1 and NO to ALL criteria in STEP 2: Prioritise transfer of care to specialist geriatric assessment service.

Patient name ....

Patient CHI ....

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Nursing notes - ongoing care

Date and Time		Name/Signature
1015 1035	Brought to resus due to seizure activity. Given Imm Midazolam.	
1020	Given cooled IV Saline, antibiotics as prescribed. For im review.	
11:00	Aciclovir started. 250ml.	
11:20	GCS repeated score = 14	
11:30	Blood Glucose = 17.0mmol/L.	
11:30	100ml ceftriaxone ~~db~~ given at 10:45 hrs.	
1145	CXR carried out.	
11:50	Sodium Chloride 0.9% 1000ml	
12:00	Hartmans 500ml started.	
13:20	~~Blood Glucose~~. BM + Ketone Checked. Novomix 30 - 14units given.	
1334	Commenced IV Actrapid TIVx2 as prescribed.	
14:45	NEWS 3. GCS 14/15. Remains awaiting bed.	

CHI: 2208793218 Name: Henry Burgess Gender: Male DOB: 22/08/1979 Age: 42 Yrs Phone:

WARD PATIENT TRANSFER DOCUMENT

Diagnosis

SEIZURE
?CNS

Relevant Medical History

T1DM
EX IVDU
HEPATITIS
SPLENECTOMY
PREVIOUS SUICIDE ATTEMPTS

Current Treatments

LP - AWAIT RESULTS .
IF LP POSITIVE FOR IV ACCESS AND CEF, ACICLOVIR
NICOTINE PATCH
PSYCH INPUT

Any Outstanding/Planned Investigations

MEWS Score 0

- Aggregate 0
- Aggregate 1-4
- Aggregate ≥5 or 3 in one parameter
- Aggregate 7 or more

Is the patient on oxygen? No

Is there DNACPR in place No

Allergies/Alerts

NONE KNOWN

Please state any communication issues

CAN COMMUNICATE NEEDS

4AT 0

- 4 or above possibledelirium+/- cognitive impairment
- 1-3 possible cognitiveimpairment
- 0 delirium or severe cognitiveimpairment unlikely

Behavioural Issues

EDC IN PLACE - TO BE LIFTED BY METAL HEALTH TEAM
NOT REQUIRING 1-1 CARE ANYMORE
NO BEHAVIOURAL ISSUES AT PRESENT

Is the patient exhibiting risk taking behaviours? No

Is the patient a falls risk? No

Skin Assessment
CHI: 2203793218 Name: Henry Burgess

SKIN INTACT Gender: Male DOB: 22/08/1979 Age: 42 Yrs Phone:

STOPSS (Has STOPSS been done?)

N/A

Have all the required risk assessments been completed? (e.g. NUST)

No

If no, please list outstanding risk assessments

Fasting

No

Special Diet/Nutrition

NORMAL DIET AND FLUIDS

Patient Infection

No

Any other relevant information

Is the patient included in criteria led discharge

EDD Date

NOK informed of transfer

User

Emma Gordon2

Contact telephone number

Update Print

Audit Trail

Last Update User Emma Gordon2
Last Update Date 03/05/2022
Last Update Time 02:13

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patient's ni 2208783218
BURGESS M
CHI numb Henry 22/08/1979
66a Alice Street
Paisley, Renfrewshire
PA2 6EA

Ward: 27

Discharge destination: Home

Estimated Discharge Date (1) / /

Estimated Discharge Date (2) / /

Final date of discharge: 4 / 5 / 22

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

Time of Discharge: 12 45

Nurse's signature: L C MORTON Designation: SCA Date: / /

Care Rounds Checklist

Date: 4.5.22.

Attach Addre: Rm 6

2208793218
BURGESS M
Henry 22/08/1979.
96a Alice Street
Paisley, Renfrewshire
PA2 6EA

Ward: 27

NHS Greater Glasgow and Clyde

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

1. Signed [signature] Name MORTON Designation SCN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

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

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

			Times	08:00	15:00	
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		N	N	N
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.		N	N	N
S	3	SKIN INSPECTION Pressure areas checked:		S	S	I
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		—	—	—
K	4	KEEP MOVING Has the patient moved or walked?		S	S	I
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		—	—	I
		Chair Assist to walk or stand (W/ST)		—	—	—
I	5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		S	S	I
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?		N	N	N
		Drink taken?		—	—	Y
		Food, snack, or supplement taken?		—	—	Y
		Has oral hygiene been carried out as per care plan?		—	—	Y
	7	ENVIRONMENT Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		Y	Y	Y
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.		NT	NT	NT
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.		NA	N	NA
		Care provider / role				AC

Care Rounds Variance Sheet

Attach

2208783218
BURGESS
Henry
98a Alice Street
Paisley, Renfrewshire
PA2 6EA

M
22/08/1979

Ward:

NHS
Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

Care Rounds Checklist

Date: 3/5/22

2208793218
Attach BURGESS
Henry M
96a Alice Street 22/08/1979
Paisley, Renfrewshire
PA2 6EA
Ward:

NHS Greater Glasgow and Clyde

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

1. Signed D. Uniga Name Deidre Uniga Designation SW
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

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

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

		Times	0130	0530	0800	1145	1545	1940	2200											
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	S	N	N	N	N	N											
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	S	N	N	N	N	N											
S	3	**SKIN INSPECTION** Pressure areas checked:	N	S	S	I	I	I	R											
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	–	S	–	–	–	–	–											
K	4	**KEEP MOVING** Has the patient moved or walked?	N	S	S	I	I	I	I											
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B	S	–	–	–	–	–											
		Chair Assist to walk or stand (W/ST)	I	S	–	–	–	–	–											
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	S	S	I	I	I	I											
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	S	N	N	N	N	N											
		Drink taken?	I	S	S	Y	Y	Y	–											
		Food, snack, or supplement taken?	I	S	S	Y	Y	Y	–											
		Has oral hygiene been carried out as per care plan?	I	S	S	I	I	I	–											
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y	Y											
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	N	S	S	N	N	N	NT											
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	N	S																
		Care provider / role																		

Care Rounds Variance Sheet

Attac
2208783218
BURGESS M
Henry 22/08/1979
96a Alice Street
Ward Paisley, Renfrewshire
PA2 6EA

NHS
Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 2/5/22

Attach Ac

2208793218
BURGESS
Henry
M
22/08/1979

NHS Greater Glasgow and Clyde

Ward: AMU

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

1. Signed _____ Name _____ Designation _____
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

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

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

		Times	08 45	06 40	10	14 40	18 10	23 60												
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N												
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N												
S	3	**SKIN INSPECTION** Pressure areas checked:	1	1	1	1	1	1												
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	–	–																
K	4	**KEEP MOVING** Has the patient moved or walked?	1	1	1	1	1	1												
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	R	R																
		Chair Assist to walk or stand (W/ST)	/	–																
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	1	1	1	1	1	1												
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N												
		Drink taken?	1	1	4	4	4	4												
		Food, snack, or supplement taken?	1	1	4	4	4	N												
		Has oral hygiene been carried out as per care plan?	1	1	1	1	1	1												
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y												
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	N	N	N	N	N	N												
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA	NA												
		Care provider / role	LR	BH	MM	MM	MM	BH												

Care Rounds Variance Sheet

Attach Addressograph Label

2208793218
BURGESS
Henry
96a Alice Street
Paisley, Renfrewshire
PA2 6EA
M
22/08/1979

Ward:

NHS
Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 28/4/22

Attach A

2208793218
BURGESS
Henry
96a Alice Street
Paisley, Renfrewshire
PA2 6EA
M
22/08/1978

Ward:

NHS Greater Glasgow and Clyde

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

1. Signed _____ Name Cmcbride Designation SN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name Y Maulten Designation SIN

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

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

		Times	15[47]	19[00]	22[00]	03[00]	04[00]	06[00]	10[00]	12[00]	13[00]	16[00]	19[00]	21[00]	22[00]	01[00]	02[55]	04[00]	12[30]	17[30]	21[30]	02[00]	10[00]	13[10]
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	Y	Y	Y		Y		Y	Y	N	S	S	S	S	N	N	S	P	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N		N		N	N	N	S	S	S	S	N	N	S	N	N
S	3	**SKIN INSPECTION** Pressure areas checked:	N	N	N		N		N	N	I	S	S	S	S	N	I	S	I	I
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		I	I		I		I	I	I	S	S	S	I	I	I	S		
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y		Y		Y	Y	Y	Y	Y	S	N	N	I	S	I	I
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B	B	B						B	B	B		R		I	B		
		Chair Assist to walk or stand (W/ST)		I					W	I		I	I		I	W	I	H		W
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		I	I		I		I	I	I	S	S	S	I	I	I	S	I	I
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?		N	N		N		N	N	N	S	S	S	N	N	N	S	N	N
		Drink taken?		Y	Y		N		Y	N	N	S	S	S	N	Y	Y	S	Y	Y
		Food, snack, or supplement taken?		Y	N		N		N	N	N	S	S	S	N	N	Y	S	Y	Y
		Has oral hygiene been carried out as per care plan?		I	N		N		N	N	N	S	S	S	I	N	I	S	I	N
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		Y	Y		Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.		NT	Y		N		Y	Y	2:1	1:1	S	S	NT		N	S	Y	Y
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.		NA	NA		NA		N	N	NA	NA	S	S	NA	N	N	S	NA	N
		Care provider / role		CK DM			MM TL		MM	CS	MA RMN	MA RMN	CC	MM	BM	MM	CC	CC	RM	MM

Care Rounds Variance Sheet

2208793218
BURGESS
Henry
M
22/08/1979
Ward:

NHS
Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Fluid Balance Chart

2208793218
BURGESS
Henry
M
22/08/1979

Hospital: RAH
Ward: ED
Date: 28/04/22

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids? Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input								Running Total	Output						Running Total	Initials
	Oral Fluids		Enteral		IV / Other					Urine	Gastric / Vomit	Bowel	Type	Type	Type		
	Type	Volume	Type	Volume	Type	Volume	Type	Volume	INPUT							OUTPUT	
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
08:00																	
09:00																	
10:00					NaCl	1000ml											
11:00					IVABX	100											
12:00					IVMN	250ml											
13:00					HARTMAN	500ml											
14:00																	
15:00																	
16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
								*Total Intake							*Total Output		

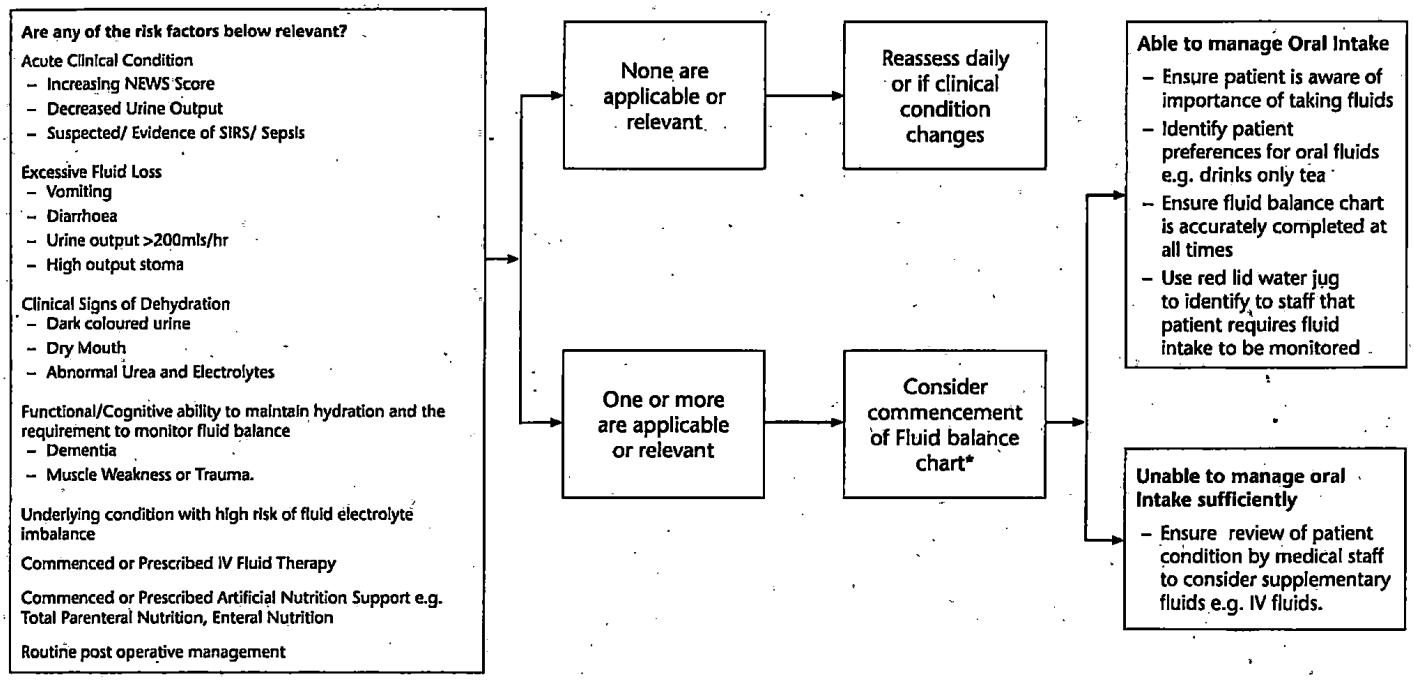
*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2

2208793218
BURGESS
Henry M
98a Alice Street [illegible] 22/08/1979
Paisley, Renfrewshire
PA2 6EA

Care Plan

NHS
Greater Glasgow and Clyde

Care discussed with patient ☐ Yes ☐ No ☐ Unable		If unable, give reason:	
Care discussed with family ☐ Yes ☐ No ☐ Unable		If unable, give reason:	

Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
29/4/22 LO	Lung dissolution		29/4/22 LO		
				5. Hydration and Nutrition	
				Normal diet and fluid	
	2, 3. Communication and senses				
				6. Elimination	
	4. Cognitive status			Continent of both.	
	Confused.				

2208793218
BURGESS
Henry M
FLAT 0/1 [illegible] 22/08/1979
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6EP

Care Plan

NHS
Greater Glasgow and Clyde

Date Commenced and Signature	7. Personal Hygiene, oral care, skin care and wound care	Date Discontinued and Signature	Date Commenced and Signature	9. Maintaining a safe environment, Technical Care	Date Discontinued and Signature
29/4/22 HH	IND/SC		29/4/22 HH	Reduce trip hazard	
				10. Sleep and Rest	
				Promote sleep	
	8. Mobility				
	IND/SC			12. Privacy, dignity and sexuality	
				NAD.	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

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2208793218
BURGESS M
Henry 22/08/1979
98a Alice Street
Paisley, Renfrewshire
PA2 6EA

FALLS RISK ASSESSMENT

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

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

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

	Ward: RMH Date: 29/4/22 Time: 20:30	Ward: 27 Date: 4/5/22 Time: 12:35	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	✓	✓			
2. Check walking aid (if required) is in reach and in use.	N/A	N/A			
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	✓	✓			
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	✓	✓			
5. If glasses are worn, check they are available and in use.	N/A	N/A			
6. If hearing aid/s are worn, check they are working and in use.	N/A	N/A			

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).
Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.
ALL patients in older people's wards must have an interventional plan in place (overleaf)

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

Highlight risk of fall at the ward safety brief.

2208793218
BURGESS M
Henry 22/08/1979
96a Alice Street
Paisley, Renfrewshire
PA2 6EA

FALLS INTERVENTION CHECKLIST

NHS Greater Glasgow and Clyde

iplete for all patients identified at risk of falling.

	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----
BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)					
Assess if a low bed is required (Patient care plan 9)					
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)					
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)					
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.					
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)					
Document continence problems and link to care rounding (Patient care plan 6)					
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)					
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.					
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)					
Update the ward team of the patient's mobility status. (Patient care plan 8)					
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)					
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)					
Signature of nurse completing interventional plan / or update					

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

2208793218
BURGESS
Henry
96a Alice Street
Paisley, Renfrewshire
PA2 6EA
M
22/08/1979

Person S[illegible] loving and Handling Assessment Form

Person's Name:		Person is totally Independent (tick here and go to date box)	✓

1. General Information

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

2. Sit to Stand to Sit Transfers (including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 2 >3	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

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

4. Move on / off bed pan

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

5. Move up / down bed

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

6. Lateral Transfer to / from trolley / bed

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

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 2 >3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

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

9. Walking

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

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:	29/4/21		
Assessor's signature:	[illegible]		
Proposed Review date:			

Continuation Sheet

1. General Information (Only complete this section if changed from over page)

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

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist ☐	Standaid ☐	Walking Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
Model		Aid Type	People: 1 ☐ 2 ☐ >3 ☐	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

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

4. Move on / off bed pan

Hoist ☐	Manoeuvre ☐	Assistance ☐	Supervision ☐	N/A ☐
See No 2 Sit to Stand Transfers for details	Roll patient ☐	People: 1 ☐ 2 ☐ >3 ☐	Additional Information:	
	Monkey pole ☐			
	Person bridges ☐			

5. Move up / down bed

Hoist ☐	Handling Aids ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details	Sliding sheets ☐	People: 1 ☐ 2 ☐ >3 ☐	Additional Information:	
	Monkey pole ☐			
	Rope ladder ☐			

6. Lateral Transfer to / from trolley / bed

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

7. Sit up over side of bed

Bed Rest ☐	Assistance ☐	Supervision ☐	Independent ☐
	People: 1 ☐ 2 ☐ >3 ☐	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

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

9. Walking

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

10. Other Instructions / Observations / Equipment Used

	4th Assessment	5th Assessment	6th Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

2208793218 BURGESS M Henry 22/08/1979 98a Alice Street Paisley, Renfrewshire PA2 6EA	Hospital: RAH Ward: RMU	**Points to consider:** • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

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

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

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

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
28/4/22	15:30	N	N	N	N	N	N	4 hrly	emp
29/4/22	00:30	N	N	N	N	N	N	4 hrly	CO
/ /	:							hrly	
01/05/22	0640	N	N	N	N	N	N	4 hrly	
3/5/22	0630	N	N	N	N	N	N	4 hrly	D.Wright
4/5/22	00:00	N	N	N	N	N	N	4 hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	

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

Prevention of Pressure Ulcer Interventional Plan

NHS Greater Glasgow and Clyde

2208793218
BURGESS
Henry M
96a Alice Street 22/08/1979
Paisley, Renfrewshire
PA2 6EA

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

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

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	SELF MANAGEMENT / SHARED CARE	Comments
Date of plan: 29/4/22	Check: • Pressure areas 4 hourly. • Skin under medical devices 4 hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition 4 hourly in bed and chair. • Overnight patient / carer has agreed to repositioning 4 hourly • Specify any manual handling equipment used:	• Skin care to be carried out 4 hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued:
Date Reviewed:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition ____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out ____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued:
Date Reviewed:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition ____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out ____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued:

Adult | 2208793218 BURGESS Henry [illegible] M 22/08/1979 | Ins: [illegible] Care Plan

Write or affix patient label

Name: _____ CHI: _____

DOB: _____ Address: _____

Ward: RAH Hospital: Arrol

NHS Greater Glasgow and Clyde

Insertion criteria: Please complete this section at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☐ Resuscitation/Chest Pain ☐ IV Drugs ☐ Fluids ☐ Transfusion ☐

PVC inserted: Day 0	Date: 28/4/22 Hospital: RAH Area: ED ☒ Theatre ☐ ITU/HDU ☐ Ward ☐ ____ Unknown ☐ _____
Insertion site:	R Hand ☐ R Arm ☐ R Foot ☒ L Hand ☐ L Arm ☐ L Foot ☐ Other: _____
Colour of cannula:	Blue ☐ Pink ☐ Green ☐ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: _____

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? (Diagnostics, Resuscitation/ Chest Pain, IV Drugs, Fluids, Transfusion)	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day 29/4/22	Yes ☒ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☒ No ☐	Yes ☒ No ☐ N/A ☐	☑
Day 1 Check 2 Night __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: __/__/__ Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: 29/4/22

*Reason For Removal: Dislodge.

Modified Visual Infusion Phlebitis (VIP) Score

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

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and S. aureus bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids ? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → Can I switch my patient from IV to oral antibiotics?

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature ≤ 37.9°C, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE** is available reliably (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, S. aureus bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abcess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy. Record the intended duration on the medicine kardex

YES

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

NO

NEWS 2 Key | 1 | 2 | 3

| | | |

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Affix Patient ID

22/07/1970
BURGESS
Henry

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

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

Document all actions and Interventions

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

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

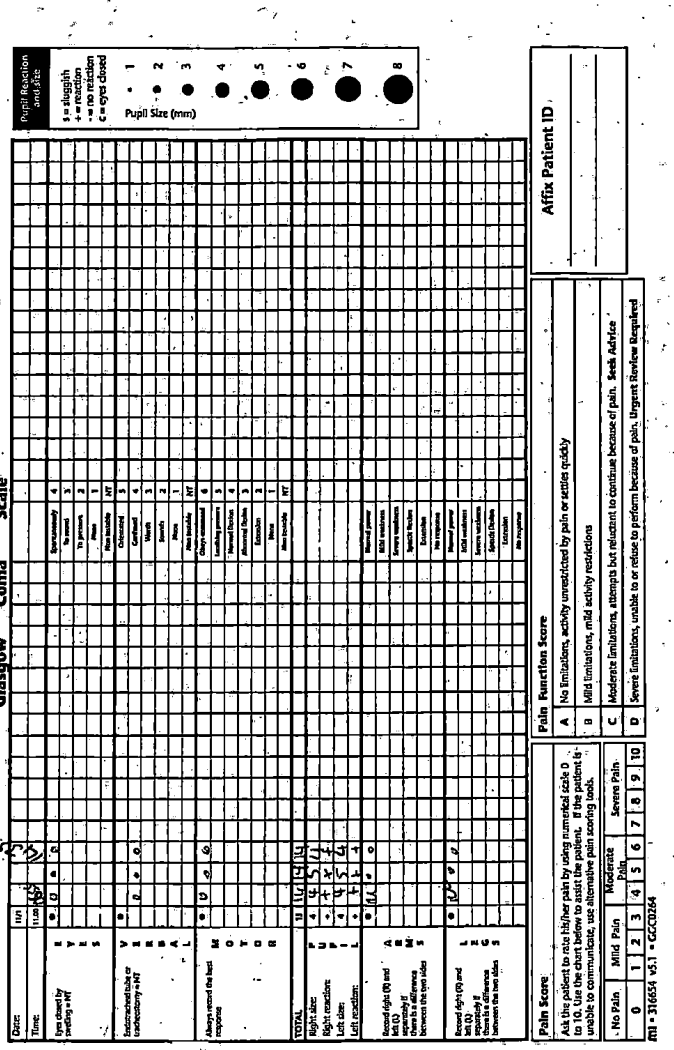
Discontinuation of NEWS

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

Signed.....

Medical: .....

Date: .....



Patient name

Patient CHI

2208793218
BURGESS
Henry M
96a Alice Street 22/08/1979
Paisley, Renfrewshire
PA2 6EA

NHS
Greater Glasgow and Clyde

Emergency Care Nursing Documentation

Presenting complaint - and relevant past medical history including allergies

Date and Time		Name/Signature
14/6/23	Self termination seizure	
1605		A-McChesney

Nursing notes - on admission

Date and Time		Name/Signature
14/6/23	Patient into Room - awaiting exam	
1605	NEWS0	A-McChesney

Triage

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

Communication

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

Risk Assessments and Screening Tools

SEPSIS	Y	N	GMAWS	Y	N
FAST	Y	N	Adult Support and Protection	Y	N
Swallow Testing	Y	N	Mental Health Triage Assessment	Y	N
Falls Risk (clinical judgeument)	Y	N	Child Protection Concerns	Y	N

Signature:

Patient name ...

Patient CHI ...

2208793218
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PA2 6EA

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Greater Glasgow and Clyde

Care Rounds Checklist

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

Signed MM Name Megan Meegan Designation Student

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Use the following Codes:
Y = Yes **N** = No **NA** = Not Applicable **NT** = No Thanks **S** = Sleeping **O** = Off the ward **I** - Independent

			Times	1829										
	1	**THINK DELIRIUM** Is the patient more confused/drowsy than normal?If yes inform registered nurse.		N										
	2	**PAIN: ASSESS AND ADDRESS.** Is the patient distressed or in pain?If yes inform registered nurse.		N										
S	3	**SKIN INSPECTION** Pressure areas checked?		N										
		R = RED **D** = Discloured **PU** - Pressure Ulcer **INT** = Intact **M**= Moisture		IND										
K	4	**KEEP MOVING** Has the patient moved or walked?		4										
		Bed **R** =Right side (30°) tilt **L** =Left side (30°) tilt **B** =Back Chair **W/ST** = Assist to walk / stand		B										
		ELIMINATION. Does the patient need the toilet?		NT										
I	5	**I** = Independent **A** - Assistance given **IC** = Incontinent (urine/faeces)		I.										
N	6	**FOOD FLUIDS AND NUTRITIO.** Is the patient nil by mouth?		N										
		Drink taken?		N										
		Food, snack, or supplements taken?		N										
		Has oral hygiene been carried out as per care plan?		N										
	7	**ENVIRONMENT CHECK** Is the patient's call buzzer to hand?		N/a										
		Is the area clutter free clean and safe?		4										
		Does the patient have everything they require in safe reach?		4										
		Is the bed in the lowest position?		4										
	8	**INFORMATION** Is there anything else I can help you with? Inform the patient of the time of return		N/k										
	9	**ESCALATION** Is there anything else I can help you with? Inform the patient of the time of return		N										
		Care provider		MM										
		Role		SN										

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

Patient na

Patient Cl

2208793218
BURGESS
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Paisley, Renfrewshire
PA2 6EA

NHS
Greater Glasgow and Clyde

Nursing notes - ongoing care

Date and Time		Name/Signature
17:45	I.V. fluids infusing as prescribed	CS. WICAT Hutcheson
1805	IV pabrinex commenced.	ERICKINNON SN
1835	Imp: ? Infective gastroenteritis,	
	? DVT, ? Alcohol induced seizure.	
	Plan: - U&S R. leg	
	- Stool culture.	
	- Monitor BMs as T1DM.	ERICKINNON SN
1920	Care taken over by dayshift attending x-ray	
1950	Pt had self terminating seizure lasting 1 minute. NEWS (1), GCS 14. Confused. Dr doctor in with pt getting 2nd I.V access at present	L-Lapsley SN
2020	GMAS score (3). 10mg diazepam gen. For ARW	

Patient I

Patient C

2208793218 M
BURGESS 22/08/1975
Henry
96a Alice Street
Paisley, Renfrewshire
PA2 6EA

NHS
Greater Glasgow and Clyde

4AT assessment - for delirium and cognitive impairment

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

4 or more possible delirium + /- cognitive impairment
1-3 possible cognitive impairment
0 delirium or severe cognitive impairment unlikey (but delirium still possibe if (4) information incomplete

TOTAL

Frailty Assessment Tool (Healthcare Improvement Scotland)

Step 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?			circle Y or N	
F	**Functional impairment**	(new or worsening) eg difficulty with self care	**Y**	**N**
R	**Resident**	in a care home	**Y**	**N**
A	**Altered mental state**	such as delirium or dementia **(4AT Assessment)**	**Y**	**N**
I	**Immobility/Instability**	decline in mobility, difficulty mobilising without help, fall leading to presentation	**Y**	**N**
L	**Living at home with support**	on a daily basis (homecare, one visit or more per day)	**Y**	**N**

If YES to any of the criteria in Step 1 move to Step 2

Step 2 Would this person be better managed by another speciality team at present?	circle Y or N	
Clear need for other specialty input eg exacerbation of known long-term condition such as COPD	**Y**	**N**
Need for HDU/ITU (including non-invasive ventilation)	**Y**	**N**
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit	**Y**	**N**
Head injury with loss of consciousness	**Y**	**N**
Acute abdominal pain/ surgical presentation	**Y**	**N**
Upper GI Bleed	**Y**	**N**
Chest pain with suspected acute coronary syndrome	**Y**	**N**
Trauma with suspected fracture	**Y**	**N**

Are any of the criteria met?
If YES to any criteria in Step 2: Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.
If YES to any criteria in Step 1 and NO to ALL criteria in STEP 2: Prioritise transfer of care to specialist geriatric assessment service.

Patient name

Patient CI

2208793218 M
BURGESS 22/08/1979
Henry
96a Alice Street
Paisley, Renfrewshire PA2 6EA

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

NHS
Greater Glasgow and Clyde

PUDRA

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

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

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

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

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

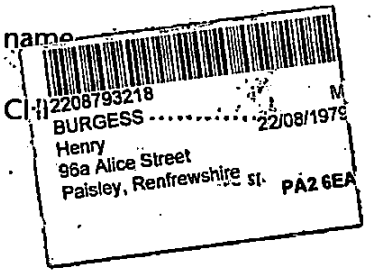
Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
/ /	:							____hrly	
/ /	:							____hrly	
/ /	:							____hrly	

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

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

Patient name

Patient CI



NHS
Greater Glasgow and Clyde

Nursing notes - discharge plannning

Date and Time		Name/Signature

Outcomes and outstanding issues

Date and Time		Name/Signature

Pause for Discharge or Transfer

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

Contact with relatives

Signature:

My Admission Record

NHS Greater Glasgow and Clyde

2208783218
BURGESS, Henry 22/08/197
96a Alice Street
Paisley, Renfrewshire
PA2 6EJ

Affix patient ID label

Hospital: RAH Ward: AMU
Date of Admission: 14-6-23 Time: 2145
Information obtained from: Name:
Patient ☑ Relative ☐ Other ☐ _____
Preferred Name: HARRY
Age: 44 Telephone Number:
Consultant:

Communication

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

Preferred first contact	**Preferred second contact**
Name: FIONA GARRETT	Name:
Relationship: PARTNER	Relationship:
Address:	Address:
Telephone: 07477774484	Telephone:
Is this person aware of your admission? Yes ☑ No ☐	Is this person aware of your admission? Yes ☐ No ☐
Can we share information with this person? Yes ☑ No ☐	Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

SEIZURE DVT

Explained to the patient? Yes ☑ No ☐ Not Applicable ☐
Do you understand the reason for your admission? Yes ☑ No ☐

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

No known allergies ☑

Relevant past medical history

TIDM PNEUMONIA
HEPC IVDU
PE
DVT

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

Power of Attorney / Guardianship / Adult with Incapacity

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

Yes ☐ No ☑

OR

Does someone have Guardianship?

Yes ☐ No ☐

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

Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

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

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:	Yes	No
1. Been an inpatient in a hospital outside Scotland?	☐	☑
2. Received holiday dialysis outside Scotland?	☐	☑
3. Been told that you have CPE?	☐	☑
4. Been in close contact with a person with CPE?	☐	☑

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

- Isolate the patient in a side room ☐
- Obtain Rectal swab marked 'for CPE' ☐
- If patient refuses rectal swab, obtain a stool specimen marked 'for CPE' ☐
- **and inform the IPCT** ☐

MRSA Screening

	Yes	No	Unsure
Will the patient be an inpatient for more than 23 hours	☐	☐	☐
If **YES** complete the following section			
1. Have you ever been told that you have MRSA?	☐	☑	☐
2. Have you been admitted from another hospital/ residential setting or care home?	☐	☑	
3. Do you have a wound / skin ulcer or invasive device which you had before admission?	☐	☑	☐

If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabs

Nasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

	Yes	No	Unsure
Have you ever been informed that you are at increased risk of CJD or vCJD?	☐	☐	☐

If **YES inform the IPCT** ☐

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Lifestyle

Smoking

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

Never smoked ☐

Do you use eCigarettes? Yes ☐ No ☐

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

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

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

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

Drugs

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

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

_____

_____

Alcohol

Do you drink alcohol? Yes ☑ No ☐ 4 CANS DAILY & 8

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

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

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

Name (Please PRINT): A DARLING Signature: DJC

Designation: CN Date: 14-6-23.

My Assessment Record

Name: _____

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1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems		✓	
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			

Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems		✓	
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

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

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3. Senses

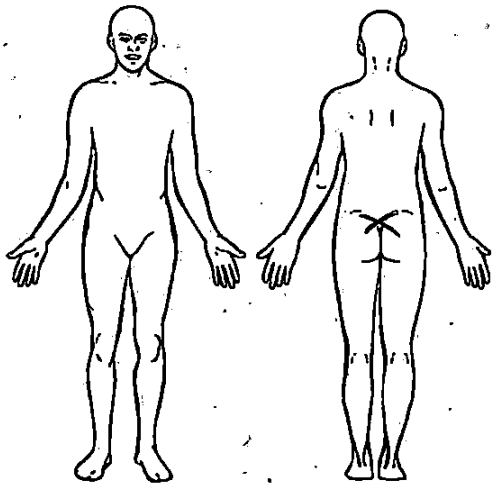
Vision	Yes ✓	No ✓	Assessment of the patient's vision
Do you have any problems with your vision?	✓		
Do you wear glasses?	✓		Distance ☐ Reading ☐ Both ☐
Do you have your glasses with you?	✓		
Do you wear contact lenses?			
Do you have your lenses with you?			
Do you wear a prosthesis?			

Hearing	Yes ✓	No ✓	Assessment of the patient's hearing
Do you have any problems with your hearing?		✓	
Do you have any hearing loss?			
Do you use a hearing aid?			
Do you have your hearing aid(s) with you?			

Pain	Yes ✓	No ✓	Assessment of the patient's pain
Do you have pain?	✓		

Can you describe where and what the pain is like?

Mark current pain on body chart



Have you had treatment / intervention for the pain?

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

Can you describe any chronic pain that you have?

What makes the pain better?

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4. Cognitive Status THINK DELIRIUM

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

N.B. Think Delirium

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

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

and follow the guidance

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

What do you like to eat and drink?

What do you not like to eat and drink?

coffee.

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

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓
Normal diet and fluids	DIABETIC	
Therapeutic diet		
Cultural, ethnic or religious diet		
Texture Modified Diet Please state _____		
Thickened Fluid Please state _____		
Oral Nutritional supplements Preferred flavour _____		
Enteral Nutrition		
Parenteral Nutrition		
Nil by Mouth		

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Assessment of the patient's hydration and nutrition needs

N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS) within 4 hours of admission

Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓
Independent (Green)		✓
Prompting / encouragement / opening packets/cutting up food (Amber)		
Full assistance with eating and drinking (Red)		

Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?

6. Elimination

Bladder	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Pass urine with no problems		✓	
Frequently pass urine during the day			
Frequently pass urine overnight			
Sense of urgency when need to pass urine			
Urine retention			

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓
Haematuria		
Incontinent		

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

What products do you normally use for this continence issue?

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

Date urinary catheter last changed ___/___/___

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

Bowels

When did your bowels last move?

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

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

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

What products do you normally use for this continence issue?

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

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

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

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

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

Pressure ulcer identified on admission: Yes ☐ No ☐

Pressure Ulcer Grade: _____

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

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

Wound Care	Yes ✓	No ✓
Do you have any wounds? **N.B. If yes, complete an assessment chart for wound management**		✓

Name: _____

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8. Mobility

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

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

9. Maintaining a Safe Environment

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

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

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

10. Sleep and Rest

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

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11. Social Circumstances

Do you:

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

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

If yes, who?

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

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

If yes, please provide details:

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

12. Emotional and Spiritual Care

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

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

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

Healthcare Chaplain informed Yes ☐ N/A ☐

Name: _____

Address: _____

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13. Person Centred Care

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

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

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

Informal Support

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

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

Name: .....

Contact Details: .....

.....

.....

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

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

Yes ☐ No ☐

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

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Required Support

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

Yes ☐ No ☐

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

Has the carer been advised of the Carers Information Line?

Yes ☐ No ☐ Not appropriate at this time ☐

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐ No ☐

Are you:

Employed ☐
Self-employed ☐
Full time education ☐
Unemployed ☐
Retired ☐

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

Yes ☐ No ☐ Not applicable ☐

Do you have any money worries?

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

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

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

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

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

If yes when was patient referred ___/___/___

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Risk Assessments/Other Documentation

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

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
14.6.23	999 call	
	No recollection of event	
	Partner reports LOC @ 1300hrs	
	stiffening all 4 limbs	
	slid off chair	
	looked pale	
	Looked 5-7 mins	

Name: _____
Address: _____
_____
_____
DoB: _____ 22/08/1975 M
CHI: _____
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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
14-6-23	Self terminated	
	Felt jerky beforehand	
	confused + agitated afterwards	
	Reports 6 days being unwell	
	Lower abdo pain	
	Associated bloody diarrhoea	
	mixed into stools	
	Feels feverish	
	Also R calf pain + swelling	
	?: infective gastroenteritis	
	? DVT	
	AIC related seizure	
	D dimer < 230	
	Head AV/AW 2 min witnessed	
	tonic clonic seizure in ED	
	Given Pabrex	
	GMWS score 3 -	
	Given 10mg diazepam @ 2025	
	OTA to A&W	
	NEWS 0	A DALRYMPLE RGN
	IV fluids behind time	
0130 14-6-23.	Patient appears settled and sleeping at present. Vague + drowsy but rousable. Scoring on GMWS-2 given 10mg diazepam. BM - 9.7 mmol No further concerns a/w medical RV	ANNA ROSS STN

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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
15/6/23 0530	News 0 Am Bm: 5·5 Patients room is strong smelling of cigarettes asked if he had been smoking & denies it. Have explained the risk of doing so & that it is not permitted in the hospital.	J Walker JW SN
0700	Patient self d/c this am. No meds given. No obs taken. Cannula removed. Spoke with medics but decided was happy to leave ward anyway. d/c alone.	SN

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Care Plan

NHS Greater Glasgow and Clyde

C... Unable	☐ Yes ☐ No ☐	If unable, give reason:
Care discussed with family Unable	☐ Yes ☐ No ☐	If unable, give reason:

Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
14/06/23 A.Lo	Normal				
			14/06/23 A.Lo	5. Hydration and Nutrition Normal	
14/06/23 A.Lo	2, 3. Communication and senses No issues				
			14/06/23 A.Lo	6. Elimination No issues	
14/06/23 A.Lo	4. Cognitive status Alert & orientated				

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Care Plan

NHS Greater Glasgow and Clyde

Date Commenced and Signature	7. Personal Hygiene, oral care, skin care and wound care	Date Discontinued and Signature	Date Commenced and Signature	9. Maintaining a safe environment, Technical Care	Date Discontinued and Signature
14/06/23 ANe	Independent		14/06/23 ANe	Buzzer to hand	
			14/06/23 ANe	10. Sleep and Rest No issues	
14/06/23 ANe	8. Mobility Ind.		14/06/23 ANe	12. Privacy, dignity and sexuality NO ISSUES	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

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R8

Care Rounds Checklist

Date: 14/06/23

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

1. Signed A.Mc Name A.Balmaine Designation CV
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

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22/08/1971
Ward:

NHS Greater Glasgow and Clyde

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

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

		Times	22	15	20
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N
S	3	**SKIN INSPECTION** Pressure areas checked:	N	Y	Y
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	INT	INT	
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	R	B	
		Chair Assist to walk or stand (W/ST)			W
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	I	I
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N
		Drink taken?	N	N	Y
		Food, snack, or supplement taken?	N	N	—
		Has oral hygiene been carried out as per care plan?	N	N	I
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	N	N	NT
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	N	N	NA
		Care provider / role	[illegible]	[illegible]	[illegible]

Care Rounds Variance Sheet

NHS
Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

W
N: 2208793218
M BURGESS
D Henry
W 96a Alice Street
Paisley, Renfrewshire
PA2 6EA

CHI: _____
Address: _____
22/08/197[illegible] Hospital: _____

NHS Greater Glasgow and Clyde

Insertion criteria: **at time of insertion.**

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☐ **Resuscitation/Chest Pain** ☐ **IV Drugs** ☐ **Fluids** ☐ **Transfusion** ☐

PVC inserted: Day 0	Date: 24/6/25 Hospital: RAH Area: ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☐ _____ Unknown ☐ _____
Insertion site:	R Hand ☐ R Arm ☐ R Foot ☐ L Hand ☐✓ L Arm ☐ L Foot ☐ Other: _____
Colour of cannula:	Blue ☑ Pink ☐ Green ☐ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: _____

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? Diagnostics Resuscitation/ Chest Pain IV Drugs Fluids Transfusion	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 1 Check 2 Night __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: __/__/__ **Reason for keeping PVC in after 72 hrs/ 3 days:** _____

***Date PVC Removed:** __/__/__

***Reason For Removal:** _____

Modified Visual Infusion Phlebitis (VIP) Score

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

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and S. aureus bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids ? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → **Can I switch my patient from IV to oral antibiotics?**

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature ≤ 37.9°C, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE is available reliably** (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, S. aureus bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abcess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy.
Record the intended duration on the medicine kardex

YES → This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

NO

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Paisley, Renfrewshire PA2 6E

FALLS RISK ASSESSMENT

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

NHS Greater Glasgow and Clyde

GEN ... SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

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

	Ward: AMU Date: 14/06/23 Time: 22:00	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	✓				
2. Check walking aid (if required) is in reach and in use.	✓				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	✓				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	✓				
5. If glasses are worn, check they are available and in use.	NA				
6. If hearing aid/s are worn, check they are working and in use.	NA				

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).
Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.
ALL patients in older people's wards must have an interventional plan in place (overleaf)

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

Highlight risk of fall at the ward safety brief.

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FALLS INTERVENTION CHECKLIST

NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----
BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)					
Assess if a low bed is required (Patient care plan 9)					
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)					
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)					
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.					
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)					
Document continence problems and link to care rounding (Patient care plan 6)					
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)					
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.					
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)					
Update the ward team of the patient's mobility status. (Patient care plan 8)					
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)					
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)					
Signature of nurse completing interventional plan / or update					

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

Pers[illegible]t) Moving and Handling Assessment Form

2208793218 M
BURGESS
Henry
22/08/1979

Person's Name:		med rse:		Person is totally independent (tick here and go to date box)	✓

1. Genera

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

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 2 >3	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

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

4. Move on / off bed pan

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

5. Move up / down bed

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

6. Lateral Transfer to / from trolley / bed

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

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 2 >3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

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

9. Walking

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

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:	14/06/23		
Assessor's signature:	AN		
Proposed Review date:	on going		

Continuation Sheet

1. General Information (Only complete this section if changed from over page)

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

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist ☐	Standaid ☐	Walking Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
Model		Aid Type	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist ☐	Standaid ☐	Walking Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information:	

4. Move on / off bed pan

Hoist ☐	Manoeuvre ☐	Assistance ☐	Supervision ☐	N/A ☐
See No 2 Sit to Stand Transfers for details	Roll patient ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information:	
	Monkey pole ☐			
	Person bridges ☐			

5. Move up / down bed

Hoist ☐	Handling Aids ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details	Sliding sheets ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information:	
	Monkey pole ☐			
	Rope ladder ☐			

6. Lateral Transfer to / from trolley / bed

Hoist ☐	Handling Aids ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify) ☐			

7. Sit up over side of bed

	Bed Rest ☐	Assistance ☐	Supervision ☐	Independent ☐
		People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment ☐	Handling Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
Shower ☐	Shower chair ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath ☐	Shower trolley ☐			
Bed bath ☐	Bathing hoist (eg Aten) ☐			

9. Walking

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

10. Other Instructions / Observations / Equipment Used

	4th Assessment	5th Assessment	6th Assessment
Recording Symbol:	☐ / Forward slash	☐ X Where a forward slash exists, add a back slash to make a cross	☐ * Where a slash or cross exists add slashes to make a star
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

2208793218 M BURGESS Henry [illegible] 22/08/197[illegible] 96a Alice Street Paisley, Renfrewshire PA2 6EA	Hospital: RAH Ward: AMU	**Points to consider:** • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

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

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

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

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
11/08/22	2200	N	N	N	N	N	N	4 hrly	AR
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	

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

Prevention of Pressure Ulcer Interventional Plan

NHS Greater Glasgow and Clyde

2208793218
BURGESS
Henry
86a Alice Street
Paisley, Renfrewshire
PA2 6EA
22/08/197

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

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

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

Glasgow Assessment and Management of Alcohol

NHS Greater Glasgow and Clyde

Please Attach Patient Label

CHI: 2208793218
Name: BURGESS Henry M
Addres 96a Alice Street 22/08/1979
Paisley, Renfrewshire
PA2 6EA
Postcoc

Estimated Weekly Alcohol Units : 28.2
Daily Units x Number of Days per Week)
Excessive Weekly Consumption >14 units/week

Estimated Date / Time Of Last Drink: >12 hrs.
(If ≥ 5 Days, Re-consider Alcohol Withdrawal Status)

Presents with or has had previous alcohol withdrawal seizures/ severely agitated withdrawal:

YES: ☑ NO: ☐

IS IT ALCOHOL WITHDRAWAL?

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

Fast Alcohol Screening Tool - FAST:

Note : 1 drink = 1 unit of alcohol

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

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

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

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

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

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

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

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

Score of 3 or more: FAST Positive

Total 10

FAST Positive? Yes ☑ No ☐

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

EXCEPTIONAL PATIENT GROUP WITH CO-MORBIDITY?

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

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

REFER TO SECTION 3 (PAGE 3) FOR MANAGEMENT ADVICE

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

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Order Number GGC0169

Prophylaxis and Treatment of Wernicke-Korsakoff Syndrome

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

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

- Confusion
- Ataxia
- Decreased consciousness
- Opthalmoplegia
- Nystagmus
- Hypothermia/ hypotension

YES → Presumptive diagnosis of Wernicke's Encephalopathy (if symptoms otherwise unexplained) **GO TO BOX A**

NO → Assess Risk of Wernicke's Encephalopathy **GO TO BOX B**

BOX A	Day 1-2	Day 3-5	Day 6 onwards
Presumptive Diagnosis of Wernicke's Encephalopathy: This requires URGENT treatment	**Pabrinex IV:** 2 pairs of vials three times a day. **Magnesium** Check Serum Magnesium URGENTLY and give intravenous replacement if deficient.	**Pabrinex IV/IM** 1 pair of vials three times a day	Change to **oral Thiamine** 50mg four times a day **or** continue IV/IM **Pabrinex** at discretion of Medical Team

BOX B	RISK FACTORS for WERNICKE'S	
	Risk Factors	**Severe Risk Factors**
Assessment of Risk of Wernicke's Encephalopathy	Weight loss (MUST=1) Poor diet or vomiting for <5 days Alcoholic Liver Disease Presents with Seizure Age ≤18 or ≥65	Severe Weight loss (MUST≥2) Poor Diet or vomiting for >5 days

No Risk Factors	One Risk factor	Two or more Risk Factors or any single Severe Risk Factor
Oral Thiamine 50mg four times a day	**Pabrinex IV/IM** 1 pair of vials three times a day for **24** hours then change to **oral Thiamine** 50mg four times a day	**Pabrinex IV/IM** 1 pair of vials three times a day for **48** hours then change to **oral Thiamine** 50mg four times a day

Check Magnesium in all patients and correct deficiency

Important notes

- If oral thiamine is indicated but a patient is unable to take medicines by mouth, then consult your ward pharmacist: NG administration may be possible or IM Pabrinex® (1 pair of vials once daily) are alternatives
- Intravenous Pabrinex® should be administered over 30 minutes
- Anaphylaxis is a rare complication of IV Pabrinex® administration and even more uncommon with IM administration. Monitor patient for wheeze, tachycardia, breathlessness and skin rash. Facilities for the administration of adrenaline and other resuscitation should be available.
- Additional vitamin supplementation as clinically indicated by responsible medical team in the context of a general nutritional assessment.
- Discontinuation of oral thiamine should be considered for patients who have been abstinent for 3 months and who have an adequate dietary intake.

Management of Alcohol Withdrawal Syndrome

1. DEPENDENT DRINKING ON SCREENING - HIGH RISK

EXCEPTIONAL PATIENT GROUP WITH CO-MORBIDITY?

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

YES

NO

1. DEPENDENT DRINKING ON SCREENING - HIGH RISK

Any 2 of the following:
Presents with or has had previous withdrawal seizures or severely agitated withdrawal
High screening score (FAST ≥12)
High initial symptom score (GMAWS ≥4)

YES

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

NO

SYMPTOM TRIGGERED TREATMENT (GMAWS)

For exceptional patient groups see Section 3

2. FIXED DOSE TREATMENT REGIME: Oral Diazepam (see **Section 5** for patients unable to tolerate oral):

INITIAL DOSE: 20mg Diazepam 6 hourly

REDUCE DOSE: If after 24 hours no additional symptom triggered treatment has been required

OR

If after ≥48 hours of treatment GMAWS less than 4

REDUCING DOSE: (Not to be prescribed 24hrs in advance. Step down only if GMAWS remains less than 4)

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

3. EXCEPTIONAL PATIENT GROUPS: SYMPTOM TRIGGERED TREATMENT ONLY

- Patients with evidence of liver disease especially jaundice or encephalopathy: use oral **Lorazepam** in a symptom triggered fashion: 1-2 mg (up to 12mg in 24 hours, when senior medical review is required as below)
- Patients with other co-morbidity (i.e. COPD, pneumonia, cerebrovascular disease, reduced GCS, elderly (>70), head injury): use Lorazepam as above **OR** Diazepam at 50% of standard GMAWS dose
- In pregnancy use Diazepam at 50% of standard GMAWS dose with senior medical review if more than 30mg required in 24 hours

REVIEW PRESCRIPTION if patient is excessively drowsy

SENIOR MEDICAL REVIEW (ST3 or above) REQUIRED for diagnostic review and possible adjunctive therapy (Section 4): - If patient requires more than 120mg Diazepam in 24 hours
- If patient still requiring full dose treatment 96 hours after last alcohol ingestion

4. SEVERE WITHDRAWAL (aggressive/ uncontrollable/ dangerous behaviour)[1]

- Intravenous Diazemuls up to 40mg over first 30 minutes (up to 2mg/minute; flumazenil to be available) **(Section 5)**
- Adjunctive therapy with Haloperidol 2-5mg IM in first instance and response assessed **(refer to alcohol withdrawal section in the GGC Therapeutics Handbook regarding Haloperidol and patients with prolonged QTc)**
- Consultation regarding intensive care support may be necessary in extreme situations

5. PATIENTS UNABLE TO TOLERATE ORAL MEDICATION / PARENTERAL BENZODIAZEPINES

- Patients unable to tolerate oral medication may receive parenteral therapy as an alternative at 50% of the oral dose in the first instance, and response assessed
- Intravenous benzodiazepines should be administered by an experienced member of medical (FY2 or above) or nursing staff who have completed the appropriate Competency Training to administer IV sedation

6. MONITORING

- All patients should be closely observed for signs of over-sedation with regular observations
- Exceptional Patient Groups **(Section 3)**, patients with Severe Withdrawal **(Section 4)** and patients requiring parenteral sedation **(Section 5)** require close monitoring (NEWS) ideally with one-to-one nursing care

Glasgow Modified Alcohol Withdrawal Scale (GMAWS) **Treatment Option:** GMAWS Only ☐ GMAWS & Fixed Dose ☐

Date	14/6/23	14/6/23	15/6/23																
Time	2020	23[oc]	0130	0420	0645														
Tremor 0) No tremor 1) On movement 2) At rest	0	0	0	0	0														
Sweating 0) No sweat visible 1) Moist 2) Drenching sweats	1	1	0	0	0														
Hallucination 0) Not present 1) Dissuadable 2) Not dissuadable	0	0	0	0	0														
Orientation 0) Orientated 1) Vague, detached 2) Disorientated, no contact	1	1	0	0	0														
Agitation 0) Calm 1) Anxious 2) Panicky	1	0	0	0	0														
Score	3	2	0	0	0														
Treatment	10mg oral	10mg Diaz	Nil	Nil	Nil														
Staff Signature			JW	JW	JW														

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

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

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

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

9 – 10 :Give 20mg Diazepam : Repeat Score in 1 hour

EXCEPTIONAL PATIENT GROUPS: SYTMPTOM TRIGGERED TREATMENT
Patients with evidence of liver disease especially jaundice or encephalopathy: use oral Lorazepam 1-2 mg .
Patients with other co-morbidity (i.e. COPD, pneumonia, cerebrovascular disease, reduced GCS; elderly (>70), head injury): use Lorazepam as above **OR** Diazepam at 50% of standard GMAWS dose.
In pregnancy use Diazepam at 50% of standard GMAWS

PATIENTS MAY REQUIRE TO BE WOKEN FOR CONTINUING ASSESSMENT

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

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

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

APPROXIMATE ORAL BENZODIAZEPINE EQUIVALENCE: 10mg Diazepam = 1mg Lorazepam = 25mg Chlordiazepoxide
Patients should not be discharged on regular benzodiazepine

Developed by the Acute Alcohol Screening & Withdrawal Management Guideline Group Chaired by Dr Ewan Forrest, Consultant Physician and Gastroenterologist, GRI
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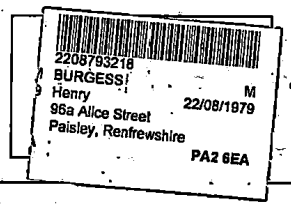
Published: August 2020
Review Date: January 2023
Version: 5th Edition Amendment



NHS Greater Glasgow and Clyde

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

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

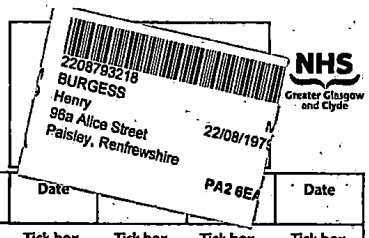
This should be done on admission; at each transition of care; if SQiD positive; or if any clinical concerns.

4AT

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

Score >4 This is a possible DELIRIUM +/- COGNITIVE IMPAIRMENT, start 'T' and 'I' of TIME and escalate to medical staff to confirm diagnosis	**Score 1-3** This is a possible COGNITIVE IMPAIRMENT, and requires further assessment	**Score 0** DELIRIUM or SEVERE COGNITIVE impairment unlikely

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



TIME checklist to guide Delirium risk reduction, Identification and Management

The TIME checklist is a joint medical and nursing responsibility.

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

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GGC0138

NEWS 2 Key | 1 | 2 | 3

Affix Patient ID

| | | |

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

2208783218 2208781579
BURGESS
Henry

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

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

Document all actions and interventions

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

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

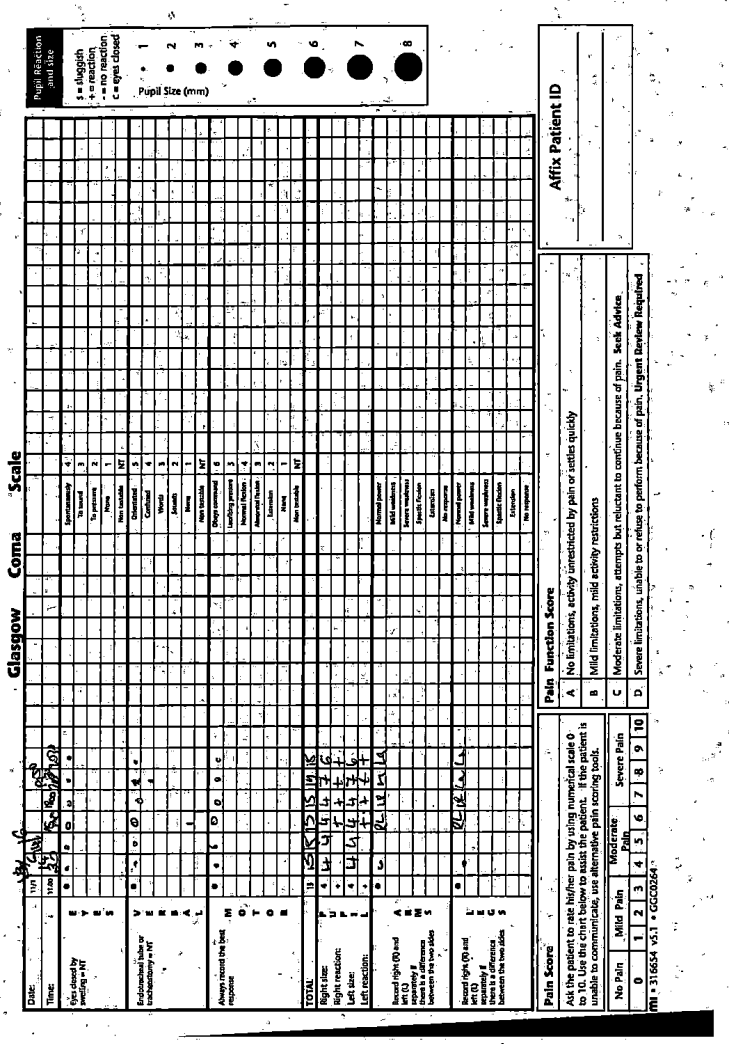
Discontinuation of NEWS

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

Signed.....

Medical: .....

Date: .....



2205793218 3/6

Care Rounds Checklist

Date: 16/12/20

Attach Addressograph Label
Henry Burgess

Ward: 24

NHS Greater Glasgow and Clyde

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

1. Signed [signature] Name [signature] Designation SN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

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

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

		Times	02:30	04:30	06:30	8	10	12	15			20:30							
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N	N			N							
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N	N			N							
S	3	**SKIN INSPECTION** Pressure areas checked:	S	S	S	Y	Y	Y	Y			Y							
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	S	S	S	R	R	R	R			R							
K	4	**KEEP MOVING** Has the patient moved or walked?	S	S	S	Y	Y	Y	Y			Y							
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	S	S	S	B	ST	/	/			B							
		Chair Assist to walk or stand (W/ST)	S	S	S	ST	C	CH	CH			/							
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	S	S	S	A	A	A	A			A							
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N	N			N							
		Drink taken?	N	N	N	Y	Y	Y	Y			Y							
		Food, snack, or supplement taken?	N	N	N	Y	Y	Y	/			/							
		Has oral hygiene been carried out as per care plan?	N	N	N	Y	Y	/	/			/							
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y	Y			Y							
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	N	N	N	NT	NT	NT	NT			NT							
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	N	N	N	NA	NA	NA	NA			NA							
		Care provider / role	EM	EM	EM	SN	SN	SN	SN FW			SN							

Care Rounds Variance Sheet

Attach Addressograph Label
Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • CGC0098

Royal Alexandra Hospital

Endoscopy

Date: 8/2/23

Named Nurse: Karla

Patient liked to be known as: HARRY

- ☐ Gastroscopy
- ☑ Colonoscopy
- ☐ Bowel Screening Colon
- ☐ Bi-directional
- ☐ Sigmoidoscopy
- ☐ Ebus
- ☐ Bronchoscopy

2208793218
BURGESS M
Henry 22/08/1979
FLAT 0-1
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6EP

Transport arrangements

Contact person: Fiona Greer

Contact Phone Number: 07868 392 152

Escort return arranged (time):

Escort to be contacted YES / NO

Overnight supervision:

Overnight stay in Ward:

Pre-procedure check

Procedure Explained: (Yes) / No

Consent Form Signed: (Yes) / No

Fasted Since: Am / Pm

Bowel Prep:
- ☐ Not applicable
- ☐ Picolax x
- ☐ Klean Prep x
- ☐ Moviprep x
- ☐ Enema at Home
- ☐ Enema on Arrival

Time given: Plenvu 1

Participates in Bowel Screening Programme YES NO

Result:
- ☑ Good
- ☐ Poor

Vomited:

Patient requests:
- ☐ Throat spray
- ☑ IV sedation
- ☐ No sedation
- ☐ Not applicable
- ☑ Dentures YES NO Top.

Venflon Inserted:
- ☐ Right Hand
- ☐ Left Hand
- ☐ Right Arm
- ☐ Left Arm

Time .....

Inserted by.....

Presenting complaint

Food 1900. | PR Bleeding - 4x per day diarrhoea
Fluids 0800.

Covid 19 asked no symptoms

Medical history

Condition Yes / no	Yes / No	Details
Allergies	YES	OPIATES.
Diabetes / Glaucoma	YES	T1DM.
Epilepsy	NO.	
Hypertension	NO.	
Hepatitis B or C	YES	HEP C. CHRONIC HEPATITIS.
Asthma / COPD	NO.	
Angina / Ischaemic heart disease	NO.	
Cardiac / Valvular heart disease	NO.	
Heart surgery / pacemaker	NO.	
Joint implants	NO.	
Relevant illness/ surgery/family history	YES	FAMILY COPD. Memory loss., (Sister had Bowel Ca. Colostomy bag)
Have you ever been notified that your are at increased risk of CJD / VCJD for public health purposes	NO.	Alcohol dependance. ABRS. Alcohol seizures, lungs - pulmonary Embolus 2020

Current medication (list below, ticking those taken today)

MATRIZACINE		AMOXICILLIN.			
PREGABALIN.		LANSOPRAZOLE.			
THIAMINE.		INSULIN - NOVORAPID.			

Admission observations

Blood Pressure	140 / 94	Pulse	95	SAO2	92
Respirations		Blood Glucose	16.6.	INR	
Return Clinic Appointment (If appropriate)		Admitting Nurse Sign:			

Further Comments:
cannula sited ~~[illegible]~~ right hand - on yellow

Endoscopist. Miss Creamer **Endoscopy Pause : YES/NO**

PROCEDURE DETAILS

Medication	Dose	Time	Route (circle appropriately)
Xylocaine Spray			Venflon Bolus Topical
Lignocaine gel			Venflon Bolus Topical
Lignocaine solution 2%			Venflon Bolus Topical
Buscopan			Venflon Bolus Topical
Pethidine			Venflon Bolus Topical
Fentanyl	No fentanyl.		Venflon Bolus Topical
			Venflon Bolus Topical
Midazolam	4mg	1210	Venflon Bolus Topical
			Venflon Bolus Topical
Flumazenil			Venflon Bolus Topical
Naloxone			Venflon Bolus Topical
IV DRUG CHECK INITIALS			

clare 6
Alison F

Procedure & Scope Used	Specimens (Tick appropriately)			
COLONOSCOPY	o Cold Bx	o Hot Bx	o Polypectomy	o Proctoscopy o Banding of Haemorroids
	ID: 606547642000020B7 07/02/2023 EXPIRES: 07/02/2023 20:22 RAH			
	(1) caecal bx			
FLEXIBLE SIGMOIDOSCOPY				
Please affix scantrack label here				

Procedure & Scope Used	Specimens (Tick appropriately)			
Gastroscopy	o Cold Bx	o Clotest	o Banding of Varcies x.....	o Oesophageal Dilitation .....mm
Please affix scantrak label here				
PEG: Change of PEG:	Size:	Make:	Mark to skin:	
Bronchoscopy	o Biopsy	o Brush o Smear	o Washing	
Please affix scantrak label here				
EBUS	o Fine Needle Aspirate:			
Please affix scantrak label here				

Argon Beamer Site(s) :	Injection of Gelofusine/Indigo Carmine & Adrenaline 1 in 10000 Site(s) :	Injection of Inkspot (site)

Diathermy Pad	Time Applied		Site		Time Removed		Skin (comment)	

Supplementary details **(Tick / complete Appropriately)**

Comfort Level Scoring			Time	Resps	SAO2 95	Pulse	O2/	Nasal Cannula	Mask	Sign
	1	None. Resting comfortably								
	2	One or two episodes of mild discomfort, well tolerated	1210 1215		96% 96%	81 72	AIR 2L	✓		CG CG
	3	More than two episodes of discomfort, adequately tolerated.	1225 1235		97% 97%	78 74	2L 2L	✓		CG CG
	4	Significant discomfort experienced several times.	1240		96%	70	AIR			CG
	5	Extreme discomfort frequently during test.								

Specimens obtained. Awaiting pathology

Signature: CG

Provisional Discharge Time:	

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Paisley, Renfrewshire
PA2 6EP

Escort contacted:	

Recovery details

Time	Post-procedure: BP:	P:	Resps:	SaO2:	Discomfort Score:	Sign
1240	156/99.	80.	14	98	0	Heart Hodgson Hcare
	BM @ 1245.	14.5mmols				
1310	147/98.	93.	14	98%	0	

Discharge Evaluation

	Yes	No	Not Applicable
Alert and orientated	✓		
Tolerating diet/fluids **(If appropriate)**	✓		
Cannula/Butterfly removed	✓		
Injection site satisfactory	✓		
Outpatient appointment indicated on Discharge Appointment Form		✓	
Verbal and written aftercare instructions given	✓ (KARLA)		
Clotest result – POSITIVE NEGATIVE			✓
Unisoft report updated	✓		
REPEAT PROCEDURE			✓
Patient received discharge letter	✓		
Warfarin discharge letter/Diabetic advice given	✓		✓
Haemodynamically Stable	✓		
Escort present	✓		

Discomfort Score	0
Discharge Time	1326

Discharged by... Hcardon

Consent Form

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128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6EP

Patient agreement to colonoscopy investigation

Test: Colonoscopy

Inspection of the lower gastrointestinal tract with
a flexible endoscope (with or without biopsy and photography) Specimens will be retained.

You have the right to change your mind at any time, including after you have signed this form.

Patient statement

I have read and understood the information in this booklet including the benefits and any risks.

I agree to the test described in this booklet and on the form.

I understand that you cannot give me a guarantee that a particular person will perform the test.

I understand that any test in addition to that named on this form will only be carried out:

if it is necessary;

- is reasonable in the circumstances,
- in relation to the medical treatment proposed,
- and to safeguard or promote physical or mental health.

Have you ever been notified that you are at an increased risk of CJD/VCJD for public health purposes? ☐ Yes ☑ No

Consent signature

Signed: M. B ..... Date: 8/2/2023

Name: (print in capitals) H BURGESS

Please sign here if you refuse to consent to the emergency administration of blood or blood products.

Signature: ..... Date: .....

(For staff only)

Confirmation of consent (to be completed by a health care professional when the patient is admitted for the test)

I have confirmed that the patient understands what the test involves including any risks.

I have confirmed that the patient has no further questions and wishes the test to go ahead.

Signed: Karla Teaz ..... Date: 8/2/23

Name: (print in capitals) K TEAZ

Job title: STAFF NURSE

What happens after a Polyp is removed?

Often when large or multiple polyps are removed, the Endoscopist will advise a repeat procedure after a certain timescale to make sure the polyp has not re-grown and that new polyps have not developed. We will write to you about this after your colonoscopy.

After the Colonoscopy

You will be able to rest after the colonoscopy. We will offer you a drink and something to eat. You may feel a little bloated after the procedure as some of the air may remain in your bowel. This may cause some discomfort but will quickly pass

Before you leave the department, a nurse or doctor will discuss results. You will receive a report of your test and we will tell you if you need any medication or further appointments.

Remember, if you had sedation:

- You may not remember the results. If you agree, we will tell your family or friend your results, so that they can remind you.
- You may feel fully alert after your test but as the drug stays in your body for up to 24 hours. You can feel drowsy with lapses of memory. It is important not to drive or drink alcohol during this time.
- You will need to arrange for someone aged 18 years or over to stay with you, or arrange to stay with your family or a friend overnight.

NHS Endoscopy Care Plan

Greater Glasgow and Clyde

2208793218
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Henry 22/08/1979
0/1 128 Neilston Road
Paisley, Renfrewshire
PA2 6EP

Date: 04/06/24 **Consultant / Endoscopist:** Dr Ricketts

Patient liked to be known as: "Harry"

Procedure

Gastroscopy	☐	E.R.C.P	☐	EBUS	☐
Colonoscopy	☐	E.U.S	☐	Enteroscopy	☐
Sigmoidoscopy	☐	Bronchoscopy	☑	Thoracoscopy	☐

Discharge Arrangements * Alcohol smell from pt on arrival *

Name of Escort /contact ..... Relationship ..... Contact tel no ..... patient has no escort	**Escort Required** Yes ☐ No ☐ **Escort to be contacted** Yes ☐ No ☐	**Overnight supervision arranged** Yes ☐ No ☐ **Overnight stay in ward** Yes ☐ No ☐

Have you received Patient Information and understood it: Yes ☐ No ☐

Medical History and Pre Procedure check

Condition	Yes	No	Details
Diabetes	✓		Type 1 ☑ Type 2 ☐ on insulin
Angina/ Ischaemic heart Disease			
Hypertension			
Myocardial Infarction			Date:
Artificial valves			
Pacemaker			
CABG			
Coronary artery stent			
Stroke/TIA			
Asthma			
COPD			
Epilepsy			
Liver disease			
Arthritis			
Orthopaedic implants			Specify:
Glaucoma			
Anaemia			
Recent surgery			
Previous endoscopy			
CJD/VCJD risk			
Other			

left the department patient

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PA2 6EP
M
22/08/1979

Presenting complaint	Yes	No	Detail other illness or complaint
Reflux			
Dysphagia			
Barretts			
Oesphageal/Gastric Varices			
Gastric ulcer			
Altered bowel habit			
PR bleeding			
Crohns disease			
Ulcerative colitis			
Surveillance colonoscopy			
Screening programme			
Other:			

Mobility Assessment

Independent Yes ☐ No ☐ If No, complete all questions

Aids and/ or assistance required Yes ☐ No ☐

Walking stick ☐ Zimmer ☐ Wheelchair ☐ Other ☐ Specify .....

Sight impairment Yes ☐ No ☐ if yes specify .....

Communication Needs (answer only applicable question)

Hearing impairment Yes ☐ No ☐

Hearing aid Yes ☐ No ☐ right ear ☐ left ear ☐ both ears ☐

Sign Interpreter required Yes ☐ No ☐

Lip reads Yes ☐ No ☐

Interpreter Required Yes ☐ No ☐ Language .....

Interpreter present Yes ☐ No ☐

Relative / friend present Yes ☐ No ☐

The use of relatives and friends as interpreters is discouraged unless it is the patient's choice to use them.

Learning Disability Yes ☐ No ☐ Carer present Yes ☐ No ☐

Dementia Yes ☐ No ☐ Incapacity form completed Yes ☐ No ☐

Current Medication (list below and tick those taken today)

ANTICOAGULANT THERAPY Yes ☐ No ☐ If yes current medication .....

When was this medication last taken Specify .....

INR Result .....

2208793218
BURGESS
Henry
0/1 128 Neilston Road
Paisley, Renfrewshire
PA2 6EP
M
22/08/1979

Intra Procedure

Endoscopist (print) .....

Endoscopy Room Nurses (print) .....

Surgical Pause carried out Yes ☐ No ☐

Medication Administered Pre, Intra and Post Procedure

Drug	Yes	No	Time	Dose	Route	Given/Sign/Dr/Nurse
Xylocaine spray						
Midazolam				mg	IV	
Midazolam				mg		
Midazolam				mg		
Pethidine				mg		
Pethidine				mg		
Pethidine				mg		
Fentanyl				mcg		
Fentanyl				mcg		
Fentanyl				mcg		
Buscopan				mg		
Buscopan				mg		
Buscopan				mg		
Antibiotics						
				mg		
				mg		
				mg		
Reversal Agents						
				mg		
				mg		
Local anaesthetic						
				mg		
				mg		
Other						
Botox				mg		

Prescribed by.....

Endoscopist Signature.....

Start Time ..... Finish Time .....

Patient position Left Lateral ☐ Supine ☐ Prone ☐ All ☐

Oxygen therapy Yes ☐ No ☐ nasal sponge ☐ cannula ☐ mask ☐ rate .....

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Admission Observations

BP 150/78 Pulse 84 Oxygen Saturation 94% air (97% after few breaths)

BM (if applicable) 17.9mmol/s Respirations (if applicable) .....

Fasted since 03/06/24 (p.m) Fluids 11°° 04/06/24

Bowel Prep	Klean Prep	Moviprep	Picolax	Enema / home	Enema / dept	Other
No of sachets						
Result- Good / Poor						

Patient Requests

Throat Spray ☐ IV Sedation ☐ No Sedation ☐ Not Applicable ☐

IV Cannulation

R Hand	L Hand	R Arm	L Arm	Other	Time	Inserted by (please print)

Dentures removed (if applicable) Yes ☐ No ☐

Crowns Yes ☐ No ☐ upper ☐ lower ☐ front ☐ back ☐ R side ☐ L side ☐

Bridgework Yes ☐ No ☐ upper ☐ lower ☐ front ☐ back ☐ R side ☐ L side ☐

Identiband details checked Yes ☐ No ☐

Consent form signed Yes ☐ No ☐

Consent form countersigned Yes ☐ No ☐

Underwear removed (if applicable) Yes ☐ No ☐

Jewellery removed Yes ☐ No ☐

ALLERGIES Yes ☐ if yes detail below No ☐

Details .....

Name of Admission Nurse (Print) K.GOGAN

Signature of Admission Nurse ..... S/N (Please see overleaf)

Patient's Declaration

I have read and understood the warnings regarding the after effects of sedation.

Patient's signature .....

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Observations during procedure

Time						
Pulse						
SpO2						
BP						
Resps						

Procedure (please tick all relevant)

Gastroscopy		Biopsy		Varices		Adrenaline	
Colonoscopy		Hot Biopsy		Gastric Ulcer		Spot Dye	
Sigmoidoscopy		Snare Polypectomy		Duodenal Ulcer		Indigo Carmine	
E.R.C.P.		Balloon dilatation		Oesophagus		Gelofusine	
E.U.S		Injection		Duodenum		Normal Saline	
Bronchoscopy		Laser		Biliary		Haemospray	
E.B.U.S		Heater Probe		Pancreatic			
Thoracoscopy		Endo clip		Haemorrhoids			
Enteroscopy		Insertion of Stent		Rectum			
		EMR		Sigmoid			
		PEG		Descending			
		Needle Aspiration		Splenic flexure			
		Brushings		Transverse			
		Washings		Hepatic flexure			
		Banding		Ascending			
		Insert of NJ tube		Caecum			
		Gastric Pacing Wire		Terminal Ileum			

Other .....

Sedation score	Tick	Comfort Score	Tick
Asleep		None, resting comfortably	
Drowsy		One or two episodes of mild discomfort, well tolerated	
Awake		More than two episodes of discomfort, adequately tolerated.	
		Significant discomfort experienced several times	
		Extreme discomfort frequently during procedure	

Comments

Specimens Yes ☐ No ☐

Pathology ☐ No of pots ..... H pylori test ☐ bacteriology ☐ cytology ☐ mytology ☐

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Diathermy Yes ☐ No ☐ Type mono ☐ Argon ☐

Site of diathermy pad leg ☐ back ☐ R side ☐ L side ☐ Upper ☐ Lower ☐

Other .....

Condition of skin post diathermy normal ☐ other ☐ comment below

.....

Recovery Room Instructions (if applicable)

Oxygen 4 litres per minute if SpO2 drops below 95% ☐

Oxygen 4 litres per minute until fully awake ☐

Oxygen ..... per minute via .....until ..... ☐

Normal Diet ☐ Fluids only ☐ Soft Diet ☐ Nil orally till further medical instructions ☐

To be seen by endoscopist before discharge ☐

Further Instructions .....

.....

Endoscopy Room Nurse Signature .....

Recovery care

Post endoscopy observations

Time										
Blood pressure										
Pulse										
O2 Saturation										
Respiratory Rate										
Sedation score										
Pain score										
Oxygen										
IV Cannula										
BM										
Nurse initials										

Pain score 0 = no pain, 1 = minimal, 2 = mild, 3 = moderate, 4 = severe

Sedation score A - Asleep 0 - Alert 1 - Responds to verbal command

2 - Responds to painful stimuli 3 - Unresponsive

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Discharge Criteria	Yes	No
Stable vital signs	☐	☐
Alert and Orientated	☐	☐
Pain score is 2 or below	☐	☐
Diet and fluids taken	☐	☐
IV Cannula removed	☐	☐
Received written instructions regarding sedation	☐	☐
Received verbal and written aftercare instructions	☐	☐
Patient Advice Leaflet given (if applicable)	☐	☐

Received Endoscopy Report/ Patient letter Yes ☐ No ☐

If no

Verbal report by endoscopist ☐

cancelled BY PT.

Follow up appointment indicated on report Yes ☐ No ☐

Follow up appointment (if given in department) .....time .....

Comments.....

.....

.....

I confirm patient is satisfactory for discharge

Print Name .....Signature .....

Discharged at .....to care of .....

Irregular discharge Reason .....

.....

Patients' Signature ..... Nurses Signature .....

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Nurses notes

04/06/24 @ 1250 Patient arrived in department – explained to patient on arrival that the Bronchoscopy test required sedation. Patient stated there is no one to pick him up. Patient tried to contact girlfriend who stated (after having words) that she will not attend the patient or stay with him overnight. Pt keen to leave. Patient states he has no one else to escort him home. Patient was asked to remain in department until advice sought from endoscopy. Liased with SCN of endoscopy who contacted Dr Ricketts for advice. As patient BM 17.9 mmol/l on admission, and as no escort home or overnight Dr Ricketts reappointed Patient for 25th June @ 1250 as he was keen to leave. Upon return to patient he had already left the building. Telephone call made to patient to make him aware of plan however no answer – voice message left advising patient of new appointment advised on his BM / Anticoags and reiteration on advice of escort required on next occasion.

KG S/N

NHS Greater Glasgow and Clyde
Clyde VTE MDT Discussion

NHS
Greater Glasgow and Clyde

Date of Meeting:	13/5/22				
Name of Referring Clinician:	A Murphy				
Admitting Hospital / Ward:	RAH MAU				
Patient details		**Type of VTE:**	**Date of diagnosis:**	**New / Recurrent:**	
Surname	Forename	Right leg DVT	11/5/22	Recurrent	
Burgess	Henry				
CHI	M/F F	**PMHx:** Prev PTE, Prev DVT. Splenectomy, Hep C, Alc xs, IVDU			
2208793218	Age 42				

Unprovoked:	**Provoked:**	
Consider: PSA, Myeloma screen, Breast examination, CXR, Urinalysis, Bone profile and Abdominal exam.	Risk factors:	Malignancy ☐
	Known Thrombophilia ☐	Pregnancy or post-partum ☐
Suspected Malignancy ☐	Recent Prolonged Travel ☐	HRT ☐
Please detail in Clinical Info	Recent Surgery ☐	Obesity ☐
	Trauma ☐	Ex or Current IVDU* ☐
	Immobility ☐	- Likely to engage ☐
		- Unlikely to engage ☐

Clinical info – including detail of above mentioned risk factors

Painful swollen leg. Unsure of how long for. Unprovoked DVT. Chaotic lifestyle. Continues to inject heroin. Alcohol daily. Unlikely to comply with treatment. Commenced on rivaroxaban for 6 weeks.

Imaging and other relevant investigations

CTPA/US Doppler: Positive for DVT

CXR: Requested - awaited.

Blood tests: D-dimer 1896. Platelets 605. CRP 101

MDT outcome: *(TO BE COMPLETED BY CONSULTANT FOLLOWING MEETING)*

VTE f/u clinic required: No

Thrombophilia screen: Not required

Duration of anticoagulation: 6 weeks

Any specific plans/tests/queries at clinic:

6 weeks minimum and 3 months if compliant with the anticoagulation.

Please email completed form to clyde.thrombosismdt@ggc.scot.nhs.uk
The completed proforma and outcome of MDT will be uploaded to clinical portal approx. within 1 week.

CHI	**2208793218**
Patient Name	**Henry Burgess**
Age (Admission)	**41 years**

NHS
Greater Glasgow and Clyde

Physiotherapy Discharge Summary

RAH ICU Physiotherapy Summary (03-12-2020 15:32)

Allergies & Sensitivities

Situation	
Hospital Admit Date & Time	**24/11/2020 16:13**
Critical Care Admit Date & Time	**24/11/2020 21:07**
Discharge Date	**02/12/2020**
Discharged To	
Discharging ICU Consultant	**Gemmell, L**
Ward Consultant	**Under surgeons**
Admission Comments	**41 year old gentleman presented to ED with general decline, recent 3stone weight loss and signs of severe sepsis and hypotension ; resuscitated with fluids and noradrenaline; CT scan revealed pneumoperitoneum ; taken to theatre**
DNA CPR Form	Valid: **Not applicable** Form Date & Time:
Adults With Incapacity Form	Valid: **Not applicable** Form Date & Time:
Infection Control Details	**NIL**
Safety Issues	**NIL**

Background	
Past Medical History	**Type 1DM** **Previous ivdu on methadone treated HCV**

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CHI	**2208793218**
Patient Name	**Henry Burgess**
Age (Admission)	**41 years**

	HIV and HBV negative
Relevant Social Circumstances/Relative Information	**Lives at home with partner - no social input**

Objective Assessment	
Observations	**high sitting in bed on arrival with on 2L of O2 via nasal cannula** **HR 96 , BP 118/69 ,SpO2 96% , RR 17** **feacal collector , NG and central line and cathter in situ**
Auscultation	**scattered crcakles throughout espically in UZ's**
Palpation/Expansion	**Palp creps in UZ's, good exp bilat on command**

Respiratory Problems & Analysis	
Extubation History	Previous Extubation: **Yes** Extubation History: **Previous failed extubation** Extubation date 1: **27/11/2020** Extubation date 2: **01/12/2020** Extubation date 3:
General Problems	**Fatigue**
Respiratory Problems	**Sputum retention; Decreased air entry; Areas of consolidation**
Oxygen Delivery	Oxygen Delivery: **Yes** Oxygen Delivery Method: **Nasal cannula** Oxygen %: **35 %** Oxygen L/min: **2 L/min**
Humidification	Type: **None** Temperature:
Coughing/Expectorating	**Coughs & clears**
Suction	**Not required**
Breathing Comments	**Air entry can be heard throughout.**
SALT Referral	Date Referred: Swallow Assessment:
SALT Comments	**STOPPS passed**

Rehabiliation Problems & Analysis	
Current Level of Mobility	**Up to sit; Standing transfer**
Rehabilitation Problems	**Bedrest/decreased mobility; Poor exercise tolerance**

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CHI	**2208793218**
Patient Name	**Henry Burgess**
Age (Admission)	**41 years**

Treatment	
Respiratory Treatment	Respiratory Treatment: **Manual expiratory shakings; Breathing control; DBX's; Cough on request** Note: **expiratory shakes to bilateral UZ's // patient tolerating well** **Huff // good technique performed with verbal prompting** **secretions // copious muco purlent / green secretions , coughing and clearing** **SpO2 risisng to 97% after Chest Rx**
Rehabilitation Treatment	Rehabilitation Treatment: **Sit to stand; Stand transfer** Note: **sit to stand with encore stand - aid and Ao2, patient tolerating well and intiating good stand. Patient anxious requirirng ++ reassurance and encouragment.** Treatment Position: **Chair**

Outcome Measures	
CPAX Score	Respiratory Function: Cough: Moving in bed: Supine to sitting: Dynamic sitting: Standing balance: Sit to stand: Transfer from bed to chair: Stepping: Grip strength: **Total CPAx Score:**

Falls Risk & Bedrail Assessment	
Falls Risk Assessment	Falls History: **No Hx of falls last 6 mths** Cognitive Impairment: **Pt has cognitive impairment** Mobility: **Pt does not try to walk alone** Fear of Falls: **Pt/Relative no fear Pt falling** Clinical Opinion: **On clinical opinion no fall risk** If Falls Risk Consider: Falls Comments:
Bedrail Assessment	**Level 2 Pt complete bed rail assessment**

Findings and Conclusion	
Airway	**Natural**
Secretions	**Muco-purulent; Green**
Suction/Cough Amount	**Not required**

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CHI	**2208793218**
Patient Name	**Henry Burgess**
Age (Admission)	**41 years**

Findings	Problems with Rx: **No** Cough Response: **Strong** Effectiveness of Cough: **Clearing intermittently** Overall Clearance: **Good** Rehabilitation Findings: **Active resistance (R); Active resistance (L)**
Conclusion & Management Plan	Outcome Measure: **SPO2 and secretion clearance** Goals: **Assist in chest clearance as able, to march on spot when appropaite** Conclusion: **Patient chest remains productive and with verbal prompting patient is able to cough and clear** Next Planned Review: **review in 1/7 or sooner if required**

Rehabiliation Treatment	
Treatment 1/Note	Treatment: **02/12/2020** Note: **@10am.** **S. Consent. Seen with B5PT Helena Friel** **NS say patient stable and appropriate to sit.** **O. Awake and orientated** **HR 84; BP 132/83 (96)** **SpO2 94% on 2L O2 via NC** **Cough strong and productive** **SLR to approx 5 deg bilat** **LIE TO SIT - indep with legs initially then Ao2 to complete** **Indep sitting balance** **Quads 4/5 bilat** **Rx 1) bed edge sit - kicks and hip marching** **2) hoisted up to sit** **A. Doing well off vent. SpO2 >94% in chair.** **Appears to have good residual strength in legs.** **May manage stand aid tomorrow.** **P. Sit to stand Ax with stand aid** **Kirsty Graham B5PT**
Treatment 2/Note	Treatment: Note:
Treatment 3/Note	Treatment: Note:
Treatment 4/Note	Treatment: Note:

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CHI	**2208793218**
Patient Name	**Henry Burgess**
Age (Admission)	**41 years**

Treatment 5/Note	Treatment: Note:
Treatment 6/Note	Treatment: Note:
Treatment 7/Note	Treatment: Note:
Treatment 8/Note	Treatment: Note:
Treatment 9/Note	Treatment: Note:
Treatment 10/Note	Treatment: Note:
Treatment 11/Note	Treatment: Note:
Treatment 12/Note	Treatment: Note:
Treatment 13/Note	Treatment: Note:
Treatment 14/Note	Treatment: Note:
Treatment 15/Note	Treatment: Note:
Treatment 16/Note	Treatment: Note:
Treatment 17/Note	Treatment: Note:
Treatment 18/Note	Treatment: Note:
Treatment 19/Note	Treatment: Note:
Treatment 20/Note	Treatment: Note:
Treatment 21/Note	Treatment: Note:
Treatment 22/Note	Treatment: Note:
Treatment 23/Note	Treatment: Note:
Treatment 24/Note	Treatment: Note:
Treatment 25/Note	Treatment: Note:
Treatment 26/Note	Treatment: Note:
Treatment 27/Note	Treatment: Note:
Treatment 28/Note	Treatment: Note:

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CHI	**2208793218**
Patient Name	**Henry Burgess**
Age (Admission)	**41 years**

Treatment 29/Note	Treatment: Note:
Treatment 30/Note	Treatment: Note:
Treatment 31/Note	Treatment: Note:
Treatment 32/Note	Treatment: Note:
Treatment 33/Note	Treatment: Note:
Treatment 34/Note	Treatment: Note:
Treatment 35/Note	Treatment: Note:
Treatment 36/Note	Treatment: Note:
Treatment 37/Note	Treatment: Note:
Treatment 38/Note	Treatment: Note:
Treatment 39/Note	Treatment: Note:
Treatment 40/Note	Treatment: Note:

If you have any questions about any of the information in this form, please contact RAH ICU: 0141 314 (0)7069 or (0)6125

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BURGESS, Henry
BORN 22-Aug-1979 (46y) GENDER Male
CHI 2208793218

Goals and Treatment Plan; Occupational Therapy and Physiotherapy

Last updated by Connor SCOTT (Connor Scott) 6 years ago (v. 2) Show History

Amendments (1)
v.2 - Update
23-Dec-20 12:26 by Connor SCOTT

Sensitivity

Content Restricted	No	Sensitivity	Sensitive
If the information on this form merits further restriction than that of Highly Sensitive, please select **Yes** to apply a Privacy Seal		The information on this form **will** be viewable by health and care providers with the appropriate access permissions	

Admission Details

Hospital	Royal Alexandra Hospital	Specialty	General Surgery

Expectations

Patient or carers understanding of condition:	Limited - patient has reported being "stabbed 8 times" when nursing staff report this is not the case
Patient or carers perception of need:	reasonable
Patient or carers expectation of outcome:	To be D/C'd home safe
Therapists expectation of outcome:	To be D/C'd t baseline

Goals and Treatment Plan

Problem	Goal	Goal type	Treatment Plan	Set by	Date Identified	Active	Completion date	Clinician	Comments
UnAx'd stairs	patient will perform 8 steps as of home in 1/7 indep	Short Term	Stair Ax	Connor Scott	21-Dec-2020	No	23-Dec-2020	Connor Scott	Declined
W/S for MOB'ing	Patient will mob indep 20m	Short Term	MOB Px	Connor Scott	21-Dec-2020	No	23-Dec-2020	Connor Scott	—

Problem	Goal	Goal type	Treatment Plan	Set by	Date Identified	Active	Completion date	Clinician	Comments
BURGESS, Henry									
BORN 22-Aug-1979 (46y) CHI 2208793218			GENDER Male						

Outcome Measures

Outcome measures	Details
Tinetti	Yes

Date	Balance	Gait	Score	Notes
23-Dec-2020	16	10	26	Low falls risk

EMS	No
TOMS	No
Pain VAS	No
Other Outcome Measure	No

Discharge Summary

Yes

Discharge Summary	PT D/C Summary 23/12/20 patient indep and nil further concerns re D/C to temporary accommodation decline stair Px as new accommodation has nil Nil further PT input indicated Left with W/S for longer distances or when out upon patients request
Walking Aid Issued	Yes
Type of walking aid	Stick(s)

Make — Model / Code No. — Batch / Lot No. — Manufacturer Date —

—
—
—
—
—
—
—
—
—

I confirm the walking aid(s) is clean, in accordance with NHS GG&C infection control procedures, and in good working order according to the NHS GG&C walking aid guidelines.
Yes

I confirm that the the above walking aid(s) provided is deemed safe and suitable at the date of issue.
Yes

Sign Off

Name	Connor Scott	Designation	Physiotherapist
Date	23-Dec-2020		
Completed by a Student	No		

BURGESS, Henry
BORN 22-Aug-1979 (46y) GENDER Male
CHI 2208793218
Amend

BURGESS, Henry
BORN 22-Aug-1979 (46y) GENDER Male
CHI 2208793218

Pharmacy Communication

Last updated by Fiona MACGREGOR1 (Fiona MacGregor1) 6 years ago (v. 6) Show History
Amendments (5)
v.6 - .
03-Dec-20 15:18 by Fiona MACGREGOR1
Show All

Hospital Royal Alexandra Hospital

Sensitivity

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If the information on this form merits further restriction than that of Highly Sensitive, please select **Yes** to apply a Privacy Seal		The information on this form **will** be viewable by health and care providers with the appropriate access permissions	

Drug Interaction

Prescription Note —

Completed By — Designation — Date —

Med Reconciliation

Prescription Note —

Completed By — Designation — Date —

Comments

Prescription Note Admitted to ICU with ?sepsis. CT shows multiple infarcts - spleen/kidneys/liver, lung embolus, pneumonia. Intraperitoneal perforation. Laparotomy and splenectomy today. ?Infected endocarditis - for echo today.

PMH- T1DM, Previous IVDU on methadone (not collected for >3 days so will need retitrated), Treated HCV.

On QS Norad and vasopressin.

ABx - Tazocin/ gent/clindamycin/fluconazole/ as per microbiology. Unsure of patient weight and height so have prescribed based on estimates. 74kg on clinical note 2 years ago, nurse will measure height for tomorrow.

LFTS deranged. PT 20. May be for heparin infusion as ?prothrombotic/multiple infarcts. Awaiting repeat coag/fibrinogen

Completed By F MAcGregor Designation — Date 27-Nov-2020

Comments

Prescription Note Splenectomy on 25/11.

BURGESS, Henry
BORN 22-Aug-1979 (46y) GENDER Male
CHI 2208793218

Echo -no valvular lesions. Pulmonary venous thrombus extending to left atrium. Commenced on UFH infusion yesterday, to be switched to dalteparin today, heparin ceased since 9am. 74 kg - 15000 units dalteparin prescribed. PT now 15 (20).

Cavitating lesion in lung, awaiting further results from micro. Currently on clindamycin, fluconazole, tazocin and gentamicin - 48 hrly dosing. WCC 23 (falling).

LFTs deranged but improving. Probable hypoxic hit but if do not continue to improve review fluconazole.

Off noradrenaline and vasopressin. Steroids stopped today.

Cr 91, Ur 15.

Will need LT antibiotics and vaccines post splenectomy.

Completed By F MacGregor Designation Pharmacist Date 27-Nov-2020

Comments

Prescription Note

On dalteparin 15000 Units OD

Renal Function normal, LFTs normalised.

Tazocin and gentamicin stopped. Now on meropenem 2g TDS, vancomycin infusion, fluconazole, clindamycin.

Vancomycin level 30.8 this morning - infusion currently stopped. Level to be rechecked this afternoon and restart at lower dose if level <25.

Actively withdrawing. Received methadone 20mls yesterday and already given usual dose of 70ml today. Note usually on sugar free preparation. Also on morphine infusion 4ml/hr

Pulling at NG tubes - commenced n clonidine

Propofol 1ml/hr

Completed By J Yates Designation Pharmacist Date 30-Nov-2020

Comments

Prescription Note

? for extubation today.

On clonidine 50mcg tds and diazepam 5mg qds for agitation. Back on full dose methadone. Will need close monitoring if extubated as may be drowsy.

Awaiting result TOE. Remains on clindamycin/fluconazole/meropenem/vancomycin-restarted at 1.25g overnight as level 16 - awaiting level today.

Completed By F MacGregor Designation Pharmacist Date 01-Dec-2020

Comments

Prescription Note

Extubated and doing well.

Antibiotics rationalised by micro yesterday - fluconazole and vancomyicn stopped. Meropenem 1g tds as unlikely endocarditis.

Dalteparin treatment dose - will require anticoagulation for at least 3 months as per Mr Macgoey.

Clonidine stopped - remains on methadone and diazepam.

BURGESS, Henry

BORN 22-Aug-1979 (46y) GENDER Male

CHI 2208793218

Completed By F MacGregor Designation — Date 02-Dec-2020

Comments

Prescription Note

Doing well, may be for step down tomorrow.

Antibiotic rationalised further to meropenem - PICC line requested for access. Will need LT amoxicillin once IV antibiotics stop. Vaccines 2/52 post-op.

Consider restarting usual medication at lower doses if not too drowsy.

Completed By F MacGregor Designation — Date 03-Dec-2020

Print

Previous Patient Notes for Occupational Therapy (newest at the top).

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

Patient Note		**Inpatient Note**
Date/Time: 21-Dec-2020 11:33	**Created By:** Senior Occupational Therapist - Amanda Gillespie	**Role:** AHP - GGC
Specialty: Occupational Therapy	**Organisation:**	Sensitive

Note:

11.00am OT observed patient to be independent with wash/dress on ward. Patient in agreement to OT input.

Cognition: Fully Alert and Orientated

P/C OT observed patient to be independent

Transfers:
Chair Patient independent sit-stand-sit
Bed Patient independent in/out
Toilet Patient independent sit-stand-sit nil aid required and correct hand placement demonstrated.
Bath Patient declined as reports nil issues feels he will manage
Kitchen: Patient declined as reports partner will be attending to and feels nil issues doing this at home.

Mobility:
Patient mobilised independently using WWF around the ward safe and steady - does not feel he requires a WWF.

OT feels patient fit for D/C once all MDT are happy. Now D/C from OT
MDT informed.
Plan: D/C

Patient Note		**Inpatient Note**
Date/Time: 18-Dec-2020 15:50	**Created By:** Senior Occupational Therapist - Amanda Gillespie	**Role:** AHP - GGC
Specialty: Occupational Therapy	**Organisation:**	Sensitive

Note:

9.00am OT observed patient to be independent with wash/dress on ward, Patient reports independent with all transfers, bed/chair/toilet nil issues - Patient declined OT as reports he has not had his breakfast - 11.00am Patient declined OT due to talking to partner on the phone and reports unsure how long he will be - 1.00pm Patient declined OT due to not having his medication - Patient consistently declining OT - N/S Paul aware of this. Plan: ?OT Assessment or D/C as not engaging in Therapy.

Patient Note		**Inpatient Note**

Date/Time: 18-Dec-2020 10:25	**Created By:** Senior Occupational Therapist - Amanda Gillespie	**Role:** AHP - GGC
Specialty: Occupational Therapy	**Organisation:**	Sensitive

Note:

9.00am OT observed patient to be independent with wash/dress. Patient declined OT as reports not had his breakfast - N/S informed.

Plan:Transfer Assessment Chair/bed/toilet/bath, Kitchen Assessment, set goals, liaise with MDT

Patient Note		**Inpatient Note**
Date/Time: 14-Dec-2020 14:14	**Created By:** Senior Occupational Therapist - Amanda Gillespie	**Role:** AHP - GGC
Specialty: Occupational Therapy	**Organisation:**	Sensitive

Note:

2.00pm OT explained her role and patient agreed to assessment when feels well enough. ROC completed. Patient reports he and his girlfriend are not in employment.
Plan: P/C Assessment, Transfer Assessment Chair/bed/toilet/bath, Kitchen Assessment, set goals, liaise with MDT

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

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

Patient Note		**Inpatient Note**
Date/Time: 23-Dec-2020 12:24	**Created By:** Rotational Physiotherapist - Connor Scott	**Role:** AHP - GGC
Specialty: Physiotherapy	**Organisation:**	Sensitive

Note:

S// patient consented to input with Hiliary Snowdon PT present
Nil issues
Refused stair px as stated going to temporary accommodation after D/C where all will be on the flat

O// obs - seated on chair appears bright
Sit to stand: Indep
Gait: approx. 20m indep with W/S R hand 2 point gait with simultaneous L foot and W/S contact, bilat foot clearance
Also indep approx. 10m nil W/S nil issues or unsteadiness
Tinetti completed - see goals doc
Stand to sit: indep

A// patient indep and nil further concerns re D/C to temporary accommodation
decline stair Px as new accommodation has nil
Nil further PT input indicated
Left with W/S for longer distances or when out upon patients request

P// D/C PT

Patient Note		**Inpatient Note**
Date/Time: 22-Dec-2020 15:44	**Created By:** Rotational Physiotherapist - Connor Scott	**Role:** AHP - GGC
Specialty: Physiotherapy	**Organisation:**	Sensitive

Note:

S// PT's attempted to review at approx. 13:50
patient declined stating he felt sickand would participate in 1/7

A// refusal

P// Review in 1/7

Patient Note		**Inpatient Note**
Date/Time: 21-Dec-2020 14:39	**Created By:** Rotational Physiotherapist - Connor Scott	**Role:** AHP - GGC
Specialty: Physiotherapy	**Organisation:**	Sensitive

Note:

S// patient seen at approx. 14:00
nil issues
States having fll 2/7 ago in bathroom slipped on toilet paper nil injury

O// obs - NG feed insitu not running
Sit to stand: indep
Gait: approx. 20m indep with WWF bilat foot clearance toe off and heel strike
Stand to sit: indep

Gait: with W/S R hand indep nil issues, reciprocal 2 point gait

A// patient progressing well and engaging with PT today
Progressed to indep with W/S, WWF left for when patient fatigued

P// Review as able
Progress mob

Patient Note		**Inpatient Note**
Date/Time: 18-Dec-2020 16:04	**Created By:** Rotational Physiotherapist - Hilary Snowdon	**Role:** AHP - GGC
Specialty: Physiotherapy	**Organisation:**	Sensitive

Note:

S// Pt attended at 14.00 for PT input however pt declined due to not getting methadone this AM.
Pt has been mobilising to toilet with WWF
Staff nurse states pt has been in bad mood all day due to above however reasons for same have been explained and pharmacy order has been put in

P// R/v over weekend for gait px with WWF or nil aid if appropriate

Patient Note		**Inpatient Note**
Date/Time: 18-Dec-2020 16:04	**Created By:** Senior Physiotherapist - Kirstine Graham	**Role:** AHP - GGC
Specialty: Physiotherapy	**Organisation:**	Sensitive

Note:

PHYSIO
S. Approached at 1pm. Refused PT input.
P. Review with a view to DC

Patient Note		**Inpatient Note**
Date/Time: 17-Dec-2020 14:55	**Created By:** Rotational Physiotherapist - Hilary Snowdon	**Role:** AHP - GGC

Specialty: Physiotherapy	Organisation:	Sensitive

Note:

S// Pt consented to PT input at approx. 10.00 .
Pt reports has not walked away from bedspace yet.
Nursing staff happy for pt to mobilise
Pt for IV ABx for 4-6 weeks

O// Pt 1/2 sitting in bed on arrival
Obs stable, nil attachments, alert and oriented
Lie to sit - indep
Sit to stand to WWF - pt able indep with bed raised + use of ULs, unable from low bed on 2 attempts
Gait px 20m with WWF - pt managed indep // short step length, moderate floor clearance, good balance
Toilet t/fs - pt managed indep with use of grabrail

Rx// Mobility px as above
Pt up to sit in chair post Rx

A// Pt mobilising with WWF indep // nursing staff informed
Pt previously not engaging with PTs however happy to engage today

P// R/v in 1/7 for mobility px as able
Aim for indep with nil aid 20m in 2-3/7

Patient Note		Inpatient Note
Date/Time: 16-Dec-2020 15:14	Created By: Rotational Physiotherapist - Rhonwyn Smith	Role: AHP - GGC
Specialty: Physiotherapy	Organisation:	Sensitive

Note:

Attempted to review patient in PM and patient refusing to engage remaining on his phone throughout.
P/ review in 1/7

Patient Note		Inpatient Note
Date/Time: 15-Dec-2020 14:51	Created By: Rotational Physiotherapist - Connor Scott	Role: AHP - GGC
Specialty: Physiotherapy	Organisation:	Sensitive

Note:

S// Staff nurse reports patient has Hb 78 and refusing to get up today

A// Leave

P// See when more medically appropriate

Patient Note		Inpatient Note

Date/Time: 11-Dec-2020 14:20	Created By: Senior Physiotherapist - Kirstine Graham	Role: AHP - GGC
Specialty: Physiotherapy	Organisation:	Sensitive

Note:

PHYSIO
s. consent at 1:30pm
seen with B5PT Connor Scott
agreeable to get up but lacks confidence
medically stable - no change

o. SpO2 93% on 4L via FM (FM not on face on PT arrival)
LIE TO SIT - indep
SIT TO STAND - supervision.
TRANSFER - WWF and ao1 for attachments.
Stepping fair height, consistent, no loss of balance.

Rx 1) mobility Ax
2) transfer bed to chair and march on spot

A. Good potential to improve.
without O2 attachments would likely be independent in/out bed and to chair

P. Inc distance with WWF - wean to EC or no aid as able
Aim indep transfer bed to chair

Patient Note		Inpatient Note
Date/Time: 10-Dec-2020 13:46	Created By: Senior Physiotherapist - Kirstine Graham	Role: AHP - GGC
Specialty: Physiotherapy	Organisation:	Sensitive

Note:

PHYSIO
S. Consent at 1320. ASTP by respiratory consultant - inc O2 requirements and weak cough
NS say not appropriate to mobilise as NEWS reportedly now 9
Harry says he is feeling well - has been coughing and clearing intermittently but difficult when sore.

O. NEWS 5
SpO2 96% on 4L via NC
HR 111
RR 14

No SOBAR
Ausc - air entry throughout - quieter at bases. No added sounds.
Exp - poor thoracic due to pain - reluctant to take deep breth initially
Palp - nil

Rx 1) high sit in bed
2) DBEx and supported cough/huff

A. Chest sounds clear. Does not appear clinically unwell - FY1 says he is stable and improving however nursing staff concerns noted and patient left in bed for now.
P. Review for mobility Ax and trial walk with WWF

Patient Note		Inpatient Note
Date/Time: 09-Dec-2020 14:15	Created By: Rotational Physiotherapist - Connor Scott	Role: AHP - GGC
Specialty: Physiotherapy	Organisation:	Sensitive

Note:

S// patient seen at approx. 14:00 with Hiliary Snowdon PT present
patient refused PT stating he had been up for hours in the chair this am and was to fatigued
Agreeable to attempt mob with WWF and WWF left at bedspace

A// refusal

P// Review when able
Rx as compliance allows

Patient Note		Inpatient Note
Date/Time: 09-Dec-2020 10:28	Created By: Senior Physiotherapist - Kirstine Graham	Role: AHP - GGC
Specialty: Physiotherapy	Organisation:	Sensitive

Note:

PHYSIO
S. Attempted to review mobility at 10am with student PT Kirsten Turnbull.
Initially Henry agreed to try then refused after failing to stand. We returned with the offer of a wwf to make mobilising easier but he was on the phone and refused to engage.
NS say he transferred minimal assistance to the commode and chair this morning, no aid.

P. Review PM if agreeable. Check transfers and aim to mobilise a few metres Monitor chest

Patient Note		Inpatient Note
Date/Time: 06-Dec-2020 14:29	Created By: Rotational Physiotherapist - Rhonwyn Smith	Role: AHP - GGC
Specialty: Physiotherapy	Organisation:	Sensitive

Note:

Patient off ward for new central line when attended for chest PT review. NS aware can be contacted if requiring further input/patient deteriorates.

Patient Note		Inpatient Note
Date/Time: 06-Dec-2020 11:51		Role: AHP - GGC

	Created By: Rotational Physiotherapist - Rhonwyn Smith	
Specialty: Physiotherapy	**Organisation:**	Sensitive

Note:

Rx approx. 11:00

S/ Patient consents to physio input with encouragement, patient very disgruntled being bothered repeatedly. Medical notes show overnight patient deteriorated NEWS 7 and ? worsening sepsis, now improved but for repeat CT CAP this AM and continued chest PT. Patient reports tired and sore, does not feel need input..

O/ Patient slumped in bed, initially appeared drowsy but improved throughout Rx.
Self-ventilating on 35% venture mask, RR appeared relaxed, SpO2 96%. HR 89
IV fluids and NG feed in place. Faecal collector and catheter in place, abdo dressing intact.
Ausc: clear to L side, good breath sounds. Crackling to R UZ and MZ, quieter to base.
Palp: fair expansion R<L. Palpable creps R UZ.
Cough: weak moist// nil expectorated..

Rx/ DBX's 2 x 3// fair effort with increasing SpO2
Manual AD and expiratory shakes to R side only// patient not keen for input.
Cough on request following manual techniques cleared moderate amounts of thick dark secretins for sputum sample.

A/ SpO2 increased to 99% following Rx, unable to reposition as ported arrived for CT. Patient not enaging but would still benefit from chest PT as weak cough and productive requiring O2.

P/ Review in PM as patient allows.

Patient Note		Inpatient Note
Date/Time: 05-Dec-2020 16:04	**Created By:** Rotational Physiotherapist - Connor Scott	**Role:** AHP - GGC
Specialty: Physiotherapy	**Organisation:**	Sensitive

Note:

S// staff nurse reports patient retaining secretions and requiring PT review
patient consented to input at approx. 15:30
patient initially resistant to Rx - reports "bloody physios won't leave me alone" and reports PT visits last few days have "burst open my wound" with manual therapy referring to his laparotomy wound
Agreeeable to breathing exs

O// obs - 1/2 lying in bed. SpO2 92% onn 1L O2 via NC RR 20
catheter and wound drains insitu
Ausc: breath sounds throughout and course crackles L>R, bronchial breath sounds UZ's and MZ's
Palp: fiar expansion throughout and creps at UZ's

Rx
DBE's 10x
AD 10x
cough - fair min secretions yielded MP

A// post- Rx - chest clear aside from R UZ - min course crackles
Palp as above
engages to certain degree
Staff nurse reports patient has been reporting being "stabbed 8 times" referring to laparotomy wound

P// Rx in 1/7 as compliance will allow

Patient Note		Inpatient Note
Date/Time: 05-Dec-2020 10:34	**Created By:** Rotational Physiotherapist - Connor Scott	**Role:** AHP - GGC
Specialty: Physiotherapy	**Organisation:**	Sensitive

Note:

S// Staff nruse Maggie reports patient coughing and clearing indep
SpO2 99% on 3L O2 via NC

A// Not required Chest PT

P// Review as required

Patient Note		Inpatient Note
Date/Time: 04-Dec-2020 16:28	**Created By:** Rotational Physiotherapist - Rhonwyn Smith	**Role:** AHP - GGC
Specialty: Physiotherapy	**Organisation:**	Sensitive

Note:

Rx approx. 13:45

S/ Patient reluctantly consents to physio input, seen with Mhairi Burke PT. Patient reports very sore. NS report fit for input.

O/ Patient lying in bed on arrival, bright
Self-ventilating on 5L/min O2 via N/C, RR 25, SpO2 94.
Abdominal wound dressing intact, faecal collector and catheter in place, ART line in place.
Indep coughing and clearing although weak cough
Lie to sit min Ao1
Sitting balance indep
Sit to stand to WWF Ao2
Standing balance with WWF indep
Transfer with WWF and Ao2.
Rx/ Lie to sit x 1
Sit to stand x 2
Transfer x 2
breathing control and supported cough.

A/ Patient safe to transfer WWF Ao2, weak cough limited by pain.

P/ On oon-call list for review over weekend.

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

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

Patient Note		**Inpatient Note**
Date/Time: 15-Jan-2021 11:15	**Created By:** Dietetic Support Worker - Helen Black	**Role:**
Specialty: Dietetics	**Organisation:** Inverclyde Royal Hospital	Sensitive

Note:

Administration tasks completed as listed in "Dietetic Assessment & Intervention

Patient Note		**Inpatient Note**
Date/Time: 22-Dec-2020 14:43	**Created By:** Dietitian - Rachel Knowles	**Role:** AHP - GGC
Specialty: Dietetics	**Organisation:**	Sensitive

Note:

DIETITIAN
Patient review.
Weight updated which suggests weight decreased 10.5kg over 18/7 which is likely secondary to a combination of fluid shifts, periods of suboptimal nutritional intake, catabolism and decreasing lean mass through reduced function.
Patient continues normal diet and fluids, food chart in place however not fully completed and therefore little information available for assessment. Patient continues with ensure compact qds to meet ~ 50-57% energy and protein requirements.
++ encouragement given to improve oral intake however unlikely that patient able to meet estimated nutritional through diet alone at this point therefore suggest continue with ONS in support. Limited information available to justify changes to current plan therefore suggest continue with current plan until further information available.

Aim:
Meet estimated nutritional requirements with high energy diet and nutritional supplements to minimise weight loss and support energy for recovery

Plan:
(1) encourage high energy diet as able - for regular carbohydrate intake
(2) additional yoghurts as snacks
(3) ensure compact qds = 1200kcal, 48g protein

Monitoring:
(1) accurate food chart
(2) weekly weight/MUST
(3) close blood glucose monitoring

review 9/7

Patient Note		Inpatient Note
Date/Time: 18-Dec-2020 13:42	**Created By:** Dietitian - Rachel Knowles	**Role:** AHP - GGC
Specialty: Dietetics	**Organisation:**	Sensitive

Note:

DIETITIAN
Patient review.
New weight suggests weight decreased ~ 1.8kg over the past 10/7 which is likely secondary to ongoing catabolism. periods of suboptimal nutritional intake and decreasing lean mass through reduced function. Continues on normal diet and fluids, food chart in place suggests patient meeting ~ 30-35% energy and protein requirements from diet alone however note that this is from yoghurts and milk only. Patient not currently taking any meals which is likely secondary to patient preferences. Spoke with catering re alternative menu options which patient may prefer and that may improve patients oral intake - they will arrange.
Patient continues on ensure compact bd to support oral intake and overnight NGT feeding. No issues with either reported.
Patient would not be for longer term NGT feeding and ultimately would be wanting to titrate ONS down as oral intake allows. Suggest stop NGT feed and increase ensure compact to QDS to provide similar kcals, protein and CHO as current suggestion of ONS and NGT feed provides. Have suggested leaving NGT in situ over the weekend and flushing daily with H20 should NGT feeding be required to re-start. Spoke with medical staff re changes and they are in agreement. Have suggested they speak with diabetes team re blood glucose management and insulin due to overnight feed stopping.
Unable to discuss plan in full with patient as on telephone ++, therefore dietetic plan changed in patients best interests.

Aim:
Meet estimated nutritional requirements with high energy diet and nutritional supplements to minimise weight loss and support energy for recovery/rehab

Plan:
(1) Encourage high energy diet as able - offer from additional choices menu e.g. tomato soup, ham s'wiches, sausages, chips, beans, spaghetti hoops
(2) additional yoghurts as snacks
(3) full cream milk as able
(4) ensure compact qds = 1200kcal, 48g protein, 144g CHO
(5) Stop NGT feed, leave tube in place and flush daily with water.
(6) medical staff to speak with diabetes re blood glucose levels and insulin due to changes in feed

Monitoring:
(1) accurate food chart
(2) blood glucose levels
(3) weekly weight

review 4/7

Patient Note		Inpatient Note
Date/Time: 14-Dec-2020 16:44	**Created By:** Dietitian - Rachel Knowles	**Role:** AHP - GGC
Specialty: Dietetics	**Organisation:**	Sensitive

Note:

DIETITIAN
Patient review.
No new weight available for assessment however likely weight loss during admission secondary to periods suboptimal nutritional intake, catabolism and decreasing lean mass through reduced function.

No food chart available however both nursing staff and patient reports poor dietary intake secondary to satiety and fear of eating due to surgical wound. Discussed how long term NGT feeding would not be in patients best interests and therefore keen to return patient back to eating and drinking.
Agreed to continue with oral nutritional supplements to support oral intake however to trial reduced NGT feeding to see if this stimulates more of an appetite. Aware by reducing feed this will provide less carbohydrates and therefore may impact on blood glucose levels - patient will require review from medical staff/diabetes team re insulin prior to changing to new feeding regimen therefore agreed to commenced new regimen PM 15/12/2020 to allow these conversations.
Aiming to continue to wean off NGT feeding as oral intake allows.

Aim:
Meet estimated nutritional requirements with NGT feed, high energy diet and nutritional supplements to minimise weight loss and support energy for recovery

Plan:
(1) Encourage high energy diet as able - additional yoghurts as snacks
(2) full cream milk as able
(3) ensure compact bd = 600kcal, 26g protein
(4) NGT feed - 500mls Peptamen HN @41mls/hr - 665kcal, 33g protein, 78g CHO
(5) 50mls H20 flush pre and post feed

Monitoring:
(1) food chart
(2) update weight

Review 4/7

Patient Note		**Inpatient Note**
Date/Time: 10-Dec-2020 16:38	**Created By:** Dietitian - Rachel Knowles	**Role:** AHP - GGC
Specialty: Dietetics	**Organisation:**	Sensitive

Note:

DIETITIAN
Patient review on ward 24 RAH.
No new weight available for assessment, patient declining PT and therefore likely to be loosing lean mass which will impact on overall weight.
Continues normal diet and fluids however no FRC available for assessment.
Continues on overnight NGT feeding to meet ~ 63% energy and 69% protein requirements. Patient also continues on ensure compact bd which if taken in full will meet ~27-28% energy and protein requirements.
Limited information at present to suggest changes to dietetic plan. Need updated weight and food chart for assessment.

Aim:
Meet estimated nutritional requirements with high energy diet, oral nutritional supplements and supplementary NGT feeding to minimise weight loss and support energy for recovery

Plan:
(1) Encourage high energy diet as able
(2) ensure compact bd = 600kcal, 26g protein
(3) Overnight NGT feed - 1000mls Peptamen HN @ 83mls/hr X 12hrs
(4) 50mls H20 flush pre and post feed

Monitoring:
(1) accurate food chart
(2) update weight/MUST

review 4/7

Patient Note		Inpatient Note
Date/Time: 07-Dec-2020 16:09	**Created By:** Dietitian - Rachel Knowles	**Role:** AHP - GGC
Specialty: Dietetics	**Organisation:**	Sensitive

Note:

DIETITIAN
Patient review.
Patient stepped down to ward level since last seen.
Oral intake remains poor as per food chart and unlikely to be having a significant impact on overall nutritional requirements. Tolerating oral nutritional supplements well and remains on overnight NGT feeding to meet ~ 74-75% energy and protein requirements. Encouragement given to patient to try and increase oral intake as no issues with appetite reported. At present limited information to suggest ability to reduce/stop NGT feeding at this time and therefore suggest continue with plan as per previous. Aim to reduce/stop NGT feed as oral intake allows.

Aim
Meet estimate nutritional requirements with high energy diet little and often, nutritional supplements and supplementary NGT feeding

Plan;
(1) Encourage high energy diet as able
(2) full cream milk
(3) ensure compact bd
(4) NGT feed - 1000mls Nestle peptamin HN @ 83mls/hr X 12hrs overnight
(5) 50mls H20 flush pre and post feed/meds

Monitoring:
(1) weekly weight/MUST
(2) food chart
(3) blood glucose levels

Review 3/7

Patient Note		Inpatient Note
Date/Time: 04-Dec-2020 13:22	**Created By:** Specialist Dietitian - Jenny Gregg	**Role:** AHP - GGC
Specialty: Dietetics	**Organisation:**	Sensitive

Note:

DIETITIAN. Stepped down to HDU. Current NG feed and oral intake has potential to overfeed and exceed nutritional requirements which would likely cause increase in BMs. Currently I don't believe he would manage to meet full nutritional requirements orally therefore for supplementary overnight NG feed. Note history of weight loss prior to admission. Has been commenced on ensure compact by surgeons. Seems reasonable that these should continue in the short term.

Requirements: 25-30kcal/kg = 1900-2286kcal and 91g protein.

Aim: minimise weight loss and loss of lean body mass while promoting wound healing and recovery post

op

Plan: 1. 83ml/hr x 12hours peptamen HN (1000ml, 1300kcal and 66g protein and 160g CHO) 6pm-6am (fits best with nursing handover)
2. flush 50ml pre and post feed
3. oral intake as able - daily food chart
4. ensure compact tds (900kcal and 38g protein (36g CHO with each bottle)

monitor:
5. hydration, bowels, electrolytes and feed tolerance - daily
6. weigh if able - weekly as per MUST
7. consider stopped VRII and liaising with diabetes team about appropriate insulin regimen now off 24h feeding

review in 3/7 re tolerance of feed, on-going need for NG and ONS. Duty of care open.

Patient Note		**Inpatient Note**
Date/Time: 02-Dec-2020 13:16	**Created By:** Specialist Dietitian - Jenny Gregg	**Role:** AHP - GGC
Specialty: Dietetics	**Organisation:**	Sensitive

Note:

DIETITIAN: 41 year old gentleman requiring NG feeding to support him nutritionally while critically unwell. Now extubated and has started sipping water orally but still likely to have significant nutritional deficits in the short term. Current feeding regimen as per starter regimen for ICU but only meeting 89% lower end energy requirements and 74% lower end of protein requirements. Also having loose stools which may be related to feed but also could be related to medications/abx. Needs tailored NG feeding regimen to better meet nutritional needs at this stage in his recovery. Would benefit from trial of peptamen HN to see if improves GI tolerance

Requirements: 25-30kcal/kg = 1750-2100kcal and 84-105g protein

Aim: minimise weight loss and loss of lean body mass while maintaining skin integrity and promote rehab from critical illness

Plan: 1. 55ml/hr x 24hours peptamen HN (1320ml, 1755kcal and 87g protein)
2. flush 50ml pre and post feed and meds
3. oral intake as able - daily food chart

monitor:
4. hydration, bowels, BMs, NG aspirates - daily
5. weigh when able - weekly as per MUST

review in 5/7 in next available review slot to see if he has on-going need for enteral feeding. Duty of care open.

Previous Patient Notes for Acute Specialties GGC (newest at the top).

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

Patient Note		**Outpatient Note**
Date/Time: 18-May-2022 15:04	**Created By:** Clinical Development Fellow - Minjie Zhou	**Role:** Doctor - GGC
Specialty: Acute Specialties GGC	**Organisation:**	Sensitive

Note:

Patient attended today with partner Fiona for compliance check. Partner states she stays with Harry and confirms he has been taking as prescribed. Denies missing doses. 6 tablets left in the 2nd box.
Re-issued Rivaroxaban 20mg OD for 10 days and booked to return on 26/5/2022 at 14.30 for rechecking compliance and re-issue Rivaroxaban.

Previous Patient Notes for General Medicine (newest at the top).

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

Patient Note		**Outpatient Note**
Date/Time: 26-May-2022 15:10	**Created By:** Specialist Nurse - Marie Therese McKay	**Role:** Nurse - GGC
Specialty: General Medicine	**Organisation:**	Sensitive

Note:

Patient attended AEC today for compliance check of Rivaroxaban. Patient has had 5 weeks so far, partner insuring that compliance is good. Patient given a further 2 weeks of rivaroxaban 20mg. GP to kindly prescribe remainder, at least 6 weeks and if compliance good 12 week treatment is recommended. Worsening advice given.

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

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Affix Label

Hospital (*circle*)	IRH	RAH	RHSC	GRI	WIC	VI	VMMH	Stob	WOI	EGH

Inverclyde Royal Hospital

CHI: 2208793218

Total Att: **10**

12 Mth Att: **7**

Title: **MR**

BURGESS **Henry**

DOB: **22/08/1979** Age: **37y** Sex: **Male**

14 Thompson Brae

Next of kin: **MCDERMITT, LAUREN**
Relationship: **Partner**

Paisley
Renfrewshire
PA1 1TP

GP: **WI Weir**
0141 889 3144

Attendance Date: **23/03/2017** Arrival Time: **23:02**

Registration Time: **23:02** Date of Incident: **23/03/2017**

Major Incident Desc:

Reason for Attendance: **diabetic, pt is under arrest and states not had insulin all day**

Affix Label

Nursing Assessment

Alerts: **Yes**

Triage Category: **5**

Allergies: **None Known** Pain Score:

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **23/03/2017 23:11**

Temp		C
HR		bpm
BP	/	mmHg
MAP		mmHg
RR		bpm
SpO2		%
Oxygen		%

Nurse name: **Nurse Lynsey Cole**

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

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **patient under arrest states unsure why been brought to depart, police concerned as patient diabetic and mentioned he had hypo last week, bm 14.3 no complaints**

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

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

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES
23/3/17	Seen by (Dr) DANCE Time seen 2320.

PC Brought in by police

HPC brought in by Police as patient says not taken insulin in 2 days. Denies any symptoms. BM (14.3) - Says he's "brand new"

O/E Not in distress, breathing normally. Comfortable at rest

NEWS (1) RR 16
SpO_2 95% OA
T 36.3
HR 82
BP 155/95.

Date	CLINICAL NOTES

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

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

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

Discharge Prescription Packs

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

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

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Name
Address
2208793218 22/08/1979
BURGESS
Henry

CHI No.
DoB

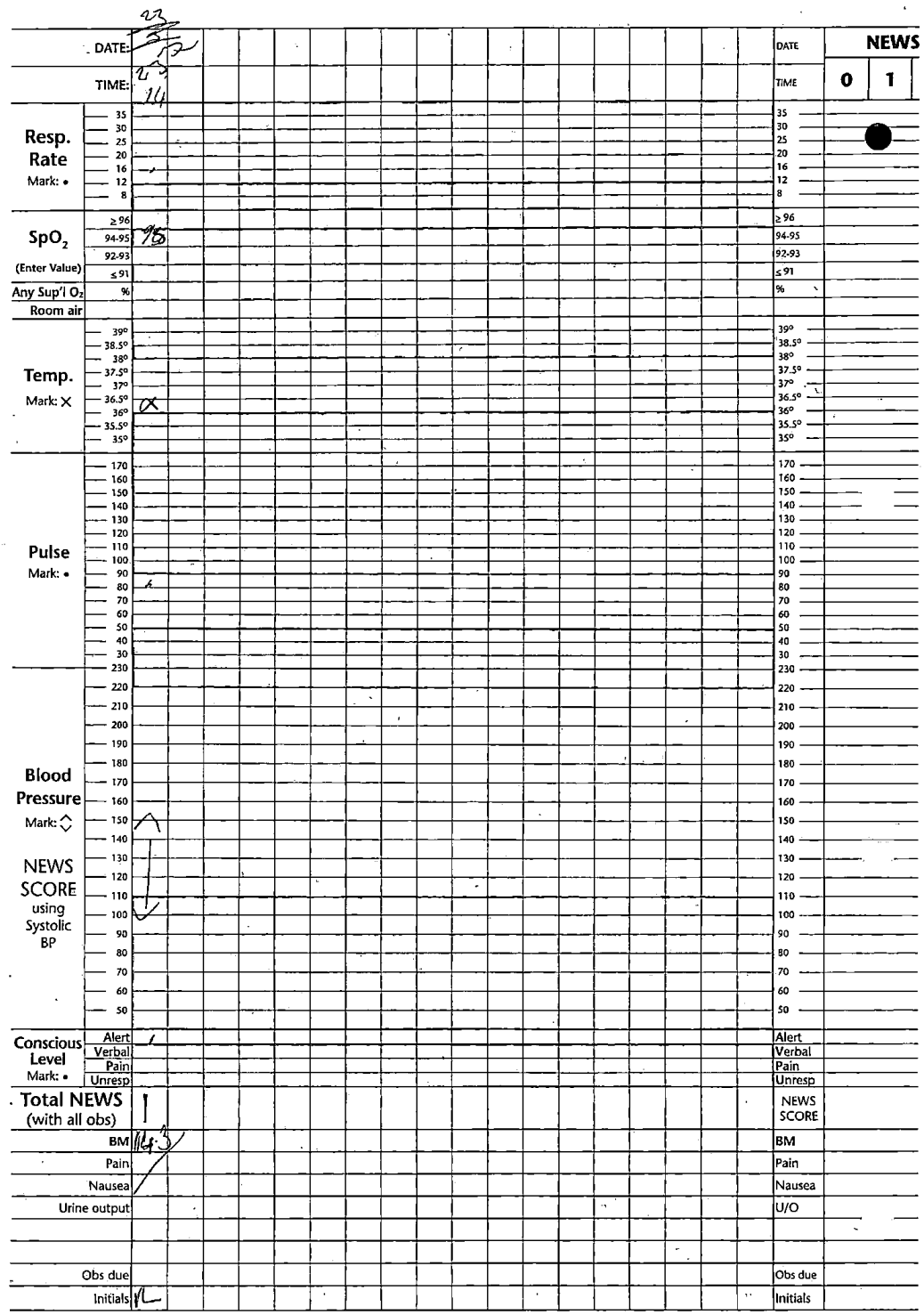
	Date	Ward
Admitted	23/3/17	ED
Transferred		
Transferred		

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

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

See NEWS Actions Reference Tool for local escalation policy

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


DATE:
TIME:
Resp. Rate
Mark: •
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25
20
16
12
8
SpO2
(Enter Value)
≥ 96
94-95
92-93
≤ 91
Any Sup'l O2
%
Room air
Temp.
Mark: ×
39°
38.5°
38°
37.5°
37°
36.5°
36°
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35°
Pulse
Mark: •
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30
Blood Pressure
Mark: ◇
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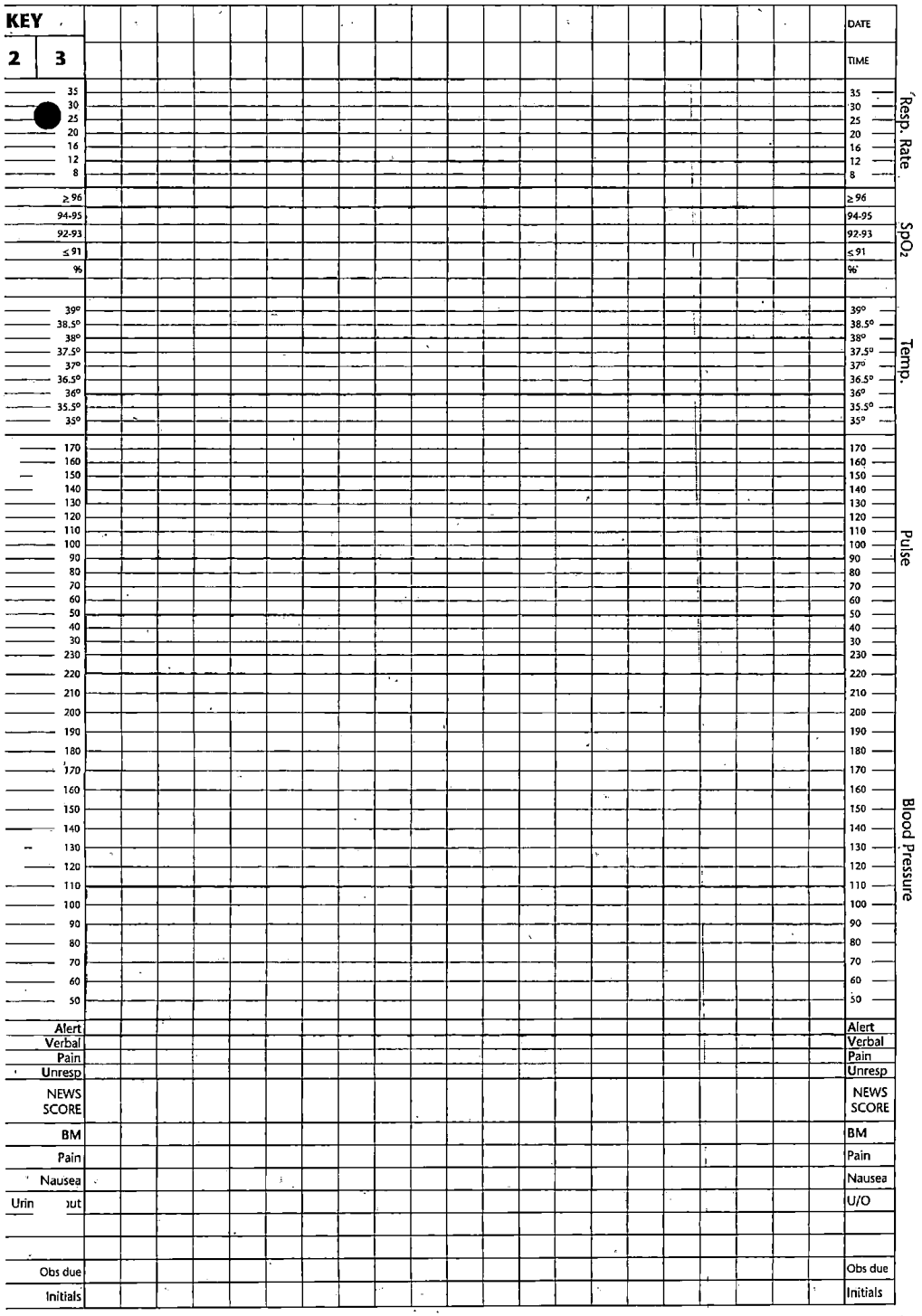
50
NEWS SCORE using Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
BM
Pain
Nausea
Urine output
Obs due
Initials
DATE
TIME
NEWS
0
1
NEWS SCORE
U/O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Resp. Rate
≥ 96
94-95
92-93
≤ 91
%
SpO2
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190
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170
160
150
140
130
120
110
100
90
80
70
60
50
Pulse
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
Urin ut
U/O
Obs due
Initials

Glasgow Coma Scale

Neurological Observations

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

Pain Score

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

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

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

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

CHI: 2208793218

Royal Alexandra Hospital

Total Att: 12

12 Mth Att: 3

Title: MR

BURGESS **Henry**

DOB: **22/08/1979** Age: **38y** Sex: **Male**

14 Thompson Brae

Paisley
Renfrewshire
PA1 1TP

Next of kin: **THOMSON, Lorna**
Relationship: **Sister**

GP: **S Goyal**
0141 889 3144

Attendance Date: **13/09/2017** Arrival Time: **20:07**

Registration Time: **20:07** Date of Incident: **13/09/2017**

Major Incident Desc:

Reason for Attendance: **diabetic incident**

Affix Label

Nursir

Presentir

Triage ca

Allergie:

Observa

Nursing Assessment

Alerts: **Yes**

Triage Category: **1**

Allergies: **None Known** Pain Score:

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **13/09/2017 20:23**

Nurse name: **Nurse Michelle McMillan**

Temp		C
HR		bpm
BP	/	mmHg
MAP		mmHg
RR		bpm
SpO2		%
Oxygen		%

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

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **ALTERED GCS**

Nursing N

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

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

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

DO NOT WRITE HERE PLEASE.

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By
13/9/17	NALOXONE	400mcg	IM	2100.	FB	JByrne

* LEFT DEPARTMENT 22:00pm *

Date	CLINICAL NOTES
	Seen by (Dr) / Time seen

See Surg Proforma

220879321S

Burgess

Date	CLINICAL NOTES

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

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

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

Discharge Prescription Packs

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

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name
Address

2208793218 22/08/1979
CHI No. BURGESS Henry
DoB

	Date	Ward
Admitted		
Transferred		
Transferred		

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

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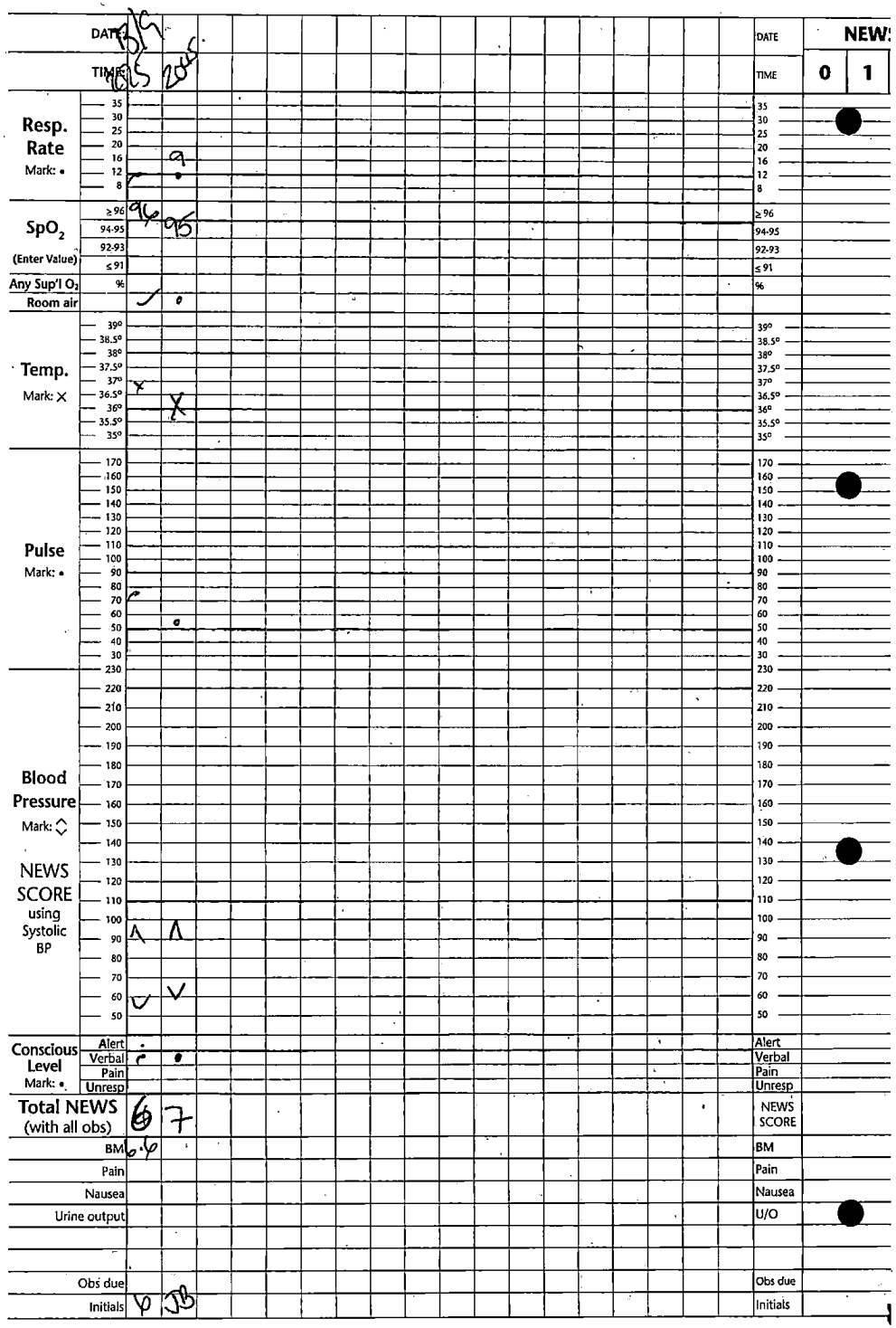
DATE
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Resp. Rate
Mark: •
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SpO2
(Enter Value)
≥96
94-95
92-93
≤91
96
95
Any Sup'l O2
%
Room air
Temp.
Mark: X
39°
38.5°
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36°
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Pulse
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Blood Pressure
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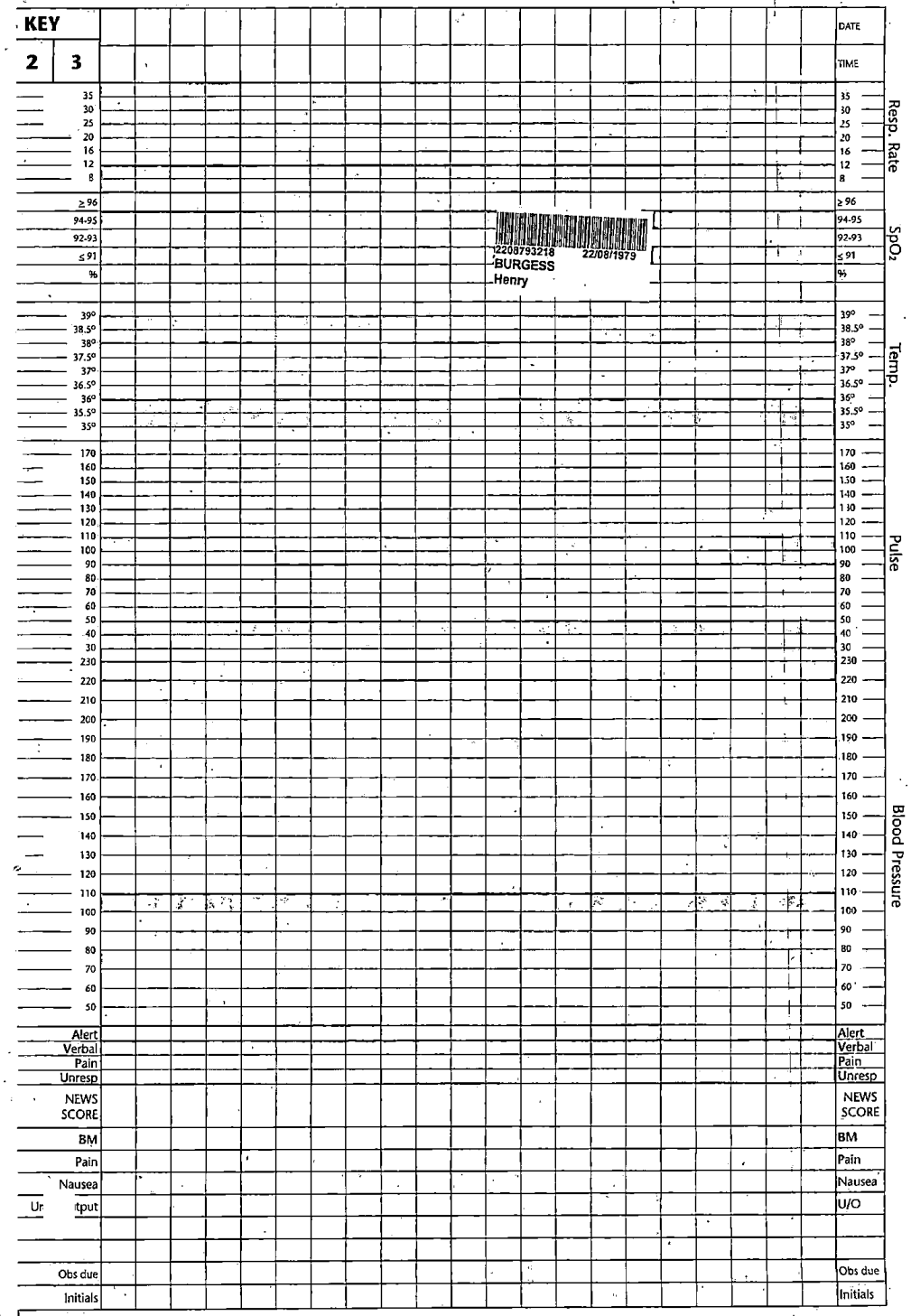
60
50
NEWS SCORE using Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
6
7
BM
6.6
Pain
Nausea
Urine output
Obs due
Initials
JB
DATE
TIME
NEWS
0
1
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials


KEY
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TIME
Resp. Rate
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12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
2200793218
22/08/1979
BURGESS
Henry
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
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Pulse
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160
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50
40
30
230
220
210
200
190
180
170
160
150
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70
60
50
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Glasgow Coma Scale

Pupil size (mm)

Neurological Observations

| | | |

Emergency Department Nursing Documentation

NHS Greater Glasgow and Clyde

aph Label
2208793218 22/08/1979
BURGESS
Henry

Presenting Complaint: Collapse - found in street - drug paraphernalia

Date and Time: 13/9/17 2045

Named Nurse(s): E STEWART

Patient preparation (Please tick when completed)	Initials:	Communication (Please tick when completed)	Initials:
Prepare patient for examination and provide blankets if required	☑	Communication Aids (spectacles / hearing aid)	☐
		Relatives present, who? Police	☐
Clothing bagged, labelled and stored under trolley	☑	Relatives / NOK informed	☐
Name-band (if required) NKDA	☑	Interpreter required	☐
		Telephone interpretation required	☐

Observations and Investigations (Please tick when completed)			Initials:
Vital Signs recorded on NEWS chart and NEWS score recorded. Record Pain, blood sugar and neuro obs on NEWS chart if appropriate.	☐	IV cannula (if required)	☐
Peak Flow 1. 2. 3.	☐	Blood samples taken	☐
12 Lead ECG	☐	Urinalysis and Specimen if indicated *Results:*	☐
Cardiac Monitoring	☐		
X-rays performed	☐	HCG specimen if indicated +ve ☐ -ve ☐ Strip Lot no:	☐
Other: please add	☐	Weight:	☐

Screening Tools (Please circle or tick as appropriate)			Initials:
SEPSIS risk? SIRS Criteria 2 or more and suspicion of infection Sepsis 6 protocol initiatise and departmental documentation started	Y (N) Y (N)	**Preliminary Pressure Ulcer Risk Assessment** The patient can reposition themselves whilst in the department?	Y / (N)
AMT 4 (if >65 years) SCORE 4		There is **no** reported skin damaged other than presenting trauma?	Y / N
At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc). *If at risk complete risk assessment*	Y (N)	The person is fully continent? *If NO to any of the above initiate Waterlow risk assessment (within 4 hrs)*	Y / N
Mental Health Triage Assessment	Y (N)	**Waterlow Score** *If >10 commence Active Care*	☐
Child Protection considered (in line with policy)	Y (N)	**Active Care** (clinical judgement) (include all trolley patients at risk of pressure ulcers and all trolley patients in department for >4hrs) *Record on Active Care Chart*	☐
FAST	Y (N)		
GMAWS	Y (N)	Pressure damage identified on arrival in ED is documented in clinical notes	☐
Has Swallow test been carried out?	Y (N)	Grade 3 or 4 Pressure Ulcers are reported on DATIX	☐

Pause for Transfer (Please tick when completed)		Tick when completed	N/A	Notes
	Relatives informed	☐	☐	Information on discussion with relatives
	Cannula	☐	☐	
	Name band	☐	☐	
	AMT4	☐	☐	
	NEWS chart NEWS >7 - Name and Page number of senior doctor caring for patient	☐	Always	
Prescriptions signed	Infusions	☐	☐	
	Drugs	☐	☐	
	Allergies are recorded (e.g. on Kardex)	☐	☐	
	Fluids	☐	☐	
	Two hour plan in place e.g. Fluids, Antibiotics and emergency drugs written up on Kardex	☐	☐	
	GMAWS	☐	☐	
	Belongings (including patient's medications)	☐	Always	Please note here if any other tasks required prior to transfer
	Bed requested, accepted and ward informed	☐	Always	
	Notes: medical notes, GP letter, PRF	☐	Always	
Investigations	CXR reviewed	☐		
	ECG reviewed	☐	☐	Print name
	Bloods sent	☐	☐	
	Bloods reviewed	☐	☐	
	Patient on O_2 cylinder checked	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	

Patient Addressograph Label

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☑	Information on discussion with relatives
Belongings (including patient's medications)	☑	Always	
New medications explained	☐	☑	
Cannula removed	☑	☐	
Relatives aware of discharge	☑	☐	Please note here if any other tasks required prior to discharge
Social/ Support Services required and contacted	☐	☑	
SAS transport required and ref no	☐	☑	Print name E. STEWART
Other means of transport arranged by nurse	☐	☑	

Nursing Notes and Care Plan

Date and Time		Print Name and Signature
	Pt found in street with drug paraphenalia (: what exactly) around him	
9/A	(A) patent (B) RR 9 SpO2% on air 95%. (C) BP ↓ as charted HR 50 (D) GCS 13/15 3m as charted. 5·5 on VBG.	
7	Monitoring in situ ✓ ECG ✓	
	Pt is type 1 DM on Insulin Family in relatives room.	JSgme
21⁰⁰	c/o 3L O2 via nasal cannula as SpO2%. Periodically ↓ to 92/93	
7	also given 400mg Im naloxone as prescribed	JSgme
22⁰⁰	Patient wakened and wished to leave dept. Ed dr in Attendance, Advice given + explained he may deteriorate, however Still wished to leave dept. Relative present + spoken to by Dr. Also. Changed into own clothes independantly + left dept.	

Patient Addressograph Label

2208793218
BURGESS M
Henry 22/08/1979

Nursing Notes and Care Plan

Date and Time		Print Name and Signature

Emergency Department - Active Care

2208793218 22/08/1979
BURGESS
Henry

ph Label

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every:

(Please circle) ½ hour 1hour 2 hours

Signed ..... Name .....

USE FOLLOWING CODE:

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

			Time							
	1.	PAIN: Assess and address If in pain inform registered nurse Y/ N or N/A								
S	2.	SKIN INSPECTION Pressure areas checked: Y / N / I (independent)								
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)								
K	3.	KEEP MOVING: Have you moved or walked Y / N / I (independent)								
		Bed Right side (30° tilt) – R Left Side (30° tilt) – L Back– B								
		Chair Assist to walk, stand or tilt (W /ST/ T)								
I	4.	ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine/faeces								
N	5.	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)								
		Encourage the patient to drink? (if appropriate) Y / N / N/A								
		Food, snack or supplement taken? (if appropriate) Y / N / N/A								
	6.	ENVIRONMENT: Is the patient able to call for assistance? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? Y / N								
	7.	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return. Y / N								
	8.	ESCALATION: Escalate any issues to the Registered Nurse? Y / N/A								
			Nurse Initials							

USE FOLLOWING CODE	Specialist Pressure Redistributing equipment	Variations			
V = Variant I = Independent NT = No thanks	☐ Repose Mattress ☐ Moving and handling aids ☐ Other:	Time	No.	Variation	Signed

Waterlow Pressure Area Risk Assessment

Build/Weight		Skin Type/Visual Risk Areas		Sex/Age		Special Risks - Tissue Malnutrition	
Average (BMI 20-24.9)	0	Healthy	0	Male	1	Multiple organ failure/ Terminal cachexia	8
Above Average (BMI 25-29.9)	1	Tissue Paper (thin/fragile)	1	Female	2		
Obese (BMI > 30)	2	Dry (appears flaky)	1	14-49	1	Single organ failure	5
Below Average (BMI < 20)	3	Oedematous (puffy)	1	50-64	2	Peripheral Vascular Disease	5
Continence		Clammy /pyrexia	1	65-74	3	Anaemia = Hb < 8	2
Complete/Catheterised	0	Discoloured (bruising/mottled)	2	75-80	4	Smoking	1
Incontinent urine	1			81+	5	Neurological Deficit	
Incontinent faeces	2	Broken (established ulcer)	3	Nutritional Element		Diabetes/MS/CVA Motor or sensory paraplegia (Max 6)	4-6
Doubly Incontinent (urine and faeces)	3	Mobility		Unplanned weight loss in past 3-6 months < 5% Score 0 5-10% Score 1 > 10% Score 2			
		Fully mobile	0				
Special Risks – Surgery/Trauma		Restless/Fidgety	1			Special Risks - Medication	
On table > 6 hours	8	Apathetic (sedated/depressed/ reluctant to move)	2			Cytotoxic, anti-inflammatory, long term/high dose steroids (Max 4)	4
Orthopaedic / below waist/Spinal (up to 48 hrs post-op)	5			BMI > 20 Score 0 BMI 18.5-20 Score 1 BMI < 18.5 Score 2			
On table > 2 hours (up to 48 hrs post op)	5	Bed bound (unconscious/unable to change position/traction)	4			Risk Score 10+ = 'At risk' 15+ = 'High Risk' 20+ = 'Very High Risk'	
		Chair Bound	5	Patient acutely ill or no nutritional intake > 5 days	2		

Patient's Initial Waterlow Score = If Score ≥10 Complete the Adapted Waterlow Pressure Area Risk Assessment Chart

Dr. S Goyal
King Street Surgery
The Surgery
15 King Street
Paisley
PA1 2DF

Patient Sample Report

Patient

ID:	2208793218
Last Name:	**BURGESS**
First Name:	**HENRY**
Gender/Age:	Male, 38 years
Birth Date:	22/08/1979
Status:	**NOT VALIDATED**
Analyzed:	13/09/2017 20:43:31
Sample Type:	**Venous**
Operator ID:	BRENNAN F

Analyzer

Model:	GEM® *Premier 4000*
Area:	RAHRESUS
Name:	RESUS
S/N:	12085642

Measured (37.0°C)		
cH	45.6	nmol/L
pCO_2	7.9	kPa
pO_2	6.5	kPa
Na^+	138	mmol/L
K^+	4.0	mmol/L
Cl^-	104	mmol/L
Ca^{++}	1.23	mmol/L
Glu	5.5	mmol/L
Lac	0.6	mmol/L
CO-Oximetry		
tHb	142	g/L
O_2Hb	82.8	%
COHb	5.2	%
MetHb	1.3	%
HHb	10.7	%
sO_2	88.6	%
Derived		
BE(B)	4.3	mmol/L
$HCO_3^-(c)$	31.8	mmol/L
Operator Entered		
Temp	37.0	°C

2208793218
BURGESS M
Henry 22/08/1979
14 Thompson Brae
Paisley, Renfrewshire
PA1 1TP

Cycle 20

NHS
Greater Glasgow and Clyde

Acute Medical Unit Admission Proforma

MAU/A&E/AMU

Royal Alexandra Hospital, Paisley/Vale of Leven Hospital/IRH

Patient Details		
Name: Address:	[illegible] Patient Burgess 220879 3218	Sex: F ☐ M ☑ DoB 22/8/79 Age:
Telephone:		
GP:	Dr S Gogia	
Next of Kin:		
Telephone:		

Episode Details			
Date patient seen:	13/9/17	Time seen: 20·30	
Source of referral:	GP ☐ A&E ☒ OPD ☐ Self ☐ Other =		
Admitting Dr:	Brenn	Grade Specialty	Bleep
Consultant:	Dr Ray		

Resuscitation Decision

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

Signature: [signature] Name: Brenn Grade: Specialty

If DNA CPR → Complete appropriate form

GGC0086 97644

Brought in by police

Cycle 20

Presenting Complaint(s)	
Presenting complaint	Reduced conscious level
History of presenting complaint	38 yrold male found in Jesmond Centre with evidence of drug paraphernalia around him & reduced GCS. police became concerned when he became more drowsy. { slurred speech reduced conscious level – eyes closed. reduced resp rate & admits to taking ~~H~~ street valium (30 Blues) & alcohol

Past Medical History / Review of Old Notes. Review eKIS if available
– Hep C +ve. – known to use street Drugs (Injects Heroin / oxycons Benzodiazepines) – Type I DM.

Systemic Enquiry

Cycle 20

MEDICINES RECONCILIATION – Acceptable to staple fully completed Emed Rec

Source of medication history Patient ☐ Relative/carer ☐ GP Phone call ☐ ECS ☑

(>1 source preferred) Patient own drugs ☐ Com. Pharmacist ☐ GP letter/summary ☐ Repeat Script ☐

Other (please specify) .....

Admission Medicines	Dose	Frequency	Plan for medicines (Dr complete) Continue	Amend	Withold	Stop	Comments Reason for alteration
PREGABALIN							
OMEPRAZOLE							
MIRTAZAPINE							
[illegible]							
TRIMIPRAMINE							
NOVOMIX							
NOVO RAPID							

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Allergies	List any over-the-counter or alternative medicines
None known ☑	
	Do medicines need further clarification ? Yes ☐ No ☐
List collected by :	Plan approved by :
Designation : Date :	Designation : Date :

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

Cycle 20

Social History

Smoking History

Ex-smoker/Smoker ____cpd ___yrs Never smoked

Alcohol History

_____Units/week FAST score if excess _____

Recreational Drugs Driving Status

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

Lives w mother

Family History

Observations

RR: 9 bpm **Sats:** 96% RA % **FIO2:** **Temp:** 36.8 °C **BP:** 100/59 / **HR:** 76 bpm **BM:** 6.6

General Examination

General Appearance:

Cyanosis / pallor / jaundice / clubbing / lymphadenopathy

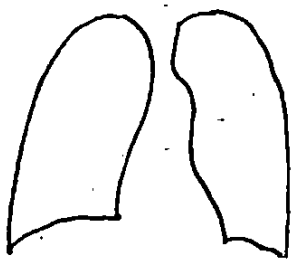
Respiratory

PEFR =

AE Good

No Added

Sounds



Cycle 20

Cardiovascular

Pulse 76 **Heart Sounds** I+II+0

JVP

Oedema

Peripheral Pulses **cap refill**

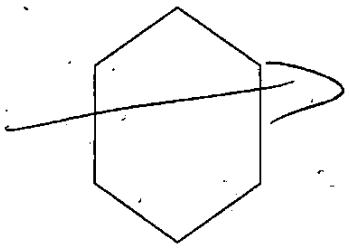
Gastrointestinal system

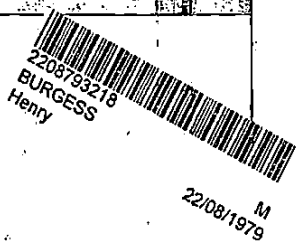
Masses:

Organomegaly:

Bowel sounds:

PR:





Neurological system

GCS: 13/15 **E:** 3 /4 **M:** 5 /6 **V:** 5 /5 **AMT:** /4 (AMT 4 = age, time, place, year)

Pupils/fundoscopy:

PERL bye 2.

Cerebellar and extrapyramidal:

Cranial Nerves:

Neck:

	RUL	LUL	RLL	LLL
Tone	↓	↓	↓	↓
Power	wang	gee	wrist	
Co-ordination				
Reflexes				
Sensation				

Gait:

Locomotor

	Tender	Swollen	Deformity	Which joint?
Arms				
Legs				
Spine				

Cycle 20

Investigations

VBGs [redacted] no GS lactate 0.6
glue 5 5

(Differential) diagnosis

Recreational drug misuse
(though denies Heroin)

Management Plan

IM Naloxone → now GCS 15.5
has taken at request & wants to go home despite being advised of the dangers of opioid overdose.

Thromboprophylaxis assessed ☐ **Medicine Reconciliation** ☐ **DD6 if required** ☐

Signature FB **PRINT NAME** Brenn **PRINT GRADE** SpR

Page:

Senior/Medical review

Admission checklist

Investigations reviewed ☐ **Kardex** ☐ **eKIS reviewed** ☐
Thromboprophylaxis assessed ☐ **Medicine Reconciliation** ☐ **DD6 if required** ☐

NHS GG&C Adult Risk Assessment for Venous Thromboembolism (VTE)

[excluding orthopaedics, obstetrics and gynaecology & ENT who have specialty-specific policies]

- **Risk Assessment must be completed for all patients within 24 hours of admission to hospital**
- **Patients must be reassessed every 48-72 hours or sooner if condition changes**
- **Reassessment must be documented in Kardex**
- **Please complete risk assessment and then sign and date Risk Assessment Result box at bottom of page.**

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Surgical patients start here

Non-operative

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

Yes ☐ No ☐

Does the patient have any risk factors for thrombosis? (tick √ all that apply)

Age >60	☐	Use of oestrogen-containing contraceptive therapy	☐
Active cancer or cancer treatment	☐	Use of hormone replacement therapy	☐
Dehydration	☐	Pregnancy or < 6 weeks post partum [seek specialist advice]	☐
Known thrombophilias	☐	Critical care admission eg HDU/ITU	☐
Obesity (BMI>30)	☐	Total anaesthetic + surgical time >90 minutes	☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or Inflammatory disease	☐	Surgery involving pelvis or lower limb with a total anaesthetic + surgical time >60 minutes	☐
Personal history or first degree relative with a history of VTE	☐	Acute surgical admission with inflammatory or intra-abdominal condition	☐
Varicose veins with phlebitis	☐	Hip fracture	☐

- No thromboprophylaxis required.
- Continue to reassess every 48-72 hours or sooner if condition changes.
- Document all reassessments in drug kardex.
- Risk assessment now complete
- Complete Risk Assessment Result Box

Yes, 1 or more risk factors identified ☐

No risk factors identified ☐

Does the patient have any contraindications to pharmacological prophylaxis? (tick √ all that apply)

Active bleeding	☐	Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands)	☐
Acquired bleeding disorders (e.g. acute liver failure)	☐	Neurosurgery, spinal or posterior eye surgery	☐
Concurrent use of anticoagulants (such as warfarin with INR>2)	☐	Lumbar puncture, epidural/spinal anaesthesia expected within the next 12 hours	☐
Acute stroke	☐	Other procedure with high bleeding risk – discuss with senior if unsure	☐
Uncontrolled hypertension (230/120 mmHg or higher)	☐	Lumbar puncture, epidural/spinal analgesia within the previous 4 hours	☐
Thrombocytopenia (<75 x 10^9/l)	☐	Thyroid surgery	☐

- Discuss with senior clinical staff before prescribing pharmacological prophylaxis
- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48-72 hours or sooner if condition changes

No contraindications to pharmacological prophylaxis identified ☐

Contraindications to pharmacological prophylaxis identified ☐

Surgical patients – Enoxaparin 40mg + AES ☐*
*prior to application of AES, please check contraindications to AES
Medical patients – Enoxaparin 40mg ☐
Prescribe Enoxaparin at 6pm
[on day of surgery, at the later of either 4h post-op or 6pm]
Reduce Enoxaparin to 20mg if <50Kg or eGFR <30ml/minute/1.73m² ☐
Discontinue at discharge or when returned to pre-morbid mobility

Contraindications to anti-embolism stockings (AES) Y ☐ N ☐

Peripheral neuropathy	☐
Peripheral vascular disease	☐
Cellulitis or Gross oedema	☐
Leg deformity or Fragile skin	☐
Leg / foot ulcers	☐
Allergy	☐
Unusual leg size/shape	☐

Risk assessment result – please tick √ all that apply

VTE risk factors: YES ☐ NO ☐ Contraindications to pharmacological prophylaxis: YES ☐ NO ☐ Prescribed: LMWH ☐ AES ☐ NONE ☐

Patient informed of VTE risks and benefits of thromboprophylaxis YES ☐ NO ☐ N/A ☐ Information leaflet provided YES ☐ NO ☐

Print Assessor's Name: _____ Signature: _____ Date: _____

DD6 All patients over 64

4AT	Y/N/Na
Carers involved	Y/N/Na
Med rec	Y/N/Na
Sepsis Screen	Y/N/Na
Resuscitation status considered	Y/N
Discharge planning	Y/N/Na

Sepsis Six

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

Cycle 20

Results

Baseline	Date									
	Time									
	Parameter	Ref Range								
	Hb	130-180								
	WCC	4.0-11.0								
	Plts	150-400								
	MCV	78 - 99								
	Neut	2.0 - 7.5								
	PT	9.0 - 13.0								
	APTT	27.0 - 38.0								
	Fibrinogen	1.5-4gm/L								
	INR	( )								
	Thromb T	11-15 secs								
	D-Dimer	<230								
	ABG/VBG									
	Na^+	135 - 145								
	K^+	3.5 - 5.0								
	Cl^-	97 - 107								
	HCO_3^-	23 - 30								
	Urea	2.5 - 7.5								
	Creat	62 - 124								
	eGFR									
	Glucose	3.5 - 5.9								
	Protein	32 - 82								
	Albumin	37 - 50								
	AlkP	33 - 117								
	Bil	0.5 - 19								
	ALT	11 - 55								
	AST	13 - 42								
	GGT	8-60								
	ESR									
	CRP	<3								
	Troponin I hs	Men 0 - 34 Women 0 - 16								
	CK	23 - 190								
	Corr Ca^{++}	2.25 - 2.60								
	PO_4^-	0.8 - 1.4								
	Mg^{++}	0.7 - 1.1								
	Digoxin	0.5 – 2.0								
	Alcohol									
	Paracetamol	<100 @4 hr								
	Salicylate									
	Amylase	<100								
	LDH	240 - 480								
	Folate	3.1 - 20								
	B12	200 - 900								
	Ferritin	15 - 200								
	TSH	0.35 – 5.00								
	T4	9 - 21								
	Urinalysis									

DON'T MISS AKI Checklist within 24 hrs of admission

D Dipstick Urine: _____

O Obtain Ultrasound: Yes ☐ N/A ☐

(Stage 2/3: within 24 hours of Admission)

N Need for Catheter: Long-term ☐ Yes ☐ No ☐ Refused ☐

T Team Renal to contact: Considered ☐ Done ☐ N/A ☐

M Medicine Reconciliation: ☐

I Intravenous Fluids: Yes ☐ Contraindicated ☐

S Suspected Cause: _____

S Staging of AKI: (Tick Box Below)

☐ 1 (RISK if: Creatinine X 1.5)
☐ 2 (INJURY if: Creatinine X 2)
☐ 3 (FAILURE if: Creatinine X 3)
(compared to baseline)

Signature/Name/Grade_____

Cycle 20

Post Take Ward Round AMU/MAU/OAAU

Consultant: ..... Date: ..... Time: .....

Summary

Temp:

Pulse:

BP:

Sat O2:

FiO2:

RR:

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Henry
14 Thompson Brae
Paisley, Renfrewshire PA1 1TP

ECG: **Bloods:**

CXR: **Other investigations:**

Imp:

Plan:

AWI considered ☐ Thromboprophylaxis need reviewed ☐ Medicine reconciliation complete ☐

If cardiac or respiratory arrest is considered a possibility for the patient has CPR status been reviewed and documented Yes ☐ No ☐

CPR decision discussed with patient Yes ☐ No (document why) ☐ Advanced directive in situ ☐ Treatment escalation plan (circle) Ward/HDU/ITU

Family informed of CPR/escalation status? – Needs discussed at first opportunity ☐ Has been discussed ☐ Patient does not want family informed ☐

Recommended Destination: _____

Suitable to board <u>if required</u> Yes ☐ No ☐

Expected Date of Discharge: _____

Signature: _____

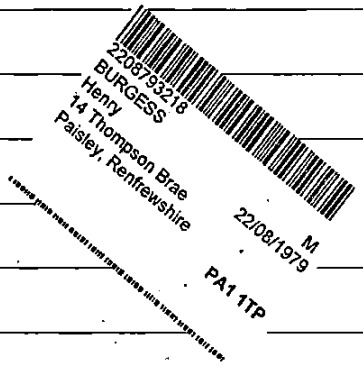
Designation: _____

Bleep Number: _____

Cycle 20

Junior/Senior additional notes, communications with relatives

NOTES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22/08/1979
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PA1 1TP

NOTES

for ENT f/u.

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

CHI: 2208793218

Royal Alexandra Hospital

Total Att: 15

12 Mth Att: 5

Title: **MR**

BURGESS **Henry**

DOB: **22/08/1979** Age: **38y** Sex: **Male**

76 STOCK STREET

Paisley
Renfrewshire
PA2 6NH

Next of kin: **THOMSON, Lorna**
Relationship: **Sister**

GP: **J Calvo Rodriguez**
0141 889 4088

Attendance Date: **16/02/2018** Arrival Time: **22:30**

Registration Time: **22:30** Date of Incident: **16/02/2018**

Major Incident Desc:

Reason for Attendance: **assault - head injuries**

Affix Label

Nursing Assessment

Alerts: **Yes**

Triage Category: **3**

Allergies: **None Known** Pain Score:

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **16/02/2018 22:38**

Nurse name: **Nurse Laura Bruce**

Temp		C
HR		bpm
BP	/	mmHg
MAP		mmHg
RR		bpm
SpO2		%
Oxygen		%

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **"Alleged assault with hammer ?LOC, lac left eye and right arm "**

ENT 1/3 @ 90 Sm.

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

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

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES
16/2/18	Seen by (Dr) D. Carran EM ST3 Time seen 06.00

ED Alleged assault

See HI proforma

requires ENT f/u.

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Henry
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Paisley, Renfrewshire PA2 6NH

Date	CLINICAL NOTES

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Paisley, Renfrewshire
PA2 6NH

M
22/08/197

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

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

Follow up	Arranged	Not arranged	To be arranged

Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

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

SCOTTISH AMBULANCE SERVICE - PATIENT REPORT FORM

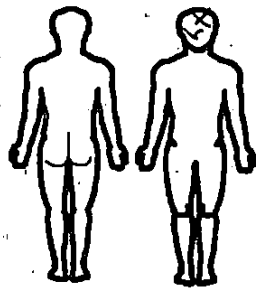
CCS INCIDENT No. AA/N NNNNNN/NN

Last Name: BURGESS
First Name: HENRY
Location: 96A ALICE STREET. 14 THOMSON BREA PAISLEY PA2 1TP
Age: 38
Sex: X M F
D of B: 22 08 79

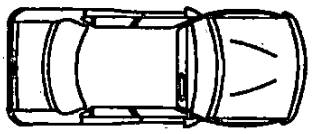
Date: 26 08 18
Time of Call: 0930 AM
Time at Patient: 0940 PM
Time Left: 1020 PM
AMPDS Code:
AMPDS Revised:

Airway Clear [X] Suction [ ] N/OPA [ ] ET [ ] LMA [ ] Successful? Y [ ] C-spine Injury Y [ ]
Breathing [X] Rate F [X] S [ ] BVM [ ] Ventilation [ ] Successful? Y [ ] Paralysis Y [ ] Fitting Y [ ]
Pulse [X] Rate F [X] S [ ] CPR [ ] IV/IO [ ] Fluids [ ] Successful? Y [ ]
ECG: NSR
Despite the above unable to
Clear airway [ ] Detect breathing [ ] Detect pulse [ ] [X] V [ ] P [ ] U [ ]

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



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



Allergies: NKDA 5 6 7 8 9
Medication: MIRTAZAPINE
Assisted by and Name -
Doctor Y [ ] Nurse Y [ ] Other Y [ ]
Saboxon Omeprazol Pregablin Naurogid

Temp. 36.0 °C
PEFR [ ] %
B. Sugar 6.2 mmol

Time	Pulse	Resp	BP		C / Refill	SpO2 %	GCS	Lpupil	Rpupil
2208	84	20	150	112	X S N	99	456	C C	C C
2210	86	20	150	D 99	F S X	99	456	C C	C C
			S Y S	D I A	F S N		E V M	S R	S R
			S Y S	D I A	F S N				

Time	Fluid/Drug/Gas	Dose	Unit	Route	Effect	Rhythm
					+ 0	
					+ 0	
					+ 0	
					+ 0	

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Condition at RAH hospital Pulse [X] Breathing [X] Conscious [X] Time at Hospital 2226

History and Additional Information: 999 38YOM Assault. Police In Attendance C/o Wound to above Upper (L) eye orbit / Laceration on (R) Forearm (Defence Wound) / Pain to (L) Rib Cage Area / Upper lip Pain Pt was orientated and Conscious to Time / Date / Place Weapon Used Was possibly a hammer LOC ??? No Vomiting PMH Diabetes Neuropathy

Working assessment: Assault
Diagnosis Code [ ]

Crew Name 1: L FRASER Grade L [X] T C
Crew Name 2: S MCCLAFFERTY Grade L P [X] C

PATIENT REFUSAL FORM

I, (name of patient/escort/proxy)_____

on behalf of (self or patient name) _____

certify that at (time) _____

on (day and date) _____

I refused an offer of: (Initial appropriate box)

Examination	☐
Treatment	☐
Transport by Ambulance	☐
Carry by Stretcher	☐
Carry by Chair	☐
Use of Safety Belt	☐

Signed _____ (tick appropriate box)

Patient	☐
Escort	☐
Guardian	☐
Relative	☐
Friend	☐

(For use in the event of refusal to complete this form)

I, (name of Ambulance Attendant) _____

have provided the above information and certify it as an accurate record of events.

Signed _____

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name	
Address	
	2208793218 22/08/1979 BURGESS Henry
CHI No.	
DoB	

	Date	Ward
Admitted		
Transferred		
Transferred		

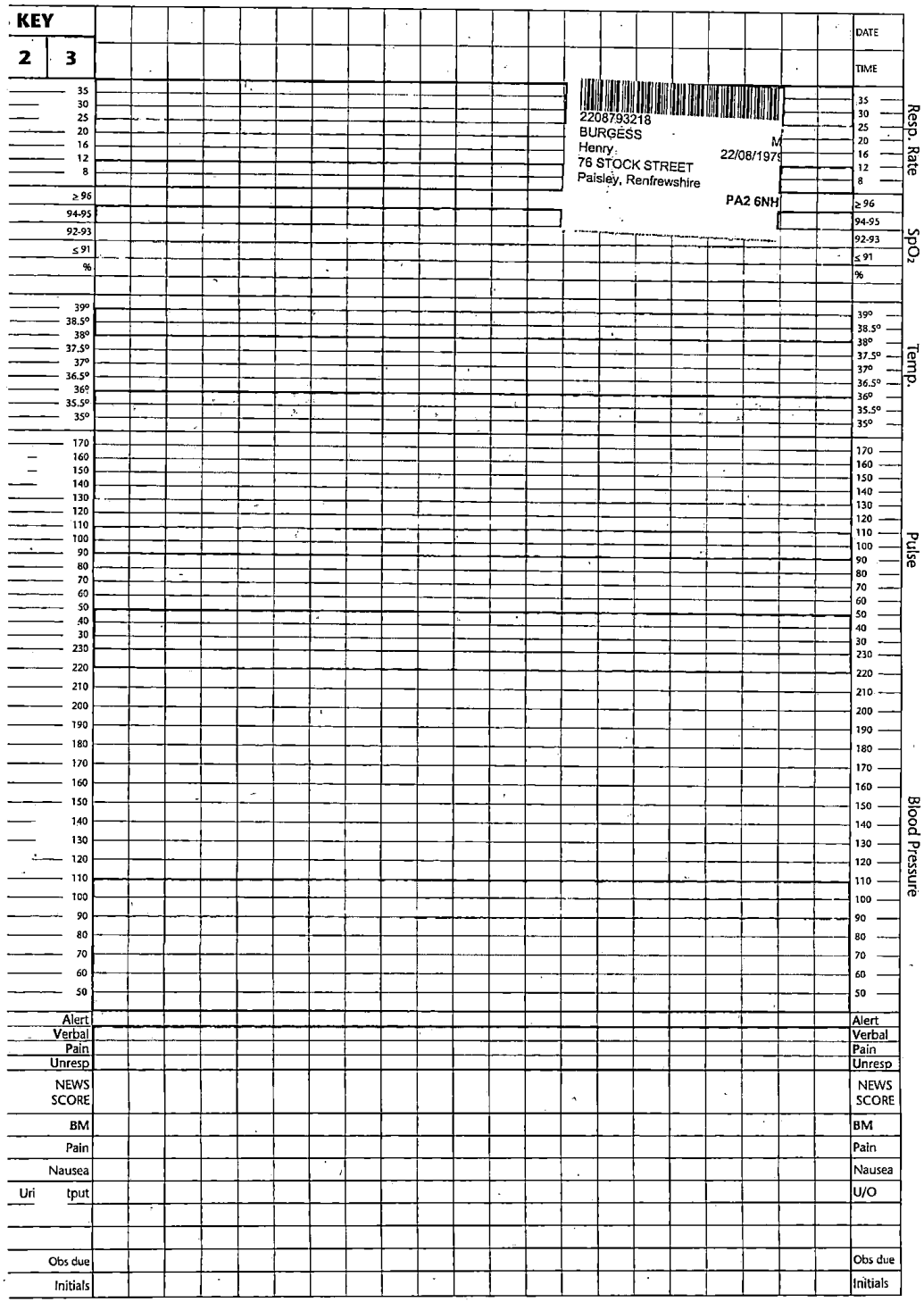
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic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

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

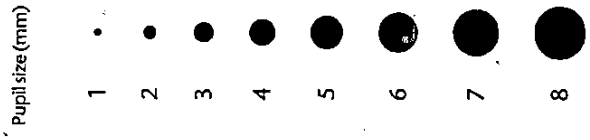
See NEWS Actions Reference Tool for local escalation policy

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

| | | |


KEY
2
3
2208793218
BURGESS
Henry
76 STOCK STREET
Paisley, Renfrewshire
PA2 6NH
M
22/08/1979
DATE
TIME
Resp. Rate
SpO2
Temp.
Pulse
Blood Pressure
35
30
25
20
16
12
8
≥ 96
94-95
92-93
≤ 91
%
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
Uri tput
U/O
Obs due
Initials

Glasgow Coma Scale



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Neurological Observations

| | | |

Royal Alexandra Hospital & Inverclyde Hospital : Form for Assessment of

HEAD INJURY

For all patients with a head injury under ED. Attach inside the ED card. For patients with anything but the simplest of presentations, other relevant information must also be recorded on the ED card.

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M
22/08/1979

Today's Date: 16/2/17
Time: 00.00
Date of injury: 16/2/17
Time of injury: ~21.00

Mechanism of injury: Alleged assault with hammer. At girlfriends house, asleep. Woke up to brother hitting him with a hammer. Unsure how many times he was hit. Status was knocked unconscious. Girlfriend says have ~21.50 / 22.00 and found him covered in blood and phoned police. Remembers girlfriend coming home

	No	Unsure	Yes	
> 65 years of age	✓			
Alcohol consumption	✓			Alcohol level if measured:
Drug abuse	✓			Specify Drug if known:
Loss of Consciousness			✓	How long? unsure
Amnesia Post Traumatic	✓	✓	✓	How long? [illegible]
Amnesia Retrograde	✓			How long?
Seizure Since Injury	✓			Describe:
Headache	✓			Describe:
Nausea	✓			
Vomiting	✓			No of times?
Visual Disturbance	✓			Comment:
Other Neuro Symptoms	✓			If yes, describe:

PRE-EXISTING DISORDERS *(Relevant to H, such as: epilepsy, diabetes, frequent falls, dementia, other medical/mental disorders)*

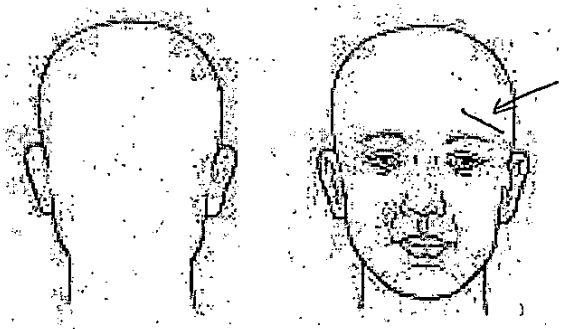
Pre existing disorder Present?			✓	Specify if present: T1DM, Asthma
Warfarin or coagulopathy	✓			Peripheral neuropathy

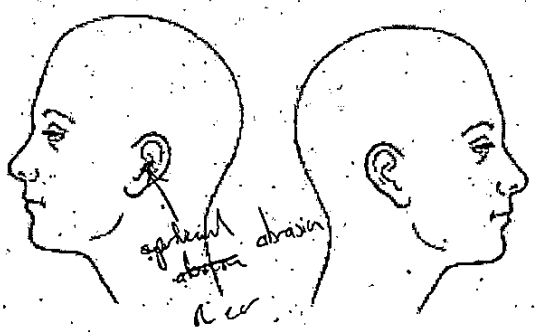
EXAMINATION	no	yes	Describe if abnormality
Neck Injury: evidence of	✓		
BOS Fracture: clinical signs of	✓		
Tympanic Membs abnormal	✓		
Vault Fracture seen or felt	✓		
Dysphasia	✓		
Vision loss	✓		
Limb Movements abnormal	✓		
Gait abnormal	✓		
Eye Movement abnormal	✓		
Behaviour abnormal	✓		
Pupils reacting abnormally	✓		
CSF leak	✓		

Lacerations, bruises, etc: indicate size in cms. *Treatment: indicate number of sutures, glue, etc*

Obvious nasal deviation - nil septal haematoma

- for ENT follow up.





2208793218
BURGESS M
Henry 22/08/197
76 STOCK STREET
Paisley, Renfrewshire
PA2 6NH

N.l facial bone tenderness. N.l injury to head apart from face. N.l boggy swelling at laceration site.

GCS when examined	E 4 /4	M 6 /6	V 5 /5	GCS 15
Lowest recorded GCS at any time (include ambulance)	E	M	V	Time

Imaging	Not needed	Done	Result
C Spine X Ray	✓		
Face X Ray	✓		
CT Brain	✓		

Have you given:	Not needed or N/A	Yes
Tetanus Booster or course started	✓	
HI Advice Card (& patient discharged)		✓

For all admitted patients:

Main Reason for admission:

	Done	Not needed
CIWA scale prescription		
IV fluids chart		
Bloods done (inc. arrangements for results)		
Compulsory for ALL admissions:		
Drug Kardex		
Neuro obs: at least two sets done in ED.		
ED card: usual admission details including PMH, drugs, general examination, etc.		

Ward Nurses please do Neuro Obs

Hourly ☐ Half Hourly ☐

Doctors Signature:

Print name: Dagmar

ECG IV

NHS GGC Hospitals, Emergency Department

16

NHS Greater Glasgow and Clyde

Royal Alexandra Hospital

CHI: 2208793218

Total Att: 16

12 Mth Att: 4

Title: MR

BURGESS

Henry

DOB: 22/08/1979

Age: 38y

Sex: Male

76 STOCK STREET

Paisley
Renfrewshire
PA2 6NH
07404979036

Next of kin: GARRETT, Fiona
Relationship: Partner
07477774484

GP: J Calvo Rodriguez
0141 889 4088

Attendance Date: 01/05/2018

Arrival Time: 01:55

Registration Time: 01:55

Date of Incident: 01/05/2018

Major Incident Desc:

Reason for Attendance: chest pain

Affix Label

Nursing Assessment

Nursing Assessment

Alerts: Yes

Allergies: None Known

Pain Score:

Triage Category: 2

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 01/05/2018 02:04

Nurse name: Nurse Michelle McMillan

Temp		C
HR		bpm
BP	/	mmHg
MAP		mmHg
RR		bpm
SpO2		%
Oxygen		%

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: self presentation chest pain t1dm alcohol excess

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

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

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

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By
	PEDIAE	10ML	O	05:45		

Date	CLINICAL NOTES
	Seen by (Dr) McCann Time seen 03.00

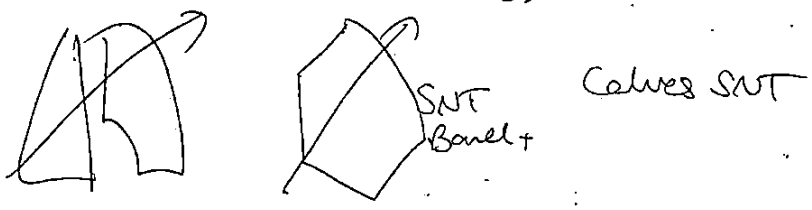
PC: Chest pain.

HPC: Sharp pain, left hand side of anterior chest wall. It was there when he woke up 3 days ago.
Now has left sided Abdo pain.
Pain worst on inspiration
Pain 6/10
Has not tried any analgesia
Feels sweaty with the pain,
~~Not~~ feels nauseous.
Drank 4 cans prior to presenting

PMH: T1DM
Asthma.

Meds: As per ECS:
no illicit substances.

2208793218 22/08/1979
BURGESS
Henry



Tender down left sternal edge and right parasternal tenderness.

Discussed with Dr Manson
Doesn't sound cardiac or like PE.
Likely MSK or possibly gastric.
Pt ECG + paracetamol and advised to attend GP

Date	CLINICAL NOTES

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

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

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

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By
8/5/18	PARACETAMOL	1g	O	QID		
1/5/18	~~PERTAC~~	~~10ml~~	O	PRN	~~[illegible]~~	

Glasgow Assessment and Management of Alcohol

NHS Greater Glasgow and Clyde

Please Attach Patient Label

CHI: 2208793218
Name: BURGESS, Henry — M — 22/08/1979
Addr: 76 STOCK STREET, Paisley, Renfrewshire — PA2 6N
Postcode:

Estimated Weekly Alcohol Units : 140
Daily Units x Number of Days per Week)
Excessive Weekly Consumption >14 units/week

Estimated Date / Time Of Last Drink: 21 23:30 on 30/4/18
(If ≥ 5 Days, Re-consider Alcohol Withdrawal Status)

Presents with or has had previous alcohol withdrawal seizures/ severely agitated withdrawal:

YES: ☑ NO: ☐

IS IT ALCOHOL WITHDRAWAL?

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

Fast Alcohol Screening Tool - FAST:

Note : 1 drink = 1 unit of alcohol

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

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

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

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

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

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

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

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

Score of 3 or more: FAST Positive

Total: 16

FAST Positive? Yes ☑ No ☐

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

EXCEPTIONAL PATIENT GROUP WITH CO-MORBIDITY?

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

- Patients with evidence of liver disease: especially jaundice, encephalopathy
- Patients with other co-morbidity (ie COPD, pneumonia, cerebrovascular disease, reduced GCS, elderly >70, head Injury; pregnancy)

REFER TO SECTION 3 (PAGE 3) FOR MANAGEMENT ADVICE

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

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Order Number GGC0169

Prophylaxis and Treatment of Wernicke-Korsakoff Syndrome

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

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

- Confusion
- Ataxia
- Decreased consciousness
- Opthalmoplegia
- Nystagmus
- Hypothermia/ hypotension

YES → Presumptive diagnosis of Wernicke's Encephalopathy (if symptoms otherwise unexplained) **GO TO BOX A**

NO → Assess Risk of Wernicke's Encephalopathy **GO TO BOX B**

BOX A	Day 1-2	Day 3-5	Day 6 onwards
Presumptive Diagnosis of Wernicke's Encephalopathy: This requires URGENT treatment	**Pabrinex IV:** 2 pairs of vials three times a day. **Magnesium** Check Serum Magnesium URGENTLY and give intravenous replacement if deficient.	**Pabrinex IV/IM** 1 pair of vials three times a day	Change to **oral Thiamine** 50mg four times a day **or** continue IV/IM **Pabrinex** at discretion of Medical Team

BOX B	RISK FACTORS for WERNICKE'S	
	Risk Factors	**Severe Risk Factors**
Assessment of Risk of Wernicke's Encephalopathy	Weight loss (MUST=1) Poor diet or vomiting for <5 days Alcoholic Liver Disease Presents with Seizure Age ≤18 or ≥65	Severe Weight loss (MUST≥2) Poor Diet or vomiting for >5 days

No Risk Factors	One Risk factor	Two or more Risk Factors or any single Severe Risk Factor
Oral Thiamine 50mg four times a day	**Pabrinex IV/IM** 1 pair of vials three times a day for **24** hours then change to **oral Thiamine** 50mg four times a day	**Pabrinex IV/IM** 1 pair of vials three times a day for **48** hours then change to **oral Thiamine** 50mg four times a day

Check Magnesium in all patients and correct deficiency

Important notes

- If oral thiamine is indicated but a patient is unable to take medicines by mouth, then consult your ward pharmacist: NG administration may be possible or IM Pabrinex® (1 pair of vials once daily) are alternatives
- Intravenous Pabrinex® should be administered over 30 minutes
- Anaphylaxis is a rare complication of IV Pabrinex® administration and even more uncommon with IM administration. Monitor patient for wheeze, tachycardia, breathlessness and skin rash. Facilities for the administration of adrenaline and other resuscitation should be available.
- Additional vitamin supplementation as clinically indicated by responsible medical team in the context of a general nutritional assessment

Glasgow Modified Alcohol Withdrawal Scale (GMAWS)

Treatment Option: GMAWS Only ☐ GMAWS & Fixed Dose ☐

Date	1/5/18																		
Time	02:25																		
Tremor 0) No tremor 1) On movement 2) At rest	0																		
Sweating 0) No sweat visible 1) Moist 2) Drenching sweats	0																		
Hallucination 0) Not present 1) Dissuadable 2) Not dissuadable	0																		
Orientation 0) Orientated 1) Vague, detached 2) Disorientated, no contact	0																		
Agitation 0) Calm 1) Anxious 2) Panicky	0																		
Score	0																		
Treatment	PP + 20																		
Staff Signature																			

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

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

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

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

9 – 10 :Give 20mg Diazepam : Repeat Score in 1 hour

EXCEPTIONAL PATIENT GROUPS: SYTMPTOM TRIGGERED TREATMENT
Patients with evidence of liver disease especially jaundice or encephalopathy: use oral **Lorazepam 1-2 mg**
Patients with other co-morbidity (i.e. COPD, pneumonia, cerebrovascular disease, reduced GCS, elderly (>70), head injury): use Lorazepam as above **OR** Diazepam at 50% of standard GMAWS dose.
In pregnancy use Diazepam at 50% of standard GMAWS

PATIENTS MAY REQUIRE TO BE WOKEN FOR CONTINUING ASSESSMENT

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

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

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

APPROXIMATE ORAL BENZODIAZEPINE EQUIVALENCE: 10mg Diazepam = 1mg Lorazepam = 25mg Chlordiazepoxide
Patients should not be discharged on regular benzodiazepine

Developed by the Acute Alcohol Screening & Withdrawal Management Guideline Group Chaired by Dr Ewan Forrest, Consultant Physician and Gastroenterologist, GRI
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Published: April 2017
Review Date: April 2020
Version: 2nd Edition

2208793218 22087979
BURGESS
Henry

Management of Alcohol Withdrawal Syndrome

1. DEPENDENT DRINKING ON SCREENING - HIGH RISK

EXCEPTIONAL PATIENT GROUP WITH CO-MORBIDITY?

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

YES

NO

1. DEPENDENT DRINKING ON SCREENING - HIGH RISK

Any 2 of the following:

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

YES

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

NO

SYMPTOM TRIGGERED TREATMENT (GMAWS)

For exceptional patient groups see Section 3

2. FIXED DOSE TREATMENT REGIME: Oral Diazepam (see **Section 5** for patients unable to tolerate oral):

INITIAL DOSE: 20mg Diazepam 6 hourly

REDUCE DOSE: If after 24 hours no additional symptom triggered treatment has been required

OR

If after ≥48 hours of treatment GMAWS less than 4

REDUCING DOSE: (Not to be prescribed 24hrs in advance. Step down only if GMAWS remains less than 4)

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

3. EXCEPTIONAL PATIENT GROUPS: SYTMPTOM TRIGGERED TREATMENT ONLY

- Patients with evidence of liver disease especially jaundice or encephalopathy: use oral **Lorazepam** in a symptom triggered fashion: 1-2 mg (up to 12mg in 24 hours, when senior medical review is required as below)
- Patients with other co-morbidity (i.e. COPD, pneumonia, cerebrovascular disease, reduced GCS, elderly (>70); head injury): use Lorazepam as above **OR** Diazepam at 50% of standard GMAWS dose
- In pregnancy use Diazepam at 50% of standard GMAWS dose with senior medical review if more than 30mg required in 24 hours

REVIEW PRESCRIPTION if patient is excessively drowsy
SENIOR MEDICAL REVIEW (ST3 or above) REQUIRED for diagnostic review and possible adjunctive therapy (Section 4): - If patient requires more than 120mg Diazepam in 24 hours
- If patient still requiring full dose treatment 96 hours after last alcohol ingestion

4. SEVERE WITHDRAWAL (aggressive/ uncontrollable/ dangerous behaviour)[1]

- Intravenous Diazemuls up to 40mg over first 30 minutes (up to 2mg/minute; flumazenil to be available) **(Section 5)**
- Adjunctive therapy with Haloperidol 2-5mg IM in first instance and response assessed
- Consultation regarding intensive care support may be necessary in extreme situations

5. PATIENTS UNABLE TO TOLERATE ORAL MEDICATION / PARENTERAL BENZODIAZEPINES

- Patients unable to tolerate oral medication may receive parenteral therapy as an alternative at 50% of the oral dose in the first instance, and response assessed
- Intravenous benzodiazepines should be administered by an experienced member of medical (FY2 or above) or nursing staff who have completed the appropriate Competency Training to administer IV sedation

6. MONITORING

- All patients should be closely observed for signs of over-sedation with regular observations
- Exceptional Patient Groups **(Section 3)**, patients with Severe Withdrawal **(Section 4)** and patients requiring parenteral sedation **(Section 5)** require close monitoring (NEWS) ideally with one-to-one nursing care

[1] *NHSGGC Guideline for use of Intramuscular Medication for Acutely Disturbed Behaviour in Mental Health and Associated Services*

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name	
Address	
CHI No.	2208793218 22/08/1979 BURGESS Henry
DoB	

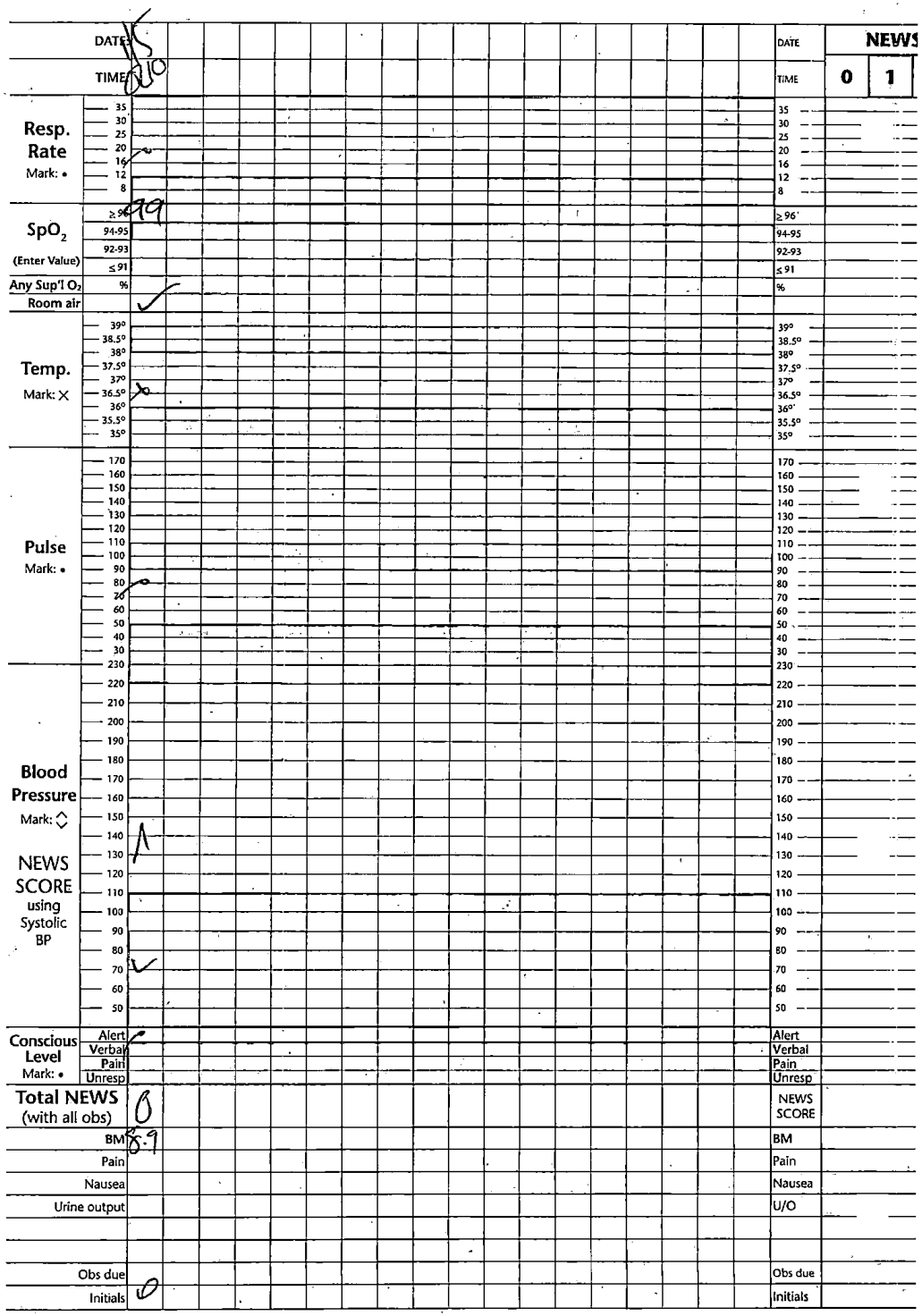
	Date	Ward
Admitted		
Transferred		
Transferred		

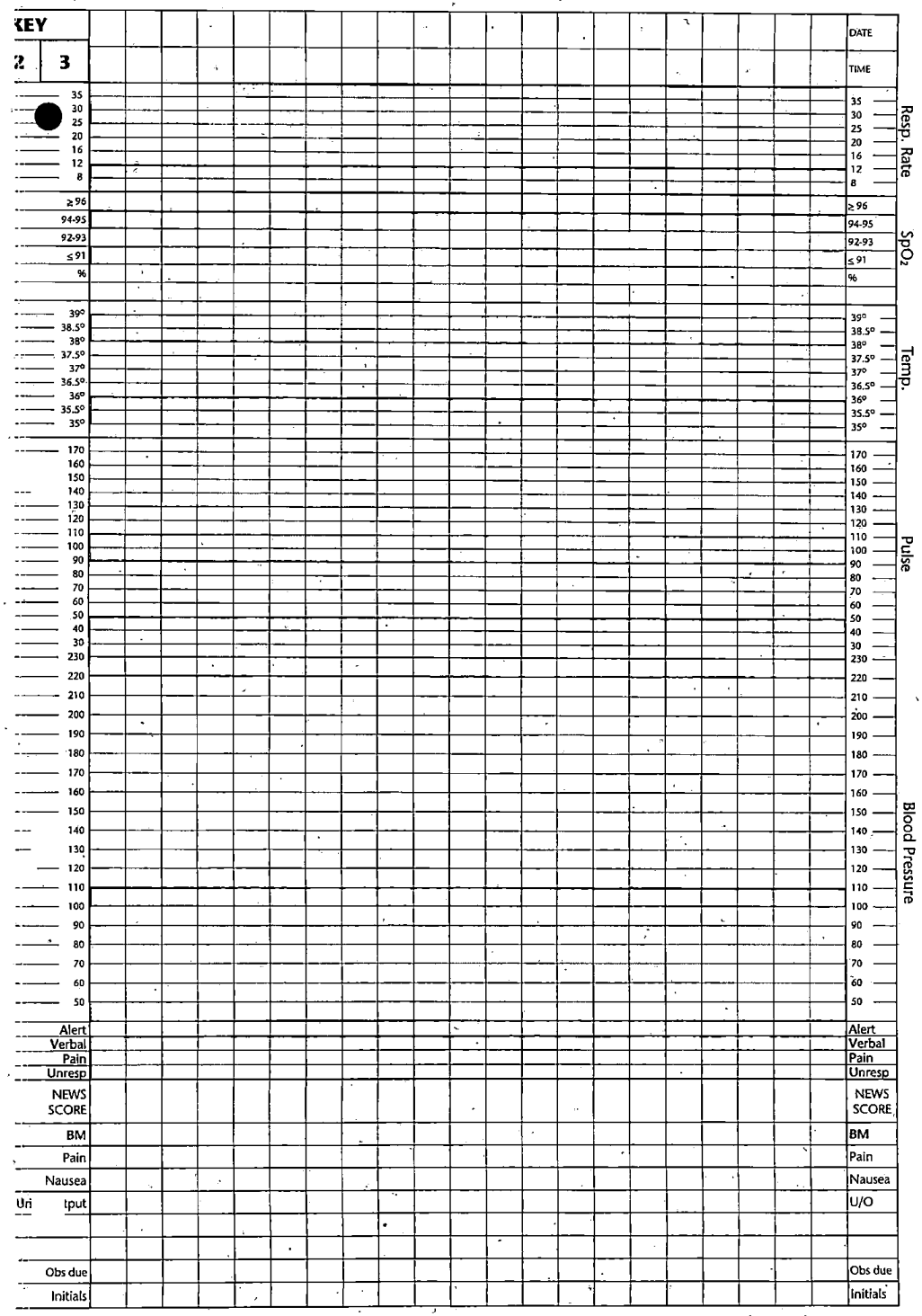
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic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

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

See NEWS Actions Reference Tool for local escalation policy

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


DATE
TIME
Resp. Rate
Mark: •
35
30
25
20
16
12
8
SpO2
(Enter Value)
≥ 96
94-95
92-93
≤ 91
Any Sup'l O2
%
Room air
Temp.
Mark: ×
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
Mark: •
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
Blood Pressure
Mark: ◇
NEWS SCORE using Systolic BP
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
BM
Pain
Nausea
Urine output
Obs due
Initials
DATE
TIME
NEWS
0
1
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials


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

Glasgow Coma Scale

Pupil size (mm)

2208793218
BURGESS
Henry
M
22/08/1979

Neurological Observations

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

Pain Score

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

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

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

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

Emergency Department Nursing Documentation

NHS Greater Glasgow and Clyde

ph Label
2208793218 22/08/1979
BURGESS
Henry

Presenting Complaint: Chest Pains

Date and Time: 1/5/18 @ 02:20

Named Nurse(s): DAVID MCNAMARA

Patient preparation (Please tick when completed)	Initials: DM	Communication (Please tick when completed)	Initials: DM
Prepare patient for examination and provide blankets if required	☑	Communication Aids (spectacles / hearing aid)	☐
Clothing bagged, labelled and stored under trolley	☑	Relatives present, who? ~~FIANCE~~ ~~F.A~~ FIANCE	☐
Name-band (if required) NKDA	☑	Relatives / NOK informed	☑
		Interpreter required	☐
		Telephone interpretation required	WA WA ☐

Observations and Investigations (Please tick when completed)		Initials:
Vital Signs recorded on NEWS chart and NEWS score recorded. Record Pain, blood sugar and neuro obs on NEWS chart if appropriate.	☑	IV cannula (if required) ☐
Peak Flow 1. 2. 3.	☐	Blood samples taken ☐
12 Lead ECG	☑	Urinalysis and Specimen if indicated *Results:* ☐
Cardiac Monitoring	☐	
X-rays performed	☐	HCG specimen if indicated +ve ☐ -ve ☐ Strip Lot no: ☐
Other: please add	☐	Weight: ☐

Screening Tools (Please circle or tick as appropriate)		Initials: DM
SEPSIS risk? SIRS Criteria 2 or more and suspicion of infection Sepsis 6 protocol initialise and departmental documentation started	Y / (N) Y / (N)	**Preliminary Pressure Ulcer Risk Assessment** The patient can reposition themselves whilst in the department? (Y) / N
AMT 4 (if >65 years) SCORE	NO /4	There is **no** reported skin damaged other than presenting trauma? (Y) / N
At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc). *If at risk complete risk assessment*	Y / (N)	The person is fully continent? (Y) / N *If NO to any of the above initiate Waterlow risk assessment (within 4 hrs)*
Mental Health Triage Assessment	Y / (N)	**Waterlow Score** *If >10 commence Active Care* ☐
Child Protection considered (in line with policy)	Y / (N)	**Active Care** (clinical judgement) (include all trolley patients at risk of pressure ulcers and all trolley patients in department for >4hrs) *Record on Active Care Chart* ☐
FAST	Y / (N)	
GMAWS	Y / N	Pressure damage identified on arrival in ED is documented in clinical notes WA ☐
Has Swallow test been carried out?,	Y / (N)	Grade 3 or 4 Pressure Ulcers are reported on DATIX WA ☐

Pause for Transfer (Please tick when completed)		Tick when completed	N/A	Notes
	Relatives informed	☐	☐	Information on discussion with relatives
	Cannula	☐	☐	
	Name band	☐	☐	
	AMT4	☐	☐	
	NEWS chart NEWS >7 - Name and Page number of senior doctor caring for patient	☐	Always	
Prescriptions signed	Infusions	☐	☐	
	Drugs	☐	☐	
	Allergies are recorded (e.g. on Kardex)	☐	☐	
	Fluids	☐	☐	
	Two hour plan in place e.g. Fluids, Antibiotics and emergency drugs written up on Kardex	☐	☐	
	GMAWS	☐	☐	
	Belongings (including patient's medications)	☐	Always	Please note here if any other tasks required prior to transfer
	Bed requested, accepted and ward informed	☐	Always	
	Notes: medical notes, GP letter, PRF	☐	Always	
Investigations	CXR reviewed	☐		
	ECG reviewed	☐	☐	Print name
	Bloods sent	☐	☐	
	Bloods reviewed	☐	☐	
	Patient on O_2: cylinder checked	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	

Pati 2208793218
BURGESS
Henry M
76 STOCK STREET 22/08/1979
Paisley, Renfrewshire
PA2 6N

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
Belongings (including patient's medications)	☐	Always	
New medications explained	☐	☐	
Cannula removed	☐	☐	
Relatives aware of discharge	☐	☐	Please note here if any other tasks required prior to discharge
Social/ Support Services required and contacted	☐	☐	
SAS transport required and ref no	☐	☐	Print name
Other means of transport arranged by nurse	☐	☐	

Nursing Notes and Care Plan

Date and Time		Print Name and Signature

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Nursing Notes and Care Plan

Date and Time		Print Name and Signature

Emergency Department - Active Care

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Henry M
76 STOCK STREET 22/08/1979
Paisley, Renfrewshire
PA2 6N

bel

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every:

(Please circle) ½ hour 1hour 2 hours

Signed ..... Name .....

USE FOLLOWING CODE:

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

			Time							
	1.	PAIN: Assess and address If in pain inform registered nurse Y/ N or N/A	Y							
S	2.	SKIN INSPECTION Pressure areas checked: Y / N / I (independent)	I							
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)	I							
K	3.	KEEP MOVING: Have you moved or walked Y / N / I (independent)	I							
		Bed Right side (30° tilt) – R Left Side (30° tilt) – L Back– B	I							
		Chair Assist to walk, stand or tilt (W /ST/ T)	I							
I	4.	ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine/faeces	I							
N	5.	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)	N							
		Encourage the patient to drink? (If appropriate) Y / N / N/A	Y							
		Food, snack or supplement taken? (if appropriate) Y / N / N/A	N							
	6.	ENVIRONMENT: Is the patient able to call for assistance? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? Y / N	Y							
	7.	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return. Y / N	W							
	8.	ESCALATION: Escalate any issues to the Registered Nurse? Y / N/A	NA							
		Nurse Initials	TC							

USE FOLLOWING CODE	Specialist Pressure Redistributing equipment	Variations			
V = Variant I = Independent NT = No thanks	☐ Repose Mattress ☐ Moving and handling aids ☐ Other:	Time	No.	Variation	Signed

Waterlow Pressure Area Risk Assessment

Build/Weight		Skin Type/Visual Risk Areas		Sex/Age		Special Risks - Tissue Malnutrition	
Average (BMI 20-24.9)	0	Healthy	0	Male	1	Multiple organ failure/ Terminal cachexia	8
Above Average (BMI 25-29.9)	1	Tissue Paper (thin/fragile)	1	Female	2		
Obese (BMI > 30)	2	Dry (appears flaky)	1	14-49	1	Single organ failure	5
Below Average (BMI < 20)	3	Oedematous (puffy)	1	50-64	2	Peripheral Vascular Disease	5
Continence		Clammy /pyrexia	1	65-74	3	Anaemia = Hb < 8	2
Complete/Catheterised	0	Discoloured (brusing/mottled)	2	75-80	4	Smoking	1
Incontinent urine	1			81+	5	**Neurological Deficit**	
Incontinent faeces	2	Broken (established ulcer)	3	**Nutritional Element**		Diabetes/MS/CVA Motor or sensory paraplegia (Max 6)	4-6
Doubly Incontinent (urine and faeces)	3	**Mobility**		Unplanned weight loss in past 3-6 months < 5% Score 0 5-10% Score 1 > 10% Score 2			
		Fully mobile	0			**Special Risks - Medication**	
Special Risks – Surgery/Trauma		Restless/Fidgety	1			Cytotoxic, anti-inflammatory, long term/high dose steroids (Max 4)	4
On table > 6 hours	8	Apathetic (sedated/depressed/ reluctant to move)	2				
Orthopaedic / below waist/Spinal (up to 48 hrs post-op)	5			BMI > 20 Score 0 BMI 18.5-20 Score 1 BMI < 18.5 Score 2			
On table > 2 hours (up to 48 hrs post op)	5	Bed bound (unconscious/unable to change position/traction)	4			Risk Score 10+ = 'At risk' 15+ = 'High Risk' 20+ = 'Very High Risk'	
		Chair Bound	5	Patient acutely ill or no nutritional intake > 5 days	2		

Patient's Initial Waterlow Score = If Score ≥10 Complete the Adapted Waterlow Pressure Area Risk Assessment Chart

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

CHI: 2208793218

Royal Alexandra Hospital

Total Att: 18

12 Mth Att: 1

Title: MR

BURGESS **Henry**

DOB **22/08/1979** Age: **41y** Sex: **Male**

0/1 128 Neilston Road

Paisley
Renfrewshire
PA2 6EP

Next of kin:
Relationship:

GP: **JR Calvo Rodriguez**
0141 889 4088

Attendance Date: **13/06/2021** Arrival Time: **15:57**

Registration Time: **15:57** Date of Incident: **13/06/2021**

Major Incident Desc:

Reason for Attendance: **collapsed/PR bleed**

Affix Label

Nursing Assessment

Alerts: **Yes** Allergies: **None Known** Pain Score:

Triage Category: **5** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **13/06/2021 16:51** Nurse name: **Nurse Molly Oneil**

Temp		C
HR		bpm
BP	/	mmHg
MAP		mmHg
RR		bpm
SpO2		%
Oxygen		%

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **"pt states has been having seizures and collapsing, and has been having pr bleeding for 3-4/52. bruise to right leg from fall this weekend. left triage before observations could be taken. cat 5 as states is going to leave "**

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

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

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES	
	Seen by (Dr)	Time seen

2208793218
22/08/1979
BURGESS
Henry

Date	CLINICAL NOTES

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

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

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

Discharge Prescription Packs

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

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

CHI: 2208793218

Royal Alexandra Hospital

Total Att: **20**

12 Mth Att: **2**

Title: **MR**

BURGESS **Henry**

DOB **22/08/1979** Age: **42y** Sex: **Male**

FLAT 0/1
128 NEILSTON ROAD
Paisley
Renfrewshire
PA2 6EP

Next of kin: **GARRETT, Fiona**
Relationship: **Partner**

GP: **LE Cormack**
0141 889 5277

Attendance Date: **26/04/2022** Arrival Time: **05:28**

Registration Time: **05:28** Date of Incide: **26/04/2022**

Major Incident Desc:

Reason for Attendance: **BIBA - Seizures**

Nursing Assessment

Alerts: **Not Recorded** gies: **Not Recorded** Pain Score:

Triage Category: **1** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **26/04/2022 05:54** Nurse name: **Nurse Claire Hainey**

Temp		C
HR		bpm
BP	/	mmHg
MAP		mmHg
RR		bpm
SpO2		%
Oxygen		%

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **Seizure**

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

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

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

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By
26/4	VALIUM	2mg	PO	07⁰⁰		
26/4	NORMAX 30	12.5	SC	07³⁰		
26/4	ZOCAN	4mg	SC	07³⁰		

Date	CLINICAL NOTES
	Seen by (Dr) Time seen

26/4

Marden AE

42 01

Seizure - 2 witnessed seizures tonight - both self terminating

Post seizure en route to hospital - again self terminating

Does not take and has taken a significant quantity of alcohol in the past 3 days.

No alcohol for >12/24.

Phys: Pronor IVDU

Hepatitis B +ve

Type II DM.

A: (A) Patent

(B) AE (L) + (R) SpO_2 98% RA

RR = 24

(C) P122. Central CRT (2)

BP - 104/60.

Palpable radial pulse.

2208793218
BURGESS
Henry
M
22/08/1979

Date	CLINICAL NOTES
	(D) Many 4 limbs No HI PERL A (V) PU ANT - Time Place Person Date (2/4) ✓ x ✓ x (E) Supp 18L No rash GCS M 5 V 4 E 6 Attempted IV access - fast he - RIGHT groin. Cannulated vessel - Mr Burgess became distressed when I was attempting to advance the guidewire. Procedure handed at patients request. ⇒ Fentanyl - pained already withdrawn → Ord dispo Observe

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

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

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

Discharge Prescription Packs

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

2208793218 22/08/1979
BURGESS
Henry

Printed: 26/04/2022 06:00:48

Patient Sample Report

Status: **ACCEPTED**
Analyzed: 26/04/2022 06:00:36
Sample Type: **Venous**
Operator ID: ANN MARIE MCFADDEN0

Patient

ID:	2208793218
Last Name:	BURGESS
First Name:	HENRY
Gender/Age:	Male, 42 years
Birth Date:	22/08/1979

Cartridge

Lot No.:	220103F
S/N:	00000000500270747
Exp. Date:	01/05/2022

Analyzer

Model:	GEM® *Premier 5000*
Area:	RAH RESUS
Name:	RESUS
S/N:	17030590

Results

			Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)						
cH	59.7	nmol/L	--	--	--	--
pCO_2	7.2	kPa	--	--	--	--
pO_2	5.2	kPa	--	--	--	--
Na^+	↓ 131	mmol/L	--	133	146	--
K^+	3.6	mmol/L	--	3.5	5.3	--
Cl^-	↓ 93	mmol/L	--	95	108	--
Ca^{++}	↓ 1.09	mmol/L	--	1.15	1.27	--
Glu	↑ 18.6	mmol/L	--	3.5	6.0	--
Lac	↑ 10.1	mmol/L	--	0.6	2.2	--
CO-Oximetry						
tHb	155	g/L	--	--	--	--
O_2Hb	↓ 61.9	%	--	95.0	98.0	--
COHb	↑ 3.0	%	--	0.5	1.5	--
MetHb	1.0	%	--	0.5	1.5	--
HHb	↑ 34.1	%	--	0.0	5.0	--
sO_2	↓ 64.5	%	--	95.0	98.0	--
Derived						
BE(B)	-6.1	mmol/L	--	--	--	--
$HCO_3^-(c)$	22.1	mmol/L	--	--	--	--
Hct(c)	47	%	--	--	--	--

↑↓ Outside Reference Range

Other Information

Operator Entered

Temp	37.0	°C

Patient name

Patient CHI

2208793218
BURGESS M
Henry 22/08/1979

NHS
Greater Glasgow and Clyde

Emergency Care Nursing Documentation

Presenting complaint - and relevant past medical history including allergies

Date and Time		Name/Signature
25/4/22 0600	Seizures	[illegible]

Nursing notes - on admission

Date and Time		Name/Signature
25/4/22 0600	A - Patent B - rr 10 Sats 96% air C - P 78 Bp 140/90 D - AVPU GCS 15/15 BM 18.9 E - Temp 36.4 Brought from triage whilst awaiting assessment. Seizure self terminated.	[illegible]

Triage

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

Communication

GGC Red Bag with Patient (nursing home resident)	Y	(N)
Language or hearing difficulty	Y	(N)
Interpreter required	Y	(N)
what arrangements have been made?		
Relatives / Carer / Next of Kin present	Y	(N)
Partner aware.		
name,relationship,location,particular concerns		

Risk Assessments and Screening Tools

SEPSIS	Y	(N)	GMAWS	Y	(N)
FAST	Y	(N)	Adult Support and Protection	Y	(N)
Swallow Testing	Y	(N)	Mental Health Triage Assessment	Y	(N)
Falls Risk (clinical judgeument)	Y	(N)	Child Protection Concerns	Y	(N)

Signature: [illegible]

Patient nam

Patient CHI

2208793218
BURGESS M
Henry 22/08/1979
FLAT 0/1
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6EP

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Greater Glasgow and Clyde

Care Rounds Checklist

I have evaluated and deemed that the frequency of care delivery over the next work shift,
based on the patient's most critical need, should be every (please circle) **1hr** **2hr** **3hr** **4hr**

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Use the following Codes:
Y = Yes **N** = No **NA** = Not Applicable **NT** = No Thanks **S** = Sleeping **O** = Off the ward **I** - Independent

			Times										
	1	**THINK DELIRIUM** Is the patient more confused/drowsy than normal?If yes inform registered nurse.											
	2	**PAIN: ASSESS AND ADDRESS.** Is the patient distressed or in pain?If yes inform registered nurse.											
S	3	**SKIN INSPECTION** Pressure areas checked?											
		R = RED **D** = Discloured **PU** - Pressure Ulcer **INT** = Intact **M**= Moisture											
K	4	**KEEP MOVING** Has the patient moved or walked?											
		Bed **R** =Right side (30°) tilt **L** =Left side (30°) tilt **B** =Back Chair **W/ST** = Assist to walk / stand											
		ELIMINATION. Does the patient need the toilet?											
I	5	**I** = Independent **A** - Assistance given **IC** = Incontinent (urine/faeces)											
N	6	**FOOD FLUIDS AND NUTRITIO.** Is the patient nil by mouth?											
		Drink taken?											
		Food, snack, or supplements taken?											
		Has oral hygiene been carried out as per care plan?											
	7	**ENVIRONMENT CHECK** Is the patient's call buzzer to hand? Is the area clutter free clean and safe? Does the patient have everything they require in safe reach? Is the bed in the lowest position?											
	8	**INFORMATION** Is there anything else I can help you with? Inform the patient of the time of return											
	9	**ESCALATION** Is there anything else I can help you with? Inform the patient of the time of return											
		Care provider											
		Role											

Ask the patient if there is anything they specifically want done today:

Patient name .....

Patient CHI .....

or use sticker

Hospital:	Points to consider:
Ward:	• Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

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PUDRA

1	**Pressure Damage**	Does the person have redness and/or existing pressure damage? **IF YES, prescribe a minimum of 2 HOURLY Pressure relieving care** to avoid further damage occurring and complete the pressure ulcer interventional plan.

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2	**Mobility**	Does the person require assistance to mobilise or change position (inappropriate for age)?
3	**Continence**	Does the person have continence issues with urine and/or faeces (inappropriate for age)?
4	**Nutrition**	Does the person appear malnourished and/or unable to eat or drink/ PYMS score>2?
5	**Skin**	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6	**Judgement**	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY Pressure Relieving Care interventions and complete the pressure ulcer interventional plan.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
/ /	:							_____hrly	
/ /	:							_____hrly	
/ /	:							_____hrly	

Complete prevention of pressure ulcer interventional plan below for all patients with redness/pressure damage and for those at risk.

S **Skin Inspection**	**S** **Surface**	**K** **Keep Moving**	**I** **Incontinence/ Moisture**	**N** **Nutrition**	**S** **Self Management/ Shared Care**
Check: • Pressure areas _____hourly • Skin under medical devices _____ hourly • Specify medical devices used	Specify: 1. Mattress 2. Cushion 3. Detail additional pressure redistributing equipment	1. Reposition ____ hourly in bed / chair 2. Overnight patient/carer has agreed to repositioning _____ hourly 3. Specify any manual handling equipment used	1. Skin Care to be carried out _____ hourly 2. Specify products required for increased moisture/ continence management:	1. Optimise nutrition and hydration 2. Refer to MUST	1. Discuss and agree plan with patient/ family/carer **YES / NO** 2. Prevent Pressure Ulcers" leaflet given to patient/family/ carer **YES / NO**

Patient name

Patient CHI

2208793218
BURGESS M
Henry ... 22/08/1979
FLAT 0/1
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6EP

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Greater Glasgow and Clyde

Nursing notes - discharge plannning

Date and Time		Name/Signature

Outcomes and outstanding issues

Date and Time		Name/Signature

Pause for Discharge or Transfer

GGC Red Bag with Patient (nursing home resident)	Y	N
Relatives / Carer with Patient	Y	N
Name Band	Y	N
Nursing Screening Tools Complete	Y	N
Bed Available	Y	N
SBAR complete	Y	N
NEWS Chart NEWS completed within 1 hour of transfer/discharge	Y	N
Prescriptions and fluid charts signed	Y	N
Cannula	Y	N
Notes Complete	Y	N
Analgesia	Y	N
Belongings	Y	N
Transport	Y	N

Signature:

Contact with relatives

Signature:

Patient name .....

Patient CHI .....

or use sticker

NHS
Greater Glasgow and Clyde

4AT assessment - for delirium and cognitive impairment

		Circle Score
(1) ALERTNESS This includes patients who may be markedly drowsy (eg. dificult to rouse and/or obviously sleepy during assessment) or agitated/ hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.	Normal (alert, but not agitated, through assessment) Mild sleepiness (<10 secs) after waking, then normal Clearly abnormal	0 0 4
(2) AMT4 Age, date of birth, place (name of the hospital/building), current year.	No mistakes 1 mistake 2 or more mistakes/untestable	0 1 2
(3) ATTENTION Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.	wAchieves 7 months or more correctly Starts but scores <7 months / refuses to start Untestable (cannot start, unwell, drowsy, inattentive	0 1 2
(4) ACUTE CHANGE OR FLUCTUATING COURSE Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs.	No Yes	0 4

4 or more possible delirium + /- cognitive impairment
1-3 possible cognitive impairment
0 delirium or severe cognitive impairment unlikey (but delirium still possibe if (4) information incomplete

TOTAL

Frailty Assessment Tool (Healthcare Improvement Scotland)

Step 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?			circle Y or N	
F	**Functional Impairment**	(new or worsening) eg difficulty with self care	**Y**	**N**
R	**Resident**	in a care home	**Y**	**N**
A	**Altered mental state**	such as delirium or dementia **(4AT Assessment)**	**Y**	**N**
I	**Immobility/Instability**	decline in mobility, difficulty mobilising without help, fall leading to presentation	**Y**	**N**
L	**Living at home with support**	on a daily basis (homecare, one visit or more per day)	**Y**	**N**

If YES to any of the criteria in Step 1 move to Step 2

Step 2 Would this person be better managed by another speciality team at present?	circle Y or N	
Clear need for other specialty input eg exacerbation of known long-term condition such as COPD	**Y**	**N**
Need for HDU/ITU (including non-invasive ventilation)	**Y**	**N**
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit	**Y**	**N**
Head injury with loss of consciousness	**Y**	**N**
Acute abdominal pain/ surgical presentation	**Y**	**N**
Upper GI Bleed	**Y**	**N**
Chest pain with suspected acute coronary syndrome	**Y**	**N**
Trauma with suspected fracture	**Y**	**N**

Are any of the criteria met?
If YES to any criteria in Step 2: Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.
If YES to any criteria in Step 1 and NO to ALL criteria in STEP 2: Prioritise transfer of care to specialist geriatric assessment service.

Patient name ..

Patient CHI ..

2208793218
BURGESS M
Henry 22/08/1979
FLAT 0/1
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6EP

NHS
Greater Glasgow and Clyde

Nursing notes - ongoing care

Date and Time		Name/Signature
0800	12 UNITS NOVOMIX 30 S/C GIVEN	
	4mg P.O ODANSETRON ONDISPERSIBLE	
0830	PT NOT WANTING TO STAY ED. Dr AWARE AND BENEFITS AND RISKS EXPLAINED TO PT BUT STILL WANTING TO LEAVE DECLINED BM CHECK BUT PACKET OF BISCUITS AND TUB OF YOGHURT GIVEN TO PT TO EAT TO MAINTAIN BLOOD GLUCOSE AS NO SANDWICHES AND PT WALKING OUT OF DEPT	

Patient Information

HENRY BURGESS

Age/Gender:	42 years 8 months 4 days Old Male
Address:	0/1 126 NEILSTON ROAD PAISLEY,PA2 6EP
DOB:	22/08/1979
CHI:	2208793218
Ethnicity:	

Date:	26/04/2022
Incident Number:	CR008599604
Incident Type:	EMG
Incident Location:	96A ALICE STREET PAISLEY, PA2 6EA

Scottish Ambulance Service

Presenting Complaint

?SEIZURES

Additional Comments

999 call to 42 yom partner reports PT to have had 3x seizures since yesterday last one at 03:30hrs. Unsure of duration... These have all self terminated. PT states to have been drinking alcohol past few days and not eating. Denies any drug use. PT c/o pain to right knee and has bitten tongue from having seizures. PT is type 1 diabetic.... BM is 18.9, does not check BM as has lost machine. States to have been taking insulin.

PATIENT ASSESSMENT

ACVPU Alert <C> No

A Clear

B Breathing Adequately: Yes | Respiratory Rate 18 | SPO2 98

Oxygen Given: No

C

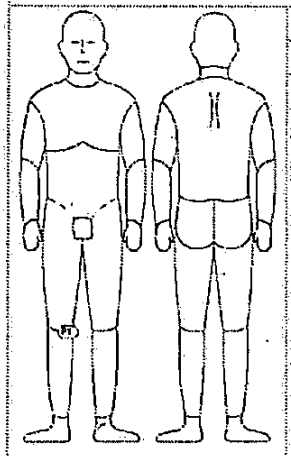
Pulse Rate	BP	Cap Refill	ECG Rhythm
60	152/82	<=2 Secs	Sinus Rhythm

Rhythm	Arm	Central/Peripheral	ECG
Reg	Right	Peripheral	3 Lead

D

GCS	Eyes	Voice	Motor	PEARL
15	Spontaneously (4)	Orientated (5)	Obeys Commands (6)	Yes

E



Pain

ID	Body Part	Pain Scale
P1	Right Lower Leg	4

2208793218
BURGESS M
Henry 22/08/1979

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
05:23	62	18	142/83	98	<=2s	15	Alert								E9886709
04:52	60	18	152/82	98	<=2 Secs	15	Alert		36.3	18.9	Sinus Rhythm				E9886709

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
04:52	18 (0)	98 (0)		0	152 (0)	60 (0)	Alert (0)	36.3 (0)	0

HISTORY

AMPLE

Allergies	None
Medication	SEE ECS
Past Medical History	Diabetes (Type 1), SPLENECTOMY
Last Eaten	>4 Hours Ago
Events Prior	SEIZURES

Social History

Lives alone	No	Living With	PARTNER	Patient Occupation	Does Not Work

Patients General Appearance	Normal
Patient Mobility	Fully Mobile
Patient Communication	No Help Required
Patient Clinical Risk Factors	Alcohol, Smoker, Recreational Substances
Patient Enviromental Risk Factors	None Identified

CLOSE RECORD

Treatment On Scene: Non Emergency

Conveyance

Transport To Hospital	Normal driving	Pre Alert	No		

INCIDENT LOG

Time Call Received	03:52	Allocated	04:41	Mobile	04:41
First Resource On Scene		Crew On Scene	04:47	Crew Left Scene	05:19
Crew At Hosp		Receiving Hospital	ROYAL ALEXANDRA PAISLEY	Clear Time	

Crew ID	Crew Grade	Driver
E9883541	Student Technician Level 4	YES
E9886709	Paramedic	NO

2208793218
BURGESS
Henry
M
22/08/1979

NEWS 2 Key | 1 | 2 | 3

| | | |

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

2208793218
BURGESS
Henry
FLAT 0/1
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6EP
M
22/08/1979

	Date	Ward	Time
Admitted	26/5/22	c/o	
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP initials ONLY:	Dr/ANP initials ONLY:	
Date:	Date:	

Document all actions and interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
	Low Clinical Risk	Medium Clinical Risk	High Clinical Risk
Min 12 Hourly Observations	Min 4 Hourly Observation	Min Hourly Observations	Continuous Monitoring
	Inform Registered Nurse	Urgent Assessment by Medical Team	Urgent Assessment by Senior Medical Team
	Agree Frequency of Observation Required	ACE Response in Medical Notes Think Sepsis if Suspicion of Infection	ACE Response in Medical Notes Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

Discontinuation of NEWS

Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed .....

Medical: .....

Date: .....

Pupil Reaction and size
s = sluggish
+ = reaction
- = no reaction
C = eyes closed
Pupil Size (mm): 1 2 3 4 5 6 7 8

Affix Patient ID

Glasgow Coma Scale

Date:	26/5/22																								
Time:	1145	1600	2000																						
Eyes closed by swelling = NT	E Y E S	4	1	1																					
		3																							
		2																							
		1																							
		NT																							
Endotracheal tube or tracheostomy = NT	V E R B A L	Spontaneously	5	1	1																				
		To sound	4																						
		To pressure	3																						
		None	2																						
		None	1																						
		NT	NT																						
Always record the best response	M O T O R	Obeys command	6	1	2																				
		Localising pressure	5																						
		Normal flexion	4																						
		Abnormal flexion	3																						
		Extension	2																						
		None	1																						
		Not testable	NT																						
TOTAL				11	15																				
Right size:	P U P I L S	Normal pound	4	2	2																				
Right reaction:		Mild eccentric	3																						
Left size:		Severe eccentric	2																						
Left reaction:		Extension	1																						
		No response	NT																						
Record right (R) and left (L) separately if there is a difference between the two sides	A R M S	Normal power	6	2	2																				
		Mild weakness	5																						
		Severe weakness	4																						
		Spastic flexion	3																						
		Extension	2																						
		No response	1																						
Record right (R) and left (L) separately if there is a difference between the two sides	L E G S.	Normal power	6	2	2																				
		Mild weakness	5																						
		Severe weakness	4																						
		Spastic flexion	3																						
		Extension	2																						
		No response	1																						

Pain Score

Ask the patient to rate his/her pain by using numerical scale 0 to 10. Use the chart below to assist the patient. If the patient is unable to communicate, use alternative pain scoring tools.

No Pain	Mild Pain		Moderate Pain			Severe Pain			
0	1	2	3	4	5	6	7	8	9	10

Pain Function Score

A	No limitations, activity unrestricted by pain or settles quickly
B	Mild limitations, mild activity restrictions
C	Moderate limitations, attempts but reluctant to continue because of pain. **Seek Advice**
D	Severe limitations, unable to or refuse to perform because of pain. **Urgent Review Required**

mi + 316654 • v5.1 • GCC0264

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

CHI: 2208793218

Royal Alexandra Hospital

Total Att: 23

12 Mth Att: 5

Title: MR

BURGESS **Henry**

DOB: **22/08/1979** Age: **42y** Sex: **Male**

96a Alice Street

Paisley
Renfrewshire
PA2 6EA

Next of kin: **GARRETT, Fiona**
Relationship: **Partner**

GP: **LE Cormack**
0141 889 5277

Attendance Date: **10/05/2022** Arrival Time: **16:12**

Registration Time: **16:12** Date of Incident: **10/05/2022**

Major Incident Desc:

Reason for Attendance: **?DVT Worsening swelling R leg**

Affix Label

Nursing Assessment

Alerts: **Not Recorded** Allergies: **Not Recorded** Pain Score:

Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **10/05/2022 18:04** Nurse name: **Nurse Marie Ryan**

Temp		C
HR		bpm
BP	/	mmHg
MAP		mmHg
RR		bpm
SpO2		%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils-Right		Pupils-Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes:

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

X-Ray and Other Reports to be filed on this side (if the patient is not being admitted)

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

Date	CLINICAL NOTES
	Seen by (Dr) Time seen

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)				Discharge date	
1. Admission	~~2. Discharge~~	~~3. Refer to GP~~	4. Transfer to other (see below)		
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge 8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged		Not arranged		To be arranged			
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

	Glucorx Nexus		TO BE USED AS DIRECTED	10-May-2022	
In Practice	Pregabalin	150 mg Capsules	TAKE ONE TWICE DAILY	23-Jul-2021	05-May-2022
In Practice	Amoxicillin	500 mg Capsules	TAKE ONE DAILY	23-Jul-2021	05-May-2022
In Practice	Glucorx Carepoint	4 mm/31 gauge Needles for insulin pens	TO BE USED AS DIRECTED	01-Jul-2021	05-May-2022
In Practice	Lansoprazole	30 mg Capsules (Gastro-Resistant)	ONE TO BE TAKEN EACH DAY	23-Jul-2021	20-Apr-2022
In Practice	Mirtazapine	15 mg Tablets	ONE TO BE TAKEN AT NIGHT	09-Sep-2021	14-Feb-2022
In Practice	Novomix 30 Flexpen	100 units/ml, 3 ml pre-filled pen Suspension For Injection	TO BE USED AS DIRECTED	23-Jul-2021	14-Feb-2022
In Practice	Thiamine	50 mg Tablets	ONE TO BE TAKEN FOUR TIMES DAILY	17-Aug-2021	17-Aug-2021
In Practice	Acamprosate Calcium	333 mg E/c tablets	TAKE TWO TABLETS THREE TIMES DAILY	17-Aug-2021	17-Aug-2021
Outwith practice	Methadone 1 Mg/Ml	Oral solution	AS PER RDS - NOT TO BE PRESCRIBED BY GP	23-Jul-2021	23-Jul-2021

81.35kg

Clinical Data

Last Emergency Care Summary received 10 May 2022

Allergy

Description	Date Recorded	Comments
Adverse reaction to opiates or related narcotics NOS	14-Sep-2017	Found unconscious. Responsed to Naloxone

Acute Medication (including those greater than 30 days) Medicines Reconciliation Report

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date
In Practice	Ibuprofen	400 mg Tablets	ONE TO BE TAKEN THREE TIMES A DAY WHEN REQUIRED WITH OR AFTER FOOD		10-May-2022	10-May-2022
In Practice	Loperamide Hydrochloride	2 mg Capsules	TWO TO BE TAKEN AT ONCE THEN ONE TO BE TAKEN AFTER EACH FURTHER LOOSE MOTION FOR UP TO 5 DAYS (MAX 8 CAPS PER 24 HOURS)		28-Mar-2022	28-Mar-2022
In Practice	Hydrocortisone And Miconazole	1 % + 2 % Cream	APPLY THINLY TO THE AFFECTED AREA ONCE OR TWICE DAILY		14-Feb-2022	18-Mar-2022
In Practice	Sildenafil Citrate	100 mg Tablets	ONE TO BE TAKEN AS DIRECTED. SLS		04-Mar-2022	04-Mar-2022
In Practice	Dermol	Cream	USE IN SHOWER TO WASH		14-Feb-2022	14-Feb-2022
In Practice	Glucorx Nexus	Test strips	TO BE USED AS DIRECTED		14-Feb-2022	14-Feb-2022
In Practice	Tadalafil	10 mg Tablets	AS DIRECTED		17-Jan-2022	17-Jan-2022
In Practice	Ibuprofen	5 % Gel	APPLY TO THE AFFECTED AREA UP TO THREE TIMES A DAY		20-Dec-2021	20-Dec-2021
In Practice	Tadalafil	10 mg Tablets	AS DIRECTED		25-Nov-2021	25-Nov-2021

Repeat Medication Medicines Reconciliation Report

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Cancel Date
In Practice		Test strips				10-May-2022		

Cycle 20

NHS
Greater Glasgow and Clyde

Acute Medical Unit Admission Proforma

MAU/A&E/AMU

Royal Alexandra Hospital, Paisley/Vale of Leven Hospital/IRH

Patient Details		
Name: **Address:**	2208793218 1 BURGESS M 3 Henry 22/08/197[illegible]	**Sex:** F ☐ M ☑ **DoB** / / **Age:** 42.
Telephone:		
GP:		
Next of Kin:		
Telephone:		

Episode Details			
Date patient seen:	11/5/22	**Time seen:**	0415.
Source of referral:	**GP** ☑ **A&E** ☐ **OPD** ☐ **Self** ☐ **Other =**		
Admitting Dr:	Mageky	**Grade** INT 3.	**Bleep**
Consultant:	Dr Kiyani		

Resuscitation Decision

Resuscitation status: (please circle) **FOR RESUSCITATION / DNA CPR**

Signature: _____ **Name:** _____ **Grade:** _____

If DNA CPR → Complete appropriate form

Cycle 20

Presenting Complaint(s)	
Presenting complaint	Ⓡ leg pain.
History of presenting complaint	Stater had "dead leg" since LP on recent admission. Pain + swelling Ⓡ leg. No SOB. Dry cough. No hemm. No abdo pain. No fevers Recently immobile during hospital admission for agitation / confusion following buprenorphine overdose.

Past Medical History / Review of Old Notes. Review eKIS if available
Hepatitis C DVT PE Pneumonia TIDM Alcohol XS

Systemic Enquiry

Cycle 20

MEDICINES RECONCILIATION – Acceptable to staple fully completed Emed Rec

Source of medication history Patient ☐ Relative/carer ☐ GP Phone call ☐ ECS ☐

(>1 source preferred) Patient own drugs ☐ Com. Pharmacist ☐ GP letter/summary ☐ Repeat Script ☐

Other (please specify) .....

Admission Medicines Dose Frequency	Plan for medicines (Dr complete) Continue Amend Withold Stop	Comments Reason for alteration

Staple emed-rec to this page

Allergies	List any over-the-counter or alternative medicines
None known ☐	
	Do medicines need further clarification ? Yes ☐ No ☐
List collected by :	**Plan approved by :**
Designation : Date :	Designation : Date :

Pharmacy review	Comments
Compliance aid : Yes ☐ No ☐	Community pharmacist Phone
Reviewed by :	Designation : Date :

Cycle 20

Social History

Smoking History 20/day

Ex-smoker/Smoker ____cpd ___yrs Never smoked

Alcohol History

0 Units/week FAST score if excess _____

Recreational Drugs Driving Status

Street valium.

Social Circumstances (home, supports, functional status, occupation, travel)

Lives alone. Independent

Family History

Observations

RR: 18 bpm **Sats:** 96 % **FiO2:** (A) **Temp:** 36.9°C **BP:** 150/100 **HR:** 78 bpm **BM:**

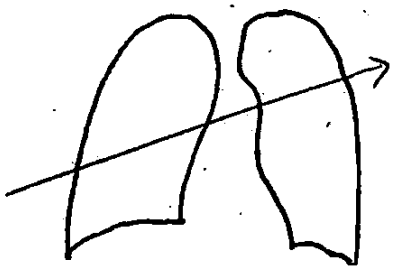
General Examination

General Appearance:

Cyanosis / pallor / jaundice / clubbing / lymphadenopathy

Respiratory

PEFR =



Cycle 20

Cardiovascular

Pulse **Heart Sounds** 1+1+0

JVP

Oedema

Peripheral Pulses **cap refill**

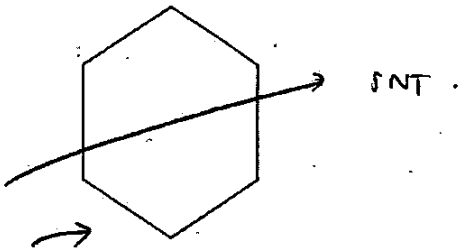
Gastrointestinal system

Masses:

Organomegaly:

Bowel sounds:

PR: small dry fistula @ groin.



Neurological system

GCS:15/15 **E:** 4/4 **M:** 6/6 **V:** 5/5 **AMT:** /4 (AMT 4 = age, time, place, year)

Pupils/fundoscopy:

Cerebellar and extrapyramidal:

Cranial Nerves:

Neck:

	RUL	LUL	RLL	LLL
Tone				
Power				
Co-ordination				
Reflexes				
Sensation				

Gait: Swollen, warm erythematous (R) calf with oedema extending past knee, tender

Locomotor

	Tender	Swollen	Deformity	Which joint?
Arms				
Legs				
Spine				

Cycle 20

Investigations

Bloods → CRP 101, WCC 14·3, d-dimer 1896, Plt 605.

(Differential) diagnosis

- DVT
- +/- cellulitis.

Management Plan

- Tx dose dalteparin.
- PO fluclox a/b.
- Urine dip +/- Culture
- US doppler.

Thromboprophylaxis assessed ☐ **Medicine Reconciliation** ☐ **DD6 if required** ☐

Signature **PRINT NAME** LUAGERY Page:

PRINT GRADE FMT 3

Senior/Medical review

Name: BURGESS

Date: 11/05/2- MSU sent? Y/N

	Neg	Trace	+	++	+++	++++
Leu						
Nit						
Prot						
Blood						
Ket						
Gluc						

*NB: Treatment of suspected UTI should not just be based on urinalysis as commonly abnormal, especially in elderly.

mi • 312922

Admission checklist

Investigations reviewed ☐ **Kardex** ☐ **eKIS reviewed** ☐

Thromboprophylaxis assessed ☐ **Medicine Reconciliation** ☐ **DD6 if required** ☐

NHS GG&C Adult Risk Assessment for Venous Thromboembolism (VTE)

[excluding orthopaedics, obstetrics and gynaecology & ENT who have specialty-specific policies]

- **Risk Assessment must be completed for all patients within 24 hours of admission to hospital**
- **Patients must be reassessed every 48-72 hours or sooner if condition changes**
- **Reassessment must be documented in Kardex**
- **Please complete risk assessment and then sign and date Risk Assessment Result box at bottom of page.**

Pt Addressograph

Surgical patients start here

Non-operative [mainly medical] patients start here

Is the patient bed-bound or expected to have reduced mobility relative to normal state for ≥ 2 days?

Yes ☐ No ☐

Does the patient have any risk factors for thrombosis? (tick √ all that apply)

Age >60	☐	Use of oestrogen-containing contraceptive therapy	☐
Active cancer or cancer treatment	☐	Use of hormone replacement therapy	☐
Dehydration	☐	Pregnancy or < 6 weeks post partum [seek specialist advice]	☐
Known thrombophilias	☐	Critical care admission eg HDU/ITU	☐
Obesity (BMI>30)	☐	Total anaesthetic + surgical time >90 minutes	☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or Inflammatory disease	☐	Surgery involving pelvis or lower limb with a total anaesthetic + surgical time >60 minutes	☐
Personal history or first degree relative with a history of VTE	☐	Acute surgical admission with inflammatory or intra-abdominal condition	☐
Varicose veins with phlebitis	☐	Hip fracture	☐

- No thromboprophylaxis required.
- Continue to reassess every 48-72 hours or sooner if condition changes.
- Document all reassessments in drug kardex.
- Risk assessment now complete
- Complete Risk Assessment Result Box

Yes, 1 or more risk factors identified ☐

No risk factors identified ☐

Does the patient have any contraindications to pharmacological prophylaxis? (tick √ all that apply)

Active bleeding	☐	Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands)	☐
Acquired bleeding disorders (e.g. acute liver failure)	☐	Neurosurgery, spinal or posterior eye surgery	☐
Concurrent use of anticoagulants (such as warfarin with INR>2)	☐	Lumbar puncture, epidural/spinal anaesthesia expected within the next 12 hours	☐
Acute stroke	☐	Other procedure with high bleeding risk – discuss with senior if unsure	☐
Uncontrolled hypertension (230/120 mmHg or higher)	☐	Lumbar puncture, epidural/spinal analgesia within the previous 4 hours	☐
Thrombocytopenia (<75 x 10⁹/l)	☐	Thyroid surgery	☐

- Discuss with senior clinical staff before prescribing pharmacological prophylaxis
- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48-72 hours or sooner if condition changes

No contraindications to pharmacological prophylaxis identified ☐

Contraindications to pharmacological prophylaxis identified ☐

Surgical patients – Enoxaparin 40mg + AES ☐*
*prior to application of AES, please check contraindications to AES
Medical patients – Enoxaparin 40mg ☐
Prescribe Enoxaparin at 6pm
[on day of surgery, at the later of either 4h post-op or 6pm]
Reduce Enoxaparin to 20mg if <50kg or eGFR <30ml/minute/1.73m² ☐
Discontinue at discharge or when returned to pre-morbid mobility

Contraindications to anti-embolism stockings (AES) Y ☐ N ☐

Peripheral neuropathy	☐
Peripheral vascular disease	☐
Cellulitis or Gross oedema	☐
Leg deformity or Fragile skin	☐
Leg / foot ulcers	☐
Allergy	☐
Unusual leg size/shape	☐

Risk assessment result – please tick √ all that apply

VTE risk factors: YES ☐ NO ☐ Contraindications to pharmacological prophylaxis: YES ☐ NO ☐ Prescribed: LMWH ☐ AES ☐ NONE ☐

Patient informed of VTE risks and benefits of thromboprophylaxis YES ☐ NO ☐ N/A ☐ Information leaflet provided YES ☐ NO ☐

Print Assessor's Name: _____ Signature: _____ Date: _____

DD6 All patients over 64

4AT	Y/N/Na
Carers involved	Y/N/Na
Med rec	Y/N/Na
Sepsis Screen	Y/N/Na
Resuscitation status considered	Y/N
Discharge planning	Y/N/Na

Sepsis Six

Antibiotics within 1 hour	☐
Appropriate Cultures	☐
Fluids	☐
Oxygen	☐
Lactate	☐
Fluid balance, consider catheter	☐

Cycle 20

Results

Baseline	Date		11/2
	Time		
	Parameter	Ref Range	
	Hb	130-180	138
	WCC	4.0-11.0	14.3
	Plts	150-400	605
	MCV	78 - 99	86.7
	Neut	2.0 - 7.5	7.2
	PT	9.0 - 13.0	11
	APTT	27.0 - 38.0	
	Fibrinogen	1.5-4gm/L	4.33
	INR	( )	
	Thromb T	11-15 secs	18
	D-Dimer	<230	1816
	~~ABG/VBG~~		
	Na^+	135 - 145	132
	K^+	3.5 - 5.0	/
	Cl^-	97 - 107	94
	HCO_3^-	23 - 30	
	Urea	2.5 - 7.5	2.8
	Creat	62 - 124	53
	eGFR		>60
	Glucose	3.5 - 5.9	
	Protein	32 - 82	
	Albumin	37 - 50	31
	AlkP	33 - 117	119
	Bil	0.5 - 19	4
	ALT	11 - 55	6
	AST	13 - 42	12
	GGT	8-60	
	ESR		
	CRP	<3	101
	Troponin I hs	Men 0 - 34 Women 0 - 16	
	CK	23 - 190	
	Corr Ca^{++}	2.25 - 2.60	
	PO_4^-	0.8 - 1.4	
	Mg^{++}	0.7 - 1.1	
	Digoxin	0.5 – 2.0	
	Alcohol		
	Paracetamol	<100 @4 hr	
	Salicylate		
	Amylase	<100	
	LDH	240 - 480	
	Folate	3.1 - 20	
	B12	200 - 900	
	Ferritin	15 - 200	
	TSH	0.35 – 5.00	
	T4	9 - 21	
	Urinalysis		

Name: Henry Burgess

Date: 11/5/22 MSU sent? Y / N

	Neg	Trace	+	++	+++	++++
Leu					✓	■
Nit		■		■	✓	■
Prot						
Blood						
Ket						
Gluc						

*NB: Treatment of suspected UTI should not just be based on urinalysis as commonly abnormal, especially in elderly.

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DON'T MISS AKI Checklist within 24 hrs of admission

D Dipstick Urine: _____

O Obtain Ultrasound: Yes ☐ N/A ☐

(Stage 2/3: within 24 hours of Admission)

N Need for Catheter: Long-term ☐ Yes ☐ No ☐ Refused ☐

T Team Renal to contact: Considered ☐ Done ☐ N/A ☐

M Medicine Reconciliation: ☐

I Intravenous Fluids: Yes ☐ Contraindicated ☐

S Suspected Cause: _____

S Staging of AKI: (Tick Box Below)

☐ 1 (RISK if: Creatinine X 1.5)
☐ 2 (INJURY if: Creatinine X 2)
☐ 3 (FAILURE if: Creatinine X 3)
(compared to baseline)

Signature/Name/Grade _____

Cycle 20

Post Take Ward Round AMU/MAU/OAAU

Consultant: DASM **Date:** 11.5.22 **Time:** 0920

Summary 42♂ Hep C
Street Vdrug | Atc x5 | 20 cpd.
Prev. PE
TIQM

Pc / R. leg swelling + pain.
No infective Sx.

↓

↓ Duke 1896

Duplex
↓ Phlebx 2q 4:
LMWH Therapeutic

(+ scd MRI
2° nibites)

↓

Dy Unit.

NB
Splenectomy

Temp:
Pulse:
BP:
Sat O2:
FiO2:
RR:

ECG: **Bloods:**

CXR: **Other investigations:**

Imp:

Plan:

D: likely DVT

AWI considered ☐ Thromboprophylaxis need reviewed ☐ Medicine reconciliation complete ☐
If cardiac or respiratory arrest is considered a possibility for the patient has CPR status been reviewed and documented Yes ☐ No ☐
CPR decision discussed with patient Yes ☐ No (document why) ☐ Advanced directive in situ ☐ Treatment escalation plan (circle) Ward/HDU/ITU
Family informed of CPR/escalation status? – Needs discussed at first opportunity ☐ Has been discussed ☐ Patient does not want family informed ☐

Recommended Destination: _____
Suitable to board if required Yes ☐ No ☐
Expected Date of Discharge: _____

Signature: _____
Designation: _____
Bleep Number: _____

Cycle 20

Junior/Senior additional notes, communications with relatives

* Rivaroxaban * O/D

→ Return in one week → 20mg for one week (Dring box with him).

↳ Amb care 1/52.

return to Amb Gde. 18/5/22 * pt informed *

7 days supply given of rivaroxaban 20mg (pending RW)

↑ Following d/c =

Dr Yasmin. (Harn)

EDL completed.

NOTES

NOTES

My Admission Record

NHS Greater Glasgow and Clyde

Nam
Add
2208793218
BURGESS
Henry
96a Alice Street
Paisley, Renfrewshire
PA2 6E
22/08/197
DoI
CH
Affix patient ID label

Hospital: RAH Ward: MAU
Date of Admission: 10/05/22 Time: 00:00
Information obtained from: Name:
Patient ☑ Relative ☐ Other ☐ _____
Preferred Name:
Age: 42 Telephone Number:
Consultant:

Lumbar ☑ -ve

Communication

What is your first language? ENGLISH
Do you require an interpreter? Yes ☐ No ☑
If yes, provide details of arrangements made_____
Do you use British Sign Language (BSL)? _ Yes ☐ No ☑
Do you need someone to help you to communicate? Yes ☐ No ☑ If yes, who_____

Preferred first contact	Preferred second contact
Name: FIONA GARRETT	Name:
Relationship:	Relationship:
Address:	Address:
Telephone:	Telephone:
Is this person aware of your admission? Yes ☑ No ☐	Is this person aware of your admission? Yes ☐ No ☐
Can we share information with this person? Yes ☑ No ☐	Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

?DVT

Explained to the patient? Yes ☑ No ☐ Not Applicable ☐
Do you understand the reason for your admission? Yes ☑ No ☐

Allergies / Sensitivities (Record food allergies in the Hydration and Nutrition section)

No known allergies ☑

Relevant past medical history

Splenectomy · Seizures, PE, DVT,
T1DM - on insulin, Alcohol xs,
Prev sepsis, Hepatitis C

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place
Yes ☐ No ☑ If yes, Who asked for a copy?_____
Date they asked for a copy __/__/__ Date Obtained __/__/__

Power of Attorney / Guardianship / Adult with Incapacity

Does someone have Power of Attorney (POA) for you?

Yes ☐ No ☑

OR

Does someone have Guardianship?

Yes ☐ No ☑

If yes, is this for:- Finance ☐ Welfare ☐ Both ☐

Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

Please obtain a copy and place in the patient's notes

Who asked for a copy?_____ Date they asked for a copy __/__/__ Date Obtained __/__/__

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

N.B. If you think the patient may lack capacity inform Medical Staff to assess and, if required, consider the need for an 'Adult with Incapacity' Section 47

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Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:	Yes	No
1. Been an inpatient in a hospital outside Scotland?	☐	☑
2. Received holiday dialysis outside Scotland?	☐	☑
3. Been told that you have CPE?	☐	☑
4. Been in close contact with a person with CPE?	☐	☑

If the answer is yes to **ANY** of the questions in this section, you must

- Isolate the patient in a side room ☐
- Obtain Rectal swab marked 'for CPE' ☐
- If patient refuses rectal swab, obtain a stool specimen marked 'for CPE' ☐
- **and inform the IPCT** ☐

MRSA Screening

	Yes	No	Unsure
Will the patient be an inpatient for more than 23 hours	☐	☑	☐
If **YES** complete the following section			
1. Have you ever been told that you have MRSA?	☐	☑	☐
2. Have you been admitted from another hospital/ residential setting or care home?	☐	☑	
3. Do you have a wound / skin ulcer or invasive device which you had before admission?	☐	☑	☐

If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit; Critical Care – obtain MRSA swabs

Nasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

	Yes	No	Unsure
Have you ever been informed that you are at increased risk of CJD or vCJD?	☐	☑	☐

If **YES inform the IPCT** ☐

Name:
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Henry
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M
22/08/1979

Lifestyle

Smoking

Are you a: smoker ☑ ex- smoker ☐ when did you stop? _____

Never smoked ☐ 20 a day

Do you use eCigarettes? Yes ☐ No ☐

If a smoker, the NHSGGC Smokefree policy has been explained and Nicotine Replacement Therapy (NRT) has been offered

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

Do you want to talk to someone about your smoking? Yes ☐ No ☐

If yes, refer to Smokefree Services (Trakcare) Date referred: ___/___/___

Drugs

Do you use recreational or illicit drugs or are you receiving opiate replacement therapy (ORT / Methadone / Suboxone)? Yes ☑ No ☐

If yes, please specify and refer to the NHSGGC Guidelines for the Management of Drug Users in Glasgow and Clyde Acute Hospitals

ZANEX. (STREET) VALIUM
on mecnadone

Alcohol

Do you drink alcohol? Yes ☐ No ☑

How often do you have more than 6 units of alcohol on one occasion:

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

NB: If daily or almost daily commence the Glasgow Assessment and Management of Alcohol (GAMA), complete FAST Tool and take further action as per guidance.

Name (Please PRINT): E-mmmm? Signature:

Designation: Date: 11/05/22

My Assessment Record

Name
Addre
2208793218
BURGESS
9 Henry M
90a Alice Street 22/08/1979
DoB: Paisley, Renfrewshire
CHI: PA2 6EA
Affix patient

1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems	✓	✓	
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			

Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems	✓	✓	
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

	Yes ✓	No ✓	Assessment of the patient's communication needs
Do you have any difficulties communicating your needs?		✓	
Do you have any difficulties with your speech?		✓	
Do you have a Learning Disability?		✓	
Do you have support from a Learning Disability Team? Contact details: _____		✓	

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3. Senses

Vision	Yes ✓	No ✓	Assessment of the patient's vision
Do you have any problems with your vision?		✓	
Do you wear glasses?			Distance ☐ Reading ☐ Both ☐
Do you have your glasses with you?			
Do you wear contact lenses?			
Do you have your lenses with you?			
Do you wear a prosthesis?			

Hearing	Yes ✓	No ✓	Assessment of the patient's hearing
Do you have any problems with your hearing?		✓	
Do you have any hearing loss?			
Do you use a hearing aid?			
Do you have your hearing aid(s) with you?			

Pain	Yes ✓	No ✓	Assessment of the patient's pain
Do you have pain?	✓		

Can you describe where and what the pain is like?

? DVT

Have you had treatment / intervention for the pain?

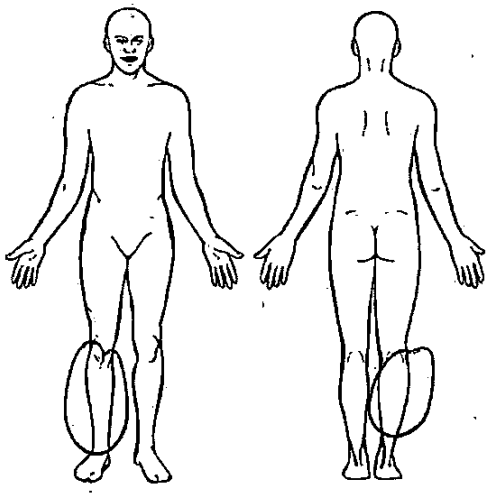
Codein

N.B. Complete generic pain assessment chart. If unable to self report complete Abbey Pain Scale.

Can you describe any chronic pain that you have?

What makes the pain better?

Mark current pain on body chart



Name: _____

A 2208793218
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Henry 22/08/1979
D 96a Alice Street
C Paisley, Renfrewshire
A PA2 6EA

4. Cognitive Status – THINK DELIRIUM

	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's cognitive status
Alert and orientated	✓	✓	
Impaired conscious level			
Confused			
Dementia			
Stressed / Distressed			

~~N.B. Think Delirium~~

Complete 4AT for all patients 65 and over, AND for patients of any age with one or more of the following:

- existing cognitive impairment
- previous delirium
- current hip fracture
- severe illness

and follow the guidance

N.B. 'Getting to Know Me' and 'What Matters to Me' should be completed for all patients with dementia, cognitive impairment or complex needs

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

None Known

What do you like to eat and drink?

Not specific

What do you not like to eat and drink?

Not specific

N.B. Malnutrition Universal Screening Tool (MUST) to be completed for all patients within 24 hours of admission

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓
Normal diet and fluids	✓	✓
Therapeutic diet		
Cultural, ethnic or religious diet		
Texture Modified Diet Please state _____		
Thickened Fluid Please state _____		
Oral Nutritional supplements Preferred flavour _____		
Enteral Nutrition		
Parenteral Nutrition		
Nil by Mouth		

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Assessment of the patient's hydration and nutrition needs

N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharnygeal Swallow Symptoms (STOPSS) within 4 hours of admission

Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓
Independent (Green)	✓	✓
Prompting / encouragement / opening packets/cutting up food (Amber)		
Full assistance with eating and drinking (Red)		

Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?

6. Elimination

Bladder	Admission Presentation ✓	Normal for the patient ✓
Pass urine with no problems	✓	✓
Frequently pass urine during the day		
Frequently pass urine overnight		
Sense of urgency when need to pass urine		
Urine retention		

Assessment of the patient's elimination needs

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓
Haematuria		
Incontinent		

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N.B. If new incontinence report to medical staff to rule out infection or physiological cause

What products do you normally use for this continence issue?

No urinary catheter ☑ Urinary catheter in situ: Urethral ☐ Suprapubic ☐

Date urinary catheter last changed ___/___/___

N.B. If Urinary Urethral Catheter (UCC) in situ commence NHSGGC Adult UCC Insertion and Maintenance Care Plan

Bowels

When did your bowels last move? Today

How often in a day/week do you have a bowel movement? Per day 1 Per week

Do you use any medication e.g. laxative to help your bowels move? Yes ☐ No ☑

Bowel Habit	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Regular	✓	✓	
Constipated			
Diarrhoea / loose stools			
Blood in stools			
Incontinent			

What products do you normally use for this continence issue?

N.B. If concerned about bowel patterns (e.g. infrequent movement or frequent loose stools) consider using the Bristol Stool Chart

Stoma	Yes ✓	No ✓	Assessment of the patient's needs in relation to their stoma
Do you have a stoma?		✓	
Do you require assistance with your stoma care?		✓	
Have you brought any of your stoma products with you?		✓	

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Affix patient ID label

7. Personal Hygiene, Oral Health, Skin Care and Wound Care

Personal Hygiene	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's personal hygiene needs
Independent	✓	✓	
Requires assistance with washing and dressing			

Oral Health	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's oral health needs
No problems	✓	✓	
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			

Dental work	**Yes** ✓	**No** ✓	Description of any dental work
Do you wear dentures?	✓		
Do you have your dentures with you?	✓		
Are your dentures a good fit?	✓		
Do you have any other dental work that we need to be aware of?		✓	

Skin Care	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's skin care needs
No problems	✓	✓	
Skin broken			
Skin oedematous			
Skin discoloured / red			

N.B. Complete PUDRA for all patients within 8 hours of admission

Pressure ulcer identified on admission: Yes ☐ No ☑

Pressure Ulcer Grade: _____

Pressure Ulcer Site: _____ **Adult wound assessment and management chart required**

N.B If Grade 2 pressure damage on ankle or below refer to Podiarty via TrakCare

Wound Care	Yes ✓	No ✓
Do you have any wounds? **N.B. If yes, complete an assessment chart for wound management**		✓

N A 2208793218 BURGESS Henry 22/08/197 96a Alice Street Paisley, Renfrewshire PA2 6E/

Affix patient

8. Mobility

Mobility	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's mobility needs
Fully mobile and independent	✓	✓	
Unsteady when walking			
Do you use a mobility aid	Yes ☑	No ☐	CRUTCH
Do you have your mobility aid with you?	Yes ☑	No ☐	

N.B. If not fully mobile and independent on admission complete moving and handling assessment within 24 hours of admission

9. Maintaining a Safe Environment

N.B. Complete a falls risk assessment for all patients within 24 hours of admission. If a falls risk is identified complete the falls intervention checklist and document all nursing actions in the care plan.

Safety	Yes ✓	No ✓	Assessment of the patient's ability to maintain a safe environment
Is the patient at risk of falling, rolling, slipping or sliding from the bed?		✓	
Would you like bedrails to be used while in hospital?		✓	

N.B. If yes, to either of the two questions above complete a bedrail risk assessment

10. Sleep and Rest

Sleep	Yes ✓	No ✓	Assessment of the patient's sleep and rest needs
Do you have any difficulties with sleeping?		✓	
Do you do or use anything to help you sleep?		✓	

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Affix patient ID label

11. Social Circumstances

Do you:

Live alone	☐	Live with family/ friend/ other	☑
Live in a nursing home	☐	Live in a care home	☐
Live in residential supported care	☐	Live in student accommodation	☐
Live in 'homeless' accommodation	☐	Have no fixed abode	☐

Other please specify_____ ☐

Dependants	**Yes** ✓	**No** ✓
Do you have any dependants?		✓
Do you support anyone (e.g. partner, children, relatives, animals)?		✓
Do they need support from someone else whilst you are in hospital?		✓
Would someone else be able to provide this support when you are in hospital? If yes, who?		✓

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

Services	**Yes** ✓	**No** ✓
Do you have support from social work, social services or a care package?		✓
If yes, please provide details:		
If yes, has contact been made to cancel arrangements during admission?		✓

12. Emotional and Spiritual Care

Do you have a religion or beliefs that we can help you observe while you are in hospital?

NO

Is there anything else with regards to your values, religion or culture that we can support you with during your stay in hospital (e.g. prayer meditation)?

NO

Would you like to talk to someone (e.g. Hospital Healthcare Chaplain) about you, your loved ones, your values and beliefs, or any worries you have? Yes ☐ No ☑

Healthcare Chaplain informed Yes ☐ N/A ☑

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13. Person Centred Care

What matters and is important to you whilst you are in hospital?
This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

Getting home

N.B. Participating in 'What Matters to Me' should be offered to all patients

Informal Support

Who is important to you, to help support you whilst you are in hospital?

NB. If the person who helps is not a preferred contact please ensure their details are listed below.

Name: .....

Contact Details: .....
.....
.....

How do you want the people who matter to you to be involved in your care?

Do you have someone who looks after you or someone that helps you, i.e. an informal carer?

Yes ☐ No ☐

If yes, has the help or support listed above been confirmed with the patient's family/ friends?
(please tick) Yes ☐ No ☐

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Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?
Yes ☐ No ☐
Referrals can be made via the central phone number: 0141 452 2387

Has the carer been advised of the Carers Information Line?
Yes ☐ No ☐ Not appropriate at this time ☐
Carers Information Line: 0141 353 6504
Carers Information Leaflet provided?
Yes ☐ No ☐

Are you:
Employed ☐ Unemployed ☐
Self-employed ☐ Retired ☐
Full time education ☐

Has your health had an impact on your ability to carry out your day to day activities at work?
Yes ☐ No ☐ Not applicable ☐

Do you have any money worries?
Yes ☐ No ☐ Not appropriate to ask at this time ☐
If yes would you like referred to a money advice service that can offer confidential advice/ support?
Yes ☐ No ☐ If yes when was patient referred ___/___/___

Would you like a referral to a service that can support you with employment / education/ training/ skills volunteering?
Yes ☐ No ☐ Not applicable ☐ Not appropriate to ask at this time ☐
If yes when was patient referred ___/___/___

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Paisley, Renfrewshire
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Risk Assessments/Other Documentation

Additional NHSGGC Documentation	Required		Required documents completed		Date, Print and Sign when completed
	Yes ✓	No ✓	Yes ✓	No ✓	
Glasgow Assessment and Management of Alcohol (GAMA)					
Generic Pain Scale Assessment Chart					
Abbey Pain Scale (if unable to self report pain)					
4AT and TIME for Detection, Management and Prevention of Delirium					
Getting to Know Me – Relatives to complete					
What Matters to Me					
Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)					
Malnutrition Universal Screening Tool (MUST)	✓				
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan					
Bristol Stool Chart					
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓				
Adult Wound Assessment and Management Chart					
Moving and Handling Assessment					
Falls Risk Assessment	✓				
Bedrail Risk Assessment					

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
11/05/22	GP ref. ? DVT. (R) leg 41cm	
	36cm (L). Pain 7/10. Been	
	ongoing for passed week.	
A	Patent	
B	RR 19. Sats 96% on RA	
C	HR 72 bpm. BP 160/100.	
	ECG ☑ IVC ☑ Bloods ☑	

Name
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Paisley, Renfrewshire
PA2 6E
DoB:
CHI:
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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
D	(A) ✓ PJ	
E	Temp 36.3°C.	
11/05/22 04:40	Ward medical r/v R/v by medical staff, presented with (R) leg pain, stated had a dead leg since lumbar puncture on recent admission. Recently immobile during hospital admission for agitation / confusion following buprenorphine overdose. Bloods: CRP 101, WCC 14.3, d-dimer 1896, Plt 605. Imp: DVT. +/- cellulitis. Plan: -Treatment dose of dalteparin (15,000 units). -Po flucloxacillin, -urine dip ☐, -doppler ☐. News 0. Bm 5.0mmol.	Emanuel Emanuel Hills RN

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
11/05/22	Urinalysis done. Negative for everything. Sample not sent.	Emergency
08:40	Patient care taken over by	
11/5/22	day staff.	
	Medication given.	
	Alert and orientated.	
	Pt took own BMs 9.3.	
	Pt refused to take any	
	insulin as he states that	
	he does not take anything	
	when BMs <10. He wishes	
	to stick to own insulin plan.	
	Clarified with ANP, documented	SN
	on insulin prescription chart.	KAFLOCKHART
11:30	Patient has been argumentative	
	with other patients in the	
	bay.	
	reviewed by consultant.	
	imp: DVT.	
	plan: Doppler ☑ - Await report	
	: dalta ☑	SN
	: oral Mox ☑	KAFLOCKHART
1350	Doppler attended.	
	DVT positive.	
	Patient to return to medical	
	day unit in one week on	
	the 18/5/22. Given rivaroxaban	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☑

Please tick ✔ appropriate directorate

Henry Burgess
02/08/1979
96a Alice Street,
Paisley, Renfrewshire
PA2 6EA

Date & Time		Signature, Print Name & Designation
11/5	for one week. 80mg once	
1350	daily for week.	
	TDL completed. Given to	
	patient.	
	Intervention insitu	
	Organising own transport	
	home.	C Laverty SW

83949 GGC0072

Date & Time		Signature, Print Name & Designation

NEWS 2 Key | 1 | 2 | 3

| | | |

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

2208793218
BURGESS
Henry
96a Alice Street
Paisley, Renfrewshire
PA2 6E
22/08/197

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

~~Sp02 Scale 1~~ Target >96%	~~Sp02 Scale 2~~ Target 88-92%	Patient on home oxygen Y ☐ N ☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP Initials ONLY:	Dr/ANP Initials ONLY:	
Date:	Date:	

Document all actions and Interventions

NEWS 0	NEWS 1-4	~~NEWS 5-6 or 3 in one parameter~~	NEWS 7 or more
	Low Clinical Risk	Medium Clinical Risk	High Clinical Risk
Min 12 Hourly Observations	Min 4 Hourly Observation	Min Hourly Observations	Continuous Monitoring
	~~Inform Registered Nurse~~	~~Urgent Assessment by Medical Team~~	Urgent Assessment by Senior Medical Team
	Agree Frequency of Observation Required	ACE Response in Medical Notes	ACE Response in Medical Notes
		Think Sepsis if Suspicion of Infection	Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

Discontinuation of NEWS

Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed.....

Medical: .....

Date: .....

Glasgow Coma Scale

Date:
Time:
INIT
HSID

| | | |

Care Rounds Checklist

Date: 11/05/22

I have evaluated and deemed that the frequency of care delivery over the next work shift, **based on the patient's most critical need** should be every (please circle) 1hr 2hr 3hr (4hr)

1. Signed _____ Name E-mond Designation SN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

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BURGESS
Henry 22/08/197
98a Alice Street
Paisley, Renfrewshire
War
PA2 6E

NHS Greater Glasgow and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

			Times	0500	0800	0800	1140																
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		N	N	N	N																
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.		N	N	N	N																
S	3	**SKIN INSPECTION** Pressure areas checked:		Y	N	N	N																
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		I	I	I	I																
K	4	**KEEP MOVING** Has the patient moved or walked?		Y	I	Y	Y																
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		/	I	I																	
		Chair Assist to walk or stand (W/ST)		W	I	I																	
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		I	I	I	I																
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?		N	N	N	N																
		Drink taken?		Y	I	Y	Y																
		Food, snack, or supplement taken?		I	I	Y	Y																
		Has oral hygiene been carried out as per care plan?		I	I	I	I																
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		Y	Y	Y	Y																
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.		Y	NT	N	N																
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.		NA	NA	NA	NA																
		Care provider / role																					

Care Rounds Variance Sheet

Attach

2208793218

M BURGESS M
9 Henry 22/08/1979
96a Alice Street
Paisley, Renfrewshire
Ward: A PA2 6EA

NHS
Greater Glasgow and Clyde

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

Date	Time	Code	Variance			Sign & Print Name

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Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

2208793218
M BURGESS
Henry
96a Alice Street
Paisley, Renfrewshire
22/08/197
PA2 6E

CHI: _____
Address: _____
Hospital: _____

NHS Greater Glasgow and Clyde

Insertion criteria: Please complete this section at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☐ Resuscitation/Chest Pain ☐ IV Drugs ☐ Fluids ☐ Transfusion ☐

PVC Inserted: Day 0	Date: 11/05/22 Hospital: RAH Area: ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☑ ORR Unknown ☐ _____
Insertion site:	R Hand ☐ R Arm ☑ R Foot ☐ L Hand ☐ L Arm ☐ L Foot ☐ Other: _____
Colour of cannula:	Blue ☐ Pink ☑ Green ☐ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: _____

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? (Diagnostics, Resuscitation/ Chest Pain, IV Drugs, Fluids, Transfusion)	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 1 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: ___/___/___ **Reason for keeping PVC in after 72 hrs/ 3 days:** _____

***Date PVC Removed:** 11/5/22

***Reason For Removal:** dislodged

Modified Visual Infusion Phlebitis (VIP) Score

Modified V.I.P (Visual Infusion Phlebitis) Score	
IV site appears healthy	0
One of the following is evident : slight pain or redness near site	1 Possible first signs : Observe cannula
Two or more of the following are evident: pain, redness, swelling	
All of the following are evident: pain, redness, hardening of surrounding tissue	
As above including: palpable venous cord	
As above including: pyrexia	

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and S. aureus bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids ? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → Can I switch my patient from IV to oral antibiotics?

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature ≤ 37.9°C, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE is available reliably** (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, S. aureus bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abcess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy. Record the intended duration on the medicine kardex

YES

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

NO

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

2208793218 M BURGESS M 9 Henry 22/08/1979 96a Alice Street Paisley, Renfrewshire A PA2 6EA	Hospital: RAH Ward: MAN	**Points to consider:** • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

1	Pressure Damage	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan overleaf.

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2	Mobility	Does the person require assistance to mobilise?
3	Continence	Does the person have continence issues with urine and/or faeces?
4	Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5	Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?
6	Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY pressure relieving care interventions and complete the pressure ulcer interventional plan overleaf.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
11/05/22	00:00	N	N	N	N	N	N	4hrly	[signature]
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	

Complete prevention of pressure ulcer interventional plan overleaf for all patients with redness/pressure damage and for those at risk.

Prevention of Pressure Ulcer Interventional Plan

NHS Greater Glasgow and Clyde

2208793218
M BURGESS 22/08/197
'9 Henry
96a Alice Street
Paisley, Renfrewshire
A PA2 6E

Aim: To incorporate effective pressure ulcer prevention strategies to reduce/eliminate potential for pressure ulcer development.

Outcome: To prevent pressure ulcer development through establishment of effecting work practices in line with SSKINS bundle.

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____

Insulin Prescription and Administration Form

NHS Greater Glasgow and Clyde

Name: ..... Address:... ..... DoB:..... Chi numb	2208793218 BURGESS Henry 96a Alice Street Paisley, Renfrewshire PA2 6E	Diabetes: Type 1 ☑ Type 2 ☐ Secondary ☐ Self administering insulin: Yes ☐ No ☐ Usual diabetes medication and device: If unwell, vomiting or septic, check for ketones and request urgent medical review.

- When prescribing insulin always write the word units in full (do not abbreviate to U or IU)
- Always measure the dose and administer insulin using an insulin syringe
- Rapid acting and premix insulin should be given with meals
- Long acting insulin should be given at the same time every day

****Ensure that the insulin type and adminstration times are also prescribed on the Kardex. Adminstration of all doses must be recorded on both chart and Kardex.****

Refer to **guidelines on reverse of form** when blood glucose falls into the shaded areas.

Frequency of capillary blood glucose (CBG) monitoring: _____ /day.

Date	Time	CBG Readings (mmol/L) <4	CBG Readings (mmol/L) 4.0-14.9	CBG Readings (mmol/L) ≥15	Insulin Preparation	Insulin Dose (units)	Print prescriber's name and sign below	Given by	Checked by	Time given	Ketones present Y / N
						units units					Y / N
1/5	0730		6.4		NOVOMIX	12 units units	[signature] DID NOT HAVE				Y / N
	Before Breakfast					units units					Y / N
PATIENT REFUSED TO TAKE SEE NURSING NOTES →	AFTER		9.3			units units					Y / N
	Before Lunch					units units					Y / N
	1805			19.3	NOVOMIX	12 units units	[signature]	CL	VAF		Y / N 0.6
	Before Dinner					units units					Y / N
						units units					Y / N
	Before Bed					units units					Y / N
						units units					Y / N
						units units					Y / N
	Before Breakfast					units units					Y / N
						units units					Y / N
	Before Lunch					units units					Y / N
						units units					Y / N
	Before Dinner					units units					Y / N
						units units					Y / N
	Before Bed					units units					Y / N
						units units					Y / N
						units units					Y / N
	Before Breakfast					units units					Y / N
						units units					Y / N
	Before Lunch					units units					Y / N
						units units					Y / N
	Before Dinner					units units					Y / N
						units units					Y / N
	Before Bed					units units					Y / N

Date	Time	CBG Readings (mmol/L)			Insulin		Print prescriber's name and sign below	Given by	Checked by	Time given	Ketones present Y / N
		<4	4.0-14.9	≥15	Preparation	Dose (units)					
						units					Y / N
						units					Y / N
						units					Y / N
	Before Breakfast					units					Y / N
						units					Y / N
						units					Y / N
	Before Lunch					units					Y / N
						units					Y / N
						units					Y / N
	Before Dinner					units					Y / N
						units					Y / N
	Before Bed					units					Y / N
						units					Y / N
						units					Y / N
						units					Y / N
	Before Breakfast					units					Y / N
						units					Y / N
	Before Lunch					units					Y / N
						units					Y / N
	Before Dinner					units					Y / N
						units					Y / N
	Before Bed					units					Y / N

Guidelines for capillary blood glucose readings falling into the shaded area

Hypoglycaemia: Glucose < 4mmol/L	Hyperglycaemia: Glucose ≥ 15mmol/L
Requires urgent treatment as per protocol: **www.diabetes.org.uk** or **StaffNet** Urgent medical review if unwell/deteriorating at any stage. • **Mild and able to swallow:** 15-20g carbohydrate such as 4-5 Glucotabs®, 60ml Glucojuice®, 100ml original Lucozade® or 150-200ml pure fruit juice • **Severe:** 100mls IV 20% Glucose or 150-200mls IV 10% Glucose (or 1mg Glucagon IM if venous access problematic) Check glucose after 10-15 minutes to ensure resolved – if glucose >4mmol/L give two biscuits / sandwich, if not then treat again as per protocol. Following treatment of hypoglycaemia, review insulin doses, but **do not omit insulin in type 1 diabetes.**	Check urine or blood for ketones – need urgent medical review if ketones present or if unwell. Assess risk of DKA in patients with type 1 diabetes and monitor closely – consider increase in insulin doses; may need IV insulin infusion. Assess risk of hyperglycaemic hyperosmolar syndrome in type 2 diabetes. If hyperglycaemic at same time on two consecutive days (even if mild), ask medical team to review diabetes treatment.

Consider and address causes of hypoglycaemia or hyperglycaemia

- Assess oral intake: too little or too much carbohydrate
- Consider renal failure, liver failure, pancreatic disease, sepsis or steroid therapy
- Review medication: check correct insulin (or other medication), dose and time of administration
- Check injection sites in patients taking insulin

Contact Numbers

On-call medical page: _____ Hospital at night _____

Diabetes specialist nurse page: _____ Ext: _____

Name: .....

Address: .....

.....

DoB: .....

Chi number: .....

Affix patient data label

Approved by: NHSGGC Safer Use of Medicines Committee, Dec 2014. Date of review: Dec 2016

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2208793218
BURGESS M
Henry 22/08/1979
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NHS
Greater Glasgow and Clyde

Emergency Care Nursing Documentation

Presenting complaint - and relevant past medical history including allergies

Date and Time		Name/Signature
7.9.22 2010	? DVT	

Nursing notes - on admission

Date and Time		Name/Signature
7.9.22 2010	Brought into bay prepared for exam & awaits review	
	Humira Rx	

Triage

Patient prepared for exam - clothing bagged (Y) N

NEWS Chart	(Y)	N	X-rays	Y	N
ID band	(Y)	N			
Peak Flow	Y	N	Please specify		
12-lead ECG	Y	N	Urinalysis	Y	N
IV access	Y	N			
Blood samples	Y	N	Positive findings		
Blood Gas	Y	N	B-HCG	Y	N

Communication

GGC Red Bag with Patient (nursing home resident)	Y	(N)
Language or hearing difficulty	Y	(N)
Interpreter required	Y	(N)
what arrangements have been made?		
Relatives / Carer / Next of Kin present	Y	(N)
name,relationship,location,particular concerns		

Risk Assessments and Screening Tools

SEPSIS	Y	(N)	GMAWS	Y	(N)
FAST	Y	(N)	Adult Support and Protection	Y	(N)
Swallow Testing	Y	(N)	Mental Health Triage Assessment	Y	(N)
Falls Risk (clinical judgeument)	Y	(N)	Child Protection Concerns	Y	(N)

Signature:

Patient n

2208793218

Patient C BURGESS . . . . M
Henry 22/08/1979

NHS
Greater Glasgow and Clyde

Care Rounds Checklist

I have evaluated and deemed that the frequency of care delivery over the next work shift, **based on the patient's most critical need**, should be every (please circle) **1hr** **2hr** **3hr** **4hr**

Signed [illegible] Name [illegible] Designation [illegible]

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Use the following Codes:
Y = Yes **N** = No **NA** = Not Applicable **NT** = No Thanks **S** = Sleeping **O** = Off the ward **I** - Independent

			Times	2010									
	1	**THINK DELIRIUM** Is the patient more confused/drowsy than normal?If yes inform registered nurse.		N									
	2	**PAIN: ASSESS AND ADDRESS.** Is the patient distressed or in pain?If yes inform registered nurse.		N									
S	3	**SKIN INSPECTION** Pressure areas checked?		N									
		R = RED **D** = Discloured **PU** - Pressure Ulcer **INT** = Intact **M**= Moisture		/									
K	4	**KEEP MOVING** Has the patient moved or walked?		Y									
		Bed **R** =Right side (30°) tilt **L** =Left side (30°) tilt **B** =Back Chair **W/ST** = Assist to walk / stand		B									
		ELIMINATION. Does the patient need the toilet?		N									
I	5	**I** = Independent **A** - Assistance given **IC** = Incontinent (urine/faeces)		I									
N	6	**FOOD FLUIDS AND NUTRITIO.** Is the patient nil by mouth?		N									
		Drink taken?		N									
		Food, snack, or supplements taken?		N									
		Has oral hygiene been carried out as per care plan?		N									
	7	**ENVIRONMENT CHECK** Is the patient's call buzzer to hand? Is the area clutter free clean and safe? Does the patient have everything they require in safe reach? Is the bed in the lowest position?		Y									
	8	**INFORMATION** Is there anything else I can help you with? Inform the patient of the time of return		N									
	9	**ESCALATION** Is there anything else I can help you with? Inform the patient of the time of return		N									
			Care provider	KH									
			Role	[illegible]									

Ask the patient if there is anything they specifically want done today:

Patient name .....

Patie 2208793218
BURGESS M
Henry 22/08/1979
0/1 128 Neilston Road
Paisley, Renfrewshire
PA2 6EP

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Hospital: RAH	Points to consider:
Ward: ED	• Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

NHS Greater Glasgow and Clyde

PUDRA

1	**Pressure Damage**	Does the person have redness and/or existing pressure damage? **IF YES, prescribe a minimum of 2 HOURLY Pressure relieving care** to avoid further damage occurring and complete the pressure ulcer interventional plan.

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2	**Mobility**	Does the person require assistance to mobilise or change position (inappropriate for age)?
3	**Continence**	Does the person have continence issues with urine and/or faeces (inappropriate for age)?
4	**Nutrition**	Does the person appear malnourished and/or unable to eat or drink/ PYMS score>2?
5	**Skin**	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6	**Judgement**	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY Pressure Relieving Care interventions and complete the pressure ulcer interventional plan.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
/ /	:							____hrly	
/ /	:							____hrly	
/ /	:							____hrly	

Complete prevention of pressure ulcer interventional plan below for all patients with redness/pressure damage and for those at risk.

S Skin Inspection	S Surface	K Keep Moving	I Incontinence/ Moisture	N Nutrition	S Self Management/ Shared Care
Check: • Pressure areas ____ hourly • Skin under medical devices ____ hourly • Specify medical devices used	Specify: 1. Mattress 2. Cushion 3. Detail additional pressure redistributing equipment	1. Reposition ____ hourly in bed / chair 2. Overnight patient/carer has agreed to repositioning ____ hourly 3. Specify any manual handling equipment used	1. Skin Care to be carried out ____ hourly 2. Specify products required for increased moisture/ continence management:	1. Optimise nutrition and hydration 2. Refer to MUST	1. Discuss and agree plan with patient/ family/carer YES / NO 2. Prevent Pressure Ulcers" leaflet given to patient/family/ carer YES / NO

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Greater Glasgow and Clyde

Nursing notes - discharge plannning

Date and Time		Name/Signature

Outcomes and outstanding issues

Date and Time		Name/Signature

Pause for Discharge or Transfer

GGC Red Bag with Patient (nursing home resident)	Y	N
Relatives / Carer with Patient	Y	N
Name Band	Y	N
Nursing Screening Tools Complete	Y	N
Bed Available	Y	N
SBAR complete	Y	N
NEWS Chart NEWS completed within 1 hour of transfer/discharge	Y	N
Prescriptions and fluid charts signed	Y	N
Cannula	Y	N
Notes Complete	Y	N
Analgesia	Y	N
Belongings	Y	N
Transport	Y	N
Signature:		

Contact with relatives

Signature:

Patient name.....

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0/1 128 Neilston Road
Paisley, Renfrewshire
PA2 6EP

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NHS
Greater Glasgow and Clyde

4AT assessment - for delirium and cognitive impairment

		Circle Score
(1) ALERTNESS This includes patients who may be markedly drowsy (eg. dificult to rouse and/or obviously sleepy during assessment) or agitated/ hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.	Normal (alert, but not agitated, through assessment) Mild sleepiness (<10 secs) after waking, then normal Clearly abnormal	0 0 4
(2) AMT4 Age, date of birth, place (name of the hospital/building), current year.	No mistakes 1 mistake 2 or more mistakes/untestable	0 1 2
(3) ATTENTION Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.	wAchieves 7 months or more correctly Starts but scores <7 months / refuses to start Untestable (cannot start, unwell, drowsy, inattentive	0 1 2
(4) ACUTE CHANGE OR FLUCTUATING COURSE Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs.	No Yes	0 4

4 or more	possible delirium +/- cognitive impairment	**TOTAL**	
1-3	possible cognitive impairment		
0	delirium or severe cognitive impairment unlikey (but delirium still possibe if (4) information incomplete		

Frailty Assessment Tool (Healthcare Improvement Scotland)

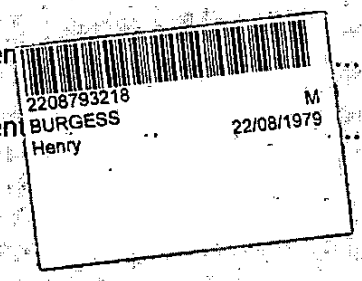
Step 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?			circle Y or N	
F	**Functional impairment**	(new or worsening) eg difficulty with self care	**Y**	**N**
R	**Resident**	in a care home	**Y**	**N**
A	**Altered mental state**	such as delirium or dementia **(4AT Assessment)**	**Y**	**N**
I	**Immobility/Instability**	decline in mobility, difficulty mobilising without help, fall leading to presentation	**Y**	**N**
L	**Living at home with support**	on a daily basis (homecare, one visit or more per day)	**Y**	**N**

If YES to any of the criteria in Step 1 move to Step 2 **Step 2 Would this person be better managed by another speciality team at present?**	circle Y or N	
Clear need for other specialty input eg exacerbation of known long-term condition such as COPD	**Y**	**N**
Need for HDU/ITU (including non-invasive ventilation)	**Y**	**N**
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit	**Y**	**N**
Head injury with loss of consciousness	**Y**	**N**
Acute abdominal pain/ surgical presentation	**Y**	**N**
Upper GI Bleed	**Y**	**N**
Chest pain with suspected acute coronary syndrome	**Y**	**N**
Trauma with suspected fracture	**Y**	**N**

Are any of the criteria met?
If YES to any criteria in Step 2: Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.
If YES to any criteria in Step 1 and NO to ALL criteria in STEP 2: Prioritise transfer of care to specialist geriatric assessment service.

Patien

Patien



NHS
Greater Glasgow and Clyde

Nursing notes - ongoing care

Date and Time		Name/Signature

NEWS 2 Key | 1 | 2 | 3

| | | |

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

CHI	2205783218 2205/1979
Surname	BURGESS
Forename	Henry

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP Initials ONLY:	Dr/ANP Initials ONLY:	
Date:	Date:	

Document all actions and interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
Min 12 Hourly Observations	Low Clinical Risk Min 4 Hourly Observation Inform Registered Nurse Agree Frequency of Observation Required	Medium Clinical Risk Min Hourly Observations Urgent Assessment by Medical Team ACE Response in Medical Notes Think Sepsis if Suspicion of Infection	High Clinical Risk Continuous Monitoring Urgent Assessment by Senior Medical Team ACE Response in Medical Notes Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

Discontinuation of NEWS

Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed.....

Medical: .....

Date: .....

Glasgow Coma Scale

| | | |

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Royal Alexandra Hospital

CHI: 2208793218

Called @ 2015 no reply 2025

carried @ 2025 - no reply

Total Att: 24

12 Mth Att: 5

Title: MR

BURGESS

Henry

DOB 22/08/1979

Age: 43y

Sex: Male

0/1 128 Neilston Road

Paisley
Renfrewshire
PA2 6EP
07960524514

Next of kin: THOMSON, Lorna
Relationship: Sister

GP: LE Cormack
0141 889 5277

Attendance Date: 07/09/2022

Arrival Time: 18:01

Registration Time: 18:01

Date of Incident: 07/09/2022

Major Incident Desc:

Reason for Attendance: (R) leg blood clot

Affix Label

Nursing Assessment

Alerts: Not Recorded

Allergies: Not Recorded

Pain Score:

Triage Category: 3

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 07/09/2022 18:42

Nurse name: Nurse Laura Colville

Temp		C
HR		bpm
BP	/	mmHg
MAP		mmHg
RR		bpm
SpO2		%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils-Right		Pupils-Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: ?DVT right leg, HX of same, patient is clearly intoxicated, states has consumed alcohol and his prescribed pregabalin

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

X-Ray and Other Reports to be filed on this side (if the patient is not being admitted)

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

HENRY BURGESS 2208793218

Date	CLINICAL NOTES
	Seen by (Dr) Time seen

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant if admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

MWA

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Royal Alexandra Hospital

CHI: 2208793218

Total Att: 25

12 Mth Att: 6

Title: MR

BURGESS **Henry**

DOB 22/08/1979 Age: 43y Sex: Male

0/1 128 Neilston Road

Paisley
Renfrewshire
PA2 6EP
07960524514

Next of kin: GARRETT, Fiona
Relationship: Partner
07477774484

GP: LE Cormack
0141 889 5277

Attendance Date: 16/11/2022 Arrival Time: 12:42

Registration Time: 12:42 Date of Incident: 16/11/2022

Major Incident Desc:

Reason for Attendance: vomiting blood/PR bleed

Affix Label

Nursing Assessment

Alerts: Not Recorded Allergies: Not Recorded Pain Score:

Triage Category: 3 Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 16/11/2022 13:14

Nurse name: Nurse kayla Kerr

Temp		C
HR		bpm
BP	/	mmHg
MAP		mmHg
RR		bpm
SpO2		%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils-Right		Pupils-Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: "fresh red blood in stools for 1-2 days with dark vomit. Hx: alcohol xs and on methadone programme - on rivaroxaban" Taken ix street valium this morning

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

X-Ray and Other Reports to be filed on this side (if the patient is not being admitted)

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

Date	CLINICAL NOTES	
	Seen by (Dr)	Time seen

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged		Not arranged		To be arranged			
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Affix Patient ID

2208793218 22/08/1979
BURGESS
Henry

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP Initials ONLY:	Dr/ANP Initials ONLY:	
Date:	Date:	

Document all actions and interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
	Low Clinical Risk	Medium Clinical Risk	High Clinical Risk
Min 12 Hourly Observations	Min 4 Hourly Observation	Min Hourly Observations	Continuous Monitoring
	Inform Registered Nurse	Urgent Assessment by Medical Team	Urgent Assessment by Senior Medical Team
	Agree Frequency of Observation Required	ACE Response in Medical Notes	ACE Response in Medical Notes
		Think Sepsis if Suspicion of Infection	Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

Discontinuation of NEWS

Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed.....

Medical: .....

Date: .....

Glasgow Coma Scale

Pupil Reaction if visible
s = sluggish
a = action
- = no reaction
c = eyes closed
Pupil Size (mm) 1 2 3 4 5 6 7 8

Date:
Time:
Score
Alert

Eyes (best response)
Spontaneously 4
To sound 3
To pressure 2
None 1
NT

Verbal (Endotracheal tube or tracheostomy = NT)
Orientated 5
Confused 4
Words 3
Sounds 2
None 1
NT

Motor (Always record the best response)
Obeys command 6
Localising pain 5
Flexion/withdrawal 4
Abnormal flexion 3
Extension 2
None 1
NT

TOTAL 15

Right size:
Right reaction:
Left size:
Left reaction:

Normal power
Mild weakness
Severe weakness
Specific fixation
Extension
No response

Normal power
Mild weakness
Severe weakness
Specific fixation
Extension
No response

Pain Score

Ask the patient to rate his/her pain by using numerical scale 0 to 10. Use the chart below to assist the patient. If the patient is unable to communicate, use alternative pain scoring tools.

No Pain	Mild Pain			Moderate Pain			Severe Pain		
0	1	2	3	4	5	6	7	8	9	10

Pain Function Score

A	No limitations, activity unrestricted by pain or settles quickly
B	Mild limitations, mild activity restrictions
C	Moderate limitations, attempts but reluctant to continue because of pain. **Seek Advice**
D	Severe limitations, unable to or refuse to perform because of pain. **Urgent Review Required**

Affix Patient ID

NEWS 2 Key | 1 | 2 | 3

| | | |

(9) cmt

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

CHI: 2208793218

Royal Alexandra Hospital

Total Att: 27

12 Mth Att: 0

Title: MR

BURGESS **Henry**

DOB 22/08/1979 Age: 45y Sex: Male

0/1
128 NEILSTON ROAD
Paisley
Renfrewshire
PA2 6EP

Next of kin: GARRETT, Fiona
Relationship: Partner
07868 392 152

GP: GC Perrett
0141 889 5277

Attendance Date: 05/12/2024 Arrival Time: 22:09

Registration Time: 22:09 Date of Incident: 05/12/2024

Major Incident Desc:

Reason for Attendance: seizures biba

Affix Label

Nursing Assessment

Alerts: Yes

Allergies: Not Recorded Pain Score:

Tetanus up to date/fully immunised:

Triage Category: 3

Presenting Complaint:

Observation Date: 05/12/2024 22:49

Nurse name: Nurse Amy Hughes3

Temp		C
HR		bpm
BP	/	mmHg
MAP		mmHg
RR		bpm
SpO2		%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils-Right		Pupils-Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: 3 witnessed seizures by partner today in the space of 20 minutes, partner states patient had a seizure yesterday didn't seek medical help. no seizures witnessed by sas denies any alcohol or drug use hx alcohol dependent

Type 1 Bx diabetic :

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

X-Ray and Other Reports to be filed on this side (if the patient is not being admitted)

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By
06/12	NOVORAPID	6units	S/C.	01:32		Self Administered

2208793218 Henry Burgess

Date	CLINICAL NOTES
	Seen by (Dr) ... Time seen 0050
05/12	H. CLAIG F42 45 → BIBA w/ 3x seizured at home. Witnessed by Partner. PC: Seizure HPC: 3x Sei See AMU Proforma

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Patient Information		Date:	05/12/2024	
HENRY BURGESS		Incident Number:	CR011592646	2208793218
Age/Gender:	45Y Old Male	Incident Type:	EMG	BURGESS M
Address:	128 NEILSON ROAD, PAISLEY	Incident Location:	96A ALICE STREET PAISLEY, PA2 6EA	Henry 22/08/1979
DOB:	22/08/1979			
CHI:				
Ethnicity:	White Scottish			

Presenting Complaint

SEIZURE

Additional Comments

999 call to a 45yom. Pt partner called tonight and advises pt had 3 seizures within 20 mins unsure approx time. Partner also advises pt may have had a seizure this morning and had one yesterday also but did not seek medical help. (unwitnessed by SAS). O/A pt alert, pacing round livingroom, gcs14. O/E pt is hypertensive 151/92, tachycardic 113, 12 lead ecg nsr, hyperglycaemic 22.6, pupils PERRLA size 5, abc and all others obs noted and within normal parameters. Pt advises he has new muscle pain from after his seizures but denies any nausea, headaches or dizziness. Pt has a hx of spleen removal, prev alcohol dep, prev IVDU, T1D. Pt advises his blood sugars dropped yesterday then spiked again. Unsure if pt has a hx of seizures as unable to get a clear accurate answer from pt or partner. Pt denies any recent drug or alcohol use. Pt advises he stopped drinking in Aug 2024. Pt advises he has taken all his medication today. Unable to gain IV access. Pt has been stable and monitored enroute to ED triage

PATIENT ASSESSMENT

ACVPU	Alert			<C>	No		
A	Clear						
B	**Breathing Adequately**	Yes	**Respiratory Rate** 16		**SPO2**	94	
C	**Pulse Rate**	**BP**	**Cap Refill**		**ECG Rhythm**		
	70	151/92	<=2 Secs		Sinus Rhythm		
	Rhythm	**Arm**	**Central/Peripheral**		**ECG**		
	Reg	Left	Peripheral		12 Lead		
D	**GCS**	**Eyes**	**Voice**		**Motor**		**PEARL**
	14	Spontaneously (4)	Confused (4)		Obeys Commands (6)		Yes

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
22:01	73		161/81	95											P122025S
21:46	78		143/87	98											P122025S
21:35	113	16	151/92	94	<=2 Secs	14	Alert		36.9	22.6	Sinus Rhythm	5	5		P122025S

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
21:35	16 (0)	94 (1)		0	151 (0)	113 (2)	Alert (0)	36.9 (0)	3

HISTORY

AMPLE

Allergies	None
Medication	METHADONE, PREGABALIN, INSULIN
Past Medical History	Diabetes (Type 1), PREV ALCOHOL AND DRUG DEP
Last Eaten	Within Past Hour
Events Prior	PT HAS TAKEN 3 SEIZURES IN PAST HOUR UNWITNESSED BY SAS

Social History:

Lives alone	Yes	Patient Occupation	Does Not Work
Patients General Appearance	Normal		
Living Arrangement	SPENDS MAJORITY OF TIME AT PARTNERS HOUSE		
Patient Mobility	Fully Mobile		
Patient Communication	No Help Required		
Patient Clinical Risk Factors	Smoker		
Patient Enviromental Risk Factors	Loose Carpets		

2208793218
BURGESS M
Henry 22/08/1979
0/1
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6EP

CLOSE RECORD

Treatment On Scene	Non-Emergency

Conveyance

Transport To Hospital	Normal driving	Pre-Alert	No	Patient Accompanied By	PARTNER

INCIDENT LOG

Time Call Received	21:08	Allocated	21:15	Mobile	21:16
First Resource On Scene		Crew On Scene	21:27	Crew Left Scene	22:00
Crew At Hosp	22:05	Receiving Hospital	ROYAL ALEXANDRA - PAISLEY	Clear Time	

Crew ID	Crew Grade	Driver
E0044369	Paramedic	YES
E9880857	Newly Qualified Paramedic	NO
P122025S	Student Paramedic (BSc Placement)	NO

Cycle 20

NHS Greater Glasgow and Clyde

Acute Medical Unit Admission Proforma

MAU/A&E/AMU

Royal Alexandra Hospital, Paisley/Vale of Leven Hospital/IRH

Patient Details		
Name: **Address:**	2208793218 BURGESS M Henry 22/08/1979 0/1 128 NEILSTON ROAD Paisley, Renfrewshire PA2 6E	**Sex:** F ☐ M ☑ **DoB** 22/08/1979 **Age:**
Telephone:		
GP:		
Next of Kin:		
Telephone:		

Episode Details			
Date patient seen:	06/12/2024	**Time seen:** 0050	
Source of referral:	GP ☐ A&E ☑ OPD ☐ Self ☐ Other =		
Admitting Dr:	H. CRAIG	**Grade** FY2	**Bleep**
Consultant:			

Resuscitation Decision

Resuscitation status: (please circle) **FOR RESUSCITATION / DNA CPR**

Signature: _____ **Name:** _____ **Grade:** _____

If DNA CPR → Complete appropriate form

Cycle 20

Presenting Complaint(s)	
Presenting complaint	Seizure.
History of presenting complaint	• 3x seizure this evening. All occured within 10 minutes. Lasting a few minute each time. • Partner witnessed → described arms pulling in, stiff w/ jerking movements. Looked grey. • Post-ictal confusion, now resolved. Pt appears ++ drowsy (as does partner). • No incontinence. No tongue biting. No visual disturbances. No precipitating event or sense. • unaware throughout episode. • Previous episode on Tuesday. • No injuries sustained. Denies drug of or alcohol use since August. Ex-IVDU + prenavo diazepam.

Past Medical History / Review of Old Notes. Review eKIS if available
T1DM. Ex-IVDU. Splenectomy. Prev - DVT + PE.

Systemic Enquiry
ϕ CP ϕ SOB - slight dry cough. ϕ abdo pain ϕ LUTS ϕ Δ bowels ϕ headache ϕ neurology.

Cycle 20

2208793218
BURGESS M
Henry 22/08/1979
0/1
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6EP

MEDICINES RECONCILIATION – Acceptable to staple fully co

Source of medication history Patient ☐ Relative/carer ☐ GP Phone call ☐

(>1 source preferred) Patient own drugs ☐ Com. Pharmacist ☐ GP letter/summary ☐

Other (please specify) .....

Admission Medicines	Dose	Frequency	Plan for medicines (Dr complete) Continue	Amend	Withold	Stop	Comments Reason for alteration
TOUJEO							
NOVORAPID							
PREGABALIN							
MIRTAZEPINE							

Staple med-rec to this page

Allergies	List any over-the-counter or alternative medicines
None known ☐	
	Do medicines need further clarification ? Yes ☐ No ☐
List collected by :	Plan approved by :
Designation : Date :	Designation : Date :

Pharmacy review	Comments
Compliance aid : Yes ☐ No ☐	Community pharmacist Phone
Reviewed by :	Designation : Date :

Cycle 20

Social History

Smoking History

Ex-smoker / Smoker 20 cpd 25 yrs Never smoked

Alcohol History

Nil Units/week FAST score if excess _____

Recreational Drugs Driving Status

Denies.

Social Circumstances (home, supports, functional status, occupation, travel)

Lives wl partner.

Family History

Nil

Observations

RR: 14 bpm **Sats:** 96 % **FiO2:** (A) **Temp:** 36.5°C **BP:** 109/70 **HR:** 60 bpm ~~**BMI:**~~ 22.6

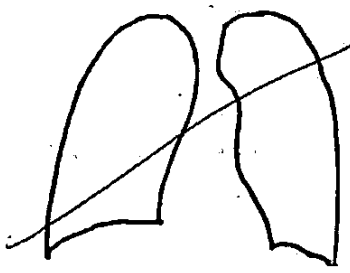
General Examination

General Appearance: Drowsy.

Cyanosis / pallor / jaundice / clubbing / lymphadenopathy

Respiratory

PEFR =



Cycle 20

Cardiovascular

Pulse regular. **Heart Sounds** 1 + 11 + 0.

JVP –

Oedema nil

Peripheral Pulses present. **cap refill** < 2 S.

2208793218
BURGESS M
Henry 22/08/1979
0/1
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6E

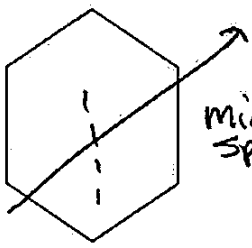
Gastrointestinal system

Masses: nil

Organomegaly: nil

Bowel sounds: +ve.

PR:



Neurological system

GCS: 15/15 **E:** 4/4 **M:** 6/6 **V:** 5/5 **AMT:** 4/4 (AMT 4 = age, time, place, year)

Pupils/fundoscopy: PEARL. **Cerebellar and extrapyramidal:**

Cranial Nerves: intact. **Neck:**

	RUL	LUL	RLL	LLL
Tone	N	N	N	N.
Power	5/5	5/5	5/5	5/5
Co-ordination	intact	intact	intact	intact
Reflexes	N	N	N	N
Sensation	N	N	N	N.

Gait:

Locomotor

	Tender	Swollen	Deformity	Which joint?
Arms				
Legs				
Spine				

Cycle 20

Investigations

(Differential) diagnosis

? drug related seizure.
Hyperglycaemia - ketones 0.1.

Management Plan

Admit for observation.
Await bloods + formal ECG
Rpt BM +/- novorapid. - Rpt BM 20.6. ketones 0.1.
↳ STAT 6units novorapid

Thromboprophylaxis assessed ☐ **Medicine Reconciliation** ☐ **DD6 if required** ☐

Signature Hereg **PRINT NAME** H. CRAIG **Page:**
PRINT GRADE FY2

Senior/Medical review

SENIOR REVIEW

Patient remains settled overnight.
· NEWS 1. No headache, no agitation
· polle 1° daily.
CT head: NAD
DTC home to GP practice.
- To contact GP for f/u and
to see diabetes nurse at GP practice.

Admission checklist

Investigations reviewed ☐ **Kardex** ☐ **eKIS reviewed** ☐
Thromboprophylaxis assessed ☐ **Medicine Reconciliation** ☐ **DD6 if required** ☐

NHS GG&C Adult Risk Assessment for Venous Thromboembolism (VTE)

[excluding orthopaedics, obstetrics and gynaecology & ENT who have specialty-specific policies]

- Risk Assessment must be completed for all patients within 24 hours of admission to hospital
- Patients must be reassessed every 48-72 hours or sooner if condition changes
- Reassessment must be documented in Kardex
- Please complete risk assessment and then sign and date Risk Assessment Result box at bottom of page.

2208793218
BURGESS M
Henry 22/08/1979
0/1
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6EP

Surgical patients start here

Non-operative [mainly medical] patients start here

Is the patient bed-bound or expected to have reduced mobility relative to normal state for ≥ 2 days?

Yes ☐ No ☐

Does the patient have any risk factors for thrombosis? (tick √ all that apply)

Age >60	☐	Use of oestrogen-containing contraceptive therapy	☐
Active cancer or cancer treatment	☐	Use of hormone replacement therapy	☐
Dehydration	☐	Pregnancy or < 6 weeks post partum [seek specialist advice]	☐
Known thrombophilias	☐	Critical care admission eg HDU/ITU	☐
Obesity (BMI>30)	☐	Total anaesthetic + surgical time >90 minutes	☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or inflammatory disease	☐	Surgery involving pelvis or lower limb with a total anaesthetic + surgical time >60 minutes	☐
Personal history or first degree relative with a history of VTE	☐	Acute surgical admission with inflammatory or intra-abdominal condition	☐
Varicose veins with phlebitis	☐	Hip fracture	☐

- No thromboprophylaxis required.
- Continue to reassess every 48-72 hours or sooner if condition changes.
- Document all reassessments in drug kardex.
- Risk assessment now complete
- Complete Risk Assessment Result Box

Yes, 1 or more risk factors identified ☐

No risk factors identified ☐

Does the patient have any contraindications to pharmacological prophylaxis? (tick √ all that apply)

Active bleeding	☐	Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands)	☐
Acquired bleeding disorders (e.g. acute liver failure)	☐	Neurosurgery, spinal or posterior eye surgery	☐
Concurrent use of anticoagulants (such as warfarin with INR>2)	☐	Lumbar puncture, epidural/spinal anaesthesia expected within the next 12 hours	☐
Acute stroke	☐	Other procedure with high bleeding risk – discuss with senior if unsure	☐
Uncontrolled hypertension (230/120 mmHg or higher)	☐	Lumbar puncture, epidural/spinal analgesia within the previous 4 hours	☐
Thrombocytopenia (<75 x 10^9/l)	☐	Thyroid surgery	☐

- Discuss with senior clinical staff before prescribing pharmacological prophylaxis
- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48-72 hours or sooner if condition changes

No contraindications to pharmacological prophylaxis identified ☐

Contraindications to pharmacological prophylaxis identified ☐

Surgical patients – Enoxaparin 40mg + AES ☐*
*prior to application of AES, please check contraindications to AES

Medical patients – Enoxaparin 40mg ☐
Prescribe Enoxaparin at 6pm
[on day of surgery, at the later of either 4h post-op or 6pm]
Reduce Enoxaparin to 20mg if <50Kg or eGFR <30ml/minute/1.73m² ☐
Discontinue at discharge or when returned to pre-morbid mobility

Contraindications to anti-embolism stockings (AES) Y ☐ N ☐

Peripheral neuropathy	☐
Peripheral vascular disease	☐
Cellulitis or Gross oedema	☐
Leg deformity or Fragile skin	☐
Leg / foot ulcers	☐
Allergy	☐
Unusual leg size/shape	☐

Risk assessment result – please tick √ all that apply

VTE risk factors: YES ☐ NO ☐ Contraindications to pharmacological prophylaxis: YES ☐ NO ☐ Prescribed: LMWH ☐ AES ☐ NONE ☐

Patient informed of VTE risks and benefits of thromboprophylaxis YES ☐ NO ☐ N/A ☐ Information leaflet provided YES ☐ NO ☐

Print Assessor's Name: _____ Signature: _____ Date: _____

DD6 **All patients over 64**

4AT	Y/N/Na
Carers involved	Y/N/Na
Med rec	Y/N/Na
Sepsis Screen	Y/N/Na
Resuscitation status considered	Y/N
Discharge planning	Y/N/Na

Sepsis Six

Antibiotics within 1 hour	☐
Appropriate Cultures.	☐
Fluids	☐
Oxygen	☐
Lactate	☐
Fluid balance, consider catheter	☐

Cycle 20

Results

Baseline	Date									
	Time									
	Parameter	Ref Range								
	Hb	130-180								
	WCC	4.0-11.0								
	Plts	150-400								
	MCV	78 - 99								
	Neut	2.0 - 7.5								
	PT	9.0 - 13.0								
	APTT	27.0 - 38.0								
	Fibrinogen	1.5-4gm/L								
	INR	( )								
	Thromb T	11-15 secs								
	D-Dimer	<230								
	ABG/VBG									
	Na^+	135 - 145								
	K^+	3.5 - 5.0								
	Cl^-	97 - 107								
	HCO_3^-	23 - 30								
	Urea	2.5 - 7.5								
	Creat	62 - 124								
	eGFR									
	Glucose	3.5 - 5.9								
	Protein	32 - 82								
	Albumin	37 - 50								
	AlkP	33 - 117								
	Bil	0.5 - 19								
	ALT	11 - 55								
	AST	13 - 42								
	GGT	8-60								
	ESR									
	CRP	<3								
	Troponin I hs	Men 0 - 34 Women 0 - 16								
	CK	23 - 190								
	Corr Ca^{++}	2.25 - 2.60								
	PO_4^-	0.8 - 1.4								
	Mg^{++}	0.7 - 1.1								
	Digoxin	0.5 – 2.0								
	Alcohol									
	Paracetamol	<100 @4 hr								
	Salicylate									
	Amylase	<100								
	LDH	240 - 480								
	Folate	3.1 - 20								
	B12	200 - 900								
	Ferritin	15 - 200								
	TSH	0.35 – 5.00								
	T4	9 - 21								
	Urinalysis									

DON'T MISS AKI Checklist within 24 hrs of admission

D **Dipstick Urine:** _____

O **Obtain Ultrasound:** Yes ☐ N/A ☐
(Stage 2/3: within 24 hours of Admission)

N **Need for Catheter:** Long-term ☐ Yes ☐ No ☐ Refused ☐

T **Team Renal to contact:** Considered ☐ Done ☐ N/A ☐

M **Medicine Reconciliation:** ☐

I **Intravenous Fluids:** Yes ☐ Contraindicated ☐

S **Suspected Cause:** _____

S **Staging of AKI:** (Tick Box Below)

☐ 1 (RISK if: Creatinine X 1.5)
☐ 2 (INJURY if: Creatinine X 2)
☐ 3 (FAILURE if: Creatinine X 3)
(compared to baseline)

Signature/Name/Grade _____

Cycle 20

Post Take Ward Round AMU/MAU/OAAI

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BURGESS
Henry M
0/1 22/08/1979
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6EP

Consultant: ..... **Date:** .....

Summary

BP:

Sat O2:

FiO2:

RR:

ECG: **Bloods:**

CXR: **Other investigations:**

Imp:

Plan:

AWI considered ☐ Thromboprophylaxis need reviewed ☐ Medjcine reconciliation complete ☐
If cardiac or respiratory arrest is considered a possibility for the patient has CPR status been reviewed and documented Yes ☐ No ☐
CPR decision discussed with patient Yes ☐ No (document why) ☐ Advanced directive in situ ☐ Treatment escalation plan (circle) Ward/HDU/ITU
Family informed of CPR/escalation status? – Needs discussed at first opportunity ☐ Has been discussed ☐ Patient does not want family informed ☐

Recommended Destination: _____
Suitable to board if required Yes ☐ No ☐
Expected Date of Discharge: _____

Signature: _____
Designation: _____
Bleep Number: _____

Cycle 20

Junior/Senior additional notes, communications with relatives

NOTES

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Henry
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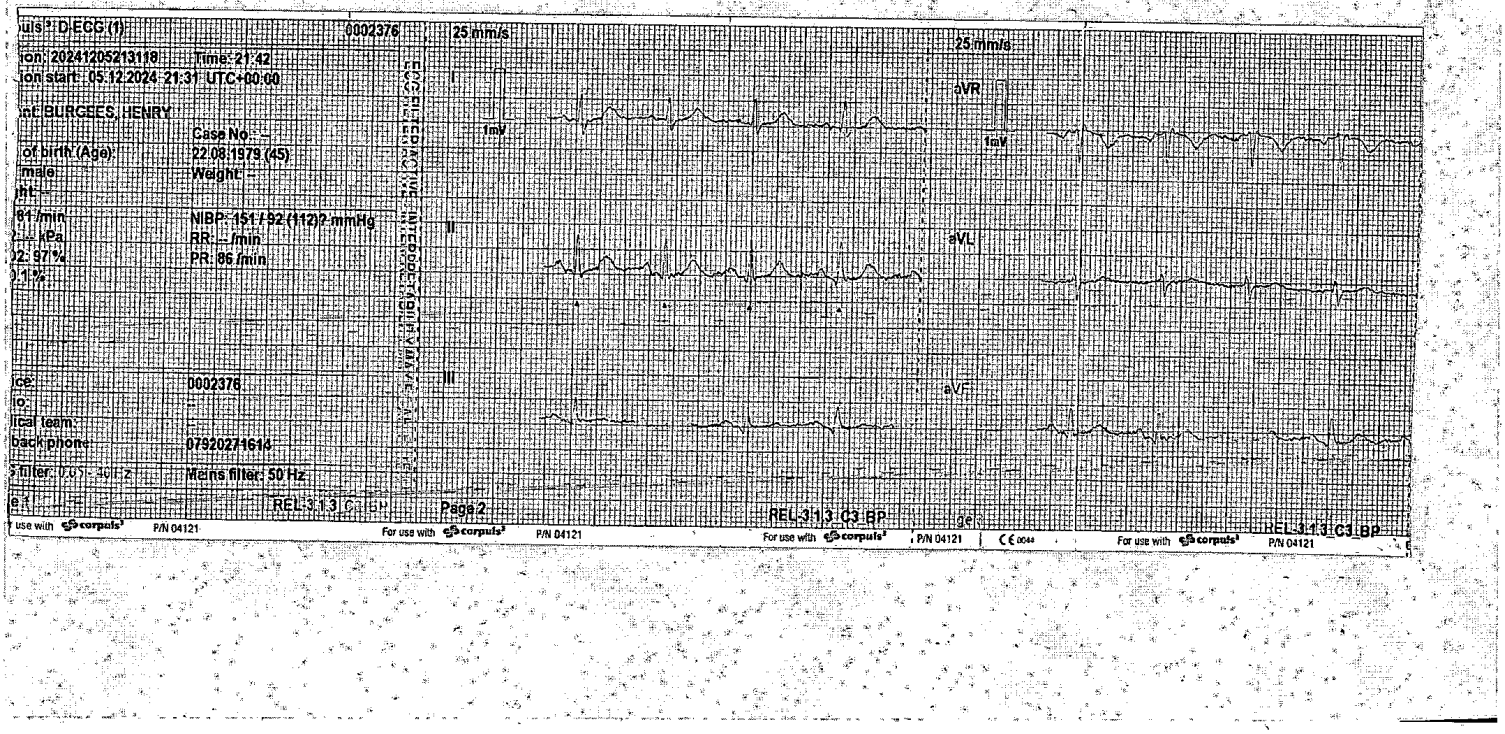
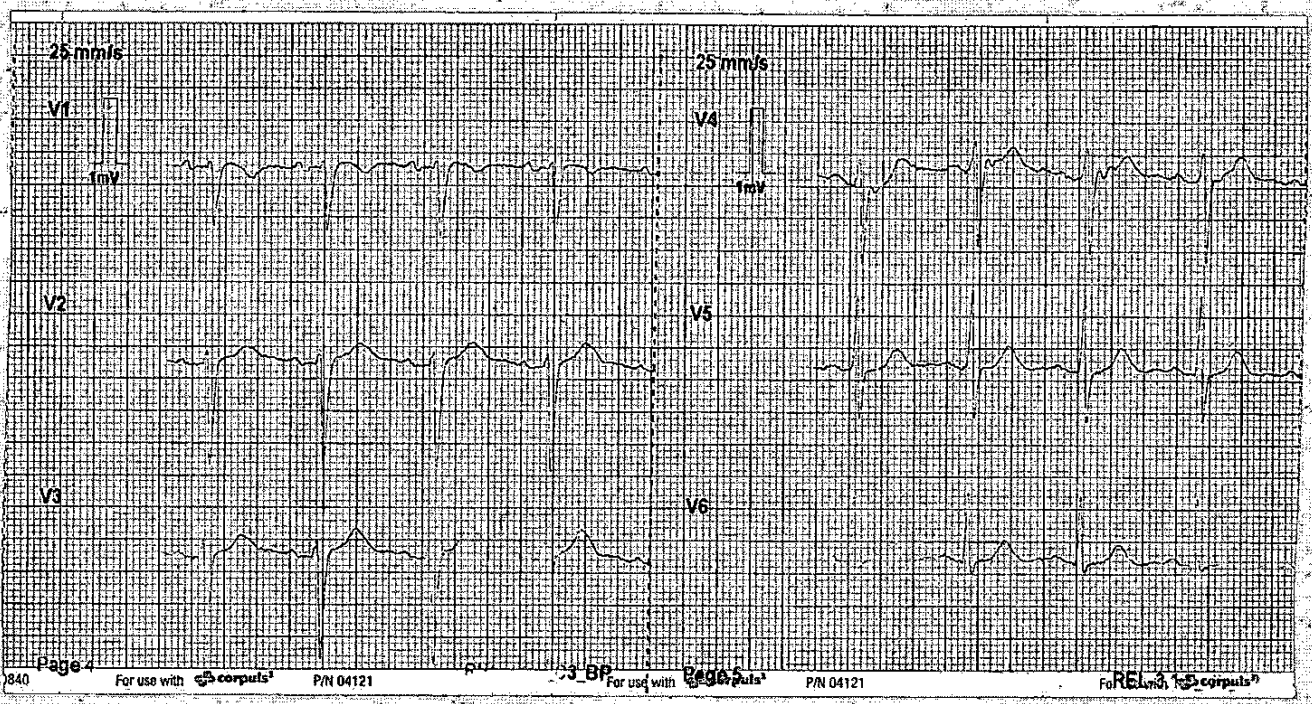
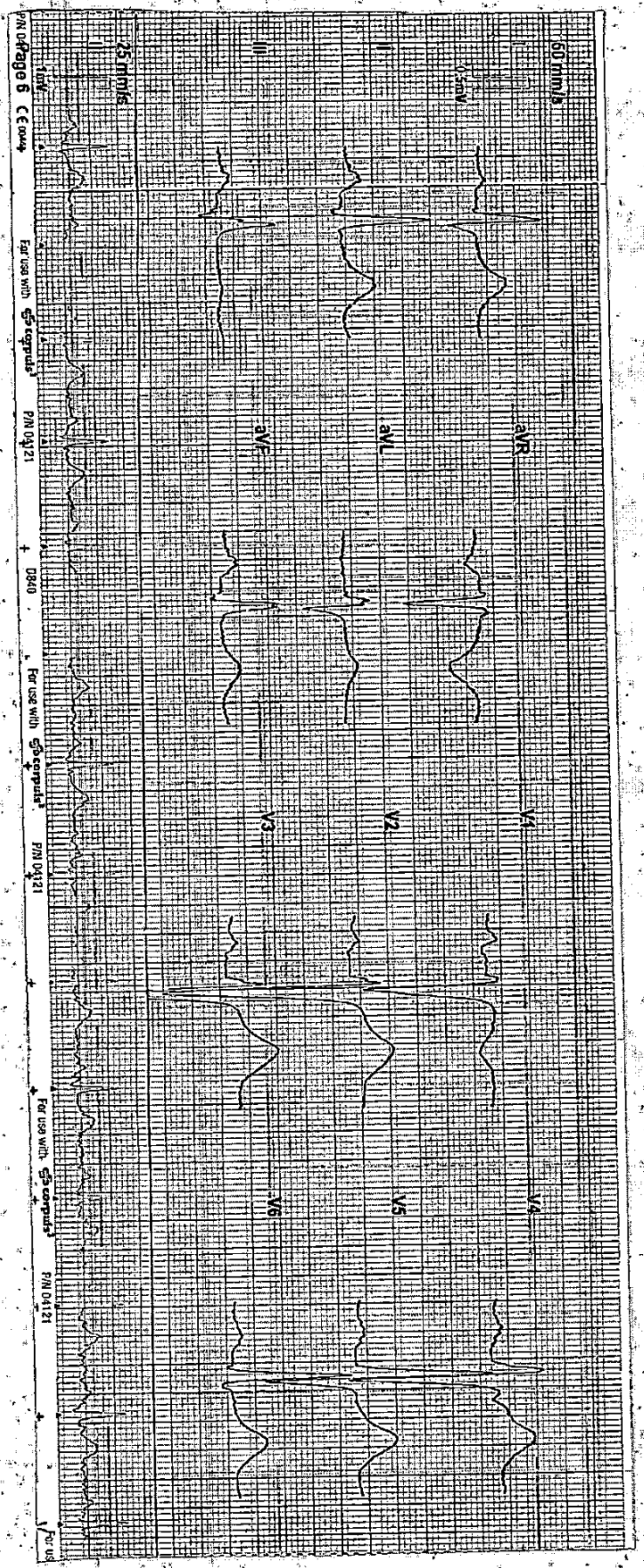
Paisley, Renfrewshire PA2 6E

NOTES

2208793218
BURGESS
Henry
0/1
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6EP
M
22/08/1979




25 mm/s
V1
1mV
V2
V3
25 mm/s
V4
1mV
V5
V6
Page 4
840
For use with corpuls³
P/N 04121
For use with corpuls³
P/N 04121



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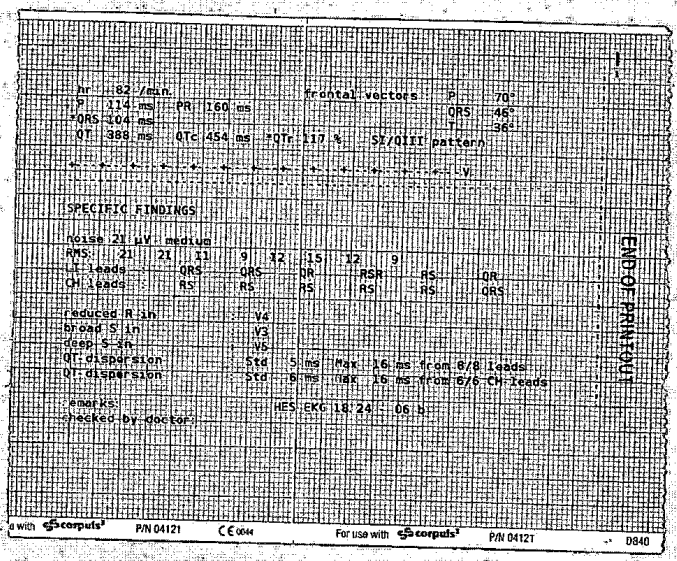
Hr 82 /min.
P 114 ms PR 160 ms
*QRS 104 ms
QT 388 ms QTc 454 ms *QTr 117 %
frontal vectors P 70°
QRS -46°
T -36°
SX/QIII: pattern
V
SPECIFIC FINDINGS
noise 21 µV medium
RMS: 21 21 11 9 12 15 12 9
Lt leads QRS QRS QR RSR RS QR
CH leads RS RS RS RS RS QRS
reduced R in V4
broad S in V3
deep S in V5
QT dispersion Std 5 ms max 16 ms from 6/8 leads
QT dispersion Std 9 ms max 16 ms from 6/6 CH leads
remarks:
checked by doctor:
HES EKG 10 24 06 b
END OF PRINTOUT
d with corpuls³ P/N 04121 CE 0044 For use with corpuls³ P/N 04121 D840

Patient name

Patient CHI

2208793218
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Henry
0/1
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Paisley, Renfrewshire
PA2 6EP
M
22/08/1979

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Emergency Care Nursing Documentation Seizure TIOM.

Initial Investigations

Patient prepared for exam - clothing bagged					Y	N
NEWS Chart	Y	N	X-rays		Y	N
ID band	Y	N	Pain Score		Y	N
Peak Flow	Y	N	Please specify			
12-lead ECG	Y	N	Urinalysis		Y	N
IV access	Y	N				
Blood samples	Y	N	Positive findings			
Blood Gas	Y	N	B-HCG		Y	N

Signature:

Communication

GGC Red Bag with Patient (nursing home resident)	Y	N
Language or hearing difficulty	Y	N
Interpreter required	Y	N
what arrangements have been made?		
Relatives / Carer / Next of Kin present	Y	N

Pat

name,relationship, location, particular concerns

Signature:

Risk Assessments and Screening Tools

	SEPSIS		Y	N	GMAWS	Y N
	FAST		Y	N	Adult Support and Protection	Y N
Time:	Swallow Testing		Y	N	Mental Health Triage Assessment	Y N
	Falls Risk (clinical judgement)		Y	N	Child Protection Concerns	Y N
	4AT Assessment		Y	N	Frailty Assessment	Y N
					Public Protection (NOC)	Y N

Signature:

Pause for Discharge or Transfer

GGC Red Bag with Patient (nursing home resident)	Y	N
Relatives / Carer with Patient	Y	N
Name Band	Y	N
Risk Assessment/Screening Tools	Y	N
Bed Available	Y	N
SBAR complete	Y	N
NEWS Chart NEWS completed within 1 hour of transfer/discharge	Y	N
Prescriptions and fluid charts signed	Y	N
Cannula	Y	N
Notes Complete	Y	N
Analgesia	Y	N
Belongings	Y	N
Transport	Y	N

Signature:

Patient name .....

Patient CI

2208793218
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Henry 22/08/1979
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Care Rounds Checklist

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need, should be every (please circle) 1hr (2hr) 3hr 4hr

Signed J Name [illegible] Designation [illegible]

Signed J Name _____ Designation _____

Signed _____ Name _____ Designation _____

Use the following Codes:
Y = Yes N = No NA = Not Applicable NT = No Thanks S = Sleeping O = Off the ward I - Independent

			Times	23 50	06	09 55	22	10 30						
	1	**THINK DELIRIUM** Is the patient more confused/drowsy than normal? If yes inform registered nurse.		N	N	N	N	N						
	2	**PAIN: ASSESS AND ADDRESS** Is the patient distressed or in pain? If yes inform registered nurse.		N	N	N	N	N						
S	3	**SKIN INSPECTION** Pressure areas checked?		N	N	N	N	N						
		R = RED D = Discloured PU - Pressure Ulcer INT = Intact M = Moisture		I	I	I	I	I						
K	4	**KEEP MOVING** Has the patient moved or walked?		I	Y	I	I	Y						
		Bed R =Right side (30°) tilt L =Left side (30°) tilt B =Back		I	B	I	B	B						
		Chair W/ST = Assist to walk / stand												
		ELIMINATION Does the patient need the toilet?		I	N	I	I	N						
I	5	I = Independent A - Assistance given IC = Incontinent (urine/ faeces)		I	I	I	I	I						
N	6	**FOOD FLUIDS AND NUTRITION** Is the patient nil by mouth?		N	N	N	N	N						
		Drink taken?		N	Y	N	N	Y						
		Food, snack, or supplements taken?		N	N	N	N	Y						
		Has oral hygiene been carried out as per care plan?		N	NA	N	N	N						
	7	**ENVIRONMENT CHECK** Is the patient's call buzzer to hand?		Y	NA		NA	NA						
		Is the area clutter free clean and safe?			Y		Y	Y						
		Does the patient have everything they require in safe reach?				Y		Y						
		Is the bed in the lowest position?												
	8	**INFORMATION** Is there anything else I can help you with? Inform the patient of the time of return		NT	N	NT	NT	NT						
	9	**ESCALATION** Is there anything else I can help you with? Inform the patient of the time of return		N	N	N	N	N						
		Care provider		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]						
		Role		[illegible]	[illegible]	[illegible]	SSN	SSN						

Ask the patient if there is anything they specifically want done today:

Patient n

Patient C

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Paisley, Renfrewshire
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Hospital:	Points to consider:
Ward:	• Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

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Greater Glasgow and Clyde

PUDRA

1	Pressure Damage	Does the person have redness and/or existing pressure damage? **IF YES, prescribe a minimum of 2 HOURLY Pressure relieving care** to avoid further damage occurring and complete the pressure ulcer interventional plan.

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2	Mobility	Does the person require assistance to mobilise or change position (inappropriate for age)?
3	Continence	Does the person have continence issues with urine and/or faeces (inappropriate for age)?
4	Nutrition	Does the person appear malnourished and/or unable to eat or drink/ PYMS score>2?
5	Skin	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6	Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY Pressure Relieving Care interventions and complete the pressure ulcer interventional plan.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
/ /	:							____hrly	
/ /	:							____hrly	
/ /	:							____hrly	

Complete prevention of pressure ulcer interventional plan below for all patients with redness/pressure damage and for those at risk.

S Skin Inspection	S Surface	K Keep Moving	I Incontinence/ Moisture	N Nutrition	S Self Management/ Shared Care
Check: • Pressure areas ____ hourly • Skin under medical devices ____ hourly • Specify medical devices used	Specify: 1. Mattress 2. Cushion 3. Detail additional pressure redistributing equipment	1. Reposition ____ hourly in bed / chair 2. Overnight patient/carer has agreed to repositioning ____ hourly 3. Specify any manual handling equipment used	1. Skin Care to be carried out ____ hourly 2. Specify products required for increased moisture/ continence management:	1. Optimise nutrition and hydration 2. Refer to MUST	1. Discuss and agree plan with patient/ family/carer **YES / NO** 2. Prevent Pressure Ulcers" leaflet given to patient/family/ carer **YES / NO**

Patient nar

Patient CH

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Nursing notes cont.

Date and Time		Name/Signature

Patient name ....

Patient CHI ....

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Henry
M
22/08/1979

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Ongoing Care

	4 Hours	5 Hours	6 Hours	7 Hours	8 Hours	9 Hours	10 Hours	11 Hours	12 Hours
Time									
Nursing notes updated including (NEWS, MEWS,PEWS)									
FFN (provide details)									
IVI/IVABs									
Routine Medications prescribed and administered									
Falls risk assessment									
Skin assessed and supported (PURDRA)									
Analgesia assessment									
Nurse call system in place									
SBAR commenced									
Patient/ relatives updated									
Elimination needs met (does the patient know where toilet is)									
If patient not in cubicle space think about patients dignity requirements eg hearing aids, mobility aids, glasses, interpreter									
STOPPS completed									

Patient name .....

Patient CHI

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Greater Glasgow and Clyde

Nursing notes

Date and Time	Name/Signature
2355 – Into Rm Avault RIV	
01:12 BM - 22.6, ketones 0.1	
01:34 Patient self administered 6 units of Novarapid as prescribed. Macgregor SN	
0145 Avault bed Amu	
0405 BM now 15.0 ketones 0.5.	
0750 Avault transfer to ward. Care handed over to dayshift. Observations obtained NCHO=1 BM done 13.4 and ketones 0.2 / Lucy Dalton SCN	
0926 Not for any more insulin as request by ED Reg. If CT is okay then patient for home.	M. McDougall.

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Affix Patient ID

BURGESS Henry

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP Initials ONLY:	Dr/ANP Initials ONLY:	
Date:-	Date:	

Document all actions and interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
	Low Clinical Risk	Medium Clinical Risk	High Clinical Risk
Min 12 Hourly Observations	Min 4 Hourly Observation	Min Hourly Observations	Continuous Monitoring
	Inform Registered Nurse	Urgent Assessment by Medical Team	Urgent Assessment by Senior Medical Team
	Agree Frequency of Observation Required	ACE Response in Medical Notes	ACE Response in Medical Notes
		Think Sepsis if Suspicion of infection	Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

Discontinuation of NEWS

Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed .....

Medical: .....

Date: .....

Glasgow Coma Scale

Date:
Time:
NEWS

Eyes: Spontaneously 4 · To sound 3 · To pressure 2 · None 1 · Not testable NT
Verbal: Oriented 5 · Confused 4 · Words 3 · Sounds 2 · None 1 · Not testable NT
Motor: Obeys command 6 · Localising pressure 5 · Normal flexion 4 · Abnormal flexion 3 · Extension 2 · None 1 · Not testable NT
Endotracheal tube or tracheostomy = NT
Always record the best response
TOTAL 15

Right size: 1 2 3 4 5 6 7 8
Right reaction: B S C
Left size: 1 2 3 4 5 6 7 8
Left reaction: B S C

Record right (R) and left (L) separately if there is a difference between the two sides
Normal power · Mild weakness · Severe weakness · Spastic flexion · Extension · No response
Record right (R) and left (L) separately if there is a difference between the two sides
Normal power · Mild weakness · Severe weakness · Spastic flexion · Extension · No response

Pupil Reaction and Size
S = Sluggish
B = Brisk reaction
C = no reaction
c = eyes closed
Pupil Size (mm): 1 2 3 4 5 6 7 8

Affix Patient ID

Pain Score

Ask the patient to rate his/her pain by using numerical scale 0 to 10. Use the chart below to assist the patient. If the patient is unable to communicate, use alternative pain scoring tools.

No Pain	Mild Pain		Moderate Pain		Severe Pain				
0	1	2	3	4	5	6	7	8	9	10

Pain Function Score

A	No limitations, activity unrestricted by pain or settles quickly
B	Mild limitations, mild activity restrictions
C	Moderate limitations, attempts but reluctant to continue because of pain. **Seek Advice**
D	Severe limitations, unable to or refuse to perform because of pain. **Urgent Review Required**

m1 • 316654 v5.1 • GCC0264

NEWS 2 Key | 1 | 2 | 3

| | | |

CWA ego unable to stand 3.

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Royal Alexandra Hospital

CHI: 2208793218

Total Att: 28

12 Mth Att: 1

Title: MR

BURGESS **Henry**

DOB 22/08/1979 Age: 45y Sex: Male

0/1
128 NEILSTON ROAD
Paisley
Renfrewshire
PA2 6EP
07362299385

Next of kin: GARRETT, Fiona
Relationship: Partner
07868 392 152

GP: GC Perrett
0141 889 5277

Attendance Date: 17/01/2025 Arrival Time: 20:01

Registration Time: 20:01 Date of Incident: 17/01/2025

Major Incident Desc:

Reason for Attendance: intoxicated/biba

Nursing Assessment

Alerts: Yes

Triage Category: 2

Allergies: Not Recorded Pain Score:

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 17/01/2025 20:41

Nurse name: Nurse Natasha Hyndman

Temp		C
HR		bpm
BP	/	mmHg
MAP		mmHg
RR		bpm
SpO2		%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils Right		Pupils Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: "found intoxicated at bus stop - unable to mobilise safely. hx T1DM, known to take street Valium GCS 11 "

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

X-Ray and Other Reports to be filed on this side (if the patient is not being admitted)

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

Date	CLINICAL NOTES
	Seen by (Dr) ST4 Ross Time seen 2245

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(45)↗ - ↓ GCS

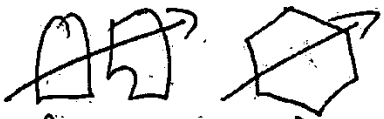
HPC/- Vague Hx from pt
↳ reports drinking 6 pints today (usually 4-5 pints/day)
↳ denies other substances
↳ reports fall onto ® elbow yesterday (RHD)
↳ checked BM today but can't remember what it was
↳ reports took normal fixed dose insulin
- SAS PRF reports pt found asleep in bus stop

PMH/- T1DM
- Alcohol XS, prev IVDU
- Prev DVT + anticoagulation → not now

DH/- Insulin
- Pregabalin
- Pt denies any other medications

SH/- Stays alone

O/E - Drowsy but alert/orientated when roused.
GCS 15, PEARL, small superficial abrasion above (L) eye (scalp otherwise NAD), no c-spine tenderness / full ROM neck (↑45° ↻ ↺), normal facial tone/no asymmetry or slurred speech. Normal sensation/tone/power all four limbs.



HS H+I+O, wwp
Calves SNT, nil oedema.
BM 3.9 → given glucogel. Full ROM ® elbow, no bony tenderness

Imp/- Likely alcohol intoxication
- ? low BMs / infection
- ?? head inj

Patient name ..

Patient CHI ..

2208793218
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pital:

d:

Points to consider:

- **Use within 8 hrs of admission to care area**
- **Re-assess daily and more frequently if a person's condition changes**

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PUDRA

1	**Pressure Damage**	Does the person have redness and/or existing pressure damage? **IF YES, prescribe a minimum of 2 HOURLY Pressure relieving care** to avoid further damage occurring and complete the pressure ulcer interventional plan.

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2	**Mobility**	Does the person require assistance to mobilise or change position (inappropriate for age)?
3	**Continence**	Does the person have continence issues with urine and/or faeces (inappropriate for age)?
4	**Nutrition**	Does the person appear malnourished and/or unable to eat or drink/ PYMS score>2?
5	**Skin**	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6	**Judgement**	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY Pressure Relieving Care interventions and complete the pressure ulcer interventional plan.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
/ /	:							____hrly	
/ /	:							____hrly	
/ /	:							____hrly	

Complete prevention of pressure ulcer interventional plan below for all patients with redness/pressure damage and for those at risk.

S Skin Inspection	S Surface	K Keep Moving	I Incontinence/ Moisture	N Nutrition	S Self Management/ Shared Care
Check: • Pressure areas ____ hourly • Skin under medical devices ____ hourly • Specify medical devices used	Specify: 1. Mattress 2. Cushion 3. Detail additional pressure redistributing equipment	1. Reposition ____ hourly in bed / chair 2. Overnight patient/carer has agreed to repositioning ____ hourly 3. Specify any manual handling equipment used	1. Skin Care to be carried out ____ hourly 2. Specify products required for increased moisture/ continence management:	1. Optimise nutrition and hydration 2. Refer to MUST	1. Discuss and agree plan with patient/ family/carer YES / NO 2. Prevent Pressure Ulcers" leaflet given to patient/family/ carer YES / NO

Patient name ...

Patient CHI ....

2208793218 M
BURGESS 22/08/1979
Henry
0/1
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6EP

NHS
Greater Glasgow and Clyde

Ongoing Care

	4 Hours	5 Hours	6 Hours	7 Hours	8 Hours	9 Hours	10 Hours	11 Hours	12 Hours
Time									
Nursing notes updated including (NEWS, MEWS,PEWS)									
FFN (provide details)									
IVI/IVABs									
Routine Medications prescribed and administered									
Falls risk assessment									
Skin assessed and supported (PURDRA)									
Analgesia assessment									
Nurse call system in place									
SBAR commenced									
Patient/ relatives updated									
Elimination needs met (does the patient know where toilet is)									
If patient not in cubicle space think about patients dignity requirements eg hearing aids, mobility aids, glasses, interpreter									
STOPPS completed									

Patient name .....

Patient CHI .....

2208793218 M
BURGESS
Henry 22/08/1979
0/1
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6E

NHS
Greater Glasgow and Clyde

Nursing notes

Date and Time		Name/Signature
17.1.25 2245	Found lying in street. Into room + ~~[illegible]~~ ED registrar. receiving at present. Given [illegible]	

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP initials ONLY:	Dr/ANP initials ONLY:	
Date:	Date:	

Document all actions and interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
Min 12 Hourly Observations	Low Clinical Risk Min 4 Hourly Observation Inform Registered Nurse Agree Frequency of Observation Required	Medium Clinical Risk Min Hourly Observations Urgent Assessment by Medical Team ACE Response in Medical Notes Think Sepsis if Suspicion of Infection	High Clinical Risk Continuous Monitoring Urgent Assessment by Senior Medical Team ACE Response in Medical Notes Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

Discontinuation of NEWS

Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed .....

Medical: .....

Date: .....

Glasgow Coma Scale

| | | |

NEWS 2 Key 1 2 3

| | | |

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

CHI: 2208793218

Royal Alexandra Hospital

Total Att: **29**

12 Mth Att: **2**

Title: **MR**

BURGESS **Henry**

DOB **22/08/1979** Age: **45y** Sex: **Male**

0/1
128 NEILSTON ROAD
Paisley
Renfrewshire
PA2 6EP
07362299385

Next of kin: **GARRETT, Fiona**
Relationship: **Partner**
07868 392 152

GP: **GC Perrett**
0141 889 5277

Attendance Date: **13/02/2025** Arrival Time: **14:41**

Registration Time: **14:41** Date of Incident: **13/02/2025**

Major Incident Desc:

Reason for Attendance: **? blood clot in right leg**

Nursing Assessment

Alerts: **Yes**

Allergies: **Not Recorded** Pain Score:

Triage Category: **3**

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **13/02/2025 14:55** Nurse name: **Nurse Tracy Smith2**

Temp		C
HR		bpm
BP	/	mmHg
MAP		mmHg
RR		bpm
SpO2		%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils-Right		Pupils-Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: **"pain and swelling right leg past week IDDM "**

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

X-Ray and Other Reports to be filed on this side (if the patient is not being admitted)

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

Date	CLINICAL NOTES	
	Seen by (Dr)	Time seen

2208793218
BURGESS
Henry
M
22/08/1979

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)		Discharge time	
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.		

Ward number (if admitted):	Transfer to hospital:	Consultant if admitted):

Follow up	Arranged	Not arranged	To be arranged

Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

2208793218
BURGESS
Henry
0/1
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6EP
M
22/08/1979

Patient ID .....

Patient Name .....

leg pain
Tlon - fell
BM checked on Dentist examination

NHS
Greater Glasgow and Clyde

Emergency Care Nursing Documentation

Initial Investigations

Patient prepared for exam - clothing bagged				Y	N
NEWS Chart	Y	N	X-rays	Y	N
ID band	Y	N	Pain Score	Y	N
Peak Flow	Y	N	Please specify		
12-lead ECG	Y	N	Urinalysis	Y	N
IV access	Y	N			
Blood samples	Y	N	Positive findings		
Blood Gas	Y	N	B-HCG	Y	N

Signature: CA / Nicol Hutchison CN

Communication

GGC Red Bag with Patient (nursing home resident)	Y	N
Language or hearing difficulty	Y	N
Interpreter required	Y	N
what arrangements have been made?		
Relatives / Carer / Next of Kin present	Y	N
name,relationship, location, particular concerns		

Signature: CA / Nicol Hutchison CN

Risk Assessments and Screening Tools

	SEPSIS	Y	N	GMAWS	Y	N
	FAST	Y	N	Adult Support and Protection	Y	N
Time:	Swallow Testing	Y	N	Mental Health Triage Assessment	Y	N
	Falls Risk (clinical judgement)	Y	N	Child Protection Concerns	Y	N
	4AT Assessment	Y	N	Frailty Assessment	Y	N
				Public Protection (NOC)	Y	N

Signature: CA / Nicol Hutchison CN

Pause for Discharge or Transfer

GGC Red Bag with Patient (nursing home resident)	Y	N
Relatives / Carer with Patient	Y	N
Name Band	Y	N
Risk Assessment/Screening Tools	Y	N
Bed Available	Y	N
SBAR complete	Y	N
NEWS Chart NEWS completed within 1 hour of transfer/discharge	Y	N
Prescriptions and fluid charts signed	Y	N
Cannula	Y	N
Notes Complete	Y	N
Analgesia	Y	N
Belongings	Y	N
Transport	Y	N

Signature:

2208793218
BURGESS M
Henry 22/08/1979
0/1
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6EP

or use sticker

NHS
Greater Glasgow and Clyde

Care Rounds Checklist

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need, should be every (please circle) 1hr 2hr 3hr (4hr)

Signed _____ Name Nicola Hutchison Designation CN

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Use the following Codes:
Y = Yes N = No NA = Not Applicable NT = No Thanks S = Sleeping O = Off the ward I - Independent

			Times	LC										
	1	**THINK DELIRIUM** Is the patient more confused/drowsy than normal? If yes inform registered nurse.		N										
	2	**PAIN: ASSESS AND ADDRESS** Is the patient distressed or in pain? If yes inform registered nurse.		N										
S	3	**SKIN INSPECTION** Pressure areas checked?		/										
		R = RED D = Discloured PU - Pressure Ulcer INT = Intact M = Moisture		I										
K	4	**KEEP MOVING** Has the patient moved or walked?		Y										
		Bed R =Right side (30°) tilt L =Left side (30°) tilt B =Back Chair W/ST = Assist to walk / stand		B										
		ELIMINATION Does the patient need the toilet?		-										
I	5	I = Independent A - Assistance given IC = Incontinent (urine/ faeces)		I										
N	6	**FOOD FLUIDS AND NUTRITION** Is the patient nil by mouth?		N										
		Drink taken?		N										
		Food, snack, or supplements taken?		N										
		Has oral hygiene been carried out as per care plan?		N										
	7	**ENVIRONMENT CHECK** Is the patient's call buzzer to hand? Is the area clutter free clean and safe? Does the patient have everything they require in safe reach? Is the bed in the lowest position?		N Y										
	8	**INFORMATION** Is there anything else I can help you with? Inform the patient of the time of return		NT										
	9	**ESCALATION** Is there anything else I can help you with? Inform the patient of the time of return		NT										
		Care provider		N										
		Role												

Ask the patient if there is anything they specifically want done today:

2208793218
BURGESS
Henry M
0/1 22/08/1979
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6EP

or use sticker

Hospital:	Points to consider:
Ward:	• Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

NHS
Greater Glasgow and Clyde

PUDRA

1	Pressure Damage	Does the person have redness and/or existing pressure damage? **IF YES, prescribe a minimum of 2 HOURLY Pressure relieving care** to avoid further damage occurring and complete the pressure ulcer interventional plan.

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2	Mobility	Does the person require assistance to mobilise or change position (inappropriate for age)?
3	Continence	Does the person have continence issues with urine and/or faeces (inappropriate for age)?
4	Nutrition	Does the person appear malnourished and/or unable to eat or drink/ PYMS score>2?
5	Skin	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6	Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY Pressure Relieving Care interventions and complete the pressure ulcer interventional plan.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
/ /	:							____hrly	
/ /	:							____hrly	
/ /	:							____hrly	

Complete prevention of pressure ulcer interventional plan below for all patients with redness/pressure damage and for those at risk.

S Skin Inspection	S Surface	K Keep Moving	I Incontinence/ Moisture	N Nutrition	S Self Management/ Shared Care
Check: • Pressure areas ____ hourly • Skin under medical devices ____ hourly • Specify medical devices used	Specify: 1. Mattress 2. Cushion 3. Detail additional pressure redistributing equipment	1. Reposition ____ hourly in bed / chair 2. Overnight patient/carer has agreed to repositioning ____ hourly 3. Specify any manual handling equipment used	1. Skin Care to be carried out ____ hourly 2. Specify products required for increased moisture/ continence management:	1. Optimise nutrition and hydration 2. Refer to MUST	1. Discuss and agree plan with patient/ family/carer YES / NO 2. Prevent Pressure Ulcers" leaflet given to patient/family/ carer YES / NO

Patient name

Patient CHI

2208793218
BURGESS
Henry
0/1
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6EP
M
22/08/1979

NHS
Greater Glasgow and Clyde

Nursing notes cont.

Date and Time	Name/Signature

2208793218 M
BURGESS 22/08/1979
Henry
0/1
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6EP

Da.....

...se sticker

NHS
Greater Glasgow and Clyde

Ongoing Care

	4 Hours	5 Hours	6 Hours	7 Hours	8 Hours	9 Hours	10 Hours	11 Hours	12 Hours
Time									
Nursing notes updated including (NEWS, MEWS,PEWS)									
FFN (provide details)									
IVI/IVABs									
Routine Medications prescribed and administered									
Falls risk assessment									
Skin assessed and supported (PURDRA)									
Analgesia assessment									
Nurse call system in place									
SBAR commenced									
Patient/ relatives updated									
Elimination needs met (does the patient know where toilet is)									
If patient not in cubicle space think about patients dignity requirements eg hearing aids, mobility aids, glasses, interpreter									
STOPPS completed									

Pa
2208793218
BURGESS M
Pat Henry 22/08/1979
0/1
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6E

NHS
Greater Glasgow and Clyde

Nursing notes

Date and Time		Name/Signature
16:15	Ward room. Unwell e-cl r/v	W/ Nicola Hutcheon
16:35	Patient became irate, verbally abusive to staff members, accusing staff of being discriminative, rude & ostracising towards him due to him being an ex I.V.D.U, this knowledge was unbeknownst to nursing staff. Patient has called nursing staff pathetic due to this and continues to be disruptive ~~des~~ despite multiple warnings. Given complaints information as per patient request.	W/ Nicola Hutcheon W/ Nicola Hutcheon

NEWS 2 Key | 1 | 2 | 3

| | | |

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Affix Patient ID

2206783216 22/08/1979
BURGESS
Henry

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1
Target >96%
Signature:
Print Name:
Dr/ANP initials ONLY:
Date:

Sp02 Scale 2
Target 88-92%
Signature:
Print Name:
Dr/ANP initials ONLY:
Date:

Patient on home oxygen Y☐ N☐
If yes, add details of oxygen therapy

Document all actions and interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
Min 12 Hourly Observations	Low Clinical Risk Min 4 Hourly Observation Inform Registered Nurse Agree Frequency of Observation Required	Medium Clinical Risk Min Hourly Observations Urgent Assessment by Medical Team ACE Response in Medical Notes Think Sepsis if Suspicion of Infection	High Clinical Risk Continuous Monitoring Urgent Assessment by Senior Medical Team ACE Response in Medical Notes Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

Discontinuation of NEWS

Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed.....

Medical: .....

Date: .....

Glasgow Coma Scale

| | | |

Resus

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

CHI: 2208793218

Royal Alexandra Hospital

Total Att: 30

12 Mth Att: 3

Title: MR

BURGESS

Henry

DOB 22/08/1979 Age: 45y Sex: Male

0/1
128 NEILSTON ROAD
Paisley
Renfrewshire
PA2 6EP
07362299385

Next of kin:
Relationship:

GP: GC Perrett
0141 889 5277

Attendance Date: 06/03/2025 Arrival Time: 16:26

Registration Time: 16:26 Date of Incident: 06/03/2025

Major Incident Desc:

Reason for Attendance: BIBA - collapse

Nursing Assessment

Alerts: Yes

Triage Category: 1

Allergies: Not Recorded Pain Score:

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 06/03/2025 16:49

Temp		C
HR		bpm
BP	/	mmHg
MAP		mmHg
RR		bpm
SpO2		%
Oxygen		%

Nurse name: Nurse Lorraine Rhodes

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils-Right		Pupils-Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: "reduced GCS - found stumbling about banging into things. GCS 11 with crew. drowsy, denies drug use admits alcohol. GCS 12 in triage "

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

X-Ray and Other Reports to be filed on this side (if the patient is not being admitted)

DO NOT WRITE HERE PLEASE

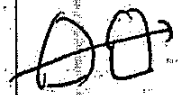
ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

Date	CLINICAL NOTES
6/3/2018	Seen by (Dr) Lailan Peel (Sen CDF) Time seen 1715

2208793218 22/08/1979
BURGESS
Henry

45♂ BIBA ↓ GCS
- found staggering on the streets
- No injury from pt
- Admits to a drink
- had insulin earlier? this morning

OE smells strongly of alcohol



14.11+0 regular

PEARL
alert & voice
GCS E3 V4 M6 = 13
No evidence of any head injury or body injury
Imp - ↓ GCS likely 2° to alcohol

CNS
bowel sounds
saturations ↑ improved on O_2
mild hypertonia
otherwise (N)

ECG
NSR.

MM
T1DM
ex IVDU
alcohol excess

BG - 25.1
peak 0.2

PLAN - monitor with recheck BM / ketones
- reassess mobility - aim home
- any concerns may need admission
- Aim SpO_2 ≥ 94%.

Lailan Peel
FM CDF

Date	CLINICAL NOTES
6/3/25	Pt recovered to GCS 15 & self discharged N/S ensured had app to monitor BMs on phone prior to discharge. Lailan Reed Enrol

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant if admitted):

Follow up	Arranged		Not arranged		To be arranged			
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Patient name ...

Patient CHI ...

2208793218
BURGESS M.
Henry 22/08/1979
0/1
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6E

NHS
Greater Glasgow and Clyde

Emergency Care Nursing Documentation

Initial Investigations

Patient prepared for exam - clothing bagged				Y	N
NEWS Chart	Y	N	X-rays	Y	N
ID band	Y	N	Pain Score	Y	N
Peak Flow	Y	N	Please specify		
12-lead ECG	Y	N	Urinalysis	Y	N
IV access	Y	N			
Blood samples	Y	N	Positive findings		
Blood Gas	Y	N	B-HCG	Y	N

Signature: AMc

Communication

GGC Red Bag with Patient (nursing home resident)	Y	N
Language or hearing difficulty	Y	N
Interpreter required	Y	N
what arrangements have been made?		
Relatives / Carer / Next of Kin present	Y	N
name,relationship, location, particular concerns		

Signature: AMc

Risk Assessments and Screening Tools

	SEPSIS	Y	N	GMAWS	Y	N
	FAST	Y	N	Adult Support and Protection	Y	N
Time:	Swallow Testing	Y	N	Mental Health Triage Assessment	Y	N
	Falls Risk (clinical judgement)	Y	N	Child Protection Concerns	Y	N
	4AT Assessment	Y	N	Frailty Assessment	Y	N
				Public Protection (NOC)	Y	N

Signature: AMc

Pause for Discharge or Transfer

GGC Red Bag with Patient (nursing home resident)	Y	N
Relatives / Carer with Patient	Y	N
Name Band	Y	N
Risk Assessment/Screening Tools	Y	N
Bed Available	Y	N
SBAR complete	Y	N
NEWS Chart NEWS completed within 1 hour of transfer/discharge	Y	N
Prescriptions and fluid charts signed	Y	N
Cannula	Y	N
Notes Complete	Y	N
Analgesia	Y	N
Belongings	Y	N
Transport	Y	N

Signature:

Patient na

Patient CHBURGESS

2208793218 M
Henry 22/08/1979
0/1
128 NEILSTON ROAD
Paisley, Renfrewshire PA2 6E

NHS
Greater Glasgow and Clyde

Care Rounds Checklist

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need, should be every (please circle) 1hr 2hr 3hr 4hr

Signed _____ Name JDUNCAN Designation CN

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Use the following Codes:
Y = Yes N = No NA = Not Applicable NT = No Thanks S = Sleeping O = Off the ward I - Independent

			Times	12:00									
	1	**THINK DELIRIUM** Is the patient more confused/drowsy than normal? If yes inform registered nurse.		Y									
	2	**PAIN: ASSESS AND ADDRESS** Is the patient distressed or in pain? If yes inform registered nurse.		N									
S	3	**SKIN INSPECTION** Pressure areas checked?		N									
		R = RED D = Discloured PU - Pressure Ulcer INT = Intact M = Moisture		-									
K	4	**KEEP MOVING** Has the patient moved or walked?		Y									
		Bed R =Right side (30°) tilt L =Left side (30°) tilt B =Back Chair W/ST = Assist to walk / stand		BT									
I	5	**ELIMINATION** Does the patient need the toilet?		N									
		I = Independent A - Assistance given IC = Incontinent (urine/ faeces)		-									
N	6	**FOOD FLUIDS AND NUTRITION** Is the patient nil by mouth?		N									
		Drink taken?		N									
		Food, snack, or supplements taken?		N									
		Has oral hygiene been carried out as per care plan?		N									
	7	**ENVIRONMENT CHECK** Is the patient's call buzzer to hand?		N									
		Is the area clutter free clean and safe?		Y									
		Does the patient have everything they require in safe reach?											
		Is the bed in the lowest position?											
	8	**INFORMATION** Is there anything else I can help you with? Inform the patient of the time of return		Y									
	9	**ESCALATION** Is there anything else I can help you with? Inform the patient of the time of return		NA									
			Care provider	JD									
			Role	CN									

Ask the patient if there is anything they specifically want done today:

Patient name .....

Patient CHI

2208793218 M
BURGESS 22/08/1979
Henry
0/1
128 NEILSTON ROAD
Paisley, Renfrewshire PA2 6EP

Hospital:

ard:

Points to consider:

- **Use within 8 hrs of admission to care area**
- **Re-assess daily and more frequently if a person's condition changes**

NHS
Greater Glasgow and Clyde

PUDRA

1	**Pressure Damage**	Does the person have redness and/or existing pressure damage? **IF YES, prescribe a minimum of 2 HOURLY Pressure relieving care** to avoid further damage occurring and complete the pressure ulcer interventional plan.

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2	**Mobility**	Does the person require assistance to mobilise or change position (inappropriate for age)?
3	**Continence**	Does the person have continence issues with urine and/or faeces (inappropriate for age)?
4	**Nutrition**	Does the person appear malnourished and/or unable to eat or drink/ PYMS score>2?
5	**Skin**	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6	**Judgement**	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY Pressure Relieving Care interventions and complete the pressure ulcer interventional plan.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
/ /	:							_____hrly	
/ /	:							_____hrly	
/ /	:							_____hrly	

Complete prevention of pressure ulcer interventional plan below for all patients with redness/pressure damage and for those at risk.

S **Skin Inspection**	**S** **Surface**	**K** **Keep Moving**	**I** **Incontinence/ Moisture**	**N** **Nutrition**	**S** **Self Management/ Shared Care**
Check: • Pressure areas _____ hourly • Skin under medical devices _____ hourly • Specify medical devices used	Specify: 1. Mattress 2. Cushion 3. Detail additional pressure redistributing equipment	1. Reposition _____ hourly in bed / chair 2. Overnight patient/carer has agreed to repositioning _____ hourly 3. Specify any manual handling equipment used	1. Skin Care to be carried out _____ hourly 2. Specify products required for increased moisture/ continence management:	1. Optimise nutrition and hydration 2. Refer to MUST	1. Discuss and agree plan with patient/ family/carer **YES / NO** 2. Prevent Pressure Ulcers" leaflet given to patient/family/ carer **YES / NO**

Patient nam

2208793218 ..... M
BURGESS 22/08/1979
Henry
0/1 ...
128 NEILSTON ROAD ...
Paisley, Renfrewshire PA2 6EP

Patient CHI

NHS
Greater Glasgow and Clyde

Nursing notes cont.

Date and Time		Name/Signature

Patient na

Patient Cl

2208793218
BURGESS
Henry M
0/1 22/08/1979
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6E

NHS
Greater Glasgow and Clyde

Ongoing Care

	4 Hours	5 Hours	6 Hours	7 Hours	8 Hours	9 Hours	10 Hours	11 Hours	12 Hours
Time									
Nursing notes updated including (NEWS, MEWS,PEWS)									
FFN (provide details)									
IVI/IVABs									
Routine Medications prescribed and administered									
Falls risk assessment									
Skin assessed and supported (PURDRA)									
Analgesia assessment									
Nurse call system in place									
SBAR commenced									
Patient/ relatives updated									
Elimination needs met (does the patient know where toilet is)									
If patient not in cubicle space think about patients dignity requirements eg hearing aids, mobility aids, glasses, interpreter									
STOPPS completed									

Patient na

Patient C

2208793218
BURGESS
Henry M
0/1 22/08/1979
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6EP

NHS
Greater Glasgow and Clyde

Nursing notes

Date and Time		Name/Signature
6/3/25	Brought to ress by triage nurse.	
17.25	GCS reduced. Found in street banging into things. A - airway patent B - rr 10 sats C - bp 97/83 p 70 D - GCS 12 - bm 25 1 ketons 0.2 E - no obvious injuries. ED doctor assessing patent	J Duncan (RN)
17:30	ECG obtained	
1945	Care taken over by nightshift. Continues to remain drowsy. Alert oriented to voice. ~~Alert~~ to place & time.	

Patient Information

HENRY BURGESS

Age/Gender:	45 years 7 months 2 days Old
Address:	FLAT 0/1, 128 NEILSTON ROAD, PAISLEY,PA2 6EP
DOB:	22/08/1979
CHI:	2208793218
Ethnicity:	

Date:	06/03/2025
Incident Number:	CR011860175
Incident Type:	EMG
Incident Location:	JCT WITH GREGGS ON 67 NEILSTON ROAD PAISLEY, PA2 6NA

2208793218 22/08/1979
BURGESS
Henry

Presenting Complaint

EMERG

Additional Comments

Amb service recieved a call of a male struck by a car. crew not able to find male / scene of rtc. crew spoke to local shops, none aware of rtc but say they has been a male standing in street, " banging" off walls. crew found a male in general area of reported locus, staggering. male walked into ambo with the assistance of crew steadying him. obs obtained, pt able to tell amb crew his name / dob, but took multiple attempts as pt's speech incomprehensible at times. no obvious smell of alcohol from pt although pt's pupils constricted and slightly decreased loc. crew decided against narcan as pt was "managable" at this time. ecs accessed. pt is on novorapid, methadone and other meds

PATIENT ASSESSMENT

ACVPU	Alert	<C>	No
A	Clear		
B	Breathing Adequately: Yes	Respiratory Rate: 18	SPO2: 94
	Oxygen Given: Yes		

C	Pulse Rate	BP	Cap Refill	ECG Rhythm
	80	121/82	<=2 Secs	
	Rhythm	**Arm**	**Central/Peripheral**	**ECG**
	Reg	Right	Peripheral	

D	GCS	Eyes	Voice	Motor	PEARL
	13	To Speech (3)	Confused (4)	Obeys Commands (6)	

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
16:20	72	20	107/66	99	<=2s	11	Voice								E002824X
16:10	80	18	121/82	94	<=2 Secs	13	Alert		35.6	24.5		1	1		E002824X

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
16:10	18 (0)	94 (1)		2	121 (0)	80 (0)	Alert (0)	35.6 (1)	4

CLOSE RECORD

Treatment On Scene: Non-Emergency

Conveyance

Transport To Hospital	Normal driving	Pre-Alert	No

INCIDENT LOG

Time Call Received	15:45	Allocated	15:46	Mobile	15:46
First Resource On Scene		Crew On Scene	15:51	Crew Left Scene	16:17
Crew At Hosp	16:21	Receiving Hospital	ROYAL ALEXANDRA - PAISLEY	Clear Time	

Crew ID	Crew Grade	Driver
E9864906	Ambulance Technician	YES
E002824X	Paramedic	NO

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Affix Patient ID

220872514 BURGESS Henry 22081979

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP Initials ONLY:	Dr/ANP Initials ONLY:	
Date:	Date:	

Document all actions and interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
	Low Clinical Risk	Medium Clinical Risk	High Clinical Risk
Min 12 Hourly Observations	Min 4 Hourly Observation	Min Hourly Observations	Continuous Monitoring
	Inform Registered Nurse	Urgent Assessment by Medical Team	Urgent Assessment by Senior Medical Team
	Agree Frequency of Observation Required	ACE Response in Medical Notes	ACE Response in Medical Notes
		Think Sepsis if Suspicion of Infection	Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

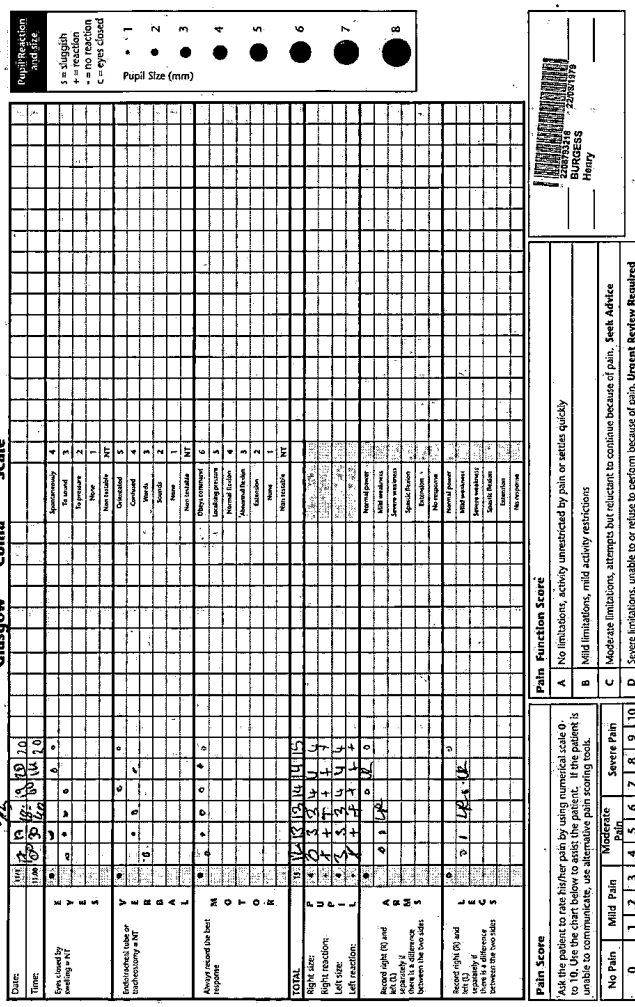
Discontinuation of NEWS

Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed.....

Medical: .....

Date: .....



mi - 316654 v5.1 - GCCD264

NEWS 2 Key | 1 | 2 | 3

| | | |

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

CHI: 2208793218

Royal Alexandra Hospital

Total Att: 33

12 Mth Att: 6

Title: MR

BURGESS **Henry**

DOB: 22/08/1979 Age: 46y Sex: Male

0/1
128 NEILSTON ROAD
Paisley
Renfrewshire
PA2 6EP
07956111083

Next of kin: THOMSON, Lorna
Relationship: Sister
07914528461

GP: GC Perrett
0141 889 5277

Attendance Date: 02/10/2025 Arrival Time: 19:27

Registration Time: 19:27 Date of Incident: 02/10/2025

Major Incident Desc:

Reason for Attendance: GP REF - AEC ?DVT

Affix Label

Nursing Assessment

Alerts: Yes Allergies: Not Recorded Pain Score:

Triage Category: 3 Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 02/10/2025 20:08 Nurse name: Nurse Catriona Livingston

Temp		C
HR		bpm
BP	/	mmHg
MAP		mmHg
RR		bpm
SpO2		%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils-Right		Pupils-Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: 2R leg DVT. PMH IDDM

Nurse:

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

X-Ray and Other Reports to be filed on this side (if the patient is not being admitted)

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

Date	CLINICAL NOTES	
	Seen by (Dr)	Time seen

2208793218
BURGESS
Henry
0/1
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6EP

M
22/08/1979

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)		Discharge time	
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.		

Ward number (if admitted):	Transfer to hospital:	Consultant if admitted):

Follow up	Arranged		Not arranged				To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Patient name .

Patient CHI .

2208793218 22/08/1979
BURGESS
Henry

or use sticker

NHS
Greater Glasgow and Clyde

Emergency Care Nursing Documentation

Initial Investigations

Initial when complete	Required?		Init		Required?		Init
Patient prepared for exam	Y	N		Pain score	Y	N	
NEWS/MEWS/ PEWS chart	Y	N		Peak flow	Y	N	
ID Band	Y	N		MSSU Results:			
12-Lead ECG	Y	N					
Blood samples	Y	N					
Blood Gas	Y	N					
Viral Swab	Y	N		B-HCG	+ve	-ve	

Communication

	Required?	
GGC Red Bag with Patient (nursing home resident)	Y	N
Language or hearing difficulty	Y	N
Interpreter required	Y	N
what arrangements have been made?		
Relatives / Carer / Next of Kin present	Y	N

name,relationship, location, particular concerns

Signature:

PVC

Circle reason: **D R I F T**

Diagnostic
Resuscitation
Intravenous Fluids
Transfusion

Insertion
Date:
Time:

Insertion Side: L R

Insertion Site:

Size of PVC:

Inserted by
Signature

Hand Hygiene Yes ☐

Skin Decontamination 2% chlorhexidine in 70% isopropyl alcohol Yes ☐

Sterile transparent semi-permeable dressing affixed Yes ☐

PVC Reason Explained Yes ☐

Risk Assessments and Screening Tools

	Required?		Init
SEPSIS	Y	N	
FAST +VE Y N STOPPS	Y	N	
ED Falls Risk Assessment	Y	N	
Mental Health Triage Assessment	Y	N	
Ligature low room	Y	N	

	Required?		Init
GMAWS	Y	N	
Public Protection Concern (Adult/Child)	Y	N	
Notification of Concern Completed (NOC)	Y	N	
Frailty Assessment Completed	Y	N	
4AT Assessment	Y	N	

Pause for Discharge

GGC Red Bag with Patient (nursing home resident)	Y	N
Relatives / Carer with Patient	Y	N
Name Band Removed	Y	N
Risk Assessment/Screening Tools Completed	Y	N
Discharge Information	Y	N
NEWS Chart completed within 1 hour of discharge	Y	N
Medications/Fluids prescribed as per medication prescription form	Y	N
Notes Complete	Y	N
Belongings	Y	N
Transport arranged	Y	N
Own/Taxi/Relative/SAS (Please circle)	Y	N
PVC Removed Prior to Discharge	Y	N

Signature:

Pause for Transfer

GGC Red Bag with Patient (nursing home resident)	Y	N
Relatives / Carer with Patient	Y	N
Name Band in situ	Y	N
Risk Assessment/Screening Tools Complete	Y	N
Bed Available	Y	N
SBAR complete	Y	N
NEWS Chart completed within 1 hour of transfer	Y	N
Medications/Fluids prescribed as per medication prescription form	Y	N
PVC/CVC Bundle	Y	N
Notes Complete	Y	N
Belongings	Y	N
Escort Required	Y	N

Signature:

Patient name .....

Patient CHI .....

or use sticker

NHS
Greater Glasgow and Clyde

Care Rounds Checklist

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need, should be every (please circle) 1hr 2hr 3hr 4hr

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Use the following Codes:
Y = Yes N = No NA = Not Applicable NT = No Thanks S = Sleeping O = Off the ward I - Independent

			Times										
	1	**THINK DELIRIUM** Is the patient more confused/drowsy than normal? If yes inform registered nurse.											
	2	**PAIN: ASSESS AND ADDRESS** Is the patient distressed or in pain?If yes inform registered nurse/ Review analgesia											
S	3	**SKIN INSPECTION** Pressure areas checked? R = RED D = Discloured PU - Pressure Ulcer INT = Intact M = Moisture											
K	4	**KEEP MOVING** Has the patient moved or walked?											
		Bed R =Right side (30°) tilt L =Left side (30°) tilt B =Back Chair W/ST = Assist to walk / stand											
		ELIMINATION Does the patient need the toilet?											
I	5	I = Independent A - Assistance given IC = Incontinent (urine/ faeces)											
N	6	**FOOD FLUIDS AND NUTRITION** Is the patient nil by mouth?											
		Drink taken?											
		Food, snack, or supplements taken?											
		Has oral hygiene been carried out as per care plan?											
	7	**ENVIRONMENT CHECK** Is the patient's call buzzer to hand? Is the area clutter free clean and safe? Does the patient have everything they require in safe reach? Is the bed in the lowest position?											
	8	**INFORMATION** Is there anything else I can help you with? Inform the patient of the time of return											
	9	**ESCALATION** Is there anything else I can help you with? Inform the patient of the time of return											
		Care provider											
		Role											

Ask the patient if there is anything they specifically want done today:

Patient

2208793218
BURGESS
Henry
0/1
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6EP
M
22/08/1979

Patient

Hospital:	Points to consider:
Ward:	• Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

NHS
Greater Glasgow and Clyde

Attach addressograph	Hospital: Ward:	Points to consider: • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

Pressure damage	No RISK	At RISK	Grade 1 – non blanching skin Grade 2,3,4, suspected deep tissue injury (SDTI), ungradable pressure ulcer, Moisture Associate Skin Damage (MASD)	Device Related Pressure Damage i.e. nasogastric, catheters, oxygen tubing
I MUST CK SKIN at pressure points	Daily skin check	4 hourly positioning Complete SSKINS care plan (below)	2 hourly positioning with skin checks, Complete SSKINS care plan (below)	All devices need a SSKINS care plan (below)

1	PressureDamage	Does the person have Pressure damage; Grade 1, 2, 3, 4, SDTI, Ungradable?
2	Mobility	Does the person require assistance to mobilise or change position?
3	Continence	Does the person have moisture issues, or, continence issues with urine and/or faeces?
4	Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5	Skin	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6	Judgement	In your clinical judgement, is this person at risk of developing pressure damage?

Date	Location of pressure damage	Grade of ulcer	Date	Location of pressure damage	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

If NO to all questions, continue Care Rounds Prescribed as assessed for individual need and re-assess daily.
If you have answered YES to any of the questions above, please complete the SSKINS care plan below.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Check Skin	Signature
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used: Catheter ☐ Naso gastric ☐ Oxygen mask ☐ Nasal oxygen ☐ Vascular Access Device ☐ Off loading boot ☐ Other:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment: Off loading boot: ☐ Protective product:	• Reposition ____ hourly in bed. • Reposition ____ hourly in chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used: Tilting device ☐ • Knee bend in place ☐ Record reason for no knee bend:	• Does patient have Moisture Associated Skin Damage Yes ☐ • Skin care to be carried out ____ hourly. • Specify products required for increased moisture / continence management: Barrier Cream ☐ Pad / Pants ☐	• Optimise nutrition and hydration. • Refer to MUST	• Provide information in a format appropriate to patient / family/ carer needs : • Specify: Leaflet ☐ Verbal ☐ Not provided record reason:	Date discontinued:

Patient name .....

Patient CHI .....

or use sticker

NHS
Greater Glasgow and Clyde

Nursing notes cont.

Date and Time		Name/Signature

Patient n

Patient C

2208793218
BURGESS M
Henry 22/08/1979
0/1
128 NEILSTON ROAD
Paisley, Renfrewshire
PA2 6EP

NHS
Greater Glasgow and Clyde

Use the following Codes: **Y** = Yes **N** = No **NA** = Not Applicable **NT** = No Thanks **S** = Sleeping **O** = Off the ward **I** - Independent

Ongoing Care

	4 Hours	5 Hours	6 Hours	7 Hours	8 Hours	9 Hours	10 Hours	11 Hours	12 Hours
Time									
Nursing notes updated including (NEWS, MEWS,PEWS)									
Food, Fluid, Nutrition (provide details)									
IVI/IVABs									
Routine Medications prescribed and administered									
Falls risk assessment reviewed/checklist									
Skin assessed and supported (PURDRA)									
Pain assessment									
SBAR up to date and completed									
Patient/ relatives updated									
If patient not in cubicle space think about patients dignity requirements eg hearing aids, mobility aids, glasses, interpreter									
STOPPS completed									
PVC/CVC Bundle. Consider is; Dressing intact? PVC patent?									Commence CVC/PVC chart

Patient name .....

Patient CHI .....

or use sticker

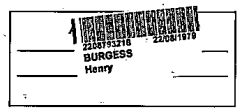
NHS
Greater Glasgow and Clyde

Nursing notes

Date and Time		Name/Signature
2/10/12	patient left the department prior to assessment	M. Bacarro, CN

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde



	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP initials ONLY:	Dr/ANP initials ONLY:	
Date:	Date:	

Document all actions and interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
	Low Clinical Risk	Medium Clinical Risk	High Clinical Risk
Min 12 Hourly Observations	Min 4 Hourly Observation	Min 1 Hourly Observations	Continuous Monitoring
	Inform Registered Nurse	Urgent Assessment by Medical Team	Urgent Assessment by Senior Medical Team
	Agree Frequency of Observation Required	ACE Response in Medical Notes	ACE Response in Medical Notes
		Think Sepsis if Suspicion of Infection	Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

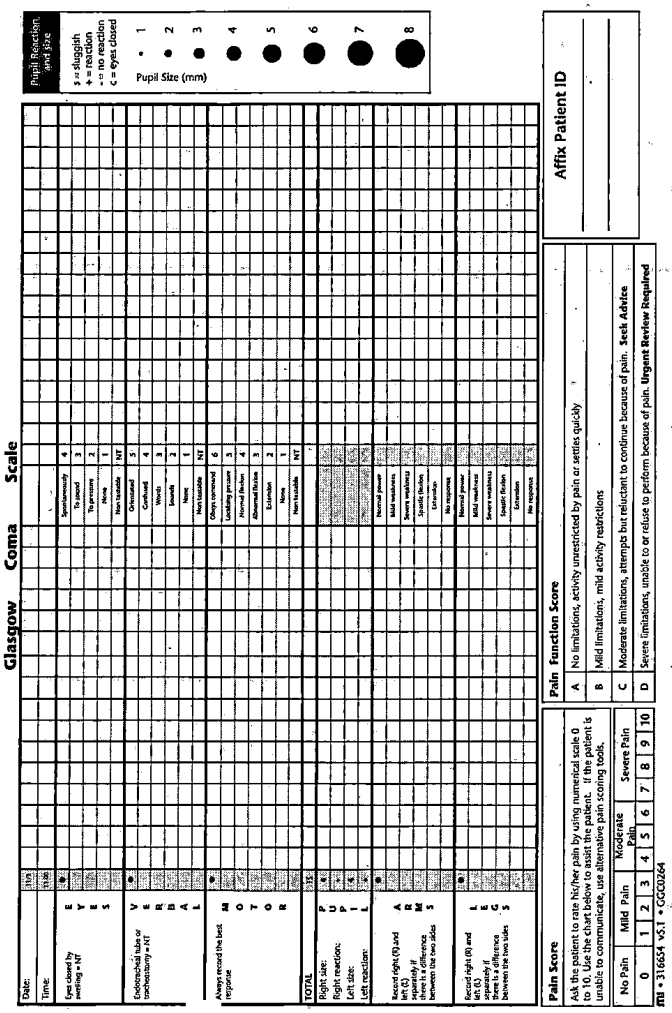
Discontinuation of NEWS

Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed.....

Medical: .....

Date: .....



NEWS 2 Key | 1 | 2 | 3

| | | |

CHI	2208793218
Patient Name	Henry Burgess
Age (Admission)	41 years

SIGNIFICANT INVESTIGATION RESULTS

Significant Investigation Results	

MICROBIOLOGY INFORMATION

Microbiology Results, Advice & Action	25/11/2020 - rationalise antibiotics to high dose Tazocin (4 times/day), high dose clindamycin (1.2g 4 times/day), continue Gentamicin and fluconazole for at least 48hrs post theatre. Stop Amoxicillin and Metronidazole Ensure BBV screen done and AFB from ETA - M Brett 26.11.2020 - Strep milleri on microscopy from spleen. Sputum/blood culture - taxi over for AFB. Level 4 GRI. 27/11 - Mixed orgainisms from intrabdominal swabs. Penis swab has been taken. One more gentamicin dose and then reivew with culture results. Suggest TOE may be helpful when more well. Advice Resp opinion re Tb. AFB x1 is -ve. Ceftrioxone might provide better cover if deteriotes. 28.11 - Change to Tazocin to Ceftriaxone 2g bd. Keep clindamycin. Keep fluconazole. Add vancomycin. Stop gentamicin. Send respiratory samples to micro. Serum galactomannan. Further discussion - for meropenem instead of ceftriaxone. LG 29/11- Continue current ABx therapy. Raised the concern of Lemierre's syndrome - I think unlikelyu - no mention of IJV involvement on CT, but I will have a look with USS today (left side was clear with siting of CVC yesterday. If TB remains a concern, bronchoscopy and sampling should be considered. However, in the context of improving inflam response and main issue holding him back being weakness/secretion clearance - I would not rush to perform bronchoscopy at moment. C McGovern 30/11 await results of TOE prior to rationalising abx. Only just escalated to meropenem so review tomorrow 01/12 Discontinue vancomycin and fluconazole. meropenem reduced to 1g TDS as IE felt unlikely in the presence of no vegetations on TTE. Likely needs 2 weeks total of antibiotic therapy. Recent E.Coli in ETT

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NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

Hospital (circle)	IRH	RAH	RHSC	GRI	WIG	VI	VIMIU	Stob	VOL	SGH

CHI: 2208793218

Royal Alexandra Hospital

Total Att: 17

12 Mth Att: 0

Title: MR

BURGESS **Henry**

DOB 22/08/1979 Age: 41y Sex: Male

96A ALICE STREET

Paisley
Renfrewshire
PA2 6EA
07477774484

Next of kin: Fiona (partner)
Relationship: 07435910104

GP: JR Calvo Rodriguez
0141 889 4088

Attendance Date: 24/11/2020 Arrival Time: 16:13

Registration Time: 16:13 Date of Incident: 24/11/2020

Major Incident Desc:

Reason for Attendance: ?dka - biba (no NOK details)

Nursing Assessment

Alerts: Yes Allergies: None Known Pain Score:

Triage Category: 1 Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 24/11/2020 16:13 Nurse name: Nurse Joanne Rae

Temp		C
HR		bpm
BP	/	mmHg
MAP		mmHg
RR		bpm
SpO2		%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils-Right		Pupils-Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: dka

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

X-Ray and Other Reports to be filed on this side (if the patient is not being admitted)

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By
24/11/20	CO-AMOXICLAV	1.2g	IV	19:20	[illegible]	[illegible]
24/11/20	METRONIDAZOLE	500mg	IV	1815	[illegible]	KS/[illegible]
24/11/20	GENTAMICIN		IV		[illegible]	
24/11/20	OMEPRAZOLE	40mg	IV	19:25	[illegible]	[illegible]

Date	24/11/20	CLINICAL NOTES
	Seen by (Dr) V. PRINCE	Time seen 16[10]

41 O→ PC – unwell adult, BIBA to resus

HPC – 3/7 hx of worsening weakness, on background of general decline over past 4/52
- partner reports 3 stone of weight loss in past 1/12, ↓ appetite + oral intake.
- no hx from patient
- not reporting any abdo pain / N or V / Chest pain
- SOB on arrival (Sats 80% with SATS)
- taken insulin today

PMHx – T1DM
- Previous IVDU / on methadone.

DHx – Pregabalin, Omeprazole, Novorapid/Novomix, Mirtazepine
Allergy – opiates

SHx – Lives with partner, normally independent

O/E
- looks grey, ↑ WOB, unable to speak in sentences.

NEWS = 14
- RR = 55
- Sats = 95% on 15 litres
- HR = 139
- BP = 99/50
- Afebrile

Date	CLINICAL NOTES

Confused GCS = 12/15 E_3 M_6 V_3
moving all limbs independently

Ⓡ sided creps HS I + II RO
Pulse regular

generally tender guarding in epigastrium

Lactate = 15 on ABG.

CXR - Ⓡ upper zone consolidation
pneumoperitoneum
(d/w Hub @ GRI who confirmed above findings)

Femoral + arterial lines inserted by Dr McMahon
Urinary catheter placed

Bloods: WCC = 13.7, CRP = 383
eGFR > 60, deranged LFTs

D/w ITU + surgical registrars who will kindly attend department

for - CT TAP (d/w Hub).
- IV co-amox, mer + Gentamicin 1gm.
- fluids + inotropes commenced

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged		Not arranged		To be arranged			
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Patient Information		Date:	24/11/2020
HENRY BURGESS		Incident Number:	CR00697948
Age/Gender:	41 years 3 months 2 days Old Male	Incident Type:	EMG
Address:	96 (96A) ALICE STREET PAISLEY,PA2 6EA	Incident Location:	96 (96A) ALICE STREET PAISLEY, PA2 6EA
DOB:	22/08/1979		
CHI:	2208793218		
Ethnicity:			

Scottish Ambulance Service

Presenting Complaint

? DKA ? COVID UNWELL

Additional Comments

999 call for 41yom, has declined in health over recent weeks, partner advised has lost 3 stone in 4 weeks, over last 3 days has become weak with partner having to dress him, pt is type 1 diabetic has had insulin but not eating, o/e pt very grey in colour, low sats, presents unwell, time critical therefore no ecg or iv access gained, 2 minute eta to rah therefore pt taken as prealert, prf completed by danielle gray pa47005

PATIENT ASSESSMENT

ACVPU	Alert		<C>	No
A	Clear			
B	Breathing Adequately: No	Respiratory Rate: 48	SPO2: 80	Oxygen Given: Yes
C	Pulse Rate: 131	BP: 97/66	Cap Refill: >2 Secs	ECG Rhythm: Rhythm: Reg
	Arm: Right	Central/Peripheral: Central	ECG	
D	GCS: 15	Eyes: Spontaneously (4)	Voice: Orientated (5)	Motor: Obeys Commands (6)
	PEARL			

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
15:55	131	48	97/66	80	>2 Secs	15	Alert		37.5	HI					E9886790

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
15:55	48 (3)	80 (3)		2	97 (2)	131 (3)	Alert (0)	37.5 (0)	13

HISTORY

AMPLE

Allergies	OPIATES
Past Medical History	Diabetes (Type 1)
Last Eaten	>4 Hours Ago

CLOSE RECORD

Treatment On Scene	Resuscitation

Conveyance

Transport To Hospital	Emergency driving	Pre Alert	Yes

INCIDENT LOG

Time Call Received	14:43	Allocated	15:48	Mobile	15:48
First Resource On Scene		Crew On Scene	15:51	Crew Left Scene	16:02

Crew At Hosp	16:05	Receiving Hospital	ROYAL ALEXANDRA PAISLEY	Clear Time

Crew ID	Crew Grade	Driver
E9888217	Ambulance Technician	YES
E9886790	Ambulance Technician	NO

Printed: 24/11/2020 21:04:45

Patient Sample Report

Status: **ACCEPTED**
Analyzed: 24/11/2020 21:04:31
Sample Type: **Arterial**
Operator ID: ARLEEN MITCHELL0

Patient

ID:	2208793218
Last Name:	**BURGESS**
First Name:	**HENRY**
Gender/Age:	Male, 41 years
Birth Date:	22/08/1979

Cartridge

Lot No.:	200914H
S/N:	000000000500100674
Exp. Date:	13/12/2020

Analyzer

Model:	GEM® *Premier 5000*
Area:	RAHTHEATRE
Name:	THEATRE
S/N:	17030634

Results

				Crit. Low	Reference Low	Reference High	Crit. High
Corrected (36.2°C)							
cH(T)	↓ **58.8**	nmol/L	[	--	36.0	44.0	--]
pCO_2(T)	↑ **7.2**	kPa	[	--	4.6	6.0	--]
pO_2(T)	↓ **10.4**	kPa	[	--	10.5	14.0	--]
Measured (37.0°C)							
cH	↑ **60.8**	nmol/L	[	--	36.0	44.0	--]
pCO_2	↑ **7.4**	kPa	[	--	4.6	6.0	--]
pO_2	**10.9**	kPa	[	--	10.5	14.0	--]
Na^+	↓ **126**	mmol/L	[	--	133	146	--]
K^+	**4.4**	mmol/L	[	--	3.5	5.3	--]
Cl^-	↓ **82**	mmol/L	[	--	95	108	--]
Ca^{++}	↓ **1.08**	mmol/L	[	--	1.15	1.27	--]
Glu	↑ **22.5**	mmol/L	[	--	3.5	6.0	--]
Lac	↑ **6.9**	mmol/L	[	--	0.6	2.2	--]
CO-Oximetry							
tHb	**110**	g/L	[	--	--	--	--]
O_2Hb	↓ **93.6**	%	[	--	95.0	98.0	--]
COHb	↑ **1.8**	%	[	--	0.5	1.5	--]
MetHb	**0.8**	%	[	--	0.5	1.5	--]
HHb	**3.8**	%	[	--	0.0	5.0	--]
sO_2	**96.1**	%	[	--	95.0	98.0	--]
Derived							
BE(B)	**-5.5**	mmol/L	[	--	--	--	--]
HCO_3^-(c)	**22.9**	mmol/L	[	--	--	--	--]

↑↓ Outside Reference Range

Other Information

Operator Entered		
Temp	36.2	°C
O2 and Vent Settings		
FIO_2	70.0	%

Printed: 24/11/2020 22:24:51

Patient Sample Report

Status: **ACCEPTED**
Analyzed: 24/11/2020 22:24:38
Sample Type: **Arterial**
Operator ID: KIRSTY WILSON8

Patient

ID:	2208793218
Last Name:	**BURGESS**
First Name:	**HENRY**
Gender/Age:	Male, 41 years
Birth Date:	22/08/1979

Cartridge

Lot No.:	200914H
S/N:	000000000500100674
Exp. Date:	13/12/2020

Analyzer

Model:	GEM® *Premier 5000*
Area:	RAHTHEATRE
Name:	THEATRE
S/N:	17030634

Results

				Crit. Low	Reference Low	Reference High	Crit. High
Corrected (36.4°C)							
cH(T)	↓ **60.5**	nmol/L	[	--	36.0	44.0	--]
pCO_2(T)	↑ **7.1**	kPa	[	--	4.6	6.0	--]
pO_2(T)	**12.6**	kPa	[	--	10.5	14.0	--]
Measured (37.0°C)							
cH	↑ **61.3**	nmol/L	[	--	36.0	44.0	--]
pCO_2	↑ **7.3**	kPa	[	--	4.6	6.0	--]
pO_2	**13.1**	kPa	[	--	10.5	14.0	--]
Na^+	↓ **125**	mmol/L	[	--	133	146	--]
K^+	**5.0**	mmol/L	[	--	3.5	5.3	--]
Cl^-	↓ **93**	mmol/L	[	--	95	108	--]
Ca^{++}	↓ **1.07**	mmol/L	[	--	1.15	1.27	--]
Glu	↑ **20.9**	mmol/L	[	--	3.5	6.0	--]
Lac	↑ **7.3**	mmol/L	[	--	0.6	2.2	--]
CO-Oximetry							
tHb	**113**	g/L	[	--	--	--	--]
O_2Hb	**95.2**	%	[	--	95.0	98.0	--]
COHb	↑ **2.6**	%	[	--	0.5	1.5	--]
MetHb	**1.0**	%	[	--	0.5	1.5	--]
HHb	**1.2**	%	[	--	0.0	5.0	--]
sO_2	↑ **98.8**	%	[	--	95.0	98.0	--]
Derived							
BE(B)	**-6.4**	mmol/L	[	--	--	--	--]
HCO_3^-(c)	**22.0**	mmol/L	[	--	--	--	--]

↑↓ Outside Reference Range

Other Information

Operator Entered		
Temp	36.4	°C
O2 and Vent Settings		
FIO_2	75.0	%

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☒
NURSING ☐

Please tick ✔ appropriate directorate

2208793218
BURGESS M
Henry 22/08/1979
96A ALICE STREET
Paisley, Renfrewshire
PA2 6EA

Date & Time		Signature, Print Name & Designation
	McMahon Cons EM under m rehospat	
	41 ♂ standby	
	limited hx	
	unwell 2-3/52	
	now weak/grey/in bed	
	last vomit today	
	background ex IVDU no track marks	
	not well known to ED	
	type 1 DM	
O/A	speaking	
	air hunger/resp distress pO_2 17 on trauma mask	
	cool periph. sinus tachy	
	confused GCS $E_3M_6V_{3-4}$ moving all 4 limbs	
	↑BM but ketones (N)	
	abdo tender guarded epigastrium signif. guarding lat/lat	
Rx	(R) femoral CVC	
	crystalloid + pressors	
	catheter - oliguria	
	(R) radial art line - pt moved + dislodged	
	CXR - RUZ consolidation	
	pneumoperitoneum	

Date & Time		Signature, Print Name & Designation
	Imp perf ? underlying malignancy NV2 pneumonia multi organ dysfunction	
	Plan triple therapy Abx further resus + investigations surgical + int care review	
	→ CT then likely theatre	
	MMalton	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

2208793218
BURGESS M
Henry 22/08/197
96A ALICE STREET
Paisley, Renfrewshire
PA2 6EA

Date & Time	MRSSLE (ST) Gerard Mackay	Signature, Print Name & Designation
24/4/15		on call.
1140	ABG as above pain, CXR free	
Resus	gas + lactate 15 ⇒ 9:2	
	minimal hx from patient	TIDM
(41)	- ~1/12 abdo pain	
	- has been taking ibuprofen for this, unsure how much.	
	- has a "stomach ulcer"	
	- apparently significant wt loss	
	- ICU team in attendence.	
	Obs A - patent, own.	
	B - sats 100% on 15 litres.	
	C - BP 82/39. HR. 124. on	relatively bounding
	guarded upper	tachycardic.
	abdomen, and generally tender	
	throughout.	
	- femoral line in situ, left radial	
	arterial line	
	D - drowsy ~20:	
	- responds to voice & answering	
	questions appropriately.	
	CXR: air under diaphragm	
	right upper zone consolidation.	
	Imp: perforated viscus	
	Pneumonia	

83949 GGC0072

2208793218
BURGESS
Henry M
96A ALICE STREET 22/08/197
Paisley, Renfrewshire
PA2 6EA

Date & Time		
	~~Hb 13.7 WCC~~	CRP 383
24/11/20	WCC 13.7	Neut 123
1800	Hb 135	eGFR >60
	Glucose 31	Albumin 15
		AST 385
		ALT 65
		Alk P 97
	Plan (1) CT abdo/pelvis	
	(2) INF	
	(3) IV insulin	
	(4) IV Abx to cover chest + abdo	
	(5) IV Omeprazole	
	(6) NBM	
	(7) Will review CT results	
		MASSIE ST4 5645O
24/11/20	Williamson - ANAES CONS	
1900	(RETROSPEC) ADMITTED APPROX 17:40	
	HISTORY NOTED PROBABLE PERFORATED ABDOMINAL	
	VISCUS. INITIALLY OBTUNDED + HYPOTENSIVE + V CAO	
	NOW HAD 3L FLUID L IS ON 10ml/h NORAD VIA	
	FEMORAL LINE. PERIPHERALLY WELL COOL + CC	
	HAS IMPROVED TO ~14/15 (CONFUSED)	
	FULL HANDOVER GIVEN TO CT SCAN.	
	CT AP & CONTRAST	
	D/W SURGEON REG - DEFINITE PERFORATED	
	VISCUS, POSSIBLY DUODENUM. NEED THEATRE.	
	WILL PROB. REQUIRE ITU BED OP.	
		Williamson

NHS GREATER GLASGOW & CLYDE

CLINIC

2208793218
BURGESS
Henry
ING

3218
.SS
M
22/08/1979
M ICE STREET
22/08/1979 , Renfrewshire
PA2 6EA

Date
Time

Name
on

Printed: 24/11/2020 17:30:10

Patient Sample Report
DUPLICATE

Status: ACCEPTED
Analyzed: 24/11/2020 16:18:21
Sample Type: Arterial
Operator ID: KATIE SUTER0

Patient

ID:	2208793218
Last Name:	BURGESS
First Name:	HENRY
Gender/Age:	Male, 41 years
Birth Date:	22/08/1979

Cartridge

Lot No.:	200826E
S/N:	00000000500096195
Exp. Date:	08/12/2020

Analyzer

Model:	GEM® *Premier 5000*
Area:	RAH RESUS
Name:	RESUS
S/N:	17030590

Results			Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)						
cH	↑ 49.1	nmol/L	--	36.0	44.0	--
pCO_2	↓ 3.6	kPa	--	4.6	6.0	--
pO_2	↑ 17.3	kPa	--	10.5	14.0	--
Na^+	↓ 120	mmol/L	--	133	146	--
K^+	4.5	mmol/L	--	3.5	5.3	--
Cl^-	↓ 82	mmol/L	--	95	108	--
Ca^{++}	↓ 1.04	mmol/L	--	1.15	1.27	--
Glu	↑ 33.2	mmol/L	--	3.5	6.0	--
Lac	↑ 15.5	mmol/L	--	0.6	2.2	--
CO-Oximetry						
tHb	140	g/L	--	--	--	--
O_2Hb	97.0	%	--	95.0	98.0	--
COHb	1.4	%	--	0.5	1.5	--
MetHb	0.8	%	--	0.5	1.5	--
HHb	0.7	%	--	0.0	5.0	--
sO_2	↑ 99.3	%	--	95.0	98.0	--
Derived						
BE(B)	-11.0	mmol/L	--	--	--	--
HCO_3^-(c)	13.6	mmol/L	--	--	--	--
Hct(c)	42	%	--	--	--	--

↑↓ Outside Reference Range

Other Information

Operator Entered

Temp	37.0	°C

on trauma mask

Printed: 24/11/2020 17:38:18

Patient Sample Report

Status: ACCEPTED
Analyzed: 24/11/2020 17:38:06
Sample Type: Arterial
Operator ID: ELISABETH ROWE0

Patient

ID:	2208793218
Last Name:	BURGESS
First Name:	HENRY
Gender/Age:	Male, 41 years
Birth Date:	22/08/1979

Cartridge

Lot No.:	200826E
S/N:	00000000500096195
Exp. Date:	08/12/2020

Analyzer

Model:	GEM® *Premier 5000*
Area:	RAH RESUS
Name:	RESUS
S/N:	17030590

Results			Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)						
cH	↑ 56.5	nmol/L	--	36.0	44.0	--
pCO_2	5.6	kPa	--	4.6	6.0	--
pO_2	↑ 24.5	kPa	--	10.5	14.0	--
Na^+	↓ 125	mmol/L	--	133	146	--
K^+	↓ 3.4	mmol/L	--	3.5	5.3	--
Cl^-	↓ 89	mmol/L	--	95	108	--
Ca^{++}	↓ 0.97	mmol/L	--	1.15	1.27	--
Glu	↑ 27.3	mmol/L	--	3.5	6.0	--
Lac	↑ 9.2	mmol/L	--	0.6	2.2	--
CO-Oximetry						
tHb	118	g/L	--	--	--	--
O_2Hb	97.3	%	--	95.0	98.0	--
COHb	1.2	%	--	0.5	1.5	--
MetHb	1.0	%	--	0.5	1.5	--
HHb	0.6	%	--	0.0	5.0	--
sO_2	↑ 99.4	%	--	95.0	98.0	--
Derived						
BE(B)	-8.5	mmol/L	--	--	--	--
HCO_3^-(c)	18.4	mmol/L	--	--	--	--
Hct(c)	35	%	--	--	--	--

↑↓ Outside Reference Range

Other Information

Operator Entered

Temp	37.0	°C

83949 GCC0072

Date & Time		Signature, Print Name & Designation
	Called ~~wife~~ partner	
	→ Explored understanding	
	→ unwell for 3/52	
	→ vomiting	
	→ stopped drinking alcohol few days ago, normally drinks 1 bottle of ~~wine~~ alcohol/day	
	→ explained dust infection + perforation	
	→ quite unwell	
	→ will need to go to theatre to repair perforation	
	→ will call later and update after theatre	Mr [illegible] SHO.
24/4/20	post op updated partner Fiona + mom	
2330	→ Fiona : explained CT findings + intraop findings	
	: explained that Henry is quite unwell	
	: will bring him back to theatre mane	
	→ mom : explored understanding	
	⇒ not sure what happened	
	: any hard that he was unwell	
	: not spoken to son ? covid ? drugs related	
	: explained unwell and CT found PE, pneumonia, fluid in abdo and infarcted spleen which is source of infection	
	: washout in theatre, plan to relook tomorrow	
	: post op still unwell but in ITU for now	
	: there is a chance he will recover but may in hosp for a while or deteriorate	
	: supporting him through this	[illegible] SHO

Henry Burgess 2208793218

2208793218
1 BURGESS 22/08/197
9 Henry
96A ALICE STREET
Paisley, Renfrewshire
PA2 6E

Clinical History :

41yo, ex-IVDU, ITU step-down. Currently has femoral line in place. Previous central line in situ, all 4 lumens blocked. Currently on IV meropenem, vancomycin + fluconazole as per micro for progressive patchy consolidation in RUL / LUL with possible early necrosis + cavitation within RLL. Advised to get PICC line insertion due to need for lengthy IV antibiotic regime.

PICC Line insertion :

Witnessed verbal consent. Procedural risks including pain, infection, vascular injury and line blockage have been explained to the patient. Happy to proceed.

Supine position. Aseptic technique. Venous puncture of the left basilic vein under ultrasound guidance. Single lumen 5-French PICC line inserted over a guide wire to a length of 45 cm. Tip is in the region of the distal SVC. Bleeding freely.

No complications.

Line available for immediate use.

Chlorhexidine impregnated disc (Biopatch) to insertion site, to be replaced weekly.

Stat lock fixation device and transparent occlusive dressing, to be replaced weekly.

1st Reporter: Dr Mark Majury

2nd Reporter: None

Last Verified By: Dr Mark Majury

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

2208793218 22/08/1979
BURGESS
Henry

Date & Time		Signature, Print Name & Designation
25/11/20	update mother (NOK) post op	
1040	- explained procedure → splenectomy	
	- stable during procedure	
	- mother worried about son ~~[illegible]~~	
	still taking drugs. I was	
	unable to confirm / deny as I	
	did not ask at pre-op	
	- mother has no further question	
	- aware he is still intubated back to	
	ITU	

83949 GGC0072

Date & Time		Signature, Print Name & Designation
8/12	MR Ward Rounds	
09:00		
	Still mild pain	
	Ward appears well	
	Chase PICC line for Friday	

Referral letter:

NHS
Greater Glasgow and Clyde

Royal Alexandra Hospital
Corsebar Road
Paisley
PA2 9PN
0141-887-9111

Diabetes team

Main Switchboard:
Department:
Contact Tel:
Enquiries to:
Letter Date: 02/12/2020
Reference:
Dictated Date: 02/12/2020
Transcribed Date:

Dear ,

Henry Burgess; D.O.B: 22/08/1979; CHI: 2208793218
96A ALICE STREET, Paisley, Renfrewshire, PA2 6EA

Dear Diabetes team,

I would appreciate your input on restarting pre-admission insulin therapy in this type 1 diabetic.

Henry Burgess is in ICU2 following an admission with septic shock. He underwent an emergency laparotomy for septic emboli to his liver, kidneys and spleen resulting in a splenectomy and ICU stay.

He was extubated yesterday and is now on the mend, though continues on antibiotics for Step Milleri cultured from the spleen and is anticoagulated for a pulmonary vein embolus.

His other PMH includes ex-IVDU on methadone and treated Hep C.

He has been receiving NG feed and with this a background actrapid infusion with sugars between 8-15.

He is not yet ready to stop his feed but will hopefully start to eat and drink a bit over the next few days and gradually stop his feed. For this reason we were hoping to start reintroducing his normal insulin and would like your advice.

He was previously on Novomix 30 12 units morning and evening and says his sugars were usually around 8. I cant see that he has ever had input from the diabetes team in the past and he is not clear on this.

Many thanks,

Olivia Pittman

ACCS CT2 #56177

ICU 2

Electronically Signed: ,

cc.

2208793218, Henry Burgess, 06/12/20

CT Thorax abdomen pelvis with contrast : Reference to previous 24/11/20.

Lines and tubes:

Left internal jugular CVC with tip in the upper SVC.

NG tube with tip in the proximal duodenum.

Urinary catheter with balloon inflated in the bladder.

Thorax:

Superior right upper lobe consolidation with cavitations as before. There is further more patchy consolidation in the adjacent right upper lobe and superior left upper lobe. Progressive right lower lobe and left lower lobe consolidation is seen inferiorly, there is focal low attenuation within the right lower lobe consolidation suggesting possible early necrosis / cavitation. Elsewhere there has been improvement with apparent resolution of patchy inflammatory changes and small cavitating lesions in the left upper lobe.

As before thrombus within the right superior pulmonary vein is extending towards the left atrium, though there is no apparent propagation of thrombus into this.

New small bilateral pleural effusions have developed. There is no new thoracic lymphadenopathy.

Abdomen and pelvis:

Interval midline laparotomy noted with splenectomy. There is a solitary locule of free gas deep to the midline incision in keeping with relatively recent surgery. There is a shallow (<1cm depth) rim enhancing collection involving the lateral conal fascia adjacent to the splenectomy site, tracking to the undersurface of the diaphgram.

Small volume of fluid is present within the anterior abdomen, within the gastrohepatic recess, posterior to the right lobe of liver and tracking down the right para-colic gutter. There is some minor enhancement surrounding some of these suggesting organisation, though there is no single large drainable collection to target. In addition there are multiple pockets of intra-loop fluid predominantly in the left side of the abdomen between jejunal small bowel loops. The associated jejunal loops are thick walled, which in the context is

presumed reactive. No intramural gas or hypoattenuation to suggest ischaemia.

The unprepared colon is grossly unremarkable.

Multifocal left sided renal infarcts and solitary right renal infarct as before.

Grossly normal liver. Normal pancreas and adrenals. Contracted gallbladder contains several gallstones. No gross biliary duct dilatation.

Patent portal vein. Allowing for phase of contrast the aorta and major branch vessels appear patent.

Skeleton:

Well corticated old antero-superior corner fracture of L5. No new skeletal findings.

Summary:

1. Evolving multifocal consolidation within the chest as described.

2. Fluid collections as described adjacent to the splenectomy site, within the anterior abdomen and between jejunal loops which are likely reactively thickened.

Though no clear target for drainage.