Legal Aspects Team
Health Records Department
Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN

NHS
Greater Glasgow and Clyde

MMA Legal
43-59 Princes Street
Stockport
SK1 1RY

Date: 27th May 2026
Your Ref: 100278
Our Ref: LAT/ACCESS/ES
Enquiries to: Emily Svensson
Direct Line: 0141 211 3020
Email: Emily.svensson@nhs.scot

Re: Subject Access Request under the General Data Protection Regulation

PATIENT: GEORGE HARKNESS **D.O.B: 17/07/1958**

Thank you for your request received **11TH MAY 2026** in which you seek a copy of your client's personal information.

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

NEW VICTORIA HOSPITAL/ QUEEN ELIZABETH UNIVERSITY HOSPITAL

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

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

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

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

- Emails

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

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

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

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

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

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

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

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

Yours sincerely

Legal Aspects Team

ELECTRONIC PATIENT RECORDS

(1)

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

Including:

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

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

CHI: 1707583579

New Victoria Hospital

Total Att: 0

12 Mth Att: 0

Title: **MR**

HARKNESS **George**

DOB: **17/07/1958** Age: **60y** Sex: **Male**

49 Newton Street
CATRINE
Mauchline
Ayrshire
KA5 6RD
07706505537

Next of kin: **UNKNOWN**
Relationship: **Unknown**

GP: **DA Richardson**
01290 456001

Attendance Date: **22/08/2018** Arrival Time: **11:45**

Registration Time: **11:45** Date of Incident: **15/08/2018**

Major Incident Desc:

Reason for Attendance: **right elbow inj**

Affix Label

Nursing Assessment

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

Triage Category: Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: Nurse name:

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:

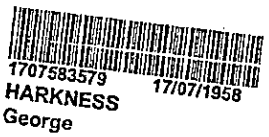
Child Assessment Questionnaire

	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
22/8/18	CODAMOL 30/500	X2	ORAL	12^{00}	[signature]	[signature]

Date	22/8/18	CLINICAL NOTES
	Seen by ~~(Dr)~~ ENP E O'DONNELL	Time seen 1145

1707583579 17/07/1958
HARKNESS
George

60yr old ♂, RHD, Van driver POSA

P/C Right elbow injury

Hx P/C Approx 1/52 ago carrying furniture backwards, states fell over other furniture and landed on metal stank with elbow

PMH Surgery x 2 to same elbow for tennis elbow
C-spine 8yrs ago
↑ BP
Cholesterol
Reflux

MEDS Polypharmacy. ALLERGIES NKDA

O/E Hot obvious swelling +++ to elbow at olecranon, warm to touch, Temp 36.4°c
No obvious bruising or deformity.

SCJ
Clavicle
ACJ
Shoulder
Humerus
Both Epicondyles
Radius / Ulna
Hand / Fingers / Thumb
} NBT

CRT < 2secs
pulses intact
CNS intact distally

170° 80°

Decreased ROM on extension & flexion
Slight decreased ROM on supination / pronation
Tender over olecranon with crepitus felt

X-ray elbow
→ avulsion # proximal Ulna at epicondyle with large bursitis evident

Date	CLINICAL NOTES
	Tx Polyslings Virtual # clinic FU Has on analgesic, cannot take NSAIDs Resolving bursitis advised apply ice, ice, ice to reduce swelling. PRICE If feels unwell / feverish etc to attend ED/GP Now informed lives in Ayrshire. Advised to attend local ED. Advised NOT to drive as will not be insured and to contact work to be picked up ENP

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	1305

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

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
New Victoria Hospital
Grange Road
Glasgow
Lanarkshire
G42 9LF

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 22/08/2018

Consultant: Dr Jonny Gordon

DA Richardson
Ballochmyle Medical Group
The Clinic
Institute Avenue
Catrine
Mauchline
KA5 6RU

Dear DA Richardson

Re: **Harkness George** DOB: **17/07/1958** CHI: **1707583579**
49 Newton Street
Mauchline KA5 6RD

Attended on: **22/08/2018 at 11:45 hrs.** Departed on: **22/08/2018 at 13:05 hrs.**
Discharge Type: **03 - Transferred** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
right elbow inj

Nursing Assessment:

Investigations in ED:
1. XR Elbow Rt

Diagnosis:

Diagnosis	Side	Site
Fracture of proximal ulna, closed	**Right**	**Elbow**

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

fell onto elbow 1/52 ago,now has bursitis of elbow with reduced rom, x-ray and # proximal ulna-avulsion, polysling applied and advised to attend local ed as presented in Glasgow, apyrexial although elbow warm to touch,advice given re care, has own analgesia

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Elaine Odonnell
Nurse Practitioner

Copies to:

1. DA Richardson (GP)

School Address:

DEPARTMENT OF NEUROSURGERY
Institute of Neurological Sciences

Direct Line: 0141 201 2020
Direct Fax: 0141 201 2995
Enquiries: Secretary, Mrs Janice Lafferty
E-mail: Janice.Lafferty@ggc.scot.nhs.uk

Southern General Hospital
1345 Govan Road
GLASGOW
G51 4TF

LTD/JL
Clinic: 09/06/11
Typed: 10/06/11

DR DAVID DA RICHARDSON
BALLOCHMYLE MEDICAL GROUP
INSTITUTE AVENUE
KA5 6RU

Dear Dr Richardson

GEORGE HARKNESS DOB: 17/07/58 (SG03251486) CHI: 1707583579
32C MILL SQUARE, CATRINE, AYRSHIRE, KA5 6RD

I reviewed Mr Harkness and his wife in the clinic today on behalf of Mr Dunn. He is now just over 4 months following his revisional anterior cervical decompression. As you are aware he underwent a 2 level ACDF in 2009 for right arm pain which did improve post operatively but unfortunately returned after a short period of time. Ultimately he was readmitted for revisional surgery, which was performed on the 1st February this year, the access was not easy but the lower of the 2 levels was decompressed and an iliac crest graft inserted.

Mr Harkness tells me that his symptoms have now completely resolved and he has been back at work 6 weeks following his procedure. He is very happy with the outcome of his surgery, his wound has healed nicely and I am happy to discharge him from the neurosurgical clinic. Post operative x-ray shows the bone graft in good position and cage at the upper level.

Yours sincerely,

Mr M White
SpR to Mr Dunn, Consultant Neurosurgeon

DEPARTMENT OF NEUROSURGERY
Institute of Neurological Sciences

Direct Line: 0141 201 2020
Direct Fax: 0141 201 2995
Enquiries: Secretary, Mrs Janice Lafferty
E-mail: Janice.Lafferty@ggc.scot.nhs.uk

Southern General Hospital
1345 Govan Road
GLASGOW
G51 4TF

LTD/JL
Clinic: 26/08/10
Typed: 31/08/10

DR DAVID DA RICHARDSON
BALLOCHMYLE MEDICAL GROUP
INSTITUTE AVENUE
KA5 6RU

Dear Dr Richardson

GEORGE HARKNESS DOB: 17/07/58 (SG03251486) CHI: 1707583579
32C MILL SQUARE, CATRINE, AYRSHIRE, KA5 6RD

I reviewed Mr Harkness alongside his wife in the out patient clinic on behalf of Mr Dunn today. As you may recall he had a 2 level C5/6 and C6/7 anterior cervical decompression and fusion in April 2009 for predominantly right C6 radiculopathy. At the time of surgery he had some left sided symptoms as well but no evidence of myelopathy. For a short while after surgery he improved. However, 6 months later his right-sided brachalgia recurred. This is again in C6 distribution. He describes this as a dull pain radiating from the shoulder in a posterolateral upper arm, forearm and terminating in the 3 lateral fingers. There is associated numbness in the same distribution. The whole arm feels heavy. The recent electrophysiological studies of the upper arm shows only evidence of a very mild right carpal tunnel syndrome. The MRI scan of cervical spine shows good decompression at C6/7 level but some degree of nerve root compression at C5/6 levels bilaterally. Interestingly it is worse on the left, however the symptoms are mainly on the right.

On clinical examination he has normal gait and posture. Neurological examination is essentially normal except for diminuted pin prick sensation in a right C6 dermatomal distribution. Reflexes are symmetrical and within normal range.

Clinical impression is of recurrent right C6 radiculopathy. This is consistent with the MRI findings of right C6 nerve root compression. I have explained the findings to this gentleman. After a long discussion he feels that he would like something surgical done for this. There is an option of posterior foraminotomy to create room for a nerve root from the back or revisional surgery from the front. This could be determined when the level of fusion from the cage is ascertained. I have therefore organised an x-ray of cervical spine, flexion extension views to ascertain this. We will write to him with the results and

GEORGE HARKNESS
17/07/58
CHI:1707583579

further appointment.

Yours sincerely,

Mr M Behbahani
SpR to Mr Dunn, Consultant Neurosurgeon

DEPARTMENT OF NEUROSURGERY
Institute of Neurological Sciences

Direct Line: 0141 201 2020
Direct Fax: 0141 201 2995
Enquiries: Secretary, Mrs Janice Lafferty
E-mail: Janice.Lafferty@ggc.scot.nhs.uk

Southern General Hospital
1345 Govan Road
GLASGOW
G51 4TF

LTD/JL
Clinic: 20/08/09
Typed: 20/08/09

DR DAVID DA RICHARDSON
BALLOCHMYLE MEDICAL GROUP
INSTITUTE AVENUE
KA5 6RU

Dear Dr

GEORGE HARKNESS DOB: 17/07/58 (SG03251486) CHI: 1707583579
32C MILL SQUARE, CATRINE, AYRSHIRE, KA5 6RD

I reviewed this gentleman some 4 months following a two level anterior cervical decompression and fusion procedure for right-sided brachialgia. I am pleased to say that he has had a good relief from his right-sided arm pain. He had temporary relief of the paraesthesia that he had experienced in the hand but this has now recurred. The history that he gave today in the clinic was that these symptoms are markedly worse at night, occasionally waking from sleep and are relieved by hanging his arm over the bed. His symptoms are markedly exacerbated by riding his motorbike.

On examination his operative wound is well healed. I could not detect any neurological deficit in the lower limbs and no particular features consistent with carpal tunnel syndrome

I am going to organise an MRI scan to confirm an adequate decompression at the operated levels. I am also requesting some nerve conduction and EMG studies in case his persisting symptoms are related to significant carpal tunnel compression. I will arrange to review him again with the results of these investigations in due course.

Yours sincerely

Mr L T Dunn
Consultant Neurosurgeon/
Honorary Senior Clinical Lecturer in Neurosurgery

DEPARTMENT OF NEUROSURGERY
Institute of Neurological Sciences

Direct Line: 0141 201 2020
Direct Fax: 0141 201 2995
Enquiries: Secretary, Mrs Janice Lafferty
E-mail: Janice.Lafferty@ggc.scot.nhs.uk

Southern General Hospital
1345 Govan Road
GLASGOW
G51 4TF

LTD/JL
Dictated: 03/03/11
Typed: 09/03/11

DR DAVID DA RICHARDSON
BALLOCHMYLE MEDICAL GROUP
INSTITUTE AVENUE
KA5 6RU

Dear Dr Richardson

GEORGE HARKNESS DOB: 17/07/58 (SG03251486) CHI: 1707583579
32C MILL SQUARE, AYRSHIRE, KA5 6RD

DISCHARGE SUMMARY
Consultant: Mr L T Dunn
Admitted: 31/01/11
Discharged: 04/02/11
Diagnosis: Cervical Radiculopathy 7001
Cervical Spondylosis 7008
Procedure: Revision anterior cervical decompression 9107

History: Mr Harkness was admitted with a view to revision surgery for his cervical spondylosis. He underwent a 2 level anterior cervical decompression and fusion in 2009 for predominantly right-sided arm pain. He had initial improvement following his surgery but approximately 6 months later his right-sided brachalgia recurred in a similar distribution to that present pre operatively. Pain radiated from the shoulder in the upper arm, forearm and lateral three fingers with some associated sensory change in the same area. Pre operative electrophysiological studies showed mild right-sided carpal tunnel syndrome but were otherwise unhelpful in localising the level. Post operative imaging suggested some persisting nerve root compression at the previously operated surgical levels.

Operation (MB/LD 1/2/11) - Revision C6/7 anterior cervical decompression, removal of cage and insertion of bone graft from the right iliac crest. Intraoperatively access to the previously operated levels was poor and only the lower of the two levels could be adequately accessed. The cage at this level was removed and the decompression extended. The resulting bony defect was too large for a further cage and a bone graft was therefore taken from the right iliac crest.

GEORGE HARKNESS
17/07/58
CHI:1707583579

Progress: Mr Harkness felt there had been a significant improvement in the sensory symptoms in his right arm and hand. He mobilised with the help of the physiotherapists and wearing a hard collar, which he has been instructed to wear for 4 to 6 weeks post operatively. He was well enough to be discharged home on 4 February 2011.

Follow Up: Neurosurgical out patient review 3 -4 months time

Copies: GP

Yours sincerely

Mr L T Dunn
Consultant Neurosurgeon/
Honorary Senior Clinical Lecturer in Neurosurgery

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL, 1345 GOVAN ROAD, GLASGOW G51 4TF
TEL: 0141 201 1100

DEPARTMENT OF NEUROSURGERY
INSTITUTE OF NEUROLOGICAL SCIENCES

WARD: S65 CONSULTANT: MR LAURENCE DUNN
CONTACT NO: 0141 201 2020

IMMEDIATE DISCHARGE LETTER

PATIENT: GEORGE HARKNESS
32C MILL SQUARE
AYRSHIRE
KA5 6RD

DOB: 17/07/58 UNIT NO: SG03251486
ACCT NO: IP0002457/11
CHI NO: 1707583579

GP: DR DAVID DA RICHARDSON
BALLOCHMYLE MEDICAL GROUP
INSTITUTE AVENUE
KA5 6RU

DATE OF ADMISSION: 31/01/11
ADMISSION TYPE: ELECTIVE
DATE OF DISCHARGE: 04/02/11
DISCHARGE TO: HOME

REASON FOR ADMISSION: POSTERIOR FORAMINOTOMY @ C6 on right.
MAIN DIAGNOSIS: NERVE ROOT COMPRESSION C5/6 BILATERALLY; RECURRENT RIGHT RADICULOPATHY
OTHER ACTIVE PROBLEMS: ASTHMA; CRUCIATE LIGAMENT REPAIR LEFT KNEE

OPERATIONS/PROCEDURES/ TREATMENT: C6/7 ANTERIOR CREVICAL DECOMPRESSION, REVISION REMOVAL OF CAGE AND BONE GRAFT FROM ILIAC CREST
RESULTS AWAITED: N
CURRENT MEDICATION: SEE PRESCRIPTION
DISCONTINUED DRUGS? N
COMMENT: COLLAR FOR 6 WEEKS WHEN OVER 45 DEG

ALLERGIES:
NIL

REVIEW? Y DETAILS: OPC TIMESCALE: TBA

FURTHER LETTER TO FOLLOW? Y DETAILS: FORMAL HOSPITAL LETTER

Highly Sensitive Document Y/N N Patient consent to share information Y/N Y

SIGNED: FY2.MURAL MURDOCH,ALLISON
DESIGNATION: FOUNDATION DR YEAR 2
PAGE NUMBER: 7040

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL, 1345 GOVAN ROAD, GLASGOW G51 4TF
TEL: 0141 201 1100

DEPARTMENT OF NEUROSURGERY
INSTITUTE OF NEUROLOGICAL SCIENCES

WARD: S65 CONSULTANT: MR LAURENCE DUNN
CONTACT NO: 0141 201 2020

IMMEDIATE DISCHARGE LETTER

PATIENT: GEORGE HARKNESS
32C MILL SQUARE
AYRSHIRE
KA5 6RD

DOB: 17/07/58 UNIT NO: SG03251486
ACCT NO: IP0002457/11
CHI NO: 1707583579
GP: DR DAVID DA RICHARDSON

DISCHARGE MEDICATION

Time Required? Routine - within 4 hours
Childproof Containers? Y
Compliance Aid Required? N
Patient's Weight (Kg):
Comment:

Medication	Form	Dose	Frequency	Duration
LANSOPRAZOLE	OTAB	30MG	IN THE MORNING	INDEFINITE

New Drug? N New Dose? N Comments:
Patient's Own Supply? N Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration
VENTOLIN INHALER	INH	2PUFFS	AS REQUIRED	INDEFINITE

New Drug? N New Dose? N Comments:
Patient's Own Supply? Y Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration
PARACETAMOL	OTAB	1G	4 TIMES A DAY	REVIEW

New Drug? Y New Dose? Y Comments:
Patient's Own Supply? N Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration
DIHYDROCODEINE	OTAB	60MG	4 TIMES A DAY	REVIEW

New Drug? Y New Dose? Y Comments:
Patient's Own Supply? N Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration
TRAMADOL	OTAB	50-100MG	AS REQUIRED	REVIEW

New Drug? Y New Dose? Y Comments:
Patient's Own Supply? N Pharmacy Notes: 4-6 HOURLY Supply:

Medication	Form	Dose	Frequency	Duration

New Drug? New Dose? Comments:
Patient's Own Supply? Pharmacy Notes: Supply:

Medication	Form	Dose	Frequency	Duration

New Drug? New Dose? Comments:
Patient's Own Supply? Pharmacy Notes: Supply:

PHARMACY USE ONLY DISPENSED BY: DATE: CHECKED BY:
CLINICAL PHARMACIST CHECK: COLLECTED BY: _____

Medicine received on ward by: _____ Issued by: _____

Named Nurse: _____ Signature of Receipt: _____

Report Number: 0302-0054 Date(Time): 03/02/11 (2225 Hours) Status: Signed

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL, 1345 GOVAN ROAD, GLASGOW G51 4TF
TEL: 0141 201 1100

DEPARTMENT OF NEUROSURGERY
INSTITUTE OF NEUROLOGICAL SCIENCES

WARD: S65 CONSULTANT: MR LAURENCE DUNN
CONTACT NO: 0141 201 2020

IMMEDIATE DISCHARGE LETTER

PATIENT: GEORGE HARKNESS
32C MILL SQUARE
AYRSHIRE
KA5 6RD

DOB: 17/07/58 UNIT NO: SG03251486
ACCT NO: IP0015850/09
CHI NO: 1707583579

GP: DR DAVID DA RICHARDSON
BALLOCHMYLE MEDICAL GROUP
INSTITUTE AVENUE
KA5 6RU

DATE OF ADMISSION: 27/04/09
DATE OF DISCHARGE: 30/04/09

ADMISSION TYPE: ELECTIVE
DISCHARGE TO: HOME

REASON FOR ADMISSION: RT BRACHALGIA
MAIN DIAGNOSIS: CERVICAL RADICULOPATHY

OTHER ACTIVE PROBLEMS: NIL

OPERATIONS/PROCEDURES/ TREATMENT: C5/6 + C6/7 ANTERIOR CERVICAL DECOMPRESSION AND FUSION
RESULTS AWAITED: N
CURRENT MEDICATION: SEE PRESCRIPTION
DISCONTINUED DRUGS? N
COMMENT:

ALLERGIES:
NKDA

REVIEW? Y DETAILS: OUT PATIENT TIMESCALE: TO BE ADVISED

FURTHER LETTER TO FOLLOW? Y DETAILS: FORMAL HOSPITAL LETTER

SIGNED: STR.BENDA BENNETT,DAVID
DESIGNATION: SPECIALIST TRAINEE REG
PAGE NUMBER: 7102

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL, 1345 GOVAN ROAD, GLASGOW G51 4TF
TEL: 0141 201 1100

DEPARTMENT OF NEUROSURGERY
INSTITUTE OF NEUROLOGICAL SCIENCES

WARD: S65 CONSULTANT: MR LAURENCE DUNN
CONTACT NO: 0141 201 2020

IMMEDIATE DISCHARGE LETTER

PATIENT: GEORGE HARKNESS
32C MILL SQUARE
AYRSHIRE
KA5 6RD

DOB: 17/07/58 UNIT NO: SG03251486
ACCT NO: IP0015850/09
CHI NO: 1707583579
GP: DR DAVID DA RICHARDSON

D I S C H A R G E M E D I C A T I O N

Time Required? Routine - within 4 hours
Childproof Containers? Y
Compliance Aid Required? N
Patient's Weight (Kg):
Comment:

Medication	Form	Dose	Frequency	Duration
PARACETAMOL	OTAB	1G	4 TIMES A DAY	7 DAYS
New Drug? Y New Dose? Y	Comments:			
Patient's Own Supply? N	Pharmacy Notes:			Supply:

Medication	Form	Dose	Frequency	Duration
DIHYDROCODEINE	OTAB	30-60MG	4 TIMES A DAY	7 DAYS
New Drug? Y New Dose? Y	Comments:			
Patient's Own Supply? N	Pharmacy Notes:			Supply:

Medication	Form	Dose	Frequency	Duration
TRAMADOL	OTAB	50-100MG	EVERY 4-6 HOURS	7 DAYS
New Drug? Y New Dose? Y	Comments: AS REQUIRED			
Patient's Own Supply? N	Pharmacy Notes:			Supply:

Medication	Form	Dose	Frequency	Duration
SALBUTAMOL 100	INH	2 PUFFS	AS REQUIRED	INDEFINITE
New Drug? N New Dose? N	Comments:			
Patient's Own Supply? Y	Pharmacy Notes:			Supply:

Medication	Form	Dose	Frequency	Duration
New Drug? New Dose?	Comments:			
Patient's Own Supply?	Pharmacy Notes:			Supply:

Medication	Form	Dose	Frequency	Duration
New Drug? New Dose?	Comments:			
Patient's Own Supply?	Pharmacy Notes:			Supply:

Medication	Form	Dose	Frequency	Duration
New Drug? New Dose?	Comments:			
Patient's Own Supply?	Pharmacy Notes:			Supply:

PHARMACY USE ONLY DISPENSED BY: DATE: CHECKED BY:
CLINICAL PHARMACIST CHECK: PHA.MURLE COLLECTED BY: _____

Medicine received on ward by: _____ Issued by: _____

Named Nurse: _____ Signature of Receipt: _____

Report Number: 3004-0007 Date(Time): 30/04/09 (0933 Hours) Status: Draft

Department of Trauma and Orthopaedics
University Hospital Ayr
Dalmellington Road
Ayr
KA6 6DX
01292 610555

www.nhsaaa.net

NHS Ayrshire & Arran

Confidential - Clinical Information

Neurophysiology Department
Institute of Neurological Sciences
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

06 NOV 2023

Our Ref:	SG/SL
Hospital No:	1707583579
Clinic Date:	26/10/2023
Date Dictated:	26/10/2023
Date Typed:	30/10/2023
Enquiries to	Sinead Lynch
Direct Line:	01292 610555
Ext. Number:	16021
Email:	sinead.lynch@aapct.scot.nhs.uk

NERVE CONDUCTION STUDIES

07 NOV 2023

Dear Colleague,

GEORGE HARKNESS DOB: 17/07/1958 CHI No: 1707583579
107 MAIN STREET, MUIRKIRK, CUMNOCK, AYRSHIRE, KA18 3QS

I would be grateful for your help with this patient. He was referred to me with pain around the base of his right thumb, however this is very longstanding and the patient could tell me that his main concern is intermittent numbness that he finds in all fingers of his right hand. He tells me the pain is worse when on his motor cycle and he has to stop to shake his hand frequently. Only when I specifically asked him about night waking did he tell me that he is completely unable to sleep due to the sensory symptoms in his hand. Normally patients with such severe nocturnal symptoms would volunteer this with history taking.

I note that this patient has previously had an anterior cervical decompression and fusion and was noted previously to have a C6 nerve root compromise. The patient tells me that he had nerve conduction studies done some years ago but I couldn't find any documentation of this or any results either on his electronic record or in his old case notes. I have seen this patient previously regarding his thumb CMC degenerative change. I have previously given him a steroid injection there and I note that he found the pain following this intolerable and had to attend the Emergency Department. For this reason he is a bit reluctant to consider a further steroid injection.

On examination this patient had no muscle wasting at-all in any of the main muscle groups in his hand or forearm. He had full power of thumb abduction, and intrinsic's were of good power. Froment's test was negative. On further examination Tinel's test even done very lightly caused tingling in his fingertips and Froment's test gave instantaneous tingling to his middle and ring fingers.

I found it really difficult to evaluate whether this patients main concern was his arthritic thumb base or the paraesthesia in his hand. The patient feels that the paraesthesia in his hand is new despite this having been documented in his case notes many years ago following neck surgery.

I would be grateful for your help with nerve studies to see whether there is any evidence of peripheral nerve entrapment in his right arm. This will help with future

INVESTING IN VOLUNTEERS

management. In the meantime I have checked his HBA1C, thyroid function test, vitamin B12 levels and supplied him with a night splint.

Yours sincerely

Authorised on 30/10/2023 15:24:14 by Suzy Gibson.

Suzy Gibson FRCS (Glas) (Tr & Orth), PG Cert Med Ed
Consultant Orthopaedic Surgeon & Honorary Clinical Senior Lecturer GMC: 4087997

Dr A Sharma
Ballochmyle Medical Group
The Clinic
Institute Avenue
Catrine
KA5 6RU

Department of Trauma and Orthopaedics
University Hospital Ayr
Dalmellington Road
Ayr
KA6 6DX
01292 610555

www.nhsaaa.net

NHS Ayrshire & Arran

Confidential - Clinical Information

Neurophysiology Department
Institute of Neurological Sciences
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

06 NOV 2023

Our Ref:	SG/SL
Hospital No:	1707583579
Clinic Date:	26/10/2023
Date Dictated:	26/10/2023
Date Typed:	30/10/2023
Enquiries to	Sinead Lynch
Direct Line:	01292 610555
Ext. Number:	16021
Email:	sinead.lynch@aapct.scot.nhs.uk

NERVE CONDUCTION STUDIES

07 NOV 2023

Dear Colleague,

GEORGE HARKNESS DOB: 17/07/1958 CHI No: 1707583579
107 MAIN STREET, MUIRKIRK, CUMNOCK, AYRSHIRE, KA18 3QS

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INVESTING IN VOLUNTEERS

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Authorised on 30/10/2023 15:24:14 by Suzy Gibson.

Suzy Gibson FRCS (Glas) (Tr & Orth), PG Cert Med Ed
Consultant Orthopaedic Surgeon & Honorary Clinical Senior Lecturer GMC: 4087997

Dr A Sharma
Ballochmyle Medical Group
The Clinic
Institute Avenue
Catrine
KA5 6RU

Neurosurgery
Southern General Hospital
1345 Govan Road
Glasgow G51 4TF

29/03/2013

DR DA Richardson
Ballochmyle Medical Group
The Clinic
Institute Avenue
Catrine
KA5 6RU

Dear Dr DA Richardson

Patient Name: **Mr George Harkness**
CHI Number: **1707583579**
Referral Date: **26/03/2013**

Thank you for your referral. On this occasion I am unable to offer a consultation to your patient.

Please see the following reasons.

( ) Please refer to the referral guidance directory for referral criteria for this service.

http://www.staffnet.ggc.scot.nhs.uk/Info%20Centre/PoliciesProcedures/GGC%20Referral%20Guidance/Pages/GGCReferralGuidance.aspx

( ) Insufficient clinical information to allow specialty to triage referral.

Enter free text here

( ) Other

Enter free text here

Yours sincerely

Mr Laurence Dunn

User ID Laurence Dunn

SCGC Opwl Rem Ref Hosp Req V1

DEPARTMENT OF CLINICAL NEUROPHYSIOLOGY

THE QUEEN ELIZABETH UNIVERSITY HOSPITAL GLASGOW
1345 GOVAN ROAD
GLASGOW G51 4TF

Consultant Clinical Neurophysiologists:

Dr Arup Mallik 0141-201 2480
Dr Veronica Leach 0141-201 2462
Dr Shona Livingstone 0141-201 2462
Dr Aisyah Yaacob 0141-201 2480

EMG REPORT

Patient:	George Harkness
Patient ID	1707583579
Date of Birth:	17/07/1958
Address:	107 Main Street Muirkirk Ayrshire KA18 3QS
Referred by:	Ms Suzy Gibson, Consultant Orthopaedic Surgeon
Hospital:	University Hospital Ayr
Ward or OP:	op

Clinical Opinion

Thanks for referring this gentleman who describes paraesthesia and numbness in his right hand particularly when going long distances on his motorbike or driving for any length of time. He is wakened at night by paraesthesia and shakes his hand to relieve. There is no weakness or wasting on clinical examination.

Upper limb electrodiagnostic testing shows a right sided grade 2 mild carpal tunnel syndrome. On the left only one of our sensitive sensory measures is just positive for carpal tunnel syndrome. There are no abnormalities in ulnar studies. Unfortunately splinting hasn't addressed the right sided symptoms.

Yours sincerely

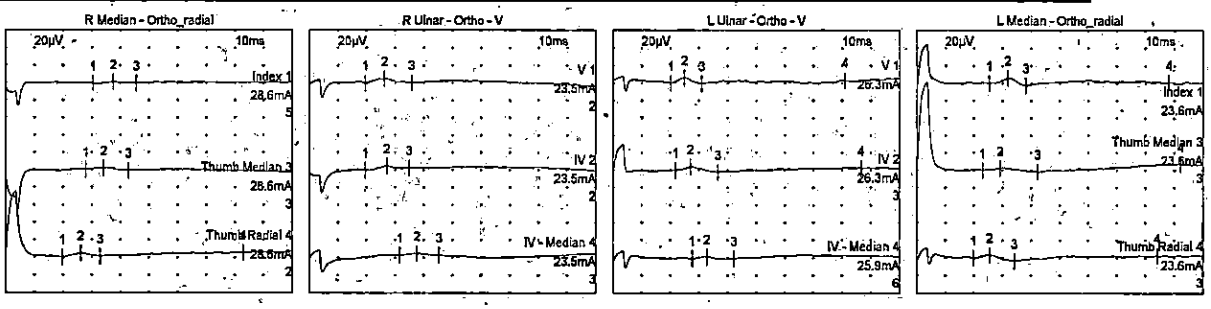
Dr Veronica Leach
Consultant Clinical Neurophysiologist
Electronically verified

VL/CB – 21/02/2024

Sensory NCS

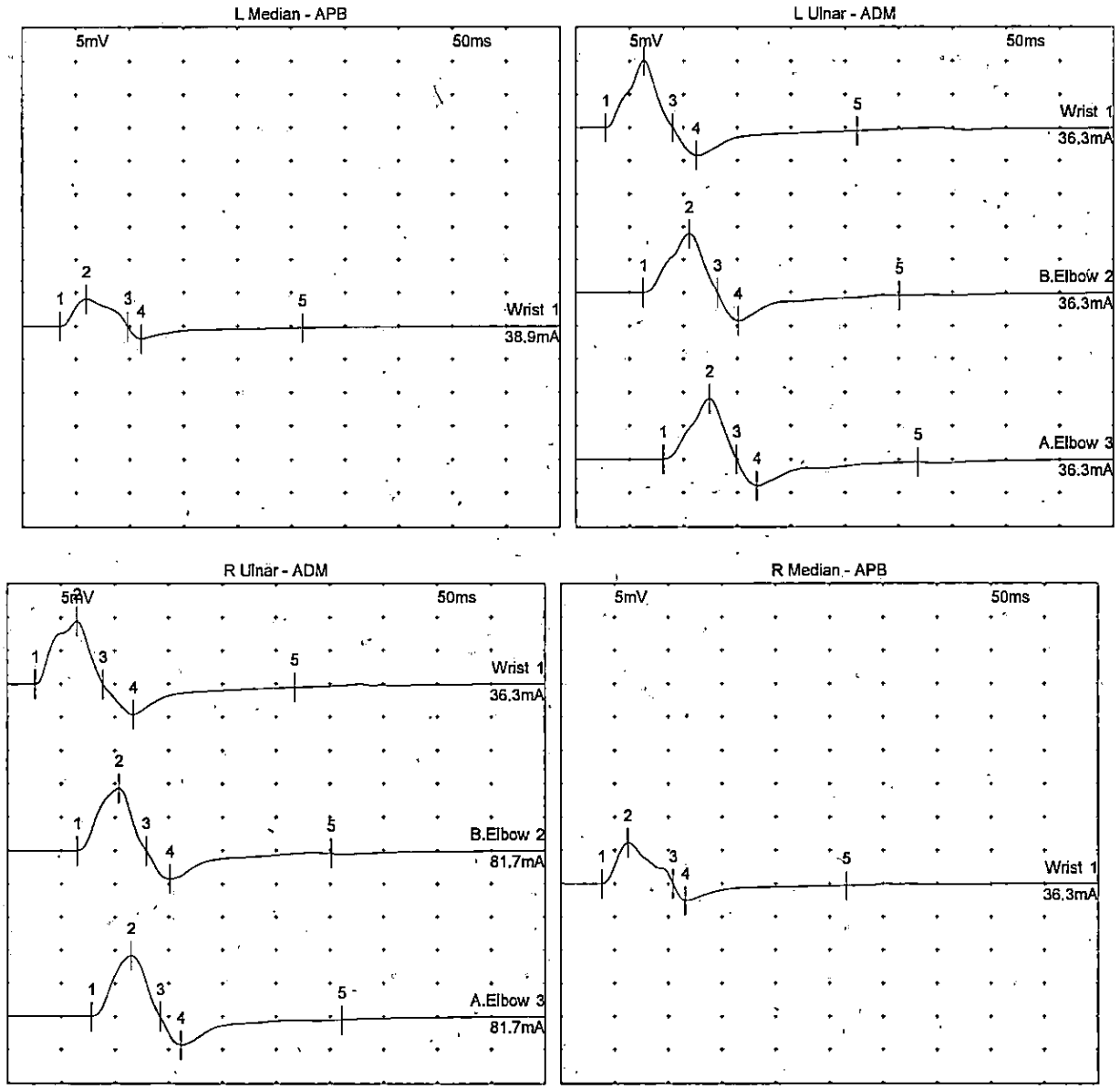
Nerve / Sites	Lat. 2 ms	Lat. ms	Amp.1-2 µV	Amp.2-3 µV	Dur. ms	Area µVms	Vel. Pk m/s

Nerve / Sites	Lat. 2 ms	Lat. ms	Amp.1-2 µV	Amp.2-3 µV	Dur. ms	Area µVms	Vel. Pk m/s
R Median - Ortho_radial							
Index	3.75	3.04	1.4	1.3	1.52	0.8	34.7
Thumb Median	3.42	2.79	1.8	3.0	1.50	1.7	
Thumb Radial	2.63	1.98	4.8	3.6	1.31	2.5	
L Median - Ortho_radial							
Index	3.19	2.54	6.1	8.9	1.27	4.4	42.4
Thumb Median	2.92	2.31	2.3	4.2	1.92	2.9	
Thumb Radial	2.56	2.00	3.3	6.9	1.42	3.3	
R Ulnar - Ortho - V							
V	2.63	1.96	5.1	4.8	1.63	3.7	
IV	2.71	1.96	4.7	2.1	1.54	1.7	
IV - Median	3.77	3.17	1.8	1.8	1.38	1.4	
L Ulnar - Ortho - V							
V	2.50	2.02	6.2	6.9	1.08	3.3	
IV	2.71	2.19	4.2	6.6	1.48	3.1	
IV - Median	3.29	2.77	2.2	2.4	1.46	1.3	



Motor NCS

Nerve / Sites	Lat. ms	Amp.1-2 mV	Dur. ms	Area mVms	Amp.1-2 %	Dur. %	Area %	Dist. cm	Vel. m/s
L Median - APB									
Wrist	3.54	4.1	6.27	15.4	100	100	100	8	
R Median - APB									
Wrist	3.79	6.2	6.65	21.7	100	100	100	8	
L Ulnar - ADM									
Wrist	2.75	10.1	6.25	29.8	100	100	100	8	
B.Elbow	6.29	9.0	6.87	30.5	88.8	110	102	24	67.8
A.Elbow	8.13	9.0	6.79	29.8	89.6	109	99.9	9	49.1
R Ulnar - ADM									
Wrist	2.58	9.4	6.31	34.0	100	100	100	8	
B.Elbow	6.48	9.3	6.44	31.9	98.9	102	93.6	25	64.2
A.Elbow	7.81	9.2	6.40	31.3	97	101	92.1	10	75.0


L Median - APB
5mV
50ms
Wrist 1
38.9mA
L Ulnar - ADM
5mV
50ms
Wrist 1
36.3mA
B.Elbow 2
36.3mA
A.Elbow 3
36.3mA
R Ulnar - ADM
5mV
50ms
Wrist 1
36.3mA
B.Elbow 2
81.7mA
A.Elbow 3
81.7mA
R Median - APB
5mV
50ms
Wrist 1
36.3mA

XR Elbow Rt

Performed	22-Aug-2018 11:58	Received	22-Aug-2018 15:49
Reported	22-Aug-2018 15:47	Order Number	G306H34190552
Status	Final	Source System	MiSys

XR Elbow Rt Final
George Harkness
Clinical History :

fall onto elbow, tender over olecranon with decreased rom ?#

XR Elbow Rt :
There is a minimally displaced avulsion fracture affecting the medial aspect of the right proximal ulna.
Significant soft tissue swelling is noted overlying the olecranon.

Code A: Agreement: No major discrepancy between the radiologist report and the referrer's 'sticky note' interpretation.

Report by Kim Barrett trainee Reporting Radiographer.

Reported by: Kimberley Barrett and Jonathan McConnell
Verified by: Jonathan McConnell

XR Cervical spine

Performed	02-Feb-2011 14:45	Received	04-Feb-2011 16:02
Reported	04-Feb-2011 15:42	Order Number	G588C25601024
Status	Final	Source System	MiSys

XR Cervical spine Final
George Harkness
Clinical History : Post op. 1 day post ACDF. ? Cage position.

XR Cervical spine :
C5/C6 and C6/C7 fusion noted. Cage device in position at the C5/C6 level. Bony fusion appears to have occurred at level C6/C7 with the cage device, which was present on the 26/08/10, no longer in situ. Spinal alignment is maintained.

Reported by: Dr NE Fullerton (SpR) and Dr Ravi Jampana
Verified by: Dr Ravi Jampana

Mobile image intensifier cervical spine

Performed	01-Feb-2011 16:34	Received	01-Feb-2011 16:55
Reported	01-Feb-2011 16:55	Order Number	G588C25598596
Status	Final	Source System	MiSys

Mobile image intensifier cervical spine Final

George Harkness

This examination has been formally assessed and reported by the referring practitioner. Please see case notes for the formal report.

Reported by: Auto Reporting
Verified by: Auto Reporting

Mobile image intensifier cervical spine

Performed	01-Feb-2011 12:50	Received	01-Feb-2011 16:49
Reported	01-Feb-2011 16:49	Order Number	G588C25597270
Status	Final	Source System	MiSys

Mobile image intensifier cervical spine Final

George Harkness

This examination has been formally assessed and reported by the referring practitioner. Please see case notes for the formal report.

Reported by: Auto Reporting
Verified by: Auto Reporting

XR Cervical spine

Performed	26-Aug-2010 11:51	Received	01-Sep-2010 14:51
Reported	01-Sep-2010 14:31	Order Number	G588C25182439
Status	Final	Source System	MiSys

XR Cervical spine Final
George Harkness
Clinical History : Previous C5/6 and 6/7 ACDF ? fusion.

XR Cervical spine :

Flexion extension views.

No abnormal movement occurs. There is no movement of the fixed segments from C5 to C7. There is bony infilling of the disc spaces at the fused segments. The position of the cage is unchanged since the previous examination of 29/04/09.

Reported by: Dr Evelyn Teasdale
Verified by: Dr Evelyn Teasdale

MRI Spine cervical

Performed	03-Sep-2009 10:04	Received	07-Sep-2009 16:54
Reported	07-Sep-2009 16:34	Order Number	G588C13174440
Status	Final	Source System	MiSys

MRI Spine cervical Final
George Harkness
Clinical History : 2 level ACDF April '09. Good relief of brachialgia but persisting paraesthesia in right hand ? adequate nerve root compression.

MRI Spine cervical :

Comparison: MRI cervical spine from 05/09/08, Crosshouse Hospital.

Technique: Routine sagittal images with selected axial images obtained.

Findings: Normal vertebral body alignment. Haemangioma demonstrated in C4 vertebral body. ACDF demonstrated at levels C5/6 and C6/7.

At the surgical levels of C5/6 and C6/7 there is some artefact from inserted metalwork. There is no evidence of cord compression. However, at both these levels there remains nerve root compression bilaterally.

Reported by: Dr. KIRSTEN FORBES and BLANK RADIOL
Verified by: Dr. KIRSTEN FORBES

XR Cervical spine

Performed	29-Apr-2009 10:25	Received	10-Sep-2009 12:47
Reported	29-Apr-2009 11:38	Order Number	G588C12922205
Status	Final	Source System	MiSys

XR Cervical spine Final
George Harkness
Clinical History :

XR Cervical spine :

This examination has been formally assessed and reported by the referring practitioner. Please see case notes for the formal report.

Reported by: AUTO REPORTING and BLANK RADIOL
Verified by: DR N BARLOW

Mobile image intensifier cervical spine

Performed	28-Apr-2009 16:12	Received	03-Jun-2009 14:16
Reported	03-Jun-2009 14:16	Order Number	G588C12921315
Status	Final	Source System	MiSys

Mobile image intensifier cervical spine Final

George Harkness

This examination has been formally assessed and reported by the referring practitioner. Please see case notes for the formal report.

Reported by: AUTO REPORTING and BLANK RADIOL
Verified by: AUTO REPORTING

(2)

MANUAL PATIENT RECORDS

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

Including:

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

NHS GREATER GLASGOW

SURNAME (Block Letters)	FIRST NAME	UNIT No.
HARKNESS	GEORGE	3251486.

ADDRESS 32C MILL SQUARE
CATRINE
AYRSHIRE
KA5 6RD.

RELIGION	SEX	DATE OF BIRTH
	M	17/7/58

PHONE No.

CHANGE OF ADDRESS

NEXT OF KIN (Name and Address)

PHONE No.

CHANGE OF ADDRESS

NAME AND ADDRESS OF OWN DOCTOR
DR DAVID RICHARDSON
BALLOCHMYLE MEDICAL GROUP
THE CLINIC
INSTITUTE AVENUE, CATRINE, KA5 6RD.

PHONE No.

NAME AND ADDRESS OF OWN DOCTOR

UNITCASE RECORDS (Delete)

DISABILITY YES ☐ NO ☐

CHI NUMBER
1707583579.

ETHNIC ORIGIN

INDEX OF ATTENDANCES

Every NEW out-patient attendance, and EACH in-patient admission must be noted below

DATE	CLINIC / WARD	DOCTOR	DIAGNOSIS / OPERATION	CODED	DISCH. DATE
5.2.09	N/KA. N/SURG	DUNN			HOME 30/4/09
20.8.09	N/surg	Dunn			
26/08/10		DUNN			
3/11/11	WD65	Dunn			4/2/11
9.6.11	NEURO of	DUNN			

USE RED INK FOR NOTIFICATION OF DEATH – ALL OTHER ENTRIES IN BLACK

18045

SOUTH GLASGOW HOSPITALS

7

SG03251486
GEORGE HARKNESS
32C MILL SQUARE
CATRINE
17/07/1958
KA5 6RD CHI 1707583579

CLINICAL NOTES

DATE

5/2/09

50yr ♂
(R) handed
Driver - Heavy Vehicles.

Symptomatic since July 08. after heavy lifting some heavy articles.

Neck pain → (R) arm.
Paraesthesia/numbness - all fingers (R) hand
Weakness ++. fingers (R), Bl/Bowel (N)

PMH: Asthma
Drugs: Inhalers.

° Smoking
° EtOH

O/E: No wasting
Power ↓ (R) side
Sensation ↓ (R) C5/6/7/8.
Reflexes (N)

(P) - ACF

7481
SRKSDA

JMcC/71589

DATE | CLINICAL NOTES (Continued)

27/4/09

A. SAXENA

50yr ♂

- Seen by myself in Clinic 2/12 ago.
- Symptomatic for almost 1yr
- (R) arm radiculopathic symptoms.
- (L) side - intermittent tingling - tips of fingers.
- No myelopathic symptoms

- O/E EOM - C Spine restricted due to pain
  - Power - (R) MRC 4.
  - Sensation to PP - C_5-C_8 (R).
  - Reflexes (N) B/L

MRI: C5/6 Disc Bulge
CT C-Spine - C6/7 Osteophyte bar | (R)

Nature of Surgery (both single / Two levels) explained & complications that include swallowing difficulty, hoarseness of voice, bleeding, infection & nerve damage

Consent ✓

- Mr. Sinn to Xray & decide.

SAXENA
7481.

GEORGE HARKNESS
17/7/58

CLINICAL NOTES

DATE	
27/4/9	dated Elective admission from home. Cons: Mr Dunn. 50 ♂ Neck pain radiating down @ arm since July '08. occured following heavy lifting. ↑ Numbness in all fingers @ hand & assoc'd weakness occasional paraesthesia in finger tips of @ hand, resolves spontaneously. No lower limb Sx PMHx: Asthma Cruciate ligament repair @ knee Tennis elbow op @ elbow. DHx: Amoxicillin – stated used by GP for 'sniffles' Co-dydramol Codeine Salbutamol Prednisone. NKDA. SHx: Lives & wife Ex Smoker – 18yrs. Nil alcohol.

DATE	CLINICAL NOTES (Continued)
	O/E, GCS 15/15
	PERL J+
	CN II – XII intact.

	RUL	LUL	RLL	LLL
Tone	N	N	N	N
Power	4/5	5/5	5/5	5/5
Sens^n	↓ C4, 5, 6,	N	N	N
reflexes	++	++	++	++
plantars			↓	↓

chest clear
HS I + II + O
Abdo SNT, BS ✓

Plan Bloods
Kardex
SpR r/v.

Barrett
FTSTA1
(7102)

7/4/09
Rt arm Sx [illegible]
Symptomatic level not identifiable on clinical [illegible] grounds
Plan – 2 level ACDF
Above discussed with patient
Risks of surgery discussed again
Consent already taken by Mr Soran

9/4/9
WR SpRs + CD
Arm feels better post op, obs stable
Plan Drain out
Mobilise lat. C-spine XR
(7102)

SOUTH GLASGOW HOSPITALS
SOUTHERN GENERAL HOSPITAL

7

CLINICAL NOTES

SG03251486
GEORGE HARKNESS
32C MILL SQUARE
CATRINE
AYRSHIRE 17/07/1958
KA5 6RD CHI 1707583579

DATE	
30/4/9	WR SpRs. c/o neck pain post. op. Ⓔ am much better. mobilising. obs stable. XR ok. Reg Hand. (7102)
20/8/09	Initial emergency resolution of fr arm pain & swelling ½ length wi large tip. Rt > Lt - worse @ night. - walk from clinic. Some chronic pain but fr broadly in pain Rt Wrist ✓ Rgmt — MS — NCS/EMG ? carpal tunnel.

JMcC/71589

DATE	CLINICAL NOTES (Continued)
1/1/11	FTSTA 1 LANH ELECTIVE ADMISSION MR DUNN
	RIGHT C6 cervical root compression For cervical decompression.
	PC Pain in neck radiating down lateral aspect of (R) upper arm. Numbness & tingly in (R) hand fingertips → all fingers. Pt feels that his grip strength in the right hand is weaker than it was & he finds he often drops objects with his right hand.
	Background 2 level C5/6 & C6/7 ACDF in April 2009 for predominantly (R) C6 radiculopathy.
	MRI → good decompression at C6/7 level but some degree of nerve root compression at C6/C6 bilaterally
	Pt does not report (L) sided symptoms.
	Denies any leg symptoms although he is occasionally a little off balance.

SOUTH GLASGOW HOSPITALS
SOUTHERN GENERAL HOSPITAL

7

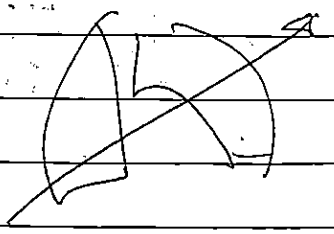
SG03251486
GEORGE HARKNESS
32C MILL SQUARE
CATRINE
AYRSHIRE 17/07/1958
KA5 6RD CHI 1707583579

CLINICAL NOTES

DATE	
	PMHx
	IBS Hypercholesterolaemia no Tx with statin?
	Asthma.
	Arthroscopy for ruptured ACL (L) leg.
	# (L) foot.
	Several gastroscopes & biopsy of polyp in Ayr.
	DHx NKDA.
	FHx
	Mother had MI in her 50s.
	SHx
	lives with wife
	Ex-smoker 15 years of 40/day.
	No alcohol.
	OE. Looks fit & well.
	CVS
	Pulse regular
	Heart sounds & well perfused, cap refill < 2 sec.
	HS. I+II+0.

0367691-SGH7

DATE | CLINICAL NOTES (Continued)



Abdomen soft, some generalised tenderness, ? hepato
it has been there for 10 years ? IBS
No guarding / rebound.

Name	LUL	RUL	LLL	RLL
Tone	(N)	(N)	(N)	(N)
Power	5/5	4/5 all muscle groups	5/5 proximal 4/5 ankle plant flexion & dorsiflexion	5/5
Reflexes	++	+	++	++
Sensation	(N)	↓ forearm, thumb on all finger tips, including thumb.	(N)	(N)

(P) Bloods ✓
Kardex.
Pt reports having chest pains last week. central chest
crampy ?. in light of family Hx & ↑ cholesterol
Suggest ECG

1/1/2011 Pt. radicular Sx in C6/7 dermatomal pattern
eg numbness and pain radiating to shoulder
Imaging reviewed - panicking root compression @ C6/7 &
C5/6 bilaterally (non vascular aetiology).
Best of discussing risks would be via anterior
approach although previous surgery and fusion
may make this difficult/impossible
Patient seen Above discussed Offered re-do
anterior decompression and if this not technically
feasible, interval posterior foraminotomy

CLINICAL NOTES

DATE	
	Aware that risks (nerve/cord damage, CSF leak, dysphagia, hoarseness, infection, failure to improve) discussed in full.
	Consent for surgery
	(CONSULTANT) - Anxious
31/1/11	Anaesthetic. for Tedro ACDF tomorrow
	Has mark phobia — but had GA last year — for the same — ACDF
	52 ♂. Asthma.
	Knee op, elbow op — many yrs ago
	gastric polyp — removal — May 10 — Ayr — however ill.
	oreflux since — Lansoprazole
	Meds obsessed OCD with 14
	- Lansoprazole
	- Ventolin — inhaler. PRN — last taken today.
	- Analgesia
	NKDA.
	Airway — Top denture — Previous Grade I Laryngo.
	(*) NSATD — G/ tyret + Wheeze (*)
	- For premed — see kardex
	- Please take all meds as usual -
	- 2 puffs Ventolin on leaving ward for Recbe
	Discussed
	1) Fast 12hrs. Sips water till 0400.
	2) Preoxygenate (C Midazolam) + IV induction (Propofol) (NB 20G in situ)
	3) Nervous obtain IV cannula to deal with

DATE	CLINICAL NOTES (Continued)
1/2/2011 17:30	Access to previous surgery site difficult and only the lower of the two scars could be exposed. Review of MRI suggested previous wool compression at both previously operated levels and retrospective decision therefore made to decompress lower level (T6/C6A) Previous scar removed with difficulty and extensive further decompression undertaken. Patient however being short too large for scars available and therefore bone graft taken from R tibia west. Post-op Mr Hawkins feels there has been significant improvement in the sensory symptoms in his R hand. He is aware that we have operated at the lower of the two previously operated levels and that we needed to take a bone graft from the right hip
2/2/11	WR BT, LA, LD. Post op I/T. Wounds had collapsed drain out today. Physio Lateral C-spine. T. Ward 7338
2/2/11	WR SPRS. PT Reports seen hip. (P) → Continue. T. Ward 7338.

THEATRE CARE PLAN
NEUROSURGERY

Southern General Hospital

PATIENT NAME	[redacted]	DATE 01/02/11 WARD 65	WATERLOW
ADDR	SG03251486 GEORGE HARKNESS 32C MILL SQUARE CATRINE AYRSHIRE 17/07/1958 KA5 6RD CHI 1707583579		
D.O.B.		486	ASTHMA - INHALOR WITH PATIENT
CONS			
Hb.	Blood available:		
		WEIGHT	

Proposed op: Revision C5/6 ACDF

PRE-OPERATIVE CHECK LIST	WARD YES	WARD N/A	THEATRE YES	THEATRE N/A	
1. Identification bracelet X 2	✓		✓		✓
2. Consent form signed	✓		✓		✓
3. Theatre gown/modesty pants	✓		✓		✓
4. T.E.D. Stockings on	✓		✓		✓
5. Pre-Medication given at: 0600 Hrs. And other medication: 1035 Hrs.	✓		✓		✓
6. Fasted from: 12mn	✓		✓		✓
7. Allergies NIL		✓		✓	NIL KNOWN
8. Artificial prosthesis removed NIL CAGE FROM PREV SURGERY		✓	✓		NOTED
9. Dentures/capped/crowned/loose teeth TOP SET	✓		✓		ON WARD
10. Nail polish/make-up/jewellery removed		✓		✓	NONE
11. Wedding ring taped	✓		✓		TAPED
12. I.V. in situ (R) hand ventlon.	✓		✓		NOTED
13. Urinary catheter in situ		✓		✓	NONE
14. To accompany patient: Case Notes	✓		✓		✓
Drug Kardex	✓		✓		✓
(Where appropriate) Hearing Aid				✓	NONE
Glasses NO CONTACT LENSES IN				✓	NONE
Other (Specify)				✓	NONE
15. Patient positioned correctly on trolley			✓		✓
on undersheet – Head at down – tilt end			✓		✓
16. Method of transfer: Pat Slide Straight Lift Other (Specify)					✓

WARD NURSE SIGN [signature]

THEATRE/RECOVERY NURSE SIGN [signature]

NAMED ANAESTHETIC NURSE [signature]

NAMED THEATRE NURSE C. GRIFFITHS / S. SINCLAIR

SGH 205 (0205205)

TEMP AT 1200 35.5.

ANAESTHETIC ROOM CARE:	DATE: 1/2/11	BP: 182/100	P: 115	SaO_2: 100%

ANAESTHETIST/S: DR WALKER / DR MCLUSKEY	ANAESTHETIC NURSE: SN KELLY.
TYPE OF ANAESTHETIC: INTUBATED ☑	VENOUS ACCESS (LEFT) . RIGHT
GA WITH E.T.T. SIZE 9.0 STANDARD ☑	20g LEFT WRIST INSITU.
L.M.A. ☐	16g LEFT HAND.
SEDATION/LA ☐	ARTERIAL MONITORING:
THROAT PACK ☐ NONE REMOVED ☐	
EYE GEL/VASELINE GAUZE — LACRILUBE ☑	C.V.P. MONITORING
EYES TAPED WITH MICROPORE 3X GREEN SNARES + SLEEK. ☑	
NASOGASTRIC TUBE ☐	SPINAL DRAIN: PRE-OP ☐ POST-OP ☐
CATHETER	
ANAESTHETIC NURSE SIGNATURE: Kelly.	

INTRA-OPERATIVE CARE:	METHOD OF TRANSFER:		PATIENT POSITION:	
	ROLL PATIENT	☐	SUPINE + HEAD RING.	☑
	PAT SLIDE + MAXI SLIDES	☑	PRONE	☐
	STRAIGHT LIFT	☐	SITTING	☐
	OTHER (SPECIFY)	☐	SEMI-SITTING	☐
PATIENT ON FULL LENGTH GEL MATTRESS,			LEFT/RIGHT LATERAL	☐
CONSENT AND ALLERGIES CHECKED WITH SSN. GRIFFITHS/SN. SINCLAIR. SURGICAL PAUSE COMPLETED BY SURGEONS.			3-PIN HEADREST	☐
			SKULL TRACTION	☐
			OTHER (SPECIFY)	☐

PREVENTION OF INJURY			
PILLOW UNDER KNEES UNDER GEL.	☑		
HEELS ELEVATED ON GEL SUPPORTS	☑	DIATHERMY SITE LEFT	RIGHT
LEFT ARM SECURED WITH J BOARD + ANETIC	☑	THIGH	
ACROSS ☐ AID CONFORMING PAD.		BUTTOCK	
AT SIDE	☑	OTHER (SPECIFY) # MESSY SAFETY LIGHT AT GREEN #	
RIGHT ARM SECURED WITH J BOARD + ANETIC	☑		
ACROSS ☐ AID CONFORMING PAD			
AT SIDE	☑		
LATERAL SUPPORTS	☐	TOURNIQUET TIME ON	TIME OFF
PADDING OF BONY PROMINENCES	☑	LEFT ARM/LEG	
SEQUENTIAL STOCKINGS + T.E.D.S	☑	RIGHT ARM/LEG	
WARMING BLANKET	☑		
GEL PADS	☑		

ALL ANAESTHETIC EQUIPMENT (CABLES/LEADS) PADDED AWAY FROM PATIENT.

	PRE-OPERATIVE			POST-OPERATIVE		
EVALUATION	YES	NO	N/A	YES	NO	N/A
PRESSURE AREA CHECK	#. ✓			✓		
DIATHERMY SITE CHECK	✓			✓		
TOURNIQUET SITE CHECK			✓			✓

PERI-OPERATIVE CARE:

SURGEON: MR BEHBAHANI	**SCRUB:** SSN GRIFFITHS SN SINCLAIR
ASSISTANT: MR DUNN.	**CIRCULATING NURSE:**

OPERATION PROCEDURE: C6/7 anterior cervical decompression ventrolateral and insertion of bone graft. Previous synthes cage removed
Bone graft taken from right iliac crest
13mls xylocaine with adrenaline 1% 1:400,000

SKIN CLOSURE Neck = 3/0 vicryl rapide Hip = staples.

DRESSING MEPORE to both wounds.

DRAINS x2

1 x ~~(illegible)~~ suction drain to neck

1x suction drain to hip - 10mls Chirocaine 0.5% to hip

OTHER (E.G. PACKS)

SPECIMENS TAKEN:

PATHOLOGY:

BACTERIOLOGY:

OTHER (SPECIFY):

SWAB/NEEDLE/INSTRUMENT COUNT	SCRUB NURSE SIGN	CIRCULATING NURSE SIGN
CORRECT	[signature]	[signature]
INCORRECT		
APPROPRIATE ACTION TAKEN		

IMPLANTS

POST OPERATIVE / RECOVERY CARE

NAMED NURSE: P. WEMYSS

TIME IN RECOVERY 15.05	**TIME OUT OF RECOVERY**
CONSULTANT/ANAESTHETIST Mr Behbahani / Dr Walker / Dr McCluskey	
PROCEDURE C6/7 ACD and revision and insertion of bone graft. Bone graft from Iliac Crest.	

ANGIOGRAPHY		**IMAGING**	
PUNCTURE SITE		**CT**	
PEDAL PULSE	"	**MRI**	
SHEATH SET			
AIRWAY REMOVED AT in theatre		**ICP MONITORING**	
OXYGEN 4 **LITRES** 6 hours, on SaO_2 95% on air		**VENTRIC DRAINS** – **HEIGHT**	
HUDSON MASK X		– **DRAINAGE**	
NASAL CANNULA ✓			
SaO_2 98% on 4L			

I.V.ACCESS (L) Hand R		**ARTERIAL LINE**	**C.V.P. LINE**
INFUSION RUNNING ☑	☐	**COMMENCED** ☐	**COMMENCED** ☐
CAPPED CANNULA/E ✓		**IN SITU** ☐	**IN SITU** ☐
DISCONTINUED		**REMOVED** ☐	

PAIN CONTROL	**PAIN RELIEF**	**WOUND** neck 3.0 Vicryl subcutaneous 4cm staples to neck	**DRAINS** 1x Suction to neck 1x Suction to L hip
PAIN FREE ☐	**IN SITU** ☐	**DRY** ☑	**PATENT** ☑
MILD ☐	**COMMENCED** ☐	**STAINING – SLIGHT** ☐	**BLOCKED** ☐
ANALGESIA IV morphine 4mg in theatre IV fentanyl 100 in theatre		**– HEAVY** ☐	**DRAINAGE (MLS)** ☐

PRESSURE AREAS: **POTENTIAL PROBLEM** ☐ **NO PROBLEMS** ☑

NEURO OBS: As charted. Vital signs stable. Desaturating to 92% on air. Continue on O_2 therapy as prescribed

COMMENTS: IV fluids running as prescribed. Patient feeling nauseous, IV Ondansetron 4mg given @ 15:30. Seen by Mr Behbahani in recovery. Patient warm, cold pack given. Taken sips of water. NPM. Inhaler returned with patient.

Collar to be worn for 6 weeks when over 45°, Drain out 24 hrs.

RECOVERY NURSE SIGNATURE: P. Wemyss

SOUTHERN GENERAL HOSPITAL

OPERATION REPORT 8

SG03251486
GEORGE HARKNESS
17/07/1958
KA5 6RD
Practice Code: 80749
CHI:1707583579

SURGEONS:

DATE: 01.02.11

M. Belbahaui / L. Dunn.

OPERATION PERFORMED

$C_{6/7}$ Anterior Cervical decompression; Revision and Removal of Cage and bone graft from R iliac crest.

FINDINGS & PROCEDURE

Under GA, Flucloxacillin on induction.

Position: Supine on horseshoe rest. Legs and drape. Infiltration.

Incision: Previous mid neck incision reopened.

Procedure: Neck dissection down to spine.

X Ray level marking. Cage exposed. Drilled all around to a depth of approx 14mm to release the cage. Solidly fixed in place.

Disc space drilled. Decompression both nerve roots decompressed.

Bone graft harvested from R iliac crest.

Inserted. Snug grip.

Haemostasis.

Suction drain.

Closure: Vicryl 2/0 to Fascia.

Vicryl 3/0 Rapide to subcuticular

clips to skin.

Mepore dressing.

Post-op: Collar for 6 weeks when over 45°.

TISSUE SENT FOR PATHALOGICAL EXAMINATION

Drain out 24 hrs.

Signature M. Belbahaui SpR.

0367654-SGH

South Glasgow Hospitals

ANAESTHETIC RECORD

NHS Greater Glasgow and Clyde

Date: 1 / 2 / 11.

Pre-op instructions:

Temazepam 20mg PR @ 10:75.

Fast for: AM Lunchtime PM List

SG03251486
GEORGE HARKNESS
32C MILL SQUARE
CATRINE
AYRSHIRE 17/07/1958
KA5 6RD CHI 1707583579

DOB

Proposed operation:
RG-DO C5/C6 ACDF.

Assessor: UR

Ward: 65

Pre-op assessment

Previous G.A.'s: Multiple - uneventful

CVS: HR BP /

Resp: Asthma – Ventolin PRN.

Other (specify):
Anxious ++.
See notes for rest of assessment

Fasted:

Reflux:

Drugs:
Lansoprazole
Ventolin

N.S.A.I.D's – Glupset/Wheeze.

Allergies:
NKDA.

BMI:

Weight (kg):

Airway: Previous Grade I.

Dentition: Upper denture

Investigations

Na+:	Hb:	Others (specify):
K+:	WCC:	
C1-:	Plts:	
HCO3-:	ECG: SR 66.	
Urea:	CXR:	
Creat:	Glucose	

Urgency		A.S.A.
Elective	☐	1
Scheduled	☑	(2)
Urgent	☐	3
Emergency	☐	4
		5

Comments / Warnings

Material risks explained ☐

Anaesthesia

Date: 1 / 2 / 11

Machine check: ☑ Circuit check ☑

Cannula: 16 G, (L)R (Hand) Arm Foot

Cannula: 20 G, (L)R Hand (Arm) Foot

Arterial site: CVP site:

Patient position: SUPINE

ECG ☐	NIBP ☐	S_pO_2 ☐
E_TCO_2 ☐	FiO_2 ☐	E_TAA ☐
ALLABOVE ☑		
TOF ☐	CVP ☐	IABP ☐
Blood warmer ☐	Patient warmer ☑	
Anti DVT ☑ (TEDs / sequentials)	U/O ☐	Temp ☐

Fluids
① 0.9% Nacl 1000ml ✓

Pre O_2 ☐

Cricoid ☐

Airway - (Oral) / Nasal

ETT size: 9.0 · LMA size:

(Oral) / Nasal Type: PORTEX.

(Cuffed) / Uncuffed Pack: In / Out

Venti 1 - Spontaneous / (Controlled)

600x12.

(Circle) Bain T-piece ADE

(Air) N_2O SEVO ISO (DES)

Laryngoscopy Grade: (1) 2 3 4

Time	1130	1200	30	1300	30	1400
FENTANYL ug	100					
PROPOFOL mg	200					
VECURONIUM mg	10		+4			
TEICOPLANIN	1-400mg →					
Midazolam mg			4			
SpO_2	99	98	98 98	98	98 98 98 98 98 98 98 98	
FiO_2	0.5	0.45	0.48 0.48	0.47	0.47 0.47 0.47 0.47 0.47 0.47	
$ETCO_2$	4.5	4.5	4.6 4.7	4.6	4.5 4.5 4.5 4.6 4.6 4.7 4.5	
E_TAA	6.2	6.9	7.0 7.0	7.0	7.1 7.1 7.2 7.0 6.7 6.7	
Fluids	①					
Temperature	35.5					

180 160 140 120 100 80 60 40 20

CVP

Blood loss

Urine output

Regional Anaesthesia / Other Procedures / Comments

Operation Details **Theatre:** 3

Operation as proposed on page 1 ☑ Reversal given: Yes ☐ No ☐

Anaesthetist(s): Walker / URITNIAGARAJAN@12	Surgeon(s): Dunn / Behbahani
Named Consultant: Dr	Discussed with Consultant: Yes ☐ No ☐

Post Operative Care

A. Oxygen 4 **L/min OR** **% for** 6 **hours OR SpO$_2$ >** 95 **% on air.**

B. Routine observations / postoperative care as per local protocol. ✓

C. Appropriate DVT prophylaxis precribed: Yes ☐ N/A ☐ TEDS

D. Anti-emetic given: Yes ☐ No ☐ ✓ **Drug given:**

E. Analgesia:

I.V. Morphine as per Recovery Algorithm - Sign [signature]		
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:

OR

I.V. Fentanyl as per Recovery Algorithm - Sign		
40 µm bolus - Time:	Sign:	Witness:
40 µm bolus - Time:	Sign:	Witness:
40 µm bolus - Time:	Sign:	Witness:
40 µm bolus - Time:	Sign:	Witness:
40 µm bolus - Time:	Sign:	Witness:

F. Post Operative fluids until drinking.

Fluid (additive)	Volume	Rate	Sign	Start	Lot No.	Initials
N/saline	500	100 mls/hr	[signature]			

Post operative notes / Comments

Post Operative Care

Time																	
SpO_2																	
O_2 L/min																	
Resp Rate																	
Airway																	
180																	
160																	
140																	
120																	
100																	
80																	
60																	
40																	
20																	
Temperature																	
CVP																	
Wound site																	
fected limb pulse: +ve/-ve																	
Circulation Satisfactory:S Poor: P																	
Sensation +ve/-ve																	
Movement +ve/-ve																	
Sedation/Pain score																	
Nausea score																	

Time	Fluid in	Urine	Drain 1	Drain 2

Blood results / Drug given

Additional nursing comments

Waterlow Score ☐ **Intervention required:**

Discharge criteria met:	**Discharged to:**	**Recovery Nurse name:**	**Ward Nurse name:**
Yes ☐ NO ☐	Ward:	.....	.....
Comments:	HDU ☐ ITU ☐	Signature:	Signature:
		.....	.....

VIC 638 Cat. No. 0163149 VI MEDICAL ILLUSTRATION • ANAES • 1985/6.05

INSTITUTE OF NEUROLOGICAL SCIENCES
SOUTHERN GENERAL HOSPITAL

NHS Greater Glasgow and Clyde

NAME George Harkness
UNIT No. SG0325 1486
CHI No. 1707583579
DOB 17/07/58
Use addressograph label if available

WARD: G5
CONSULTANT: Mr Dunn.

Pre-Operative Checklist

	Yes	N/A
Identification bracelets Wrist ✓ Ankle ✓	✓	
Consent Form signed	✓	
Theatre gown/modesty pants	✓	
TED stockings applied	✓	
Pre-medication given at hrs and other medication 0630 hrs	✓	
Fasted from 12 Midnight.	✓	
Allergies:		✓
Artificial prosthesis removed Previous ACDF with Cage	✓	
(Dentures)/capped/crowned/loose teeth TOP SET ON WARD	✓	
Nail polish/make-up/jewllery removed		✓
Wedding ring taped	✓	
IV insitu x1 (L) HAND	✓	
Urinary catheter insitu		✓
To Accompany Patient:		
Case Notes	✓	
Drug Kardex	✓	
Nursing Notes	✓	
Inhalers x1 SALBUTAMOL.	✓	
Glasses		✓
Hearing Aid/Other		✓
X-Rays and CT scans		✓

Checklist Completed: *Ward Nurse Signature* C. Mackie.

RECOVERY CAREPLAN-SPINAL

Date time	problem	Nursing action	Aim of care	Intl-review
1/2/11	**Compromised airway due to surgery and/or anaesthetic**	Observe patients respirations and colour. give prescribed oxygen therapy Nurse in the appropriate position	To maintain a clear airway and encourage optimum chest expansion	
11	**Abnormalities in limb power**	Check limb power as appropriate Document and chart findings on appropriate chart Report abnormalities	Early detection and appropriate intervention initiated	
11	**Deterioration in vital signs Blood pressure, pulse temp due to anaesthetic and surgery**	Monitor BP/pulse and temp until stable Report and record abnormalities	Early detection of abnormalities	
11	**Post operative nausea and vomiting**	Give prescribed anti emetics and maintain fluid regime .give patient appropriate psychological support to ensure they do not become distressed Document effect	Alleviate nausea and vomiting. Ensure Patient is comfortable and settled	
11	**Post-operative pain**	Give prescribed analgesia(see drug kardex and anaesthetic chart) document effect	To ensure patient is as pain free as possible	
11	**Maintenance of hydration**	Administer prescribed intravenous fluids Observe and chart urinary output Chart fluid balance	Maintenance of fluid balance	
11	**Wound following surgery**	Observe wound regularly Report abnormalities	Early detection of abnormalities	
11	**Post operative anxiety and disorientation**	Explain clearly all nursing interventions Re-orientate patient to environment/time/place	To relieve anxiety and re-orientate patient	

SG03251486
GEORGE HARKNESS
32C MILL SQUARE
CATRINE
AYRSHIRE 17/07/1958
KA5 6RD CHI 1707583579

SOUTHERN GENERAL HOSPITAL

OPERATION REPORT 8

SG03251486
GEORGE HARKNESS
32C MILL SQUARE
CATRINE
AYRSHIRE 17/07/1958
KA5 6RD CHI 1707583579

SURGEONS: DATE: 28.09.09

M. Ebbahani / B. Stepien.

OPERATION PERFORMED

$C_{5/6}$; $C_{6/7}$ Anterior Cervical Decompression and Fusion.

FINDINGS & PROCEDURE

Under GA, Cefuroxime on induction.

Position, Supine on horseshoe head rest and butterfly neck support.

Prep and drapes. Infiltration.

Incision, Mid cervical crease.

Procedure, Sharp and blunt dissection down to spine. X Ray level marking. Disc space excavated. Disc spaces drilled. Good lateral decompression. Large osteophyte disc bar specifically in 5/6 level excised. Good decompression achieved. 2. 5x5 Wedge implants filled with bone inserted.

Haemostasis.

Closure, Vicryl 2/0 to platisma.

Vicryl 3/0 Rapide to subcuticular.

Suction drain.

Mepore.

Post-op, Mobilize day 1.

Drain out 24 hrs.

TISSUE SENT FOR PATHALOGICAL EXAMINATION

Signature M. Ebbahani SpR

South Glasgow University Hospitals NHS Trust

CONSENT TO ANAESTHESIA, OPERATION OR TREATMENT

NHS Greater Glasgow

Name: .....

D.O.B.: .....

Unit number: .....

Notes for guidance of [illegible] overleaf.

SG03251486
GEORGE HARKNESS
32C MILL SQUARE
CATRINE
17/07/1958
KA5 6RD CHI 1707583579

..... Date: 27/4/09

TO BE COMPLETED BY MEDICAL OR DENTAL PRACTITIONER

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

ANTERIOR CERVICAL DECOMPRESSION WITH OR WITHOUT FUSION

I confirm that I have explained the procedure, important risks and appropriate alternatives to the patient in terms which, in my judgement, are suited to the understanding of the patient, and/or to one of the parents or guardians of the patient.

Name: A. SAXENA (BLOCK CAPITALS) Signature: Saxena

TO BE COMPLETED BY THE PATIENT OR CHILD'S PARENT / GUARDIAN

You should read this form and the notes overleaf carefully. If there is anything you do not understand, ask the doctor or dentist for an explanation. If the information is correct and you understand the procedure, you should sign the form.

I UNDERSTAND
- The procedure, important risks and appropriate alternatives which has been explained to me by the Doctor / Dentist on this form.
- That the procedure may not be carried out by the Doctor / Dentist who has been treating me so far.
- That any procedure in addition to that named on this form will only be carried out if it is necessary and in my best interests and can be justified for medical reasons.

I AGREE
- To the procedure named on this form.
- To the administration of an anaesthetic or sedation if required.

For female (12-55 years) who may be exposed to ionising radiation between the diaphragm and knee:

I believe that: I am or may be pregnant / I am not pregnant (Delete as appropriate)

Name: GEORGE HARKNESS Signature: G Harkness

Patient / Parent / Guardian (Delete as appropriate)

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

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

Name: ..... (BLOCK CAPITALS) Signature: .....

CONFIRMATION OF NEUROSURGEONS PAUSE
Dept of Neurosurgery
Southern General Hospital
Glasgow

Patient Details:

Name	SG03251486 GEORGE HARKNESS
DoB / CHI No.	32C MILL SQUARE CATRINE AYRSHIRE 17/07/1958
Unit No	KA5 6RD CHI 1707583579

TO BE COMPLETED BY OPERATING SURGEON AFTER POSITIONING PATIENT IN THEATRE

Date 28.04.09 Time 15,30

Site of lesion(s) or abnormality(ies)	Site of Incision
Right ✗	Right ✓
Left	Left.
Midline	Midline
Bilateral ✓	Bilateral
No lesion or abnormality	

Signature of surgeon.....

Print name..... Rehbaleem .....

THEATRE CARE PLAN
NEUROSURGERY

Southern General Hospital

PATIENT'S NAME George Harkess		**DATE** 28/4/09 **WARD** 65 **WATERLOW**	
ADDRESS			
D.O.B. 17-7-58 **UNIT No.** 03251486			
CONSULTANT			
Hb.	**Blood available:**	**WEIGHT**	

C5/6 C6/7 ACDF.

PRE-OPERATIVE CHECK LIST	WARD YES	WARD N/A	THEATRE YES	THEATRE N/A
1. Identification bracelet	✓		✓	
2. Consent form signed	✓		✓	
3. Theatre gown/modesty pants	✓		✓	
4. T.E.D. Stockings on	✓		✓	
5. Pre-Medication given at: 1900 Hrs. And other medication: Hrs.	✓		✓	
6. Fasted from: BAST 12MN.	✓		✓	
7. Allergies	✓			NONE KNOWN
8. Artificial prosthesis removed		✓		✓
9. Dentures/capped/crowned/loose teeth	✓		✓	
10. Nail polish/make-up/jewellery removed		✓		✓
11. Wedding ring taped	✓		✓	
12. I.V. in situ		✓		✓
13. Urinary catheter in situ		✓		✓
14. To accompany patient: Case Notes	✓		✓	
Drug Kardex	✓		✓	
(Where appropriate) Hearing Aid	✓	✓		✓
Glasses	✓	✓		✓
Other (Specify)		✓		✓
15. Patient positioned correctly on trolley			✓	
on undersheet – Head at down – tilt end			✓	
16. Method of transfer: Pat Slide Straight Lift Other (Specify)				

WARD NURSE SIGN	S Matthews
THEATRE/RECOVERY NURSE SIGN	J M'Gaw
NAMED ANAESTHETIC NURSE	T Laing
NAMED THEATRE NURSE	

SGH 205 (0205205)

ANAESTHETIC ROOM CARE:	DATE:	BP: 143/101	P: 92	SaO_2: 99

ANAESTHETIST/S Dr Murray/Blacoe		ANAESTHETIC NURSE Young	
TYPE OF ANAESTHETIC: GA	INTUBATED ☑	VENOUS ACCESS (LEFT)	RIGHT
GA.WITH E.T.T. Size 8.0 Standard	☑	20G hand	
L.M.A.	☐	16G hand	
SEDATION/LA	☐	ARTERIAL MONITORING:	
THROAT PACK ☐	REMOVED ☐		
EYE GEL/VASELINE GAUZE Lacri Lube	☑	C.V.P. MONITORING	
EYES TAPED WITH MICROPORE + padded	☑		
NASOGASTRIC TUBE	☐	SPINAL DRAIN: PRE-OP ☐	POST-OP ☐
CATHETER			
ANAESTHETIC NURSE SIGNATURE: T Young.			

INTRA-OPERATIVE CARE:	METHOD OF TRANSFER:		PATIENT POSITION:	
	ROLL PATIENT	☐	SUPINE	☑
	PAT SLIDE	☑	PRONE	☐
	STRAIGHT LIFT	☐	SITTING	☐
	OTHER (SPECIFY)	☐	SEMI-SITTING	☐
	Maxi Slides ✓		LEFT/RIGHT LATERAL	☐
			3-PIN HEADREST	☐
Patient on conforming mattress			SKULL TRACTION	☐
			OTHER (SPECIFY)	☐

PREVENTION OF INJURY			
PILLOW UNDER KNEES	☑		
HEELS ELEVATED	☑	DIATHERMY SITE	LEFT RIGHT
LEFT ARM SECURED WITH J BOARD	☑	THIGH	
ACROSS	☐	BUTTOCK	
AT SIDE	☑	OTHER (SPECIFY)	
GHT ARM SECURED WITH J BOARD	☑		
ACROSS	☐		
AT SIDE	☑		
LATERAL SUPPORTS	☐	TOURNIQUET TIME ON	TIME OFF
PADDING OF BONY PROMINENCES	☑	LEFT ARM/LEG	
SEQUENTIAL STOCKINGS TEDS	☑	RIGHT ARM/LEG	
WARMING BLANKET	☑		
GEL PADS	☐		

	PRE-OPERATIVE			POST-OPERATIVE		
EVALUATION	YES	NO	N/A	YES	NO	N/A
PRESSURE AREA CHECK						
DIATHERMY SITE CHECK						
TOURNIQUET SITE CHECK						

PERI-OPERATIVE CARE:

SURGEON: Mr. BEHBAHANI	**SCRUB:** L. JOHNSTON
ASSISTANT:	**CIRCULATING NURSE:** H. MCKERNIE, S. STRATON, S. THOMSON

OPERATION PROCEDURE:

RIGHT C5/6, C6/7 ANTERIOR CERVICAL DECOMPRESSION AND FUSION.

SYNTHES CAGES 5.5mm X2.

SKIN CLOSURE 3/0 VICRYL RAPIDE

DRESSING MEPORE

DRAINS X1 WOUND SUCTION DRAIN ~~X~~ STITCHED IN ~~X~~.

OTHER (E.G. PACKS)

SPECIMENS TAKEN:

PATHOLOGY:

BACTERIOLOGY:

OTHER (SPECIFY):

SWAB/NEEDLE/INSTRUMENT COUNT	SCRUB NURSE SIGN	CIRCULATING NURSE SIGN
CORRECT		
INCORRECT		
APPROPRIATE ACTION TAKEN		

IMPLANTS

NHS
Greater Glasgow and Clyde

Institute of Neurological Sciences

Anaesthetic Record

Date:	28/4/9
Operation:	ACDF
Surgeons:	Mac
Anaesthetists:	Murray Blacoe
Responsible Cons:	
D/W Cons	Yes ☑ No ☐ Level (1) 2 3

Post-operative Care 6L O2 til fully awake

a. Oxygen _____ flowrate / % for ____hrs or until SaO_2 >_____% on air

b. Routine Obs/postop are as per local protocol

c. DVT prophylaxis Yes ☐ No ☐

d. Antiemetic given Yes ☐ No ☐

e. Analgesia

Signature of Anaesthetist : [signature]

Post-op fluids

Type	Vol	Rate	Time started	Sign
0.9%NaCl	500	125ml/h		[signature]

Morphine as per recovery algorithm

Sign. Anaes:- [signature]

2mg bolus	Time 1840	Sign: [signature]	Witness: [signature]
2mg bolus	Time 1845	Sign: [signature]	Witness: [signature]
2mg bolus	Time 1855	Sign: [signature]	Witness: [signature]
2mg bolus	Time 1900	Sign: [signature]	Witness: [signature]
2mg bolus	Time	Sign:	Witness:

POST OPERATIVE / RECOVERY CARE

NAMED NURSE: Alice O'Donnell

TIME IN RECOVERY 18:00hrs	**TIME OUT OF RECOVERY**
CONSULTANT/ANAESTHETIST Mr. Behbahani / Dr Murad	
PROCEDURE Right C5/6 - C6/7 Anterior cervical Decompression	

ANGIOGRAPHY	**IMAGING**
PUNCTURE SITE	**CT**
PEDAL PULSE	**MRI**
SHEATH SET	
AIRWAY REMOVED AT Recovery - 18:05hrs	**ICP MONITORING**
OXYGEN 4 **LITRES** until fully awake discontinued	**VENTRIC DRAINS** - **HEIGHT**
HUDSON MASK ✓	- **DRAINAGE**
NASAL CANNULA	
SaO_2 99% - 100% on AVPU	

I.V.ACCESS	**L** **R**	**ARTERIAL LINE**	**C.V.P. LINE**
INFUSION RUNNING	☑ ☐ hand	**COMMENCED** ☐	**COMMENCED** ☐
CAPPED CANNULA/E		**IN SITU** ☐	**IN SITU** ☐
DISCONTINUED		**REMOVED** ☐	
PAIN CONTROL	**PAIN RELIEF**	**WOUND** Bovidyl rapide mode!	**DRAINS** ☒ (Wound drain sutured)
PAIN FREE ☐	**IN SITU** ☐	**DRY** ☑	**PATENT** ☑
MILD ☑	**COMMENCED** ☐	**STAINING - SLIGHT** ☐	**BLOCKED** ☐
ANALGESIA Morphine 2mg IV at 18:10hrs, 18:55hrs + 19:00hrs		**- HEAVY** ☐	**DRAINAGE (MLS)** ☐
ondansetron 4mgs IV at 18:20hrs.			minimal.

PRESSURE AREAS: **POTENTIAL PROBLEM** ☐ **NO PROBLEMS** ☐

~~NEURO~~ OBS: Limb movements recorded & charted every 10mins - no deficits

Vital signs recorded & charted every 10mins - Blood pressure 168/107

COMMENTS: pulse 73 Temperature 36.5°C

IV fluids running as prescribed

Was not passed urine

Tolerating sips of water

RECOVERY NURSE SIGNATURE: [signature]

Institute of Neurological Sciences

NHS Greater Glasgow and Clyde

Anaesthetic Preoperative Assessment

Na
Ur
Do

SG03251486
GEORGE HARKNESS
32C MILL SQUARE
CATRINE
AYRSHIRE 17/07/1958
KA5 6RD CHI 1707583579

Pre-op Instructions:

Date:

Fasting:

Name of Assessor:	Premed	Date	Time	Sign
Proposed Op: AeBF (5) Ward: 65				

Pre-Operative Notes:

Previous GA:
Cruciate repair ⓡ knee Asthma.
Elbow op.

PONV ++

SUBOC - stairs ex smoker 18yrs.
steep hills 30 mins on level OK.
OCP lots for months.

Drugs:
Co-dydramol Salt
Codeine
Salbutamol Generic
Prochlorp.

Amitrol - for carpal syndrome

Risks:

Technique:

Allergies:
NKDA.

HR: reg clear.

BP:

Weight:	Height:	Reflux: Heartburn x2/wk v. infrequent → mouth.	Dentition: edent.	Airway: MOV MMP I thyg A mal opt OK.	
Results				Urgency	ASA
Na^+	Gluc	Hb 160		Elective	1
K^+		WBC 7.7		Scheduled	2
Cl^- (W)		Pl 357		Urgent	3
Urea		CXR		Emergency	4
Creat		ECG SR NAD			5

(Path W)

Canulae site R☐ L☑ Size 20 hand☑ arm☐ foot☐ R☐ L☑ Size 18 hand☐ arm☑ foot☐	Pre O_2 Airway	cricoid oral☑ nasal☐
Arterial line site	ETT size:	cuffed/uncuffed
CVP line site	Oral/Nasal	
Patient position supine	Tube 8.0	Throat pack Grade (1) 2 3 4

LMA size:	
Vent: NA	Spont
TV: 500	RR: 12
Circle	Bain Tpiece
Air	N_2O ISO S

Hours / Mins.	15 00	16 00	17 00
FiO_2	1.0 0.5	0.5 0.5	0.5 0.5
SaO_2	98 98	97 97	98 98
$ETCO_2$	3.9 3.9	4.0 4.1	4.2 4.4
MAC/ETag	1.2 1.45	1.1 0.9	1.15 1.15
Temp			
CVP			

BP X 110
Pulse 100

Urine
Fluids (1) (2) (3)

Propofol 200mg
VEC 10 mg
Ceftriaxone 1.5g
Paracetamol 1g
Air/O2 / ISO

Morphine 5mg

Notes
Remi 0.4 → 0.2

Fluids
(1) 0.9% NaCl
(2) 0.9% NaCl
(3) 0.9% NaCl

	ECG		ETag	✓	Patient warmer	✓
led	NIBP		TOF	✓	Calf compression	
	SaO_2		IABP		Blood warmer	
	$ETCO_2$		CVP		Apparatus checked	✓
E	FiO_2		Temp			
DES	All above	✓	UO	✗		

Hours
Mins.
FiO_2
SaO_2
$ETCO_2$
MAC/ETag
Temp
CVP

190
180
170
160
150
140
130
120
110 B.P. X
100 Pulse
90
80
70
60
50
40
30
20

Urine
Fluids

30
50
100

NHS
Greater Glasgow and Clyde

Institute of Neurological Sciences

Anaesthetic Record

Date:	28/4/9
Operation:	ACDF
Surgeons:	Mac
Anaesthetists:	Murray Blacoe
Responsible Cons:	
D/W Cons	Yes ☑ No ☐ Level (1) 2 3

Post-operative Care 6 L O2 til achy awake

a. Oxygen _____ flowrate / % for ____ hrs or until SaO_2 >_____% on air

b. Routine Obs/postop are as per local protocol

c. DVT prophylaxis Yes ☐ No ☐

d. Antiemetic given Yes ☐ No ☐

e. Analgesia

Signature of Anaesthetist : Murray

Post-op fluids

Type	Vol	Rate	Time started	Sign
0.9% NaCl	500	125ml/h		Murphie

Morphine as per recovery algorithm

Sign. Anaes:- Murphie

2mg bolus	Time 1840	Sign: Meade	Witness: JMD
2mg bolus	Time 1845	Sign: Meade	Witness: JMD
2mg bolus	Time 1855	Sign: Meade	Witness: JMD
2mg bolus	Time 1900	Sign: Meade	Witness: JMD
2mg bolus	Time	Sign:	Witness:

Ward Theatre Check List

Neurosurgery

Patients name: George Hawkness Date: 28/4/09

Ward: 65

Address:

DoB: 17/7/58 Unit No:.....

Consultant: Mr Dunn Height:..... Weight:.....

Pre-Operative Checklist

	Yes	N/A
Identification bracelets Wrist ✓ Ankle ✓	✓	
Consent Form signed	✓	
Theatre gown/modesty pants	✓	
TED stockings applied	✓	
Pre-medication given at — hrs and other medication 0600 hrs	✓	
Fasted from hrs midnight	✓	
Allergies: Nil of note		✓
Artificial prosthesis removed		✓
Dentures/capped/crowned/loose teeth		
Nail polish/make-up/jewellery removed		✓
Wedding ring taped	✓	
IV insitu		✓
Urinary catheter insitu		✓
To Accompany Patient:		
Case Notes	✓	
Drug Kardex	✓	
Nursing Notes	✓	
Inhalers	✓	
Glasses		✓
Hearing Aid/Other		✓
X-Rays and CT scans		✓

Check List Completed: *Ward Nurse Signature*..... Voon.....

RECOVERY CAREPLAN-SPINAL

28/4/09

Date time	problem	Nursing action	Aim of care	Intl-review
(1)	**Compromised airway due to surgery and/or anaesthetic**	Observe patients respirations and colour.give prescribed oxygen therapy Nurse in the appropriate position	To maintain a clear airway and encourage optimum chest expansion	
(2)	**Abnormalities in limb power**	Check limb power as appropriate Document and chart findings on appropriate chart Report abnormalities	Early detection and appropriate intervention initiated	
(3)	**Deterioration in vital signs Blood pressure,pulse temp due to anaesthetic and surgery**	Monitor BP/pulse and temp until stable Report and record abnormalities	Early detection of abnormalities	
(4)	**Post operative nausea and vomiting**	Give prescribed anti emetics and maintain fluid regime.give patient appropriate psychological support to ensure they do not become distressed Document effect	Alleviate nausea and vomiting.Ensure Patient is comfortable and settled	
(5)	**Post-operative pain**	Give prescribed analgesia(see drug kardex and anaesthetic chart) document effect	To ensure patient is as pain free as possible	
(6)	**Maintenance of hydration**	Administer prescribed intravenous fluids Observe and chart urinary output Chart fluid blanace	Maintenance of fluid balance	
(7)	**Wound following surgery**	Observe wound regularly Report abnormalities	Early detection of abnormalities	
(8)	**Post operative anxiety and disorientation**	Explain clearly all nursing interventions Re-orientate patient to environment/time/place	To relieve anxiety and reorientate patient	

SG03251486
GEORGE HARKNESS
32C MILL SQUARE
CATRINE
17/07/1958
KA5 6RD CHI 1707583579

28/04/09.

Ward 65

0369788-SGH 157

I[illegible]TUTE OF NEUROLOGICAL
S ICES. GLASGOW

REFERRING CONSULTANT

DS

WARD

63

LABEL

NA

AD SG03251486
GEORGE HARKNESS
32C MILL SQUARE
PO CATRINE
AYRSHIRE 17/07/1958
KA5 6RD CHI 1707583579

T NO

DEPT. NO

HISTORY, FINDINGS, DIAGNOSIS
(Include previous relevant investigations and give date, place and Ref. No.)

Intra-operative imaging for localisation ? level

DETAILS OF REQUEST

X-Rays
Clinical
Spine
Please

NEURO IMAGING	Tick
EMG	
EV POT'LS	
EEG	
NEUROPATHOLOGY	
OPHTHALMOLOGY	
OTOLOGY	
PSYCHIATRY	
RADIOTHERAPY	
PSYCHOLOGY	
SPEECH THERAPY	
OCCUPATIONAL THER.	
PHYSIOTHERAPY	
SOCIAL WORKER	
CONSULTATION BY DR/MR	

PREGNANT
YES
EXEMPT
URGENT
NO

OPERATION DATE

SITE

DEPARTMENT USE

IMAGING CODE OF PRACTICE
The requesting clinician must be satisfied that this examination is necessary and a doctor must sign the card.

PREGNANCY RULE
Where the abdomen is to be irradiated the risk of harm to the foetus must be considered. If in doubt consult the radiologist.

SIGNATURE .....
NAME IN BLOCK LETTERS ..... SAXENA

DATE OF REQUEST ..... 27/4/09 .....

PAGE OR EXT. NO 7481

DEPARTMENT OF NEUROSURGERY
Institute of Neurological Sciences

Direct Line: 0141 201 2020
Direct Fax: 0141 201 2995
Enquiries: Secretary, Mrs Janice Lafferty
E-mail: Janice.Lafferty@ggc.scot.nhs.uk

Southern General Hospital
1345 Govan Road
GLASGOW
G51 4TF

LTD/JL
Clinic: 09/06/11
Typed: 10/06/11

DR DAVID DA RICHARDSON
BALLOCHMYLE MEDICAL GROUP
INSTITUTE AVENUE
KA5 6RU

Dear Dr Richardson

GEORGE HARKNESS DOB: 17/07/58 (SG03251486) CHI: 1707583579
32C MILL SQUARE, CATRINE, AYRSHIRE, KA5 6RD

I reviewed Mr Harkness and his wife in the clinic today on behalf of Mr Dunn. He is now just over 4 months following his revisional anterior cervical decompression. As you are aware he underwent a 2 level ACDF in 2009 for right arm pain which did improve post operatively but unfortunately returned after a short period of time. Ultimately he was readmitted for revisional surgery, which was performed on the 1st February this year, the access was not easy but the lower of the 2 levels was decompressed and an iliac crest graft inserted.

Mr Harkness tells me that his symptoms have now completely resolved and he has been back at work 6 weeks following his procedure. He is very happy with the outcome of his surgery, his wound has healed nicely and I am happy to discharge him from the neurosurgical clinic. Post operative x-ray shows the bone graft in good position and cage at the upper level.

Yours sincerely,

Mr M White
SpR to Mr Dunn, Consultant Neurosurgeon

Acute Services Division

Regional Services Directorate

NHS
Greater Glasgow and Clyde

DEPARTMENT OF NEUROSURGERY
Institute of Neurological Sciences

Direct Line: 0141 201 2020
Direct Fax: 0141 201 2995
Enquiries: Secretary, Mrs Janice Lafferty
E-mail: Janice.Lafferty@ggc.scot.nhs.uk

Southern General Hospital
1345 Govan Road
GLASGOW
G51 4TF

LTD/JL
Dictated: 03/03/11
Typed: 09/03/11

DR DAVID DA RICHARDSON
BALLOCHMYLE MEDICAL GROUP
INSTITUTE AVENUE
KA5 6RU

Dear Dr Richardson

GEORGE HARKNESS DOB: 17/07/58 (SG03251486) CHI: 1707583579
32C MILL SQUARE, AYRSHIRE, KA5 6RD

DISCHARGE SUMMARY
Consultant: Mr L T Dunn
Admitted: 31/01/11
Discharged: 04/02/11
Diagnosis: Cervical Radiculopathy 7001
Cervical Spondylosis 7008
Procedure: Revision anterior cervical decompression 9107

History: Mr Harkness was admitted with a view to revision surgery for his cervical spondylosis. He underwent a 2 level anterior cervical decompression and fusion in 2009 for predominantly right-sided arm pain. He had initial improvement following his surgery but approximately 6 months later his right-sided brachalgia recurred in a similar distribution to that present pre operatively. Pain radiated from the shoulder in the upper arm, forearm and lateral three fingers with some associated sensory change in the same area. Pre operative electrophysiological studies showed mild right-sided carpal tunnel syndrome but were otherwise unhelpful in localising the level. Post operative imaging suggested some persisting nerve root compression at the previously operated surgical levels.

Operation (MB/LD 1/2/11) - Revision C6/7 anterior cervical decompression, removal of cage and insertion of bone graft from the right iliac crest.
Intraoperatively access to the previously operated levels was poor and only the lower of the two levels could be adequately accessed. The cage at this level was removed and the decompression extended. The resulting bony defect was too large for a further cage and a bone graft was therefore taken from the right iliac crest.

GEORGE HARKNESS
17/07/58
CHI:1707583579

Progress: Mr Harkness felt there had been a significant improvement in the sensory symptoms in his right arm and hand. He mobilised with the help of the physiotherapists and wearing a hard collar, which he has been instructed to wear for 4 to 6 weeks post operatively. He was well enough to be discharged home on 4 February 2011.

Follow Up: Neurosurgical out patient review 3 -4 months time

Copies: GP

Yours sincerely

Mr L T Dunn
Consultant Neurosurgeon/
Honorary Senior Clinical Lecturer in Neurosurgery

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL, 1345 GOVAN ROAD, GLASGOW G51 4TF
TEL: 0141 201 1100

DEPARTMENT OF NEUROSURGERY
INSTITUTE OF NEUROLOGICAL SCIENCES

WARD: S65 CONSULTANT: MR LAURENCE DUNN
CONTACT NO: 0141 201 2020

IMMEDIATE DISCHARGE LETTER

PATIENT: GEORGE HARKNESS
32C MILL SQUARE
AYRSHIRE
KA5 6RD

DOB: 17/07/58 UNIT NO: SG03251486
ACCT NO: IP0002457/11
CHI NO: 1707583579

GP: DR DAVID DA RICHARDSON
BALLOCHMYLE MEDICAL GROUP
INSTITUTE AVENUE
KA5 6RU

DATE OF ADMISSION: 31/01/11
ADMISSION TYPE: ELECTIVE
DATE OF DISCHARGE: 04/02/11
DISCHARGE TO: HOME

REASON FOR ADMISSION: POSTERIOR FORAMINOTOMY @ C6 on right
MAIN DIAGNOSIS: NERVE ROOT COMPRESSION C5/6 BILATERALLY; RECURRENT RIGHT RADICULOPATHY
OTHER ACTIVE PROBLEMS: ASTHMA; CRUCIATE LIGAMENT REPAIR LEFT KNEE

OPERATIONS/PROCEDURES/ TREATMENT: C6/7 ANTERIOR CREVICAL DECOMPRESSION, REVISION & REMOVAL OF CAGE AND BONE GRAFT FROM ILIAC CREST
RESULTS AWAITED: N
CURRENT MEDICATION: SEE PRESCRIPTION
DISCONTINUED DRUGS? N
COMMENT: COLLAR FOR 6 WEEKS WHEN OVER 45 DEG

ALLERGIES:
NIL

REVIEW? Y DETAILS: OPC TIMESCALE: TBA

FURTHER LETTER TO FOLLOW? Y DETAILS: FORMAL HOSPITAL LETTER

Highly Sensitive Document Y/N N Patient consent to share information Y/N Y

SIGNED: FY2.MURAL MURDOCH,ALLISON
SIGNATION: FOUNDATION DR YEAR 2
GE NUMBER: 7040

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL, 1345 GOVAN ROAD, GLASGOW G51 4TF
TEL: 0141 201 1100

DEPARTMENT OF NEUROSURGERY
INSTITUTE OF NEUROLOGICAL SCIENCES

WARD: S65 **CONSULTANT: MR LAURENCE DUNN**
CONTACT NO: 0141 201 2020

IMMEDIATE DISCHARGE LETTER

PATIENT: GEORGE HARKNESS
32C MILL SQUARE
AYRSHIRE
KA5 6RD

DOB: 17/07/58 UNIT NO: SG03251486
ACCT NO: IP0002457/11
CHI NO: 1707583579
GP: DR DAVID DA RICHARDSON

---------- D I S C H A R G E M E D I C A T I O N ----------

Time Required? Routine - within 4 hours
Childproof Containers? Y
Compliance Aid Required? N
Patient's Weight (Kg):
Comment:

Medication	Form	Dose	Frequency	Duration
LANSOPRAZOLE	OTAB	30MG	IN THE MORNING	INDEFINITE
New Drug? N New Dose? N	Comments:			
Patient's Own Supply? N	Pharmacy Notes:			Supply:

Medication	Form	Dose	Frequency	Duration
VENTOLIN INHALER	INH	2PUFFS	AS REQUIRED	INDEFINITE
New Drug? N New Dose? N	Comments:			
atient's Own Supply? Y	Pharmacy Notes:			Supply:

dication	Form	Dose	Frequency	Duration
RACETAMOL	OTAB	1G	4 TIMES A DAY	REVIEW
New Drug? Y New Dose? Y	Comments:			
Patient's Own Supply? N	Pharmacy Notes:			Supply:

Medication	Form	Dose	Frequency	Duration
DIHYDROCODEINE	OTAB	60MG	4 TIMES A DAY	REVIEW
New Drug? Y New Dose? Y	Comments:			
Patient's Own Supply? N	Pharmacy Notes:			Supply:

Medication	Form	Dose	Frequency	Duration
TRAMADOL	OTAB	50-100MG	AS REQUIRED	REVIEW
New Drug? Y New Dose? Y	Comments:			
Patient's Own Supply? N	Pharmacy Notes: 4-6 HOURLY			Supply:

Medication	Form	Dose	Frequency	Duration
lew Drug? New Dose?	Comments:			
atient's Own Supply?	Pharmacy Notes:			Supply:

dication	Form	Dose	Frequency	Duration
New Drug? New Dose?	Comments:			
Patient's Own Supply?	Pharmacy Notes:			Supply:

PHARMACY USE ONLY DISPENSED BY: DATE: CHECKED BY:
CLINICAL PHARMACIST CHECK: COLLECTED BY: _____

Medicine received on ward by: _____ Issued by: K. Wilson

Named Nurse: _____ Signature of Receipt: C. McFarlane

Report Number: 0302-0054 Date(Time): 03/02/11 (2225 Hours) Status: Signed

Institute of Neurological Sciences
Department of Neurosurgery
Ward 65, 4th floor
Southern General Hospital Zone 3
1345 Govan Road
Glasgow G51 4TF

0141 201 2020
Enquiries: Secretary, Mrs Janice Lafferty
Email: Janice.Lafferty@GGC.Scot.NHS.UK

LTD/JL/3251486

Mr George Harkness
32C Mill Square
Catrine
Ayrshire
KA5 6RD

Dear Mr Harkness

Your admission to ward 65; neurosurgery has been provisionally planned for Monday 31st January 2011.
Please read through the following checklist carefully and ensure these are met before your admission. Failure to do so might result in the cancellation of your operation.

- ☐ Confirm you acceptance of the proposed date by contacting Mr Dunn's secretary on **0141 201 2020.**
- ☐ Contact ward 65 before **9 am** on the day admission to confirm your attendance and availability of bed on (**0141 201 2017)**
- ☐ Please report to ward 65 no later than **10 am** on the day of admission.
- ☐ Please find the address to ward 65 on top of this page.
- ☐ Ensure to bring all your medication with you.
- ☐ If you wish to cancel your appointment please contact Mr Dunn's secretary as soon as possible.
- ☐ If you are on any of the following medication, you must contact Mr Dunn's secretary on receipt of this letter:

Aspirin	**Clopidogrel**
Warfarin	**Plavix**
Dipyridamole	**Oral contraceptive pills**
Persantin	**Hormone replacement therapy**

Janice Lafferty
Secretary to L T Dunn
Consultant Neurosurgeon/Honorary Senior Clinical Lecturer In Neurosurgery

Institute of Neurological Sciences
Department of Neurosurgery
Southern General Hospital
1345 Govan Road
Glasgow G51 3TF

☎ : 0141 201 2020
Fax No : 0141 201 2020
Enquiries : Secretary, Mrs Janice Lafferty
E: Mail: Janice.Lafferty@GGC.Scot.NHS.UK

LTD/JL/
Dictated: 7th September 2010
Typed: 8th September 2010

Dr David Richardson
Ballochmyle Medical Group
Institute Avenue
KA5 6RU

Dear Dr Richardson

RE: **George Harkness (d.o.b. 17/7/58) – CHI 3579**
32c Mill Square, Catrine, Ayrshire KA5 6RD

Further to Mr Behbahani's clinic letter of 26 August, Mr Harkness has now had his plain x-ray of the cervical spine in flexion and extension. This shows no abnormal movement in the cervical spine and it would therefore be feasible to undertake a further decompression from behind. I have placed Mr Harkness' name on my waiting list with a view to admission for a further cervical decompression in due course

Yours sincerely,

Mr L T Dunn
Consultant Neurosurgeon/
Honorary Senior Clinical Lecturer in Neurosurgery

Mr George Harkness
32C Mill Square
Catrine
Ayrshire KA5 6AD

DEPARTMENT OF NEUROSURGERY
Institute of Neurological Sciences

Direct Line: 0141 201 2020
Direct Fax: 0141 201 2995
Enquiries: Secretary, Mrs Janice Lafferty
E-mail: Janice.Lafferty@ggc.scot.nhs.uk

Southern General Hospital
1345 Govan Road
GLASGOW
G51 4TF

LTD/JL
Clinic: 26/08/10
Typed: 31/08/10

DR DAVID DA RICHARDSON
BALLOCHMYLE MEDICAL GROUP
INSTITUTE AVENUE
KA5 6RU

Dear Dr Richardson

GEORGE HARKNESS DOB: 17/07/58 (SG03251486) CHI: 1707583579
32C MILL SQUARE, CATRINE, AYRSHIRE, KA5 6RD

I reviewed Mr Harkness alongside his wife in the out patient clinic on behalf of Mr Dunn today. As you may recall he had a 2 level C5/6 and C6/7 anterior cervical decompression and fusion in April 2009 for predominantly right C6 radiculopathy. At the time of surgery he had some left sided symptoms as well but no evidence of myelopathy. For a short while after surgery he improved. However, 6 months later his right-sided brachalgia recurred. This is again in C6 distribution. He describes this as a dull pain radiating from the shoulder in a posterolateral upper arm, forearm and terminating in the 3 lateral fingers. There is associated numbness in the same distribution. The whole arm feels heavy. The recent electrophysiological studies of the upper arm shows only evidence of a very mild right carpal tunnel syndrome. The MRI scan of cervical spine shows good decompression at C6/7 level but some degree of nerve root compression at C5/6 levels bilaterally. Interestingly it is worse on the left, however the symptoms are mainly on the right.

On clinical examination he has normal gait and posture. Neurological examination is essentially normal except for diminuted pin prick sensation in a right C6 dermatomal distribution. Reflexes are symmetrical and within normal range.

Clinical impression is of recurrent right C6 radiculopathy. This is consistent with the MRI findings of right C6 nerve root compression. I have explained the findings to this gentleman. After a long discussion he feels that he would like something surgical done for this. There is an option of posterior foraminotomy to create room for a nerve root from the back or revisional surgery from the front. This could be determined when the level of fusion from the cage is ascertained. I have therefore organised an x-ray of cervical spine, flexion extension views to ascertain this. We will write to him with the results and

GEORGE HARKNESS
17/07/58
CHI:1707583579

further appointment.

Yours sincerely,

Mr M Behbahani
SpR to Mr Dunn, Consultant Neurosurgeon

INSTITUTE OF NEUROLOGICAL SCIENCES, GLASGOW

From: *Clinical Neurophysiology*
Dr R Renganathan
MBBS, MD, DNB(PMR), CCT Neurol. (I), MRCPI, MRCP(UK)
Consultant Clinical Neurophysiologist

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Tel: 0141 201 2480
Fax: 0141 201 2734

EMG Report

Patient: George Harkness
Patient ID: (2009)/3442
Address: 32C Mill Square
Catrine
Ayrshire
KA5 6RD
Unit Number: 3251486
Referred by: Mr Dunn
Consultant Neurosurgeon
Hospital: Southern General Hospital
Ward or OP: OP
CHI: 1707583579

RECEIVED
13. 05. 2010
L. Dunn

File
13. 05. 2010
Mr. L.T. Dunn

Dear Mr Dunn
Thank you for the referral.

Reason for referral
? Carpal tunnel syndrome.

Summary of Electrophysiological Findings
Limb temperature was maintained above 32°C for conduction studies.

1. *Nerve Conduction Studies – Sensory studies*

The sensory responses from the right median nerve showed borderline delay in latency from the middle finger.
The interpeak latency difference between thumb median and thumb radial response on the right was significant at 0.85ms.
The sensory responses from the left median nerve were normal.
The sensory responses from both ulnar nerves were normal.

2. *Nerve Conduction Studies – Motor studies*

The motor responses from both median nerves were normal.
The motor responses from both ulnar nerves were normal.

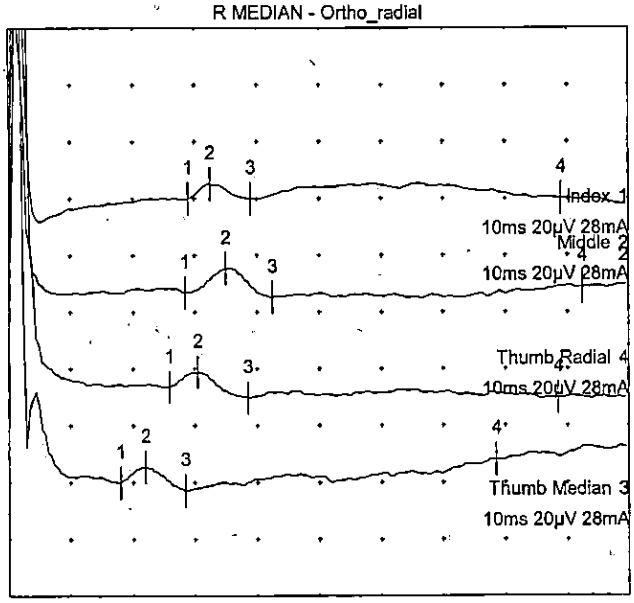
Opinion
Electrophysiological studies show evidence of very mild right carpal tunnel syndrome.

Electronically verified
Dr R Renganathan
Locum Consultant in Clinical Neurophysiology

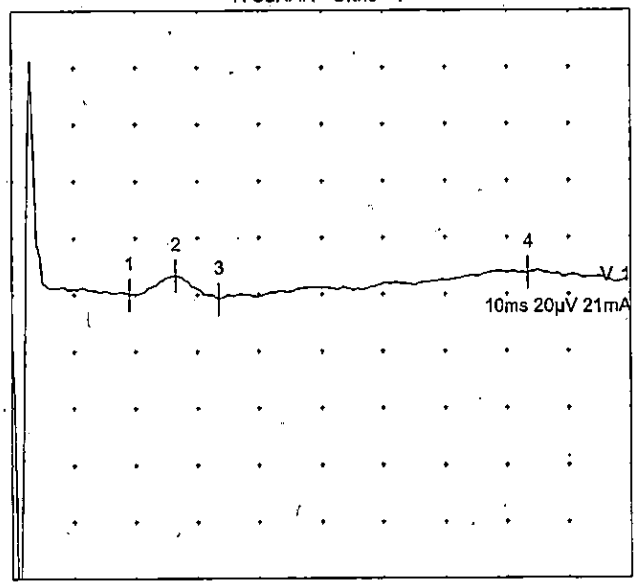
Sensory NCS

Nerve / Sites	Lat. 2 ms	Lat. ms	Amp.1-2 µV	Amp.2-3 µV	Dur. ms	Area µVms	Temp. °C
R MEDIAN - Ortho_radial							
Index	3.25	2.90	5.1	5.2	1.00	2.5	
Middle	3.50	2.85	8.7	10.3	1.40	6.1	
Thumb Median	3.05	2.60	5.4	9.1	1.25	3.9	32.4
Thumb Radial	2.20	1.80	5.5	8.4	1.05	3.7	
R ULNAR - Ortho - V							
V	2.65	1.90	6.8	8.5	1.45	5.2	
L MEDIAN - Ortho_radial							
Index	3.05	2.55	14.8	14.2	1.15	7.3	
Middle	3.10	2.60	11.7	16.1	1.25	6.5	
Thumb Median	2.75	2.25	6.1	11.6	1.40	4.4	
Thumb Radial	2.30	1.70	7.8	8.3	1.45	4.8	
L ULNAR - Ortho - V							
V	2.35	1.75	3.4	4.1	1.35	2.5	

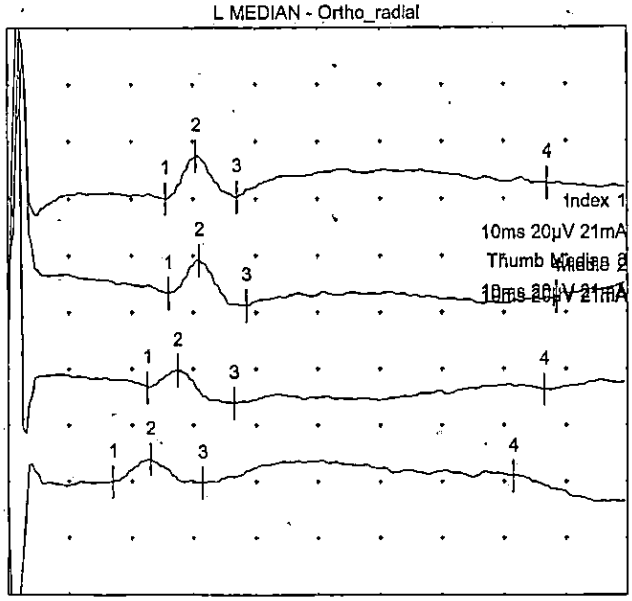
R MEDIAN - Ortho_radial



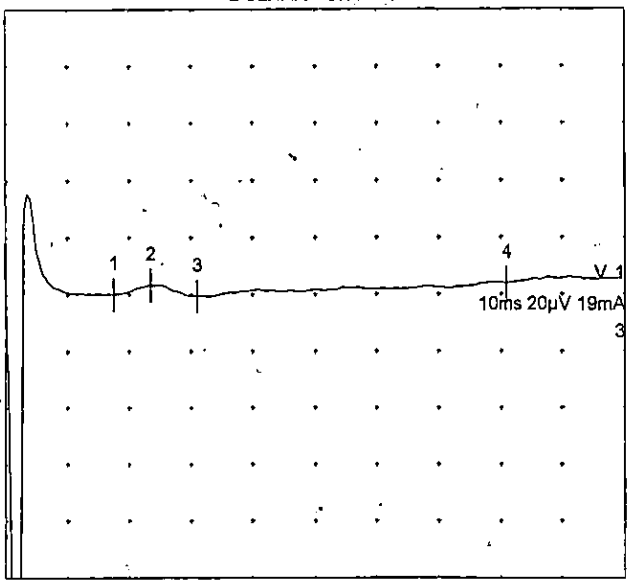
R ULNAR - Ortho - V



L MEDIAN - Ortho_radial

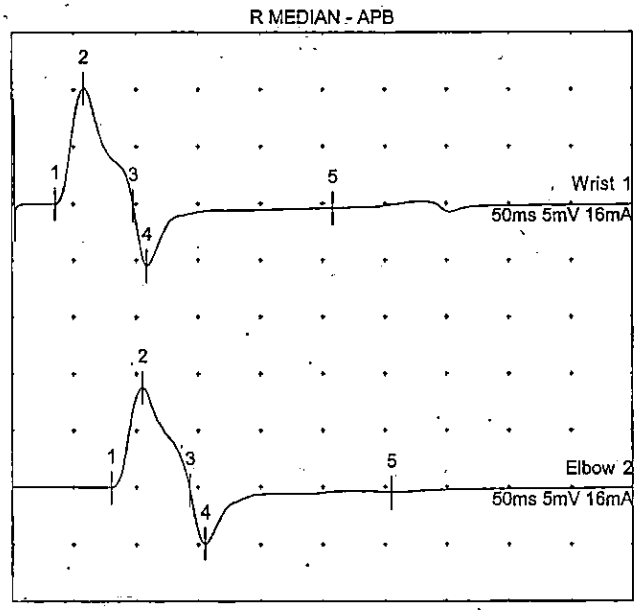


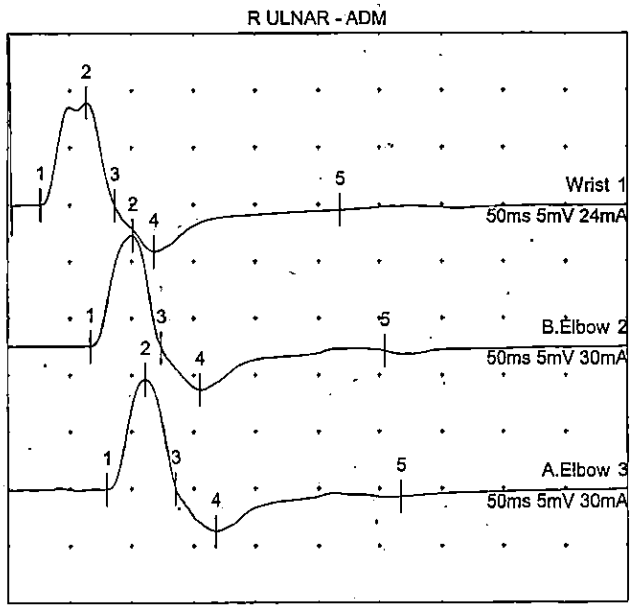
L ULNAR - Ortho - V

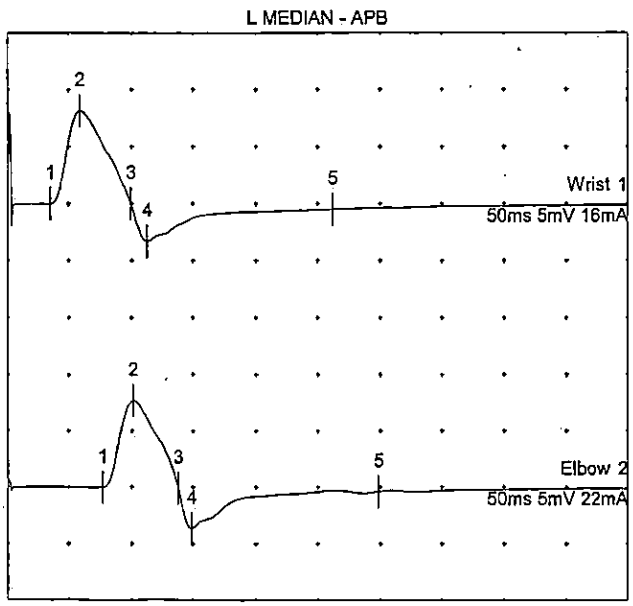


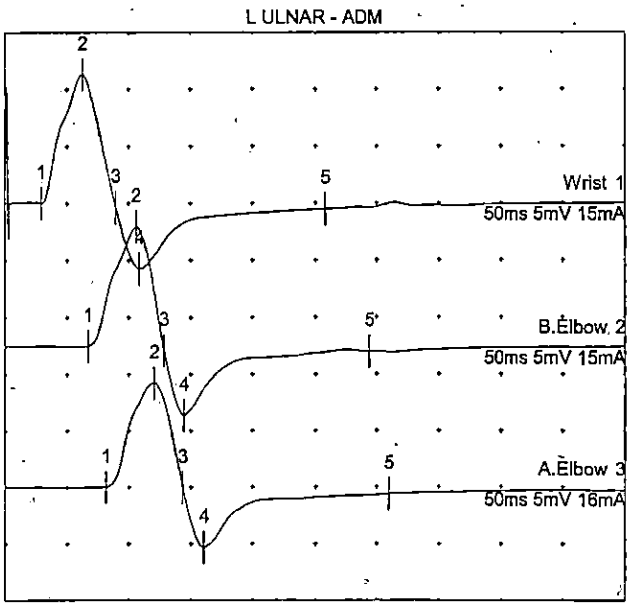
Motor NCS

Nerve / Sites	Lat. ms	Amp.1-2 mV	Dur. ms	Area mVms	Amp.1-2 %	Dur. %	Area %	Dist. cm	Vel. m/s	Temp. °C
R MEDIAN - APB										
Wrist	3.55	10.1	6.20	31.1	100	100	100	8		32.7
Elbow	8.00	8.9	6.35	29.7	87.6	102	95.7	26.5	59.6	
R ULNAR - ADM										
Wrist	2.65	8.9	6.00	32.1	100	100	100	8		33.2
B.Elbow	6.65	9.8	5.75	30.8	109	95.8	95.8	24.5	61.3	
A.Elbow	8.00	9.7	5.55	29.1	109	92.5	90.7	13	96.3	
L MEDIAN - APB										
Wrist	3.55	8.1	6.40	28.2	100	100	100	8		
Elbow	7.70	7.7	6.10	26.2	94.8	95.3	93.1	24	57.8	
L ULNAR - ADM										
Wrist	2.95	11.3	6.00	38.2	100	100	100	8		
B.Elbow	6.70	10.4	6.15	35.9	92.2	103	94.1	25	66.7	
A.Elbow	8.15	9.3	6.20	32.3	81.8	103	84.6	10	69.0	









Institute of Neurological Sciences
Department of Neurosurgery
Southern General Hospital
1345 Govan Road
Glasgow G51 3TF

GENERAL

☎ : 0141 201 2020
Fax No : 0141 201 2020
Enquiries : Secretary, Mrs Janice Lafferty
E: Mail: Janice.Lafferty@GGC.Scot.NHS.UK

LTD/JL/3251486
Clinic: 20th August 2009
Typed: 21st August 2009

Dr Richardson
Ballochmyle Medical Group
The Clinic
"Institute Avenue,
Catrine KA5 6RU

Dear Dr Richardson

RE: George Harkness (d.o.b. 17/7/58) – CHI 3579
32C Mill Square, Catrine, Ayrshire KA5 6RD

I reviewed this gentleman some 4 months following a two level anterior cervical decompression and fusion procedure for right-sided brachialgia. I am pleased to say that he has had a good relief from his right-sided arm pain. He had temporary relief of the paraesthesia that he had experienced in the hand but this has now recurred. The history that he gave today in the clinic was that these symptoms are markedly worse at night, occasionally waking from sleep and are relieved by hanging his arm over the bed. His symptoms are markedly exacerbated by riding his motorbike.

On examination his operative wound is well healed. I could not detect any neurological deficit in the lower limbs and no particular features consistent with carpal tunnel syndrome

I am going to organise an MRI scan to confirm an adequate decompression at the operated levels. I am also requesting some nerve conduction and EMG studies in case his persisting symptoms are related to significant carpal tunnel compression. I will arrange to review him again with the results of these investigations in due course.

Yours sincerely,

Mr L T Dunn
Consultant Neurosurgeon/
Honorary Senior Clinical Lecturer in Neurosurgery

Acute Services Division

Regional Services Directorate

Consultant: **Mr L. Dunn**

Enquiries to Secretary: Janice Lafferty

Tel: 0141 201 2020 Fax: 0141 201 2995

NHS
Greater Glasgow and Clyde

03-Jun-09

Name: **George Harkness** Patient No: **3251486** Date of Birth: **17/07/58**

Address: **32C Mill Square Catrine Ayrshire KA5 6RD** Age: **51**

GP: **Dr Richardson** Address: **The Clinic Institute Avenue Catrine KA5 6RU**

AdmissionType: **Elective** Ward: **65**

Date of Admission: **27/04/2009** Admitted From: **Home**

Date of Discharge: **30/04/2009** Discharged To: **Home**

Diagnosis and Code: Cervical radiculopathy M50.1

Procedure and Code: Primary anterior cervical decompression (Instrumentation) V29.8 Y02.1

History: This 50 year old right-handed patient presented with a 10-month history of right side brachialgia in a C6/ or C7 dermatomal distribution. On clinical examination there were restricted neck movements due to pain and diminuted pin prick sensation in the right hand in C6 and C7 dermatomal distribution.

Investigations: MR imaging of the cervical spine revealed disc bulges at C5/6 and C6/7 compressing the C6 and C7 exiting nerve roots on the right side consistent with the symptoms of the patient.

The patient was admitted electively and underwent the above procedure on the 28th April 2009 (Surgeon Behbahani). The procedure was uneventful. Post operative recovery was unremarkable. Post surgery the patient felt significant improvement in the right arm pain and post operative x-rays revealed satisfactory position of the intravertebral cages. He was independently mobile post surgery and was discharged home on the 30th April 2009.

Follow Up Plan: Neurosurgical out patient clinic 3 months

Copies:

GP

FollowUp: **3 months**

Signed:

Mr L T Dunn Consultant Neurosurgeon

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL, 1345 GOVAN ROAD, GLASGOW G51 4TF
TEL: 0141 201 1100

DEPARTMENT OF NEUROSURGERY
INSTITUTE OF NEUROLOGICAL SCIENCES

WARD: S65 CONSULTANT: MR LAURENCE DUNN
CONTACT NO: 0141 201 2020

IMMEDIATE DISCHARGE LETTER

PATIENT: GEORGE HARKNESS
32C MILL SQUARE
AYRSHIRE
KA5 6RD

DOB: 17/07/58 UNIT NO: SG03251486
ACCT NO: IP0015850/09
CHI NO: 1707583579
GP: DR DAVID DA RICHARDSON

DISCHARGE MEDICATION

Time Required? Routine - within 4 hours
Childproof Containers? Y
Compliance Aid Required? N
Patient's Weight (Kg):
Comment:

Medication	Form	Dose	Frequency	Duration
PARACETAMOL	OTAB	1G	4 TIMES A DAY	7 DAYS
New Drug? Y New Dose? Y	Comments:			
Patient's Own Supply? N	Pharmacy Notes:			Supply:

Medication	Form	Dose	Frequency	Duration
DIHYDROCODEINE	OTAB	30-60MG	4 TIMES A DAY	7 DAYS
New Drug? Y New Dose? Y	Comments:			
Patient's Own Supply? N	Pharmacy Notes:			Supply:

Medication	Form	Dose	Frequency	Duration
TRAMADOL	OTAB	50-100MG	EVERY 4-6 HOURS	7 DAYS
New Drug? Y New Dose? Y	Comments: AS REQUIRED			
Patient's Own Supply? N	Pharmacy Notes:			Supply: 30X

Medication	Form	Dose	Frequency	Duration
SALBUTAMOL 100	INH	2 PUFFS	AS REQUIRED	INDEFINITE
New Drug? N New Dose? N	Comments:			
Patient's Own Supply? Y	Pharmacy Notes:			Supply:

Medication	Form	Dose	Frequency	Duration
co-dydramol 30/500	T	2 tab	4-6h prn.	
New Drug? New Dose?	Comments:			
Patient's Own Supply? Y	Pharmacy Notes:			Supply:

Medication	Form	Dose	Frequency	Duration
New Drug? New Dose?	Comments:			
Patient's Own Supply?	Pharmacy Notes:			Supply:

Medication	Form	Dose	Frequency	Duration
New Drug? New Dose?	Comments:			
Patient's Own Supply?	Pharmacy Notes:			Supply:

PHARMACY USE ONLY DISPENSED BY: CM DATE: 30/4/09 CHECKED BY: CP
CLINICAL PHARMACIST CHECK: PHA.MURLE COLLECTED BY: _____

Medicine received on ward by: _____ Issued by: _____

Named Nurse: _____ Signature of Receipt: _____

Report Number: 3004-0007 Date(Time): 30/04/09 (0933 Hours) Status: Draft

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL, 1345 GOVAN ROAD, GLASGOW G51 4TF
TEL: 0141 201 1100

DEPARTMENT OF NEUROSURGERY
INSTITUTE OF NEUROLOGICAL SCIENCES

WARD: S65 CONSULTANT: MR LAURENCE DUNN
CONTACT NO: 0141 201 2020

IMMEDIATE DISCHARGE LETTER

PATIENT: GEORGE HARKNESS
32C MILL SQUARE
AYRSHIRE
KA5 6RD

DOB: 17/07/58
UNIT NO: SG03251486
ACCT NO: IP0015850/09
CHI NO: 1707583579

GP: DR DAVID DA RICHARDSON
BALLOCHMYLE MEDICAL GROUP
INSTITUTE AVENUE
KA5 6RU

DATE OF ADMISSION: 27/04/09
ADMISSION TYPE: ELECTIVE
DATE OF DISCHARGE: 30/04/09
DISCHARGE TO: HOME

REASON FOR ADMISSION: RT BRACHALGIA
MAIN DIAGNOSIS: CERVICAL RADICULOPATHY

OTHER ACTIVE PROBLEMS: NIL

OPERATIONS/PROCEDURES/ TREATMENT: C5/6 + C6/7 ANTERIOR CERVICAL DECOMPRESSION AND FUSION

RESULTS AWAITED: N
CURRENT MEDICATION: SEE PRESCRIPTION
DISCONTINUED DRUGS? N
COMMENT:

ALLERGIES:
NKDA

REVIEW? Y DETAILS: OUT PATIENT TIMESCALE: TO BE ADVISED

FURTHER LETTER TO FOLLOW? Y DETAILS: FORMAL HOSPITAL LETTER

SIGNED: STR.BENDA BENNETT,DAVID
DESIGNATION: SPECIALIST TRAINEE REG
PAGE NUMBER: 7102

Institute of Neurological Sciences
Department of Neurosurgery
Ward 65, 4th floor
Southern General Hospital Zone 3
1345 Govan Road
Glasgow G51 4TF

☎ 0141 201 2020
Enquiries: Secretary, Mrs Janice Lafferty
Email: Janice.Lafferty@GGC.Scot.NHS.UK

LTD/JL/3251486
6th April 2009

Mr George Harkness
32C Mill Square
Catrine
KA5 6RD

Dear Mr Harkness

Your admission to ward 65; neurosurgery has been provisionally planned for Monday 27th April 2009.
Please read through the following checklist carefully and ensure these are met before your admission. Failure to do so might result in the cancellation of your operation.

- Confirm you acceptance of the proposed date by contacting Mr Dunn's secretary on **0141 201 2020**.
- Contact ward 65 before **9 am** on the day admission to confirm your attendance and availability of bed.
- Please report to ward 65 no later than **10 am** on the day of admission.
- Please find the address to ward 65 on top of this page.
- Ensure to bring all your medication with you.
- If you wish to cancel your appointment please contact Mr Dunn's secretary as soon as possible.
- If you are on any of the following medication, you must contact Mr Dunn's secretary on receipt of this letter:

Aspirin	**Clopidogrel**
Warfarin	**Plavix**
Dipyridamole	**Oral contraceptive pills**
Persantin	**Hormone replacement therapy**

Institute of Neurological Sciences
Department of Neurosurgery
Southern General Hospital
1345 Govan Road
Glasgow G51 3TF

GENERAL

☎ : 0141 201 2020
Fax No : 0141 201 2020
Enquiries : Secretary, Mrs Janice Lafferty
E: Mail: Janice.Lafferty@SGH.Scot.NHS.UK

SAX/JL/3251486
Clinic: 5th February 2009
Typed: 6th February 2009

Mr Tait
Consultant Orthopaedic Surgeon
Crosshouse Hospital
Crosshouse
Kilmarnock KA2 9BE

Dear Mr Tait

RE: George Harkness (d.o.b. 17/7/58) – CHI 3579
32C Mill Square, Catrine Ayrshire KA5 6RD

Thank you for referring this gentleman who I saw on behalf of Mr Dunn in his neurosurgical out patient clinic today. Mr Harkness is a 50-year-old right-handed gentleman who is a heavy goods vehicle driver. He complained of neck pain radiating into the right arm in July 2008 after lifting some heavy objects. Since then he has been troubled with the same symptoms that have progressively gone quite worse. He also describes paraesthesia and numbness in all the fingers of his right hand associated with weakness of the muscles. The left side is completely normal and he does not report any symptoms in his legs. He has normal bowel and urinary function.

He is asthmatic and uses inhalers. He has never smoked and does not consume alcohol.

On examination range of movements of his neck were restricted due to pain. I could not however elicit any localised tenderness. There was no wasting of the muscles, but the power was decreased in all muscle groups on the right side to grade IV. Sensation to pin prick was decreased in the right C5/6/7 and 8 dermatomes. Biceps, triceps and supernator jerks were normal bilaterally.

Recent MR imaging of his cervical spine showed a C5/6 disc bulge compressing on the exiting nerve root mainly on the right side. At the level below there could be osteoarthritic involving causing some foraminal stenosis on the right side as well. After discussing with Mr Dunn, I have offered this gentleman and anterior cervical decompression procedure with or without fusion at the C5/6 and possibly C6/7 level. I have explained the nature of the surgery and emphasised that the main aim of the operation is to prevent further progression of symptoms and it is mainly targeted to relief symptoms in his arms rather than his neck pain. The surgery also carries risks of infection, haemorrhage, problems with swallowing, hoarseness of voice and damage to the nerves.

Clinic Letter: George Harkness (d.o.b. 17/7/58) - CHI 3579
32C Mill Square, Catrine Ayrshire KA5 6RD

He wished to go ahead with surgery and I have put his name on our waiting list accordingly. I have also organised a CT scan of her cervical spine just to look at the nature of bony compression on the exiting nerve roots. We shall keep you informed of his progress.

Many thanks

Yours sincerely,

Mr Saxena
SpR to
Mr L T Dunn
Consultant Neurosurgeon/
Honorary Senior Clinical Lecturer in Neurosurgery

Copy to

Dr Richardson
Ballochmyle Medical Group
The Clinic
Institute Avenue
Catrine KA5 6RU

NHS Greater Glasgow and Clyde

Institute of Neurological Sciences

Clinical Neuroradiology Report

No Rec

HARKNESS, George
32C Mill Square, Catrine, Mauchline, Ayrshire, KA5 6RD
Referrer: MR L DUNN - INSTITUTE OUT PATIENT

DoB: **17/07/1958** 27/11
Chi No: **1707583579**
CRIS No: **6259703**
Hosp No: 325 14 86

SYNTAX CHECKED by: DR C SANTOSH 24/11/08 1036 Report By: DR E TEASDALE 12/11/08.

Clinical History : Six months history of right sided arm pain. ? Nerve root compression.

Fife
2. 12. 2008
Mr. L.T. Dunn

MRI Spine cervical : Performed 05/09/2008.
Standard sequences.

The craniocervical junction is normal and the bony spinal canal is developmentally wide and normal. Disc osteophyte bars are present at the C5/6 and C6/7 levels and these indent the dura on the sagittal imaging. On the axial scans, the hard copy axial images have no slice lines on them but counting up from the first rib, there is evidence of bilateral root compression at the C5/6 and C6/7 levels but no evidence of cord compression. There is no evidence of intramedullary pathology.

Checked and verified for spellings and syntax by Dr C Santosh.

NHS Greater Glasgow & Clyde J69893
NHS Grea SGH 415

Acute Services Division

Regional Services Directorate
SOUTHERN GENERAL HOSPITAL
1345 GOVAN ROAD
GLASGOW
G51 4TF

NHS
Greater Glasgow and Clyde

DEPARTMENT OF NEUROSURGERY
INSTITUTE OF NEUROLOGICAL SCIENCES

Direct Line: 0141 201 2020
Enquiries: Secretary, Mrs Janice Lafferty
E-mail: Janice.Lafferty@sgh.scot.nhs.uk

14 November 2008

CONSULTANT: MR L T DUNN
GENERAL NEUROSURGICAL CLINIC

GEORGE HARKNESS
32C MILL SQUARE
CATRINE
KA5 6RD

Dear GEORGE HARKNESS Hospital Number SG03251486

A New / Follow-up appointment has been arranged for you to attend my clinic on:

Thursday 05/02/09 at 11:00 am

If you are unable to attend for this appointment please telephone my secretary on: 0141 201 2020 as soon as possible to arrange a more convenient date and time.

Yours sincerely

Mr L T DUNN
Consultant Neurosurgeon

CHI No.1707583579

PS: When attending the clinic could you please bring with you a list of any Medications that you currently take.

Institute of Neurological Sciences
Department of Neurosurgery
Southern General Hospital
1345 Govan Road
Glasgow G51 3TF

☎ : 0141 201 2020
Fax No : 0141 201 2020
Enquiries : Secretary, Mrs Janice Lafferty
E: Mail: Janice.Lafferty@GGC.Scot.NHS.UK

LTD/JL/
Dictated: 3rd November, 2008
Typed: 5th November, 2008

Mr Tait
Consultant Orthopaedic Surgeon
Crosshouse Hospital
Crosshouse
Kilmarnock KA2 9BE

Dear Mr Tait

RE: George Harkness (d.o.b. 17/7/58) – CHI 3579
32C Mill Square, Catrine Ayrshire

Thank you for your letter about this man, with a six-month history of right sided arm pain. I will make arrangements to see him in one of my clinics as soon as is feasible.

Yours sincerely,

Mr L T Dunn
Consultant Neurosurgeon/
Honorary Senior Clinical Lecturer in Neurosurgery

Copy to

Dr May
The Clinic
Institute Avenue
Catrine

HOSPITAL SERVICES

Crosshouse Hospital
Crosshouse
Kilmarnock KA2 0BE
Telephone: 01563 521133
Fax: 01563 577976
www.show.scot.nhs.uk/aaaht

NHS
Ayrshire & Arran

Orthopaedic Department
Direct Line: 01563 827333

GRT/AD/561415
CHI: 1707583579

23 October 2008
Dict 20/10/08

(1) Purchase new spine
(2) Copy and spec MR- C-spine

RECEIVED
13. 11. 2008
Mr. L.T. Dunn

Mr Lawrence Dunn
Institute of neurological Sciences
Southern General Hospital
Glasgow

Dear Mr Dunn

GEORGE HARKNESS 32C MILL SQUARE CATRINE 17/07/58

I wonder if you would be good enough to see this 50 year old gentleman who is now 6 months into a history of right radicular pain secondary to a C5/6 herniation on the right.

He was admitted to us some time ago and treated conservatively but his symptoms really are not settling and he remains very disabled. He has quite marked pain in his neck and arm, a torticollis and some weakness in his right arm.

An MRI scan has confirmed a central herniation, impinging on the nerve root.

I wonder if he would be a candidate for a discectomy and I would be grateful if you could see him at your earliest convenience. He is in a quite a bit of strife and has had symptoms now for quite some time.

Kind regards

Yours sincerely

G R Tait FRCS
Consultant Orthopaedic Surgeon

cc Dr May The Clinic Institute Ave Catrine

Enc (MRI films)

STA 5000

DEPARTMENT OF NEUROSURGERY
Institute of Neurological Sciences

Direct Line: 0141 201 2020
Direct Fax: 0141 201 2995
Enquiries: Secretary, Mrs Janice Lafferty
E-mail: Janice.Lafferty@ggc.scot.nhs.uk

Southern General Hospital
1345 Govan Road
GLASGOW
G51 4TF

LTD/JL
Clinic: 09/06/11
Typed: 10/06/11

DR DAVID DA RICHARDSON
BALLOCHMYLE MEDICAL GROUP
INSTITUTE AVENUE
KA5 6RU

Dear Dr Richardson

GEORGE HARKNESS DOB: 17/07/58 (SG03251486) CHI: 1707583579
32C MILL SQUARE, CATRINE, AYRSHIRE, KA5 6RD

I reviewed Mr Harkness and his wife in the clinic today on behalf of Mr Dunn. He is now just over 4 months following his revisional anterior cervical decompression. As you are aware he underwent a 2 level ACDF in 2009 for right

DEPARTMENT OF NEUROSURGERY
Institute of Neurological Sciences

Direct Line: 0141 201 2020
Direct Fax: 0141 201 2995
Enquiries: Secretary, Mrs Janice Lafferty
E-mail: Janice.Lafferty@ggc.scot.nhs.uk

Southern General Hospital
1345 Govan Road
GLASGOW
G51 4TF

LTD/JL
Clinic: 09/06/11
Typed: 10/06/11

DR DAVID DA RICHARDSON
BALLOCHMYLE MEDICAL GROUP
INSTITUTE AVENUE
KA5 6RU

Dear Dr Richardson

GEORGE HARKNESS DOB: 17/07/58 (SG03251486) CHI: 1707583579
32C MILL SQUARE, CATRINE, AYRSHIRE, KA5 6RD

I reviewed Mr Harkness and his wife in the clinic today on behalf of Mr Dunn. He is now just over 4 months following his revisional anterior cervical

HARKNESS, GEORGE ID: 1707583579 31-Jan-2011 15:40:39 SOUTHERN GENERAL HOSPITAL

17-Jul-1958
Male Caucasian

Vent. rate	66 bpm
PR interval	174 ms
QRS duration	100 ms
QT/QTc	378/396 ms
P-R-T axes	65 60 78

[redacted]

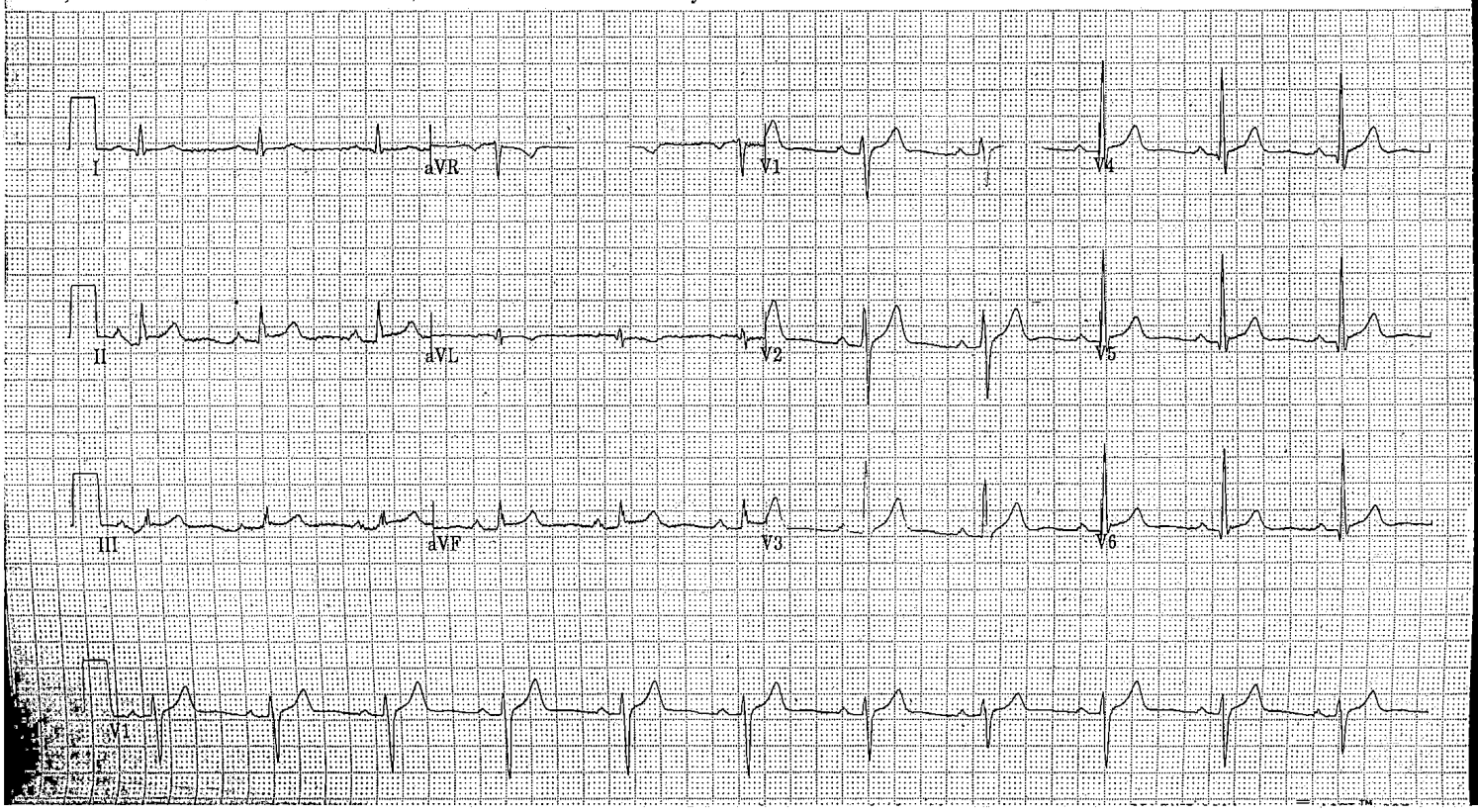
Technician: LEANNE
Test ind: N/A

nal sinus rhythm
nal ECG

Normal sinus
Rhythm.
Ant acute.
T wave.
7338.

ferred by: N/A

confirmed



17-Jul-1958
Male Caucasian

Loc: 36

Vent. rate	70 bpm
PR interval	172 ms
QRS duration	100 ms
QT/QTc	380/410 ms
P-R-T axes	51 37 40

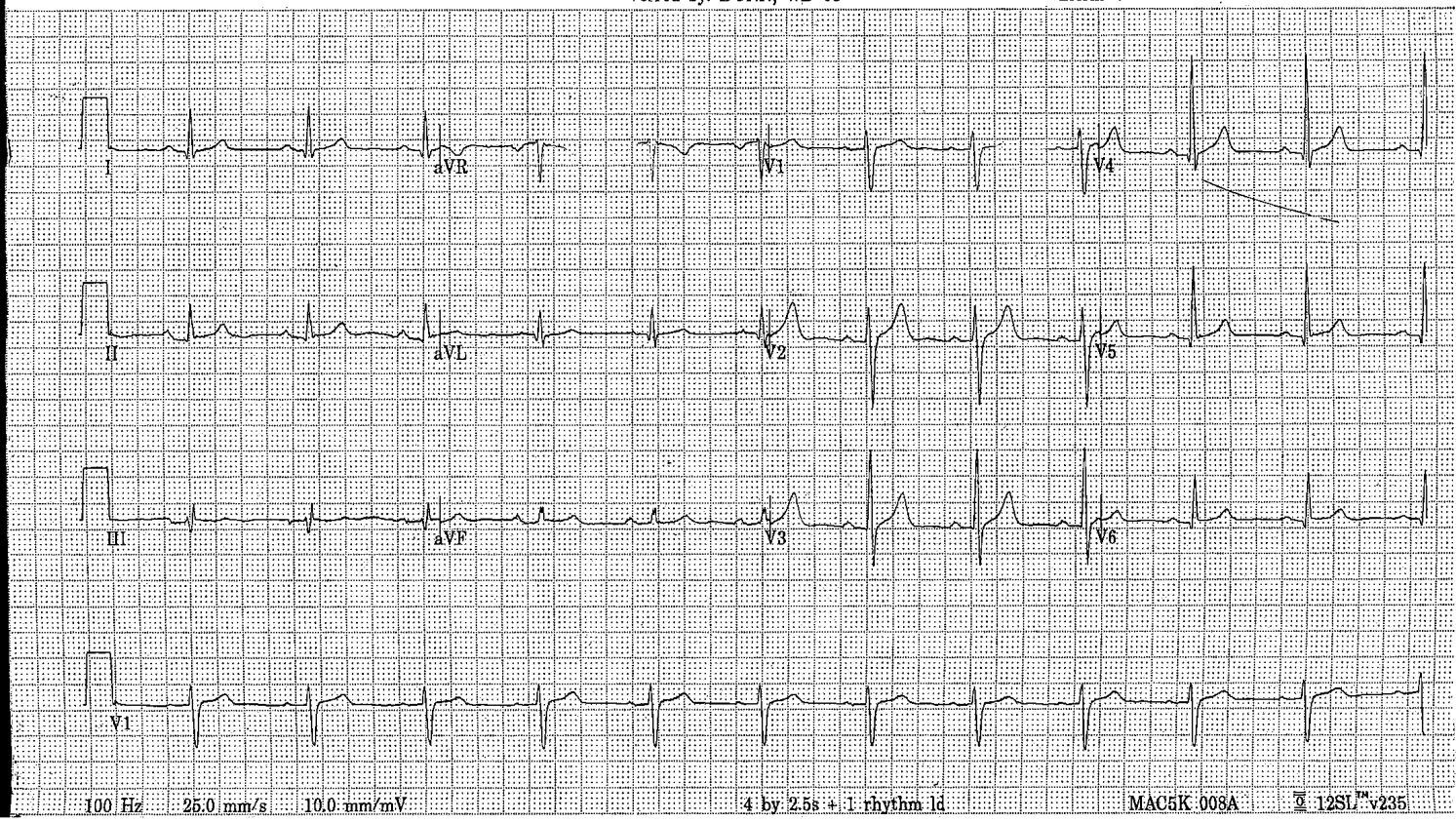
[redacted]

Technician: CAROLANN
Test ind: PRE OP HYPERTENSION

rmal sinus rhythm
rmal ECG

ferred by: DUNN, WD 65

confirmed



100 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + 1 rhythm ld MAC5K 008A 12SL™v235

Southern General Hospital Haematology System
Patient enquiry ---- Express results

Reg	Name	D.o.B.	Sex	Loc.
SG03251486	HARKNESS GEORGE	17.07.58	M	Ward 65 SGH

Specimen R,09.3091899.A Type Blood
Collected 27.04.09 12:00 A.Diag PRE OP

.....FBC.....			
WBC	7.7	MCHC	34.1
RBC	5.35	RDW	12.5
HGB	160	MPV	10.2
PCV	0.469	PCT	0.360
MCV	88	PDW	11.5
MCH	29.9		
PLT	357		
NEUT	5.3		
LYMPH	1.79		
MONO	0.40		
EOSIN	0.14		
BASO	0.03		

Quit \ Earlier req \ Later req \ LD
Back <B> ..

South Glasgow Biochemistry Department
Patient enquiry ---- Express results

Reg	Name	D.o.B.	Sex	Loc.
SG03251486	HARKNESS GEORGE	17.07.58	M	Ward 65 SGH

Specimen R,09.1129891.L Clin dets
Collected 27.04.09 12:00 A.Diag Pre op

.....ELU.....		GLO	29
SOD	140	BIL	8
POT	4.3	ALP	75
CHL	105	AST	23
BIC	22	ALT	49
URE	5.3	.....CRP.....	
CRE	81	CRP	7
.....GLU.....		.....EGFR.....	
GLU	5.1	EGFR	>60
FAST	No	.....HMI.....	
.....LFT.....			
TPR	77		
ALB	48		

Quit \ Earlier req \ Later req \ LD
Back <B> ..

Southern General Hospital Haematology System
Patient enquiry ---- Express results

Reg	Name	D.o.B.	Sex	Loc.
SG03251486	HARKNESS GEORGE	17.07.58	M	Ward 65 SGH

Specimen R,09.3091900.D Type Blood
Collected 27.04.09 12:00 A.Diag PRE OP

.....COAG.....

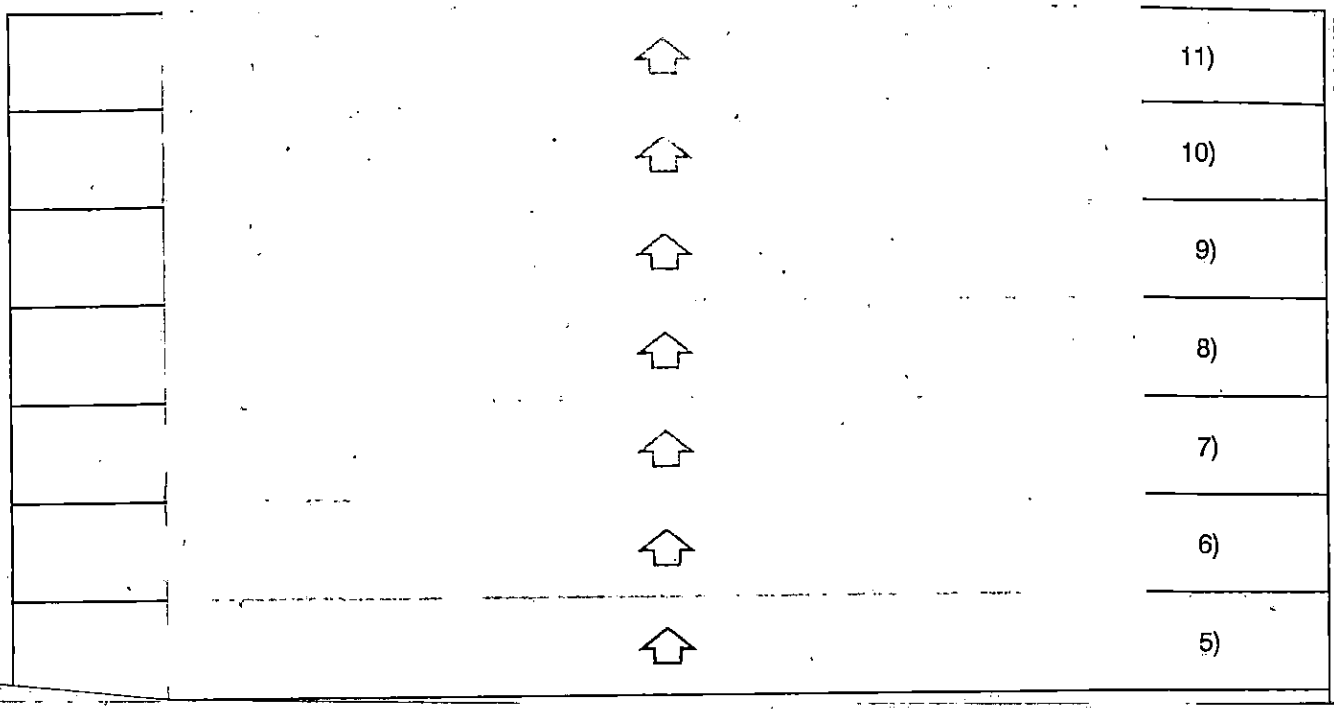
PT	11
APTT	34
PLT	357
TIME	12:00
INR	0.9
APTTR	1.1
CLFIB	4.2

COAG APTTR Therapeutic Range for I.V Heparin (1.9 -2.6)

Quit \ Earlier req \ Later req \ ED \ LD
Back <B> ..

BIOCHEMISTRY DEPARTMENT

A



BIOCHEMISTRY DEPARTMENT SOUTH GLASGOW ☎ (0141) 201 1681 NHS Greater Glasgow and Clyde A

Name **HARKNESS GEORGE** *CHI Number* **1707583579** *Location* **Ward 65 SGH**

Unit No. **SG03251486** *Lab Number* R,11.1040749.F *Consultant* **Mr.L.Dunn**

D.O.B. **17.07.58** *Sex* **M** *Received* 03.02.11 *at* 12:05 *Prov. Diagnosis*

Withdrawal		Na	K	Cl	HCO_3	Urea	Creat	eGFR	Glucose	*	CRP	Amylase	Magnesium	Urate
		135–145	3.5–5.0	98–108	23–30	2.5–7.0	40–130				<10	<100	0.70–1.00	0.22–0.45
Date	Time	mmol/L					umol/L	mL/min	mmol/L		mg/L	U/L	mmol/L	
27.04.09	12:00	140	4.3	105	22	5.3	81	>60	5.1	N	7			
31.01.11	13:00	142	4.3	106	24	5.7	78	>60						
03.02.11	10:00	140	3.9	103	27	6.4	70	>60			54			

Withdrawal		T.Protein	Albumin	Globulins	Bilirubin	Alk. Phos.	AST	ALT	GGT	CK	Calcium	Adj Ca	Phosphate
		60–80	32–45	23–38	<20	30–120	<40	<50	<70	<210		2.10–2.60	0.70–1.40
Date	Time	g/L			umol/L	U/L					mmol/L		
27.04.09	12:00	77	48	29	8	75	23	49					
03.02.11	10:00												

* Fasting: Y = Yes, N = No

CPA Accredited Medical Laboratory Reference No: 2923

Report authorised by Computer validation

Run No: 769 Issued 03.02.11 at 13:12 Specimen type: Blood

A

BIOCHEMISTRY DEPARTMENT

SOUTH GLASGOW ☎ (0141) 201 1681 NHS Greater Glasgow and Clyde **A**

Name	**HARKNESS GEORGE**	*CHI Number*	**1707583579**	*Location*	**Ward 65 SGH**
Unit No.	**SG03251486**	*Lab Number*	R,11.1035983.Z	*Consultant*	**Mr.L.Dunn**
D.O.B.	**17.07.58** *Sex* **M**	*Received*	31.01.11 *at* 15:36	*Prov. Diagnosis*	

Withdrawal		Na	K	Cl	HCO_3	Urea	Creat	eGFR	Glucose	*	CRP	Amylase	Magnesium	Urate
Date	Time	135–145	3.5–5.0	98–108	23–30	2.5–7.0	40–130				<10	<100	0.70–1.00	0.22–0.45
		mmol/L					umol/L	mL/min	mmol/L		mg/L	U/L	mmol/L	
27.04.09	12:00	140	4.3	105	22	5.3	81	>60	5.1	N	7			
31.01.11	13:00	142	4.3	106	24	5.7	78	>60						

Withdrawal		T.Protein	Albumin	Globulins	Bilirubin	Alk. Phos.	AST	ALT	GGT	CK	Calcium	Adj Ca	Phosphate
Date	Time	60–80	32–45	23–38	<20	30–120	<40	<50	<70	<210		2.10–2.60	0.70–1.40
		g/L			umol/L	U/L					mmol/L		
27.04.09	12:00	77	48	29	8	75	23	49					
31.01.11	13:00												

* Fasting: Y = Yes, N = No

CPA Accredited Medical Laboratory Reference No: 2923

Report authorised by Computer validation

Run No: 720 Issued 31.01.11 at 16:47 Specimen type: Blood

BIOCHEMISTRY DEPARTMENT

SOUTH GLASGOW ☎ (0141) 201 1681

NHS Greater Glasgow and Clyde

A

Name **HARKNESS GEORGE** *CHI Number* **1707583579** *Location* **Ward 65 SGH**

Unit No. **SG03251486** *Lab Number* R,09.1129891.L *Consultant* **Mr.L.Dunn**

D.O.B. **17.07.58** *Sex* **M** *Received* 27.04.09 *at* 14:08 *Prov. Diagnosis* Pre op

Withdrawal		Na	K	Cl	HCO_3	Urea	Creat	eGFR	Glucose	*	CRP	Amylase	Magnesium	Urate
		135–145	3.5–5.0	97–107	23–30	2.5–7.0	40–130				<10	<100	0.70–1.00	0.22–0.45
Date	Time	mmol/L					umol/L	mL/min	mmol/L		mg/L	U/L	mmol/L	
27.04.09	12:00	140	4.3	105	22	5.3	81	>60	5.1	N	7			

Withdrawal		T.Protein	Albumin	Globulins	Bilirubin	Alk. Phos.	AST	ALT	GGT	CK	Calcium	Adj Ca	Phosphate
		62–82	32–45	23–38	<20	30–120	<40	<40	<70	<210		2.15–2.60	0.70–1.40
Date	Time	g/L			umol/L	U/L					mmol/L		
27.04.09	12:00	77	48	29	8	75	23	49					

* Fasting: Y = Yes, N = No

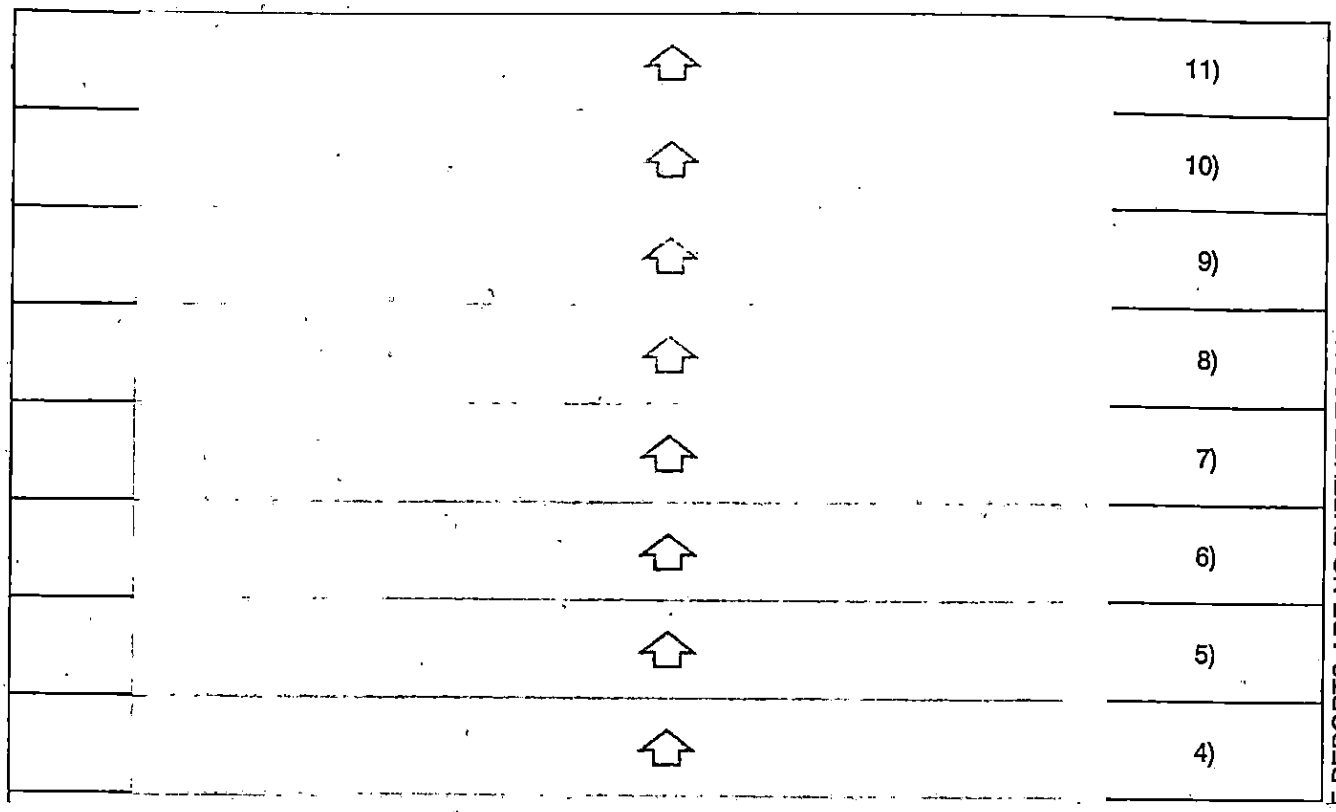
UKAS

Accredited Medical Laboratory
Reference No: 0416

Report authorised by Computer validation

Rpt No: 877 Issued 27.04.09 at 14:42 Specimen type: Blood

BLOOD TRANSFUSION



SOUTH GLASGOW HOSPITALS - BLOOD TRANSFUSION DEPARTMENT

SGH285(Rev. 03/08)

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
HARKNESS	GEORGE	Male	SG03251486	17-Jul-1958

MEDICAL OFFICER	WARD / HOSPITAL	C.H.I. NUMBER
Mr.L.Dunn	Ward 65 SGH	1707583579

BLOOD GROUP	Rh	ANTIBODY SCREEN
O	POS	Negative

REMEMBER THE FINAL NAMEBAND CHECK FOR EVERY UNIT

LABORATORY NUMBER

R.11.0003190.V

EXPIRY DATE	PRODUCT CODE	DONOR GROUP	COMPATIBLE PACK Nos.	TO BE COMPLETED BY NURSE / MED. OFF. SET UP BY / DATE / TIME	CHECKED BY	REACTION

6-FEB-2011 "THIS BLOOD WILL BE DERESERVED" AT 9.00 am ON.....

PLASMA RETAINED

ZERO TOLERANCE POLICY ON SAMPLE LABELLING EFFECTIVE 05.10.09

SPECIMEN RECEIVED: DATE 31-Jan-11 TIME 15:34 DATE OF TEST 31-Jan-11 AUTHORISED BY RP

BLOOD TRANSFUSION

SOUTH GLASGOW HOSPITALS - BLOOD TRANSFUSION DEPARTMENT

SGH285(Rev. 03/08)

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
HARKNESS	GEORGE	Male	SG03251486	17-Jul-1958

MEDICAL OFFICER	WARD / HOSPITAL	C.H.I. NUMBER
Mr.L.Dunn	Ward 65 SGH	1707583579

BLOOD GROUP	Rh	ANTIBODY SCREEN
O	POS	Negative

REMEMBER THE FINAL NAMEBAND CHECK FOR EVERY UNIT

LABORATORY NUMBER				TO BE COMPLETED BY NURSE / MED. OFF.			
R.09.0011039.1				SET UP BY	DATE / TIME	CHECKED BY	REACTION
EXPIRY DATE	PRODUCT CODE	DONOR GROUP	COMPATIBLE PACK Nos.				

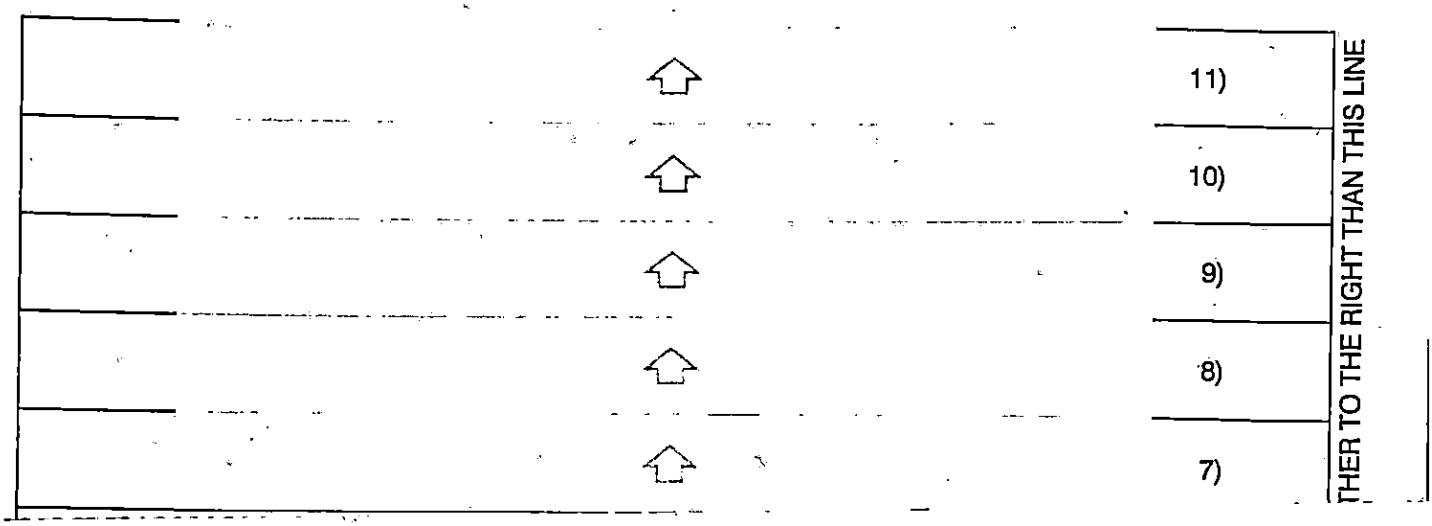
"THIS BLOOD WILL BE DERESERVED" AT 9.00 am ON.....

PLASMA RETAINED
NO UNIT NUMBER ON SAMPLE

SPECIMEN RECEIVED: DATE 27-Apr-09 TIME 13:52 DATE OF TEST 27-Apr-09 AUTHORISED BY.....

HAEMATOLOGY

MOUNT SHEET



SOUTH GLASGOW HOSPITALS - HAEMATOLOGY DEPARTMENT

NAME	FORENAME	SEX	HOSP. No.	D.O.B.
RKNESS	GEORGE	U	SG03251486.	17.07.58
MEDICAL OFFICER	**WARD / HOSPITAL**			**C.H.I. NUMBER**
Mr.L.Dunn	Ward 65 SGH			1707583579

Haemoglobin	134	g/l		White Blood Count	7.7	$x10^9/l$	(4.0-11.0)
Red Cell Count	4.47	$x10^{12}/l$		Neutrophils	5.1	$x10^9/l$	(2.0-7.5)
Haematocrit	0.397	l/l		Lymphocytes	1.9	$x10^9/l$	(1.5-4.0)
MCV	88.8	fl	(78.0-99.0)	Monocytes	0.7	$x10^9/l$	(0.2-0.8)
MCH	30.0	pg	(27.0-32.0)	Eosinophils	0.1	$x10^9/l$	(0.0-0.4)
Platelets	255	$x10^9/l$	(150-400)	Basophils	0.0	$x10^9/l$	(0.0-0.1)

Lab No:	Spec:	Collected:	Received:	Reported:	Authorised by:	Work done:
H,11.3024524.P	Blood	03.02.11 10:00	03.02.11 12:27	03.02.11 13:54		FBC

SOUTH GLASGOW HOSPITALS - HAEMATOLOGY DEPARTMENT

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
HARKNESS	GEORGE	U	SG03251486	17.07.58
MEDICAL OFFICER	**WARD / HOSPITAL**			**C.H.I. NUMBER**
Mr.L.Dunn.	Ward 65 SGH			1707583579

Prothrombin Time	11	secs	(9-12)
PT Ratio	0.9		(0.8-1.1)
APTT	32	secs	(25-37)
APTT Ratio	1.0		(0.8-1.2)
Fibrinogen	2.5	g/l	(2.0-4.1)

CS : APTTr Therapeutic Range for I.V Heparin (1.9 - 2.6)

Lab No:	Spec:	Collected:	Received:	Reported:	Authorised by:	Work done:
H,11.3021808.P	Blood	31.01.11 12:45	31.01.11 15:42	31.01.11 16:38		CS

SOUTH GLASGOW HOSPITALS - HAEMATOLOGY DEPARTMENT

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
HARKNESS	GEORGE	U	SG03251486	17.07.58
MEDICAL OFFICER	**WARD / HOSPITAL**			**C.H.I. NUMBER**
Mr.L.Dunn	Ward 65 SGH			1707583579

Haemoglobin	164	g/l		White Blood Count	7.5	$x10^9/l$	(4.0-11.0)
Red Cell Count	5.30	$x10^{12}/l$		Neutrophils	5.3	$x10^9/l$	(2.0-7.5)
Haematocrit	0.470	l/l		Lymphocytes	1.8	$x10^9/l$	(1.5-4.0)
MCV	88.7	fl	(78.0-99.0)	Monocytes	0.3	$x10^9/l$	(0.2-0.8)
MCH	30.9	pg	(27.0-32.0)	Eosinophils	0.0	$x10^9/l$	(0.0-0.4)
Platelets	291	$x10^9/l$	(150-400)	Basophils	0.0	$x10^9/l$	(0.0-0.1)

Lab No:	Spec:	Collected:	Received:	Reported:	Authorised by:	Work done:
H.11.3021807.Y	Blood	31.01.11 12:45	31.01.11 15:42	31.01.11 16:02		FBC

SOUTHERN GENERAL HAEMATOLOGY DEPARTMENT

SURNAME	FORENAMES	SEX	D.O.B.	HOSP. No.
HARKNESS	GEORGE	M	17.07.58	SG03251486

DOCTOR	WARD/HOSPITAL OR G.P. ADDRESS	
mr.L.Dunn	ward 65 SGH	Run : 1304

REPORT

COAGULATION STUDIES

PT	11	secs	(9 - 12)
APTT	34	secs	(25 - 37)
APTTR	1.1		
FIB		G/L	(2.0 - 4.1)
PLT	357	x10^9/L	(150 - 400)
TIME	12:00hrs		
INR	0.9		
DDIM		mg/L	(< 0.5)
CLFIB	4.2	G/L	(2.0 - 4.1)

APTTR Therapeutic Range for I.V Heparin (1.9 - 2.6)

DATE OF REPORT	MACHINE DIFF.	NEUT	LYMPH	MONO	EOSIN	BASO	AUTHORISED BY		
27-Apr-09	X10⁹/L						SHIMSHARE SINGH		
DATE OF SAMPLE	LAB. No.	W.B.C. X10⁹/L	PLAT. X10⁹/L	R.B.C. X10¹²/L	Hb g/L	P.C.V. L/L	M.C.V. fL	M.C.H. pg	RETIC X10⁹/L
27-Apr-09	3091900	COAGULATION STUDIES							

SOUTHERN GENERAL HAEMATOLOGY DEPARTMENT

SURNAME	FORENAMES	SEX	D.O.B.	HOSP. No.
HARKNESS	GEORGE	M	17.07.56	SG03251486
DOCTOR	WARD, HOSPITAL OR G.P. ADDRESS			
Mr. L. Dunn	Ward 65 SGH			
REPORT				Run : 7354

DATE OF REPORT	MACHINE DIFF.	NEUT.	LYMPH.	MONO.	EOSIN	BASO	AUTHORISED BY		
27-Apr-09	X10⁹/L	5.3	1.79	0.40	0.14	0.03	Kirstie Dubojski		
DATE OF SAMPLE	LAB. No.	W.B.C. X10⁹/L	PLAT. X10⁹/L	R.B.C. X10¹²/L	Hb g/L	P.C.V. L/L	M.C.V. fL	M.C.H. pg	RETIC X10⁹/L
27-Apr-09	3091899	7.7	357	5.35	160	0.469	88	29.9	

MOUNTSOUTHAMPTON EDC

078

MOUNT SHEET

NHS Greater Glasgow and Clyde

Institute of Neurological Sciences

Clinical Neuroradiology Report

HARKNESS, George
32C Mill Square, Catrine, Mauchline, Ayrshire, KA5 6RD
Referrer: Mr Lawrence Dunn - INS WARD 65

DoB: **17/07/1958**
Chi No: **1707583579**
CRIS No: **6259703**
Hosp No: **SG03251486**

SYNTAX CHECKED by: Dr Ravi Jampana 04/02/11 1542 Report By: Dr NE Fullerton (SpR) 03/02/11 and: Dr Ravi Jampana.
Clinical History : Post op. 1 day post ACDF. ? Cage position.

XR Cervical spine :
C5/C6 and C6/C7 fusion noted. Cage device in position at the C5/C6 level. Bony fusion appears to have occurred at level C6/C7 with the cage device, which was present on the 26/08/10, no longer in situ. Spinal alignment is maintained.

NHS Greater Glasgow & Clyde
SGH 415 Cat 9369893

Ref. Src: Institute of Neurological Sciences, Southern General Hospital, 1345 Govan Road, Glasgow, G51 4TF
Exams: XR Cervical spine
Exam Date: 02/02/11 Event: E-25512949

08964
JMcC/71590

Jane 8-2-11

NHS Greater Glasgow and Clyde

Institute of Neurological Sciences — Clinical Neuroradiology Report

HARKNESS, George
32C Mill Square, Catrine, Mauchline, Ayrshire, KA5 6RD
Referrer: Mr Lawrence Dunn - INS WARD 65

DoB: **17/07/1958**
Chi No: **1707583579**
CRIS No: **6259703**
Hosp No: **SG03251486**

VERIFIED Verified By: Auto Reporting 01/02/11 1634.
This examination has been formally assessed and reported by the referring practitioner.
Please see case notes for the formal report.

Ref. Src: Institute of Neurological Sciences, Southern General Hospital, 1345 Govan Road, Glasgow, G51 4TF
Exams: Mobile image intensifier cervical spine
Exam Date: 01/02/11 Event: E-25510858

08964
[McC/71590

NHS Greater Glasgow & Clyde
SGH 415 Cat 9369893

Institute of Neurological Sciences

Clinical Neuroradiology Report

HARKNESS, George
32C Mill Square, Catrine, Mauchline, Ayrshire, KA5 6RD
Referrer: Mr Lawrence Dunn - INS WARD 65

DoB: **17/07/1958**
Chi No: **1707583579**
CRIS No: **6259703**
Hosp No: **SG03251486**

VERIFIED Verified By: Auto Reporting 01/02/11 1628.
This examination has been formally assessed and reported by the referring practitioner.
Please see case notes for the formal report.

Ref. Src: Institute of Neurological Sciences, Southern General Hospital, 1345 Govan Road, Glasgow, G51 4TF
Exams: Mobile image intensifier cervical spine
Exam Date: 01/02/11 Event: E-25509721

08964
JMcC/71590

NHS Greater Glasgow & Clyde
SGH 415 Cat 9369893

X-RAY

NHS Greater Glasgow and Clyde

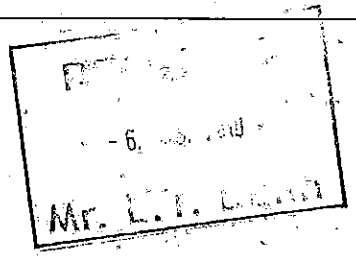
Institute of Neurological Sciences

Clinical Neuroradiology Report

HARKNESS, George
32C Mill Square, Catrine, Mauchline, Ayrshire, KA5 6RD
Referrer: Mr Lawrence Dunn - INS OUTPATIENT

DoB: **17/07/1958**
Chi No: **1707583579**
CRIS No: **6259703**
Hosp No: **SG03251486**

VERIFIED Verified By: Dr Evelyn Teasdale 01/09/10 1431.
Clinical History : Previous C5/6 and 6/7 ACDF ? fusion.



XR Cervical spine :

Flexion extension views.

No abnormal movement occurs. There is no movement of the fixed segments from C5 to C7. There is bony infilling of the disc spaces at the fused segments. The position of the cage is unchanged since the previous examination of 29/04/09.

NHS Greater Glasgow & Clyde
SGH 415 Cat 9369893

Ref. Src: Institute of Neurological Sciences, Southern General Hospital, 1345 Govan Road, Glasgow, G51 4TF
Exams: XR Cervical spine
Exam Date: 26/08/10 Event: E-25156075

08964
JMcC/71590

X-RAY

Institute of Neurological Sciences

Clinical Neuroradiology Report

HARKNESS, George
32C Mill Square, Catrine, Mauchline, Ayrshire, KA5 6RD
Referrer: MR L DUNN - INSTITUTE OUT PATIENT

DoB: **17/07/1958**
Chi No: **1707583579**
CRIS No: **6259703**
Hosp No: 325/486

VERIFIED Verified By: Dr. KIRSTEN FORBES 07/09/09 1634.
Clinical History : 2 level ACDF April '09. Good relief of brachialgia but persisting paraesthesia in right hand ? adequate nerve root compression.

File
17. 09. 2009
Mr. L.T. Dunn

RECEIVED
14. 09. 2009
Mr. L.T. Dunn
Crosshouse Hospital

MRI Spine cervical :

Comparison: MRI cervical spine from 05/09/08,

Technique: Routine sagittal images with selected axial images obtained.

Findings: Normal vertebral body alignment. Haemangioma demonstrated in C4 vertebral body. ACDF demonstrated at levels C5/6 and C6/7.

At the surgical levels of C5/6 and C6/7 there is some artefact from inserted metalwork. There is no evidence of cord compression. However, at both these levels there remains nerve root compression bilaterally.

Ref. Src: Institute of Neurological Sciences, Southern General Hospital, 1345 Govan Road, Glasgow, G51 4TF
Exams: MRI Spine cervical
Exam Date: 03/09/09 Event: E-11889583

08964
JMcC/71590

NHS Greater Glasgow & Clyde
SGH 415 Cat 9369893

X-RAY

Institute of Neurological Sciences

Clinical Neuroradiology Report

HARKNESS, George
32C Mill Square, Catrine, Mauchline, Ayrshire, KA5 6RD
Referrer: MR L DUNN - INSTITUTE OUT PATIENT

DoB: **17/07/1958**
Chi No: **1707583579**
CRIS No: **6259703**
Hosp No:

Ref. Src: Institute of Neurological Sciences, Southern General Hospital, 1345 Govan Road, Glasgow, G51 4TF
Exams: MRI Spine cervical
Exam Date: 03/09/09 Event: E-11889583

NHS Greater Glasgow & Clyde
SGH 415 Cat 9369893

08964
JMcC/71590

Institute of Neurological Sciences

Clinical Neuroradiology Report

HARKNESS, George
32C Mill Square, Catrine, Mauchline, Ayrshire, KA5 6RD
Referrer: MR L DUNN - INS WARD 65

DoB: **17/07/1958**
Chi No: **1707583579**
CRIS No: **6259703**
Hosp No:

VERIFIED Verified By: AUTO REPORTING 03/06/09 1356.
This examination has been formally assessed and reported by the referring practitioner.
Please see case notes for the formal report.

Ref. Src: Institute of Neurological Sciences, Southern General Hospital, 1345 Govan Road, Glasgow, G51 4TF
Exams: Mobile image intensifier cervical spine
Exam Date: 28/04/09 Event: E-11673560

NHS Greater Glasgow & Clyde
SGH 415 Cat 9369893

08964
JMcC/71590 78

MEDICINE **PRESCRIPTION FORM** Hospital Name: .....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐
Date _____ Name (Print) _____
Discharge Prescription Prepared & Reconciled YES ☐
Date _____ Name (Print) _____

Date and time this form prepared:	Sheet No	2nd Prescription in use
__/__/__ Time: _____	.....	YES ☐ NO ☐

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the symptomatic relief policy & local protocol:

_____

with the following exceptions: _____

Print & Sign: T. WARD Date: 30/1/11

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____
Address _____
Compliance Aid Details _____
Patient consent to share discharge information Y/N
Print & Sign _____

PATIENT DETAILS

Hospital Number:	Height:
DOB:	Weight:
Date of Admission: 31/01/11	Surface area:
Consultant Name: MR DUNN	Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
1/2/11	PARACETAMOL	1g	PO	1000	URMILA	CM	0640
1/2	TEMAZEPAM	20mg	PO	2		CR/MH	1025.
	Must get all usual meds am of surgery						
	Fast 12mn. Sips with HH only						
31/1/11	TEMAZEPAM	10mg	PO	2330		Cm/JC	2230

	DATE →
	MONTH →

RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)

IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N	
ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N	
SIGNATURE OF ASSESSOR	
ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N	

Parenteral Drugs : Regular Prescription

Patient's Own Medicine

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	A DRUG DOSE / ROUTE / DATE PRESCRIBER (PRINT & SIGN) ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	STOPPED DATE: INITIALS:	Other time 0700-0900 1200-1400 1600-1800 2200-2400 Other time	For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	B DRUG DOSE / ROUTE / DATE PRESCRIBER (PRINT & SIGN) ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	STOPPED DATE: INITIALS:	Other time 0700-0900 1200-1400 1600-1800 2200-2400 Other time	For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	C DRUG DOSE / ROUTE / DATE PRESCRIBER (PRINT & SIGN) ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	STOPPED DATE: INITIALS:	Other time 0700-0900 1200-1400 1600-1800 2200-2400 Other time	For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.

REVIEW THE NEED FOR IV ANTIBIOTIC DAILY. SWITCH TO ORAL THERAPY AS SOON AS POSSIBLE (SEE IVOST POLICY)

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	D	DRUG																									
	DOSE		ROUTE	DATE	STOPPED DATE: INITIALS:																						
	PRESCRIBER (PRINT & SIGN)																										
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																										
	Other time																										
	0700-0900																										
	1200-1400																										
	1600-1800																										
	2200-2400																										
	Other time																										

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	E	DRUG																									
	DOSE		ROUTE	DATE	STOPPED DATE: INITIALS:																						
	PRESCRIBER (PRINT & SIGN)																										
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																										
	Other time																										
	0700-0900																										
	1200-1400																										
	1600-1800																										
	2200-2400																										
	Other time																										

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	F	DRUG																									
	DOSE		ROUTE	DATE	STOPPED DATE: INITIALS:																						
	PRESCRIBER (PRINT & SIGN)																										
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																										
	Other time																										
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	1600-1800																										
	2200-2400																										
	Other time																										

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	G	DRUG																									
	DOSE		ROUTE	DATE	STOPPED DATE: INITIALS:																						
	PRESCRIBER (PRINT & SIGN)																										
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																										
	Other time																										
	0700-0900																										
	1200-1400																										
	1600-1800																										
	2200-2400																										
	Other time																										

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

[redacted]

Oral and Other Drugs: Regular Prescription

2011

DATE → 1 2 3
MONTH → 2 2 2

Patient's Own Medicine

H DRUG: LANSOPRAZOLE

DOSE: 30mg | ROUTE: PO | DATE: 31/1/11 | STOPPED DATE: | STOPPED INITIALS:

PRESCRIBER ~~(PRINT & SIGN)~~: T-LAND

~~ADDITIONAL~~ INSTRUCTIONS / COMMENTS / PHARMACY:

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

J DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | STOPPED INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

K DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | STOPPED INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

L DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | STOPPED INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & *record reason*.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

M DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

N DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

P DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

R DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Oth

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

Patient's Own Medicine
For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

S DRUG
DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:
PRESCRIBER (PRINT & SIGN)
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

T DRUG
DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:
PRESCRIBER (PRINT & SIGN)
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

V DRUG
DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:
PRESCRIBER (PRINT & SIGN)
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

W. DRUG
DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:
PRESCRIBER (PRINT & SIGN)
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

X DRUG

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Y DRUG

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

AA DRUG

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BB DRUG

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

All Routes: As Required Prescriptions

Patient's Own Medicine

BEFORE ADMISSION ☐ / NEW DOSE ☐ / NEW MEDICATION ☐	**LL** DRUG: VENTOLIN (SALBUTAMOL 100mg INHALER)	DOSE: 2 puffs	ROUTE: INH.	INDICATION: Wheeze
	PRESCRIBER (PRINT & SIGN): T. LAND	MAX.FREQ.	STOPPED DATE: / INITIALS:	DATE: 31/1/11
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			

DATE																					
TIME																					
DOSE																					
GIVEN BY																					

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐ / NEW DOSE ☐ / NEW MEDICATION ☑	**MM** DRUG: DIHYDROCODEINE	DOSE: 30 - 60mg	ROUTE: PO/SC	INDICATION: Pain
	PRESCRIBER (PRINT & SIGN): T. LAND	MAX.FREQ.: QDS	STOPPED DATE: / INITIALS:	DATE: 31/1/11
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			

DATE	31/1	31/1/11	1/2/11	1/2/11	2/2/11	2/2	2/2	2/2	3/2/11	3/2	3/2	3/2/11	4/2
TIME	1700	2220	0640	2210	0805	1330	1818	2200	0810	1030	1630	2225	1230
DOSE	60	60mg	60mg	60mg	60mg	60	60	60	60mg	60	60	60mg	60
GIVEN BY	Av	Cm	Cm	Cm	Cm	W	W	Cm	Cm	W	[illegible]	Sy	[illegible]

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐ / NEW DOSE ☐ / NEW MEDICATION ☑	**NN** DRUG: PARACETAMOL	DOSE: 1g	ROUTE: PO	INDICATION: Pain
	PRESCRIBER (PRINT & SIGN): T. LAND	MAX.FREQ.: QDS	STOPPED DATE: / INITIALS:	DATE: 31/1/11
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			

DATE	31/1	31/1/11	1/2/11	2/2/11	2/2	2/2	2/2	3/2/11	3/2	3/2	3/2/11	4/2
TIME	1700	2220	2210	0605	1330	1818	2200	0810	1030	1630	2225	1230
DOSE	1g	1g	1g	1g	1g	1g	1g	1g	1g	1g	1g	1g
GIVEN BY	Av	Cm	Cm	Cm	W	W	Cm	Cm	W	[illegible]	Sy	[illegible]

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐ / NEW DOSE ☐ / NEW MEDICATION ☑	**PP** DRUG: ONDANSETRON	DOSE: 4mg	ROUTE: IV	INDICATION: PONV
	PRESCRIBER (PRINT & SIGN): M. CLUSKEY	MAX.FREQ.: 8°	STOPPED DATE: / INITIALS:	DATE: 1/2/11
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			

DATE	1/2/11
TIME	1530
DOSE	4mg
GIVEN BY	[illegible]

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Patient's Own Medicine

BEFORE ADMISSION ☐ / NEW DOSE ☐ / NEW MEDICATION ☑	RR	DRUG: CYCLIZINE		STOPPED DATE: / INITIALS:	DATE			For Use Y/N
		DOSE: 50mg	ROUTE: IV	INDICATION: PONV	TIME			Qty:
		PRESCRIBER (PRINT & SIGN): [illegible] McCLUSKEY	MAX.FREQ.: 8°	DATE: 1/2/11.	DOSE			Date:
					GIVEN BY			Assessed by:
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY						Ordered from Pharm.

BEFORE ADMISSION ☐ / NEW DOSE ☐ / NEW MEDICATION ☑	SS	DRUG: MORPHINE		STOPPED DATE: / INITIALS:	DATE	[illegible]	[illegible]	For Use Y/N
		DOSE: 10 mg	ROUTE: sc / im	INDICATION: pain	TIME	2330	0600	Qty:
		PRESCRIBER (PRINT & SIGN): [illegible] . WALKER	MAX.FREQ.: 3 hly	DATE: 1/2/11.	DOSE	10 mg	10 mg	Date:
					GIVEN BY	[illegible]	[illegible]	Assessed by:
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY						Ordered from Pharm.

BEFORE ADMISSION ☐ / NEW DOSE ☐ / NEW MEDICATION ☑	TT	DRUG: TRAMADOL		STOPPED DATE: / INITIALS:	DATE			For Use Y/N
		DOSE: 50-100mg	ROUTE: PO	INDICATION: PAIN	TIME			Qty:
		PRESCRIBER (PRINT & SIGN): [illegible]	MAX.FREQ.: 4°	DATE: 3/2/11	DOSE			Date:
					GIVEN BY			Assessed by:
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: MAX 400mg in 24 hours						Ordered from Pharm.

BEFORE ADMISSION ☐ / NEW DOSE ☐ / NEW MEDICATION ☐	VV	DRUG:		STOPPED DATE: / INITIALS:	DATE			For Use Y/N
		DOSE:	ROUTE:	INDICATION:	TIME			Qty:
		PRESCRIBER (PRINT & SIGN):	MAX.FREQ.:	DATE:	DOSE			Date:
					GIVEN BY			Assessed by:
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY						Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

SG03251486
GEORGE HARKNESS
17/07/1958
KA5 6RD
Practice Code: 80749
CHI:1707583579

Name

CHI No GEORGE HARKNESS

Drug Allergies / Sensitivities None Known ☐ Yes ☐ (provide details below)

NKDA

Nurse/Midwife Administration by Syr tomatic Relief Policy or other Pro col - Authorised Nurses/Midwives On y (Maximum number of doses as per protocol)

Warning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed by a doctor.

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).
2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).
3. Print & Sign your full name clearly against each prescription entry.
4. Time should be recorded in 24hr format e.g. 0600, 1800.
5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.
6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.
7. The following metric unit abbreviations must be used –

Milligram = mg — Gram = g
Millilitre = ml — Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

8. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - Intrathecal **must be written in full.**

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.
2. Insert initials in the relevant date column and time row each time a drug is administered.
3. Check that all drugs prescribed at a certain time have been administered.
4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

(3) Patient refused
(4) Drug not available
(5) Nil by mouth/fasting
(6) Patient unavailable
(7) Patient asleep
(8) Time varied on doctor's instructions
(9) Dose withheld on doctor's instructions
(10) Nausea/vomiting
(11) Unable to swallow
(12) No intravenous access
(13) Patient Self-Administration of Medicine
(14) Other - Record in nursing notes
(15) Prescription clarification required

Cat. No. 40995 Ver 4, 09/2010

MEDICINE PRESCRIPTION FORM

Hospital Name: .....

PATIENT DETAILS

SG03251486
GEORGE HARKNESS
32C MILL SQUARE
CATRINE
KA5 6RD CHI 1707583579
17/07/1958

Height:

Weight:

Surface area:

Date of writing discharge prescription: __/__/__

Ward: 65

Date of Admission: 27/4/09

Consultant Name: DUNN

Date and time this form prepared: __/__/__ Time:_____

Sheet No .....

2nd Prescription in use Yes or NO

DRUG SENSITIVITIES

NKDA.

DVT Risk on Admission (SIGN Guideline)

High ☐ Moderate ☐ Low ☐

Assessed by: Date: __/__/__

OTHER CHARTS IN USE

Insulin	☐	TPN:	☐
PCA and other infusions	☐	Enteral Nutrition:	☐
Anticoagulants: Heparin	☐	Oxygen Therapy:	☐
Oral	☐	Other:	
Topical:	☐		

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF PRESCRIBER	GIVEN BY	TIME GIVEN
28-4	Temazepam	20mg	O	1400		SK/SM	1450
28-4	Ranitidine	150mg	O	1400		SK	1400
28-4	Metoclop	10mg	O	1400		SK	1400
		O					

PHARMACY INFORMATION

Community Pharmacy Details:

Rockie Pharmacy, 8 Ford St,
CATRING, KA5 6RW.

Tel No.:

Use of Patients Own Medicines in Hospital

Patient Consent Y/N	Initials	Date

Compliance Aid Details:

PATIENT'S NAME:

ADMINISTRATION

Parenteral Drugs: Regular Prescription

DATE →

MONTH →

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

A DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

B DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

C DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

D DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

E

DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

F

DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

G

DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

H

DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

Note: To discontinue a prescription, initial and date appropriate boxes and draw a diagonal line through section

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE → 27 28 29 30

MONTH → 4 4 4 4

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

J DRUG: AMOXICILLIN

DOSE: 500mg | ROUTE: oral | DATE: 27/4/19 | STOPPED DATE: | STOPPED INITIALS:

SIGNATURE OF PRESCRIBER: [signature]

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

FOR PRESCRIBERS USE ONLY

K DRUG: PARACETAMOL

DOSE: 1g | ROUTE: oral | DATE: 27/4/19 | STOPPED DATE: | STOPPED INITIALS:

SIGNATURE OF PRESCRIBER: [signature]

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

FOR PRESCRIBERS USE ONLY

L DRUG: DIHYDROCODEINE

DOSE: 60mg | ROUTE: oral | DATE: 27/4/19 | STOPPED DATE: | STOPPED INITIALS:

SIGNATURE OF PRESCRIBER: [signature]

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

FOR PRESCRIBERS USE ONLY

M DRUG:

DOSE | ROUTE | DATE | STOPPED DATE: | STOPPED INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescriptions

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

Patient's Own Medicine
For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

N DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

P DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

R DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

S DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

Note: To discontinue a prescription, initial and date appropriate boxes and draw a diagonal line through section

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE →

MONTH →

Patient's Own Medicine

For Use Y/N

Qty:

Date:

Assessed by:

Ordered from Pharm.

Other time

0700-0900

1200-1400

1600-1800

2200-2400

Other time

T DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

V DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

W DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

X DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescriptions

DATE →
MONTH →

Patient's Own Medicine

Y

DRUG

DOSE | ROUTE | DATE

SIGNATURE OF PRESCRIBER

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

AA

DRUG

DOSE | ROUTE | DATE

SIGNATURE OF PRESCRIBER

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BB

DRUG

DOSE | ROUTE | DATE

SIGNATURE OF PRESCRIBER

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

CC

DRUG

DOSE | ROUTE | DATE

SIGNATURE OF PRESCRIBER

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

Note: To discontinue a prescription, initial and date appropriate boxes and draw a diagonal line through section

PATIENT'S NAME:

All Routes: As Required Prescriptions

ADMINISTRATION

Patient's Own Medicine: For Use Y/N; Qty:; Date:; Assessed by:; Ordered from Pharm.

MM

DRUG: SALBUTAMOL 100

DOSE: 2puffs | ROUTE: INH | INDICATION: WHEEZE

SIGNATURE OF PRESCRIBER: D Bennett | MAX.FREQUENCY: PRN | DATE: 27/4/9

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

STOPPED DATE: INITIALS:

DATE	
TIME	
DOSE	
GIVEN BY	

NN

DRUG: TRAMADOL

DOSE: 50-100mg | ROUTE: oral | INDICATION: PAIN

SIGNATURE OF PRESCRIBER: D Bennett | MAX.FREQUENCY: 4° | DATE: 27/4/9

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: MAX 400mg / 24h

STOPPED DATE: INITIALS:

DATE	28/4	29/4	29/4	29/4	30/4																					
TIME	22	03	06 30	20 00	09 15																					
DOSE	100	100	100	100	100																					
GIVEN BY	JH	WT	OH	WW	WT																					

PP

DRUG: PROCTOSYL

DOSE: Apply | ROUTE: TOP | INDICATION: HAEMORRHOIDS

SIGNATURE OF PRESCRIBER: D Bennett | MAX.FREQUENCY: 12° | DATE: 27/4/9

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

STOPPED DATE: INITIALS:

DATE	
TIME	
DOSE	
GIVEN BY	

RR

DRUG: CYCLIZINE

DOSE: 50.MG | ROUTE: IV | INDICATION: nausea

SIGNATURE OF PRESCRIBER: [illegible] | MAX.FREQUENCY: 6 hrly | DATE: 28/4

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

STOPPED DATE: INITIALS:

DATE	
TIME	
DOSE	
GIVEN BY	

The 'Regular and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Patient's Own Medicine

SS DRUG: ONDANSETRON | STOPPED DATE: | STOPPED INITIALS:

DOSE: 4 mg IV | ROUTE | INDICATION: nausea

SIGNATURE OF PRESCRIBER | MAX.FREQUENCY: 6-8 hrly | DATE: 29/7

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

		For Use Y/N
DATE	28/7/05	Qty:
TIME	18/20	Date:
DOSE	4mg	Assessed by:
GIVEN BY	TMB CD	Ordered from Pharm.

TT DRUG | STOPPED DATE: | STOPPED INITIALS:

DOSE | ROUTE | INDICATION

SIGNATURE OF PRESCRIBER | MAX.FREQUENCY | DATE:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

		For Use Y/N
DATE		Qty:
TIME		Date:
DOSE		Assessed by:
GIVEN BY		Ordered from Pharm.

VV DRUG | STOPPED DATE: | STOPPED INITIALS:

DOSE | ROUTE | INDICATION

SIGNATURE OF PRESCRIBER | MAX.FREQUENCY | DATE:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

		For Use Y/N
DATE		Qty:
TIME		Date:
DOSE		Assessed by:
GIVEN BY		Ordered from Pharm.

WW DRUG | STOPPED DATE: | STOPPED INITIALS:

DOSE | ROUTE | INDICATION

SIGNATURE OF PRESCRIBER | MAX.FREQUENCY | DATE:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

		For Use Y/N
DATE		Qty:
TIME		Date:
DOSE		Assessed by:
GIVEN BY		Ordered from Pharm.

Note: To discontinue a prescription, initial and date appropriate boxes and draw a diagonal line through section

Nurse/Midwife Administration by Pro ol - Authorised Nurses/Midwive nly

(Maximum number of doses as per protocol)

Warning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed by a doctor.

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the nurse/midwife administration protocol No.(s) ..... with the following exceptions: _____

Signature: _____ Date: _____

DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF NURSE	GIVEN BY	TIME GIVEN

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).

2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).

3. Sign your full name clearly against each prescription entry.

4. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes.

5. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.

6. The following metric unit abbreviations must be used –

Milligram = mg Gram = g
Millilitre = ml Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

7. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - Intrathecal **must be written in full.**

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.

2. Insert initials in the relevant date column and time row each time a drug is administered.

3. Check that all drugs prescribed at a certain time have been administered.

4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

(3) Patient refused
(4) Drug not available
(5) Nil by mouth/fasting
(6) Patient unavailable
(7) Patient asleep
(8) Time varied on doctor's instructions
(9) Dose withheld on doctor's instructions
(10) Nausea/vomiting
(11) Unable to swallow
(12) No intravenous access
(13) Patient Self-Administration of Medicine
(14) Other - Record in nursing notes
(15) Prescription clarification required

Cat. No. 40995 Ver 2, 01/2009

INSTITUTE OF NEUROLOGICAL SCIENCES
PHYSIOTHERAPY DEPARTMENT

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST

SURNAME:

FORENAME:

UNIT NO:

SG03251486
GEORGE HARKNESS
32C MILL SQUARE
CATRINE
AYRSHIRE 17/07/1958
KA5 6RD CHI 1707583579

CONSULTANT: DUND

WARD: 65

DOB: 17/07/1958

ADDRESS: Tel: 01290 553 080

ADMISSION DATE:

G.P: DR DAVID RICHARDSON

REFERRAL DATE:

BALLOCHMYLE MEDICAL GROUP
THE CLINIC, INSTITUTE AVENUE, CATRINE
KA5 6RU

DATE OF FIRST CONTACT:

DIAGNOSIS: C6/7 Anterior Cervical decompression, revision removal of cage + bone graft from ⓡ iliac crest 1/2/11

PROBLEM LIST

DATE	NO.	PROBLEM	STILL ACTIVE OR RESOLVED	DATE	SIGNATURE
4/2/11	①	↓d Mobility			

GOAL: Safe ⓡ c mobility

DISCHARGE SUMMARY DATE OF DISCHARGE: 4/2/11

Safe ⓡ c mobility - appropriate for d/c + adherent

GEORGE DARKNESS (2) SG032514B6 CRI - 1707583579

PC: C6/7 ACDF, revision + removal of cage + bone graft from @ iliac crest.

HPC: 2 level C5/6 + C6/7 ACDF in April '09 for predominantly Ⓡ C6 radiculopathy. 6/12 post surgery Ⓡ sided brachalgia recurred in C6 distribution. Dull pain radiating from the shoulder in to posterolateral upper arm, forearm + remaining in lateral fingers + numbness

Investigation MRI - Good decompression @ C6/7 but severe ecdo compression @ C5/6. Worse on Ⓛ

PMH: PBS
Asthma
Arthroscopy for ruptured ACL Ⓛ leg
Ⓡ foot

FH NKDA

SH Lives c wife
HGV driver
ex-smoker

2/2/11 S/ N/S request pt be issued c Miami J collar prior to mobilising. Pt consenting to PT.

O/ Supine in bed - obs within normal parameters.
Ad 2 to apply sterile Miami J collar.
Hx → Sit // UE for technique safe Ⓡ.
Static sitting balance // safe Ⓡ.
Dermatomes L=R= NAD Myotomes L=R= NAD.
Muscle strength Ⓡ Grade IV Biceps.
Sit → Stand // safe Ⓡ.
Mobilised ~ 15m c IWD Ad 1 // WD WB Ⓡ H 2° to iliac crest bone graft. Slightly unsteady initially but mid stability + distance.

P/ Miami J collar fitting
TF/T - Mobility PT.

A/ Pt appropriate for Ⓨ mobility over short distances

P/ Assess stairs p.m/more.

Pain revision
(Sam)

South Glasgow Hospitals

NHS Greater Glasgow and Clyde

Physiotherapy Treatment Records

Name George Hawkness Unit Number SG0325 1486

Date of Referral

Diagnosis:-

Additional Information:-

Date	Details	Signature
3/2/11	S/ Consents to Rx.	
	O/ Collar ill fitting ∴ pt shown how to apply in front of mirror	
	On feet on arrival. Gait (I) ~30m c ↓ (R) WB 2° to pain. Fair clearance, step length R > L.	
	Stairs ↑↓ 1 flight step 2 c rail	
	Rx/ Gait + St Rx.	
	Shown how to apply collar.	
	A/ Functionally (I); pain still limits a little.	
	P/ D/C PT.	JHarvey SIPT.

INSTITUTE OF NEUROLOGICAL SCIENCES
PHYSIOTHERAPY DEPARTMENT

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST

SURNAME: Harkness	CONSULTANT:
FORENAME: George	WARD: 65
UNIT NO: SG03251486	DOB: 17/7/58
ADDRESS: 32c Mill Square Catrine Ayrshire KA5 6RD	ADMISSION DATE:
	REFERRAL DATE: 29.4.09
	DATE OF FIRST CONTACT: 29.4.09

DIAGNOSIS: (R) C5/6, C6/7 ACDF 28.4.09

PROBLEM LIST

DATE	NO.	PROBLEM	STILL ACTIVE OR RESOLVED	DATE	SIGNATURE
		No physio issues.			

GOAL (I) mobilise. Safe on stairs.

DISCHARGE SUMMARY DATE OF DISCHARGE: 29.4.09

(I) mobile & safe on stairs.

No follow-up reqd.

Vicky Sloan
VICKY SLOAN
(SCHIPT)

PC/ Right C5/6 - C6/7 Anterior Cervical Decompression
28.4.09

HPC: ⇒ Neck pain radiating down ® arm since July 08 ⇒ occured following heavy lifting.
↑ numbness in all fingers ® hand ± assoc. weakness.
⇒ Occ. paraesthesia in finger tips of © hand.

PMH: Asthma
ACL repair © knee
Tennis elbow ↑ ® elbow.

DH: See kardex.

SH: Lives ± wife.
Ex. smoker - 18 years.

29.4.09

S: Consent for R. Bright.

O: . Bed mob: Ⓘ
. STS: Ⓘ
. Balance: Ⓘ static & dynamic.
. Gait: Ⓘ, reciprocal pattn ± good step length & floor clearance.
. Stairs: Ⓘ, no issues.

A: 1. Ax as above.
Ⓘ mobile & safe on stairs. Pt happy for D/c ± no follow-up. Aware can self-refer to physio if req'd.

P: D/c from physio.

Sloan
VICKY SLOAN
(SENIOR PT)

NHS Greater Glasgow & Clyde – Institute of Neurological Sciences
Southern General Hospital

NHS Greater Glasgow and Clyde

PATIENT INVESTIGATION OR TREATMENT REQUEST FORM

This form is to be used when a mentally competent patient wishes to proceed with investigation, operation or other procedure of an invasive nature

Patient details:

SG03251486
GEORGE HARKNESS
32C MILL SQUARE
CATRINE
AYRSHIRE 17/07/1958
KA5 6RD CHI 1707583579

Date: 21 / 1 / 2011

I, George Harkness (name) request the following procedure(s) be performed:

Re-do G/6 anterior cervical discectomy and fusion

I agree: to the administration of an anaesthetic or sedation as required

I understand: that no assurance can be given that the procedure will be performed by any particular practitioner.

Signature: G. Harkness (Patient*)
Parent*
Other* (please state) _____
*(*Delete as applicable)*

Witnessed by *(Practitioner's name)*: L. Jones **Signature:** _____

For female patients, 12-55 years, who may be exposed to ionising radiation between the diaphragm and the knee:

I believe that: I am or may be pregnant / I am not pregnant *(Delete as appropriate)*

Name: _____ **Signature:** _____

Elaine Watson

19.04.56

Meningioma

VP Shunt 3/12

Lhe 07833 67424

2609 47 322.

SOUTHERN GENERAL HOSPITAL
PATIENTS PROFILE

WARD / DEPT: 65 INS		NAMED NURSE: Carolyn Robertson.	
CONSULTANT: Mr Dunn		REFERRAL: W/L	
DATE: 31/1/11		TIME: 1130	
PATIENTS NAME: George Harkness			
UNIT NUMBER: SG0325148G			
PREFERS TO BE CALLED:			
ADDRESS: 32C Mill Square, Catrine, Ayrshire KA5 6RD			
TELEPHONE NUMBER: 07742747893			
AGE: 52	D.O.B.: 17/7/58	SEX: M	MARITAL STATUS:
OCCUPATION:			
RELIGION:	CLERGY / OTHER:	CONTACT REQUIRED:	CONTACTED:

REASON FOR ADMISSION: For cervical decompression.
Theatre scheduled for 01.02.11 - re-do C-decompression.

PREVIOUS HEALTH HISTORY: Asthma.
® C5/6 - 6/7 ACDF in April 2009.

KNOWN ALLERGIES: Nil known

PATIENTS PROFILE (cont'd)

MEDICATION ON ADMISSION:

LANSOPRAZOLE 30mg daily.
PROCTOSEDYL CREAM
VENTOLIN INHALER.
REMEDINE FORTE (PARACETAMOL BASED).

PATIENTS PRECEPTION OF CURRENT HEALTH STATUS:

Aware of present condition.

RELATIVES PRECEPTIONS OF PATIENTS HEALTH STATUS:

Wife present on admission.

EMERGENCY CONTACT NAME:

NEXT OF KIN: Fiona Harkness

RELATIONSHIP: Wife.

ADDRESS: As Above

PHONE NUMBER (DAY): 01290 553030. | TELEPHONE NUMBER (NIGHT):

OTHER RELEVANT CONTACT: 07746 877 882.

G.P.'s NAME: Dr D. Richardson

G.P.'s ADDRESS: Ballochmyle Med Group Institute Ave. Ethics Theatre

G.P.'s TELEPHONE NUMBER: 01444997055

Patient / Relative spoken to by	DATE	TIME	DOCTOR	NURSE

VALUABLES: DISPOSAL HOME WARD CASHIER'S OFFICE

CLOTHING: DISPOSAL HOME WARD CASHIER'S OFFICE

NURSES SIGNATURE: C Roberts

SOUTHERN GENERAL HOSPITAL
NURSING ASSESSMENT

PATIENTS NAME: George Markness	UNIT No.:	WARD: 65

GENERAL ASSESSMENT ON ADMISSION:

Appears well on admission.
No limb deficits of note.
Independent with ADL's.

SOCIAL / HOME BACKGROUND (INCLUDING PROBLEMS RELATED TO ADMISSION):

Lives with wife.
stairs in house.
Non smoker.
Non drinker.

BLOOD PRESSURE: 146/93	WEIGHT: 86.45kg
PULSE: 73.	HEIGHT: 1.78m.
RESPIRATIONS: Sa02 96% room air	URINALYSIS:
TEMPERATURE:	WATERLOW SCORE:

SGH 310

NURSING ASSESSMENT (ASSESSMENT OF ACTIVITIES OF DAILY LIVING)

MAINTAINING A SAFE ENVIRONMENT, COMMUNICATING, BREATHING, EATING AND DRINKING, ELIMINATING, PERSONAL CLEANSING AND DRESSING, CONTROLLING BODY TEMPERATURE, MOBILISING, WORKING AND PLAYING, EXPRESSING SEXUALITY, SLEEPING, DYING.

1. Buzzer system explained
2. Communicates freely.
3. Spontaneously on room air.
4. Normal diet & fluids.
5. PU spontaneously.
6. Independent ↑ personal hygeine.
7. Apyrexial.
8. Independent with mobility.
9.
10. Lives with wife & son.
11. No problems discussed.
12 Not discussed.

NURSES SIGNATURE: [signature]

SOUTHERN GENERAL HOSPITAL

INVESTIGATION INSTRUCTION SHEET

NAME: George Harkness UNIT NO: WARD: 65

DATE		DATE	INITIAL
1/2/11	Theatre — C6/7 ACD revision and insertion of bone graft from Iliac Crest	1/2/11	PH
2/2/11	X-ray		

DATE		DATE		DATE		DATE		DATE		DATE	

0369451-SGH307

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: INS

NAME: George Harkness UNIT NO. WARD: 65

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
31/1/11		Admitted as per patient profile seen by medical staff. Fast 12 mn for theatre tomorrow	[illegible]
1/2/11		1) Observations satisfactory as charted. Mild weakness to left arm Normal leg power	
		4) Fasted from 12 midnight	
		5) Passing urine	
		8) Fully mobile	
		12) Oral analgesia taken prior to settling. 10mg temazepam also given with effect.	C. MACKENZIE C. Nadeg
1/2/11	15:05	Patient in recovery following surgery. See care plan for details.	[illegible]
	900	No problems post op. No analgesia at present IV fluids running To Mr Dunn (to be posted with ward caller)	[illegible]
2/2/11		1) Vital signs satisfactory. Patient feels L arm improved. Apyrexial.	
		(3) Sat rations 96-98% on air	
		(4) IV fluids discontinued Drinking small amounts	
		(5) Passing urine via bottles	
		(6) Wound drains x 2 in situ minimal amount in drains Mepore dressings dry and intact	
		(8) Moving in bed with encouragement	
		(11) Slept only for short periods.	
		(12) IM Morphine given x 2 with fair effect.	C. MACKENZIE C. Nadeg
2/2/11 pm	(1)	limb power good, vital signs stable, apyrexial	
	(2)	communicates needs well.	
	(3)	sats 97% on room air	
	(4)	eating and drinking well	
	(5)	up to toilet to pv uncomplaining of constipation	
	(6)	wound drains removed. wounds satisfactory	
	b.	independant with ADL's.	

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: RS

NAME: George Halkness UNIT NO. SG03251486 WARD: 6S

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
	(7)	apyrexial	
	(8)	mobilising fairly well, fitted with a hard collar.	
	(9)	family in attendance	
	(12)	routine analgesia c a fair effect	
		:- x-ray. carried out	Mackinnon
		:- hard collar for 6 weeks	
3/2/11 0035	1)	Vital signs satisfactory Apyrexial	
		NO limb deficits.	
	3)	Saturations satisfactory on air	
	4)	Eating and drinking	
	5)	Passing urine spontaneously	
	6)	Wound sites satisfactory	
	8)	Mobilising with hard collar in situ	C. MACINTYRE
	12)	Oral analgesia taken with effect	C. Mackye.
2/11 pm	(1)	no limb deficits, BP and pulse stable, apyrexial	
	(2)	communicates needs well	
	(3)	sat 96% on 100m air	
	(4)	eating and drinking well	
	(5)	no bladder / bowel problems	
	(6)	independant with AOL's.	
	b.	wound satisfactory	
	(7)	apyrexial	
	(8)	mobilising independantly with hard collar	
	(9)	family in attendance - ? home tomorrow.	
	(12)	regular analgesia with a fair effect	Mackinnon
4/02/11	(1)	Remains well. No deficits	
	(4)	Diet and fluids taken	
	(5)	Passing urine spontaneously	
	(6)	Neck wound clean + dry. Mepore removed from thigh wound; some bruising around wound evident	
	(8)	Fully mobile with collar	
	(12)	Regular oral analgesia taken with effect	C. MACINTYRE C. Mackye

SOUTHERN GENERAL HOSPITAL

DEPARTMENT:

NAME: George Hankness UNIT NO. 03251486 WARD: 65

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
4/2/10		Remains well. S/o medical staff - for discharge home today	

0369438-SGH 306A

Regional Services Division Nursing Care Plan [redacted] **Maintaining a safe environment**	Date 31/1/11 [redacted]	Time

Date and Time	Problem No	Problem	Nurse Action	Aims of Care	Initial	Review Date	Disc
	1a	Potential deterioration in conscious level / vital signs.	Assess using Glasgow Coma Scale or SEWS _____ Hourly	Detection of deterioration in conscious level / vital signs. Maintain patient safety.	CR	ongoing	
	1b	Potential risk of falls	Patient falls and restraint management risk assessment completed and implemented	Maintain patient safety.	CR	ongoing	
		Maintain bed at lowest level		Minimise risk of falls.	CR	ongoing	
		Bed rails in use Y/N	Assess level of observation required.		CR	ongoing	
			Refer to moving and handling risk assessment.		CR	ongoing	
	1c	Potential risk of acquired infection	Ensure adequate hand hygiene and infection control measures are adhered to.	Minimise risk of acquired infection.	CR	ongoing	
			Ensure area is clean, tidy and free of clutter.		CR	ongoing	
	1d	Intravenous cannula in situ Y/N	Inspect cannula site each shift and prior to use. Record date of insertion. Replace as per infection control guidance. Complete equipment change chart.		CR	ongoing	

Name George Harkness	CHI No 1707583579	Ward 65

Regional Services Division Nursing Care Plan **Communication** **Breathing**	Date	Time

Date and Time	Problem No	Problem	Nurse Action	Aims of Care	Initial	Review Date	Disc
	2	Communication Potential difficulty communicating due to: Potential anxiety due to hospital admission.	Explain all nursing interventions. Involve patient in care planning.	Minimize anxiety. Aid understanding. Patient is involved in care plan.	CR	ongoing	
	3	Altered respiratory function.		Maintain safety. Maintain adequate respiration. Maintain adequate oxygen saturation. Promote comfort. Relieve distress.	CR	ongoing	
					CR		

Name	HI No	Ward

Regional Services Division Nursing Care Plan [redacted] **Eating and Drinking** **Eliminating**	Date [redacted]	Time

Date and Time	Problem No	Problem	Nurse Action	Aims of Care	Initial	Review Date	Disc
	4	Potentially inadequate nutritional intake.	Assess nutritional status on admission. Refer to dietitian if appropriate. Provide assistance if required. Offer hand cleansing facilities before meals.	To provide adequate nutrition and hydration.	CR	ongoing	
	5	Potential alteration of bladder and /or bowel function.	Assess on admission. Provide assistance as required Administer aperients as prescribed. Urinary catheter size H20 in balloon ml Date of Insertion Date of removal Catheter hygiene as per protocol.	To encourage normal bladder / bowel function. Maintain dignity. Promote comfort. Maintain hygiene to prevent infection.	CR	ongoing	

Name	CHI No	Ward

Regional Services Division Nursing Care Plan **Personal cleansing and dressing**	Date	Time

Date and Time	Problem No	Problem	Nurse Action	Aims of Care	Initial	Review Date	Disc
	6a	Potential wound infection/poor healing.	Observe wound for signs of inflammation. Remove Clips on: Remove Drain on:	Prevent wound infection. Promote healing.	CR	ongoing	
	6b	Potential difficulty maintaining personal hygiene	Daily bed bath. Daily shower / bath.	Maintain personal hygiene.	CR	ongoing	
			Assistance Y N	Maintain dignity. Prevent infection.	CR	ongoing	
			Assist as required with: • Oral hygiene • Hair / nails • Dressing • Eye care	Maintain skin integrity.	CR	ongoing	
			Provide hand cleaning facilities prior to meals and after use of toilet.				

Name	CHI No	Ward

Regional Services Division Nursing Care Plan **Controlling body temperature** **Mobilising**	Date [redacted]	Time

Date and Time	Problem No	Problem	Nurse Action	Aims of Care	Initial	Review Date	Disc
	7	Potential alteration in body temperature due to:	Monitor and take appropriate action.	Maintain temperature within normal range.	CR	ongoing	
	8	Reduced mobility.	Independent Y N	Reduce complications of reduced mobility.	CR	ongoing	
				Promote comfort.	CR	ongoing	
			Complete moving and handling risk assessment.	Maintain skin integrity.	CR	ongoing	
			Refer to physiotherapist Y N	Assist rehabilitation.	CR	ongoing.	

Name	CHI No	Ward

Regional Services Division Nursing Care Plan **Working and playing** **Expressing sexuality**	Date	Time

Date and Time	Problem No	Problem	Nurse Action	Aims of Care	Initial	Review Date	Disc
	9	Disruption to normal work pattern / recreation.	Assess and refer to appropriate body.	Identify potential areas of concern. Refer to appropriate source of advice / support.	CR	ongoing	
	10	Potential altered body image.	Discuss. Provide support. Promote dignity.	To maintain patients dignity.	CR	ongoing	

Name	HI No	Ward

Regional Services Division Nursing Care Plan [redacted] **Sleeping** **Spiritual care**	Date [redacted]	Time

Date and Time	Problem No	Problem	Nurse Action	Aims of Care	Initial	Review Date	Disc
	11	Potential disruption to normal sleep pattern.	Provide quiet environment. Promote comfort. Relieve pain.	Promote rest / sleep.	CR	Ongoing	
	12a	Potential need for spiritual care.	Encourage discussion. Assess spiritual needs. Refer to appropriate chaplain if desired. Involve family / significant other.	Address spiritual needs. Assist patient and family to cope with illness and possible bereavement.	CR	Ongoing	

Name	CHI No	Ward

Regional Services Division Nursing Care Plan **Pain**	Date	Time

Date and Time	Problem No	Problem	Nurse Action	Aims of Care	Initial	Review Date	Disc
	12b	Pain	Assess using appropriate pain assessment tool. Provide support / comfort. Ensure adequate analgesia is given and assess effect. Liaise with medical staff.	Relieve pain. Promote comfort. Promote dignity.	CR	ongoing	

Name	CHI No	Ward

S = Sleeping

0 = No pain

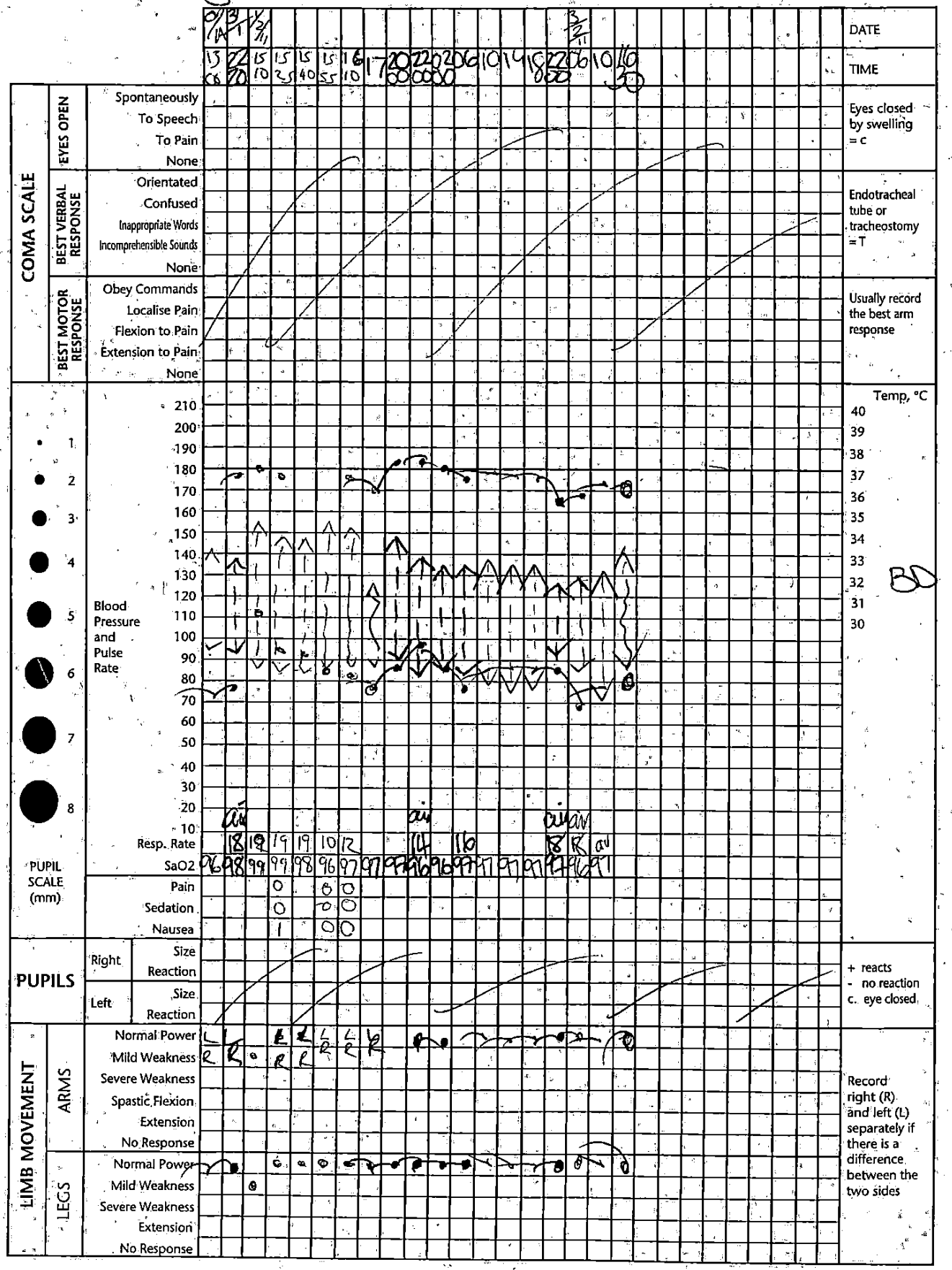
South Glasgow Hospitals

Hospital .....SGH.....

Observation Chart

NHS Greater Glasgow and Clyde

Name: George Harkness	Record No:



Cannard Falls Risk Assessment

(Must be completed within 24 hours)

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						DATE	DATE	DATE	DATE	DATE	DATE	DATE
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			0						
Sex	Male 1	Female 2				1						
Age	60-70 1	71-80 2	81+ 1			0						
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		0						
Medication type **	Drugs for mental illness 1	Blood pressure / water tablets 1	Sleeping tablets 1	None of these 0		0						
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	0						
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed bound 1		1						
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1						
				TOTAL SCORE		3						
				ACTION(S) TAKEN Enter action code(s)		1						
SCORE 2 - 8 = LOW 9 - 12 = MEDIUM 13+ = HIGH RISK				NURSE SIGNATURE		ck.						

** If you are in any doubt about whether a person's medicine belongs to one of the types listed ask the person or carer or please phone the number on the medicine container and ask the community or hospital pharmacist.

* Please see back page for clarification

Nutrition Profile

NHS Greater Glasgow and Clyde

Name: 	Date of admission: 31/1/11
Address: SG03251486 GEORGE HARKNESS 32C MILL SQUARE CATRINE AYRSHIRE KA5 6RD	Time:
DoB: 17/07/1958 CHI 1707583579	HOSPITAL: SGH
CHI number:	Ward: 65
Affix patient data label	

To be recorded within 24 hours of admission*

Height: 178cm m/ft Actual ☐ Patient/ carer reported ☑ Alternative measurement ☐

Weight: 86.45 (kg)/stones Actual ☑ Patient/ carer reported ☐ Alternative measurement ☐

Recent unplanned weight loss: Yes ☐ No ☑

If 'Yes' how much?: kg/stones. Over what period of time?: weeks/months

Is there evidence of recent weight loss?

No ☑ Loose clothing ☐ History of reduced food intake/appetite ☐ Swallowing problem ☐

Eating and drinking likes and dislikes (including appetite and/or NBM status):

no allergies
likes most things, Teat milk

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☑

Please state:

Are there any contributing factors that may affect food intake such as **physical** (e.g. swallowing difficulties), **physiological** (e.g. nausea), **psychological** (e.g. dementia), **social or environmental?** Yes ☐ No ☑

Please specify all factors:

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☑

Please state:

Profile completed by: Name (PRINT): ARINDAY Signature: Arinday Date: 31/1/11

NOTE: This is ADMISSION DATA - please refer to changes in Care Plan.

* Quality Improvement Scotland (2003). Food, Fluids and Nutritional Care in Hospitals Edinburgh QIS

Malnutrition Universal Screening Tool ('MUST')

Date	31/1/11									
Initials	AL									
Height (see page 1) 178cm . Weight	86 kg									
Oedema or ascites present Y/N	N									
BMI	27									

'MUST'

Step 1: BMI Score (refer to chart on page 4) >20 (>30 = Obese) ..... 0 18.5 - 20 ..... 1 <18.5 2	0								
Step 2: Weight Loss Score Unplanned weight loss in past 3-6 months: <5% ..... 0 5-10% ..... 1 >10% 2	0								
Step 3: Acute Disease Effect Score If patient is acutely ill **and** there has been or is likely to be no or virtually no food intake for > 5 days.....Score 2 Not applicable.....Score 0	0								
Step 4: Overall Risk of Malnutrition Total:	0								

Step 5: Management Guidelines

Score of Overall Risk of Malnutrition	Action Required
0	**LOW RISK** - *Routine Clinical Care* • Repeat screening. Hospital Acute .....Weekly Hospital Rehabilitation.....Monthly
1	**MEDIUM RISK** - *Observe* • Document dietary intake for 3 days on a Food Record Chart. • If no improvement in intake: - Encourage oral intake. - Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Repeat screening weekly.
2 or more	**HIGH RISK** - *Treat** • Refer to Dietitian **and** document food intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Monitor **and** review Care Plan weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

Management Plan

FOR ALL PATIENTS

- Provide help and advice on food choices and eating and drinking when necessary.
- Treat underlying conditions and initiate appropriate treatment to relieve symptoms that affect nutritional intake e.g. nausea, vomiting, constipation, diarrhoea and/or pain.
- Refer to dietitian if any specialist advice is required.
- Complete nursing checklist for swallowing difficulties if appropriate.
- Use a recognised system to identify when equipment or asssistance is required at mealtimes (e.g. red mats, coloured napkins).

Referral Services

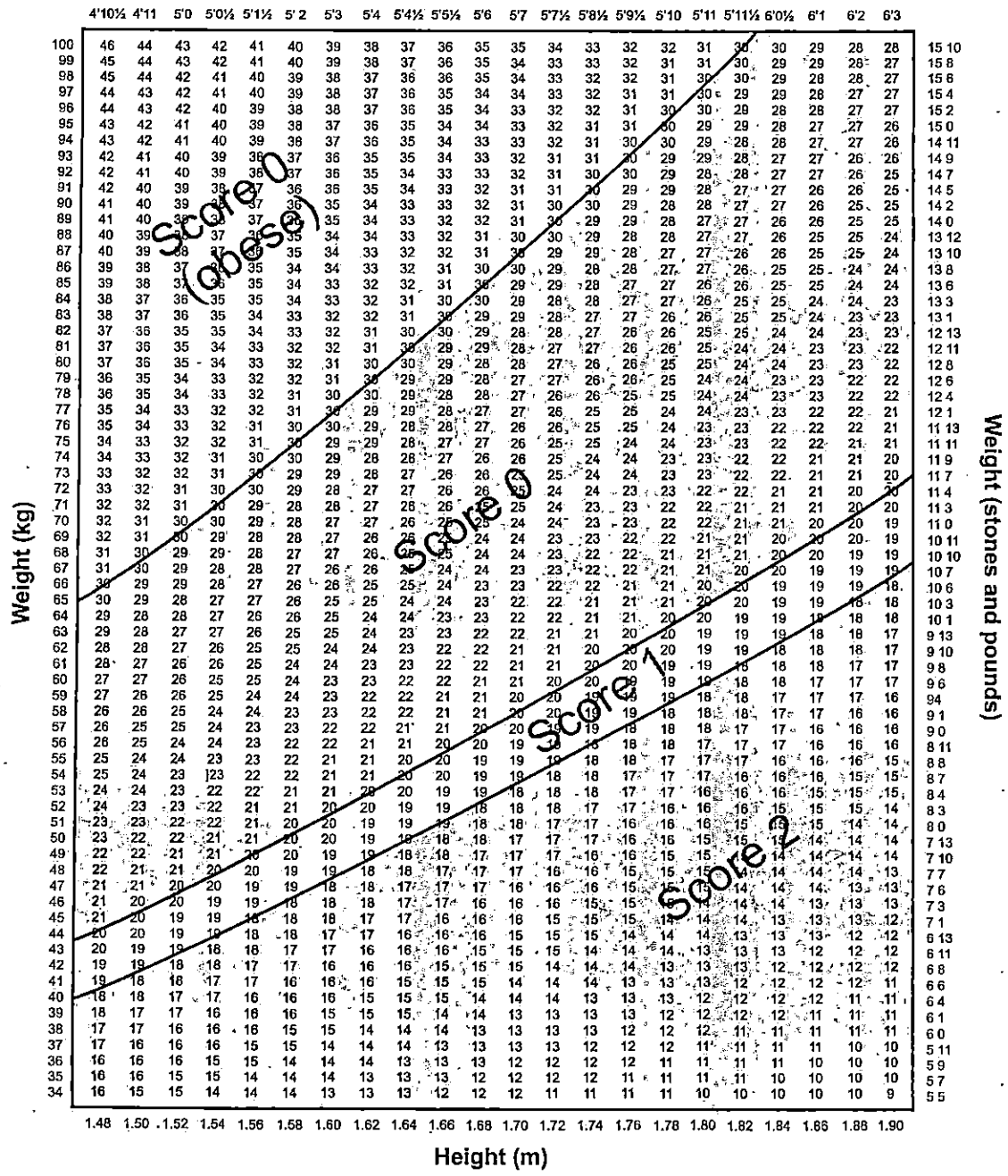
Dietitian	Date: / /	Outcome:
Speech and Language Therapy	Date: / /	Outcome:
Occupational Therapy	Date: / /	Outcome:
Dental Service	Date: / /	Outcome:

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Review date	Name (PRINT) Signature/Designation
3/1/4	0	can nde review weekly	1/52	[illegible]

N.B. Ensure discharge plan includes most recent 'MUST' score and any necessary follow-up requirements.

Step 1 - BMI Score



Step 2 - Weight Loss Score

Weight before weight loss (kg)	Score 0 W't loss <5%	Score 1 Wt loss 5-10%	Score 2 W't loss >10%
34 kg	<1.7 kg	1.7-3.4 kg	>3.4 kg
36 kg	<1.8 kg	1.8-3.6 kg	>3.6 kg
38 kg	<1.9 kg	1.9-3.8 kg	>3.8 kg
40 kg	<2 kg	2-4 kg	>4 kg
42 kg	<2.1 kg	2.1-4.2 kg	>4.2 kg
44 kg	<2.2 kg	2.2-4.4 kg	>4.4 kg
46 kg	<2.3 kg	2.3-4.6 kg	>4.6 kg
48 kg	<2.4 kg	2.4-4.8 kg	>4.8 kg
50 kg	<2.5 kg	2.5-5 kg	>5 kg
52 kg	<2.6 kg	2.6-5.2 kg	>5.2 kg
54 kg	<2.7 kg	2.7-5.4 kg	>5.4 kg
56 kg	<2.8 kg	2.8-5.6 kg	>5.6 kg
58 kg	<2.9 kg	2.9-5.8 kg	>5.8 kg
60 kg	<3 kg	3-6 kg	>6 kg
62 kg	<3.1 kg	3.1-6.2 kg	>6.2 kg
64 kg	<3.2 kg	3.2-6.4 kg	>6.4 kg
66 kg	<3.3 kg	3.3-6.6 kg	>6.6 kg
68 kg	<3.4 kg	3.4-6.8 kg	>6.8 kg
70 kg	<3.5 kg	3.5-7 kg	>7 kg
72 kg	<3.6 kg	3.6-7.2 kg	>7.2 kg
74 kg	<3.7 kg	3.7-7.4 kg	>7.4 kg
76 kg	<3.8 kg	3.8-7.6 kg	>7.6 kg
78 kg	<3.9 kg	3.9-7.8 kg	>7.8 kg
80 kg	<4 kg	4-8 kg	>8 kg
82 kg	<4.1 kg	4.1-8.2 kg	>8.2 kg
84 kg	<4.2 kg	4.2-8.4 kg	>8.4 kg
86 kg	<4.3 kg	4.3-8.6 kg	>8.6 kg
88 kg	<4.4 kg	4.4-8.8 kg	>8.8 kg
90 kg	<4.5 kg	4.5-9 kg	>9 kg
92 kg	<4.6 kg	4.6-9.2 kg	>9.2 kg
94 kg	<4.7 kg	4.7-9.4 kg	>9.4 kg
96 kg	<4.8 kg	4.8-9.6 kg	>9.6 kg
98 kg	<4.9 kg	4.9-9.8 kg	>9.8 kg
100 kg	<5 kg	5-10 kg	>10 kg
102 kg	<5.1 kg	5.1-10.2 kg	>10.2 kg
104 kg	<5.2 kg	5.2-10.4 kg	>10.4 kg
106 kg	<5.3 kg	5.3-10.6 kg	>10.6 kg
108 kg	<5.4 kg	5.4-10.8 kg	>10.8 kg
110 kg	<5.5 kg	5.5-11 kg	>11 kg
112 kg	<5.6 kg	5.6-11.2 kg	>11.2 kg
114 kg	<5.7 kg	5.7-11.4 kg	>11.4 kg
116 kg	<5.8 kg	5.8-11.6 kg	>11.6 kg
118 kg	<5.9 kg	5.9-11.8 kg	>11.8 kg
120 kg	<6 kg	6-12 kg	>12 kg
122 kg	<6.1 kg	6.1-12.2 kg	>12.2 kg
124 kg	<6.2 kg	6.2-12.4 kg	>12.4 kg
126 kg	<6.3 kg	6.3-12.6 kg	>12.6 kg

Weight before weight loss (st/lb)	Score 0 W't loss <5%	Score 1 W't loss 5-10%	Score 2 W't loss >10%
5st 4lb	<4lb	4lb-7lb	>7lb
5st 7lb	<4lb	4lb-8lb	>8lb
5st 11lb	<4lb	4lb-8lb	>8lb
6st	<4lb	4lb-8lb	>8lb
6st 4lb	<4lb	4lb-9lb	>9lb
6st 7lb	<5lb	5lb-9lb	>9lb
6st 11lb	<5lb	5lb-10lb	>10lb
7st	<5lb	5lb-10lb	>10lb
7st 4lb	<5lb	5lb-10lb	>10lb
7st 7lb	<5lb	5lb-11lb	>11lb
7st 11lb	<5lb	5lb-11lb	>11lb
8st	<6lb	6lb-11lb	>11lb
8st 4lb	<6lb	6lb-12lb	>12lb
8st 7lb	<6lb	6lb-12lb	>12lb
8st 11lb	<6lb	6lb-12lb	>12lb
9st	<6lb	6lb-13lb	>13lb
9st 4lb	<7lb	7lb-13lb	>13lb
9st 7lb	<7lb	7lb-13lb	>13lb
9st 11lb	<7lb	7lb-1st	>1st
10st	<7lb	7lb-1st	>1st
10st 4lb	<7lb	7lb-1st	>1st
10st 7lb	<7lb	7lb-1st 1lb	>1st 1lb
10st 11lb	<8lb	8lb-1st 1lb	>1st 1lb
11st	<8lb	8lb-1st 1lb	>1st 1lb
11st 4lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 7lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 11lb	<8lb	8lb-1st 3lb	>1st 3lb
12st	<8lb	8lb-1st 3lb	>1st 3lb
12st 4lb	<9lb	9lb-1st 3lb	>1st 3lb
12st 7lb	<9lb	9lb-1st 4lb	>1st 4lb
12st 11lb	<9lb	9lb-1st 4lb	>1st 4lb
13st	<9lb	9lb-1st 4lb	>1st 4lb
13st 4lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 7lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 11lb	<10lb	10lb-1st 5lb	>1st 5lb
14st	<10lb	10lb-1st 6lb	>1st 6lb
14st 4lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 7lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 11lb	<10lb	10lb-1st 7lb	>1st 7lb
15st	<11lb	11lb-1st 7lb	>1st 7lb
15st 4lb	<11lb	11lb-1st 7lb	>1st 7lb
15st 7lb	<11lb	11lb-1st 8lb	>1st 8lb
15st 11lb	<11lb	11lb-1st 8lb	>1st 8lb
16st	<11lb	11lb-1st 8lb	>1st 8lb
16st 4lb	<11lb	11lb-1st 9lb	>1st 9lb
16st 7lb	<12lb	12lb-1st 9lb	>1st 9lb
16st 11lb	<12lb	12lb-1st 9lb	>1st 9lb

VI MEDICAL ILLUSTRATION • NUTRITION & DIET • 12366/01.09.08

STORES ORDER CODE 41850

INSTITUTE OF NEUROLOGICAL SCIENCES
SOUTHERN GENERAL HOSPITAL

NHS Greater Glasgow and Clyde

N
U SG03251486
GEORGE HARKNESS
C 32C MILL SQUARE
CATRINE
D AYRSHIRE 17/07/1958
KA5 6RD CHI 1707583579

Use addressograph label if available

BED RAILS RISK ASSESSMENT

WARD: 65

CONSULTANT: Mr Dunn

Aim: An assessment of the risk of falling and the patient's ability to maintain their own safety from admission to discharge. Frequency of assessment based on professional judgement. The assessment will be discussed with the patient and reviewed every 24hours.

All patients should have a documented assessment made within 24 hours of admission made which includes maintaining a safe environment.

Indications for use	Indications for non-use
1. History of falls from bed/unable to obtain patient history 2. Fluctuating conscious level 3. Sensory loss 4. Lack of awareness of ability 5. Patients requests	1. Climbing over bed rails 2. Independent/no recent history of falls 3. Awareness of limitations 4. Distress when bed rails in situ 5. Increased risk of entrapment

Date	Time	Bed Rails Required YES	NO	Rationale	Signature
31-01-11	1130		✓	2	CR.
1-2-11	0130		✓	2	C Mackay
2-2-11	0100		✓	2	C Mackay
3-2-11	0200		✓	2	C. Mackay
04/2/11	0100		✓	2	C. Mackay

INSTITUTE OF NEUROLOGICAL SCIENCES
SOUTHERN GENERAL HOSPITAL

NHS Greater Glasgow and Clyde

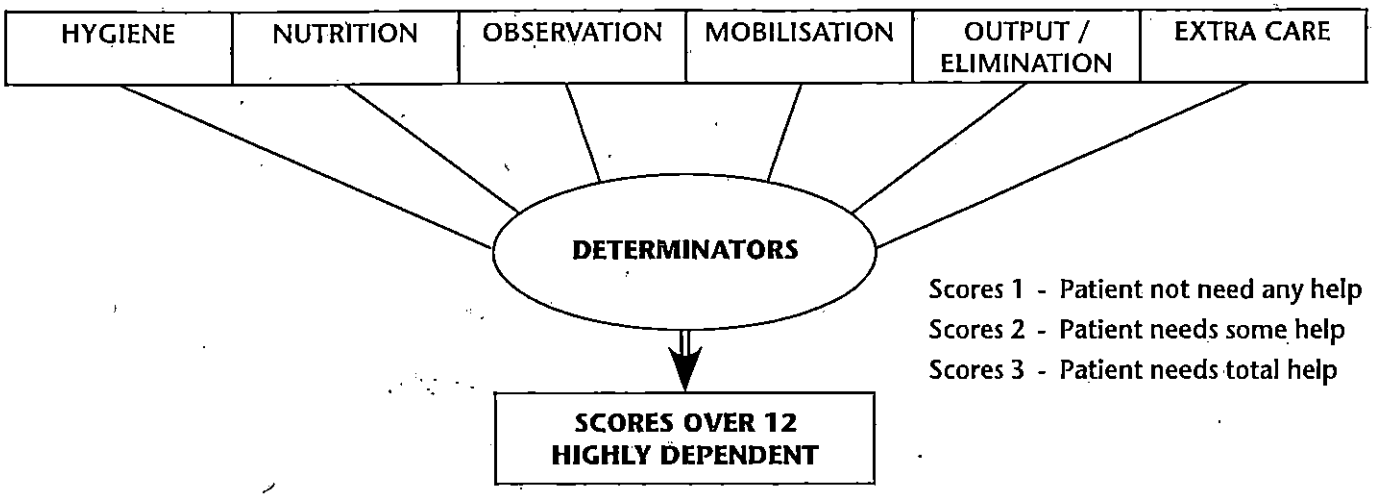
SG03251486
GEORGE HARKNESS
32C MILL SQUARE
CATRINE
AYRSHIRE 17/07/1958
KA5 6RD CHI 1707583579

Use addressograph label if available

DEPENDENCY SCORING

WARD: 65

CONSULTANT: Mr Dunn



Scores 1 - Patient not need any help
Scores 2 - Patient needs some help
Scores 3 - Patient needs total help

MODIFIED FROM THE ZEBRA PATIENT CLASSIFICATION SYSTEM

Date	Time	Hygiene	Nutrition	Obs	Mobilisation	Output	Extra Care	Score	Initial
31/8/11	1100	1	1	1	1	1	1	6	CR.
1/2/11	0130	1	1	1	1	1	1	6	CM
2/2/11	0200	2	1	3	3	2	3	14	CM
3/2/11	0200	2	1	2	2	1	1	8	CM
4/2/11	0100	1	1	2	1	1	1	7	CM

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patient's name: GEORGE HARKNESS	Ward: 65
Unit number: SG0325 1486	Discharge destination: HOME
CHI number:	Estimated Discharge Date (1) / /
	Estimated Discharge Date (2) / /
Apply addressograph label	Final date of discharge : / /

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)		✓		
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	✓	✓		Wound, glued neck clips to f/up 3/2/11
Other discharge items				
Access arrangements (e.g. keys, door entry)	✓			*Arranged to be removed
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: Staff Nurse	Date: / /

FORM NUMBER 0005752

NHS
Greater Glasgow and Clyde

NATVNS
SCOTLAND

SG03251486
GEORGE HARKNESS
32C MILL SQUARE
CATRINE
AYRSHIRE
KA5 6RD
17/07/1958
CHI 1707583579

ADAPTED WATERLOW PRESSURE AREA RISK ASSESSMENT CHART

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

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

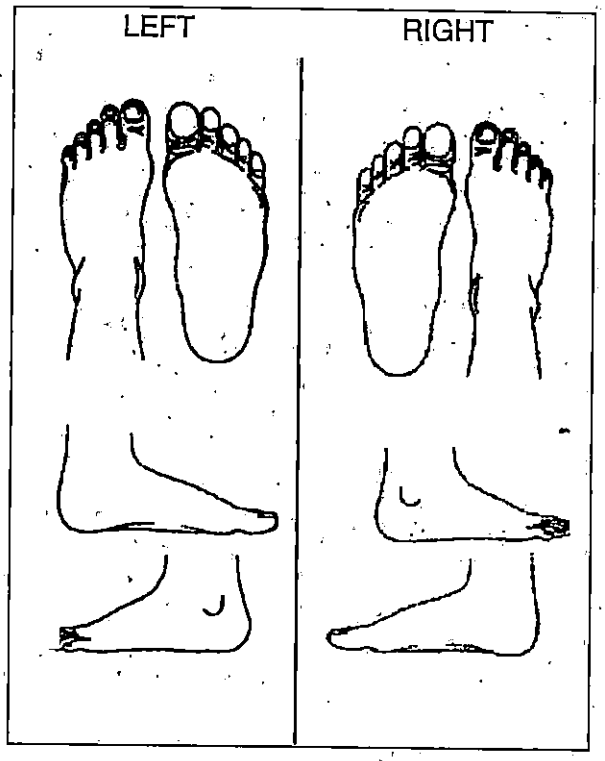
Sex									
Male	1	1	1	1	1	1			
Female	2								
Age									
14 -49	1								
50 -64	2	2	2	2	2	2			
65 - 74	3								
75 - 80	4								
81+	5								
Build/Weight for Height (BMI=weight in Kg/height in m²)									
Average - BMI 20-24.9	0	0	0	0	0	0			
Above average - BMI 25-29.9	1								
Obese - BMI > 30	2								
Below average - BMI < 20	3								
Continence									
Complete/catheterised	0	0	0	0	0	0			
Incontinent urine	1								
Incontinent faeces	2								
Doubly incontinent (urine & faeces)	3								
Skin Type - Visual Risks Area									
Healthy	0	0	0	0	0	0			
Tissue paper (thin/fragile)	1								
Dry (appears flaky)	1								
Oedematous (puffy)	1								
Clammy (moist to touch)/pyrexia	1								
Discoloured (bruising/mottled)	2								
Broken (established ulcer)	3								
Mobility									
Fully mobile	0	0	0	0					
Restless/fidgety	1					1			
Apathetic (sedated/depressed/reluctant to move)	2				2				
Restricted (restricted by sever pain or disease)	3								
Bedbound (unconscious/unable to change position/traction)	4								
Chairbound (unable to leave chair without assistance)	5								
Nutritional Element									
Unplanned weight loss in past 3-6 months									
<5% Score **0**, 5-10% Score **1**, >10% Score **2**	0-2	0	0	0	0	0			
BMI > 20 Score **0**, BMI 18.5-20 Score **1**, BMI < 18.5 Score **2**	0-2								
Patient acutely ill or no nutritional intake > 5 days	2								
Special Risks - Tissue Malnutrition									
Multiple organ failure/terminal cachexia	8								
Single organ failure e.g. cardiac, renal, respiratory	5								
Peripheral vascular disease	5								
Anaemia = Hb < 8	2								
Smoking	1	0	0	0	0	0			
Special Risks - Neurological Deficit									
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*	4-6	0	0	0	0	0			
Special Risks - Surgery/Trauma									
On table > 6 hours	8								
Orthopaedic/below waist/spinal (up to 48 hours post op)	5								
On table > 2 hours (up to 48 hours post op)	5	0	0	5	0	0			
Special Risks - Medication									
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4	0	0	0	0				
Total Score		3	3	8	5	4			
Date		31.01	1/2/11	2/2/11	3/2/11	4/2/11			
initials			cm	cm	cm	cm			
Time			0130	0100	0800	0800			

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

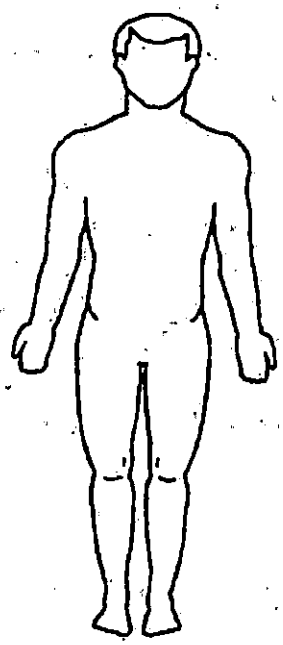
83826

PRESSURE ULCER RECORD

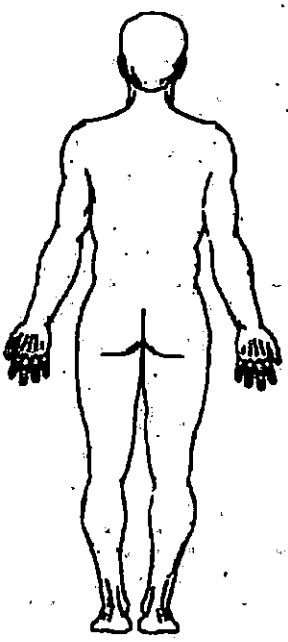
Indicate by circling and numbering all pressure damage on diagrams, then complete box below. Indicate care plan/wound assessment chart.



Anterior view



Posterior view



SCOTTISH ADAPTED EPUAP PRESSURE ULCER GRADING TOOL

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

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

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

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

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

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

SOUTH GLASGOW HOSPITALS
PATIENT MOVING AND HANDLING RISK ASSESSMENT

NHS Greater Glasgow and Clyde

Patient's Name: George Harkness	If patient is totally independent, tick here and go to date box ✓
Named Nurse:	

BODY BUILD

Obese		Tall	
Above average		Medium	✓
Average	✓	Short	
Below Average		Weight:	

Problems with comprehension, behaviour, co-operation (specify)

Handling constraints,e.g. disability, weakness, pain, skin lesions Infusions (specify)

RISK OF FALLS High ☐ Low ✓

INTO BATH OR SHOWER

HANDLING AID		WHICH BATH	
Hoist (Specify)		Parker	
Shower chair		Variable height	
		Standard	
		Any	

ASSISTANCE ✓ SUPERVISION ☐ INDEPENDENT ✓ 3/2

Staff required: X 1 Post op.

TRANSFERS (including to/from: bed, wheelchair, commode, toilet)

HOIST		MANUAL SUPPORT
Which hoist?		Staff required:
Sling type?		Specify support given
Sling size?		

ASSISTANCE ✓ SUPERVISION ☐ INDEPENDENT ✓

Additional information x 1 Requires Coller.

TOILETING

HOIST		MANUAL SUPPORT
Which hoist?		Staff required:
Sling type?		Specify support given
Sling size?		

ASSISTANCE ✓ SUPERVISION ☐ INDEPENDENT ✓ 3/2

Additional information Urinals post op.

WALKING

NO WALKING	✓	ASSISTANCE	
Staff required:		2/2/11	
Walking Aid			

SUPERVISION ☐ INDEPENDENT ☐

Distance walked / additional information

MOVE UP/DOWN BED

HOIST		MANUAL SUPPORT	
Which hoist?		Sliding aid	
Sling type?		Rope ladder	
Sling size?		Hand blocks	
		Monkey poles	

ASSISTANCE ☐ SUPERVISION ☐ INDEPENDENT ✓

Additional information (include details of any therapy beds used)

Staff required:

SIT UP OVER SIDE OF BED

Rope ladder		Sliding aid		ASSISTANCE		SUPERVISION		INDEPENDENT	

MOVE ON/OFF BED PAN

Hoist		Roll Patient		Patient bridges		Monkey pole		Not used	✓

TRANSFER TO/FROM TROLLEY (or bed etc)

Sliding aid (rigid)		Sliding aid (fabric)		Transfer aid (specify)		Staff required (specify)		INDEPENDENT	

Date assessed: 31.01.11 Assessors signature: CK.

Date reviewed	1/2/11	2/2/11	3/2/11	4/2/11					
Assessors signature	Cm	Cm	Cm	Cm					

THERAPEUTIC HANDLING INSTRUCTIONS

Date	Instruction	Therapist's Name

INTO BATH OR SHOWER

HANDLING AID		WHICH BATH	
Hoist (Specify)		Parker	
Shower chair		Variable height	
		Standard	
		Any	

ASSISTANCE		SUPERVISION		INDEPENDENT	
Staff required:					

TRANSFERS (including to/from: bed, wheelchair, commode, toilet)

HOIST		MANUAL SUPPORT
Which hoist?		Staff required:
Sling type?		Specify support given
Sling size?		

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional information					

TOILETING

HOIST		MANUAL SUPPORT
Which hoist?		Staff required:
Sling type?		Specify support given
Sling size?		

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional information					

WALKING

NO WALKING		ASSISTANCE		SUPERVISION		INDEPENDENT	
Staff required:				Distance walked / additional information			
ding Aid							

MOVE UP/DOWN BED

HOIST		MANUAL SUPPORT		ASSISTANCE		SUPERVISION		INDEPENDENT	
Which hoist?		Sliding aid		Additional information (include details of any therapy beds used)					
Sling type?		Rope ladder		Staff required:					
Sling size?		Hand blocks							
		Monkey poles							

SIT UP OVER SIDE OF BED

Rope ladder		Sliding aid		ASSISTANCE		SUPERVISION		INDEPENDENT	

MOVE ON/OFF BED PAN

Hoist		Roll Patient		Patient bridges		Monkey pole		Not used	

TRANSFER TO/FROM TROLLEY (or bed etc)

Sliding aid (rigid)		Sliding aid (fabric)		Transfer aid (specify)	Staff required (specify)		INDEPENDENT	

Date assessed:	Assessors signature:

e reviewed									
essors signature									

THERAPEUTIC HANDLING INSTRUCTIONS

Date	Instruction	Therapist's Name

SGH213
0006213

INSTITUTE OF NEUROLOGICAL SCIENCES

Fluid Balance Intake

Southern General Hospital

NAME George Hartness WARD 65

UNIT NO. 03251486 DATE 1/2/11

NASAL TUBE	INTRAVENOUS	RUNNING TOTAL	TIME	URINE	GASTRIC	OTHER	TOTAL
			12 00				
			13 00				
			14 00				
			15 00				
	4 HOUR TOTAL			CUMULATIVE 4 HOUR TOTAL			
			16 00				
			17 00				
	✱ Returned to ward		18 00	65 from Theatre ✱			
			19 00				
	8 HOUR TOTAL			CUMULATIVE 8 HOUR TOTAL			
	1000	1000	20 00				
300		300	21 00	400			400
150		150	22 00				
			23 00				
	12 HOUR TOTAL	1,450		CUMULATIVE 12 HOUR TOTAL			400
			24 00				
			01 00				
			02 00				
			03 00				
	16 HOUR TOTAL	1450		CUMULATIVE 16 HOUR TOTAL			400
			04 00				
			05 00				
150		150	06 00				
			07 00				
	20 HOUR TOTAL	1,600		CUMULATIVE 20 HOUR TOTAL			
			08 00				
			09 00				
			10 00				
			11 00				
	GRAND TOTAL			GRAND TOTAL			

INSTITUTE OF NEUROLOGICAL SCIENCES

Fluid Balance Intake

Southern General Hospital

NAME WARD

UNIT NO. DATE

NASAL TUBE	INTRAVENOUS	RUNNING TOTAL	TIME	URINE	GASTRIC	OTHER	TOTAL
			12 00				
			13 00				
			14 00				
			15 00				
	4 HOUR TOTAL			CUMULATIVE 4 HOUR TOTAL			
			16 00				
			17 00				
			18 00				
			19 00				
	8 HOUR TOTAL			CUMULATIVE 8 HOUR TOTAL			
			20 00				
			21 00				
			22 00				
			23 00				
	12 HOUR TOTAL			CUMULATIVE 12 HOUR TOTAL			
			24 00				
			01 00				
			02 00				
			03 00				
	16 HOUR TOTAL			CUMULATIVE 16 HOUR TOTAL			
			04 00				
			05 00				
			06 00				
			07 00				
	20 HOUR TOTAL			CUMULATIVE 20 HOUR TOTAL			
			08 00				
			09 00				
			10 00				
			11 00				
	GRAND TOTAL			GRAND TOTAL			

SGH215
0006215

INSTITUTE OF NEUROLOGICAL SERVICES

Southern General Hospital

Fluid Prescription Chart

NASO-GASTRO FLUIDS

WATER	MILK	FEED	ADDITIVE	RINSE	TIMIMG	24 HOUR TOTAL

N. SALINE FOR I.V. DRUGS

ALLOW FOR THIS WHEN PRESCRIBING I.V. FLUIDS	VOLUME	HOW OFTEN	24 HOUR TOTAL

INTRAVENOUS FLUID PRESCRIPTION

FLUID & ADDITIVE	VOLUME DOSE	STARTING TIME	RATE DROPS/MIN	SIGNATURE	GIVEN/CAN
Saline	500		100 ml/hr	As per anaesthetic chart	

TOTAL I.V. FLUIDS

TOTAL 24 HOUR FLUIDS

NAME George Harkness

DATE 1/2/11

INSTITUTE OF NEUROLOGICAL SERVICES

Southern General Hospital

Fluid Prescription Chart

NASO-GASTRO FLUIDS

WATER	MILK	FEED	ADDITIVE	RINSE	TIMIMG	24 HOUR TOTAL

N. SALINE FOR I.V. DRUGS

ALLOW FOR THIS WHEN PRESCRIBING I.V. FLUIDS	VOLUME	HOW OFTEN	24 HOUR TOTAL

INTRAVENOUS FLUID PRESCRIPTION

FLUID & ADDITIVE	VOLUME DOSE	STARTING TIME	RATE DROPS/MIN	SIGNATURE	GIVEN/CAN

TOTAL I.V. FLUIDS

TOTAL 24 HOUR FLUIDS

NAME

DATE

SOUTHERN GENERAL HOSPITAL
PATIENTS PROFILE

WARD / DEPT: 65. Neuro.	NAMED NURSE: Ann OSBORNE Sheila Matheson
CONSULTANT: mr. Dunn.	REFERRAL: Home
DATE: 27/4/09	TIME: 11 am
PATIENTS NAME: George Harkness	
UNIT NUMBER: 3251486.	
PREFERS TO BE CALLED:	
ADDRESS: 32c Mill square Catrine Ayrshire	
TELEPHONE NUMBER:	

AGE	D.O.B.	SEX	MARITAL STATUS
50 yrs.	17.7.58.	M.	

OCCUPATION	RELIGION	CLERGY / OTHER	CONTACT REQUIRED	CONTACTED
Heavy Goods vehicle driver.				

REASON FOR ADMISSION: neck pain which radiated into (R) arm
pain progressively getting worse.
paraesthesia & numbness in fingers on (R) arm.

admitted for C5/6 anterior Cervical decompression.

PREVIOUS HEALTH HISTORY: asthma

KNOWN ALLERGIES:

NIL KNOWN

SGH 308

PATIENTS PROFILE (cont'd)

MEDICATION ON ADMISSION:

Amoxicillin due to Sore throat TID
Salamol CFC Free inhaler
Co Dydramol 30/500
Codeine phosphate

PATIENTS PRECEPTION OF CURRENT HEALTH STATUS:

Knows he is here for op

RELATIVES PRECEPTIONS OF PATIENTS HEALTH STATUS:

EMERGENCY CONTACT NAME:

NEXT OF KIN: Fiona

RELATIONSHIP: wife

ADDRESS: S/A

TELEPHONE NUMBER (DAY): 01290 553030 | TELEPHONE NUMBER (NIGHT):

OTHER RELEVANT CONTACT: Mobile 07746 877 882.

G.P.'s NAME: Dr. N. Richardson.

G.P.'s ADDRESS: Ballochmyle M/C. The Clinic, Institute Ave. Catrine.

G.P.'s TELEPHONE NUMBER:

Patient / Relative spoken to by	DATE	TIME	DOCTOR	NURSE

VALUABLES: DISPOSAL HOME WARD CASHIER'S OFFICE

CLOTHING: DISPOSAL HOME WARD CASHIER'S OFFICE

NURSES SIGNATURE:

SOUTHERN GENERAL HOSPITAL
NURSING ASSESSMENT

PATIENTS NAME: George Harkness.	UNIT No.: 3251486	WARD: 6J

GENERAL ASSESSMENT ON ADMISSION:

On Admission No apparent Limb Deficit.
Skin intact.
Mouth clean + moist

SOCIAL / HOME BACKGROUND (INCLUDING PROBLEMS RELATED TO ADMISSION):

non Smoker
non drinker.
Lives at Home with Wife + Son
Stairs in House

BLOOD PRESSURE:	130/76	WEIGHT:	13½ Stone
PULSE:	74	HEIGHT:	5FT 10
RESPIRATIONS:	95	URINALYSIS:	
TEMPERATURE:	36·3	WATERLOW SCORE:	

SGH 310

NURSING ASSESSMENT (ASSESSMENT OF ACTIVITIES OF DAILY LIVING)

MAINTAINING A SAFE ENVIRONMENT, COMMUNICATING, BREATHING, EATING AND DRINKING, ELIMINATING, PERSONAL CLEANSING AND DRESSING, CONTROLLING BODY TEMPERATURE, MOBILISING, WORKING AND PLAYING, EXPRESSING SEXUALITY, SLEEPING, DYING.

(1) - No problems ADL

NURSES SIGNATURE:

SOUTHERN GENERAL HOSPITAL

INVESTIGATION INSTRUCTION SHEET

NAME: George Harkness UNIT NO: 3251486 WARD: 65

DATE		DATE	INITIAL
28/4/09	Theatre: Right C5/6 - C6/7 Anterior		
	Cervical Decompression & Fusion		CV
29/4/09	Check neck x-ray.		yc

DATE		DATE		DATE		DATE		DATE		DATE	

0369451-SGH307

DATE		DATE	INITIALS

DATE		DATE		DATE		DATE		DATE		DATE	

SOUTHERN GENERAL HOSPITAL

DEPARTMENT:

NAME: George Hawkness UNIT NO. WARD: 6

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
27/4	—	ADMITTED LOS Surgery for ACDF. EGI tomorrow 28/4. First 12nn NT prepn	
28/4/09	am/ 1.	Vital signs satisfactory.	
	4.	fasting from midnight.	
	6.	Independant with all ADL's.	
	11.	Settled and slept fairly well.	
	12.	No complaints of pain.	Ucox
	1800	Returned to recovery from Theatre: see discharge planner	
29/4/09	am/ 1.	Vital signs satisfactory, normal power to all limbs.	
	3.	Sats 99% on air.	
	4.	Drinking well - IV fluids discontinued.	
	5.	P.U into bottles.	
	8.	mobilising well in bed.	
	11.	Slept intermittantly.	
	12.	Wound dry + intact, drain in situ.	
		PRN analgesia given x 2 overnight.	Ucox
29/4/09	15.55	(1) Vital signs stable, apyrexial, no limb deficits.	
		(3) Sat's satisfactory on air.	
		(4) Taking oral diet + fluids.	
		(5) P.U spontaneously.	
		(6) Up for shower today.	
		(8) Seen by physio, up mobilising independantly.	
		(12b) Oral analgesia as charted, wound drain removed.	
		Check neck x-ray carried out.	
30/4/09	am/ 1.	Observations satisfactory, No limb deficits.	
		Independant with all ADL's.	
	11.	Settled and slept.	
	12.	Analgesia given with effect.	
		No issues with care.	Ucox
	pm	Seen by physio for DISCHarge. Home today	
	12	c/o some neck pain Dr Reassured that things will settle Meds Reviewed after	
	31/4/09	Discharged home	

0369438-SGH 306A

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: Neuro.

NAME: George Harkness UNIT NO. 3251486 WARD: 65

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE

Regional Services Division Nursing Care Plan **Maintaining a safe environment**	Date	Time

Date and Time	Problem No	Problem	Nurse Action	Aims of Care	Initial	Review Date	Disc
28/4	1a	Potential deterioration in conscious level / vital signs.	Assess using Glasgow Coma Scale or SEWS 4 Hourly 29/4 10-10	Detection of deterioration in conscious level / vital signs. Maintain patient safety.	GO		
	1b	Potential risk of falls	Patient falls and restraint management risk assessment completed and implemented	Maintain patient safety.			
		Maintain bed at lowest level		Minimise risk of falls.			
		Bed rails in use Y/N	Assess level of observation required.				
			Refer to moving and handling risk assessment.				
	1c	Potential risk of acquired infection	Ensure adequate hand hygiene and infection control measures are adhered to.	Minimise risk of acquired infection.			
			Ensure area is clean, tidy and free of clutter.				
	1d	Intravenous cannula in situ Y/N	Inspect cannula site each shift and prior to use. Record date of insertion. Replace as per infection control guidance. Complete equipment change chart.				

Name George Harkness	CHI No 17/07/583579.	Ward 65

2.

Regional Services Division Nursing Care Plan **Communication** **Breathing**	Date	Time

Date and Time	Problem No	Problem	Nurse Action	Aims of Care	Initial	Review Date	Disc
28/4	2	Communication Potential difficulty communicating due to: Potential anxiety due to hospital admission.	Explain all nursing interventions. Involve patient in care planning.	Minimize anxiety. Aid understanding. Patient is involved in care plan.	GJ		
	3	Altered respiratory function.		Maintain safety. Maintain adequate respiration. Maintain adequate oxygen saturation. Promote comfort. Relieve distress.			

Name George Hawkins	CHI No	Ward 62

Regional Services Division Nursing Care Plan **Eating and Drinking** **Eliminating**	Date	Time

Date and Time	Problem No	Problem	Nurse Action	Aims of Care	Initial	Review Date	Disc
28/4	4	Potentially inadequate nutritional intake.	Assess nutritional status on admission. Refer to dietitian if appropriate. Provide assistance if required. Offer hand cleansing facilities before meals.	To provide adequate nutrition and hydration.	AG		
28/4	5	Potential alteration of bladder and /or bowel function.	Assess on admission. Provide assistance as required Administer aperients as prescribed. Urinary catheter size H20 in balloon ml Date of Insertion Date of removal Catheter hygiene as per protocol.	To encourage normal bladder / bowel function. Maintain dignity. Promote comfort. Maintain hygiene to prevent infection.	AG		

Name George Hutchison	CHI No	Ward GV

Regional Services Division Nursing Care Plan **Personal cleansing and dressing**	Date	Time

Date and Time	Problem No	Problem	Nurse Action	Aims of Care	Initial	Review Date	Disc
28/4	6a	Potential wound infection/poor healing.	Observe wound for signs of inflammation. Remove Clips on: Remove Drain on:	Prevent wound infection. Promote healing. Chalk Ward	AN		
	6b	Potential difficulty maintaining personal hygiene	Daily bed bath. Daily shower / bath.	Maintain personal hygiene.			
			Assistance Y N	Maintain dignity. Prevent infection.			
			Assist as required with: • Oral hygiene • Hair / nails • Dressing • Eye care	Maintain skin integrity.			
			Provide hand cleaning facilities prior to meals and after use of toilet.				

Name Georgy Hutchinson	CHI No	Ward

Regional Services Division Nursing Care Plan **Controlling body temperature** **Mobilising**	Date	Time

Date and Time	Problem No	Problem	Nurse Action	Aims of Care	Initial	Review Date	Disc
	7	Potential alteration in body temperature due to:	Monitor and take appropriate action.	Maintain temperature within normal range.			
28/4	8	Reduced mobility.	Independent (Y) N	Reduce complications of reduced mobility.	eu		
				Promote comfort.			
			Complete moving and handling risk assessment.	Maintain skin integrity.			
			Refer to physiotherapist (Y) N	Assist rehabilitation.			

Name	CHI No	Ward

6.

Regional Services Division Nursing Care Plan **Working and playing** **Expressing sexuality**	Date	Time

Date and Time	Problem No	Problem	Nurse Action	Aims of Care	Initial	Review Date	Disc
	9	Disruption to normal work pattern / recreation.	Assess and refer to appropriate body.	Identify potential areas of concern. Refer to appropriate source of advice / support.			
28/4	10	Potential altered body image.	Discuss. Provide support. Promote dignity.	To maintain patients dignity.	CW		

Name George Hartham	CHI No	Ward 8

Regional Services Division Nursing Care Plan **Sleeping** **Spiritual care**	Date	Time

Date and Time	Problem No	Problem	Nurse Action	Aims of Care	Initial	Review Date	Disc
	11	Potential disruption to normal sleep pattern.	Provide quiet environment. Promote comfort. Relieve pain.	Promote rest / sleep.			
	12a	Potential need for spiritual care.	Encourage discussion. Assess spiritual needs. Refer to appropriate chaplain if desired. Involve family / significant other.	Address spiritual needs. Assist patient and family to cope with illness and possible bereavement.			

Name	CHI No	Ward

3.

Regional Services Division Nursing Care Plan ~~Spiritual Care~~ / Pain	Date	Time

Date and Time	Problem No	Problem	Nurse Action	Aims of Care	Initial	Review Date	Disc
28/4	12b	Pain	Assess using appropriate pain assessment tool. Provide support / comfort. Ensure adequate analgesia is given and assess effect. Liaise with medical staff.	Relieve pain. Promote comfort. Promote dignity.	[illegible]	[illegible]	

Name George Hawthorn	CHI No	Ward G7

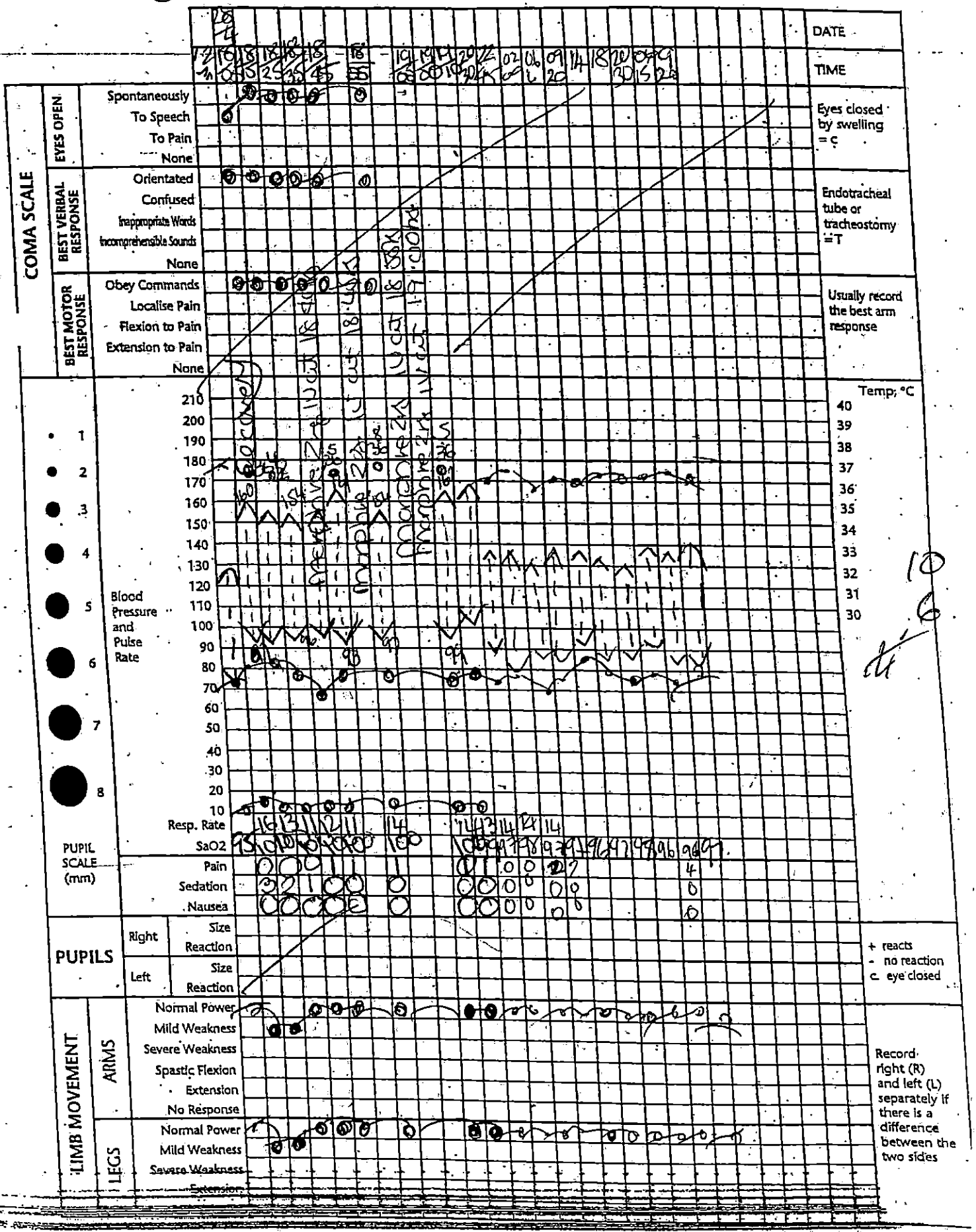
South Glasgow Hospitals

Hospital ..... S.G.H .....

NHS Greater Glasgow and Clyde

Observation Chart

Name: George Harkness	Record No: 3251486



NHS
Greater Glasgow and Clyde

SCORING

Pain Score:

S = Sleeping
0 = No pain
1 = Mild pain
2 = Moderate pain
3 = Severe pain

Sedation Score:

S = Sleep normal
0 = None. Patient alert
1 = Mildly sedated, awakes to verbal stimuli
2 = Moderately drowsy, awakes to verbal stimuli
3 = Severe. Somnolent, difficult to wake to verbal stimuli

Nausea Score:

0 = None
1 = Mild, no treatment required
2 = Nausea and vomiting, helped by treatment
3 = Nausea, persistent despite treatment

0006213 SGH213

INSTITUTE OF NEUROLOGICAL SCIENCES

Southern General Hospital

SG03251486
GEORGE HARKNESS
32C MILL SQUARE
CATRINE
KA5 6RD CHI 1707583579 17/07/1958

WARD 65

DATE 28/04/09

NASAL TUBE	INTRAVENOUS	RUNNING TOTAL	TIME	URINE	GASTRIC	OTHER	TOTAL
			12 00				
			13 00				
			14 00				
			15 00				
	4 HOUR TOTAL			CUMULATIVE 4 HOUR TOTAL			
			16 00				
			17 00				
Thorpe	2,000mls		18 00				
			19 00				
	8 HOUR TOTAL	2000		CUMULATIVE 8 HOUR TOTAL			NAD
			20 00				
400		400	21 00	440			440
			22 00				
200	IV fluids	200	23 00				
	12 HOUR TOTAL	2600		CUMULATIVE 12 HOUR TOTAL			440
			24 00				
			01 00	PU			PU
100		100	02 00				
			03 00				
	16 HOUR TOTAL	2700		CUMULATIVE 16 HOUR TOTAL			
			04 00				
			05 00				
200		200	06 00				
			07 00				
	20 HOUR TOTAL	2900		CUMULATIVE 20 HOUR TOTAL			
			08 00	450			450
			09 00				
			10 00				
			11 00				
	GRAND TOTAL			GRAND TOTAL			

INSTITUTE OF NEUROLOGICAL SCIENCES

Fluid Balance Intake

Southern General Hospital

NAME **WARD**

UNIT NO. **DATE**

NASAL TUBE	INTRAVENOUS	RUNNING TOTAL	TIME	URINE	GASTRIC	OTHER	TOTAL
			12 00				
			13 00				
			14 00				
			15 00				
	4 HOUR TOTAL			CUMULATIVE 4 HOUR TOTAL			
			16 00				
			17 00				
			18 00				
			19 00				
	8 HOUR TOTAL			CUMULATIVE 8 HOUR TOTAL			
			20 00				
			21 00				
			22 00				
			23 00				
	12 HOUR TOTAL			CUMULATIVE 12 HOUR TOTAL			
			24 00				
			01 00				
			02 00				
			03 00				
	16 HOUR TOTAL			CUMULATIVE 16 HOUR TOTAL			
			04 00				
			05 00				
			06 00				
			07 00				
	20 HOUR TOTAL			CUMULATIVE 20 HOUR TOTAL			
			08 00				
			09 00				
			10 00				
			11 00				
	GRAND TOTAL			GRAND TOTAL			

INSTITUTE OF NEUROLOGICAL SERVICES

Southern General Hospital

Fluid Prescription Chart

NASO-GASTRO FLUIDS

WATER	MILK	FEED	ADDITIVE	RINSE	TIMIMG	24 HOUR TOTAL

N. SALINE FOR I.V. DRUGS

ALLOW FOR THIS WHEN PRESCRIBING I.V. FLUIDS	VOLUME	HOW OFTEN	24 HOUR TOTAL

INTRAVENOUS FLUID PRESCRIPTION

FLUID & ADDITIVE	VOLUME DOSE	STARTING TIME	RATE DROPS/MIN	SIGNATURE	GIVEN/CAN
0.9% Sodium Chloride.	500mls	18.05	125mls/hr	anaesthetic chart	

SG03251486
GEORGE HARKNESS
32C MILL SQUARE
CATRINE
17/07/1958
KA5 6RD CHI 1707583579

TOTAL 24 HOUR FLUIDS

DATE 20/04/09

INSTITUTE OF NEUROLOGICAL SERVICES

Southern General Hospital

Fluid Prescription Chart

NASO-GASTRO FLUIDS

WATER	MILK	FEED	ADDITIVE	RINSE	TIMIMG	24 HOUR TOTAL

N. SALINE FOR I.V. DRUGS

ALLOW FOR THIS WHEN PRESCRIBING I.V. FLUIDS	VOLUME	HOW OFTEN	24 HOUR TOTAL

INTRAVENOUS FLUID PRESCRIPTION

FLUID & ADDITIVE	VOLUME DOSE	STARTING TIME	RATE DROPS/MIN	SIGNATURE	GIVEN/CAN

TOTAL I.V. FLUIDS

TOTAL 24 HOUR FLUIDS

NAME

DATE

Appendix Three

WARD 65	BED RAILS RISK ASSESSMENT	PATIENTS NAME George Harkness
DATE OF ADMISSION		UNIT NO/DOB 325 1486 17/7/58

Aim: An assessment of the risk of falling and the patients' s ability to maintain their own safety from admission to discharge. Frequency of assessment based on professional judgement . The assessment will be discussed with the patient and reviewed every 24hours.

All patients should have a documented assessment made within 24hours of admission made which includes maintaining a safe environment.

INDICATIONS FOR USE

1. History of falls from bed ' Unable to obtain patient history.
2. Fluctuating conscious level
3. Sensory loss
4. Lack of awareness of ability
5. Patients request

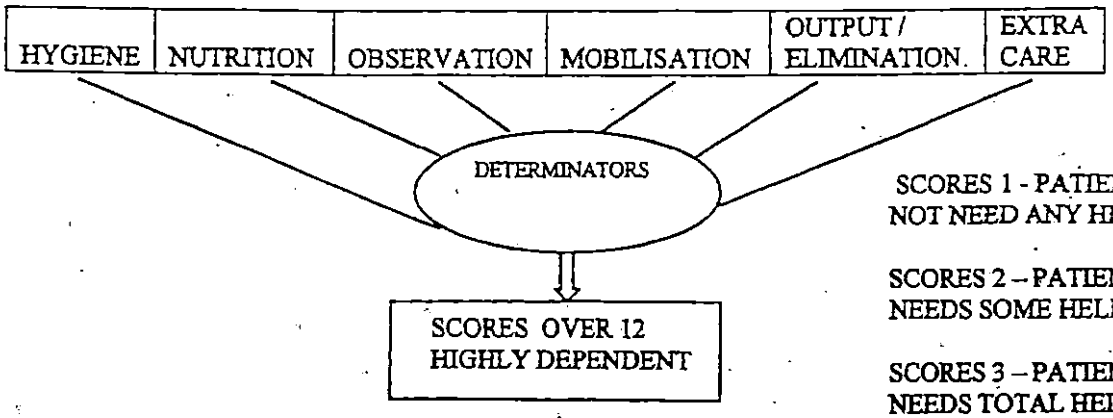
INDICATIONS FOR NON – USE

1. Climbing over bed rails
2. Independent / No recent history of falls.
3. Awareness of limitations
4. Distress when bed rails in situ.
5. Increased risk of entrapment.

DATE	TIME	BED RAILS REQUIRED YES	NO	RATIONALE	SIGNATURE
17/4/09				3	
29/4/09	0530		✓	2	
30/4	8		✓	2	

Modified Zebra Dependency Scoring

PATIENTS NAME: George Harkness UNIT NO 3251486.



SCORES 1 - PATIENT NOT NEED ANY HELP.

SCORES 2 – PATIENT NEEDS SOME HELP

SCORES 3 – PATIENT NEEDS TOTAL HELP

. MODIFIED FROM THE ZEBRA PATIENT CLASSIFICATION SYSTEM

DATE	TIME	HYGIENE	NUTRITION	OBS	MOBILISATION	OUTPUT	EXTRA CARE	SCORE	INITIAL
7/4		1	1	1	1	1	1	6	CJ*
11/4	0530	2	1	3	2	1	2	11	MM
30/4	8	1	1	3	1	1	2	9	CJ

NHS
Greater Glasgow and Clyde

Nutrition Profile

Name: George Harkness.	Date of admission: / /
Address: 32c Hill Square. Cadrine Dyrsture.	Time:
	HOSPITAL: SCH
DoB: 17.07.58	Ward: 65
CHI number: 170758 3579.	
Affix patient data label	

To be recorded within 24 hours of admission*

Height: 5FT 10 m/ft Actual ☑ Patient/ carer reported ☐ Alternative measurement ☐

Weight: 13½ kg/stones Actual ☐ Patient/ carer reported ☑ Alternative measurement ☐

Recent unplanned weight loss: Yes ☐ No ☑

If 'Yes' how much?: kg/stones. Over what period of time?: weeks/months

Is there evidence of recent weight loss?

No ☑ Loose clothing ☐ History of reduced food intake/appetite ☐ Swallowing problem ☐

Eating and drinking likes and dislikes (including appetite and/or NBM status):

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☑

Please state:

Are there any contributing factors that may affect food intake such as **physical** (e.g. swallowing difficulties), **physiological** (e.g. nausea), **psychological** (e.g. dementia), **social or environmental?** Yes ☐ No ☑

Please specify all factors:

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☐

Please state:

Profile completed by: Name (PRINT): Signature: Date:

NOTE: This is ADMISSION DATA - please refer to changes in Care Plan.

* Quality Improvement Scotland (2003). Food, Fluids and Nutritional Care in Hospitals Edinburgh QIS

Malnutrition Universal Screening Tool ('MUST')

Date	27/4									
Initials	AJ									
Height (see page 1) 5ft. 10 — Weight	13½									
Oedema or ascites present Y/N	No									
BMI	27.									

'MUST'

Step 1: BMI Score (refer to chart on page 4) >20 (>30 = Obese) ..... 0 18.5 - 20 ..... 1 <18.5 2	0								
Step 2: Weight Loss Score Unplanned weight loss in past 3-6 months: <5% ..... 0 5-10% ..... 1 >10% 2	0								
Step 3: Acute Disease Effect Score If patient is acutely ill **and** there has been or is likely to be no or virtually no food intake for > 5 days..... Score 2 Not applicable ..... Score 0	0								
Step 4: Overall Risk of Malnutrition Total:	0								

Step 5: Management Guidelines

Score of Overall Risk of Malnutrition	Action Required
0	**LOW RISK** - *Routine Clinical Care* • Repeat screening. Hospital Acute .....Weekly Hospital Rehabilitation .....Monthly
1	**MEDIUM RISK** - *Observe* • Document dietary intake for 3 days on a Food Record Chart. • If no improvement in intake: - Encourage oral intake. - Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Repeat screening weekly.
2 or more	**HIGH RISK** - *Treat** • Refer to Dietitian and document food intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Monitor and review Care Plan weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

Acute Services Division

Hospital / Department | S.G.H Neuro.

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

Patient name: George Harkness

Ward: 65

CHI number: 1707583579 Unit/Hospital number 3251486

Contents

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

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

Continuing Care Wards: Mobile and 'at risk' patients should have risk assessment and care plan reviewed monthly.

Cannard Falls Risk Assessment

(Must be completed within 24 hours)

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						DATE 21/4	DATE	DATE	DATE	DATE	DATE	DATE
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			0						
Sex	Male 1	Female 2				1						
Age	60-70 1	71-80 2	81+ 1			—						
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		—						
Medication type**	Drugs for mental illness 1	Blood pressure / water tablets 1	Sleeping tablets 1	None of these 0		—						
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	—						
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed bound 1		1						
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1						
				TOTAL SCORE		3						
				ACTION(S) TAKEN Enter action code(s)		1 6						
SCORE 2-8 = LOW 9-12 = MEDIUM 13+ = HIGH RISK				NURSE SIGNATURE		WO						

** If you are in any doubt about whether a person's medicine belongs to one of the types listed ask the person or carer or please phone the number on the medicine container and ask the community or hospital pharmacist.

* Please see back page for clarification

Falls Assessment Care Plan

Please tick all applicable nursing interventions

	NURSING INTERVENTIONS	DATE	DATE	DATE	DATE	DATE	DATE	DATE
Action code	**LOW, MODERATE AND HIGH RISK**	21/4						
1	Prevention and general safety precautions discussed with patient and family.	as						
	MODERATE AND HIGH RISK							
2	Move to more observable area of ward to optimise supervision.							
3	Refer to Physiotherapist.							
4	Refer to Occupational Therapist.							
5	Patient requires footwear or podiatry referral. (Date referred:)							
6	Commence continence assessment							
7	Monitor lying and standing BP and pulse.							
8	Request medication review.							
9	Select suitable seating (refer to policy).							
10	Non-slip mat on chair/floor following advice of OT.							
11	Bed rails/bumpers to be used (refer to policy).							
12	Falls map in use for seven days.							
13	Bed/chair monitor in use.							
14	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.							
15	Patient to be nursed on mattress on the floor (refer to policy.)							
16	Patient requires one to one nursing care.							
17	Other interventions.							
	HIGH RISK ONLY (Score of 13 or over)							
18	Provide hip protectors to patients being discharged to care homes/longterm NHS facilities							
	SIGNATURE							

Review Cannard score weekly / monthly as per policy.

Enter action code(s) selected in action taken section on Falls Risk Assessment.

Patient's name George Harkness

Unit number 3231486

Ward 65

Use addressograph label.

South Glasgow Hospitals

Pressure Ulcer Risk Assessment Record

NHS Greater Glasgow and Clyde

Modified Waterlow Risk Assessment

	Number	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Initials																
Date		27/4	29/4													
Date:																
Body weight for height:																
Average 0	Above average 1	0	0													
Obese 2	Below 3															
Continence:																
Completely / Catheterised 0	Occasionally incontinent 1	0	0													
Catheterised / Incontinent of faeces 2	Doubly incontinent 3															
Skin type - Visual risk areas:																
Healthy 0		0	0													
Tissue paper/Dry 1																
Oedematous/Clammy (temp. raised) 1																
Discoloured 2																
Broken spot 3																
Mobility:																
Fully 0	Restless/Fidgety 1	0	2													
Apathetic 2	Restricted 3															
Inert/Traction 4	Chairbound 5															
Sex/Age:																
Male/Female 1/2	14-49 1	1														
50-64 2	65-74 3	2	3													
75-80 4	80+ 5															
Appetite:																
Average 0	Poor 1	0	0													
N.G. tubes/fluids only 2	NBM / Anorexic 3															
Special risks - Tissue malunitrition:																
e.g. Terminal cachexia 8																
Cardiac failure 5																
Peripheral vascular disease 5																
Anaemia 2																
Smoking 1		—	0													
Neurological deficit:																
e.g. Diabetes, MS, CVA, Motor-sensory paraplegia 4-6		—	0													
Major surgery /trauma:																
Orthopaedic; Below waist; Spinal 5		—	5													
On table > 2 hours 5																
Medication:																
Cytotoxics; Highdose steroids; Anti-inflamatory 4		—	0													
TOTAL SCORE:		3	10													

Score as follows: <10 = Low risk; 10-14 = At risk; 15-19 = High risk; 20+ = Very high risk.

Refer to Pressure Ulcer Prevention Guidelines (GGHB) for action.

Action Plan

Date	Preventative action to be taken (e.g. turning time; position; support surface/cushion; other)	Signature

Further action

	Date	Signature
Referred to dietitian		
Referred to TVNS		
'Wound and Pressure Area Care Assessment Chart' commenced		

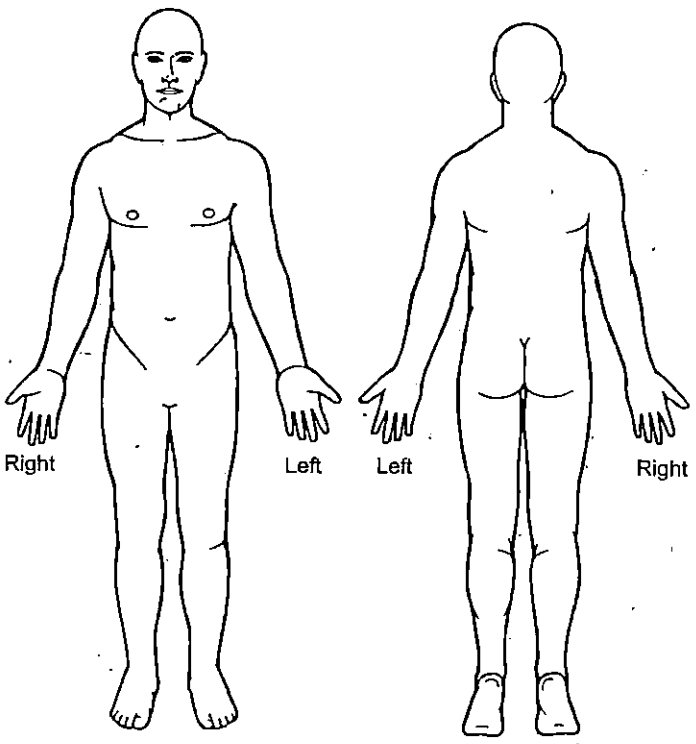
GRADE OF ULCER (Torrance)

GRADE	*DEFINITION*
1.	Blanching hyperaemia.
2.	Non-blanching hyperaemia.
3.	Ulceration progresses through to dermis.
4.	Lesion extends through to subcutaneous fat.
5.	Infective necrosis / necrotic tissue.

RECORDING THE GRADE OF ULCER

On admission, **number site of ulcer** on the diagram opposite and **enter the ulcer number and the grade** in the action plan.

Assessment should be carried out on all patients within 2 - 4 hours of admission and repeated 24 - 48 hours afterwards. Repeat assessment as condition changes or at weekly intervals.



SOUTH GLASGOW HOSPITALS
PATIENT MOVING AND HANDLING RISK ASSESSMENT

NHS Greater Glasgow and Clyde

Patient's Name: George Harkness	If patient is totally independent, tick here and go to date box ☐
Named Nurse: Sheila Mathieson	

BODY BUILD

Obese		Tall	✓
Above average		Medium	
Average	✓	Short	
Below Average		Weight:	

RISK OF FALLS High ☐ Low ☐

Problems with comprehension, behaviour, co-operation (specify)

Handling constraints,e.g. disability, weakness, pain, skin lesions infusions (specify)

INTO BATH OR SHOWER

HANDLING AID		WHICH BATH	
Hoist (Specify)		Parker	
Shower chair		Variable height	
		Standard	
		Any	

ASSISTANCE ☐	SUPERVISION ☐	INDEPENDENT ☐
Staff required:	Supervision post op	

TRANSFERS (including to/from: bed, wheelchair, commode, toilet)

HOIST		MANUAL SUPPORT
Which hoist?		Staff required:
Sling type?		Specify support given
Sling size?		

ASSISTANCE ☐	SUPERVISION ☐	INDEPENDENT ☐
Additional information: supervision post op		

TOILETING

HOIST		MANUAL SUPPORT
Which hoist?		Staff required:
Sling type?		Specify support given
Sling size?		

ASSISTANCE ☐	SUPERVISION ☐	INDEPENDENT ✓
Additional information		

WALKING

NO WALKING ☐	ASSISTANCE ☐	SUPERVISION ☐	INDEPENDENT ☐
Staff required:		Distance walked / additional information: Supervision post op	
Walking Aid			

MOVE UP/DOWN BED

HOIST		MANUAL SUPPORT	
Which hoist?		Sliding aid	
Sling type?		Rope ladder	
Sling size?		Hand blocks	
		Monkey poles	

ASSISTANCE ☐	SUPERVISION ☐	INDEPENDENT ✓
Additional information (include details of any therapy beds used)		
Staff required:		

SIT UP OVER SIDE OF BED

Rope ladder ☐	Sliding aid ☐	ASSISTANCE ☐	SUPERVISION ☐	INDEPENDENT ☐

MOVE ON/OFF BED PAN

Hoist ☐	Roll Patient ☐	Patient bridges ☐	Monkey pole ☐	Not used ☐

TRANSFER TO/FROM TROLLEY (or bed etc)

Sliding aid (rigid) ☐	Sliding aid (fabric) ☐	Transfer aid (specify)	Staff required (specify) ☐	INDEPENDENT ☐

Date assessed: 21/4/04 Assessors signature: [signature]

Date reviewed	29/4/9								
Assessors signature	KCox								

THERAPEUTIC HANDLING INSTRUCTIONS

Date	Instruction	Therapist's Name

INTO BATH OR SHOWER

HANDLING AID		WHICH BATH	
Hoist (Specify)		Parker	
Shower chair		Variable height	
		Standard	
		Any	

ASSISTANCE		SUPERVISION		INDEPENDENT	
Staff required:					

TRANSFERS (including to/from: bed, wheelchair, commode, toilet)

HOIST		MANUAL SUPPORT
Which hoist?		Staff required:
Sling type?		Specify support given
Sling size?		

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional information					

TOILETING

HOIST		MANUAL SUPPORT
Which hoist?		Staff required:
Sling type?		Specify support given
Sling size?		

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional information					

WALKING

NO WALKING		ASSISTANCE		SUPERVISION		INDEPENDENT	
Staff required:				Distance walked / additional information			
ng Aid							

MOVE UP/DOWN BED

HOIST		MANUAL SUPPORT	
Which hoist?		Sliding aid	
Sling type?		Rope ladder	
Sling size?		Hand blocks	
		Monkey poles	

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional information (include details of any therapy beds used)					
Staff required:					

SIT UP OVER SIDE OF BED

Rope ladder		Sliding aid		ASSISTANCE		SUPERVISION		INDEPENDENT	

MOVE ON/OFF BED PAN

Hoist		Roll Patient		Patient bridges		Monkey pole		Not used	

TRANSFER TO/FROM TROLLEY (or bed etc)

Sliding aid (rigid)		Sliding aid (fabric)		Transfer aid (specify)	Staff required (specify)		INDEPENDENT	

Date assessed:	Assessors signature:

reviewed									
ssors signature									

THERAPEUTIC HANDLING INSTRUCTIONS

Date	Instruction	Therapist's Name

NHS Greater Glasgow and Clyde

South Glasgow Hospitals

DISCHARGE CHECKLIST

Patient's name: George Harkins Ward: D7

Unit number: _____ Date of discharge: / / 30 4 09

Discharge destination: _____

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓			
Relative / Carer informed	✓			
Others informed: Res. / Nursing Home				
Transport arranged				
Ambulance - 1 man / 2 man am / pm		—		
Hospital car		—		
Own transport	—			
Other - Please specify:				
Discharge medication	✓			
Discharge prescription completed				
Compliance aids requested				
Medication received				
Medication explained to patient				
Own medication returned to patient				
Dressings / Continence aids (7 days supply)				
Other discharge items				
Keys				
Patients clothing available				
Valuables				
Intravenous canula removed				
Part 2 Discharge Letter - Required				
Completed				
OP clinic appointment				
Arranged				
To follow				
Not known				
Informed of discharge				
Physiotherapist				
Occupational Therapist				
Dietitian				
Speech and Laguage Therapist				
Clinical Nurse Specialist				
Liaison / District Nurse				
Social Work / Other agencies / Home help				

Additional Information / Leaflets / Factsheets

Nurse's signature: MLOP Designation: EN Date: 30/4/09

SGH 488
0005752

NHS Greater Glasgow & Clyde – Institute of Neurological Sciences
Southern General Hospital

NHS Greater Glasgow and Clyde

PATIENT INVESTIGATION OR TREATMENT REQUEST FORM

This form is to be used when a mentally competent patient wishes to proceed with investigation, operation or other procedure of an invasive nature

Patient details:

SG03251486
GEORGE HARKNESS
32C MILL SQUARE
CATRINE
AYRSHIRE 17/07/1958
KA5 6RD CHI 1707583579

Date: 21 / 1 / 2011

I, George Harkness (name) request the following procedure(s) be performed:

Re-do G/6 anterior cervical discectomy and fusion

I agree: to the administration of an anaesthetic or sedation as required

I understand: that no assurance can be given that the procedure will be performed by any particular practitioner.

Signature: G. Harkness (Patient*)
Parent*
Other* (please state) _____
*(*Delete as applicable)*

Witnessed by *(Practitioner's name)*: L. Jones **Signature:** _____

For female patients, 12-55 years, who may be exposed to ionising radiation between the diaphragm and the knee:

I believe that: I am or ~~may be~~ pregnant / I am not pregnant ~~-~~ *(Delete as appropriate)*

Name: _____ **Signature:** _____

SOUTHERN GENERAL HOSPITAL
PATIENTS PROFILE

WARD / DEPT: 65 INS		NAMED NURSE: Carolyn Robertson.	
CONSULTANT: Mr Dunn		REFERRAL: W/L	
DATE: 31/1/11		TIME: 1130	
PATIENTS NAME: George Harkness			
UNIT NUMBER: SG0325148G			
PREFERS TO BE CALLED:			
ADDRESS: 32C Mill Square, Catrine, Ayrshire KA5 6RD			
TELEPHONE NUMBER: 07742747893			
AGE: 52	D.O.B.: 17/7/58	SEX: M	MARITAL STATUS:
OCCUPATION:			
RELIGION:	CLERGY / OTHER:	CONTACT REQUIRED:	CONTACTED:

REASON FOR ADMISSION: For cervical decompression.
Theatre scheduled for 01.02.11 - re-do C-decompression.

PREVIOUS HEALTH HISTORY: Asthma.
® C5/6 - 6/7 ACDF in April 2009.

KNOWN ALLERGIES: Nil known

SGH 308

PATIENTS PROFILE (cont'd)

MEDICATION ON ADMISSION:

LANSOPRAZOLE 30mg daily.
PROCTOSEDYL CREAM
VENTOLIN INHALER.
REMEDINE FORTE (PARACETAMOL BASED)

PATIENTS PRECEPTION OF CURRENT HEALTH STATUS:

Aware of present condition.

RELATIVES PRECEPTIONS OF PATIENTS HEALTH STATUS:

Wife present on admission.

EMERGENCY CONTACT NAME:

NEXT OF KIN: Fiona Harkness

RELATIONSHIP: Wife.

ADDRESS: As above

PHONE NUMBER (DAY): 01290 553030. | TELEPHONE NUMBER (NIGHT):

OTHER RELEVANT CONTACT: 07746 877 882.

G.P.'s NAME: Dr D. Richardson

G.P.'s ADDRESS: Ballochmyle Med Group Institute Ave. Ellon The Toon

G.P.'s TELEPHONE NUMBER: 08444997055

Patient / Relative spoken to by	DATE	TIME	DOCTOR	NURSE

VALUABLES: DISPOSAL HOME WARD CASHIER'S OFFICE

CLOTHING: DISPOSAL HOME WARD CASHIER'S OFFICE

NURSES SIGNATURE: C Robertson

SOUTHERN GENERAL HOSPITAL
NURSING ASSESSMENT

PATIENTS NAME: George Harkness	UNIT No.:	WARD: 65

GENERAL ASSESSMENT ON ADMISSION:

Appears well on admission.
No limb deficits of note.
Independent with ADL's.

SOCIAL / HOME BACKGROUND (INCLUDING PROBLEMS RELATED TO ADMISSION):

Lives with wife.
stairs in house.
Non smoker.
Non drinker.

BLOOD PRESSURE: 146/93	WEIGHT: 86.45kg
PULSE: 73.	HEIGHT: 1.78m.
RESPIRATIONS: Sa02 96% room air	URINALYSIS:
TEMPERATURE:	WATERLOW SCORE:

SGH 310

Elaine Nielsen
19.04.56

Mündigkeitsalter
VP Stmk. 3/1c

Lke 07835 47425.

2609 47 3 22.

NURSING ASSESSMENT (ASSESSMENT OF ACTIVITIES OF DAILY LIVING)

MAINTAINING A SAFE ENVIRONMENT, COMMUNICATING, BREATHING, EATING AND DRINKING, ELIMINATING, PERSONAL CLEANSING AND DRESSING, CONTROLLING BODY TEMPERATURE, MOBILISING, WORKING AND PLAYING, EXPRESSING SEXUALITY, SLEEPING, DYING.

1. Buzzer system explained
2. Communicates freely.
3. Spontaneously on room air.
4. Normal diet & fluids.
5. PU spontaneously.
6. Independent ↑ personal hygeine.
7. Apyrexial.
8. Independent with mobility.
9.
10. Lives with wife & son.
11. No problems discussed.
12 Not discussed.

NURSES SIGNATURE: [illegible]

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: INS

NAME: George Harkness UNIT NO. WARD: 65

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
31/1/11		Admitted as per patient profile seen by medical staff. Fast 12 mn for theatre tomorrow	A Nursery A Rundell
1/2/11		1) Observations satisfactory as charted. Mild weakness to left arm Normal leg power	
		4) Fasted from 12 midnight	
		5) Passing urine	
		8) Fully mobile.	
		12) Oral analgesia taken prior to settling. 10mg temazepam also given with effect.	C. MACINTYRE C. Nadeg
1/2/11	15-05	Patient in recovery following surgery. See care plan for details.	L-Lyp
	900	No problems post op. No analgesia at present IV fluids running 3 to NW Dunn Q to be fitted with hard collar.	
2/2/11		1) Vital signs satisfactory. Patient feels L arm improved. Apyrexial.	
		(3) Sat rations 96-98% on air	
		(4) IV fluids discontinued Drinking small amounts	
		(5) Passing urine via bottles	
		(6) Wound drains x 2 in situ minimal amount in drains Mepore dressings dry and intact	
		(8) Moving in bed with encouragement	
		(11) Slept only for short periods.	
		(12) IM morphine given x 2 with fair effect.	C. MACINTYRE C. Nadeg
2/2/11 pm	(1)	limb power good, vital signs stable, apyrexial	
	(2)	communicates needs well	
	(3)	sats 97% on room air	
	(4)	eating and drinking well	
	(5)	up to toilet to pv uncomplaining of constipation	
	(6)	wound drains removed. wounds satisfactory	
	b.	independant with ADL's	

SOUTHERN GENERAL HOSPITAL

INVESTIGATION INSTRUCTION SHEET

NAME: George Harkness UNIT NO: WARD: 65

DATE		DATE	INITIAL
1/2/11	Theatre — C6/7 ACD revision and insertion of bone graft from Iliac Crest	1/2/11	PL
2/2/11	X-ray		

DATE		DATE		DATE		DATE		DATE		DATE	

0869451-SGH307

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: RS

NAME: George Halkness UNIT NO. SA03251486 WARD: 6S

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
	(7)	apyrexial	
	(8)	mobilising fairly well, fitted with a hard collar.	
	(9)	family in attendance	
	(12)	routine analgesia c a fair effect	
		!- x-ray. called out	Mackinnon
		:- hard collar for 6 weeks	
3/2/11 0035	1)	Vital signs satisfactory Apyrexial	
		No limb deficits.	
	3)	Saturations satisfactory on air	
	4)	Eating and drinking	
	5)	Passing urine spontaneously	
	6)	Wound sites satisfactory	
	8)	Mobilising with hard collar in situ	C.MACINTYRE
	12)	Oral analgesia taken with effect	C.Mackye.
2/11 pm	(1)	no limb defecits, BP and pulse stable, apyrexial	
	(2)	communicates needs well	
	(3)	sat 96% on 100m air.	
	(4)	eating and drinking well	
	(5)	no bladder / bowel problems	
	(6)	Independant with ADL's.	
	6.	wound satisfactory	
	(7)	apyrexial	
	(8)	mobilising independantly with hard collar	
	(9)	family in attendance - ? home tomorrow.	
	(12)	regular analgesia with a fair effect	Mackinnon
4/02/11	(1)	Remains well .. No deficits	
	(4)	Diet and fluids taken	
	(5)	Passing urine spontaneously	
	(6)	Neck wound clean + dry. Mepore removed from thigh wound; some bruising around wound evident	
	(8)	fully mobile with collar	
	(12)	Regular oral analgesia taken with effect	C.MACINTYRE C.Mackye

Regional Services Division Nursing Care Plan [redacted] **Maintaining a safe environment**	Date 31/1/11 [redacted]	Time

Date and Time	Problem No	Problem	Nurse Action	Aims of Care	Initial	Review Date	Disc
	1a	Potential deterioration in conscious level / vital signs.	Assess using Glasgow Coma Scale or SEWS _____ Hourly	Detection of deterioration in conscious level / vital signs. Maintain patient safety.	CR	ongoing	
	1b	Potential risk of falls	Patient falls and restraint management risk assessment completed and implemented	Maintain patient safety.	CR	ongoing	
		Maintain bed at lowest level		Minimise risk of falls.	CR	ongoing	
		Bed rails in use Y/N	Assess level of observation required.		CR	ongoing	
			Refer to moving and handling risk assessment.		CR	ongoing	
	1c	Potential risk of acquired infection	Ensure adequate hand hygiene and infection control measures are adhered to.	Minimise risk of acquired infection.	CR	ongoing	
			Ensure area is clean, tidy and free of clutter.		CR	ongoing	
	1d	Intravenous cannula in situ Y/N	Inspect cannula site each shift and prior to use. Record date of insertion. Replace as per infection control guidance. Complete equipment change chart.		CR	ongoing	

Name George Harkness	CHI No 1707583579	Ward 65

Regional Services Division Nursing Care Plan [redacted] **Eating and Drinking** **Eliminating**	Date [redacted]	Time

Date and Time	Problem No	Problem	Nurse Action	Aims of Care	Initial	Review Date	Disc
	4	Potentially inadequate nutritional intake.	Assess nutritional status on admission. Refer to dietitian if appropriate. Provide assistance if required. Offer hand cleansing facilities before meals.	To provide adequate nutrition and hydration.	CR	ongoing	
	5	Potential alteration of bladder and /or bowel function.	Assess on admission. Provide assistance as required Administer aperients as prescribed. Urinary catheter size H20 in balloon ml Date of Insertion Date of removal Catheter hygiene as per protocol.	To encourage normal bladder / bowel function. Maintain dignity. Promote comfort. Maintain hygiene to prevent infection.	CR	ongoing	

Name	CHI No	Ward

Regional Services Division Nursing Care Plan **Controlling body temperature** **Mobilising**	Date	Time

Date and Time	Problem No	Problem	Nurse Action	Aims of Care	Initial	Review Date	Disc
	7	Potential alteration in body temperature due to:	Monitor and take appropriate action.	Maintain temperature within normal range.	CR	ongoing	
	8	Reduced mobility.	Independent Y N	Reduce complications of reduced mobility.	CR	ongoing	
				Promote comfort.	CR	ongoing	
			Complete moving and handling risk assessment.	Maintain skin integrity.	CR	ongoing	
			Refer to physiotherapist Y N	Assist rehabilitation.	CR	ongoing.	

Name	CHI No	Ward

Regional Services Division Nursing Care Plan **Working and playing** **Expressing sexuality**	Date	Time

Date and Time	Problem No	Problem	Nurse Action	Aims of Care	Initial	Review Date	Disc
	9	Disruption to normal work pattern / recreation.	Assess and refer to appropriate body.	Identify potential areas of concern. Refer to appropriate source of advice / support.	CR	ongoing	
	10	Potential altered body image.	Discuss. Provide support. Promote dignity.	To maintain patients dignity.	CR	ongoing	

Name	HI No	Ward

Regional Services Division Nursing Care Plan [redacted] **Sleeping** **Spiritual care**	Date [redacted]	Time

Date and Time	Problem No	Problem	Nurse Action	Aims of Care	Initial	Review Date	Disc
	11	Potential disruption to normal sleep pattern.	Provide quiet environment. Promote comfort. Relieve pain.	Promote rest / sleep.	CR	Ongoing	
	12a	Potential need for spiritual care.	Encourage discussion. Assess spiritual needs. Refer to appropriate chaplain if desired. Involve family / significant other.	Address spiritual needs. Assist patient and family to cope with illness and possible bereavement.	CR	Ongoing	

Name	CHI No	Ward

Regional Services Division Nursing Care Plan **Pain**	Date	Time

Date and Time	Problem No	Problem	Nurse Action	Aims of Care	Initial	Review Date	Disc
	12b	Pain	Assess using appropriate pain assessment tool. Provide support / comfort. Ensure adequate analgesia is given and assess effect. Liaise with medical staff.	Relieve pain. Promote comfort. Promote dignity.	CR	ongoing	

Name	CHI No	Ward

South Glasgow Hospitals

Hospital .....SGH.....

Observation Chart

NHS Greater Glasgow and Clyde

Name: George Harkness	Record No:

DATE: 9/11 | 13/11 | 14/11 | 13/11

TIME: 13 | 15 | 15 | 15 | 15 | 15 | 16 | 17 | 20 | 22 | 02 | 06 | 10 | 14 | 18 | 22 | 06 | 10 | 16

COMA SCALE

- EYES OPEN: Spontaneously; To Speech; To Pain; None
- BEST VERBAL RESPONSE: Orientated; Confused; Inappropriate Words; Incomprehensible Sounds; None
- BEST MOTOR RESPONSE: Obey Commands; Localise Pain; Flexion to Pain; Extension to Pain; None

Eyes closed by swelling = c

Endotracheal tube or tracheostomy = T

Usually record the best arm response

PUPIL SCALE (mm): 1 2 3 4 5 6 7 8

Blood Pressure and Pulse Rate: 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10

Temp, °C: 40 39 38 37 36 35 34 33 32 31 30

Resp. Rate: 18 | 19 | 19 | 19 | 10 | 12 | 14 | 16 | 18 | R | air

SaO2: 96 | 98 | 99 | 99 | 98 | 96 | 97 | 97 | 97 | 96 | 96 | 99 | 97 | 97 | 97 | 97 | 97 | 96 | 97

Pain: 0 | 0 | 0

Sedation: 0 | 0 | 0

Nausea: 1 | 0 | 0

PUPILS

- Right: Size; Reaction
- Left: Size; Reaction

+ reacts
- no reaction
c. eye closed

LIMB MOVEMENT

- ARMS: Normal Power; Mild Weakness; Severe Weakness; Spastic Flexion; Extension; No Response
- LEGS: Normal Power; Mild Weakness; Severe Weakness; Extension; No Response

Record right (R) and left (L) separately if there is a difference between the two sides

NHS
Greater Glasgow and Clyde

SCORING

Pain Score:

S = Sleeping

0 = No pain

1 = Mild pain

2 = Moderate pain

3 = Severe pain

Sedation Score:

S = Sleep normal

0 = None. Patient alert

1 = Mildly sedated, awakes to verbal stimuli

2 = Moderately drowsy, awakes to verbal stimuli

3 = Severe. Somnolent, difficult to wake to verbal stimuli

Nausea Score:

0 = None

1 = Mild, no treatment required

2 = Nausea and vomiting, helped by treatment.

3 = Nausea, persistent despite treatment

Acute Services Division

Hospital / Department SGH INS

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

Patient name: George Harkness

Ward: 65

CHI number: 1707583579 Unit/Hospital number SG03251486

Contents

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

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

Continuing Care Wards: Mobile and 'at risk' patients should have risk assessment and care plan reviewed monthly.

Cannard Falls Risk Assessment

(Must be completed within 24 hours)

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						DATE	DATE	DATE	DATE	DATE	DATE	DATE
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			0						
Sex	Male 1	Female 2				1						
Age	60-70 1	71-80 2	81+ 1			0						
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		0						
Medication type **	Drugs for mental illness 1	Blood pressure / water tablets 1	Sleeping tablets 1	None of these 0		0						
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	0						
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed bound 1		1						
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1						
				TOTAL SCORE		3						
				ACTION(S) TAKEN Enter action code(s)		1						
SCORE 2–8 = LOW, 9–12 = MEDIUM, 13+ = HIGH RISK				NURSE SIGNATURE		ck.						

** If you are in any doubt about whether a person's medicine belongs to one of the types listed ask the person or carer or please phone the number on the medicine container and ask the community or hospital pharmacist.

* Please see back page for clarification

Falls Assessment Care Plan

Please tick all applicable nursing interventions

	NURSING INTERVENTIONS	DATE	DATE	DATE	DATE	DATE	DATE	DATE
Action code	LOW, MODERATE AND HIGH RISK							
1	Prevention and general safety precautions discussed with patient and family.	3.01.11						
	MODERATE AND HIGH RISK							
2	Move to more observable area of ward to optimise supervision.							
3	Refer to Physiotherapist.							
4	Refer to Occupational Therapist.							
5	Patient requires footwear or podiatry referral. (Date referred:)							
6	Commence continence assessment							
7	Monitor lying and standing BP and pulse.							
8	Request medication review.							
9	Select suitable seating (refer to policy).							
10	Non-slip mat on chair/floor following advice of OT.							
11	Bed rails/bumpers to be used (refer to policy).							
12	Falls map in use for seven days.							
13	Bed/chair monitor in use.							
14	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.							
15	Patient to be nursed on mattress on the floor (refer to policy.)							
16	Patient requires one to one nursing care.							
17	Other interventions.							
	HIGH RISK ONLY (Score of 13 or over)							
18	Provide hip protectors to patients being discharged to care homes/longterm NHS facilities							
	SIGNATURE							

Review Cannard score weekly / monthly as per policy.

Enter action code(s) selected in action taken section on Falls Risk Assessment.

Cannard Falls Risk Assessment

Glossary of terms used in risk assessment

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

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

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

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

BLOOD PRESSURE TABLETS include Captopril, atenolol and many others.

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

SLEEPING TABLETS include medicines such as Diazepam, Temazepam, Nitrazepam, Chlordiazepoxide and Zopiclone (Zimovane).

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

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

HESITANT IN INITIATING MOVEMENT means difficulty in starting to walk.

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

Nutrition Profile

NHS Greater Glasgow and Clyde

Name:	Date of admission: 31/1/11
Address: SG03251486 GEORGE HARKNESS 32C MILL SQUARE CATRINE AYRSHIRE KA5 6RD	Time:
DoB: 17/07/1958 CHI 1707583579	HOSPITAL: SGH
CHI number:	Ward: 65
Affix patient data label	

To be recorded within 24 hours of admission*

Height: 178cm m/ft Actual ☐ Patient/ carer reported ☑ Alternative measurement ☐

Weight: 86.45 (kg)/stones Actual ☑ Patient/ carer reported ☐ Alternative measurement ☐

Recent unplanned weight loss: Yes ☐ No ☑

If 'Yes' how much?: kg/stones. Over what period of time?: weeks/months

Is there evidence of recent weight loss?

No ☑ Loose clothing ☐ History of reduced food intake/appetite ☐ Swallowing problem ☐

Eating and drinking likes and dislikes (including appetite and/or NBM status):

no allergies
likes most things. Teat milk

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☑

Please state:

Are there any contributing factors that may affect food intake such as **physical** (e.g. swallowing difficulties), **physiological** (e.g. nausea), **psychological** (e.g. dementia), **social or environmental?** Yes ☐ No ☑

Please specify all factors:

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☑

Please state:

Profile completed by: Name (PRINT): ALINDSAY Signature: Alindsay Date: 31/1/11

NOTE: This is ADMISSION DATA - please refer to changes in Care Plan.

* Quality Improvement Scotland (2003). Food, Fluids and Nutritional Care in Hospitals Edinburgh QIS

Regional Services Division Nursing Care Plan **Personal cleansing and dressing**	Date	Time

Date and Time	Problem No	Problem	Nurse Action	Aims of Care	Initial	Review Date	Disc
	6a	Potential wound infection/poor healing.	Observe wound for signs of inflammation. Remove Clips on: Remove Drain on:	Prevent wound infection. Promote healing.	CR	ongoing	
	6b	Potential difficulty maintaining personal hygiene	Daily bed bath. Daily shower / bath.	Maintain personal hygiene.	CR	ongoing	
			Assistance Y N	Maintain dignity. Prevent infection.	CR	ongoing	
			Assist as required with: • Oral hygiene • Hair / nails • Dressing • Eye care	Maintain skin integrity.	CR	ongoing	
			Provide hand cleaning facilities prior to meals and after use of toilet.				

Name	CHI No	Ward

Malnutrition Universal Screening Tool ('MUST')

Date	31/1/11									
Initials	AL									
Height (see page 1) 178cm. Weight	86 KG									
Oedema or ascites present Y/N	N									
BMI	27									

'MUST'

Step 1: BMI Score (refer to chart on page 4) >20 (>30 = Obese) ..... 0 18.5 - 20 ..... 1 <18.5 2	0								
Step 2: Weight Loss Score Unplanned weight loss in past 3-6 months: <5% ..... 0 5-10% ..... 1 >10% 2	0								
Step 3: Acute Disease Effect Score If patient is acutely ill **and** there has been or is likely to be no or virtually no food intake for > 5 days..... Score 2 Not applicable ..... Score 0	0								
Step 4: Overall Risk of Malnutrition Total:	0								

Step 5: Management Guidelines

Score of Overall Risk of Malnutrition	Action Required
0	**LOW RISK** - *Routine Clinical Care* • Repeat screening. Hospital Acute .....Weekly Hospital Rehabilitation .....Monthly
1	**MEDIUM RISK** - *Observe* • Document dietary intake for 3 days on a Food Record Chart. • If no improvement in intake: - Encourage oral intake. - Assist patient to choose high-energy meals/snacks **and** offer full cream milk to drink with and between meals. • Repeat screening weekly.
2 or more	**HIGH RISK** - *Treat** • Refer to Dietitian **and** document food intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks **and** offer full cream milk to drink with and between meals. • Monitor and review Care Plan weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.