ELECTRONIC PATIENT RECORDS

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

Including:

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

Clinical letter - Others:

NHS
Greater Glasgow and Clyde

Dental Hospital
378 Sauchiehall Street
Glasgow
G2 3JZ
Main Switchboard: 0141 211 9600
Department: Oral Medicine
Contact Tel: Appts: 0800 012 1405
Enquiries to: Secretary: 0141 211 9838

Julie McGavin
General Dental Practitioner
Baillieston Dental Care
20 Muirside Road
Glasgow
G69 7AD

Letter Date: 13/07/2023
Reference: ET/KD
Dictated Date: 12/07/2023
Transcribed Date: 13/07/2023

Dear Ms McGavin,

Deborah Sullivan; D.O.B: 07/12/1972; CHI: 0712726128
Flat 0-1, 8 Boyndie Street , Easterhouse, Glasgow, Lanarkshire, G34 9JE

Problems:
- Oral dysesthesia
- Dry mouth
- Parafunctional habits
- Previous low ferritin, poor diabetic control

Management:
- Salivary substitutes/stimulation
- Lower soft splint

I reviewed this patient on behalf of Dr Jennifer Taylor on 11th July 2023. Her oral symptoms were still mostly the same; she has dryness in her mouth and finds that she is biting her tongue. She finds that chewing gum is best for dryness, but she is also using a dry mouth spray.

I believe that she has started Dulaglutide for her Diabetes and she is aware that her diabetic control can worsen her oral symptoms. She certainly has a dry mouth secondary to her diabetes and medications, but I think there are also some parafunctional habits including trauma to the tongue tip and ventral surface. It may therefore be sensible to trial a lower soft splint.

Aside from this we have reinforced dry mouth stimulation and products and have discharged from Oral Medicine with reassurance. The patient is happy with this.

Kind regards.

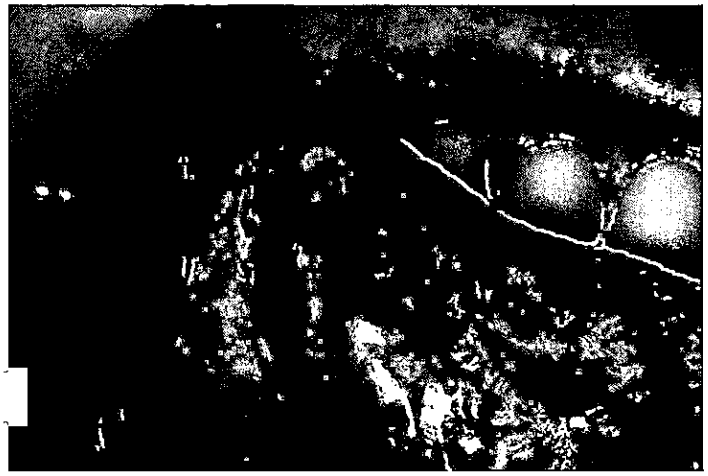
Yours sincerely,

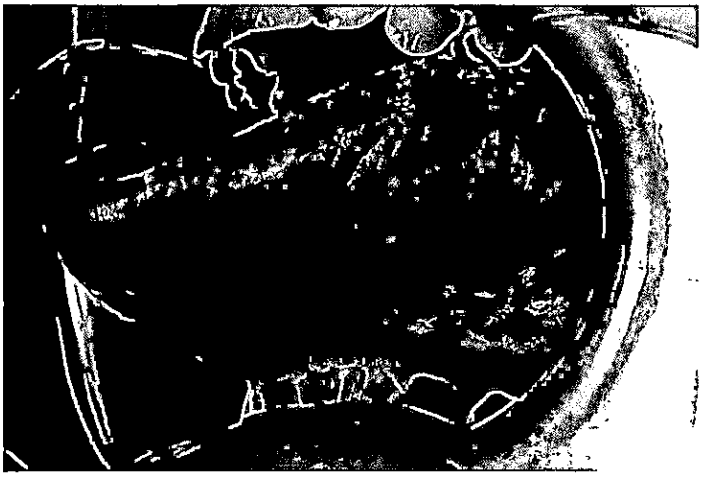
Elizabeth Todd

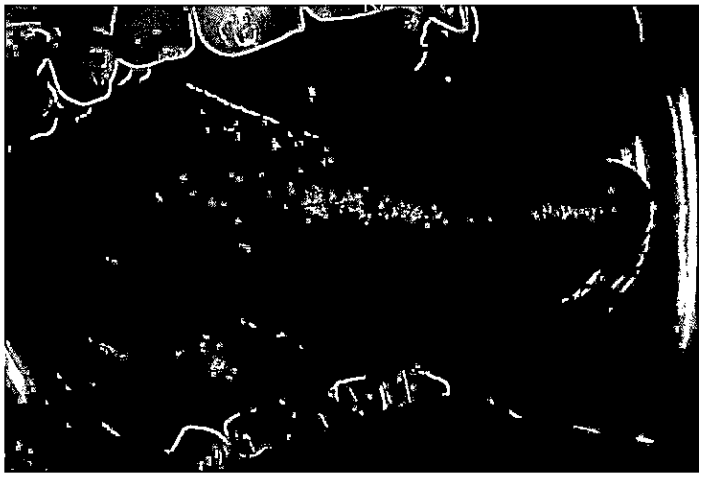
Medical Illustration Services

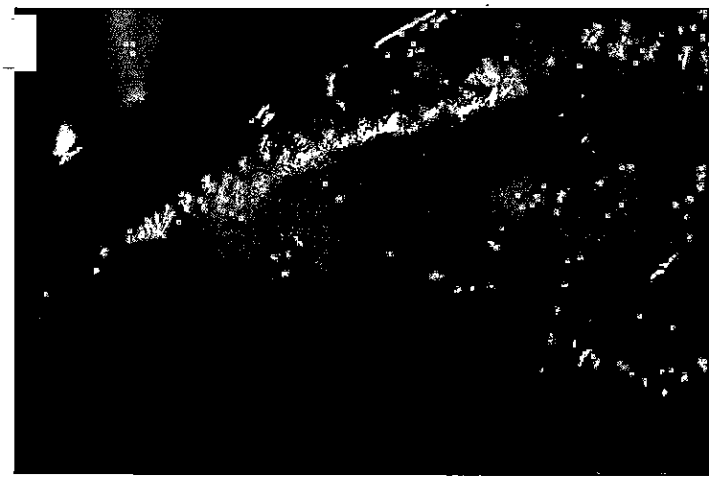
NHS Greater Glasgow and Clyde

Name: Deborah Sullivan		
Pt No: 10638479K	Site: GDH	
DOB: 07/12/1972	DIAG: ?; Trauma; Ulcer	MIS No: C17-009822
CHI: 0712726128	CONS: Ryan, Dr Kevin	Date: 13/03/2017









Consent Status	A	B	C

A = Records ONLY, B = Teaching & Records, C = Publication

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Specialty Registrar in Oral Medicine

Electronically Signed: Dentist Elizabeth Todd, Dentist

cc. Dr. E. Sheppard
Lochend Surgery
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

Mrs Deborah Sullivan
Flat 0-1
8 Boyndie Street
GLASGOW
G34 9JE

Subject Access Request Team
Health Records Department
Glasgow Royal Infirmary
8 – 16 Alexandra Parade
Glasgow
G31 2ER

NHS
Greater Glasgow and Clyde

Private

MMA Legal Limited
Stok
43 – 59 Princes Street
Stockport
SK1 1RY

Date: 8th May 2026
Your Ref: 100016
Our Ref: SAR / ACCESS / CF
Enquiries to: Caroline
Direct Line: 0141 201 3380
Email: Caroline.Forsyth@ggc.scot.nhs.uk

Dear Sir / Madam

Re: Subject Access Request under the General Data Protection Regulation

Patient: Deborah Sullivan D.O.B: 07/12/1972

Thank you for your recent request 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:

GLASGOW ROYAL INFIRMARY RECORDS / STOBHILL ACH RECORDS
PRINCESS ROYAL MATERNITY RECORDS / DENTAL HOSPITAL RECORDS

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

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

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

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

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

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

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

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

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

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

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

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

Yours sincerely

Subject Access Request Team

ELECTRONIC PATIENT RECORDS

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

Including:

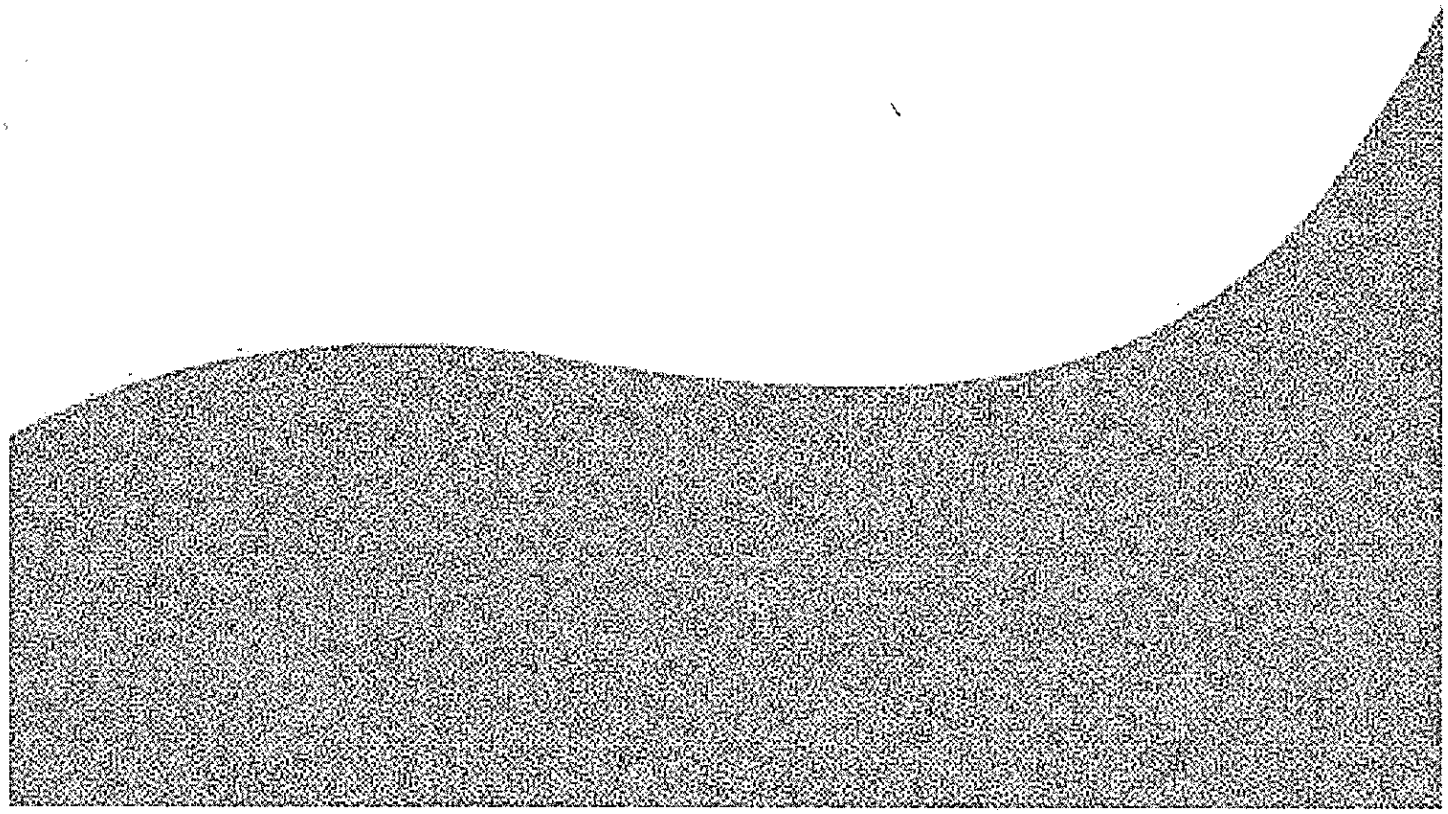
BADGERNET	☐
CAREVUE	☐
MEDICAL ILLUSTRATION	☑
METAVISION	☐
PHYSIOTHERAPY	☐
RADIOLOGY	☐
WEST MARC	☐
LABS	☐

Medical Illustration Services

NHS
Greater Glasgow and Clyde

DEBORAH SULLIVAN

0712726128



Letter to Patient: Letter to Patient

NHS
Greater Glasgow and Clyde

Dental Hospital
378 Sauchiehall Street
Glasgow
G2 3JZ

Deborah Sullivan
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow
Lanarkshire
G34 9JE

Main Switchboard:	0141 211 9600
Department:	Oral Medicine
Contact Tel:	Apps 0800 012 1405
Enquiries to:	Secretary 0141 211 9838
Letter Date:	22/12/2022
Reference:	JT/hm
Dictated Date:	16/12/2022
Transcribed Date:	19/12/2022

Dear Ms Sullivan,

Ultrasound Scan Result: Normal appearances of the bilateral major salivary glands.

I have receive the result of the ultrasound scan. This is very reassuring and makes it very unlikely that you have Sjögren's syndrome.

I hope that the treatments we have suggested for your dry mouth are helping and will look forward to reviewing you.

With kind regards.

Yours sincerely

Dr Jennifer Taylor

Consultant in Oral Medicine

GMC No. 6157834 GDC No. 77723

Electronically Signed: Dr Jennifer Taylor, Consultant

cc. Dr A L McGinley
General Medical Practitioner
Lochend Surgery
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

Clinical letter - GP: Clinical letter - GP

NHS
Greater Glasgow and Clyde

Dental Hospital
378 Sauchiehall Street
Glasgow
G2 3JZ
Main Switchboard: 0141 211 9600
Department: Oral Medicine
Contact Tel: Apps 0800 012 1405
Enquiries to: Secretary 0141 211 9838
Letter Date: 22/11/2022
Reference: JT/hm
Dictated Date: 16/11/2022
Transcribed Date: 17/11/2022

Dr. AL McGinley
Lochend Surgery
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

Dear Dr McGinley,

Deborah Sullivan; D.O.B: 07/12/1972; CHI: 0712726128
Flat 0-1, 8 Boyndie Street , Easterhouse, Glasgow, Lanarkshire, G34 9JE

Additional Blood Results:

This patient attended the Oral Medicine Department with a diagnosis of oral dysaesthesia. Her results were all generally within normal ranges, however, I note that her **ferritin level was 22 (15-200)** and in the context of oral dysaesthesia it would be worthwhile considering a short course or Iron supplementation. In addition, her **HbA1c was 60 (20-41).** Certainly, this could be influencing the soreness in her mouth and particularly oral dryness.

Many thanks for your help with this patient.

With kind regards.

Yours sincerely

Dr Jennifer Taylor

Consultant in Oral Medicine

GMC No. 6157834 GDC No. 77723

Electronically Signed: Dr Jennifer Taylor, Consultant

cc. Mrs Deborah Sullivan
Flat 0-1

8 Boyndie Street
GLASGOW
G34 9JE

Clinical letter - Others: Clinical letter - OTHERS

NHS
Greater Glasgow and Clyde

Dental Hospital
378 Sauchiehall Street
Glasgow
G2 3JZ

Dr J McGavin
Dental Practitioner
Baillieston Dental Care
20 Muirside Road
Glasgow
G69 7AD

Main Switchboard: 0141 211 9600
Department: Oral Medicine
Contact Tel: Appointments: 0800 012 1405
Enquiries to: Secretary: 0141 211 9838
Letter Date: 14/11/2022
Reference: SM/AF
Dictated Date: 09/11/2022
Transcribed Date: 09/11/2022

Dear Dr McGavin,

Deborah Sullivan; D.O.B: 07/12/1972; CHI: 0712726128
Flat 0-1, 8 Boyndie Street , Easterhouse, Glasgow, Lanarkshire, G34 9JE

Clinical impression:

Oral dysaesthesia and dry mouth.

Management plan:

- Sialometry showed less than 0.1ml in 15 minutes.
- Ultrasound scan, salivary glands.
- Full blood count, haematinics- within normal limits, **HbA1C- 60mmol/mol**
- **Could the GP please prescribe Oraleve gel and spray to be used to manage dry mouth syndrome.**
- **Could the GDP please prescribe high fluoride 5000ppm toothpaste.**
- Face to face review in four months time.

I reviewed the above patient today on behalf of Dr Jennifer Taylor, Consultant in Oral Medicine clinic face-to-face. Deborah was presenting today complaining of severe dry mouth along with habitual biting of her tongue on a daily basis. She tells me this has been occurring for 18 months and she is currently managing her dry mouth with Biotoene gel and by drinking plenty of water. She tells me that she also feels like her tongue is too big for her mouth and is sore and burning.

As you are aware, she is on a polypharmacy of medications for PTSD, hypertension, hypercholesteraemia, gastric reflux, type II diabetes and fibromyalgia.

She tells me she is currently not working and is living at home alone. In addition to this, she stopped smoking five years ago and currently vapes but does not consume any alcohol.

On examination extraorally, there was no evidence of any lymphadenopathy nor TMJ issues. Intraorally, she was scoring approximately 1-2 on the Challacombe scale with no evidence of ulceration on her tongue today.

Overall, my impression is that she is suffering from oral dysaesthesia alongside a dry mouth. Having discussed this case with Dr Taylor, we have arranged the management plan above including up to date bloods and a scan of the salivary glands to exclude Sjogren's syndrome. We will review her again in four months time once we have the results of the ultrasound scan.

Many thanks.

Yours sincerely,

Siofra Murphy

DCT2

Oral Medicine

Electronically Signed: Dentist Siofra Murphy, Dentist

cc.

Mrs D Sullivan
FLAT 0-1
8 Boyndie Street
GLASGOW
G34 9JE

Dr. AL McGinley
Lochend Surgery
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments
Oral Medicine - IMG_3584.jpeg Deborah Sullivan
Oral Medicine - IMG_3584 (1).jpg Deborah Sullivan

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Oral Medicine GGC GDH Oral Medicine	—	**Consultant / receiving practitioner** and/or **specialty clinic**
Glasgow Dental Hospital and School 378 Sauchiehall Street Glasgow G2 3JZ	—	**Hospital** and **hospital address** Hospital location code. G106H Email address -

Urgency of referral Urgent
Date of referral 10-Dec-2021 **Date sent** 10-Dec-2021

PATIENT DETAILS

Surname	SULLIVAN
Forename(s)	DEBORAH
Title	Mrs
Sex	Female
Date of birth	07-Dec-1972
CHI no.	0712726128
Area of Residence	-

Patient's address

FLAT 0-1
8 BOYNDIE ST
GLASGOW
G34 9JE

Contact number(s)
Voice: 07713718392

101025080109M

Unique Care Pathway Number: 101025080109M

REFERRING HCP DETAILS

HCP Name	JulieMcGavin
HCP code	74619
HCP Position	-
Organisation name	Baillieston Dental Care (531)
Location code	-

Organisation address

20 Muirside Road
Glasgow
G69 7AD

Contact number(s)
Voice: 0141 771 6488

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint
Description: Dental Direct Referral

Reason for referral
Care type requested: Out Patient
Expected outcome: Not Specified

Past medical history

Current medication (Active Repeat medication issued within the last 12 months)
No current medications recorded

Recent medication (Any medication issued within last 90 days not shown above)
No recent medications recorded

Blood Pressure
No Blood Pressures Recorded

Body Measurements
No Body Measurements Recorded

Clinical warnings

Additional Support Needs
No known ASN requirements

Additional relevant information
Administrative information
Are you aware of any vulnerability or protection issues in relation to this person?:Not Known
Does the patient have the capacity to consent?:Yes
Reason for Referral:Other
Other:suspicious oral cancer non healing ulcer
If Urgent, please provide reason:suspicious oral cancer non healing ulcer ventral surface of tongue
Does the patient need an interpreter?:No
Detail the problem including the history, treatment to date and complete description of any lesion:Pt is aware of ulcer on the ventral surface of tongue for 6 months only attended today. Firm to touch and pain free
Possibly some trauma stoned tooth nearby to remove sharp edge today.
alcohol occasionally as chronic pancreatitis
vapes regularly
Specify why input from secondary care is required:Suspicious oral cancer carcinoma
If this referral relates to pain and neurological dysfunction, have you attempted to exclude a dental cause?:No
Have any relevant radiographs been taken?:No
Relevant radiographic images have been included:N/A
Confirm radiographs are correctly orientated and labelled, by either saving file as name, DOB/CHI, date and site, or ensuring that the information is clearly visible on the image.:N/A
Have any relevant photographs been taken?:Yes
Relevant Photographs have been included:Yes
Details of relevant medical history: Chronic Pancreatitis. Diabetes type 2
Details of relevant medication:Metaformin, Glizidie
diazepam, dihydrocodeine, esomeprazole, lactulose,laxide, metroclopamide

Details of relevant allergies:penicillin allergy
Referrer type:GDP
Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Oral Medicine - IMG_3584.jpeg Deborah Sullivan
Oral Medicine - IMG_3584 (1).jpg Deborah Sullivan

Signature of referring doctor (or other professional) **Date**

Clinical letter - Others: Other

NHS
Greater Glasgow and Clyde

Dental Hospital
378 Sauchiehall Street
Glasgow
G2 3JZ
Main Switchboard: 0114 211 9600
Department: Department of Oral Medicine
Contact Tel: 0141 211 9653
Enquiries to: Secretary

Ms Julie Gavin
Baillieston Dental Care
2 Muirside Road
Baillieston
Glasgow
G69 7AD

Letter Date: 19/02/2018
Reference: EJ/AP
Dictated Date: 17/01/2018
Transcribed Date: 10/02/2018

Dear Ms Gavin,

Deborah Sullivan; D.O.B: 07/12/1972; CHI: 0712726128
1/1 34 Pendeen Place, Glasgow, G33 4UG

This lady was initially seen on the oral medicine clinic back in March 2017. Since then she has cancelled and failed to attend multiple appointments on the oral medicine and oral surgery clinics. The oral rinse we took at her initial visit returned no significant growth. I have not made further arrangements for review at present but if there are concerns in the future please refer her again.

Kind regards.

Yours sincerely,

Emma Jamieson

Specialty Dentist in Oral Medicine

Electronically Signed: Dentist Emma Jamieson, Dentist

cc. Dr G MacAllister
Baillieston Health Centre
20 Muirside Road
Baillieston
Glasgow
G69 7AD

Clinical letter - Others: Clinical - Other

NHS
Greater Glasgow and Clyde

Dental Hospital
378 Sauchiehall Street
Glasgow
G2 3JZ
0114 211 9600

Ms Julie McGavin
Baillieston Dental Care
20 Muirside Road
Baillieston
Glasgow
G69 7AD

Main Switchboard:
Department:
Contact Tel: 0141 211 9654
Enquiries to: emma.jamieson@ggc.scot.nhs.uk
Letter Date: 12/04/2017
Reference: EJ/AP
Dictated Date: 13/03/2017
Transcribed Date: 01/04/2017

Dear Ms McGavin,

Deborah Sullivan; D.O.B: 07/12/1972; CHI: 0712726128
6 Muirhead Court , Baillieston , Glasgow, Lanarkshire, G69 7EP

Thank you for your referral of this lady whom I saw in the oral medicine clinic on the 13th of March 2017. For around a year she has been aware of a burning sensation affecting her tongue tip and anterior tongue dorsum and also a salty taste affecting her lips. Her symptoms tend to be present most of the time. To date she has had an artificial saliva gel from her GP which she felt has probably been helpful. I note her complex medical history. She describes chronic pain, fibromyalgia and chronic pancreatitis. She is currently smoking 15 cigarettes per day but previously smoked 40. She does not consume alcohol.

Examining her today, I could palpate the local lymph nodes. Intra-orally her mouth is dry and we have discussed that this is likely to be related to her medications. She did have a small 3mm diameter ulcer to the left hand side of her tongue tip with a keratotic border and this appeared traumatic in nature. It is certainly possible that a degree of trauma from her teeth is contributing to her symptoms so I would be grateful if you would make her a lower soft acrylic splint to wear. I have also suggested that she changes to a sodium lauryl sulphate free toothpaste. I have checked an oral rinse for microbiology and I have also made an appointment with my colleagues in oral surgery for biopsy of the ulcer of the left tongue tip if it persists following the wearing of the splint. We will see her back with the results.

Kind regards.

Yours sincerely,

Emma Jamieson
Specialty Dentist
Oral Medicine

Electronically Signed: Dentist Emma Jamieson, Dentist

cc. Dr G MacAllister
Mcglone Practice
Baillieston Health Centre
20 Muirside Road
Baillieston
Glasgow
G69 7AD

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL/DENTAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Oral Medicine GGC Dental Services	—	**Consultant / receiving practitioner** and/or **specialty clinic**
Glasgow Dental Hospital and School 378 Sauchiehall Street Glasgow G2 3JZ	—	**Hospital** and **hospital address** Hospital location code. G106H Email address -

Urgency of referral Routine
Date of referral 15-Sep-2016 **Date sent** 15-Sep-2016

PATIENT DETAILS

Surname	SULLIVAN
Forename(s)	DEBORAH
Title	Mrs
Sex	Female
Date of birth	07-Dec-1972
CHI no.	0712726128
Area of Residence	

Patient's address

6 MUIRHEAD CT
BAILLIESTON
GLASGOW
G69 7EP

Contact number(s)

Voice: 07568098011
Voice: 07568098011

101012149515Q

Unique Care Pathway Number: 101012149515Q

REFERRING HCP DETAILS

HCP Name	JulieMcGavin
HCP code	074619
HCP Position	-
Organisation name	Baillieston Dental Care
Location code	G00531D

Organisation address

20 Muirside Road
Baillieston
Glasgow
G69 7AD

Contact number(s)

Voice: 0141 771 6488

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: burning sensation tip of tongue, salty taste lips, white patch tip of tongue

Comment: c/o salty taste on lips, burning sensation at tip of tongue. pt has very dry mouth due to medication and I noticed a tongue trusting habit may explain white patch at tip of tongue possible trauma
white patch 2mm by 2mm at tip of tongue

Reason for referral

Care type requested: Out Patient

Expected outcome: Treat

Investigations

Description/Question	Result/Comment
Previous investigation and treatment:	pt aware of burning sensation tingly sensation tip of tongue for about a year, previous investigate at GP -ve can blood tests
Relevant medical and drug history including allergies:	medication DIazapam,dicydovenine,Dihydrocodine,esmeprazole,hydroxychloroquine,lactulose,laxido,metaclopramide,parace sulphate,senna,tramadol
Examination findings:	Burning mouth syndrome ? please investigate and treat
Community location suitable:	yes
Are dentures worn by the patient?:	no

Additional Support Needs

No known ASN requirements

Additional relevant information
Administrative information

OK to send correspondence to home address?:Yes
Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Patient has disability or requires wheelchair access:No
Loop system required?:no
Referred By:Principal
Electronic Attachment Present:No

BPE CHART

Upper Right:0
Upper Median:0
Upper Left:0
Lower Right:0
Lower Median:0
Lower Left:0

Signature of referring doctor (or other professional) **Date**

US Salivary glands submandibular

Performed	09-Dec-2022 14:12	Received	09-Dec-2022 16:20
Reported	09-Dec-2022 16:18	Order Number	G106H39033440
Status	Final	Source System	MiSys

US Salivary glands parotid Final
Deborah Sullivan
Clinical History :
49 year old female patient with an 18 month history of intraoral dryness. Known T2DM, previous ANA negative. Query any Sjogrens like changes in the glands

US Salivary glands parotid : US Salivary glands submandibular :
The bilateral major salivary glands have a normal homogeneous echotexture with no evidence of ductal dilatation, sialolith or mass present.
No lymphadenopathy within the parotid regions or neck levels I and II.

Opinion:
Normal appearances of the bilateral major salivary glands.

Please see report for US Salivary glands parotid.

Reported by: Miss Orlagh McPolin (Dental StR) and Dr Neil Henderson
Verified by: Dr Neil Henderson

US Salivary glands parotid

Performed	09-Dec-2022 14:12	Received	09-Dec-2022 16:20
Reported	09-Dec-2022 16:18	Order Number	G106H39033439
Status	Final	Source System	MiSys

US Salivary glands parotid Final
Deborah Sullivan
Clinical History :
49 year old female patient with an 18 month history of intraoral dryness. Known T2DM, previous ANA negative. Query any Sjogrens like changes in the glands

US Salivary glands parotid : US Salivary glands submandibular :
The bilateral major salivary glands have a normal homogeneous echotexture with no evidence of ductal dilatation, sialolith or mass present.
No lymphadenopathy within the parotid regions or neck levels I and II.

Opinion:
Normal appearances of the bilateral major salivary glands.

Please see report for US Salivary glands parotid.

Reported by: Miss Orlagh McPolin (Dental StR) and Dr Neil Henderson
Verified by: Dr Neil Henderson

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 CARE AMBULATORY HOSPITAL	☐		
WESTERN INFIRMARY RECORDS	☐		

Including:

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

ROYAL MATERNITY HOSPITAL
GLASGOW G4 0NA

6017

CASE SHEET

ADMITTED FROM			P/N
BOOKED FOR			
ADMISSION DATE	ADMISSION TIME	UNIT & NUMBER	
SURNAME (BLOCK LETTERS)	RELIGION:	DATE OF MARRIAGE	DATE OF BIRTH
FIRST NAME	FORMER NAME		PARA
ADDRESS	CHANGE: Y/N	DATE OF DELIVERY	
POST CODE			
N.O.K. NAME	DELETE WORDS INAPPLICABLE		
RELATIONSHIP	CONTACT NO:	DATE OF DISCHARGE	
ADDRESS			
INFECTIOUS DISEASES IN OR NEAR HOME		P/N APPOINTMENT GIVEN	

ADMITTED FROM: Home

BOOKED FOR: EMATT

ADMISSION DATE: 25/11/98

ADMISSION TIME: 2200

UNIT & NUMBER: Fitzroy

SURNAME (BLOCK LETTERS): DUNCAN

RELIGION: RC

DATE OF MARRIAGE:

DATE OF BIRTH: 7/12/71

FIRST NAME: Rachel

FORMER NAME:

PARA: GTC

ADDRESS: 1/1 [illegible]

CHANGE: Y/N

DATE OF DELIVERY: DATE-26/11/98 Time-0039.

POST CODE: G51

Emerg Lscs

N.O.K. NAME: [illegible]

DELETE WORDS INAPPLICABLE: M/F (A/S/NND)

PREM/FT

RELATIONSHIP: Mother

CONTACT NO:

DATE OF DISCHARGE: 30/11/98

ADDRESS: 120 Commonhead Rd. Coatbridge

INFECTIOUS DISEASES IN OR NEAR HOME:

P/N APPOINTMENT GIVEN: [illegible]

ROYAL MATERNITY HOSPITAL
GLASGOW G4 0NA

2106

CASE SHEET

ADMITTED FROM HOME			P/N
BOOKED FOR EMA			
ADMISSION DATE 12-7-98	ADMISSION TIME 15.00	UNIT & NUMBER HB11 00	
SURNAME (BLOCK LETTERS) [illegible]	RELIGION: C	DATE OF MARRIAGE	DATE OF BIRTH [illegible]
FIRST NAME [illegible]	FORMER NAME	[illegible]	PARA 010
ADDRESS [illegible]	CHANGE: Y/N	DATE OF DELIVERY	
POST CODE G69			
N.O.K. NAME [illegible]	DELETE WORDS INAPPLICABLE M/F A/S/NND PREM/FT		
RELATIONSHIP [illegible]	CONTACT NO: [illegible]	DATE OF DISCHARGE	
ADDRESS [illegible]			
INFECTIOUS DISEASES IN OR NEAR HOME		P/N APPOINTMENT GIVEN	

ROYAL MATERNITY HOSPITAL 2050
GLASGOW G4 0NA

CASE SHEET

ADMITTED FROM HOME P/N

BOOKED FOR GEMH

ADMISSION DATE	ADMISSION TIME	UNIT & NUMBER	
6-7-98	20-00	11/6440	
SURNAME (BLOCK LETTERS)	RELIGION:	DATE OF MARRIAGE	DATE OF BIRTH
MACKINNON	C		7-12-78
FIRST NAME	FORMER NAME		PARA
DONNA		SINGLE	0+0
ADDRESS	CHANGE: Y/N	DATE OF DELIVERY	
160 ALMA ST			
GLASGOW POST CODE G4 9			
N.O.K. NAME	DELETE WORDS INAPPLICABLE		
K MILLER MOTHER	M/F A/S/NND PREM/FT		
RELATIONSHIP	CONTACT NO:	DATE OF DISCHARGE	
MOTHER	HOME		
ADDRESS			
187 COWCADDENS RD GLASGOW			
INFECTIOUS DISEASES IN OR NEAR HOME		P/N APPOINTMENT GIVEN	
NONE			

ROYAL MATERNITY HOSPITAL
GLASGOW G4 0NA

3178

CASE SHEET

ADMITTED FROM: HOME — P/N:

BOOKED FOR: GRMTY

ADMISSION DATE	ADMISSION TIME	UNIT & NUMBER
21·10·98	21·40	A16/100

SURNAME (BLOCK LETTERS)	RELIGION:	DATE OF MARRIAGE	DATE OF BIRTH
SULLIVAN	RC		7·12·72

FIRST NAME	FORMER NAME		PARA
DEBORAH		SINGLE	0+0

ADDRESS: 160 MAIN ST
BAILLIESTON
CHANGE: Y/N
POST CODE: G69 6HU

DATE OF DELIVERY:

N.O.K. NAME: KATHLEEN SULLIVAN

DELETE WORDS INAPPLICABLE
M/F A/S/NND
PREM/FT

RELATIONSHIP: MOTHER
CONTACT NO: 771-3401
DATE OF DISCHARGE: 24/10/98

ADDRESS: 187 COMMONHEAD S
LANARKSHIRE

INFECTIOUS DISEASES IN OR NEAR HOME: NO

P/N APPOINTMENT GIVEN
DATE

NEWHILLS MEDICAL PRACTICE
EASTERHOUSE HEALTH CENTRE
9 AUCHINLEA ROAD
EASTERHOUSE
GLASGOW
G34 9HQ

Tel: 0141 531 8170
Fax: 0141 531 8167

DR A COLE
DR F COLLINS
DR E BROWN
DR J GOLDIE
DR K LINDSAY
DR C CAHILL

22nd June 1998

Sister in Charge
Labour Ward

Dear Sister,

Deborah Sullivan
160, Main Street
Baillieston
DOB 7.12.72

Thank you to see this 25 year old woman who is

however and she is vomiting
frequently and has diarrhoea
approximately 3-4 times per week.
She is passing less urine

Thank you for seeing her,

Yours sincerely

Anne Reid

THE GLASGOW ROYAL MATERNITY HOSPITAL
ROTTENROW GLASGOW G4 0NA

DISCHARGE SUMMARY

CONSULTANT: DR MARY RODGER — HOSPITAL No: A161100

SURNAME: SULLIVAN — FIRST NAME: DEBORAH

ADDRESS: 1/1 160 MAIN STREET BAILLIESTON G69 6AH

DATE OF BIRTH: 07.12.72 — PARITY: 0+0 — BLOOD GROUP: A Rhesus Positive

DATE OF ADMISSION: 25.11.98 — DATE OF DISCHARGE: 30.11.98

GENERAL PRACTITIONER	copies to:
Dr F. Collins Easterhouse Health Centre 9 Auchinlea Road Glasgow G34	

Ante-natal Progress

Seen at 8, 16 and 19 weeks with threatened miscarriage. Admitted at 22 weeks with abdominal pain and vomitting ? due to gastroenteritis. She was transferred to GRI for further investigations.

Labour

Admitted in spontaneous labour. Prolonged fetal bradycardia and thick meconium at 7cms dilated.

Mode of Delivery
Indication: Emergency LUSCS — Date 26.11.98 — Gestation 41 weeks
Presumed fetal distress

BABY: Sex Female — Weight 3.41kg — Apgar 9/1 10/5
Progress Required oropharyngeal suction for meconium.

Breast feeding

Feeding Breast/Bottle : Guthrie Yes/No — date : Dismissal Wt.
Adm. S.C.B.U. Yes/No — Follow-up G.R.M.H. Yes/No

Puerperium Uncomplicated

Anti-D: No
Rubella Vaccine: No
3rd day Hb.: 10.3g/dl
(discharged on ferrous sulphate)

Contraception Discussed

P/N Appt: Place: Easterhouse H'Centre — Date: 8.1.99 at Time: 11a.m.

Comment and recommendations:

Baby noted to have grade 3/6 pan systolic murmur. For cardiac review in 2 weeks.

Dictated 7.12.98.
Typed 8.12.98

Signature ..... date .....

Status ..... Dr Jane Richmond, Registrar

MR/MM/A161100

Dictated24.4.98
Typed 28.4.98

Dr F. Collins
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34

Dear Dr Collins

MS DEBORAH SULLIVAN DOB 07.12 72
1/1 160 MAIN STREET BAILLIESTON G69 6AH

Thank you for referring this woman for booking. She is currently 10+ weeks pregnant giving her an EDD of 18.11.98.

She has requested alphafetoprotein estimation, and requires a postnatal smear.

I would be grateful if you could share antenatal care and I will see her again towards the end of her pregnancy.

Yours sincerely

Dr Mary Rodger
LOCUM CONSULTANT

GREATER GLASGOW
COMMUNITY AND MENTAL HEALTH SERVICES
NHS TRUST

Our Ref.

Your Ref.

If phoning ask for

Dear Deborah.

We are concerned that you did not attend for your antenatal appointment at The Health Centre today.

A new appointment has been arranged for you on Friday 24th April at 10.00

If this is not suitable please phone 531-8100.

Yours sincerely

(midwife)

0370787

Hospital use Only | Clinic Rheumatology | Day Date Tue 14.4.98 | Time 11.00 | Hospital No. N/T | GP112

REQUEST FOR OUT-PATIENT CONSULTATION
THE INFORMATION IN THIS SECTION MUST BE COMPLETED

Appointment Category: Routine ☐ Soon ☐ Urgent ☐

Hospital GRAH Date 29/3/98 CHI No. 0712772612Y

Please arrange for this patient to attend the Rheumatology clinic of Dr/Mr

PARTICULARS OF PATIENT IN BLOCK LETTERS PLEASE

Patient's Surname SULLIVAN Maiden Surname 1 APR 1998

First Names DEBORAH Single/Married/Widowed/Other

Address 160 MAIN ST 1/1 BAILLIESTON Date of Birth 7/12/72

Patient's Occupation

Postal Code G69 6AH Contact telephone number

Has the patient attended hospital before? (YES) NO If "YES" please state:

Name of Hospital GRI

Year of attendance 1989 - 98 Hospital No. 964876K

If the patient's name and/or address has/have changed since then please give details:

Can patient attend at short notice? YES / NO

If YES, minimum notice required ..... days

Name, Address and Telephone number of MEDICAL / DENTAL PRACTITIONER

DR. F. COLLINS
STEPHOUSE HEALTH CENTRE
6 AUCHINLEA ROAD
GLASGOW G34 9HQ
TEL: 0141 531 8170

46451

Please use rubber stamp

8+ NOW

I would be grateful for your opinion and advice on the above named patient. A brief outline of history, symptoms and signs is given below:

LMP - 31/1/98 Para 0+0

Clinical history:

1996 - Cholecystectomy + appendicectomy

Long hx of abdominal pain + vomiting c/f cyclical.

Extensive investigation

c/f Dysfunction Syndrome

MS SULLIVAN
Dte DEBORAH
1/1
Pri 160 MAIN STREET
BAILLIESTON

A161100

07121972

G69 6AH

X-ray (women of childbearing age). Date of first day of L.M.P.

Relevant X-rays available from: No. (if known)

Signature

355-2104

Glasgow Royal
Maternity Hospital
RottenRow
Glasgow G4 ONA

Switchboard 0141 211 540
Direct Dial
Fax-Number

• Glasgow Royal Infirmary •
• Glasgow Royal Maternity Hospital •
Canniesburn Hospital •
• Lightburn Hospital • Belvidere Hospital •

Dear Doctor,

Name ..... MS SULLIVAN DEBORAH 1/1 A161100

Address ..... 160 MAIN STREET BAILLIESTON 07121972 G69 6AH

This woman was seen at Daycare on 4/6/96

Diagnosis Threatened abortion bottom, abdominal pain

Treatment US → FHC Bld Gp A POS. HVS

Future Management Hair Analysis Return ↑ 1 pm / bleed

Follow-up Arrangements As before

Yours sincerely

Midwife/Senior House Officer

THE GLASGOW ROYAL MATERNITY HOSPITAL

Questionnaire for Stage 1 — to be completed by Medical Records Staff

Name of Patient _____ Date of Birth _____

Casesheet No. _____

Question 1

Have you
(has your husband)
(has your mother)
(has your father)
been living in the UK for the past 12 months?

NB Absences of up to 3 months duration should be disregarded.

If answer is YES, tick 'Not Liable' box - no further questions.
If answer is NO or not clear, go on to Question 2.

Question 2

Are you
(is your husband)
(is your mother)
(is your father)
going to live in the UK permanently?

If answer is YES, tick 'Not Liable' box - no further questions.
If answer is NO, tick 'For Stage 2' box and ask:

Question 3

On what date did you
(your husband)
(your mother)
(your father)
arrive in the UK?

Enter earliest of these dates in box. Enter date of Stage 1 interview.

Not Liable	✓	Date of patient's / spouse's / mother's / father's arrival
Liable		
For Stage 2		Date of interview

Entries should be deleted, or new boxes made available, when a patient returns for new episode of treatment.

NB QUESTIONS REGARDING MOTHER OR FATHER ONLY RELEVANT TO UNMARRIED PATIENTS.

Height:	Ethnic group:	SURNAME	UNIT NUMBER
Blood group:	Maiden Name		
Xray Pelvimetry Result:	Date:	FIRST NAMES	
		DATE OF BIRTH	
		Addressograph Panel	

CONTRACEPTION	Date			
Type	From	To	Recommended/ Supplied by	Comments
Microgynon 30 ED Nil.	1991	Sept 1997	GP.	

MASTER PROBLEM LIST (Non-Obstetric)

Date Entered	Problem No.	Active Problems	Date Entered	Problem No.	Inactive Problems

BOOKING ARRANGEMENTS		
ANTENATAL CARE	Tick	Note
Specialist Hospital Clinic		
Consultant		
Other Clinic		
Shared Care		
General Practitioner		
Consultation Only		

DELIVERY		
Specialist Hospital		
Consultant Only		
Other Hospital		
Domiciliary		
Early Discharge		
Previous Booking		

POST NATAL EXAMINATION		
Specialist Hospital		
Other Clinic		
General Practitioner		

SURNAME

UNIT NUMBER

FIRST NAMES

DATE OF BIRTH

ADDRESSOGRAPH PANEL

HOSPITAL

GLASGOW ROYAL MATERNITY

WARD

CONSULTANT J.R. ~~Heath~~ Rafael

EASTERHOUSE A.N.C

ADMISSION AND DISCHARGE DATA

MOTHER ADMITTED			DISCHARGED			TO ATTEND	
Date	From	To	Date	From	To	Clinic	Date
ANT							

SUMMARY OF PRESENT PREGNANCY

		LABOUR AND DELIVERY				INFANT			
Date	Place	Gest.	Onset Sp/ind	Dur. Hrs	Mode of Delivery	Sex	Weight	LB/SB 1st week Death	Name and Unit No.
26/11/98	GRMH	T+	emerg		LUSCS	F	3-4/4g	LB	

SUMMARY & COMPLICATIONS:

emerg LUSCS - fetal bradycardia + meconium

Feeding

CLINICO PATHOLOGICAL CLASSIFICATION OF PERINATAL DEATH

NAME: Debach Sullivan

UNIT No.: A161100

AGE	HEIGHT
25	1.75.
PARITY	LIVE CHILDREN
OTO	—
Yrs MARRIED	BLOOD GROUP
	A Pos.

E.D.D. 18/11/98

ANTENATAL

SPECIAL FEATURES	RECOMMENDATIONS
	Shared care ? planned
	early discharge.
Primiparous	Midwife

Last Menstrual Period: 31-1-98

		Loss	Duration	Onset
Certain	☑ Normal	☐	☐ Normal	☐ Normal
Uncertain	☐ Light	☑	☑ Shorter	☑ Late
Approx	☐ Heavy	☐	☐ Longer	☐ Early

Usual Cycle: Irregular since stopping OC pill

Bleeding since L.M.P.: NO.

Stopped Pill on: Sept 97.
Was L.M.P. withdrawal bleed? NO.

COMMENT

For Sterilisation

PPS ☐

Interval ☐ Signature

Vasectomy ☐

PREVIOUS MEDICAL HISTORY

Operations	Date
Appendicectomy	GCT
Cholecystectomy	GCT
Tonsilectomy	Galtrees

Anaesthetic difficulties: NO

Blood transfusion: NO

Allergy: None known

Steroid therapy: NO

Rheumatic Fever: NO

Heart Disease: NO

T.B.: NO

Diabetes: NO

Disease of urinary tract: NO

Psychiatric disorder: NO

Thromboembolism: NO

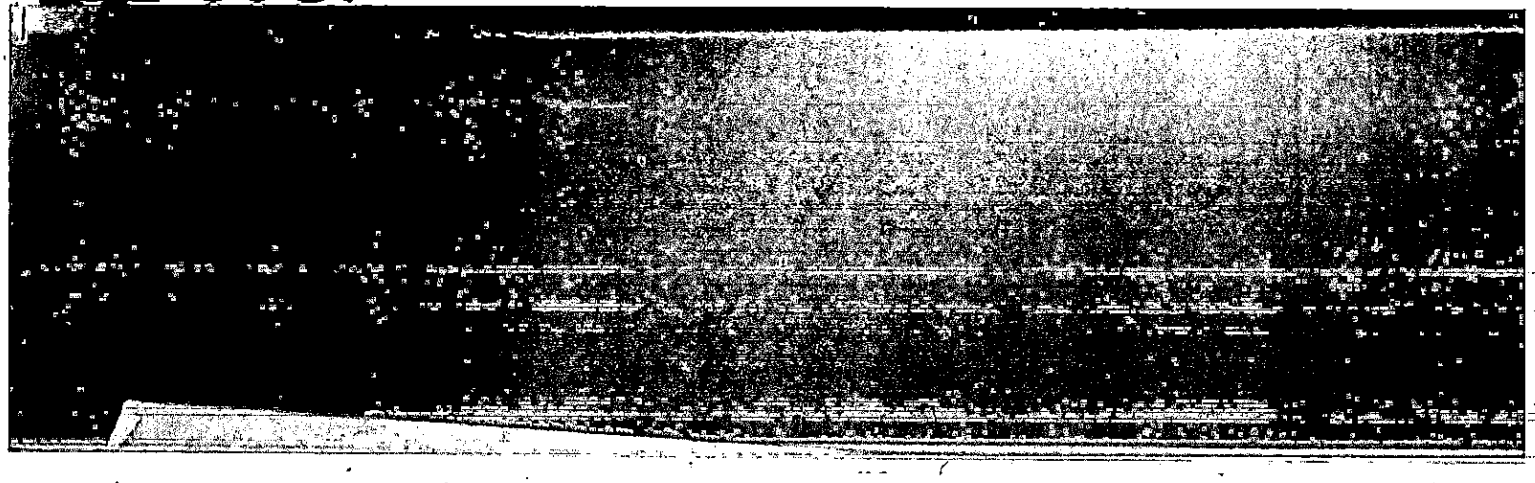
Other: jaundice - NO

Other: epilepsy - NO

FAMILY HISTORY

		RELATIVE
Hypertension	Yes	father.
Diabetes in 1° relative	Yes	Mother
TB contact	NO	
Genetic disorder	NO	
Other/Comment		
Twins in 1° relative	NO	

Smear Results	Date
Borderline for repeat this yes	1997



HISTORY OF PRESENT PREGNANCY-Date.....

Smoking History ☐

Never 0 Current 1

Former (2) N/K 9

Smokes.....per day

Stopped at beg of pregnancy (date)

Vaginoea NO

Cough NO

Vomiting Yes

Other

Intention for Infant feeding

Breast ☐

Bottle ☐

Undecided ☑

ROUTINE PHYSICAL EXAMINATION

General Examination

Breasts Teeth

Varicose Veins NO

Teeth Attend dentist.

CVS Pulse Resp Breath Sounds

Murmurs Adventitiae

Abdomen

P/V Uterine Size in Weeks

Other

DRUGS (Other than In-patient)	Dose, Frequency and Route	Initiated by			From	To
		Clinic	G.P.	Patient		
Folic Acid	x 1 daily		✓			

INVESTIGATIONS INITIATED AT FIRST VISIT

HB	✓	A.F.P. To be arranged	Other
Blood Group	✓	Smear	
VDRL	✓	Scan 7/4/98	
H.A.I. (Rubella)	✓	MSSU	

HUSBANDS' GENOTYPE

Date Blood taken

Result

DATE	WEIGHT	B.P.	Urine		Oedema	Wks. Preg.	Fundal Height	Date when F.M. first felt:	
			Alb.	Sug.				Position & Level	F.M./F.H
7/4/98	D/C	96/58	Cl	Cl	nil	9+3	/	by u/s	F.M by u/s
14/4/98	76	100/80	NOSpec.	nil.		9-10.			
24/4/98			NOSpec.	/		10+			
29.05.98	Daycare	—	—	—	—	16wks			
4/6/98.						16+			
18/6/98	Daycare	—	Cl.	Cl.	Nil.	19wks	=Date	dbd. soft.	ul

/EIGHT	B.P.	Urine		Oedema	Wks. Preg.	Fundal Height	Date when F.M. first felt:	
		Prot.	Sug.				Position & Level	F.M. /F.H.
	105/58				19	=		
	Admitted to LW - D.V							
	100/60	NoSpec		nil	20	=0	SCM	fmf fhh cephe
	110/70	NoSpec		81/81.	28+	=	Ceph.	fmf fhé cephe
	120/70.	C	HH	TV/TV.	37	=0	Ceph	fmf fhh
	120/70	C	C	+/+	38	38	Ceph 4/5	fmf fhh
	130/80	Tr	C	+/+	39+	=0	Ceph 2-3/5th	fmf fhh cephe

NAME

UNIT Number

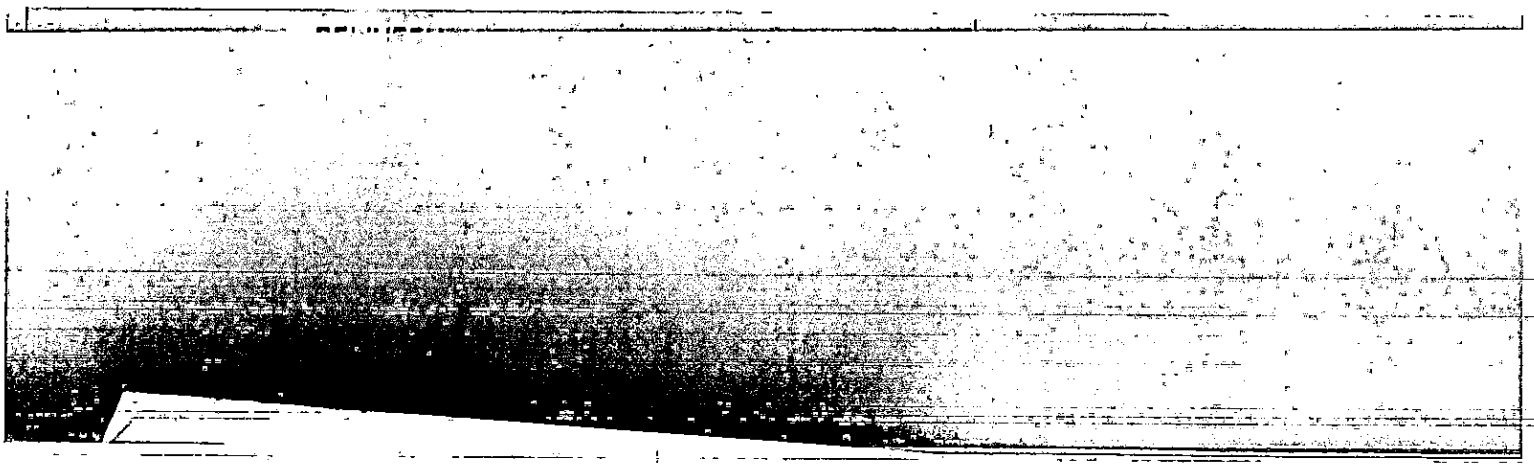
Comment on General Health etc.	Return weeks	Examined by	Investigation and Results
Seen C Hx of ~~brownish~~ brownish D/C PV - had fall 2wks ago PV bleed. Scan → Post. placenta not low Assured pt. Plan (A) FT		Her (SHO). SLOAN	HVS, LVS ✓ Rpt LFT's ✓ Hep screen next visit
s in GP. Tx acc antibiotics e-fo ? gastroenteritis Ch better GI symptoms ↓ abx on Zantac abdo soft Ut = dates ↓ review 2wks m'wives Fuks MR		Haywards	FOBT x 2 CONS.
1. No further GI upset. 2. No GI symptoms. Fmn. PV bleeding since Mon. after PIn arranged by GP Hosp		(8)	Parentcraft arranged ✓. Richard Rumens (SPR)
1 Plan Rpt Rec and 2 random glucose.	1.	LO	Pl. RBS Loughwood
0	(1)	EN	RBS - no specimen received at lab Rpt RBS + HbA1c obtained
1	1	LO	placed PV RBS result: no specimen received @ lab

ENT'S NAME UNIT Number

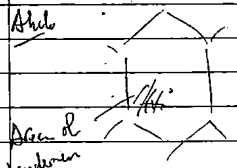
Results found 6/11/98 - 4.2.
30/10/98 5.2.

VEIGHT	B.P.	Urine		Oedema	Wks. Preg.	Fundal Height	Date when F.M. first felt:	
		Prot.	Sug.				Position & Level	F.M. /F.H.
	110/60	C	C	+/+	T+	=D	Ceph. 2/5th	

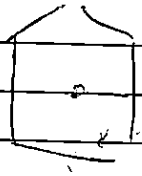
Comment on General Health etc.	Return weeks	Examined by	Investigation and Results
U. baby active v IOL at T+10 27/11/98			J Richard Greenwood (JRG)



Date and Time	ADMISSION NOTES Reason for Admission	IN-PATIENT NOTES
7/4/98 16:00	age: 25 P0+0 (9+2) 8+1 LMP: 31/1/98 K: 4 28 nauseated + faint present pains in both groins since Sunday, getting worse dysuria, frequency, last 2/7 bowels regular pos PDT 4/52 ago pains like period cramps on pill until 9/97 planned pregnancy pmh: appendicectomy lap. cholecystectomy 1985 OE: abd soft, upper tender no masses, kidneys not palpable imp: ? muscular ? bowel reassured to GP for booking	Rachel (Edbis) SHO

Date and Time	
4/6/98	0+0 at 16+6
0945	Fell down stairs last night bumping (R) lower abdomen on bannister. Attended Lightburn was told to attend Health centre today. Passed clot pr at 0500 slight clamp since. ° further bleeding ° sen
	Thank you - 16+6 Para 0+0
	Fell down c. 10 stairs last night.
	Direct abdo trauma to (R) flank
	% Pain over area of injury.
	Also had lower abdo cramps
	Passed 1x clot at 05°° - no bleeding since.
	PMH DH As below.
	°/s Well. Anxious. A PDS
	P 90 bpm
	Abdo  Sth °guarding °supraphic pain Area of mild tenderness
	Os closed.
	Spec - Healthy Cx, mild ectropion, green/white discharge -s HVS No blood seen
	Imp Threatened abortion
	Plan VS -> FH + .
	Allow home. Rest Analgesia.
	Return if ↑ pain / bleeding
	KBK FEBRUARY (Grad)

Date and Time	
	Daycare
18/6/98 14[25]	Asked to review 19
	25+0 Para 0[ND] ~~22~~/52 gestat[n]
	Hx of fall 2 wks ago + PV bleed
	Scan → FH+ve Post placenta.
	Today attended c Hx of brownish discharge PV.
	No abd pain / PV bleed.
	O/E BP 103/58 Undistressed



FHH = dates
Sz ~~ft~~ nt tender
FHH c Doptone

Spec VV(N) Cx(N)
White discharge seen
thrs. Urs ✓

Scan → FH +ve
Post placenta – NOT Low.

Plan Reassured pt.
Allow(IT)

Wen (STS).

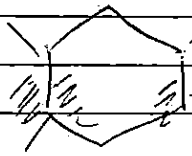
Date and Time

10/7/98
2110

Self Referral to hsp ↳ abdo pain.
(R) pmh ↳ 28/40 -

1/52 h/o (R)+(L) IF radiating to back. Commenced on Cephalexin by GP ? UTI.
Frequency & dysuria. Pain worse today. Intermittent
Vomited several times over last 3-4/7.
Diarrhoea for ~ 1/52.
Pain increased in intensity after vomiting today.
- FMs++ ° pv. loss
Previous admission ↳ 16+6 weeks after full
pmh: ~~visit~~ Cholecystectomy → Sphincter of Odd dysfunction → Vomiting + abdominal pains
drugs: Cephalexin
allergies: nil.

O/E/ Distressed. Pulse 72 BP 116/81. Apyrexial.

Abdo/ 
Abdo appears distended.
- Tenderness felt at umbilicus -
- Tender (R) + (L) IF + flanks.
No rebound / guarding.

BS - present. Dipstone FVI (+)

Imp/ ? UTI
± Gastroenteritis
Admit.

Plan/ FBC, UBSs, LFTs, Amylase.
IV fluids
IV Augmentin, IV Maxalon.
Analgesia.

G. Ferguson (SHO)

WCC 12.8
Hb 11.1
plts 229.

Na 130 TP 68
K 3.8 Alb 38
Cl 103 Bili 14
Bic 25 Alp 78
Urea 2.7 Ast 2
Ucr 260
Cr 65 Alt 19
Amy 190 GGT 8

DATE

CONTINUATION SHEET

18

17/7/98 Feeling better today
0830

T36·4°
NO diarrhoea this am has ever vomited
Continues on IVI - tolerated breakfast
abdo soft
Bilateral mild renal angle tenderness.

FOR MSSU
Repeat UKE (rdc ↑ GGT)
USS later this am
Continue IV antibiotics for 3 doses - ?
change to oral this pm.
TO stay in 'LW until diarrhoea settled.
- stool sample please.

Results

Na 135	Urea 1·8	Reg Alb 31	Alt 16	Plat 19
K 3·6	Urate 260	Bili 14	Cgt 68 *	
Chl 103	Creat 55	Alp 65	WCC 10·8	
Bic 27	Tot prot 59	Ast 13	Hb 10·3	

S/B Dr Shearer - Plan discontinue IVI, review. Left unsite

S Sutherland S/M

Patient's No.

CONTINUATION SHEET

AD - requesting further IM analgesia since admission at 2100 last night as had IM Pethidine 50mg
IM Buscopan 20mg IM
IM Morphine 10mg
IM Morphine 10mg
DF118 60mg
abdominal pain R+L lower quadrant radiating into back ; worse after eating
vomiting after eating
diarrhoea now settled
KINALYSIS NEG WCC (N)
E appreciated
P86 BP 100/60

Abdo soft, distended (apparently as been since cholecystectomy)
fundusfelt = dates
no rebound guarding
no renal angle tenderness
BS ✓ (N)

4x appendicectomy
cholecystectomy
GI dysfunction syndrome following extensive
g abdo pain - upper GI symps
st AxGT
my knee (N)

ient's Name	Unit Number

CONTINUATION SHEET

9/8 Feeling better today

T 36.4°
NO diarrhoea. Has an have ever vomited
Carries on IVI = tolerated breakfast
Abdo soft
Bilateral mild renal angle tenderness.

For MSSU
Repeat UFE (rdc ↑GGT)
USS later this am
Continue IV antibiotics for 3 doses - ?
change to oral mid pm.
To stay in LW until diarrhoea settled.
- stool sample please.

Edwards,

Na 135	Urea 1.8	Alb (Req) 31	Alt 16	Plat 19
K 3.6	Urate 260	Bili 14	Cgt 68 *	
Chl 103	Creat 55	Alp 65	WCC 10.8	
Bic 27	Tot prot 59	Ast 13	Hb 10.3	

S/B Dr Shearer - Plan discontinue IVI, venflon left insitu

Sampson S/M

Patient's Name	Unit Number
Deborah Sullivan	A161100

CONTINUATION SHEET

5 Abdo pain ? cause

D/w Dr Josephine, Tx further Mx analgesia
D/w surgeons

CA 2000
8470

Vomiting after taking meals
Tolerating oral fluids
Obs-v
Plan: - Zantac / oral buscopan to continue
- Keep on oral fluids only.

Josephine (Lei)

, 25 yr old poto at 22/40
Hx IBS & bile reflux post. lap. chole.
(N) anxiety. ↑ γGT - denies alcohol use.
Returned from Spain ½ ago.
Now = D+V.
Partner had diarrhoea earlier this week

Requi 1- IV fluids
2. Stool culture.
3. Buscopan ± pethidine

Thomas Lee

Patient's Name	Unit Number
Deborah Sullivan	A161100

CONTINUATION SHEET

IP
No diarrhoea for 24h.
Still vomiting
+/- abdo pain.

Copes v small amt food yesterday but
→ vomiting

Plan: continue current MX
- stool sample when available
- Stop Sandostatin: serology + next
review

Much improved
- (N) BM
- eating + drinking - no vomiting
No pain (PMF)

Keen for home.
⇒ home, ANC as planned.
- Return if SAP / probs.

SLOA (Sito3)

Client's Name	Unit Number

98 GP Referral to Labour Ward

Recently admitted w Vomiting, Diarrhoea + abdo. Pain.
10 days ago felt unwell (returned from Spain 1 week prior)
w symptoms of dysuria - given cephalexin.
Then had a 6 day history of
- bilious vomiting - worse after eating
x 3 today thus far
- abdo. pain - lower abdo., colicky
- no radiation
- some relief w defecation
- diarrhoea - no blood
- mucus + v. loose on Saturday - now more formed. Opened bowels x3 today
Prev. stool sample missing
Managing sips only
Not feeling pyrexic
No rigors
No evidence of jaundice etc.

indigestion + heartburn ++

Prev. double cystectomy w resultant bile reflux due to sphincter damage. Occas. vomiting pre-natally.
Prior to this illness normally was constipated - opening bowels x1 per week.
PMH of ~~Diverticulitis~~ Irritable Bowel Sy - prev. Fybogel use.
Prev on Losec now on Zantac.

Partner - one episode (24/7) of diarrhoea after eating a piece of dodgy chicken. No other symptoms

Patient's Name	Unit Number
Deborah Sullivan	A61100

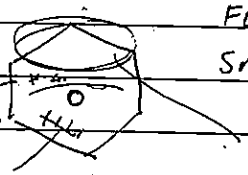
CONTINUATION SHEET

DH Zantac NUDA
Oral Stemetil

PMH IBS
Cholecystectomy
Appendicectomy
TTA.

SE nil.

OE Apyrexic Normotensive Urine Ketones tr.
Pregnancy Mask.
Fundus ✓
Sft Non Tender
No succussion splash.
Fullness in epigastric area
Bowel sounds present.



~~Appendicectomy~~

Imp ? Worsened Reflux 2° to pregnancy
? Constipation
?? Pyloric Stenosis → epigastric fullness.

Plan IV access
FBC, UE, LFT, Hepatitis screen
Stool culture
Stemetil, Analgesia
Abdo. Films
USS Liver

Jones Mrs
Sheena Jones

Patient's Name	Unit Number

CONTINUATION SHEET

Sx since 5pm.
- Hx as before.
No signs of obstruction. } => no indic^ for AXR
Observ OK.

for IV fluids
IV-Ranitidine
Observ
Urgent Stool Sample → Lab.

If no better more alk Surgeon (Dr Imrie did he ref) to review.
Awaiting results. Mackerras (Cons)

Na 130	Tot Prot. 71
K 3.7	Alb 38
Cl 102	Bil 18
Bic 25	Alp 85
urea 2.0	AST 15
urate 270	ALT 15
Creat 60	Cgt 59

Mackerras

23 wks
Still suffering pain
vomiting
moved bowels today - formed but soft
Firey papular rash on face -

Patient's Name	Unit Number

do soft. Looks distended
urdus = drakes
No generalised tenderness. Tender suprapubically

Cause of pain = no obvious surgical cause
rash associated - check for SLE ✓
Papulynia ✓
Tm Analgesia
Get AAST upoc result if -ve → surgical opinion
Dermatology opinion

R Wilson
registrar

Contacted Mr Carter's secretary - Mr Carter on holiday
advised that it would be better to contact Surgical
receiving team. D/W Surgical SWO - Iain Cameron - Receiving
team will Review Cefalexin (given)
Still c/o abdom pain - colicky in nature. Bowels have
opened today - soft but formed, not discoloured
No urinary symptoms.
Still vomiting
O/E. Distressed. Marked acne rosacea. Hyperventilating.
Abdo distended but no guarding.
Awaiting surgical review but no clear diagnosis

C Brown
(Cons)

Patient's Name	Unit Number

CONTINUATION SHEET

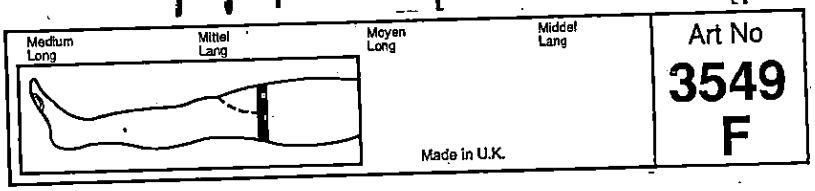
8 Results phoned: Na 136 Urate 250 Tot. Prot. 67
K 3.9 Bili 16 Alb. 37
Chl 107 GGT 52
Bic 22 AST 12
Urea 1.6 ALT 10
Creat 55 ALP 75

Nancy Todd midwife

18 10³⁰ Phone call from Surgical SHO Jan Cameron - could Mrs Sullivan be transferred to Ward 60. I think this would be OK but when I spoke to Mrs Sullivan she is not happy for this because of him she feels about her previous treatment there - she felt "no-one was interested" and was upset by someone who said the pain was all in her head. She requests to be reviewed here.

R Holloway

11.50 Fitted prophylactically c TED stockings.



S. Dive
(Sen II Physio)

Discussed situation with Mr Simon, Consultant Surgeon GRI. He feels investigation would be more appropriate at GRI and viewed by gastro-enterologist could be arranged: they will hold on to her meantime and either discharge home or transfer to Rotherham. Discussed with Mrs Sullivan: she agrees to be transferred to Ward 60 at GRI

C Coleman (Con)

Patient's Name	Unit Number
Deborah Sullivan	A161100

CONTINUATION SHEET

25 yr old ♀, Para $^{0+0}$, at 36/40 wks
Admitted in ? Early Labour.

C: H/o Ut. contractions for past 4 hrs.
Getting stronger & more frequent now.
Low back ache.
No H/o ROM / Show.
Plenty of FM.
No bladder / bowel disturbance.
H/x: Cholecystectomy - 2 yrs ago
Irritable bowel syn.

Rx: Zantac.

Allergies: NKDA.

E Pt. looks distressed.
Afebrile.
Not anaemic.
P/A - Soft.
Ut. activity +.
Cephalic 3/5.
P/v - Cx posterior.
Soft.
Os admits tip of finger.
Vx at 0^{-2} station.
A - ? in Early Labour.

Plan:- CTG.
Admit in wd. 8 for observation

ient's Name	Unit Number
Deborah Sullivan	A 161100

Registrar (SHO)

CONTINUATION SHEET

WR 3671

Slept all night after Diamorphine
Y/O VIA 1mls awake
Plenty FM
Uterus contracting. Soft mbetween
Cph free

For VE when required analgesia
Cph please.
ATS re: PCA and requiring analgesia
VE - Cx posterior, 1cm long, 1cm dilated
V_x -2
plan oral analgesia
IM if necessary

Filed
Maternity
(Spare)

A. Ryong (CSHR)

Asleep
comfy.
Can go home later today -

ALEXANDRA (JHR)

1430
Asked to see
c/o backache since 3AM this am
Some suprapubic pain = bladder
Urine < 20mls.
Nil else.

3 SULLIVAN A161100
EBOPAR
/1 07121972
50 MAIN STREET
ATLLIESTON GOS GAH

Unit Number

CONTINUATION SHEET

16 Aspo Soft
Cap 4/5 palpable

16 → Cx posterior
1cm long
Soft
Admits a fingertip.
Vx -2 — No change in cervix since 22/10/98.

Can go home if wants to this pm.
To pass to discharge
for ARC a please on 30/10/98.
Advised to return if pain ↑ / show or
PV bleeding.

J. de Vries
Intern
SHO

ESP: c/o ++ abdo pain despite coradamol + temazepam

A 16 Aundii = dates. CTG reactive
cephalic 2-3/5. many LOC due to FM
FM +.

E Cx very posterior, 1-2cm long admits
fingertip
Vx 0-1cm

MP: ndr in established labour, patient reassured

ient's Name	Unit Number

CONTINUATION SHEET

8 Pain settled
Uterus soft, non-tender
FMs ✓
Keen to go home - agree.
Hs aff NAC 30/10/18

SpR

30+.
Readmitted with ↑/o backache since this morning.
Onset of abdominal pain - irregular since 18⁰⁰
Pain now every 7-8 mins. ↑/c backache.
Fetal movement +++
°Sham SROM.

O/A. Slightly distressed with mild abd pain.
Dramboed x4 since 18⁰⁰ settled at present.

T36.3 P80 BP 113/67.

O/E fundus = dates long lie cephs pres HS palpable
CTG reassured + Reactive.

Drugs Zantac x 2 daily.
Paracetamol as required.

MS SULLIVAN A161100
DEBORAH
07/12/1972
C/O
100 MAIN STREET
BALLYMOTOR CO9 6AH

Unit Number

CONTINUATION SHEET

V.E. Cx posterior 1cm thick 1-2cm dilated
Cephalic at 0-2 station.

Self referral from home with
history of contractions since
3°° hrs @ 4/0 backache
SLOW OSEOM

IM ~~ek~~ AS before.

SH - N.K -

GS pregnancy several admissions with
bleeding PV.
Settled since July 1998.

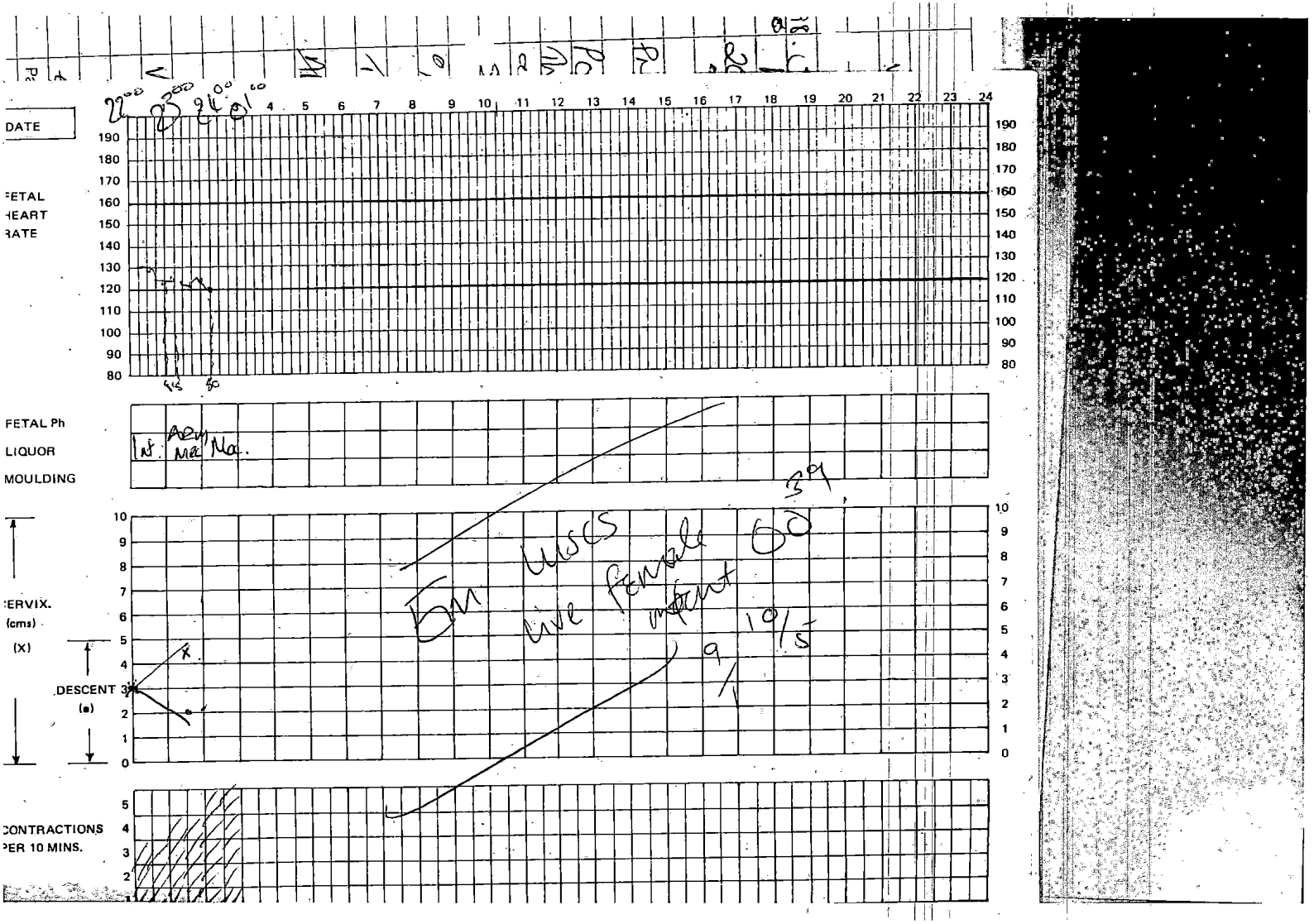
A distressed. contracting every 5 mins

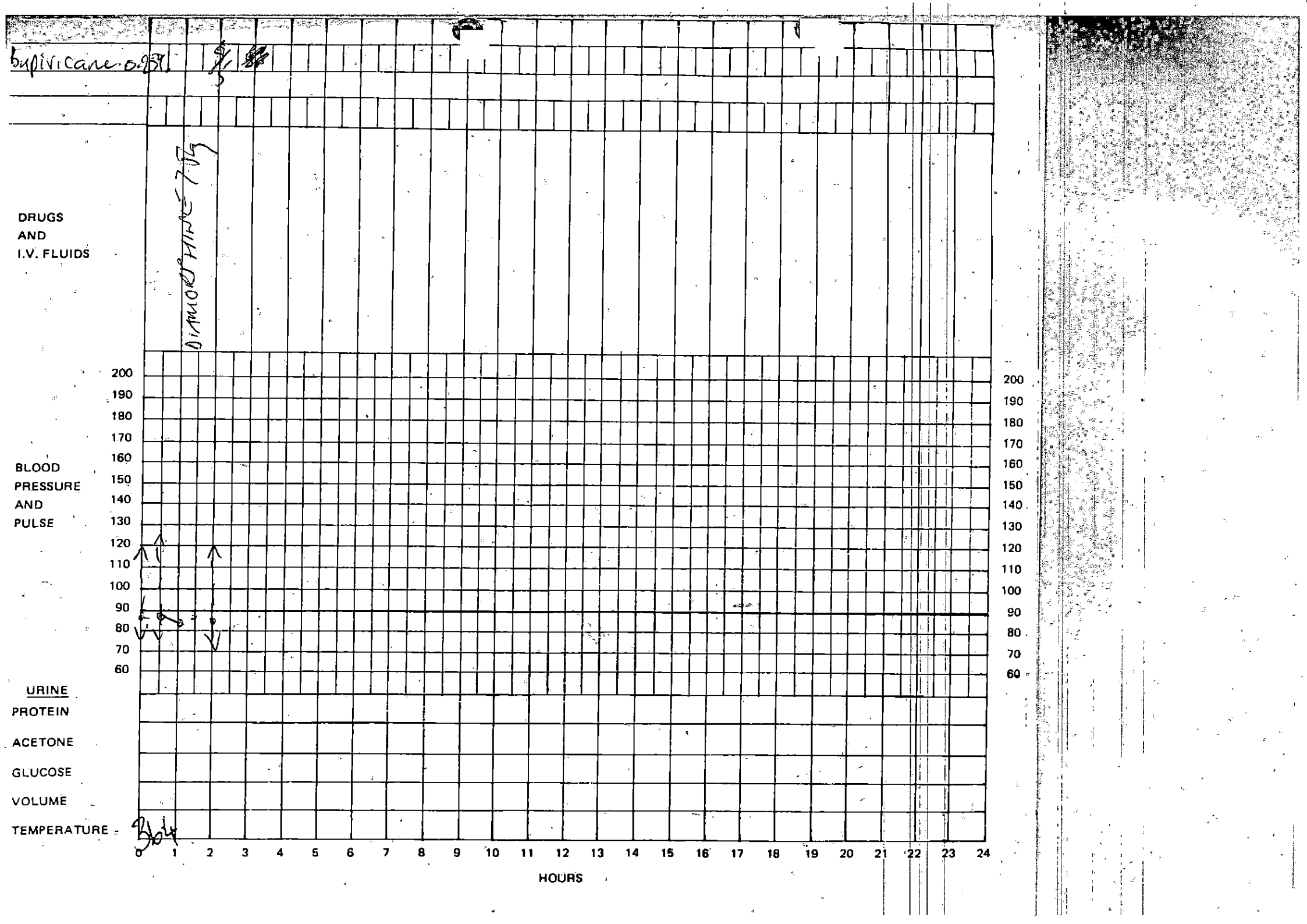
36·6 ?89 BP 131/85

xd Palp fundus. dated
long lie
cephalic pres -
Vx 3/5 palp.

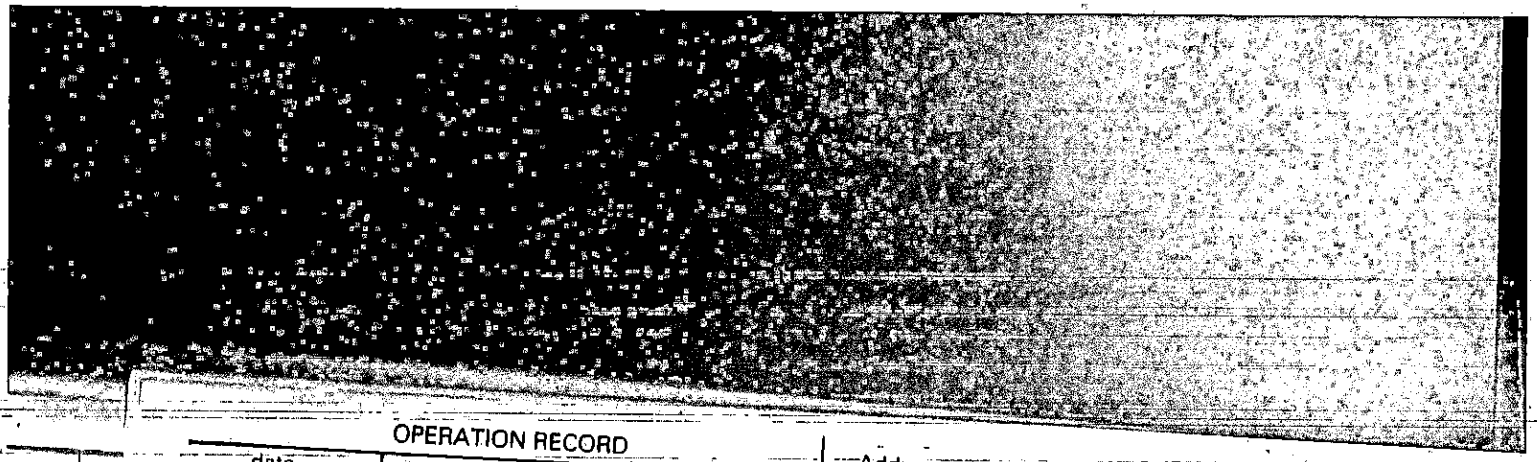
E to assess Cx and uterine
2-3 cm dilated.
forewaters felt. cephalic 0-2. station.
Early labour - PV IM analgesia. Fwcokg

ient's Name	Unit Number


DATE
FETAL HEART RATE
FETAL Ph
LIQUOR
MOULDING
CERVIX. (cms)
(X)
DESCENT (●)
CONTRACTIONS PER 10 MINS.
Int. Mal.
LUSCS
Live Female infant
10/7
9/1


bupivicaine 0.5%
DIAMORPHINE 7.5mg
DRUGS AND I.V. FLUIDS
BLOOD PRESSURE AND PULSE
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
URINE
PROTEIN
ACETONE
GLUCOSE
VOLUME
TEMPERATURE
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24
HOURS

Date	Time	Progress Notes
25/11/98	2345	ATS c/c Head hurt background. Pain Jaws c/o. excellent mobility Neck c/o VE/ 4-5cm ϕ LOT SP-1 ARM - Mechanism FSE explained Subsequent c/c satisfactory. → expedite management SC SP. Reg
26/11/98	0030	ATS Pulse bradycardic ~ 50 bpm 8-10 min VE/ I. Stretton Jones Thinks Normal → L/S Mrs J. Keeble SC



OPERATION RECORD

date	time of delivery	Addressograph label
26/11/78		

Authorised by	Status
T. Kelly	

Surgeon: S. Crowell | Assistant: E. Stenton | Sister:

Nature: Emergency LSCS

Reasons in order of importance: Fetal bradycardia + Meconium

- Cathetes
- entry via low transverse incision
- transverse lower segment entry
- baby easily delivered
- Placenta by CCT
- Layered closure in two layers
- Haemostasis excellent
- Repaired Abdomen in layers.

c VoM, S/C V:M to ohs.

NBL. 270 ml in Amps.

Cord & subs. ok ✓

Vulval

Antibiotics ✓

Instructions: To Enoxaparin

Swabs checked by

Signature

MS SULLIVAN A161100
DEBORAH
1/1 07121972
160 MAIN STREET
BAILLIESTON G69 6AH

ASGOW ROYAL MATERNITY HOSPI

uction:
- None
- Oxytocics
- ARM+Oxytocics
- Prostaglandins (including Cervical priming)
- Prostaglandins+Oxytocics
- Prostaglandins+ARM+ Oxytocics

Most senior midwife present at delivery:
- No Midwife present
- Sister
- Staff Midwife
- Student Midwife
- Not known

algesia/Anaesthesia:

ring Labour	During Delivery
None	
Opiate (including diamorphine)	
Epidural	
Spinal	
Gas & Oxygen (only)	
General Anaesthesia	
Other	
Not known	

Most senior doctor present at delivery:
- No doctor present at delivery
- Consultant
- Senior Registrar
- Associate Specialist/ Non Training Grade
- Registrar
- GP
- SHO
- Not known

esentation at Delivery

Baby	1	2	3
cipito-anterior			
cipito-posterior			
cipito-lateral			
eech			
ce/Brow			
oulder			
rd			
her			
t known			

Episiotomy

Tears:
- No (includes intact perineum & unsutured lacerations)
- Tear 1st degree
- 2nd degree
- 3rd degree
- Vaginal Laceration
- Cervical Laceration

erilisation following delivery:
- paroscopy
- parotomy
- erilisation with Caesarean Section
- her method

Named Midwife transfer to Consultant:
- No transfer
- Transfer in Ante-natal period
- Transfer in Labour Ward
- Transfer in Post-natal period
- Transfer back to midwife care

te-natal steroids given Yes/No

LABOUR AND DELIVERY

Mode of Delivery: EM-LWSCS 26/11/98 0039

Presentation at Delivery: Vx

BLOOD LOSS: 300ml

Start of Stages	Date	Time	Length (Hrs)
First	25/11/98	2000	
Second			
Third			
End of Third		0039	0

Incomplete

Fetal Distress — 1st Stage — 2nd Stage

Meconium
Bradycardia: Baseline
Type I ✓ ✓
Type II
Tachycardia
Irregularity

PLACENTA — WEIGHT 440g.

Delivery: Controlled Cord Traction / Manual Removal / Other .....

Complete	✓	Membranes	
Incomplete		Complete	✓
Doubtful		Incomplete	
Retroplacental Clot		Doubtful	
Calcification		Nearest point of rupture to placenta	cm.
Infarction			
Other			

Cord Length: Adh cm. — Nuchal Cord ☐

No. of Vessels: Three

Insertion Type: Central

Abnormality: none.

Episiotomy
Laceration
Sphincter inv.

Suture and Vaginal Swab Check by (Signature)

Suture Material

No. for Removal

Oxytocic drugs at delivery	Dose

INFANT SUMMARY

SEX: Female

WEIGHT (g): 3.41kg

Time 1st resp.

Time sust. resp.

APGAR	1	5	10
Heart Rate	2	2	
Respiration	2	2	
Muscle Tone	2	2	
Reflexes	2	2	
Colour	1	2	
Total	9	10	

RESUSCITATION

		Remarks
Nil (inc. clearing airway, Mask, O_2)	✓	Labour ward
Mask and IPPV		cord →
Intub & IPPV (no drugs)		emergency
Intub & IPPV (with drugs)		c-section for
Drugs only (Specify)		fetal distress
Other		+ meconium
		Stacey
Transfer to Ward		
Transfer to Special Nursery		Cord immediately

Urgently on delivery → suction under direct vis → meconium in oropharynx, none below cords. Facial O_2 only. Baby well. At 5 min pink, regular resp, no evidence resp distress. Vitamin K given.

Plan:- stay with mum on PNW. Any problems please contact P.D.

O.F.C. C.R.L.

Cord blood taken ☐ HVS ☐

Maternal Recordings after Delivery

Temp. 36.8 B.P. 120/80

Pulse 80

Delivered by Dr Crawford (S) FM Hogan (P) Dr Stenhouse (A) M Brown (D)

Supervised by

Resuscitated by A Turner (SHO)

OPERATION RECORD

Addressograph label

date	time of delivery
26/11/78	

Authorised by	Status
T. Kelly	

Surgeon	Assistant	Sister
S. Crawford	S. Stenhouse.	

Nature: Emergency LSCS

Reasons in order of importance: Fetal bradycardia + Meconium

- Cathetes
- entry in low transverse incision
- transverse lower segment entry
- baby easily delivered
- Placenta by CCT
- Repaired uterus in two layers
- Haemostasis excellent
- Repaired Abdomen in layers.

± V of M s/c V:M to obs.

Est. BL. 270 ml in Aneps.

Counts, swabs etc ✓

Vol Mat ✓

Antibiotics ✓

To Enoxaparin

Instructions: S Lund

Swabs checked by

PUERPERAL RECORD

CONTRACEPTION

Discussed ✓

Method Decided

FOLLOW-UP

Postnatal Clinic E.H.E. ✓

G.P.

F.P.C.

Appt. made ✓

Date: 8/7/99 @ 11-AM

RECOMMENDATIONS

Anti-D

Required 0

Given

Rubella Vaccine

Required 0

Given

INVESTIGATIONS BOOKED

Pelvimetry

I.V.P.

G.T.T.

FBC

Hb.

Mode of Delivery

Date	Progress Notes	Baby
28/4/88 11[00]	UCC 11·8 Hb 10·3 Plat 200 Krishnamurthy	
3d/11/88	wishes to go home well Hb 10·3 started a ferry ~~went~~ wants Mrs Khan	

FINDINGS:

WEIGHT:

DELIVERY AND POST NATAL

Special Features	Recommendations	NOTES FOR PAEDIATRICIAN
Loc. Breast feeding Initiation		
POST natal smear.		

POST NATAL RECORD Date: 8/1/99

Infant: well Name: Cawley

Progress: H2a USO attending F/U C. Feeding: Breast ☐

Artificial ✓

MOTHER: History

Bleeding: stopped 2/52 ago. General Health: well.

Discharge NO

Dyspareunia NO

L.M.P. not yet Backache Sometimes.

Frequency NO

Dysuria NO

Incontinence NO

Bowel upset NO

EXAMINATION:

Weight 85 B.P. 120/70.

Breasts SNN

Abdomen SNN wound healed.

Urinalysis Alb. ☐ Sugar ☐

Pelvic Examination

Perineum N/A.

Vagina

Uterus

Cx Appears intact on speculum.

Adnexae

Hb

Investigations:

Smear ✓

HVS ☐

MSSU ☐

IVP ☐

IVGTT ☐

Other

CONTRACEPTION

Method Decided

Oral ☐

I.U.C.D. (specify) ☐

Diaphragm ☐

Sheath ✓

Other ☐

Sterilisation PPS ☐

Vasectomy done ☐

Commenced ☐

Follow-up Appt.

G.P. ☐

F.P.C. ☐

Vasectomy W.L. ☐

Sterilisation W.L. ☐

Other Treatment and Recommendations

invited to conference ACPN.

Return on Signature

RETURN VISITS

Date 8/1/99 discussed future labour - antenate vaginal delivery was anticipated. Richard Rumney SHO

Date

GLASGOW ROYAL MATERNITY HOSPITAL

Reg Ind. No.

Affix Addressograph Label

CONSULTANT: Dr Rodgers

Rh:

L.M.P.:

E.D.D: 18/11/98

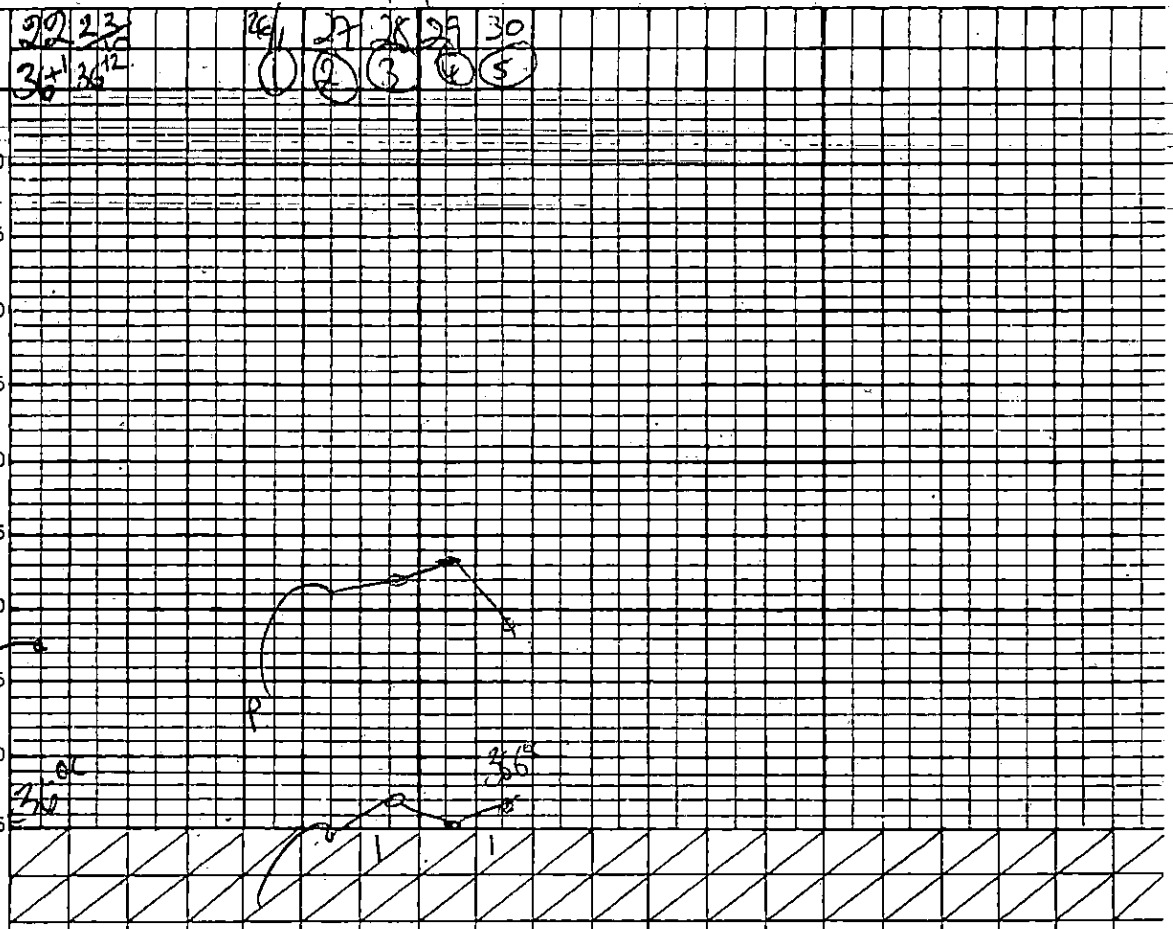
Infant Wt.: A./S.B.: N.N.D.:

(Oct 98 Emusses 0039 26/11/98

Date: 26 27 28 29 30

Days: 36+1 36+2 36+3 36+4 36+5

P	T
150	41.0
140	40.5
130	40.0
120	39.5
110	39.0
100	38.5
90	38.0
80	37.5
70	37.0
60	36.5



Hb.

Blood Loss: NIL

FLUIDS IN: ✓ ✓ ✓ ✓

FLUIDS OUT: ✓ ✓ ✓ ✓

Oedema: +/- +/- +/- +/-

B.P. morning: 130/70 129/72 110/75 149/65 130/80

B.P. evening:

URINE protein:

URINE Glucose:

URINE Ketones:

URINE bile:

Wound: C/D.

Breasts: Tone

Legs: ✓ ✓

To the Medical Staff and [illegible]

MS SULLIVAN
DEBORAH
1/1
160 MAIN STREET
BAILLIESTON

A161100 RNITY/PAEDIATRIC UNIT

07121972

G69 6AH

I ..... hereby sanction the giving of

a general, local or other anaesthetic to my Self and leave the decision as to the nature and extent of the operation to the Obstetrician in charge, excluding sterilisation. I understand that an assurance has NOT been given that the operation will be performed by a particular Obstetrician.

Dated this 25 day of 11 19 98

Signature ..... Witness .....

Date
Days

P	T
	41.0
50	
	40.5
40	
	40.0
30	
	39.5
20	
	39.0
10	
	38.5
00	
	38.0
90	
	37.5
80	
	37.0
70	
	36.5
60	

Hb.

Blood Loss

FLUIDS { IN / OUT

Oedema

B.P. { morning / evening

URINE { protein / Glucose / Ketones / bile

Rosalie Summers

A16110

POST NATAL CARE PLAN

DATE: 27/11/98

POST NATAL DAY: (2)

MATERNAL OBSERVATIONS	MIDWIFERY CARE	BABY OBSERVATIONS	BABY CARE
BREASTS: FUNDUS: LOCHIA: Daily PERINEUM: N/A ABDOMINAL WOUND: LEGS: BLADDER: BOWELS: TEMPERATURE: PULSE: BLOOD PRESSURE: HAEMATOLOGY: 36 hrs MSSU: OTHER:	SLEEP: Encourage DIET: Normal BATHS: Bed bath x 3 days VULVAL TOILET: FAMILY PLANNING ADVICE: On discharge PELVIMETRY: ANTI-D: A Pos ALMEVAX: Immune OTHER: ORIENTATE TO WARD: DEMONSTRATION/PRACTICE: TOP AND TAIL: 26/11/98 LB FEEDING: BATHING: 29/11/98 BATH BY MOTHER: ADVICE RE POSITIONING	IDENTIFICATION ON ADMISSION: *SIGNATURE:* 2 NAME BANDS: Stmyle SEX (MALE OR FEMALE): COLOUR: TEMPERATURE: WEIGHT: All days Daily SKIN: EYES: MOUTH: CORD: BUTTOCKS: URINE: STOOLS: OTHER: SOCIAL SERVICES: PHYSIOTHERAPY:	FEEDING: BREAST: ✓ BOTTLE: (type) FIRST BATH & EXAMINATION: 1 + 3 PAEDIATRIC EXAMINATION: GUTHRIE TEST: OTHER: SBR: DATE AGE IN HOURS DATE RESULT
REGISTRATION OF BIRTH CARD: On discharge CERTIFICATE OF CONFINEMENT:			

PROBLEM SOLVING

DATE	PROBLEM	PROPOSED ACTION	Print Name & Signature	DATE OF REVIEW	EVALUATION OF ACTION	Print Name & Signature
26/11/98	Spinal Asthma	1) Early mobilisation –	[illegible]	26/11/98	Mobile	[illegible]
		2) Encourage full meter +	[illegible]			
		Sensy return prn to ward				
28/11	Wound moist	Advised re cleaning	K Fitzsimmons	29/11/98		
28/11	Passed mod sized clot down toilet	1) Advised to inform staff if any further clots passed				
		2) Observe bleeding	K Fitzsimmons	29/11/98		
DATE	BABY					
27/11/98	Murmur on feed check	1) Chest x-ray today ? VSD				
		2) Review ~~tomorrow~~ Monday + Echo	K Hyde			
		? echo + cardiology opinion				
27/11/98	Poor feeding	1) BM 22 mmol/l				
		2) Discussed Feed for 30 Breast Feed with top ups as required	M Martin			

Deborah Sullivan

A161100.

MIDWIVES DAILY REPORT

SHEET NO.

DATE	GESTATION/ POST/NATAL DAY	MOTHER	BABY (FETUS)	PRINT NAME & SIGNATURE
		1st Community Visit		
1/12/98	6 LUSCS	BP 130/80 P84 T36.6 Fundus firm involuting. Lochia average. °clots °odour. Legs & perineum NAD. Breasts engorged; Advice given. Abdo wound clean & dry PU/BO.	T37. Full check NAD. Eyes✓ skin✓ cord on: base dry✓ PU/BO. Mouth✓ ~~PU/BO~~. feeding well. Settled.	(L. Foy)
2/12/98	(7)	Postnatally well. Abdo wound clean & dry.	T37. Full check NAD PKU✓	
3/12/98	(8)	Afebrile. Postnatally well. Q bit sore today. Abdo wound clean & dry. BO today. Lochia average °clots °odour.	T37. Full check NAD. PU/BO feeding well. Settled.	(L. Foy)
4/12/98	(9)	Afebrile. Postnatally well. fundus involuting. lochia same average. Passed a clot 3½ cm. - No infection. Still remains sore: advised to keep taking analgesic regularly.	T37. Full check NAD. Cord on: separating. PU/BO. feeding well. Settled.	(L. Foy)
5/12/98	(10) Sat	Miss visit.		
6/12/98	& (11) Sun	Miss visit.		
7/12/98	(12) Mon	BP 120/80. Afebrile. Postnatally well. Breast & legs NAD fundus involuting. Lochia diminishing serosa. °clots °odour. Wound clean & healing. Fit for discharge. SV 13/12 +2 mins.	T37. Full check NAD. Eyes✓ skin✓ cord off: base dry. PU. BNO today. mouth✓ Nails✓ buttocks	(L. Foy)

Deborah Sullivan

A161100

MIDWIVES DAILY REPORT

SHEET NO.

DATE	GESTATION/ POST/NATAL DAY	MOTHER	BABY (FETUS)	PRINT NAME & SIGNATURE
9.11.98		Complaining of abdominal pain overnight, analgesic, + hot pack + peppermint water given, please observe today. Anusol cream given for haemorrhoids.	Eyes ✓ Skin ✓ Breast feeding + TOP UPS	
	4 F/nurse		Mouth very coated Colour poor	
	08⁰⁰	PN examination satisfactory. Pain not as severe BP 140/95 recheck — 2hrs. PU/BO ✓ wound clean + dry. Top pad free -	For Paed R/V — D/W paed — no need for review today.	MWATTSON
		K Hyde		N Summers
9.11.98	21⁰⁰	BP re-checked 124/83 P84. Asymptomatic		
10.11.98	5 EUSCS 10⁰⁰	Deborah requesting baby have a top up of SMA as nipples sore. 01³⁰	10x2 Correct T36.8 PU/BO. Breastfeeding + top-ups Eyes. skin nails mouth clear. Wt. 3.40kg. Cord A/D ? For paed review re baby's colour.	L Burnett S/N
				L Burnett S/N
10.11.98	07⁰⁰	Deborah had fallen on stairs outside ward — not seen by any staff Fell on hand + knee. ? For Medical review. Uncomplaining		L Burnett

Rosamund Stanley

A16110

MIDWIVES DAILY REPORT

SHEET NO

DATE	GESTATION/ POST/NATAL DAY	MOTHER	BABY (FETUS)	PRINT NAME & SIGNATURE
	30/4/98 (5) LUSCS	29 2/7 PIN well this morning - Kay for home — Uterus Lochia normal Bowels - Voided clear + dry BP [illegible] today Not wishing to breast feed now - Cog discussion has already decided to bottle feed Advised re support breaks. Contraception discussed — To GP PIN Codeine given at present Await baby feed review by [illegible]	11lbs SLB Bad Resp - meconium on hands - Fr [illegible] Im 2/52 + ½ today Discharged at 24hrs to go to Ward 6 on discharge GP Cardiologist check letter given to mum to take	SM/Stanley
		13lbs SLB Dr Costello - Fit & discharged 30hrs discharge drugs given - Known to Plane if needs re anything		SM/Stanley

DEBORAH SULLIVAN

A161100

MIDWIVES DAILY REPORT

SHEET NO.

DATE	GESTATION/ POST/NATAL DAY	MOTHER	BABY (FETUS)	PRINT NAME & SIGNATURE
26/11/98	① EM LUSCS	05⁴⁵hrs	Put to breast. Fixed + sucked well. BO+. All nad IDbnd #2 NAD	Sullivan
		0645hrs. Pad bathed. Ward dry - Lochia rubra. III Fundus firm. PCA morphine still in situ.		S Sullivan
		Vital signs satisfactory left to rest	0900 Good breast feed taken.	M Mantagh
	12⁴⁰	Vital signs satisfactory, IVI & PCA discontinued managed 1 unit urinary catheter removed up to shower		
	13⁰⁰	Voltarol Supp 100mgs given PR		
	15⁰⁰	Passed urine ✓ Passed few clots, fundus firm advised tell staff if passes more.		M Mantagh
27/11/98	② 16⁰⁰ EM LUSCS	AN examination: Sat. B/P 120/70 P 80 Wound dressing dry. Feeling quite sore and tired today. KJ Sinnwell	SB passed ? murmur heard Chest clear ? VSD SB paediatric registrar review on Mon ? echo	M Mantagh

Deborah Sullivan
M76100.

MIDWIVES DAILY REPORT

SHEET NO.

DATE	GESTATION/ POST/NATAL DAY	MOTHER	BABY (FETUS)	PRINT NAME & SIGNATURE
7/4/98	② LUSCS.	18:00	T 37° id bd dot 2 P 4 BO breast fed U HU	KS
		21:45 Mum concerned baby is not fed well today. Temp 37.4, nappy dry. BM 2.2 mmol/L 30mls of SMA taken. Colour pale Resp Rate 60 pm. Discussed with H Midwife Paed. Feed baby 3° overnight with top ups if necessary. Observe for tachycardia during & after feeds		KS
8/11/98	3 Em LUSCS 09:55	PN examination satis - B/P 120/70. 06:00 Anxious re breast feeding - reassured Wound moist - advised BC	16 x 2 Temp 37°C BO/PU BM 4.1 MMol/L Cord dry. Skin intact but pale A/F 40MLS SMA overnight KS Signature	SM
9/11/98	4 Em LUSCS	05:00	05:00 T 37° ID Bands x 2 BO PU Cord C/DRY	KS

1 C70501726 29 ...

HISTORY

Community Room (8-9pm)
Senior Midwife (211 5400) - Gifted Sp
Dr Rowan

DATE OF ADMISSION 16/1/98

PRE-NATAL

PARITY: GTO

LMP:

EDD: 13/11/98

PRESENT OBSTERIC PROBLEMS: U.T.I

BLOOD GROUP/RH FACTOR: A pos

PAST OBSTETRICS PROBLEMS:

PREVIOUS INFANT DEATHS:

DELIVERY EM LSCS Fetal distress + Meconium

~~SVD/FORCEPS/CS/BREECH:~~ 26/11/98 0039

PERINEUM: INTACT/TEAR/

EPSIOTOMY:

PLACENTA: COMPLETE/INCOMPLETE:

MEMBRANES: COMPLETE/INCOMPLETE: uterus confirmed empty

RAGGED:

BLOOD LOSS: 300ml vicryl throughout

TRANSFUSION:

U

Hb 10.3 28/11/98

POST-NATAL

HOSPITAL: GBMH

DISCHARGED DAY: (3)

DATE: 30/11/98

PHYSICAL CONDITION: Fit well [illegible]

FAMILY PLANNING ADVICE: [illegible]

GP NOTIFIED:

COMMUNITY

DISCHARGE DAY:

DATE:

PHYSICAL CONDITION:

BABY

LIVE/~~STILLBORN~~/NND:

FEMALE/MALE:

GESTATION: T

BIRTH WEIGHT: 3.41kg

DISCHARGE WEIGHT:

APGAR SCORE AT 1 MINUTE: 9

5 MINUTES: 10

FEEDING: BREAST/ARTIFICIAL:

TYPE OF ARTIFICIAL MILK: Nan Bottle Feeding on SMA

SPECIAL PROBLEMS: Feeding well

ADMISSION TO SPECIAL CARE NURSERY YES/(NO):

FOLLOW-UP CLINIC APPOINTMENT: 452 OPD

GUTHRIE TEST ~~NO~~/YES: 2/12/98 HEART MURMUR NEWBORN DAY (2) TO YOUNG CARDIOLOGY AS OUTPATIENT FOR CHECK. 30/11/98

OTHER:— Vit K

PARENTCRAFT — DATE

PREGNANCY:

MINOR DISORDERS:

NUTRITION:

FINANCIAL BENEFITS:

SAFETY IN THE HOME:

LAYETTE:

BREAST FEEDING:

STERILISATION OF EQUIPMENT :

BOTTLE FEEDING:

LABOUR:

PAIN RELIEF IN LABOUR:

BABY BATHING:

POST-NATAL CARE:

FAMILY PLANNING:

OTHER:

PHYSIOTHERAPY

CLASSES

ADDITIONAL SERVI /APPOINTMENTS

SOCIAL SERVICES:

HEALTH VISITOR:

OTHER:

APPOINTMENTS — ANTENATAL OPD:

LABOUR/THEATRE UNIT:

POSTNATAL CHECH:

GP:

POST - NATAL CHECK

	SIGNATURE MUM	SIGNATURE BABY		SIGNATURE MUM	SIGNATURE BABY
1			8		
2			9		
3			10		
4			11		
5			12		
6			13		
7			14		

Baby Sullivan

A 16/100

MIDWIVES DAILY REPORT

SHEET NO.

DATE	GESTATION/ POSTNATAL DAY	MOTHER	BABY (FETUS)	PRINT NAME & SIGNATURE
8-09	0 900	Seen at ward round. given opportunity to stay if wishes but wants to go home.		
	12 MN	home.		L Stead
1/11/98	39+ 2 2020	Readmitted with ↑↑ backache since this morning. Onset of irregular abd pain. since 1830 now every 7-8 min. ↑/c backache. Fetal movement ++ ↓Show ↓Srom. ↓A Slightly dishevised with mild ↑/A. T 36.3 P 80 BP 113/67 ↑/c diarrhoea since 1800 ×4 now settled. VE (see notes) Keen to go home. Advised to return if concerned	Fundus = dates long l/c cephalic fix 4/5 palpable. CTG commenced + Reactive.	S.A. McKe

Deborah - Sullivan.

A161100

MIDWIVES DAILY REPORT

SHEET NO.

DATE	GESTATION/ POST/NATAL DAY	MOTHER	BABY (FETUS)	PRINT NAME & SIGNATURE
5/11	41+2 22⁰⁰	Self referral from home with history of contractions since 20⁰⁰ hrs. Show +ve. C/A distressed contracting 2.10 ~~mode~~ moderate. T 36.5 P 80 BP 120/80 PV E to assess see notes. Requesting analgesia. DIAMORPHINE 7.5mgs + STEMETIL 12.5 given I.M for pain relief.	P/P Knows dates labour Le cephalic. 3/5 palp FMF. FHH ✓ Sinusoidal CTG commenced FH 120-130 bpm.	Sullivan
	23⁰⁵	Contracting 3.10 moderate	FH ↓ 78-80 bpm slow to recovery despite postural change	Sullivan
		Transfer to Rm 2 SIB Dr Crawford. VE, ARM, fresh meconium. See notes. Continue to observe.	FSE applied FH 110-120 bpm	Sullivan
	23³⁰	Contracting 4.10 strong ~~pain~~ during entonox requesting epidural anaesthesia ~~being~~ given at present.	FH 120-130 bpm early decelerations good recovery.	Sullivan

Deborah Sullivan

A16110.

MIDWIVES DAILY REPORT

SHEET NO.

DATE	GESTATION/ POST/NATAL DAY	MOTHER	BABY (FETUS)	PRINT NAME & SIGNATURE
1/11/98	23[30]	SIB Epidural Anesthetist sitting upright for epidural -.	FH 120-130bpm shallow early deceleration good recovery	Finlay
	23[55]	Epidural sited		
2/11/98	00[00]	BP satisfactory		
	00[20]	Contracting (4):10. no strong epidural effective. Fetal O2 given SIB Dr Stenhouse VE to assess see notes. Dr Crawford present — to theatre.	FH ↓ 90bpm ↓ 80bpm to change with maternal position change	Finlay
	00[38]	TIF to theatre II explained given to Deborah + Steven. Skin prep cyclumin 30mls - catheter inserted clear urine draining	FH 160-170bpm in theatre	Finlay
	00[56]	knife to skin	FSE off.	
	00[59]	Progressed to EMLUSES	Live female infant. PD present for delivery	Finlay

Deborah Sullivan

A161100

MIDWIVES DAILY REPORT

SHEET NO.

DATE	GESTATION/ POST/NATAL DAY	MOTHER	BABY (FETUS)	PRINT NAME & SIGNATURE
24/4/98	(1)	Third stage complete.	apgars 9, 10 5	
		Uterus contracted empty.	Vit K given	
		Vicryl sheath	1.0 bands checked	
		" skin.	correct.	
		Voltarol 100mg given PR.	Birth weight 3.41 kg	
		clear urine draining	T 36.8°C.	
	01[00]	Transferred to recovery area.		
	01[30]	Observations satisfactory.		
		Epidural catheter removed		
		in theatre.		
		fundus firm, lochia average		
		minimal staining from wound.		
		IV hartmans in progress.		
		PCA given.		
	02[00]	Observations satisfactory.		
		Transferred to ker ward		
26/4/98	02[30]	Admitted, + orientated to ker	None bands x 2 checked +	
		ward. IV hartmans running - Urapidil	correct. Mum unable to	
		with Dr Connell - Ward dr - Lochen	BF but wants to express	
		Avenyl PCA Morphine insitu	hep PIF at present	
			0230hrs. Cyclins Card + Gate taken	
			well. BO - Nil by yet	

[redacted] [redacted]

INTENSIVE MONITORING SHEET

GLASGOW ROYAL MATERNITY
A161100

MS SULLIVAN
DEBORAH
1/3
160 MAIN STREET
BALLIESTON

07121972

G69 6AH

Date and Time	NBP	P	TEMP	IV	CATH	WOUND	LOCHIA		REMARKS
26/11/98									
02.00	120/84	92	36.6°	R/L	CLEAR	DRY	MINIMAL		PCA MORPHINE 1mg/5ml
02.30	121/80	80		11	11	11	11		
03.45	124/78	94		11	1000	11	11		EMPTIED
06.45	120/72	84		5% DEXT	11	11	11		BED BATH
09.00	120/68	88	36.6°	5% DEXT	1200 mls	11	ANY		
12.30	120/70	84		—	2 Urine emptied	ANY	ANY		Cath out

GLASGOW ROYAL MATERNITY HOSPITAL
ANAESTHETIC RECORD

PATIENT DETAILS A161100

ANAESTHETIST: O'Hare
DATE: 25/11/98
PROCEDURE: Epidural
OBSTETRICIAN:

MS SULLIVAN
DEBORAH
1/1
160 MAIN STREET
BAILLIESTON

07-12-1972
G69 6AH

PARITY: 0+0

PREMEDICATION

DATE/TIME	DRUG/DOSE	ORDERED BY	GIVEN BY	TIME GIVEN

PAST MEDICAL HISTORY

PREVIOUS ANAESTHESIA/OPERATIONS:
CVS: Many
BP:
RS:
OTHER:

DRUG THERAPY: Nil
ALLERGIES: Nil
SMOKING:
AIRWAY:
Hb:

ANAESTHETIC TECHNIQUE

Epidural

NEEDLE SIZE: 18
LOR: (AIR) FLUID
INTERSPACE:
SKIN - EPID SPACE 5 cm
CATHETER IN SPACE: 5 cm

Spinal

NEEDLE TYPE
GAUGE:
INTERSPACE:

Maintenance

INFUSION
DRUG:
CONC:
RATE:

TOP-UPS
DRUG: Bupivacaine
CONC: 0.25%
VOLUME: 5+5

COMMENTS

Aseptic 1% Lignocaine
3+7 } 0.25% Bupiv
+100 µg fentanyl

GENERAL ANAESTHETIC

	Pre O2	Cricoid Pressure	SIZE
INDUCTION:		Airway: MASK	
MAINTENANCE:		LMA	
		ETT	

POST-OPERATIVE INSTRUCTIONS

ANALGESIA:
OTHER:
OBSERVATIONS:

O_2 THERAPY

0039 9

TIME 0000 0050

EPID/ SPINAL DRUGS: Lignocaine 2% 1.5 FT 5000 @ 15 ml

IV DRUGS: EPHEDRINE Adrenaline Dw 1/25 Amp

SYNTOCINON Bd Syntocinon 10 iu IM

Foetal bradycardia 1/2 h after epidural commenced

SpO_2 4 l/min 98 98

$ET CO_2$ O_2

BLOOD PRESSURE 200 180 160 140 120 100 80 60 40 20

SENSORY LEVEL R L

IV FLUID NOS

1	SOP	5	
2	0.9%	6	
3		7	
4		8	

FLUIDS

HARTMANNS SOLUTION

1		5	
2		6	
3		7	
4		8	

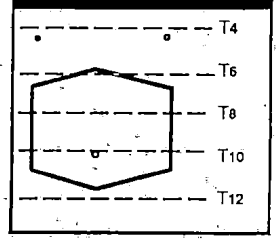
COLLOID SOLUTION

BLOOD NOS:

1		5	
2		6	
3		7	
4		8	

MANAGEMENT HYPOTENSION	EPIDURAL OPIOIDS	EPIDURAL INFUSIONS
1) Avoid Aorto-caval occlusion-use wedge 2) If systolic BP< a) Turn to lateral position b) Turn IV on full c) Call anaesthetist 3) Never give more than 5 mls local anaesthetic at one time	If respiratory rate < 8 bpm and/or patient difficult to rouse or unrousable GIVE NALOXONE 0.4 mgs/ im and O_2 8 l/m CALL ANAESTHETIST	1) Monitor BP half hourly 2) Monitor BP every 5 minutes after extra top-up for 20 minutes 3) Chart sensory level hourly (loss of cold sensation to ice) 4) Inform anaesthetist if block height above T6

SENSORY LEVELS



GLASGOW ROYAL INFIRMARY UNIVERSITY N.H.S. TRUST
PATIENT CONTROLLED ANALGESIA OBSERVATION CHART

DRUG	DOSE	ROUTE	TIME	OTHER	SIGNATURE
ORIGINAL SETTING MORPHINE	1 (ONE) mg	IV	3 (THREE) minute lockout	Concentration_mg/ml No background	[signature]
FIRST CHANGE MORPHINE	mg	IV	minute lockout	Concentration_mg/ml No background	
SECOND CHANGE MORPHINE	mg	IV	minute lockout	Concentration_mg/ml No background	
DROPERIDOL		IV		In PCA Syringe	
MORPHINE	1-3mg	IV	2-10 minute lockout	No background. Acute pain team only	
MORPHINE	1-3mg	IV bolus	Up to half hourly p.r.n.	If required for pain. Acute pain team only	
ONDANSETRON	4mg	IV/IM	once if required		[signature]

The prescription must also be recorded in the drug Kardex

SEDATION SCORE
- 0 = awake
- S = normal sleep
- 1 = drowsy, easy to rouse: eyes open to speech or light shake
- 2 = sedated, difficult to rouse: eyes open only to vigorous shaking
- 3 = unconscious, unrousable

PAIN SCORE
- 0 = no pain at rest, no pain on movement
- 1 = no pain at rest, slight pain on movement
- 2 = intermittent pain at rest, moderate pain on movement
- 3 = continuous pain at rest severe pain on movement

COMMENTS
(Use abbreviations)
- N = nausea
- V = vomiting
- I = itch
- U = urinary retention
- C = catheterized
- R = resp. depression
- n = naloxone given

DATE /TIME	RESP. RATE	SEDATION SCORE	PAIN SCORE	SYSTEM CHECK	VOLUME REMAINING	COMMENTS	INITIALS
26/11/98 02⁰⁰	16	0	0	✓	50 mls	C	[initials]
04⁰⁰	14	0	1	✓	46 mls	C	[initials]
05⁰⁰	13	0	1	✓	38 mls	C	[initials]
06.45	15	0	1	✓	26	C	[initials]
09.00	16	0	1	✓	12 mls	C	KM
10.40	16	0	0		2 mls	C	KM

Deborah Sillivan
Y1
160 Main St.
Ballinster 469 A161100

MIDWIVES DAILY REPORT

SHEET NO.

DATE	GESTATION/ POST/NATAL DAY	MOTHER	BABY (FETUS)	PRINT NAME & SIGNATURE
3/10/98	42 36 12⁰⁵	Flushed. T 36³. Still c/o tightnings + backache. ? brown show at toilet this morning.	Abdomen soft on palpation. long. lie. cephalic pres. fmf fhh x minutes	
	14⁰⁰	c/o abdo pain - irregular.	CTG commenced.	
	14³⁰	S/B Dr Tierney (Rg). See notes. (VE - cx un-charged) May go home if wanted. for CTG prior to this.	Reactive trace	N Todd
		Up for bath + co-codamol II tabs orally.	CTG re-commenced Reactive trace.	N Todd
	21⁵⁵	Co-codamol 2 tabs o for lower abdo pain.		
	23⁵⁵	c/o painful contractions	CTG commenced	
		Mild tightenings palpated 3:10. NO relief from oral analgesia		DM'Call
		Dr Ritchie asked to review.		
4/10	00³⁰	Dr Ritchie busy in LW explanation given to Deborah		
	01¹⁰	S/B Dr Ritchie (see notes) for review by Dr Rana.		
	02³⁰	S/B Dr Rana.		
		DF118 60mgs o		DMCall
	06³⁰	Settled + slept soundly after analgesia		DMCall

Deborah Sullivan
1/1 160 main Street Ballston
A161100

MIDWIVES DAILY REPORT

SHEET NO.

DATE	GESTATION/ POST/NATAL DAY	MOTHER	BABY (FETUS)	PRINT NAME & SIGNATURE
12/10/98	36+1	Pulse 84 BP 130/70 Still having some abdominal discomfort occasional uterine tightenings overall satisfactory felt wil PV loss. S/B Dr MacKenzie ward round.	Vx abt term FMF Abdo CTG commenced satisfactory Brace S/B	
	15[20]	Requesting analgesia DF118 30mgs as prescribed.		
	16[50]	C/o painful contractions. Contracting 2-3:10 nil PV S/B Dr Yong - VE (see casenotes) For IM. analgesia.	CTG - baseline 110 ✓ accelerations ✓ No decelerations S/B Dr Yong.	
	17[25]	DIAMORPHINE 5mgs STEMETIL 12.5mgs		
	18[00] VS	Deborah settled.	18[15] CTG satisfactory discontinued	
	23[00]	Asleep.		
13.10.98	03:15	Has been asleep. Mum awake & irregular u/A + ✓ Mum. Cocodamol (1) given		
	36+2			
	03:30	Betamethasone 12mg IM (2) DR		
	07.20	Asleep		
	09[00]	been up for b/cak/fast. Now asleep again		
	09[15]	Asleep for w/R. Mum later.		N. Sole

Blacktown Hospital

AH1100

MIDWIVES DAILY REPORT

SHEET NO.

DATE	GESTATION/ POST/NATAL DAY	MOTHER	BABY (FETUS)	PRINT NAME & SIGNATURE
2-1048	02	Returned from bath - still sore.	O/C comm.	
36+1	03·20	Having mild u/A 3:10. ∨ cramp. D/w Dr. Richmond. 7/24 stands.	03·25. Baseline 140 reactive over past 15 mins. 100-120 B/M. ? good B/B variability Yo 4/6 S/B Dr. Richmond	DRich
	03·30	Buvamethasone 12mg IM. Deborah requests further analgesia. Ward urinalysis - WNL. MSSU.		DRich.
	03⁴⁰	Deborah remains uncomfortable D/w Dr CHITRA (STO) for IM Analgesia	Baseline remains 110-120 bpm good variability S/B Dr CHITRA (S+TO) satisfactory.	
	04⁰⁵	Diamorphine 5mg & Stemetil 12.5mg given IM for pain relief		O/M ADon
	05⁰⁰	Good pain relief from analgesia settled & slept well	Variability reduced - ? due to diamorphine reaction	
	05³⁰		discontinued	ADon
		Deborah sleeping for most of morning - fairly settled	Abdomen slightly tender Long lie	
	10³⁰	P/V Examination Apyrexial	cephalic presentation	

MIDWIVES DAILY REPORT SHEET NO.

DATE	GESTATION/ POST/NATAL DAY	MOTHER	BABY (FETUS)	PRINT NAME & SIGNATURE
10/98	0+0	34 yr old booked for home birth G abdominal	36/52	
	36/52	pain since early morning. NO show	Long lie	
	21/40	symptoms NO SROM NO history of SH	Cephalic presenting	
		NKDA.	of Bw	
		O/A Pushed 10cm comfortable	CTG Fetal heart	
		abdom SFE. mild tone active bell		ST-bll
		T 36.4 P80 BP 120/70		
		commenced CTG.		
		during medical review All stable baby & placent		
	23/40	seen by DR Chitra.		ST-bll
		PV see notes Cx posterior effaced	CTG reactive	
		finger tip	? Isolated decelerations	
		Discussed options to labs &	or UC. seen by DR Chitra	
		may require Syntocin & IOL active	to check CTG in labs &	
		phase ST-bll	prior to going down lick	
22.10.98	00.15	Welcomed & escorted to	night	ST-bll
		ward 8. looks quite		
	36	uncomfortable. Paracetamol		
		IV Terbutaline 10mg given.		JRobb
	02.35	Has been asleep. Awake		
		again & lower abdominal		
		cramps. Warm bath suggested		

TPR – 4 HOURLY

SURNAME (Block Letters)	UNIT NUMBER	WARD No.
Mrs. Miss SULLIVAN	A161180	
FIRST NAMES (Block Letters)	CONSULTANT	
DEBORAH		

DATE	16-7-98	17.7.98	8/7/98				
TIME	2030	0800 1200 1830 2200	0800				

TEMPERATURE: 41° 40° 39° 38° 37° 36° 35°

PULSE: 150 140 130 120 110 100 90 80 70 60

RESPIRATION: 50 45 40 35 30 25 20 15 10

B.P.

A161100

MIDWIVES DAILY REPORT SHEET NO.

DATE	GESTATION/ POST/NATAL DAY	MOTHER	BABY (FETUS)	PRINT NAME & SIGNATURE
7/98		0230 Becoming windy uncomfortable PR for further IM Buscopan as prescribed.	0620 Abdomen soft, non tender FMF ++ by mum	CARDIFF MIDWIFE.
		0330 Buscopan 20mgs IM given as Described Apyrexial NO Further vomiting Fluids Catheter as prescribed		
		0620 Vomited + bile stained fluid only Apyrexial Shortly 12 Stugs given I/M for relief of nausea		
	0755	iom taken over by myself s/m C. Doherty IVI continues N saline 20mmols KCL - site sahs. Pt c/o abd discomfort BP 100/60 HR 80 T - 36.6 No diarrhoea or vomiting Sij D; sloan to obtain stool specim -ve ; bloods - see notes IVI tissued - removed	Abd soft NABS Fundus = dates abd soft FMF by Mum FHH ; dopplonic found & clear.	C Doherty
	1100	up for immersion bath Tolerating		

Baby of [illegible] Sullivan

MIDWIVES DAILY REPORT

SHEET NO.

DATE	GESTATION/ POST/NATAL DAY	MOTHER	BABY (FETUS)	PRINT NAME & SIGNATURE
5.7.98		oral fluids at present		C Ferris
	1900	Has tolerated diet and tea day		/
		Feels a lot better.		
		9/3 Dr Sloan:- Can go home.		
		ANC arranged 11/8/98.		MDean
7.7.98	1420	Admitted to LW via GP. C/O diarrhoea	Abdomen bloated	
		and vomiting, really since discharge	(as before on Friday)	
		on Saturday.	Difficult to palpate fundus	
		Vomiting food + fluids. Diarrhoea	FH 14cm	
		about 8/day.		
		O/E flushed		
		T 36.4 P 72 BP 116/63. Vomited		
	1430	S/B Dr Jones.		MMackenzie
		Bloods taken for U+E FBC, UTI		
		For abdominal x-ray		
		Stool specimen ✓ MSU ✓ + ketones.		
	1620	S/B Dr Mackenzie		MMackenzie
		For iv Zantac and iv fluids.		
	2000	Care taken over by AM PACELLI	2	
		Settled at present		APacelli

Deborah Sullivan

A161180

MIDWIVES DAILY REPORT SHEET NO.

DATE	GESTATION/ POST/NATAL DAY	MOTHER	BABY (FETUS)	PRINT NAME & SIGNATURE
17/7/18	12/5	results c/B Dr Shearer	FmF FHH 126bpm	
		Plan – Discontinue fluids	loud & regular.	S Simpson
		venflon left insitu		
		Up for assisted bath.		
		not requesting analgesia		
		light lunch given		
	1245	Buzzed – vomited 200mls,		
		'foodstuffs' Diclofenac 60mgs given		
		as c/o pain returning		
	1250	Dr Shearer informed will		
		review MSSU ✓		
	1320	RIV by Dr Shearer, recommence		
		IVI		
	1400	IV Antibiotics given, commenced		S Simpson
		on oral due @ 10pm.		
	1700	Light evening meal given		
	1800	Vomited small amount of meal.		
	1830	c/o further discomfort	Non tender on palpation	
		T 36/5 P 86 BP 100/50 for RIV by	FmF, FHH c doptone	
		medical staff	137bpm, loud & regular.	
	1845	c/B Dr Shearer (SHO)		
		Plan – will D/W Dr Josephine		S Simpson

Deborah Sullivan A161100

MIDWIVES DAILY REPORT

SHEET NO.

DATE	GESTATION/ POST/NATAL DAY	MOTHER	BABY (FETUS)	PRINT NAME & SIGNATURE
17/7/97	1910	Re further IM analgesia		
	1915	Stemetil 12.5mg2 IM given		
	1915	For oral Zantac & oral Buscapan. Rno Buscapan in L/W, Ward 8, Kemsor		
	1925	McKennar — Sr Jack Contacted will get from pharmacy Dr Josephine aware.		
		For oral fluids only overnight to remain on oral augmentin		
	21[00]	Care taken over by myself NO change in present management IV fluids continue as prescribed. Tolerating small amounts of oral fluids BP 120/74 Pulse 76 bpm T - 36.2°C PR Oral Augmentin given as prescribed — Discussed w Dr De Concini (SHO) for IV fluids & IM Buscapan as prescribed	21[00] O/E :- Abdomen soft. FMF ++ by mum	S Simpson Clynelish Graduate Midwife Clynelish

MS SULLIVAN
DEBORAH
1/1
160 MAIN STREET
BAILLIESTON

A161100
07121972
G69 6AH

MIDWIVES DAILY REPORT

SHEET NO. 1

DATE	GESTATION/ POST/NATAL DAY	MOTHER	BABY (FETUS)	PRINT NAME & SIGNATURE
1/1/98	20[30]	Admitted to yw with history of abdominal pain and backache	Abd soft -	
	22	Has had UTI. On Cephalexin	Fundus difficult to feel	
		since Tuesday. Also Hx diarrhoea		
		°A feeling sore		
		T36[5] P68 BP 116/81		
		S/B Dr Fergus.		
		Blood taken for CBR, risk, UTI's		
	2[00]	S/B Dr Khaind. Abdomen palpated		
		— ? distended stomach		
	2[10]	i/v maxalon and augmentin		
		given by Dr Fergus 22.00 IV pharm commenced		
	22[30]	Pethidine 50mgs given for pain relief	22[30] Maternal sleeping	
			now resting. FHR 11	
			by mum.	
	23.30	Not ready settling c Pethidine		
		S/B DR Jthaud for buscopan		
	00.05	Buscopan 20mg IM given		
	01.50	Not settled. S/B DR Fergus		
		for further analgesia		

MS SULLIVAN
DEBORAH
1/1
160 MAIN STREET
BAILLIESTON

A161100
07121972
G69 6AH

MIDWIVES DAILY REPORT

SHEET NO. 2

DATE	GESTATION/ POST/NATAL DAY	MOTHER	BABY (FETUS)	PRINT NAME & SIGNATURE
	02.10	10g Morphine given I.M. vomited 150ml bile stained fluid.		P Nichols
	06.10	10g Morphine given I.M.		
7-90	0745	Change of shift Deborah feeling better Still has some backache T36+ P72 BP 90/50 nil PV. IVI in progress light breakfast given	Findus = 20-22 week size FMF FHH ½ doptone 133bpm loud & regular	
	0800	D/W Dr. Fergus ? for IV antibiotics in view of being apyrexial - decision to be made on ward round -		L Simpson
	0830	W/R Dr Mullocks Plan - for USG / Repeat bloods		
	0930	USG request sent (Scan Dept very busy)		
	1100	Tolerating oral fluids		
	1205	T36+ P77 BP 100/70 Blood		

FLUID BALANCE

SURNAME (Block Letters) Mrs. / Miss.	UNIT NUMBER	WARD No.
SULLIVAN	A161L00.	
FIRST NAMES (Block Letters)	Date	
DEBORAH	16-17/7/98	

Measurements should all be in millilitres or all in ounces.

INTAKE				OUTPUT		
Details	Amount	Total	TIME Total	Details	Amount	Total
A	2200	500	500	UTT	200	200
B	2410	500	1000			
C	0615	500	1500	UTT	100	300
D	1130	500	2000	Vomited	150	450
water	0830	300	2300	Vomited	50	500
Bl fast	0830	100	2400			
tea	0900	100	2500	UTT	150	650
lunch	1200	200	2700	UTT	200	850
E	1430	500	3200.			
				Vomited	300	1150

1 Fluid Ounces 28.4 ml. 1 Pint 568 ml.

I.V. THERAPY PRESCRIPTION SHEET

MS SULLIVAN A161100
DEBORAH
1/1 07121972
160 MAIN STREET
BAILLIESTON G69 6AH

germ LK

No. 1206

PLEASE WRITE OVER WHITE LETTERS

	DATE	FLUID (USE BLOCK LETTERS) ADDITIVE DRUG	Vol. (ml) Dose (mg)	Route of Admin.	Dur. of Admin.	SIGNATURE	Serial No. Batch No.	Time Begun	Given by Added by
A	17.~~7~~	Plasmanate	500	IV	2°	[signature]	98L (2 BB)	2200	RNBeat
B	17.7	N. Saline	500	IV	4°	[signature]	98 F 22 BL	2400	RNBeat
C	17.7	5% Dextrose +20mmol KCl	500	IV	4°	[signature]	98A 23BL	0015	RNBeat
D	17/7	(N) Salve	500	IV	4	[signature]	98 F 22 BL	1130	SSimpson
E	17/7	20mmol KCl (N) Salve	500	IV	4	[signature]	98 B 11 BB	1430	SSimpson
F	17/7	(N) Salve	500	IV	4	[signature]	98F 22BL	1830	SSimpson
G	17/7	20mmol KCl 5% dextrose	500	IV	4	[signature]	98A 23BL 12/99	2225	SSimpson
H	18/7/98	N Saline	500	IV	4		98F 22BL 5/2000	0800	RNJohn
I									
J									
K									
L									
M									
N									
O									

VOL. OF FLUID (ml) x 15
Duration (Mins.)
(1ml = 15 drops)

Approximate Rate for 500 ml.

1 hr. = 120 Drops/min. 6 hr. = 22 Drops/min.
4 hr. = 30 Drops/min. 8 hr. = 15 Drops/min.

CHART NO.....

MIDWIVES DAILY REPORT

SHEET NO.

DATE	GESTATION/ POST/NATAL DAY	MOTHER	BABY (FETUS)	PRINT NAME & SIGNATURE
3/7/98	13^{30}	s/s Dr Kumar Deb. – agrees to transfer to GR1 (Wd 60).		NANCY TODD

Deborah Sullivan

A161100

MIDWIVES DAILY REPORT

SHEET NO.

DATE	GESTATION/ POST/NATAL DAY	MOTHER	BABY (FETUS)	PRINT NAME & SIGNATURE
23/7/98		Requesting further analgesia.		
	08[00]	DF118 60mg orally.		
		S/B Dr Holman (Reg.) See notes		
		Mr Carter's (GRI) secretary contacted by Dr Fergus (SHO) - to contact surgical receiving team. ✓		
	10[30]	S/B Dr Luman - see notes.		
		Co-codamol II tabs orally		
	10[35]	Biochem results phoned - see notes.		
	10[50]	Dr Cameron (GRI) discussed care with Dr Holman (Reg). He wishes Deborah to be transferred to GRI - see notes.		
	10[50]	Awaiting Dr Cameron (GRI) to call back to see if he will assess here.		
		Deborah encouraged up for bath ✓		
		stool & urine specimen requested.		
	11[05]	Vomiting - clear fluid only. Requesting s/ting.		
	11[10]	Metoclopramide 10mg IV by Dr Fergus		
	11[50]	S/B Physiotherapist - fitted = TED stockings		
		GRI spoken to again by Dr Holman. SHO unable to come here, as he is on-call there. DLW Dr Luman + he will contact Cons. Surgeon.		Nancy Foote

A16HCC

MIDWIVES DAILY REPORT SHEET NO.

DATE	GESTATION/ POST/NATAL DAY	MOTHER	BABY (FETUS)	PRINT NAME & SIGNATURE
22.7.98	2100	Vomiting +++	—	
	2030	Feeling sick. Requesting analgesia		
		Buscopan as prescribed.	/	
	2100	Vomiting +++		
		Dr Morris informed		
		IV Maxolon given & good effect		
	2150	Temp 37.1 Drug given		
		IVI continued	FHR	
		Settled + sleep	—	
	2330	Settled Looks better		
23.7.98	0030	Pain starting again		
	0300	Buscopan 20mg orally	C	
	0345	No relief from Buscopan		
		NIW Dr Orr & Anaesthetist		
		Diff x clothing given orally		
	0430	More settled		
	0645	Remains settled		NELLIS
	0745	Care taken over by myself. Deborah		NANCY
		distressed & low abdominal pain. New upper		TCOD
		abdominal swelling - says this is normal for		
		her since cholecystectomy. Abdomen soft.		
		T 35.4 P 82 BP 122/62.	FMF	

7-12-72 : A161100.
DEBORAH SULLIVAN

I.V. THERAPY
PRESCRIPTION SHEET

GRMH ---- Labels

No. 1206

PLEASE WRITE OVER WHITE LETTERS

	DATE	FLUID (USE BLOCK LETTERS) / ADDITIVE DRUG	Vol (ml) / Dose (mg)	Route of Admin.	Dur. of Admin.*	SIGNATURE	Serial No. / Batch No.	Time Begun	Given By / Added By
A	22.7.98	N Saline	500	IV	4°	Sheena Comas	98L09BY	10[10]	
B	22.7.98	5% Dextrose	500	"	4°	Sheena Comas		21[55]	AMP
C	22.7.98	5% Dextrose +20mmol KCl	500	"	4°	Sheena Comas	98A 23BL	02[40]	AMP
D	22.7.98	N Saline	500	"	4°	Sheena Comas		07[45]	MDD
E	23/7/98	5% Dextrose	500	IV	4°	dcta	98C10 BA	12[45]	MDD
F	23/7/98	5% Dextrose +20mmol KCl	500	IV	4°	dcta			
G	23/7/98	N Saline	500	IV	4°	dcta			
H									
I									
J									
K									
L									
M									
N									
O									

RATE OF FLOW (Drops/Min.) = VOL.OF FLUID (ml) x 15 / Duration (Mins.) (1ml = 15 drops)

0.02

Approximate Rate for 500 ml.

1 hr. = 120 Drops/min. — 6 hr. = 22 Drops/min.

4 hr. = 30 Drops/min. — 8 hr. = 15 Drops/min.

SHEET NO .....

MEDICINE TION FORM

THIS F[illegible] I MU[illegible]E COMPLETED FULLY BEFORE IT WILL BE DISPENSED

GLASGOW ROYAL [illegible]ERNITY HOSPITAL
ROTTENR[illegible]
GLASGOW, G4 0NA
Telephone 0141-211 5400

FORM NO. 02645

Your patient [illegible]

Age [illegible] Unit No. [illegible]

Address [illegible]

Under the care of [illegible]

was seen as an outpatient/discharged from Ward*. [illegible] on 30/1/14

with a diagnosis of [illegible]

Please TICK box if child proof containers are UNSUITABLE ☐

A discharge letter will follow. The patient was discharged on the medicine treatment detailed below. Further duration of treatment ***from date of discharge*** is shown in "Recommended Duration of Treatment" column. Please check Pharmacy use column to identify the product supplied.

(A SEVEN DAYS SUPPLY HAS/HAS NOT* BEEN DISPENSED BY THE HOSPITAL.)

(*Delete as applicable).

Note to hospital prescriber :

(a) Use a ballpoint pen

(b) In the "Recommended Duration of Treatment" column it is important to state the number of days for which the treatment should be continued from the date of discharge.

(c) If treatment is to be for an indefinite period, mark "INDEFINITE".

(d) If treatment is to be intermittent or irregular, give FULL DETAILS in the COMMENTS space below.

Medicine	Dosage Form eg. Tablets	Dose	Times of Administration	Recommended Duration of Treatment from Date of Discharge (Days)	PHARMACY USE: No. of Days Supply	PHARMACY USE: Quantity, Name and Strength supplied by Pharmacy.
[illegible]	tabs	2x	[illegible]	6/52	[illegible]	[illegible]

Medicine Sensitivity 1. _____ 2. _____ Dispensed by: [illegible] Checked by: _____ Date Dispensed 30/1/14

OTHER TREATMENT and COMMENTS (Including details of appliances, etc.)

MEDICATION COLLECTED BY (MESSENGER)

.....

FOR WARD USE ONLY

Received on Ward by .....

Issued by .....

Date Issued .....

Signature of Patient or Representative .....

DRs. NAME IN BLOCK CAPITALS [illegible] SIGNATURE [illegible] DATE [illegible]

White - GP Copy, Pink - Medical Records Copy, Blue - Pharmacy Copy

Radiopager No .....

OBSTETRIC

PRESCRIPTION SHEET No.

SIDE 2

REGULAR PRESCRIPTIONS - OTHERS

Pharmacy Use		Date Started	MEDICINE (Block Capitals)	DOSE	ROUTE	TIMES FOR ADMINISTRATION: am 6 / am 8 / am 10 / md 12 / pm 2 / pm 4 / pm 6 / pm 10 / pm 12 / Other Times	Prescribers Signature (Full)	DISCONTINUED: Date	Signed
	A	16/7/98	Coradamol	2 tabs	PO	4-6 pm prn prn x 8 days			
	B	16/7/98	Stemetil	25 mg	PV	✓			CP
	C	16/7/98	DF 118	60mg	PO	4-6 pm prn		22/10	BK
	D	16/7/98	Buscopan	20mg	PO	6a		22/10	BK
	E	17/7/98	Augmentin	375mg	PO	✓		22/7	
	F	17/7/98	ZANTAC (RANITIDINE)	150mg	PO	✓			
	G	22/2/97	TEMAZEPAM	10-20mg	ORAL	(if req-N)			
XH	6/11/98		solpadol	100mg	PR	120 4hrly 3 doses		27/11	
X	J	27/11/98	VOLTAROL (DICLOFENAC)	50mg	PO	8am PRN max 150mg/24			
	K								
	L								
	M								
	N								
	O								
	P								
	R								
	S								
	T								
	V								
	W								
	X								

REGULAR PRESCRIPTIONS - INJECTIONS

	YA	16/7/98	Fragmentin	10mg	IM	8a pm prn		17/7
	YB	17/7/98	Morphine	10mg	IM	8a pm prn		
	YC	17/7/98	Stemetil	12.5mg	IM	8a pm prn		
	YD	18/7/98	BUSCOPAN	20mg	IM	PRN		23/10 BK
	YE	22/7/98	Ranitidine	50mg	IV	✓ ✓		23/10 BK
	YF	26/11/98	MORPHINE	1mg/ml	IV	VIA PCA		
	YG	28/11/98	ZNOXARON	40	IV	✓	S	
	YH							
	YJ							
	YK							
	YL							

WARD	NAME OF PATIENT	AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	TIMES FOR ADMINISTRATION: am 6 / am 8 / am 10 / md 12 / pm 2 / pm 4 / pm 6 / pm 10 / pm 12 / Other Times	CONSULTANT
	Deborah Sullivan				A161100		

OBSTETRIC PRESCRIPTION SHEET

SIDE 1

ONCE ONLY PRESCRIPTIONS

DIET

DATE GIVEN	TIME GIVEN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN
16.7.98	21.50	Maxalon	10mg	IV			
16.7.98	22.50	Pethidine	50mg	IM		Upwilliam	2250
16.7.98	23.00	Pentazocan.	30 mg	IM		midwife	2300
17/7/98		Temazepam	10 ml	PO			
17/7/98	2230	BISEPAN	20mg	IM			2230
17/7/98	2239	Mupirocin	1-2g	IV		Upwilliam	2230
22.7.98		Maxalon	10mg	IV	SC Jones	SC Jones	15:30
22.7.98		Kaluridine	5mg	IV			
22/7/98		METOCLOPRAMIDE	10	IV			2130
22.7.98		METOCLOPRAMIDE	10mg	IM			
15/10/98		Temazepam	10mg	O			00.25
16/10/98		Betamethasone	12mg	IM			03.30
		Diamorphine	2.5mg	IM			0405
		Stemetil	12.5mg	IM			0405
23/10/98		BETAMETHASONE	12.mg	IM			03.30
23/10/98		DF118	30mg	O			1520
22-10-98		DIAMORPHINE	5mg	IM		DMCa	1725
22-10-98		STEMETIL	12.5mg	IM		DMCa	1725
24/10/98		DF118	60mg	O		DMCee	0235
25/10/98		Diamorphine	7.5mg	IM			2225
25/10/98		Stemetil	12.5mg	IM			2225

STANDING INSTRUCTIONS

..... may receive any preparation on the Unit Midwifery Standing Instructions except for the following:-

Signed ..... (Doctor)

Date 16/7/98

NOTES

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

LABOUR RECORD			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

KNOWN MEDICINE SENSITIVITIES

MS SULLIVAN A161100

MARI DEBORAH

1/1 07121972

160 MAIN STREET

BATTLESTON

HEIGHT WEIGHT UNIT NUMBER CONSULTANT

HOSPITAL

MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

REGULAR PRESCRIPTIONS

DATE	6 a.m.	8 a.m.	10 a.m.	12 m.d.	2 p.m.	4 p.m.	6 p.m.	10 p.m.	12 m.n.	OTHER TIMES	COMMENTS ON DISCREPANCIES
27/11/99	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	
28/11/99	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	
29/11/99	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Ae 02-00
30/11/99	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	

NAME: Deborah Sullivan

UNIT NUMBER: A161100

WARD:

KEY: CODE LETTER CIRCLED E.G. (A) = MEDICINE REFUSED AND MEDICAL STAFF INFORMED

CODE LETTER SCORED E.G. A = PATIENT ABSENT

HOSPITAL

MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

REGULAR PRESCRIPTIONS

DATE	6 a.m.	8 a.m.	10 a.m.	12 m.d.	2 p.m.	4 p.m.	6 p.m.	10 p.m.	12 m.n.	OTHER TIMES	COMMENTS ON DISCREPANCIES
	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	
17/7/98		YA		12 US am			YA 1900			YD	D/C 2050 CK
18/7/98	YC	E F CO					E			YD @ 0230 mo	YD given 0820 CO
19/7/98	LB				YE			F @ 2a CTG 21 AMS		YD 15	
20/7/98		C F	A							F @ 15 AMS C. ... AMS A @ 15	
21/7/98	98	A									A 00.25 SK
22/7/98		F	A LB					A CTG 22 00 21		A @ 15	03.30 SR A.
23/7/98		YG		# @ 1300			A			A @ 1100	MM.
24/7/98								E H			

PS SULLIVAN
DEBORAH
241
150 MAIN STREET
FARMINGTON

A161100
NIT NUMBER
07121972

WARD

KEY: CODE LETTER CIRCLED E.G (A) = MEDICINE REFUSED AND MEDICAL STAFF INFORMED
CODE LETTER SCORED E.G X = PATIENT ABSENT

PRENATAL SCREENING ASSAY REPORT

FROM: DUNCAN GUTHRIE INST. OF MEDICAL GENETICS
YORKHILL, GLASGOW G3 8SJ
Tel: 0141-201 0372

Date Sample Taken	Lab. Ref. No.
26-05-98	809763

Surname: SULLIVAN
Forename: DEBORAH
Address: 1/1 160 MAIN ST
BAILLIESTON
G69 6AH
Weight: 76.0 Kg. Height: m.
Date of Birth: 07-12-72

Hospital: GLASGOW ROYAL MATERNITY
Address: HOSPITAL
ROTTENROW
GLASGOW
Hospital No.: 161100
Clinic/Ward:
Consultant: RODGERS

Previous Serum Report Number: None

		By Dates	Ultrasound
L.M.P.	01-01-98 Certain	Gestation 16+3	15+1

Previous History of Neural Tube Defect: No

Complication of this Pregnancy: None

Low risk
DMCG/ET

Remarks

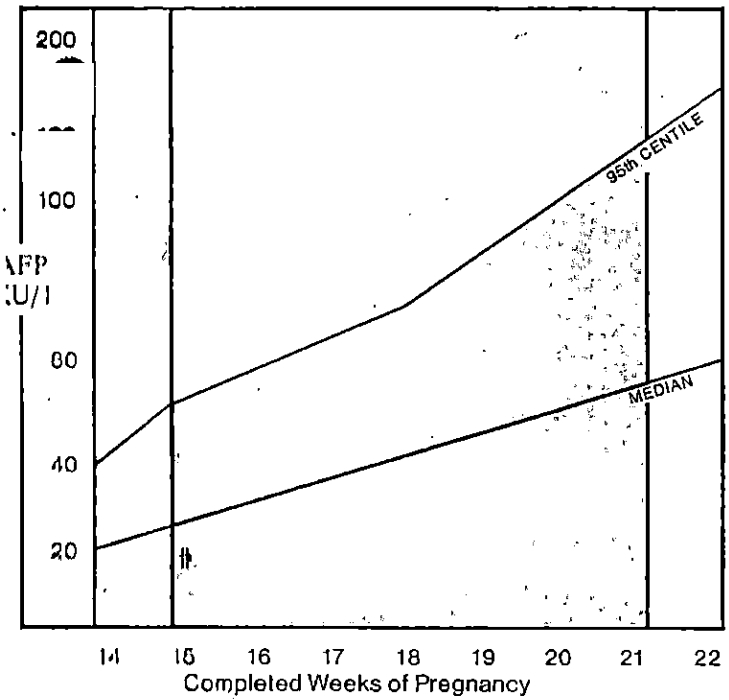
Serum AFP result: 21.4 kU/l Weight adjusted AFP = 0.90 MOM

Serum hCG result: 14 IU/ml Weight adjusted HCG = 0.39 MOM

Comment: AFP value not elevated for stated gestation.

The AFP and HCG results at maternal age 25 years, 170 days give a combined risk of Down's syndrome at mid trimester of less than 1:220, which falls within the LOW RISK group (see graph).

ALPHAFETOPROTEIN ASSAY



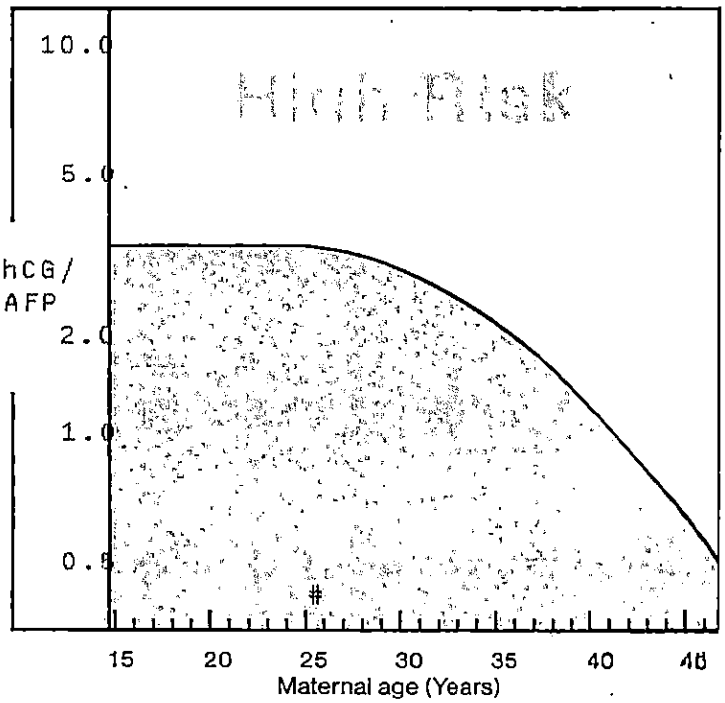
RECOMMENDED ACTION ON FIRST SERUM AFP LEVEL:

ABOVE 95th CENTILE: CHECK GESTATION BY ULTRASOUND, EXCLUDE TWINS, THREATENED AND MISSED ABORTION, REPEAT SerAFP

BETWEEN 90-95th CENTILE: VALIDATE GESTATION

BELOW 90th CENTILE: NO ACTION INDICATED IF GESTATION VALID

DOWN'S RISK (hCG/AFP)



DOWN'S RISK ESTIMATE ONLY VALID IF GESTATION AND DATE OF BIRTH CORRECT

Date 01-06-98

Signature

[redacted]

DOB 7/6/1

DAYCARE UNIT
GLASGOW ROYAL MATERNITY HOSPITAL
ROTTENROW
G4 0NA

Telephone No.: 0141 211 5400 Ext 5217 or 5276
Direct Line: 0141 211 5217/5276

Dear [redacted]

LOW RISK

You will be pleased to know that the results of your recent blood test indicate that there is little chance of your baby having Spina Bifida or Down's Syndrome.

Please let your GP see this letter at your next visit.

It may be that you already have an appointment for a detailed scan or other special test. You should still keep such an appointment.

Yours sincerely

AH

Daycare Unit pp S McGeachan

GLASGOW ROYAL MATERNITY HOSPITAL ULTRASOUND REPORT

PATIENT NAME: MS SULLIVAN DEBORAH J/J — A161100 — DATE OF BIRTH 07121972

ADDRESS: 160 MAIN STREET BAILLIESTON G69 6AH — HOSPITAL NUMBER

Single/Twins/Triplets

LMP 31.1.98 — EDD (BY DATES) 8.11.98

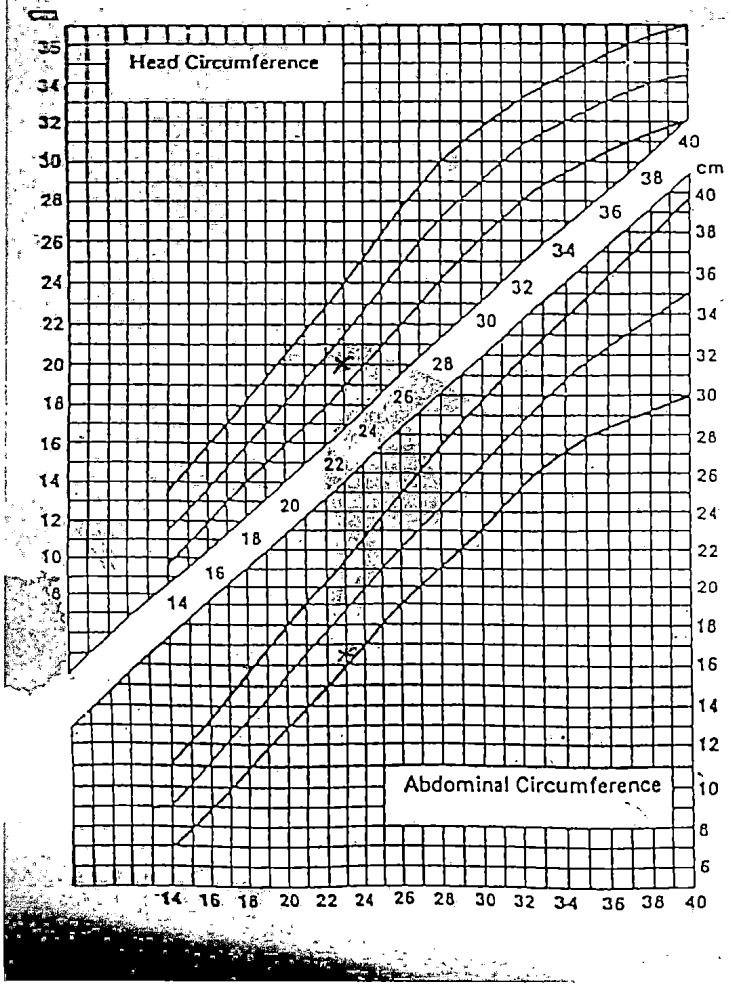
Ultrasound = dates YES/NO — EDD (BY SCAN) 18.11.98

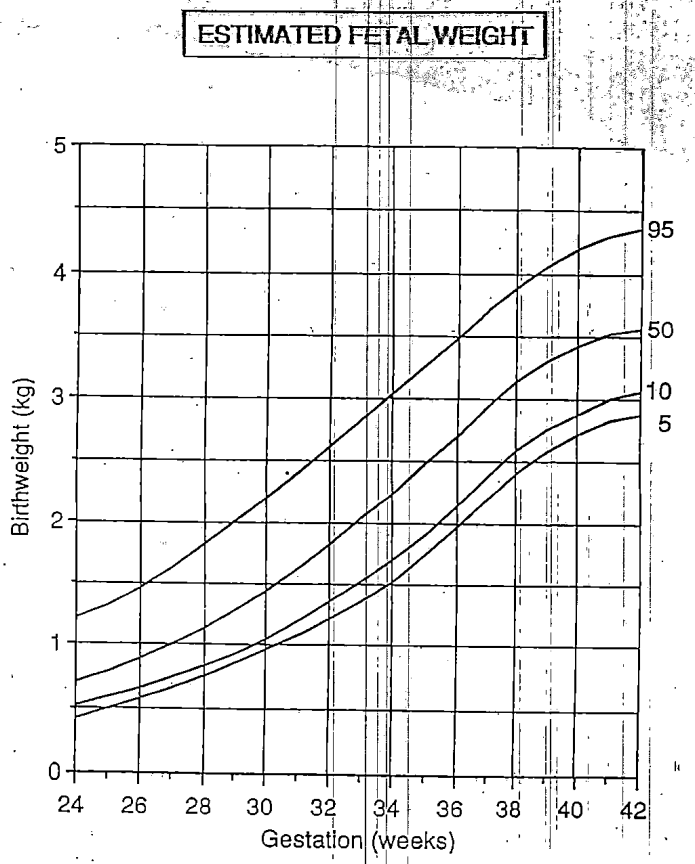
BOOKING DATA AND EARLY PREGNANCY SCANNING

Date	7.4.98	12.5.98	4.6.98
Menstrual age	9+4	13+4 by scan	16+
Ultrasound age	8+1		16+3
Fetal number	1	(1)	1
Fetal heart	+ve	+ve	+ve
CRL	14 9/7 = 8+1	60 mm. 13w2	12 = 12 9 - 16+3
BPD		23.2 : 14 .	34 = 16+3
FL		9.8 . 13w.	19 = 16+4
Yolk sac			
Second sac			
Placenta			post.
Membrane separation			
Molar changes			
Pelvic mass/IUCD			
Comment	1. U preg 5/52 for BPD	Cervical os closed scan = dates	fetal stomach seen Anhe
Review			CHRISTINE BROWN
Operator	CMacleay MSCERT Sen II Rad	Member 3/24	SENIOR RADIOGRAPHER

POSTNATAL SCANS

Date			
Indication	Comment	Comment	Comment
Review			
Operator			





Gestation and Birthweight

Singletc... born in Scotland 1975-89

FETAL GROWTH, BIOPHYSICAL PROFILE AND DOPPLER

Date	18.6.98	17 7 98	
Gestational age	18+4	23+1	
Presentation	Ceph	CEPHALIC	
Fetal heart	+ve	+VE	
BPD	↑	56mm	
CI	≡ 18+6 wks.		
HC		200mm	
CC		CEREBELLUM 24mm	
AC		165mm	
FL	↓	37.3mm	
EFW			
HC/AC			
Amniotic fluid	Average	AVERAGE	
AFI (4 quadrant)			
Fetal movements	vigorous	V. ACTIVE	
Tone		✓	
Breathing			
BPP score/8			
UA RI			
UA PI			
AO RI			
AO PI			
MID CER RI			
MID CER PI			
Placental site	post not low	POSTERIOR	
Placental grade			
Comment	cobell = 19mm fetal bladder & stomach seen	FETAL STOMACH, BLADDER, KIDNEYS SEEN N.A.D. Adnexae NO MATERNAL RENAL DILATATION	
Review			
Operator	ACB	H. Hughes / HUGHC	

CHRISTINE BROWN
SENIOR 2 RADIOGRAPHER

INDOOR
OUTDO

THE GLASGOW ROYAL MATERNITY HOSPITAL

INFANT RECORD

Name BABY SULLIVAN | Reg. No. A161100

Address 1/1, 160 MAIN STREET
BAILLIESTON
GLASGOW. G69 6AH

Category

Religion

Diagnosis:— HEART MURMUR

Father's Occupation

MOTHER

Age 25 Para 0+0 E.D.D. 13/11/98. Maturity W.R. A Pos

Previous Pregnancies	Present Pregnancy	
		Blood Group { A.B.O.:— Rh:—
		X-Ray: yes: no

LABOUR

Duration	Membranes ruptured at
Second Stage	Drugs given
Mode of delivery	Analgesia
Placenta	Anaesthesia
	Oxygen to Mother: yes: no

INFANT

Born on 26-11-98 at a.m. p.m.	Birth Weight 3410
Male: [Female]	Dismissal weight
Condition at birth 9/1 10/5	Malformations
Resuscitation	Blood group { A.B.O.:— Rh.:—
Admitted	Highest bilirubin
Dismissed	Urine
Feeding	Drugs
	B.C.G.

APPT WED 16-12-98 AT 11-45AM

General Practitioner: DR GOLDIE
EASTERHOUSE H/C
GLASGOW,

GLASGOW ROYAL MATERNITY HOSPITAL
ROTTENROW
GLASGOW G4 ONA

REQUEST FOR OUT-PATIENT REFERRAL TO PAEDIATRIC CLINIC

FOR 2/52 APPOINTMENT

Referred from: KRH Unit

Mother's Unit No: A161100 Baby's Unit Number: (if applicable)

Baby's Surname: SULLIVAN

Address: 1/1
160 MAIN ST. BAILLIESTON G69 6AH

Baby's Sex: FEMALE

Date of Birth: 26.11.98 Birth Weight: 3.41

Delivery: EMSCS Apgar: 9/1 10/5

Maturity: TERM Rususcitation: FACE MASK ONLY

Reason for Referral
(e.g. Prematurity, Rhesus etc): HEART MURMUR FOUND ON 2/7 CHECK

Discharge Date: 30/11/98 Discharge Weight: 3.404kgs

Please cirle: Consultant / Registrar Clinic

Named Paediatric Consultant (if applicable)

Own G.P's Name: DR GOLDIE

Address: EASTERHOUSE H/C

On Completion, return form to the Medical Records Department to arrange an appoitment. Telephone requests without the form are not acceptable.

wed 16/12/98 11.45
Dr Powls

GLASGOW ROYAL MATERNITY HOSPITAL

HOSPITAL No. A 161100

INFANT CHART

NAME Boy [illegible]

PEDIATRIC NO.

DATE	26/11	27	28	29	30																
AGE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
TYPE FEED	B/F	+	SMA																		
VOL. FEED m/l	90ml				SMA																
FREQUENCY	✓	✓	✓	✓	✓																
STOOLS	✓	✓	✓	✓	✓																
	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E

40° 400 300 30° 200 100

30° kgms

000 37° 800 700 36° 600 500 35° 400 300 34° 200 100

33° 3 kgms.

900 32° 800 700 31° 600 500 30° 400 300 20° 200 100 kgms.

20°

EYES	✓	✓	✓	✓	✓	
SKIN	[illegible]	✓	[illegible]	[illegible]	✓	
CORD	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
MOUTH	✓	[illegible]	[illegible]	[illegible]	✓	

3rd/Ka

3 days

EXAMINATION		DESCRIPTION OF ABNORMALITIES
POSTURE	✓	
COLOUR Including Cyanosis, Jaundice, Pallor	✓	
SKIN	✓	
NUTRITION Subcut Tissue	✓	
OEDEMA	✓	
SKULL Including Sutures, Fontanelle	✓	OFC 34·8 cm.
FACIES	✓	
CHEST	✓	
RESPIRATION Rate/Min	✓	
AIR ENTRY	✓	Clear
HEART SOUNDS Including Murmurs	X	1 +11 + 3/6 65M - heard + loves precordium -
FEMORAL PULSES	✓	- Rt equal to feet, left palpable
EARS	✓	
EYES	✓	
NOSE/NASAL AIRWAY	✓	
MOUTH/PALATE	✓	
NECK Including Clavicles	✓	
UMBILICUS Including 2 Arteries	✓	
ABDOMEN	✓	
GENITALIA	✓	
ANUS	✓	
SPINE	✓	
ARMS/HANDS Including Palmar Creases	✓	
LEGS/FEET	✓	
BEHAVIOUR/ACTIVITY	✓	
MUSCLE TONE	✓	
MOVEMENTS	✓	
PALMAR GRASP	✓	
HEAD CONTROL	✓	
MORO	✓	
HIPS	✓	
CRY	✓	

CONCLUSION **NORMAL = ✓** **ABNORMAL = X** **NOT EXAMINED = O**

NORMAL HEALTHY INFANT [ ] If not, specify:-

DATE OF EXAM 24/11/58 AGE IN HOURS ~32 hrs

EXAMINED BY Dr. A. Gallagher STATUS Std 1

NAME: SULLIVAN.

DATE	TIME	I.C.T.		INVESTIGATIONS
26/11/98	00.39hrs.		Paed Dr called for Emergency LSCS for fetal distress. Baby born in good condition Apgars 9/10 5. Meconium noted in oropharynx none below cords. Baby cleared & applied Kenakion 0.5ml given I.M. Mc parental consent	C. Dawson
27/11/98	10am.		Routine 2 day check: - Heart murmur heard	
			O/E: Pink active. HS I+II + 3/6 SM-heard all over praecordium, loudest at apex Lungs clear Abdo: NAD -	Pal but palpable.
			IMP: ?VSD.	
			(P) CXR.	
27/11/98	15^{00}		Paed Reg Review 38 hours old. Murmur detected at routine check Baby breast feeding well on demand O/E AF normotensive Pink Active Well perfused HS I + II + Loud 3/6 parasystolic murmur loudest at LSE but heard all over praecordium.	

→

CONTINUATION SHEET

Femoral pulses normal
No respiratory distress
Good air entry Chest clear
Abdomen soft Undistended
No organomegaly
BS Normal
Normal tone.

CXR - no cardiomegaly
- ↑ lung markings bilaterally - looks like oedema.

Imp: agree VSD

Plan: staying in hospital over weekend
review on Monday am and arrange echo then - cont
please call paediatrician if any concerns
I have explained this to parents

U N Gerald
MCURNHS

28 F/H Mother is Cousin had heart murmur sug TOF
9 of them
O/E - Pink not breathless feeding well
- No cyanosis
CVS H.S. I + II + grade 3/6 systolic murmur,
max ULSE heard at apex & pulm area
Brachials ✓ femorals ✓
No heaving Cardiac No parasternal heave
Abd No hepatosplenomegaly. Plan as above D/W Cardiologist re Echo.

Patient's Name	Unit Number
SULLIVAN	26/11/98 A161100

CONTINUATION SHEET

16/12/98

[redacted]

MUM PHONED BABY ATTENDING RHSC

tient's Name	Unit Number

[redacted] HOSPITAL

PRESCRIPTION SHEET No.

REGULAR PRESCRIPTIONS – INJECTIONS			DOSE	ROUTE	TIMES FOR ADMINISTRATION										Prescribers Signature (Full)	DISCONTINUED	
Date Ended	Date Started	MEDICINE (Block Capitals)			6	8	10	12	2	4	6	10	12	Other Times		Date	Signed
	A																
	B																
	C																
	D																
	E																
	F																
	G																

REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

	H																
	J																
	K																
	L																
	M																
	N																
	O																
	P																
	R																
	S																
	T																
	V																

ONCE ONLY PRESCRIPTIONS

DIET

DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN
16/11/98	00.45	KONAKION	0.5ml	I.M.	S/O	E Dewsa	0045

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW:

MEDICINE		ADVERSE REACTION
1.		
2.		

KNOWN MEDICINE SENSITIVITIES 1.

WARD	NAME OF PATIENT	AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
	BABY SULLIVAN					A/16/11/00

AP/CA/A161100

16th December, 1998.

Dr. Goldie,
Easterhouse Health Centre,
GLASGOW..

Dear Dr. Goldie,

Baby SULLIVAN,
Flat 1/1., 160 Main Street, Baillieston, Glasgow, G69 6AH..
D.O.B. 26.11.1998.

This child was supposed to be coming back to us regarding a heart murmur. Since we last saw the baby, however, they have been to the Cardiologists who confirmed that the heart murmur is due to a VSD and they are going to continue to review it themselves.

On the maternal request, therefore, we will not offer any further appointments ourselves.

Yours sincerely,

ANDREW POWLS,
Consultant Paediatrician.

4305BAO COROMETRICS MEDICAL SYSTEMS, INC. 68381 130 PAGES REMAINING

4305BAO COROMETRICS MEDICAL SYSTEMS, INC. 68382 129 PAGES REMAINING

4305BAO COROMETRICS MEDICAL SYSTEMS, INC. 68383 128 PAGES REMAINING

4305BAO 127 PAGES REMAINING

9/11/98 2:53 PM

MS SULLIVAN
DEBORAH
171 -
160 MAIN STREET
RATTLESTON
559 BAH

07121972

A161100

FHR-bpm 200 180 160 140 120 100 80 60

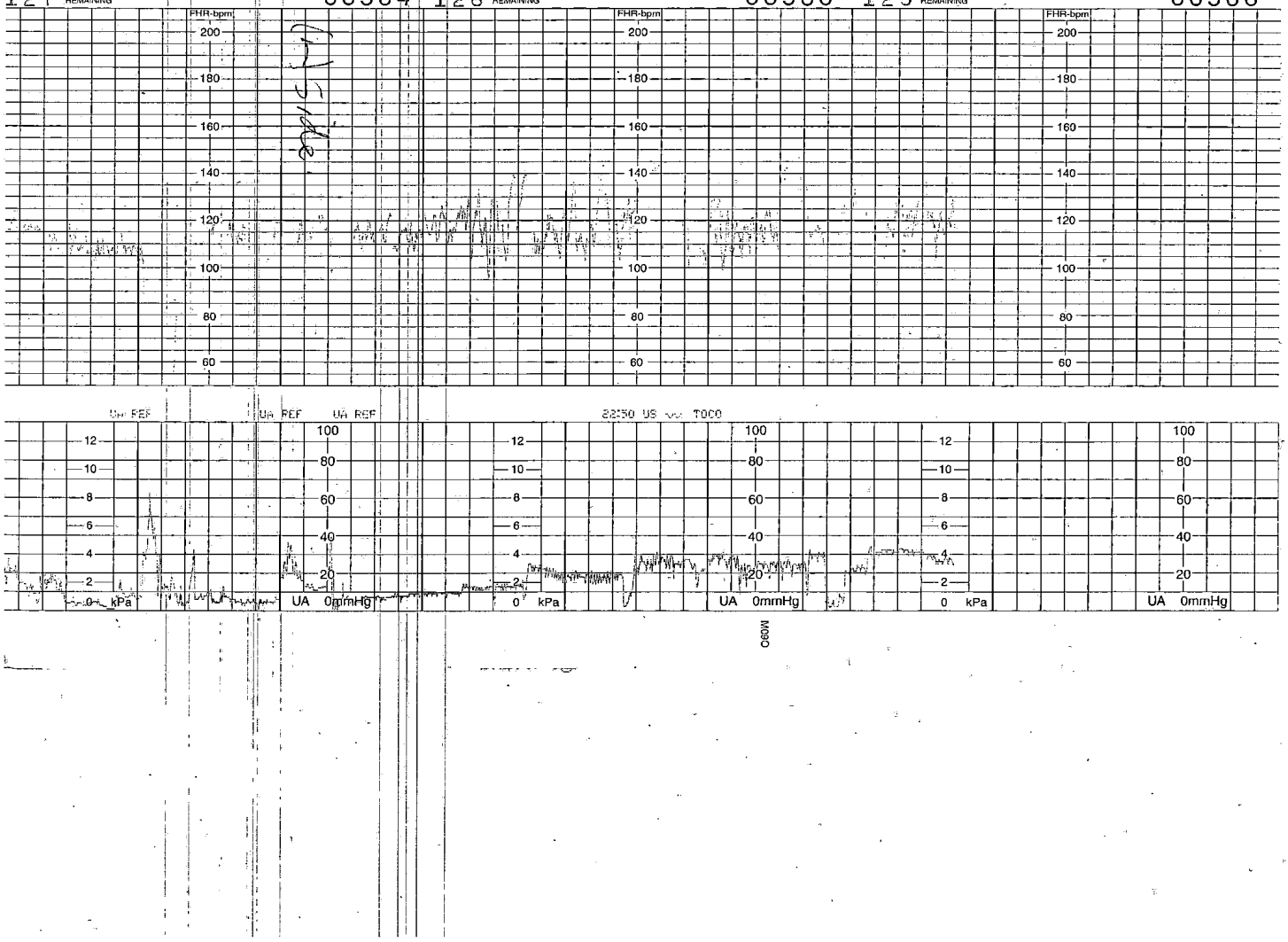
UA 0mmHg 100 80 60 40 20

0 kPa 12 10 8 6 4 2

UA REF

4305BAO COROMETRICS MEDICAL SYSTEMS, INC. 4305BAO COROMETRICS MEDICAL SYSTEMS, INC. 4305BAO COROMETRICS MEDICAL SYSTEMS, INC.

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LABOUR ADMISSION/ADVICE CALL

L/W.2001

Date: 21·10·98 Time 21^10

DR Rodger

PATIENT'S FULL NAME AND ADDRESS:

Deborah Sullivan Unit. No. A161100

160 Main St

Postcode: Baillieston G69 Tel. No.

If Patient's address is a flat, details of floor level, door number and name on the door are required.

PRESENT LOCATION: Well.

Clinic Day: AM/PM

Last Clinic Visit

E.D.D. 18·11·98 Parity 0+0 (SVD/Forceps/C.S.)

36. wks

REASON FOR CALL:

1. Urine activity - sore

2.

Contractions ☐ Ruptured Membranes ☐/◯

DEBORAH SULLIVAN
A161100
160 MAIN STREET
7·12·72

Glasgow Royal Maternity Hospital
X– RAY DEPARTMENT

REQUEST FORM

UNIT Labour Ward WARD/~~OP~~

~~LMP~~ 23 weeks gestation REQUESTI

PROVISIONAL DIAGNOSIS ? Constipation ? Obstruction

CLINICAL DETAILS Vomiting, Diarrhoea. No abnormal inf
Prev. chole cystectomy + late reflux.
Prev. constipation.
? Pyloric Stenosis ? to reflux. ? const

EXAMINATION REQUESTED Erect + Supine Abdo. Films

WARD PORTABLE/ WALKING/ TROLLEY.

Signature.

PROBLEMS

/ /	Acne rosacea	
/ /	Dysmenorrhoea	
/ /	Dyspepsia	
/ /	Hay fever	
/ /	Type of GIT pain	
	Frequent hosiptal admissions	
/ /	Never smoked tobacco	
08/01/1994	FH: Ischaemic heart dis. <60	Father
08/01/1994	FH: Raised blood lipids	Father
16/03/1996	Appendicitis	
16/03/1996	Appendicectomy	
23/04/1996	Acute cholecystitis	
23/04/1996	Cholelithiasis	
23/04/1996	Cholecystectomy	
23/04/1996	Cholecystectomy	
14/11/1996	Type of GIT pain	
	Sphincter of oddi dysfunction	

REPEAT MEDICATION

Prescribe every 30 days — Review every 0 weeks

				Start	Last
1	LOSEC CAPS 20MG	30	1 CAP DAILY	30/06/94	09/10/97
2	METOCLOPRAMIDE HCL TABS 10MG	60	1 TAB THREE TIMES DAILY	20/01/95	09/10/97
3	DICYCLOMINE HCL TABS 10MG	90 tabs	1 TAB THREE TIMES DAILY	20/01/95	
4	PREPULSID TABS 10MG	120 tabs	1 TAB FOUR TIMES DAILY	20/01/95	11/04/95
5	LACTULOSE SOL 3.35G/5ML	500mls	USE AS DIRECTED	22/11/96	

PROCEDURES

24/05/1990	O/E - BP reading normal	
24/05/1990	O/E - weight	
07/02/1991	Cervical smear: negative	GP Care
01/01/1993	Ex-smoker - amount unknown	
08/01/1994	[V]Tobacco usage screen	
08/01/1994	Trivial drinker - <1u/day	
09/06/1994	Cervical smear:inadequate spec	GP Care
09/06/1994	Cervical smear:inadequate spec	GP Care
06/09/1994	Admit medical emergency unsp.	Plus 1
10/11/1994	Cervical smear: negative	GP Care
01/12/1994	Admit surgical emergency unsp.	
01/01/1995	Cystoscopy	Minimal cystitis
01/01/1995	Cystoscopy	Negative
22/12/1995	Never smoked tobacco	
16/03/1996	Admit surgical emergency unsp.	Plus 4
18/09/1997	Cerv.smear: severe dyskaryosis	GP Care





LABOUR ADMISSION/ADVICE CALL

L/W.2001

Date: 8-11-98. Time 2130.

PATIENT'S FULL NAME AND ADDRESS:

Deborah Sullivan Unit. No. A161100

160 Main Street

Postcode: Baulkeston Tel. No. 771-0635

If Patient's address is a flat, details of floor level, door number and name on the door are required.

PRESENT LOCATION:

~~[illegible]~~

Clinic Day: AM/PM Dr Rodgers

Last Clinic Visit

E.D.D. 18-11-98 Parity 0+0.

(SVD/Forceps/C.S.)

REASON FOR CALL:

1. Contractions 1:4 mins.

2.

Contractions ☑ Ruptured Membranes ☒

MS SULLIVAN
DEBORAH
1/1
160 MAIN STREET
NAME BAILLIESTON

A161100
07121972
G69 6AH

GLASGOW ROYAL MATERNITY HOSPITAL

DELIVERY SUITE INTENSIVE OBSERVATIONS CHART

AMWSCS
0039.

GESTATION:

TIME OF ADMISSION:

DATE:

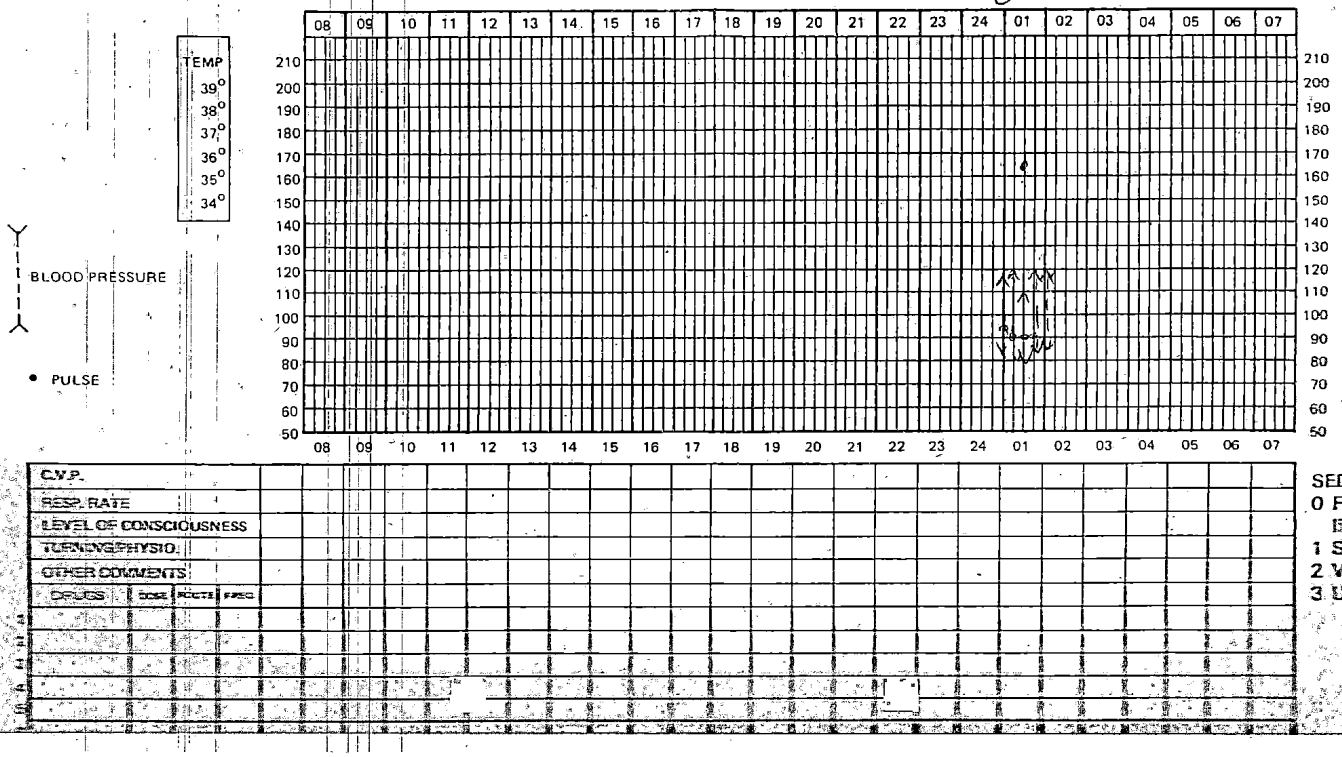
HOSP. No.:

CONSULTANT:

AGE:

DIAGNOSIS:

D1&D



	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
C.V.P.																								
RESP. RATE																								
LEVEL OF CONSCIOUSNESS																								
TURNING/PHYSIO.																								
OTHER COMMENTS																								
DRUGS / DOSE / ROUTE / FREQ																								

SEDATION SCORE
0 Fully awake or
light/normal sle
1 Slightly Drowsy
2 Very Drowsy
3 Unrousable

INTRAVENOUS FLUIDS		08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07	TOTALS
LINE 1 Hartmann's	ml/hr																		1000							
LINE 2	ml/hr																									
LINE 2	ml/hr																									
C.V.P.	ml/hr																									
ORAL FLUIDS	ml/hr																									
CUMULATIVE FLUIDS IN																										
URINE ANALYSIS	PROTEIN BLOOD GLUCOSE																		clear							
FLUIDS OUT	HOURLY URINE																									
	CUMULATIVE URINE																									
	N.G. & OTHER LOSSES																									
CUMULATIVE FLUIDS OUT																										
FLUID BALANCE																										

INVESTIGATIONS
Hb
WCC
ELECTROLYTES
1 SODIUM
2 POTASSIUM
UREA
CREATININE
TOTAL PROTEIN
PTR
PTTK
FIBRINOGEN
FDP's
PLATLETS
OTHERS

CONVERSION TABLE		
drm		ml/24
5	15	360
10	30	720
15	45	1080
20	60	1440
25	75	1800
30	90	2160
35	105	2520
40	120	2880
45	135	3240
50	150	3600
55	165	3960
60	180	4320
70	210	5040
80	240	5760
90	270	6480
100	300	7200

20 DROPS = 1 ml.

Subject Access Request Team
Health Records Department
Glasgow Royal Infirmary
8 – 16 Alexandra Parade
Glasgow
G31 2ER

NHS
Greater Glasgow and Clyde

Private

MMA Legal Limited
Stok
43 – 59 Princes Street
Stockport
SK1 1RY

Date: 8th May 2026
Your Ref: 100016
Our Ref: SAR / ACCESS / CF
Enquiries to: Caroline
Direct Line: 0141 201 3380
Email: Caroline.Forsyth@ggc.scot.nhs.uk

Dear Sir / Madam

Re: Subject Access Request under the General Data Protection Regulation

Patient: Deborah Sullivan D.O.B: 07/12/1972

Thank you for your recent request 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:

GLASGOW ROYAL INFIRMARY RECORDS / STOBHILL ACH RECORDS
PRINCESS ROYAL MATERNITY RECORDS / DENTAL HOSPITAL RECORDS

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

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

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

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

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

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

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

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

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

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

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

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

Yours sincerely

Subject Access Request Team

MANUAL PATIENT RECORDS

ALL HOSPITAL RECORDS HELD NHSGGC	☐		
ACS	☐		
BEATSON HOSPITAL	☐		
CANNIESBURN HOSPITAL	☐		
DENTAL HOSPITAL	☐		
GARTNAVEL GENERAL HOSPITAL	☐		
GLASGOW ROYAL INFIRMARY (VOL 1)	☑		
INVERCLYDE ROYAL HOSPITAL	☐	MATERNITY	☐
NEW VICTORIA ACH	☐		
PRINCESS ROYAL MATERNITY	☐		
QUEEN ELIZABETH UNIVERSITY HOSPITAL	☐	MATERNITY	☐
ROYAL ALEXANDRA HOSPITAL	☐	MATERNITY	☐
ROYAL HOSPITAL FOR CHILDREN	☐		
STOBHILL HOSPITAL	☐		
VALE OF LEVEN	☐	MATERNITY	☐
WEST CARE AMBULATORY HOSPITAL	☐		
WESTERN INFIRMARY RECORDS	☐		

Including:

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

GLASGOW ROYAL INFIRMARY
UNIVERSITY NHS TRUST
Department of Nuclear Medicine
Tel: 0141 211 4762

Name: DEBORAH SULLIVAN
Address: 6 Muirhead Court
Glasgow::G69 7EP
Date of Birth: 07/12/1972 Hosp. No: 0964876
Consultant: IMRIE
Directorate: ---::---
Hospital: GRI::SOPD

Study Code: gas01021

Study: Gastric Emptying

Date: 20/04/2001

Study: gas01021 Name: DEBORAH SULLIVAN

REPORT:

Findings: T half of the first phase was 32 minutes the second phase 100 minutes. This may well mean dumping. The alternative explanation is that her solid phase T half was 58 minutes without dumping. The data are not unfortunately specifically enough for me to tell which is correct.

H W GRAY

Signature:

NUCLEAR MEDICINE REPORT

Date: 24/04/2001

Study: Gastric Emptying

GLASGOW ROYAL INFIRMARY
UNIVERSITY NHS TRUST
Department of Nuclear Medicine
Tel: 0141 211 4762

Name: DEBORAH SULLIVAN
Address: 1/1 160 Main Street
Glasgow::G69 6AH
Date of Birth: 07/12/72 Hosp. No: 964876
Consultant: MURRAY
Directorate: ---::---
Hospital: GRI::61

Study Code: bus96034

Study: Buscopan Study

Date: 15/10/96

REPORT: Study: bus96034 Name: DEBORAH SULLIVAN

Procedure: Buscopan augmented HIDA study

Findings: Normal transit of tracer is seen in the biliary system with a T max of 10 minutes.

Conclusion: No evidence of Sphincter of Oddi dysfunction.

H W GRAY
*

Please file

DRB

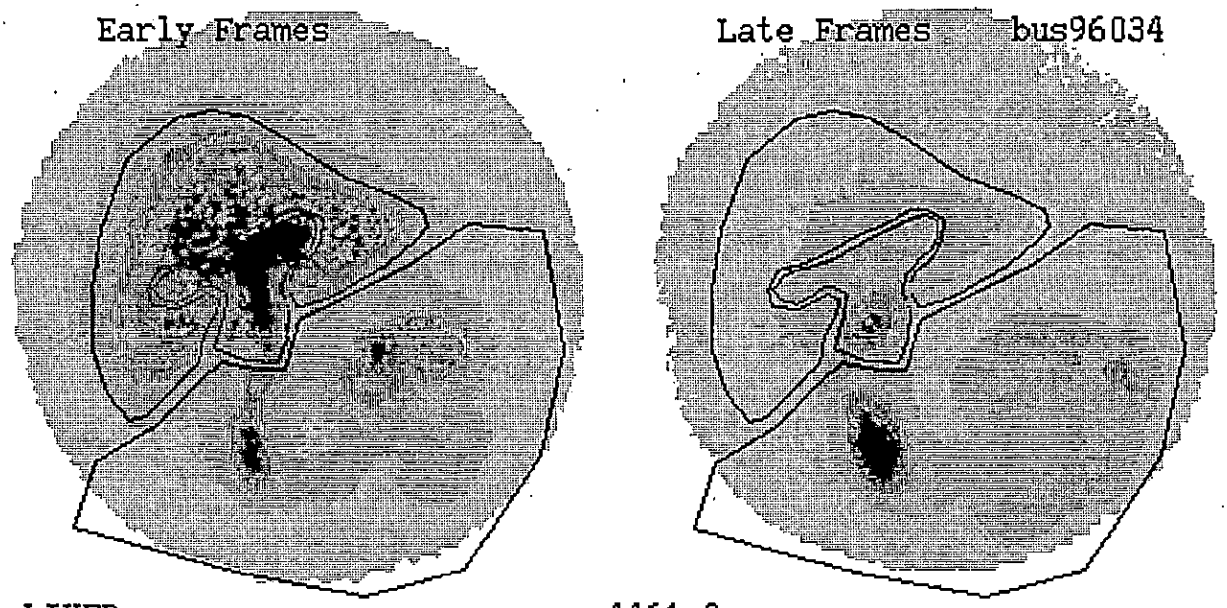
Signature:

NUCLEAR MEDICINE REPORT Date: 16/10/96 Study: Buscopan Study

Consultant
Dr H W Gray

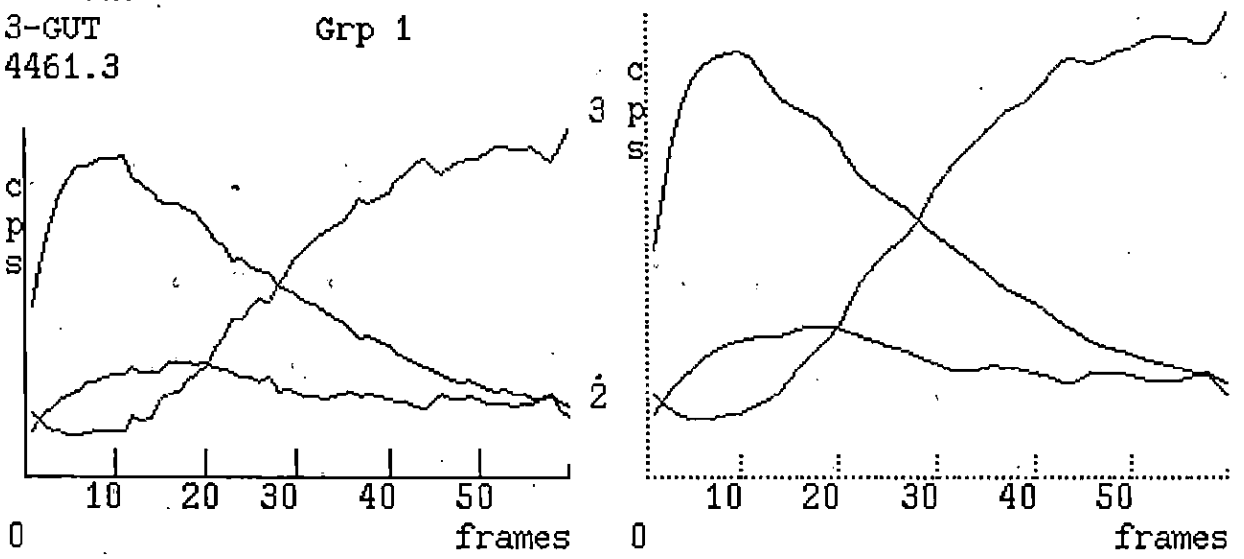
ROYAL INFIRMARY, GLASGOW
DEPARTMENT OF NUCLEAR MEDICINE

Telephone
0141-211 4762



1-LIVER
2-DUCTS
3-GUT
4461.3

4461.3



Name := DEBORAH SULLIVAN
Hospno := 964876
DoB := 07/12/72

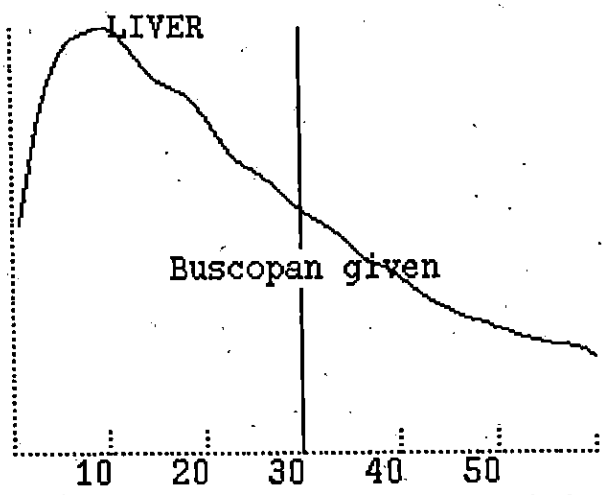
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Exam date := 15/10/96

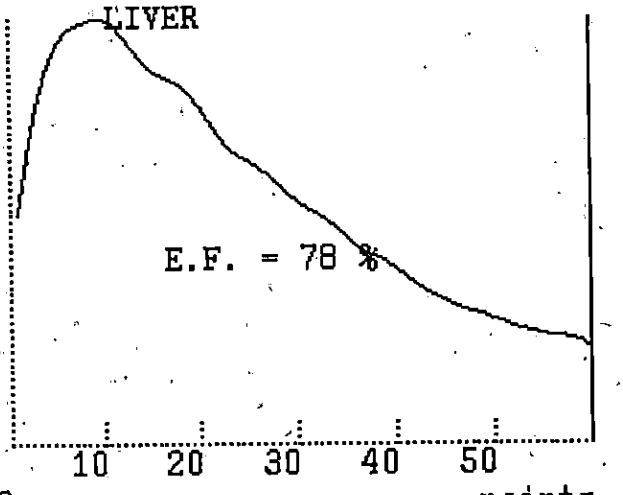
Consultant
Dr H W Gray

ROYAL INFIRMARY, GLASGOW
DEPARTMENT OF NUCLEAR MEDICINE

Telephone
0141-211 4762

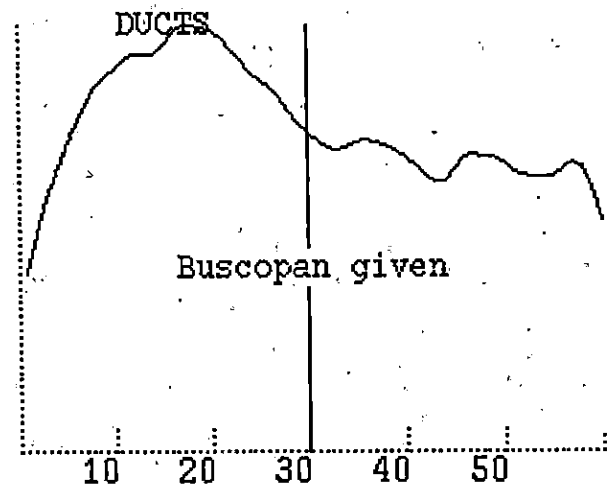
30 2331.2 57%60 916.7 22%
4079.5 4079.5

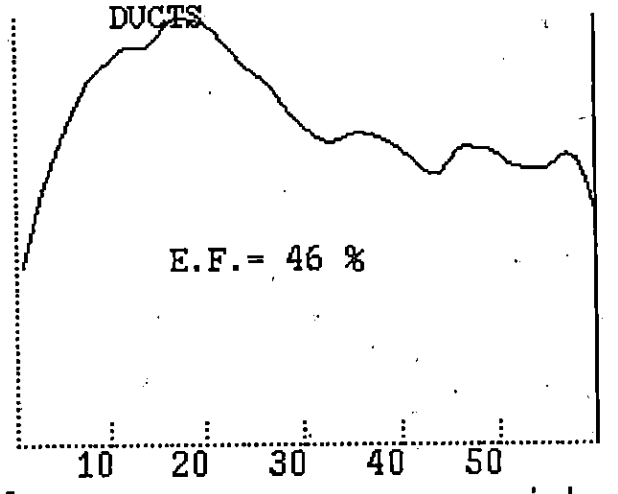




0 points 0 points

30 1095.4 75%60 796.4 54%
1463.3 1463.3





0 points 0 points

Name := DEBORAH SULLIVAN
Hospno := 964876
DoB := 07/12/72

Study ID := bus96034
Exam date := 15/10/96

Consultant
Dr H W Gray

ROYAL INFIRMARY, GLASGOW
DEPARTMENT OF NUCLEAR MEDICINE

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0141-211 4762

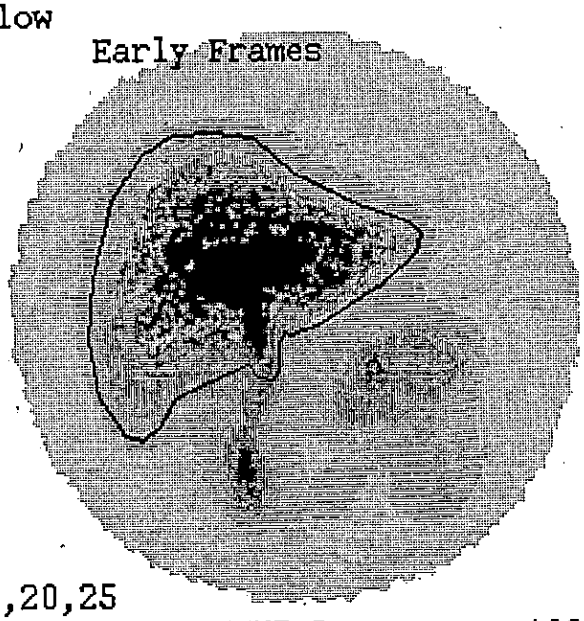
bus96034 on 15/10/96at 10:10

964876
Deborah Sullivan
1/1 160 Main Street
Glasgow::G69 6AH
DoB 07/12/72

GRI::61
gem::lep::S

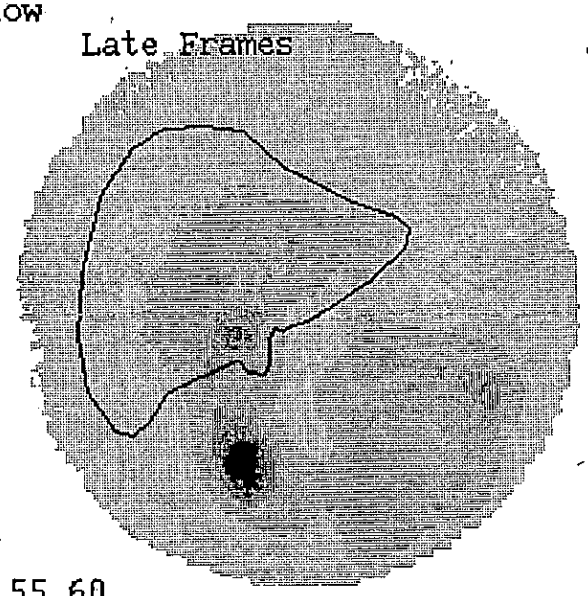
Filmed on 15/10/96by as

flow

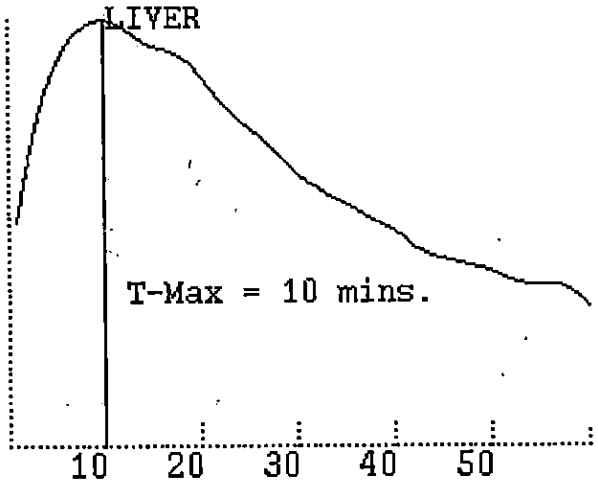


1,20,25
10 5577.2 100%
5577.2

flow



1,55,60



0 points

Name := DEBORAH SULLIVAN
Hospno := 964876
DoB := 07/12/72

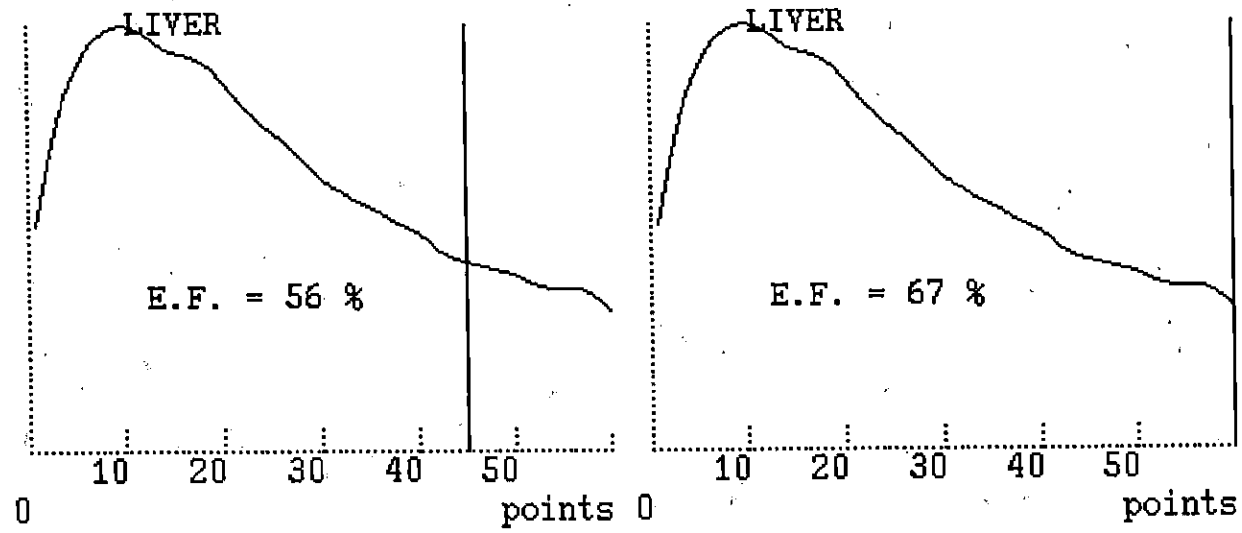
Study ID := bus96034
Exam date := 15/10/96

Consultant
Dr H W Gray

ROYAL INFIRMARY, GLASGOW
DEPARTMENT OF NUCLEAR MEDICINE

Telephone
0141-211 4762

45 2452.6 44%60 1813.1 33%
5577.2 5577.2



Name := DEBORAH SULLIVAN
Hospno := 964876
DoB := 07/12/72

Study ID := bus96034
Exam date := 15/10/96

Glasgow Royal Infirmary University NHS Trust

PATIENT PROFILE

Date of Admission:	Time:	Ward:	Consultant:	Completed by:	Type of Admission
23/1/98		60	Stirrat / Swan		Emergency ✓ Planned ☐ Transfer ☐ Boarder ☐

Deborah Sullivan

PATIENT ID LABEL

Next of Kin: Kathleen Sullivan

Address: 187 commonhead rd Easterhouse

Age: 25

Tel. No.: 771 - 3401

G.P.: DR Clarke

Address: Easterhouse HIC.

Tel. No.: 531 - 8170

Relationship: Mother

Tel. No.: 771 3743

Relatives notified of admission: YES ☑ NO ☐

Religion: RC

Marital Status: (S) M D Sep W

SOCIAL CIRCUMSTANCES

Occupation:	Insurance
Lives with/Dependents:	Fiance
Type of House:	1st floor
District Nurse:	N/A
Social Services:	N/A

VALUABLES (✓)

Ward:	
Finance Department:	
Transferred to: (please state)	
Returned:	

CLOTHING

Clothing Listed:

YES ☐ NO ☐

PATIENT'S UNDERSTANDING OF ILLNESS

PAST MEDICAL HISTORY:
Nonsuture ectomy 1993
laparoscopic cholecystectomy 1996
Appendicectomy 1996
sphincter of oddi dysfunction
several admissions abdominal pain & vomiting
IBS

DIAGNOSIS/DATE:
23/52 pregnant 2/52 hx of abdominal pain vomiting & diarrhoea.

OPERATIVE PROCEDURE/DATE

CURRENT DRUG THERAPY:
Zantac.

ALLERGIES:
Nil known.
?voltarol.

CHEMICAL DEPENDENCY:

COMMUNICATIONS:

0309429

DISCHARGE PLAN

DISCHARGE: SIMPLE ☐ COMPLEX ☐	NAMED NURSE FOR DISCHARGE PLAN:
Actual discharge date:	
Relative informed:	

PATIENT'S OWN DRUGS

Returned:	
Stored in Ward:	
Returned to Pharmacy:	
Other (please state):	
Discharge letter given to patient: YES ☐ NO ☐	

SERVICE	Required	Ordered	Patient/Carer informed	Signature	Date
Transport					
District Nurse					
Physiotherapy					
Occupational Therapy					
Speech and Language Therapy					
Nutrition and Diet Therapy					
Out-Patient Appointment					

HEALTH EDUCATION

SOCIAL SERVICES (Please state)

ADVICE ON SPECIAL NEEDS (Resuming to work, driving, activities etc)

DISCHARGE DRUGS

Prescription Written:	
Prescription sent to Pharmacy:	
Prescription returned from Pharmacy:	

OTHER DISCHARGE INFORMATION

DRESSINGS (Please state)

EQUIPMENT/APPLIANCES (Please state)

Deborah Sullivan

PATIENT ID LABEL

Glasgow Royal Infirmary
University NHS Trust

PATIENT ASSESSMENT BASED ON ACTIVITIES OF LIVING

WARD: 60	DATE:	COMPLETED BY:

SAFETY AND COMFORT	FUNCTION PRIOR TO ADMISSION	FUNCTION ON ADMISSION
Conscious level	✓	
Orientation	✓	
Hazards to safety	✓	
Pain (Specify type & site)	complaining of pain on admission.	
Pain relieved by:		
Pain score on admission (Specify pain tool)		
Any other comments		
BREATHING		
Assessment of breathing pattern	no problems.	
Respiratory related problems (eg Asthma)		
If appropriate, effect on AL		
Smoker: Y/N . Amount:		
Any other comments		
CIRCULATION		
Assessment of circulation	no problems	
Circulatory related problems (eg PVD)		
If appropriate, effect on AL		
Risk of DVT (Tick as per ward protocol) **Low** ☐ **Moderate** ☑ **High** ☐	TED's in situ	
Vital signs: **BP** **T** **P** **R**		
Any other comments		
EATING AND DRINKING		
Appetite	normally good appetite	
Nutrition score (≥ 10 - refer to dietitian):		
Recent weight changes		
Difficulty swallowing		
Ability to self feed		
Special/artificial diet	normal diet	
Dentures: Y/N - (Specify)		
Alcohol intake (Units per week) no alcohol		
Any other comments		

MOBILITY	FUNCTION PRIOR TO ADMISSION	FUNCTION ON ADMISSION
Specify level of mobility		
fully mobile		
Walking aids required		
Assessment form completed ☐ Height: 5'10 Weight: 7 12st		
Moving & Handling		
Any other comments		
PERSONAL HYGIENE/SKIN CONDITION		
Assessment of skin ✓		
Waterlow score on admission:		
Hair		
Assessment of ability to attend to own hygiene		
Any other comments		
ELIMINATION		
Bowel pattern	diarrhoea for past 2/52	
Laxatives etc used		
Bladder pattern/Appliances	no problems.	
Stoma Y/N (Specify type & appliance used)		
Urinalysis ~~K~~ NAD 24TH PROTEIN +	K NAD	
Any other comments		
SLEEPING		
Assessment of sleeping pattern	usually sleeps well	
Night sedation		
Any other comments		
COMMUNICATION/SENSORY IMPAIRMENT		
Assessment of ability to communicate		
Communication aids used		
Sensory impairments (sight, hearing, other)		
Fears/Apprehensions		
Any other comments		

Glasgow Royal Infirmary
University NHS Trust

Nursing Notes

Name: Deborah Sullivan | Hospital Nos. | Ward: 60

Date	Problem No.s	Nursing Notes / Evaluation	Signature
23/7/08		Transfer from Rottenrow	
		complaining of pain on admission	
		Awaiting review by medical staff	EMA
		seen by Mr Stuart	EMA
		may have fluid & diet, not for IV fluids meantime	EMA
		orat analgesia with good effect	EMA
		c/o pain oral analgesia as charted	
		now c/o nausea and vomited 600mls food stuffs	
		anti-emetic as charted	
24/7/08		Voltarol 100mg PR settled and slept well	
		Thereafter	
		Urinary output satisfactory.	L Duff
	am	Seen by Mr Simons team. vomited x 2 this am. complaining	
		of abd pain. Analgesia given with good effect managing	
		fluids + diet fairly well. records stable apyrexial	V Cashmore
		Pethidine 75mg given IM at 2.30pm	V Cashmore
		for transfer to ward 31. family informed Pain has	
		settled no further vomiting. Encouraged with oral fluids	V Cashmore
		No episodes of diarrhoea today	V Cashmore
	pm	Transfered from ward 60 this afternoon. Surgical booklet.	
	(2)	Vomited X 2 times. evening.	
	(1)	Tea and toast taken @ 1700.	
	(4)	Complaining of abdominal pain. Given Pethidine 75 milligrams intramuscularly	
		@ 1840. With good effect.	
		Care as charted	C WILSON.

Name: DEBORAH SULLIVAN	Hospital Nos:	Ward:

Date	Problem No.s	Nursing Notes / Evaluation	Signature
24/7/98		Oral analgesia given as prescribed	
25/7/98		Continues to complain of abdominal pain.	
		Vomited small amount.	
		Seen by Dr Cooper Surgical SHO	
		Pethidine 75mgs and Maxolon 10mgs IM stat has	
		for regular review in am	G Bell.
		Settled and slept, no further complaints of	
		pain overnight.	
1120 AM	(2)	Vomited 400 ml of foodstuff. Given Metoclopramide 10 milligrams intramuscularly @ 10.35.	
	(3)	Patient mobilising about ward independently this morning No complaints of pain.	
	(4)	Given Co-codamol and Buscopan @ 0800. orally ~~@~~	
		Complaining of pain and given DF118 60 milligrams. orally @. 0940.	
		Ward 60 contacted this morning. and patient will be reviewed. Iael.	
		Care as charted.	C.WILSON.
1250.		Still awaiting. review. Ward 60 phoned again.	
1250		Vomited 250 foodstuff following lunch.	
1255.	(4)	Given. Co-codamol @ lunchtime. as prescribed.	
		Dr Colin McKay paged. and will review patient within the next 30 minutes.	
1320.		Seen by registrar. Will review again tomorrow. Patient wore opiates to be	
		avoided if possible. Complaining of pain. and so given Pethidine ~~75~~ milligrams	
		intramuscularly @ 1340. as charted.	C.WILSON.
1700 hrs	(4)	Oral co-codamol given as requested.	
1800 hrs		Vomited 200 mls of foodstuffs at this time. Pethidine 75 milligrams	
		and metoclopramide 10 milligrams given at 18.15 hrs with effect.	

Glasgow Royal Infirmary
University NHS Trust

Nursing Notes

Name: DEBORAH SULLIVAN		Hospital Nos	Ward	
Date	Problem No.s	Nursing Notes / Evaluation		Signature
25/7/98		Advised to take fluids only this evening until vomiting settles. Urine negative for ketones.		
20.00hrs		Mobilising around ward. Patient states that pain & nausea only a problem shortly after eating.		V. Cummings
26/7/98	4	Oral analgesia given at bedtime with effect.		
	1	Fluid balance satisfactory		
	2	Vomited x 75 millilitres of foodstuffs – Maxalon 10 milligrams given by injection at 5.30 pm. Down to settle		
7.00		Care as planned		J. Brown
		Vomited 600 mls at 9.30 am approx. Pethidine 75 milligrams administered intramuscularly at 10 am to settle pain. Did attempt diet this am. Resident paged at 2270 with regards to reviewing as condition does not appear to be improving. Following discussion with Mr Stewart's team, patient is 'happy' to go home tomorrow. Keen to see Dr Rogers prior to discharge as this is her observation. Discharge prescription in basket for pharmacy. To have small, light diet only & concentrate on fluid intake at present.		V. Cummings
21.10.	(2)	Vomited foodstuffs this afternoon.		
	(4)	Given Pethidine 75 milligrams intramuscularly @ 1640.		
		Care as planned.		C. Wilson
27/7/98		Care as planned.		
	4	Pethidine 75 milligrams & Maxalon 10 milligrams intramuscularly @ 10.10 pm		
7am		to relieve pain & nausea		G. Thomson

Name		Hospital Nos	Ward	
Date	Problem No.s	Nursing Notes / Evaluation		Signature
27/7/98		Case ag ebanked.		
	①	Vomited following breakfast and complaining of abdominal pain. Maxalon 10 mgs intramuscularly at 8.15 am to relieve vomiting with good effect. NO further vomiting.		
		Reviewed by surgeons who are happy for her to go home. To be reviewed by Dr Gibson this afternoon.		M Kirby
5pm.		Complaining of frequency of micturition - urine appears very cloudy M.S.S.U obtained.		
		For gastroenterology review - referral. To be allowed home on pass this evening. Will return in am.		V. Cumming.
28/7/98		Did not arrive back in ward until 1pm.		
1pm		Had some pain last night but has not vomited. Dr Rodger wishes review by S.H.O. & if satisfactory could be discharged home & request made for outpatient Gastro Enterology clinic and to be reviewed at GRMH Ambulatory clinic on Friday (please ensure GRMH notes are sent back for them).		M Kirby
		Dr Kaufmann contacted gastro-enterologists who agreed to see Deborah when their clinic ended to-day		
1800hrs	4	In some discomfort. DF118 by 60mg given.		
1830hrs.		Reviewed by gastro-enterologist. Has vomited x2 prior to review		A McMahon.

Glasgow Royal Infirmary
University NHS Trust

Nursing Notes

Name: Deborah Sullivan	Hospital Nos:	Ward:	

Date	Problem No.s	Nursing Notes / Evaluation	Signature
28.7.98		Complaining of diarrhoea. Specimens x 3 to be sent to lab.	
1830.		for porphyria screen - urine + blood - mane.	
		To be reviewed by Dr Goddard in the morning	
2000 hrs.	4	Continues to complain of pain. Buscopan 20mg given and	
		promptly vomited back. Repeat when vomiting settled.	
	2.	Metoctopramide 10mg intramuscularly @ 2000 hrs	DMcMahon
11.00pm	4	Vomited x2. Complaining of pain - oral analgesia	
		ineffective. Pethidine 75milligrams given intramuscularly	
		at 11.30pm.	
29/7/97		No diahorrea overnight	CBulloch
	4	No further complaints of pain	CB
1200.		Reviewed by gastroenterologist this morning. Pre happy for	
		her to go home. Requested Nefopam as analgesia.	
		However, it's use is not indicated in pregnancy.	
		Discussed with Dr Gibson. Ok to use paracetamol if	
		required for pain.	
		Discharged home.	
		Follow-up at Ante-natal clinic on Friday @ 1000 hrs	DMcMahon.
		(notes in Dr Gibson's pigeon-hole. She is aware that	
		they have to be picked up prior to Clo clinic).	

0280469

Glasgow Royal Infirmary

Investigations Sheet

NAME Deborah Sullivan HOSPITAL No.s WARD 60

DATE/TIME LOCATION	INVESTIGATION	PREPARATION	SIGNATURE	DATE OF REQUEST	SPECIMEN	INSTRUCTION/PREPARATION	DATE OBTAINED	SIGNATURE
				23/7/98	U+S			
				29/7/98	Porphyria screen			
					Diarrhoea (1)			

GLASGOW ROYAL INFIRMARY NHS TRUST WARD 60.

LISTER DEPARTMENT OF SURGERY

ame: D. Sullivan Date: 24.7.98.

NAUSEA/VOMITING

ROBLEM (2)	GOALS	INTERVENTIONS	EVALUATE/DISCONT DATE AND SIGN
ausea/Vomiting	To promote comfort/relieve nausea/vomiting	Position patient where he/she can be easily observed with nurse call system to hand:-	
		Position in bed to maintain comfort (if airway is at risk, left lateral position with suction apparatus to hand):-	
		Provide emesis bowl and ensure privacy:-	
		Monitor and record gastric loss:-	✓ Cashmore
		Test gastric loss if appropriate:-	
		Administer antiemetic as prescribed:-	
		Pass naso-gastric tube if appropriate:-	
		Aspirate tube:-	
		24/7/98 Exd. V-C	

m.lh/34
97

Deborah Sullivan

PROBLEMS / AIMS

6c

NO	PROBLEM	AIM	NURSING INTERVENTIONS	SIGNATURE
3	Patient requires assistance when moving due to ... fully mobile	To minimise the risk of injury to patient and staff	Ascertain patient's weight	
			Ascertain patient's height	
		To promote patient comfort	Assess and document patient's weight bearing ability	
			Assess and document patient's dependence on nursing staff to mobilise	
			Encourage patient to mobilise within own capabilities	
			Observe for and document any changes in patient's circumstances	

2017

(✓) TRANSFERRING INDEPENDENTLY	(✓) MANOEUVRE WHEN MOVING IN BED	(✓) NO. OF NURSES	TYPE OF MANOEUVRE WHEN MOVING FROM BED TO COMMODE	(✓) NO. OF NURSES	EQUIPMENT REQUIRED TO ASSIST WITH MOBILISING	BED (✓)	CHAIR/ COMMODE (✓)	BATH (✓)
Able to weight bear and balance	Anterior Hold		Front Hold		Handling Sling			
Able to weight bear and balance with equipment	Rolling		Side Hold		Turning Disc			
Specify Equipment: (eg. Zimmer)	Turning		Through Arm Hold		Hoist			
Weight bears but unstable (eg. Dizzy)					Specify Hoist Type			
Specify :					Pat Slide			
Unable to weight bear					Easy Slide			
No. of Nurses required to assist when mobilising					Rollboard			
					Slip Sheets			

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s / Aims PAIN

D. Sullivan | Hospital Nos. | Ward Nos. 60

No.	Problem	Aim	Nursing Intervention	Signature	Evaluation Date	Disc Date
(4)	PAIN	To monitor and relive pain	A) Ask patient to report to nursing staff when he/she is in pain			
237		Patient will state he/she is comfortable.	B) Administer prescribed analgesia & monitor effect			
			C) Inform medical staff if analgesia is ineffective.			
			FxO			

gow Royal Infirmary

me / Alms

9

F

D Sullivan

No.	Problem	Aim	Nursing Intervention	Signature	Evaluation Date	Disc Date
1	A) Potential for fluid & electrolyte imbalance due to.....	To maintain hydration	A) Administer intravenous fluids as prescribed by doctor			
2317	a) Operative procedure	Electrolytes within normal limits	B) Maintain accurate record of intake & output			
	b) Anaesthetic	Increase appetite & promote healthy/balanced diet	C) If necessary, administer antiemetics as prescribed & monitor effect with patient			
	c) Nausea & Vomiting		D) Dietary restrictions.....			
	B) Loss of appetite due to surgery	2317 F/D				
			E) [illegible] appetite/any meals & observe dietary intake			

NAME: Deborah Sullivan

DATE:

TELEPHONE: 0141-211-5060. / 211-1274

SURGICAL RECEIVING UNIT. WARD 60.

WELCOME, YOU HAVE BEEN ADMITTED TO : GLASGOW ROYAL INFIRMARYS SURGICAL RECEIVING UNIT.

DUE TO THE NATURE OF THIS WARD, YOU MAY BE TRANSFERRED TO ANOTHER WARD.

DURING YOUR STAY YOU WILL BE INTRODUCED TO YOUR "NAMED NURSE" WHO WILL BE RESPONSIBLE FOR PLANNING YOUR NURSING CARE.

NAMED NURSE : SN Muldoon

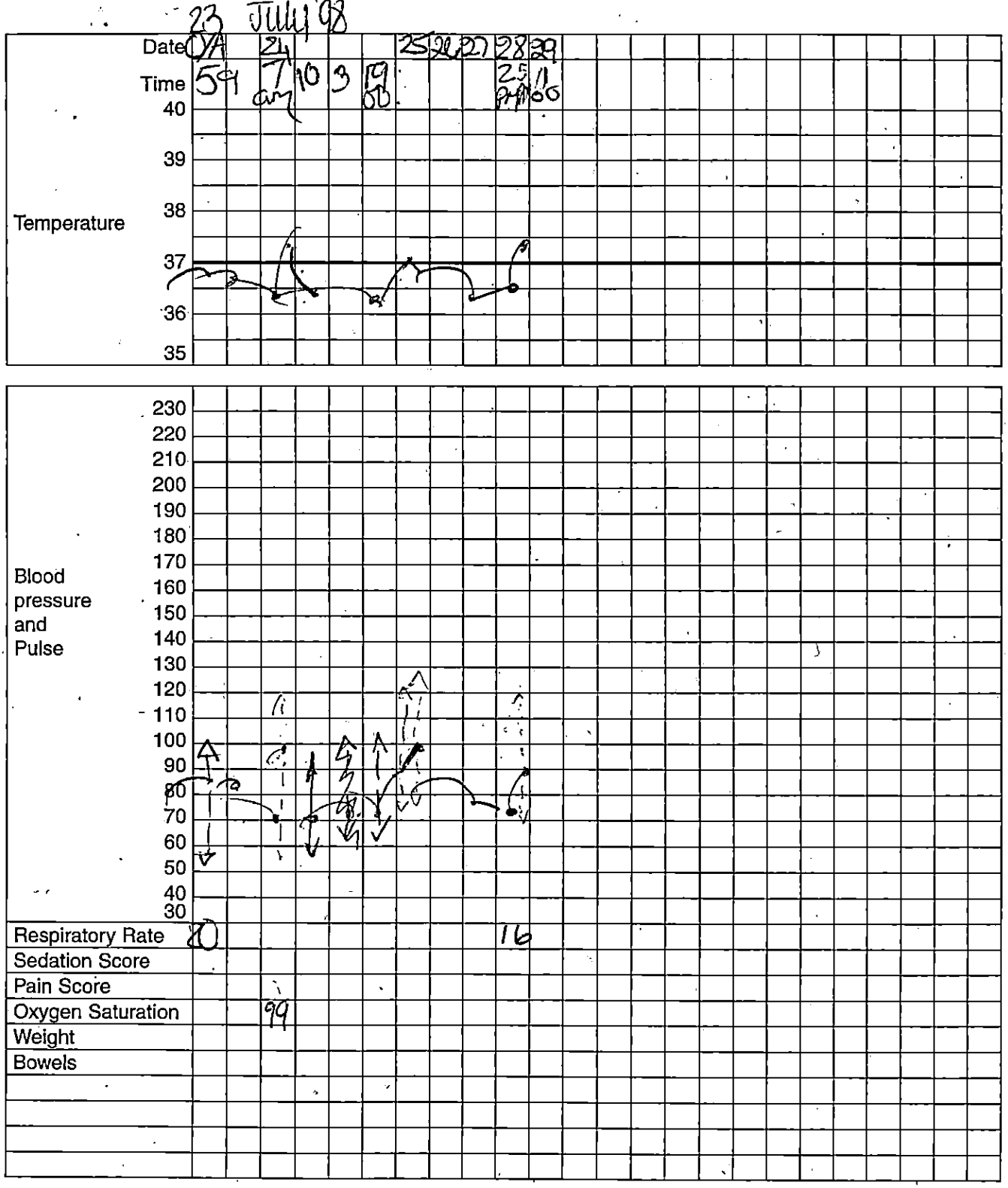
WARD MANAGER: SISTER PENDER

Glasgow Royal Infirmary University NHS Trust

Patient Label

Deborah Sullivan

Observations and Pain Score



SEDATION SCORE

O= *awake*
S= *normal sleep*
1 = *drowsy, easy to rouse: eyes open to speech or light shake*
2 = *sedated, difficult to rouse: eyes open only to vigorous shaking*
3 = *unconscious, unrousable*

PAIN SCORE

O= *no pain at rest, no pain on movement*
1 = *no pain at rest, slight pain on movement*
2 = *intermittent pain at rest, moderate pain on movement*
3 = *continuous pain at rest, severe pain on movement*

DAILY SUMMARY OF FLUID BALANCE

DATE OF BIRTH HOSPITAL NO.
FEMALE SURVIVOR
ADDRESS SEX/MARITAL STATUS
ADDRESS OCCUPATION
HOSPITAL WARD CONSULTANT

0187497

PLEASE WRITE OVER WHITE LETTERS

DATE	INTAKE				OUTPUT			
	ORAL	I.V.	OTHER	TOTAL	URINE	GASTRIC	OTHER	TOTAL
23/7	500				300	750		1050
24/7	1000			1000	960	1670		2650
25/7	1750			1750	1600	1150		2750
26/7	1070			1070	885	1375		2760
27/7	1800			1800	900	1350		1250

JRM FST 10/90

* MAX. 40mg of A or N in 24 HRS

HOSPITAL PRESCRIPTION SHEET No.

REGULAR PRESCRIPTIONS – INJECTIONS

Pharmacy Use	Date Started	MEDICINE (Block Capitals)	DOSE	ROUTE	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	mid 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times	Prescribers Signature (Full)	DISCONTINUED: Date	Signed
	A 23/7/98	Metoclopramide *	10 mg	IM			4-6°			PRN							
	B 24/7/98	PETHIDINE	75mg	IM			4-6hrly										
	C																
	D																
	E																
	F																
	G																

REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

* MAX 40mg/24HRS.	H 23/7	CYCLIZINE	2 Tabs	PO			4-6hrly			PRN							
* MAX 240mg/24HRS	J 23/7	DF 1.18 DIHYDROCODEINE	60mg	PO			4-6hrly			PRN							
	K 23/7	BUSCOPAN	20mg	PO			6hrly										
	L 23/7	RANITIDINE	150mg	PO													
	M 23/7	TEMAZEPAM	10-20mg	PO						(if req'd)							
	N 23/7	Metoclopramide *	10 mg	PO			4-6°			PRN							
	O																
	P																
	R																
	S																
	T																
	V																

ONCE ONLY PRESCRIPTIONS

DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN
23/7/98		VOLTAROL	75mg	PR		[illegible]	12:30
24/7/98		VOLTAROL	100mg	PR		Rahmeo	10:25 a
24/7/98	1700	GAVISCON.	10ml.	ORM	GAVISCON	GAVISCON	1700.

DIET

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

WARD	NAME OF PATIENT	AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
60	Deborah Sullivan	17/12/72.				Suma

KNOWN MEDICINE 1.

HOSPITAL

MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

REGULAR PRESCRIPTIONS

DATE	6 a.m.	8 a.m.	10 a.m.	12 m.d.	2 p.m.	4 p.m.	6 p.m.	10 p.m.	12 m.n.	OTHER TIMES	COMMENTS ON DISCREPANCIES
23/7/98	Initial	Initial	Initial	Initial	Initial	Initial	Initial	J K L 10.20pm Initial	Initial	H Initial	HAV 6.30pm Adm 11.45pm
24/7/98		N J L VC			A 1.50pm VC		N1 B	L Initial			B 2.30pm VC B@1840 as.
25/7/98		H K L CW	A@1035 CW	H. C			A B 15 6pm H E	L J M BB		A B C SE	Adm JC @ 0940.
26/7/98	A. S 20 BJR	H L B VC	YP					L A DC 10.10 m JC			B@1640 as.
27/7/98	L A1	MK		H1 MK							
28/7/98	on pain						L	L JM	B at pm +1.30 CB	K @ 1950 - vomited back, A @ 20 pms NM	
29/7/98	H L N	NM									

NAME: Deborah Sullivan

UNIT NUMBER

WARD: 60

KEY: CODE LETTER CIRCLED E.G. (A) = MEDICINE REFUSED AND MEDICAL STAFF INFORMED

CODE LETTER SCORED E.G. X = PATIENT ABSENT

FORM MR1 10/90

ATE DISCHARGE LETTER

GLASGOW ROYAL INFIRMARY
AUSPICE CÆLO
University N.H.S. Trust

Tel. No. 0141-211-4000

PATIENT IDENTIFICATION

964876K
SULLIVAN F/S
DEBORAH 07/12/1972
1/1 160 MAIN STREET
BAILLIESTON
G69 6AH

DATES

ADMISSION 25/10/97
DISCHARGE 27/10/97
RE-ADMISSION
DEATH

IDENTIFICATION

OTHER DISTRIBUTION

MEDICAL IDENTIFICATION

WARD 62
CONSULTANT FH (BLOCK CAPITALS)
CONTACT (BLOCK CAPITALS)

PRESENTING COMPLAINT(S)
abdo pain

ADMISSION
DAY CASE ☐ ARRANGED ☐ EMERGENCY ☑ TRANSFER ☐

ACTIVE DIAGNOSIS/PROBLEMS/OPERATIONS

1 [illegible] → early diverticular dis - ? inflamed
2
3 meal + follow through → NAD
4
5
6

INACTIVE DIAGNOSIS/PROBLEMS

1)
2)
3)

INFORMATION GIVEN TO PATIENT (SPECIFY)

THE PATIENT WAS DISCHARGED ON THE MEDICATION/TREATMENT DETAILED BELOW. RECOMMENDED DURATION OF TREATMENT IS FROM THE DATE OF DISCHARGE. WHERE TREATMENT IS INDEFINITE, A SEVEN DAY COURSE HAS BEEN DISPENSED.

MEDICINE	FORM	DOSE	TIMES OF ADMINISTRATION (8am 10am 12pm 2pm 6pm 10pm)	DURATION	PHARMACY TO COMPLETE: DAYS SUPPLIED	QUANTITY, STRENGTH, BRAND SUPPLIED

SIGNED (PRESCRIBER) BLEEP NO DATE

PRESCRIPTION DISPENSED BY CHECKED BY DATE

FOLLOW-UP REVIEW

HOSPITAL OP YES/NO SPECIFY 2 wks
GP SURGERY YES/NO SPECIFY

CARE ARRANGEMENTS
NONE ☐
SWD ☐
DISTRICT NURSE ☐
OTHER

DRESSING/SUNDRIES SUPPLIED TO PATIENT

PRODUCT	SIZE	NUMBER ISSUED
		Signature:-

COMMENTS: Ms Sullivan's pain eventually resolved itself once she had slept
Opiates - these should be avoided. (Buscopan often helps her)
She will be followed up at gastro-enterology clinic

White Copy - GP Pink Copy - Case Notes Blue Copy - Pharmacy Yellow Copy - Retain in Ward

0159369

Glasgow Royal Infirmary

Profile / Careplan for 24 / 72 hour stay

WATERL N:- 6
NAMED NURSE:- S/N TAYLOR

DATE OF ADMISSION 29/10/97	TIME 2pm	WARD 60	TYPE OF ADMISSION (EMERGENCY) / PLANNED / TRANSFER FROM : OTHER		ADMITTING NURSE H Watson

SURNAME 964876K SULLIVAN F/S FORENAME DEBORAH 07/12/1972 ADDRESS 1/1 160 MAIN STREET BAILLIESTON G69 6AH TEL. Nos.	DATE OF BIRTH 7/12/72 AGE 24 RELIGION R/C Fully attended 29/10/97. G.P. AND ADDRESS Dr Goldie Easterhouse HC.	MENSTRUAL CYCLE PARA URINALYSIS trace protein Non haem blood MSSU ✓	ALLERGIES NONE KNOWN but intolerance to VOLTAROL + MORPHINE CHEMICAL DEPENDANCY / PROSTHESIS	BASELINE RECORDS HEIGHT WEIGHT B.P. 109/86 TEMP. 36·2 PULSE 76. RESPIRATION 14 DENTURES —

WISHES TO BE KNOWN AS	SOCIAL CIRCUMSTANCES		STORAGE OF VALUABLES	STORAGE OF DRUGS
NEXT OF KIN Kathleen Sullivan ADDRESS 187 Commonhead Rd Glasgow RELATIONSHIP Mother TEL.Nos. 771 3743	OCCUPATION LIVES WITH fiancee. TYPE OF HOUSE —	SUPPORTING SERVICES ✓	RETURNED —	RETURNED —

REASON FOR ADMISSION	PAST MEDICAL HISTORY	CURRENT DRUG THERAPY
Epigastric pain and vomiting since Sunday (known patient of Mr Mutray).	Cholecystectomy 1996. (April) Several admission with epigast. pain. Appendicectomy (March 96)	CISIPRIDE (recently from GP). MAXALON LOSEC
Amylase 300 WCC 11·4.		
		Mr Finlay ~~Goldie~~ SURGERY

CONSULTANT

ASSESSMENT

SAFETY AND COMFORT	BREATHING & CIRCULATION	MAINTAINING BODY TEMPERATURE	EATING & DRINKING	MOBILITY
Pethidine 75mg im 12midnight + Stemetil 12.5mg im 12 midnight in A+E.	Smokes 10cig. Dly	No problems	occasional alcohol.	ambulant.

PERSONAL HYGIENE	ELIMINATION	SLEEP	COMMUNICATION (INCLUDING FEARS & ANXIETIES)
self caring SKIN CONDITION N/A/UT	↑ frequency/ Nocturia and dysuria.	no problems	Doesn't appear anxious. O/A.

PRE-OPERATIVE CARE PLAN

DATE	No.	PROBLEM	AIM	INTERVENTION	SIGNATURE	EVALUATION	DISC.
		PREPARATION OF PATIENT FOR THEATRE	PATIENT WILL BE CORRECTLY PREPARED FOR OPERATIVE PROCEDURE	A) EXPLAIN PROCEDURE/SEQUENCE OF EVENTS TO PATIENT B) NIL BY MOUTH FROM: C) SKIN PREPARATION: D) BOWEL PREPARATION E) BATH/SHOWER F) COMPLETE PRE-OPERATIVE CHECK LIST G) PREMEDICATION			
		UNABLE TO MAINTAIN OWN SAFETY WHILE ANAESTHETISED/ MEDICATED	TO MINIMISE THE RISK OF INJURY	A) ENSURE COTSIDES ARE IN POSITION UNTIL THE PATIENT IS FULL AWAKE B) PROVIDE PATIENT WITH NURSE CALL SYSTEM TO ENSURE HE/SHE HAS THE MEANS TO SUMMON ASSISTANCE C) NURSE PATIENT IN A POSITION WHICH CAN BE EASILY OBSERVED			

DATE	No.	PROBLEM	AIM	INTERVENTION	SIGNATURE	EVALUATION	DISC
		See folder					

DATE	No.	EVALUATION/NURSING NOTES	SIGNATURE
29/10/97		Uncomplaining of pain on admission following analgesia in A+E Dept.	
		IV fluids commenced. Nil orally. MSSU obtained.	H Watson
		DF 118 30mgs orally at 4.30am - Complaining of nausea	
		Complaining of persistent nausea - pain not relieved with oral analgesia	
		Pethidine 75mg im 5.20am + maxalon 10mg im 5.20am	H Watson
		Pethidine 50mg IM @ 10.10 am	H Watson
		R/V Mr Finlay for referral to Prof Cooke	
		Up to shower Self Care apyrexical	
		IV fluids continue 4° regime Urinary output satisfactory.	
		Care as charted.	H Watson
		Pethidine 50mgs im & Stemetil 12.5mg im at 4.35pm	E Whitehead
		Settled evening IV fluids maintained.	E Whitehead
		Pethidine 50mgs im at 9.15pm	E Whitehead
30/10/97		Pethidine 50mg IM at 1.35am	E Whitehead

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Glasgow Royal Infirmary
University NHS Trust

Nursing Notes

Name: Deborah Sullivan | Hospital Nos: | Ward: 60

Date	Problem No.s	Nursing Notes / Evaluation	Signature
30/10/97.		Settled + slept well. IV fluids maintained. Output satisfactory	Abel
		Morp Pethedine 50→ + Stemetil 12.5→ IM at 680→	
		Seen by Mr Finlay. Not to have opiate	
		analgesics. For referral to Prof Cooke	
		Settled morning	
		IV fluids maintained	
		Apyrexical	Eightbody
		S/B mr finlay. To have NG tube passed as	
		pt complaining of nausea. NG tube inserted.	
		200mls aspirated from same. Patient	
		complaining of pain. oral analgesia given.	
		further complaints of pain after 2nd of	
		analgesia. Resident paged. Prescribed	
		endometracin PR with effect. IV fluids	
		maintained. NG drain yielding 100mls.	
		settled and uncomplaining meantime.	smcniven
31/10/97.		N/G tube dislodged. - Nausea settled. Dr Riggs	
		informed - not to re-insert N/G tube meantime	
		IV fluids continue. Slept well.	
		Settled morning.	
		I.V. fluids maintained. output satisfactory	
		Fasting.	
		SIR medical staff.	
		For referral to mr stuart.	K Taylor
		[illegible] by Mr Stuart.	
		For transfer to G4 as c [illegible]	

D280489

Name: Deborah Sullivan | Hospital Nos. | Ward 62

Date	Problem No.s	Nursing Notes / Evaluation	Signature
31/10/97	pm	family settled since transfer, Venflon rested into (R) hand IV fluids commenced 4 hourly, Remains on ice bottle.	
		Pethidine 100mgs given IM at 6:40pm & IM Stemetil given at 6:40pm with good effect.	
		Valeral 50mgs given PR at 7:15 pm.	
		No episodes of vomiting this evening.	Shaw
1/11/97.		PATIENT SETTLED & SLEPT ON + OFF OVERNIGHT · UP TO SMOKE ROOM	
		PETHIDINE 100mgs GIVEN IM @ 12.45AM. IM STEMETIL GIVEN ALSO.	L. Deacy
		WRITTEN AS ONCE OFF PRESCRIPTIONS. ? TO BE WRITTEN UP FOR	
		BUSCOPAN TOMORROW RATHER THAN PETHIDINE.	
		NO EPISODES OF VOMITING.	
		PATIENT UNABLE TO TOLERATE K+ IN IV FLUIDS THEREFORE BAG	
		DISCONTINUED. IV FLUIDS CONTINUE 4°.	L. Deacy.
		NIL BY MOUTH.	
	am.	Independant with personal hygiene	
		IV fluids continue & body	
		c/o of pain, stated that tablets ineffective, requesting pethidine - medical staff informed	
		Venflon dislodged - medical staff informed	
		Up to pt's smoke room through out morning.	M. Rennie
	pm	C/O pain IM zydol given as prescribed with good effect.	
		Mobile around ward & to day room this p.m.	
		Venflon resited & IVI recommenced as prescribed	
	23^{30}	C/o severe abdominal pain radiating to left shoulder. IM zydol given at 23^{00} hrs	
		without effect. Observations ~~given~~ within normal limits. Apyrexial. JHO informed.	
		Pethidine 100mgs and Stemetil 12.5mgs IM prescribed and given at 00 10 hrs as	
		once only. Chest and abdominal x-rays obtained.	M Shande
2-11-97		IV infusion continues 4 hourly. No further complaints of pain. Remains on nil orally.	M Shande

Glasgow Royal Infirmary
University NHS Trust

Nursing Notes

Name: Deborah Sullivan | Hospital No: | Ward: 62

Date	Problem No.s	Nursing Notes / Evaluation	Signature
2-11-97		Urine output satisfactory. No vomiting noted.	M Shende
		Independent this a.m.	
		IV fluids continue, running 4 hourly.	
		IM zydol given as prescribed, with good effect.	
		Mobile to day room.	
		S/B Mr. Stuart may now have 60mls increasing to free fluids this evening as tolerated.	E. McAllister
	pm.	Fairly settled evening. IM tramadol 50mgs given IM this evening.	
		IV fluids continue 4 hourly as charted. Tolerating free fluids well.	
		Mobilising well to smoke room.	Glen.
	2330	Complaining of abdominal pain radiating to left shoulder. Vomited 30 mls	
		clear fluid. Tramadol 100mgs im given at 23.15 Reviewed by Dr Jenkins.	
		Buscopan 20mgs IM prescribed and given at 00.30. NG Tube passed - Nil	
		returned. Chest and abdominal x-rays organised.	M Shende
2-11-97		X-ray shows no abnormalities. NG Tube yielding very minimal amounts of clear	
		fluid. IV infusion running 4 hourly. Urine output satisfactory. No further complaints of	
		nausea. Tramadol 100mgs im given at 04.30 for pain relief with good effect.	
		Continues on free fluids.	M Shende
		S/B Medical staff, N/G tube to be removed ✓	
		c/o severe pain. JHO informed. IM Buscopan & IM zydol given as	
		prescribed as a 'once' only. Vomitted x 1 this a.m.	
		IV fluids continue as charted.	
		Independent with personal hygiene.	E. McAllister
	PM.	Complaining of migraine pain this pm. Paracetamol given as per kardex.	
		IV fluids continue 4° as charted.	
		Mobilising around W[illegible] - up to smoke room x [illegible] times.	[illegible]

Name: Deborah Sullivan | Hospital Nos: [illegible] | Ward: [illegible]

Date	Problem No.s	Nursing Notes / Evaluation	Signature
4-11-97		IV infusion continues 4 hourly. Venflon rested. No nausea, vomiting or pain reported overnight. Settled and slept well. Oral intake appears low - 500mls only - inaccurate? Urine output excellent.	M Sheridan
	am.	Settled and self caring this am. Stayed in bed most of the Morning. For barium enema and ultrasound this afternoon No prep given. Continues on fluids only. IV fluids stoped at 11am for barium enema.	CMurray
	pm	Commenced on picolax this p.m in preparation for barium enema tomorrow. IV fluids continue as charted. Now on clear fluids only. c/o severe pain & nausea, oral analgesia given with little effect. Severe pain persists JHO informed, no action taken. Oral antiemetic given as prescribed with settling effect. Debbie's father spoken to by JHO regarding pain control. Patient remains upset throughout visiting hour.	
	830pm	2nd dose of picolax given. Debbie appears calmer now; mobile to smoking dayroom. IV infusion infiltrated, JHO informed	E. Mallett
5-11-97		Clear fluids overnight in preparation for barium enema. IV infusion running 4°. No analgesia required overnight. Slept well.	M Sheridan
	am	IVI continues 4°. Settled & uncomplaining. Independent with personal hygiene, prepared & transfered to Xray for Barium Enema. Returned & resumed to free fluids	E. Mallett
	pm.	Settled and uncomplaining this pm. Independent. Mobilising well around ward.	

Glasgow Royal Infirmary
University NHS Trust

Nursing Notes

Name: DEBORAH SULLIVAN	Hospital Nos:	Ward: 62

Date	Problem No.s	Nursing Notes / Evaluation	Signature
	cont pm.	IV fluids continue 4°.	
		Continues on free fluids only.	CMcAuley RMT
	9.30pm.	Venflon ~~tissued~~ ISSued. Taken out by Sister Kinsella. Not to be restod	CMcAuley RMT
6/11/97.	am	Up to day room overnight. Slept for short periods only.	
		Uncomplaining of pain.	CMaullan
	1300	Settled morning. Seen on ward round this morning and can commence on light diet. Had a small amount at lunch time. Observations satisfactory, temp now 36.1°c.	R Collie Agency
		Possibly for home tomorrow. Can arrange own transport.	
		Barium enema yesterday showed diverticular disease. Advised	
		to have a high fibre diet.	CMcAuley
		Settled evening.	
		Mobile to day room. Managing fluids & light diet	
		For Barium follow through on Monday 10th November	CMcAuley
7-11-97	am.	Slept throughout night. No complaints offered.	
		On awaking asking ~~for~~ anti-emetic — feeling 'seedy'.	
		10mgs metoclopramide given	CMaullan
	pm	Independent a.m.	
		fluids & light diet well tolerated.	
		S/B medical staff for check X-ray to confirm the barium from	
		the enema has left body, prior to Barium follow through on monday	
		Observations satisfactory.	CMcAuley
	pm.	PATIENT REMAINED IN BED THIS PM VOMITED X1 @ 2PM 300ml	
		CONSTANTLY COMPLAINING OF PAIN. WRITTEN UP FOR BUSCOPAN ORALLY.	
		GIVEN WITH LITTLE EFFECT. MEDICAL STAFF INFORMED.	
		MEDICAL STAFF RELUCTANT TO PRESCRIBE ANY OPIATES. c.o PRESCRIBED ANALGESICS +	K. Binney.

0280469

Name: Deborah Sullivan | Hospital Nos. | Ward: 02

Date	Problem No.s	Nursing Notes / Evaluation	Signature
7/11/97.		ANTISPASMODICS TO BE GIVEN REGULARLY.	K. Beagy.
		FOR BARIUM FOLLOW THROUGH ON MONDAY + CHEST X-RAY FOLLOWING SAME.	
8/11/97.		Slept for long periods - up to day room once overnight.	
		Uncomplaining.	D Maullan
		PATIENT SETTLED THIS AM.	
		WASHED INDEPENDANTLY.	
		UNCOMPLAINING OF PAIN.	
		FOR BARIUM FOLLOW THROUGH TOMORROW. CHEST X-RAY FOLLOWING SAME.	K. Beagy.
	pm	Patient vomited approximately 850 mls foodstuffs this evening.	
		Buscopan 20mgs given orally and Metoclopramide 10mgs given	
		IM as prescribed.	
		Patient continued to complain of pain and requesting to see	
		a doctor. Resident informed and Gaviscon given as prescribed.	
		Observations stable - apyrexial	L McFarlane
9/11/97.	am.	Slept overnight - no complaints offered.	
		Attend barium follow-thrugh tomarow - fast as per instructions	D Maullan
		No episodes of vomiting overnight.	
		Settled morning. Self caring with personal hygiene.	
		Tolerating fluids and diet. Passing urine spontaneously.	
		No episodes of vomiting this morning.	
		Temp 37.3°C this morning and T36.1°C at 2pm.	
		Seen by Mr Carter. Commenced on Voltarol suppositories for	
		pain. Buscopan 20mgs given orally as prescribed.	
		For barium follow thraigh tomorrow at 11.15am. Please fast	
		as per protocol.	L McFarlane
	pm.	SETTLED THIS AFTERNOON. UNCOMPLAINING - TO BE ENCITED FROM 12 M/N	K. Beagy.

Glasgow Royal Infirmary
University NHS Trust

Nursing Notes

Name: Deborah Sullivan | Hospital Nos: | Ward: 62

Date	Problem No.s	Nursing Notes / Evaluation	Signature
10/11/97	am.	Settled overnight, uncomplaining.	
		Fasted from 12m.n. for barium - follow through at 11.15.	DMacMillan
	pm	Attended for barium follow through. Settled on return and resumed to fluids and diet.	
		Observations stable.	
		Losec given at 6pm as withheld this morning.	
		Patient requesting to see a doctor due to pain. Resident informed and Voltarol 100mgs given p.r. as prescribed.	LMcFarlane
11/11/97.	am	Settled uncomplaining.	
		SETTLED + UNCOMPLAINING THIS AM.	
		FOR DISCHARGE HOME TODAY S/B MEDICAL STAFF.	
		REFERRED TO GASTROENTEROLOGY + S/B MR BOWMAN (MCKENZIE TEAM).	
		OPD TO BE ARRANGED FOR MONDAY MORNING GASTROENTEROLOGY CLINIC.	K. Beach.
		DISCHARGE PRESCRIPTION ORDERED.	K. B.

0280469

Glasgow Royal Infirmary

Problems / Aims

Name DEBORAH SULLIVAN | Date of Birth | Ward No's 60

Date	No	Problem	Aim	Nursing Intervention	Signature	Date Evaluation	Date Disc
29/10/97	5 (1)	Pain following surgical ~~procedure~~	Patient will state she is comfortable	A) Nurse patient in comfortable position B) Administer analgesia as prescribed by doctor & monitor effect with patient C) If analgesia is ineffective, notify doctor & review prescription	MWatt	0/5.	

Glasgow Royal Infirmary

Problems / Aims

Name DEBORAH SULLIVAN

Date	No	Problem	Date of Aim	Aim	Ward No: 60	Nursing Intervention	Signature
29/10/97	2	Nausea / Vomiting due to..		To promote patient comfort & relieve nausea / vomiting		a) Position patient where he/she can be easily observed, with nurse call system to hand b) Position in bed to maintain comfort N.B. If airway at risk left lateral position with suction apparatus to hand) c) Provide emesis bowl & ensure patient privacy d) Offer mouthwashes to freshen mouth e) Stay with ...	HWalsh

asgow Royal Infirmary

oblem / Aims

DEBORAH SULLIVAN

Date of Birth

Ward No: 60

9/10/73 (3)	A) Potential for fluid & electrolyte imbalance due to... a) Operative procedure b) Anaesthetic c) Nausea & Vomiting	To maintain hydration Electrolytes within normal limits Increase appetite & promote healthy/balanced diet	Nursing Intervention A) Administer intravenous fluids as prescribed by doctor B) Maintain accurate record of intake & output C) If necessary, administer antiemetics as prescribed & monitor effect with patient D) Dietary restrictions... 29/10 NBM. ICE 31/10 Fast.	Signature HWalsh O/S.

Date

9

F

dietary intake

asgow Royal Infirmary

oblems / Aims

Name: DEBORAH SULLIVAN | Date of Birth | Ward No: 60

No	Problem	Aim	Nursing Intervention	Signature	Evaluation Date	Disc Date
29/10/97 (5) (P)	Has high Temperature - feels hot and uncomfortable and unable to restore normal temperature because ...	To help restore normal temperature (specify) ... and comfort.	a. Reduce amount of clothing worn in bed and assist in choosing suitable attire and appropriate bedclothes. b. Ensure fluid intake of at least (specify) 2L in 24 hours. c. Use of fan. d. Position in well ventilated environment. e. Tepid sponge if temperature exceeds and follow set guidelines as per procedure manual. f. Accurately record and monitor body temperature (frequency) 4°	HW Watson	0/5	

GLASC 'OYAL INFIRMARY UNIVERSITY 'RUST
PROBLEMS / AIMS

NAME:			HOSPITAL NUMBER:			WARD: LO		
DATE	NO	PROBLEM	AIM	NURSING INTERVENTIONS	SIGNATURE	EVAL. DATE	DISC. DATE
29/10		Patient requires assistance when moving due to ... Independant	To minimise the risk of injury to patient and staff To promote patient comfort	Ascertain patient's weight Ascertain patient's height Assess and document patient's weight bearing ability Assess and document patient's dependence on nursing staff to mobilise Encourage patient to mobilise within own capabilities Observe for and document any changes in patient's circumstances			

Debbie Sullivan

DATE	WEIGHT BEARING ABILITY	(✓)	TYPE OF MANOEUVRE WHEN MOVING IN BED	(✓)	NO.OF NURSES	TYPE OF MANOEUVRE WHEN MOVING FROM CHAIR / COMMODE	(✓)	NO. OF NURSES	EQUIPMENT REQUIRED TO ASSIST WITH MOBILISING	BED (✓)	CHAIR/ COMMODE (✓)	BATH (✓)
	Able to weight bear and balance	✓	Anterior Hold			Front Hold			Handling Sling			
HEIGHT	Able to weight bear and balance with equipment		Rolling			Side Hold			Turning Disc			
WEIGHT	**Specify Equipment:** (eg. Zimmer)		Turning			Through Arm Hold			Hoist			
	Weight bears b it unstable (eg. Dizzy)								**Specify Hoist Type**			
	Specify :								Pat Slide			
	Unable to weig it bear								Easy Slide			
	No.of Nurses required to ass st when mobilisin g								Rollboard			
									Slip Sheets			

Glasgow Royal Infirmary
University NHS Trust

Investigations Sheet

NAME Deborah Sullivan HOSPITAL No.s WARD 62

DATE/TIME LOCATION	INVESTIGATION	PREPARATION	SIGNATURE	DATE OF REQUEST	SPECIMEN	INSTRUCTION/PREPARATION	DATE OBTAINED	SIGNATURE
1-11-97	CXR Abdo Xray	—						
2-11-97	CXR Abdo Xray	—						
10/11/97	Ba. Follow through	FASTING	LM Farlane					

DATE			WHRD						NHHE			
		NORMAL RESULTS	28	10	30	10	31	10	4	11		
F	WBC	4-11			9.4		10.1		17.7			
B	HB.	M 13.18 F 11.5-16.5			13.7		13.2		13.1			
C	PLT	150-400			291		238		256			
C O A G	KCCT	33-50										
	PT	13.18										
	TETA	6-9										
U	Na^+	135-145	190		141		142		141			
	K^+	3.5-5.0	4.2		3.7		4.1		3.7			
	CHL	97-107	102		104		106		103			
	CO2	23-30	26		22		22		30			
	UREA	2.5-3.6	3.4		2.2		2.9		1.5			
	CR:M.	40-130	85		80		85		60			
	GLU.	4.0-5.5										
	AMY.	70-300	300						190			
	AD Ca	2.2-2.6					2.40					
	Ca	2.2-2.6					2.30					
	PO2	0.7-1.4					1.20					
	T/P	62-82					69					
	ALB.	35-55					42					
	GLOB.	22-33					27					
	BIL.	3-22					7		9			
	ALK. P.	80.280					160		145			
	AST	12.48					36		26			
	ALT	3.55					65		37			
	LDH	230.529					310					
	CK	< 150					320					
	MAG	0.7-1.0										
	C-R.P.	≤ 10					<6		<6			
	GAN GT	< 36										
G A S	H+	7.37-7.43										
	PO_2	12-15										
	PCO_2	4.4-5.6										
	HCO_3											
O/H												

GLASGOW ROYAL INFIRMARY
UNIVERSITY NHS TRUST

1) Deborah Sullivan
GRI W1) 62

24hr. FLUID BALANCE CHART (including Blood)
12mn - 12mn

Date 10/11/1997 PATIENT I.D. LABEL

Fluids + Diet INTAKE 1400				TIME	OUTPUT 1200 U.I.T.			
CODE LETTER OR DESCRIPTION OF INTAKE	ORAL ml.	I.V. ml.	OTHER		URINE	GASTRIC	OTHER	COMMENTS
Fasting				1				
				2	400			
				3				
				4				
				5				
				6				
				7				
				8				
				9				
				10				
				11				
				12				
				1				
				2				
Tea + Toast	150.			3	150.			
				4				
Dinner	400			5				
				6	50			
				7		250		
Tea	150			8				
				9	150.			
				10				
				11	100			
				12				
	700.			12mn.	850.	250.		

TOTAL INTAKE = 700 mls. TOTAL OUTPUT = 1100 mls.

APPROXIMATE MEASURES:- TUMBLER = 200mls. ORDINARY CUP = 150 mls. FEEDING CUP = 175mls. SOUP BOWL = 250n

0159394

GLASGOW ROYAL INFIRMARY
UNIVERSITY NHS TRUST

Deborah
SULLIVAN
QRI - W062

24hr. FLUID BALANCE CHART (including Blood)
12mn - 12mn

Date 11/11/97 PATIENT I.D. LABEL

INTAKE 700				TIME	OUTPUT 1100			
CODE LETTER OR DESCRIPTION OF INTAKE	ORAL ml.	I.V. ml.	OTHER		URINE	GASTRIC	OTHER	COMMENTS
				1am				
				2	300			
				3				
				4				
				5				
				6				
				7				
				8				
				9				
				10				
				11				
				12				
				1pm				
				2				
				3				
				4				
				5				
				6				
				7				
				8				
				9				
				10				
				11				
				12				
				12mn.				

TOTAL INTAKE = mls. TOTAL OUTPUT = mls.

APPROXIMATE MEASURES:- TUMBLER = 200mls. ORDINARY CUP = 150 mls. FEEDING CUP = 175mls. SOUP BOWL = 250r

0159394

DAILY SUMMARY OF FLUID BALANCE

DATE OF BIRTH HOSPITAL NO
FOSNAR SUNGEI BAJ
ADDRESS SEX/MARITAL STATUS
ADDRESS OCCUPATION
HOSPITAL WD/BOT CONSULTANT

0187497

PLEASE WRITE OVER WHITE LETTERS

DATE	INTAKE				OUTPUT			
	ORAL	I.V.	OTHER	TOTAL	URINE	GASTRIC	OTHER	TOTAL
29/10/97		3000		3000	1900			1900
30/10/97	20	1000		1020	200	350		550
31/10/97	—	1,450.		1450	1430			1430.
1-11-97	NBM	2000		2000	1600			1600
2/11/97	450	2750		3200	3300		50	3350
3-11-97	500?	1625		2125	2900	300		3100
4/11/97	600	1525		2125	2250			2250
5/11/97	1125	2125		3250	600		B/O	600 H
6/11/97	1500			1500	750+			750+
7/11/97	1450			1450	1200	300.		1500.
8/11	1600.			1600.	700.	850.		1550.
9/11	1400			1400	1200 HTT			1200 HTT
10/11	700.			700	850	250.		1100.

DEBORAH
SULLIVAN
W060 GRI
PATIENT ID LABEL

TEMPERATURE, PULSE, RESPIRATION AND BLOOD PRESSURE CHART

0160240

OCT'97 Nov

DATE	29th	30	31	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th
POST-OP DAY	O/A													

TEMPERATURE

F	C
107.6	42
105.8	41
104	40
102.2	39
100	38
98.4	37
96.8	36
95	35

PULSE / RESPIRATION

200	200
190	190
180	180
170	170
160	160
150	150
140	140
130	130
120	120
110	110
100	100
90	90
80	80
70	70
60	60
50	50
40	40
30	30
20	20
10	10

Weight														
No. of Stools			1	11	1					1	1	1		

GLASGOW ROYAL INFIRMARY UNIVERSITY NHS TRUST

I.V. THERAPY
PRESCRIPTION SHEET

Deborah.
Sullivan.
wd 62.
PATIENT ID LABEL

0159486

	DATE	FLUID (USE BLOCK LETTERS) / ADDITIVE DRUG	Vol (ml). / Dose (mg)	Route of Admin.	Dur. of Admin.*	SIGNATURE	Serial No. / Batch No.	Time Begun	Given B / Added
A	3/11	(N) SALINE	500	IV	4°	I. Brown			
B	3/11	5% DEXTROSE	500	IV	4°	I. Brown	97J0 8BH	2.40 pm	EMCN
C	3/11	5% DEXTROSE	500	IV	4°	I. Brown	97I 04BJ.	6.50 pm	
D	3/11	5% DEXTROSE	500	IV	4°	I. Brown	97104 BJ	20 23	
E	3/11/97	5% DEXTROSE	500ml	IV	4 HRS		97I04 BJ	20 03	
F	3/11/97	5% DEXTROSE	500ml	IV	4 HRS		97I04 BJ	10.25 AM.	
G	4/11/97	5% DEXTROSE	500ml	IV	4 HRS		97I0 4BJ	8.50 AM	
H	4/11/97	5% DEXTROSE	500ml	IV	4 HRS		97104 BJ	30 00	
I	4/11/97	5% DEXTROSE	500ml	IV	4 HRS		97I02 BA	30 04	
J	5/11/97	5% dextrose	500	IV	4°		97J 08BH	10.30 am	EMCN
K	5/11/97	5% dextrose	500	IV	4°		BJ 10 BC EXP 01/99	4.35 AM	
L	5/11/97	5% dextrose	500	IV	4°				
M	6/11/97								
N									
O									

RATE OF FLOW (Drops/Min.) = VOL.OF FLUID (ml) x 15 / Duration (Mins.)

(1ml = 15 drops)

Approximate Rate for 500 ml.
1 hr. = 120 Drops/min.
4 hr. = 30 Drops/min.
6 hr. = 22 Drops/min.
8 hr. = 15 Drops/min.

6.62

SHEET NO .....

PATIENT NAME DEBORAH SULLIVAN MOGO

RESULTS

Date	Normal	31/10	1/11	1/11
WCC	4-11	9·4		
Hb	~~M 13-18 F 11.5-16.5~~	13·7		
Plts	150-400	241		
Na	135-145	141	131	140
K	3.5-5.0	3·7	4.7	
Cl	97-107	104	91	
Bic	23-30	22	29	
Ur	2.5-8.0	2·2	5·3	
Cr	40-130	80		
Gluc	<11.0			
Amyl	70-200			
Ad Ca	2.2-2.6			
Ca	2.2-2.6			
PO4	0.7-1.4			
T/P	62-82			
Alb	35-55			
Glb	22-33			
Bil	3-22			
ALP	80-280			
AST	12-48			
ALT	5-55			
GGT	11-51			
CH	230-525			
CK	<150			
CRP	<10			
ESR				
APTT	~~35-50~~	28.4		
PT	~~13-18~~	12.1		
TCT	~~6-9~~	10.1		
H+	35-45			
pO2	12-15			
pCO2	4.4-5.6			
HCO3				

VENFLON 3

Patient name DEBORAH SULLIVAN			Hosp Number		M060		
Date	No	Problem	Aim	Intervention	Signature	Review date	
29/10/97.	(4)	Venflon in-situ: potential for local and systemic infection. (L) hand	Minimise the risk. Detect early.	Ask patient to report any pain, swelling or discharge at venflon site. Inspect cannula site daily. Inform medical staff of any inflammation, discharge or dysfunction. Record venflon site condition - see below. Review with medical staff the need for cannula and need to change cannula. Maintain a dry dressing at insertion site.	MWalker	daily	

Review date	Day	Inflammation at site 0 <1 1-2 2-3 >3 cms	Discharge & Amount Blood/Serous Pus + ++ +++	Comment	Medical staff informed	Signature	Date whe removed Signature
30/10	1	—	—			ICT	//
	2						
	3						
	4						
	5						

GLASGOW ROYAL INFIRMARY

DATE OF BIRTH | HOSPITAL NO.
FIRST NAME: Deborah | SURNAME: Sullivan | MARITAL STATUS
ADDRESS | OCCUPATION
HOSPITAL: [illegible] 6D | CONSULTANT: Furlay

I.V. THERAPY PRESCRIPTION SHEET

No H1206 JMcC/914240

PLEASE WRITE OVER WHITE LETTERS

	DATE	FLUID (USE BLOCK LETTERS) / ADDITIVE DRUG	Vol. (ml) / Dose (mg)	Route of Admin.	Dur. of Admin.	SIGNATURE	Serial No. / Batch No.	Time Begun	Given By / Added By
A	29/10	(N) Saline	500	IV	4	C Rodgers	975 13BL	45 1am	[illegible]
B	29/10	5% Dextrose	500	IV	4	C Rodgers	97508 BH	6Am	[illegible]
C	29/10	5% Dextrose	500	IV	4	C Rodgers	975 08BH	10am	[illegible]
D	29/10	(N) Saline	500	IV	4°	[illegible]	971 13BL	2	[illegible]
E	29/10	5% dextrose	500	IV	4°	[illegible]	9750 8BH	30 6pm	[illegible]
F	29/10	5% dextrose	500	IV	4°	[illegible]	975 08BH	10 30	[illegible]
G	30/10	(N) Saline 20 mmol KCl	500	IV	4	C Rodgers	971 16BZ	2 40	[illegible]
H	"	5% Dextrose	500	IV	4	C Rodgers	975 08BH	6 40	[illegible]
I	"	5% Dextrose 20 mmol KCl	500	IV	4	C Rodgers	97916 BG	1pm	[illegible]
J	30/10	(N) Saline	500	IV	4	C Rodgers	97913 BL	9pm	SMcN
K	"	5% Dextrose 20 mmol KCl	500	IV	4	C Rodgers	97916 BG	1a	[illegible]
L	"	5% Dextrose	500	IV	4	C Rodgers	975 01BH	5 30	[illegible]
M	31/10	(N) Saline	500	IV	4		975 13BL	10	[illegible]
N									
O									

RATE OF FLOW (Drops/Min.) = **VOL. OF FLUID (ml) x 15** / Duration (Mins.) (1ml = 15 drops)

6.62

Approximate Rate for 500 ml.

1 hr. = 120 Drops/min. | 6 hr. = 22 Drops/min.
4 hr = 30 Drops/min. | 8 hr. = 15 Drops/min.

SHEET NO .....

GLASGOW ROYAL INFIRMARY UNIVERSITY NHS TRUST

I.V. THERAPY PRESCRIPTION SHEET

DEBORAH
SULLIVAN
GRI 62
PATIENT ID LABEL

0159486

	DATE	FLUID (USE BLOCK LETTERS) / ADDITIVE DRUG	Vol (ml). / Dose (mg)	Route of Admin.	Dur. of Admin.*	SIGNATURE	Serial No. / Batch No.	Time Begun	Given E / Added
A	31/10/97	(N) SALINE 20 KCL 20mmol	500ml	IV	4HRLY		97I16 B2	7pm	
B	31/10/97	5% DEXTROSE	500ml	IV	4 HRLY		97J08 BH	11.30 pm	
C	31/10/97	5% DEXTROSE 20 KCL 20mmol	500ml	IV	4HRLY		97C24 BK	3.40 DISCONTINUED	
D	31/10/97	(N) SALINE	500ml	IV	4 HRLY		97I 22BK	4.20 4AM	
E	1/11/97	5% dextrose 20 KCl	500	IV	4°		97124 BP	9.25 9.a	
F	1/11/97	5% dextrose	500	IV	4°		97J 08BH	5.15 pm	
G	1/11/97	(N) saline [redacted]	500	IV	4°		97122 BK	10 22	
H	1/11	S.-Dextrose	500	IV	4°		97J08 BH	20 02	
I	1/11	N Saline	500	IV	4°		97J21 BW	30 06	
J	1/11	S.-Dextrose	500	IV	4°		97J0 8BH	12 noon	
K	2/11	N.Saline	500	IV	4°		97J21 BW	4.30 pm	
L	2/11	5% Dextrose 1/2 normal saline	500	IV	4°		97I 24 BP	8:50 pm.	
M	2/11	N.Saline	500	IV	4°		97J01 BW	30 01	
N	2/11/97	5% DEXTROSE 20 KCL 20mmol	500ml	IV	4HRLY		97C24 BK	30 05	
O	2/11/97	(N) SALINE	500ml	IV	4HR		97J 21BW	9am	

RATE OF FLOW (Drops/Min.) = VOL.OF FLUID (ml) x 15 / Duration (Mins.)

(1ml = 15 drops)

Approximate Rate for 500 ml.

1 hr. = 120 Drops/min. 6 hr. = 22 Drops/min.

4 hr. = 30 Drops/min. 8 hr. = 15 Drops/min.

6.62

SHEET NO .....

VENFLON

Patient name DEBORAH SULLIVAN | Hosp Number | 62

Date	No	Problem	Aim	Intervention	Signature	Review date	
31/10/97.		Venflon in-situ: potential for local and systemic infection. Venflon (R) hand.	Minimise the risk. Detect early.	Ask patient to report any pain, swelling or discharge at venflon site. Inspect cannula site 4 hly. Inform medical staff of any inflammation, discharge or dysfunction. Record venflon site condition - see below. Review with medical staff the need for cannula and need to change cannula. Maintain a dry dressing at insertion site.			
1/11/97.		pink (R) hand.					

Review date	Day	Inflammation at site 0 <1 1-2 2-3 >3 cms	Discharge & Amount Blood/Serous Pus + ++ +++ ++++	Comment	Medical staff informed	Signature	Date wh removed Signatu
1/11/97..	1			Dislodged restad 5pm. KE	Yes	E.McM	
2/11/97	2	"	"			EMcM	
3.11.97	3	0	0	Dislodged	Yes.	A Robinson.	3-11-97 M Sherael
5.11.97.	4	0.	0.			CMcCann	
..	5						

HOSPITAL

PRESCRIPTION SHEET No.

REGULAR PRESCRIPTIONS – INJECTIONS

Pharmacy Use	Date Started	MEDICINE (Block Capitals)	DOSE	ROUTE	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times	Prescribers Signature (Full)	DISCONTINUED: Date	Signed
	A																
	B																
	C																
	D																
	E																
	F																
	G																

REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

	8/11/97																
	J																
	K																
	L																
	M																
	N																
	O																
	P																
	R																
	S																
	T																
	V																

ONCE ONLY PRESCRIPTIONS

DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN
8/11/97	8.30.	PARACETAMOL	1g.	ORAL		K. DEACY	8.30
8/11		Methotrimeprazine	10mg	IM		S Lochrie	6.50 pm
8/11		Cardizem	10ml.	PO		L M Harlane	7.20 pm
9.11	5.30 pm	Paracetamol	1g	P.O		A Gowans	5.30 pm
10/11		VOLTAROL	100mg	PR		L M Harlane	7.30 pm
10/11		VOLTAROL	100mg	PR			

DIET

WARD	NAME OF PATIENT	AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
67	DEBORAH SULLIVAN				9648766	Mr. FINLAY.

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

KNOWN MEDICINE 1.

ORM PST 10/90

HOSPITAL
PRESCRIPTION SHEET No.

REGULAR PRESCRIPTIONS – INJECTIONS

Pharmacy Use	Date Started	MEDICINE (Block Capitals)	DOSE	ROUTE	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	md 12.	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times	Prescribers Signature (Full)	DISCONTINUED: Date	Signed
	A																
	B																
	C																
	D																
	E																
	F																
	G																

REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

	H																
	J																
	K																
	L																
	M																
	N																
	O																
	P																
	R																
	S																
	T																
	V																

ONCE ONLY PRESCRIPTIONS

DIET

DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN
3/11/97	11.45pm	Prochlorperazine	12.5mg	IM		Ushende	00:10
3/11/97		BUSCOPAN	20mg	IM			12.30am
3/11/97	10.30	Tramadol	50mg	IM		E.McMurdo	10.45am
3/11/97	10.30	Buscopan	20mg	IM		E.McMurdo	10.45am
3/11/97	5pm	Paracetamol	1g	P.O		AP.	5pm
3/11/97	9pm	Ciprofloxacin	1 tablet	P.O		K Dewey	9pm
4/11/97	6am	Paracetamol	1gm	P.O		MSheppard	06:10
4/11/97	after IV	Predox	1 sachet	P.O		E.McMurdo	5pm
4/11/97		Predox	1 sachet	PO		E.McMurdo	7.30pm
4/11/97		PARACETAMOL	1g	ORAL			6.15pm
7/11/97		Paracetamol	1g	Oral		E.McMurdo	2.30pm

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

KNOWN MEDICINE 1.

WARD	NAME OF PATIENT	AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
L2	D. Cullinane					

HOSPITAL

PRESCRIPTION SHEET No.

REGULAR PRESCRIPTIONS – INJECTIONS

Pharmacy Use	Date Started	MEDICINE (Block Capitals)	DOSE	ROUTE	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	md 12	pm 12	pm 4	pm 6	pm 10	pm 12	Other Times	Prescribers Signature (Full)	DISCONTINUED: Date	Signed
	A 29/10/97	~~PETHIDINE~~	~~50 mg~~	~~IM~~						~~4 - 6°~~	as req				~~C Roche~~	~~29/10/97~~	
	B 29/10/97	~~STEMETIL~~	~~12.5 mg~~	~~IM~~						~~6 - 8'~~	as req				~~C Roche~~	30/10	
	~~C 30/10/97~~	~~PCM~~		~~PR~~													
	D 4/11/97	Tramadol	50 mg - 100 mg	IM						4 - 6	PRN	pain				30/10	CK
	E	~~PCM~~															
	F																
	G																

REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

	~~H 29/10/97~~	~~DIHYDROCODEINE~~	~~30 mg~~	~~oral~~		~~4 - 6 hrly~~				~~PRN~~				~~C Roche~~	
AX	J 29/10/97	MAXOLON / METOCLOPRAMIDE	10 mg	oral		6 - 8 hrly				PRN				C Roche	
	~~K 30.10.97~~	~~VOLTAROL~~	~~75 mg~~	~~PR~~		✓						✓			30/10 CK
	L 30/10/97	INDOMETHACIN	100 mg	PR		✓						✓			
	ME 1/11/97	~~LOSEC~~	20 mg	oral		✓									
	N 6/11/97	GAVISCON	10 ml	oral		✓				✓		✓			
	O 7/11/97	BUSCOPAN	20 mg	oral		~~✓~~		~~✓~~ max 4/d					10 Spasm	C Roche	
MAX 50mg IM	~~P 9/11/97~~	~~VOLTAROL~~	~~50 mg~~	~~PR~~		~~6 - 8~~ hourly						~~PRN pain~~		~~C Roche~~	10/11
	~~Q 10/11/97~~	DIC order Fe.													
	S														
	T														
	V														

ONCE ONLY PRESCRIPTIONS

DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN
29/10/97		PETHIDINE	75 mg	IM	C Roche	[illegible]	5.20 am
29/10/97		MAXOLON	10 mg	IM	C Roche	[illegible]	5.20 am
30/10/97		INDOMETHACIN	100 mg	oral	C Roche		
31/10/97		TEMAZEPAM	10 mg	oral	C Roche		
31/10/97		PETHIDINE	100 mg	~~IM~~ SC	[illegible]	[illegible]	6:40 pm
31/10/97		PROCHLORPERAZINE	12.5 mg	IM	[illegible]	[illegible]	6:40 pm
31/10/97		DICLOFENAC	50 mg	PR	[illegible]	[illegible]	7:15 pm
31/10/97		TEMAZEPAM	10 mg	ORAL	[illegible]	[illegible]	11.45 pm
1/11/97		PETHIDINE	100 mg	IM	[illegible]	P. DEACY	12.45 am
1/11/97		~~PROCHLORPERAZINE~~ STEMETIL	12.5 mg	IM	[illegible]	R. DeACY	12.45 am
1/11/97		Pethidine	100 mg	IM	[illegible]	Mshende	0010

DIET

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION		
INSULIN		FLUID/ADDITIVE
ORAL ANTICOAGULANT		ANAESTHETIC
TOPICAL APPLICATION		VARIABLE DOSE

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

KNOWN MEDICINE 1.

WARD		AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
60	NC	964876K SULLIVAN F/S DEBORAH 07/12/1972	24			MR FINLAN

HOSPITAL

MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

DATE	REGULAR PRESCRIPTIONS: 6 a.m.	8 a.m.	10 a.m.	12 m.d.	2 p.m.	4 p.m.	6 p.m.	10 p.m.	12 m.n.	OTHER TIMES	COMMENTS ON DISCREPANCIES
7/11/97	Initial	L M N	Initial	Initial	N	0 @3.20pm	0@6.40	L N	Initial	Initial	J at 715am.
8/11/97	Initial	M L N LD	Initial	Initial	Initial	Initial	0 at 5.15 pm LM	L N 0-10 35. DM	Initial	Initial	
9/11/97	Initial	L N 0850 am N LM	Initial	Initial	N Initial	Initial	Initial	L N 0-10 50 pm DM	Initial	Initial	P at 11.30am
10/11/97	Initial	AS 7.10 BD	Initial	Initial	N Initial LM	Initial	N Initial LM	L N 0-10 DM	Initial	Initial	
11/11/97	Initial	M L N LD	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	
	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	
	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	
	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	

NAME: D. Sullivan

UNIT NUMBER:

WARD:

KEY: CODE LETTER CIRCLED E.G. Ⓐ = MEDICINE REFUSED AND MEDICAL STAFF INFORMED

CODE LETTER SCORED E.G. ✗ = PATIENT ABSENT

FORM MR1 10/00

HOSPITAL

MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

REGULAR PRESCRIPTIONS

DATE	6 a.m.	8 a.m.	10 a.m.	12 m.d.	2 p.m.	4 p.m.	6 p.m.	10 p.m.	12 m.n.	OTHER TIMES	COMMENTS ON DISCREPANCIES
29/10/97	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	H at 1.30 am HAT 9 10am. A at 9.15pm CMS
30/10/97	6.30 pm H B				H Initial						H 21 35 L @ 8.55pm SMcN. Heart Sounds J @ 4.50pm SMcN.
31/10/97				L Initial				L Initial			
1/11/97	L DM.					D (50mg) 3.5pm D(50mg) at 4.45pm SMc AP.		D (50mg) at 9pm L AP MS.			D (5 mgs) 2300 MS
2/11/97	L AK.			(1)			Dal 5: 35pm L			Dal 11.40am Dal 21.15 MS EMC	O given 1pm J at 7.15pm MS
3/11/97	J L SMK							J L MS.			Dal 04.30 hrs Dal 9am SMcN.
4/11/97	J L MD							L MS.			Dal 19-00 hrs.
5/11/97	J L AK.							L DM			
6/11/97	D L M. AK				N H			L N DM.			

NAME	UNIT NUMBER	WARD
DEBORAH SULLIVAN		60

KEY: CODE LETTER CIRCLED E.G. (A) = MEDICINE REFUSED AND MEDICAL STAFF INFORMED

CODE LETTER SCORED E.G. X = PATIENT ABSENT

FORM MR1 10/89

...-4000

IMMEDIATE DISCHARGE LETTER AND MEDICINE PRESCRIPTION FORM

To be completed for every discharge and inter specialty transfer

78979

CONFIDENTIAL

FIX ID LABEL TO ALL 4 COPIES

Name: 964876K SULLIVAN F/S
DEBORAH 07/12/1972
1/1 160 MAIN STREET
BAILLIESTON
G69 6AH

Addr:

DOB:

Unit:

Diagnosis (inc, cause of injury)

1 Epigastric Pain
2
3
4
5
6

Procedures

1 Date
2 Date
3 Date
4 Date

Type of Admission			
WL/ARRANGED		DAY CASE	
EMERGENCY		INTERNAL TRANSFER	
		TRANSFER FROM OTHER HOSPITAL	

DOA 12/12/97
CONSULTANT Cook
WARD 66
DATE OF DISCHARGE/DEATH
TRANSFERRED TO WARD DATE

FOLLOW UP ARRANGEMENTS

Clinic Date
Home Help YES NO
District Nurse YES NO
GP YES NO
Meals on Wheels YES NO
OTHER

PROCEDURES PERFORMED BY OTHER SPECIALITIES

Procedure	Specialty	Consultant	Date
1			
2			

Medicine	Form	Dose	Frequency	Duration	Days Supplied	PHARMACY TO COMPLETE Quantity, Strength, Brand

COMMENTS (Information given to patients, investigating pending, pharmacy, medicine sensitivities, etc)

Bloods (W)
IV fluids & analgesia
Still discharged.

Doctor's Name Davies Signature Page No 1235 Date 17/12/97 Pharmacist

White Copy - GP Pink Copy - Case Notes Blue Copy - Pharmacy Yellow Co...coding

0159369

Glasgow Royal Infirmary University NHS Trust

Profile/Careplan for 24 / 72 hour stay

DATE OF ADMISSION	TIME	WARD	TYPE OF ADMISSION	TRANSFER FROM	OTHER	ADMITTING NURSE
12.10.97	10.45 AM	60	(EMERGENCY) / PLANNED /			

SURNAME: **964876K**
FORENAME: SULLIVAN F/S
DEBORAH 07/12/1972
ADDRESS: 1/1 160 MAIN STREET
BAILLIESTON
G69 6AH

TEL Nos. 771 3401
WISHES TO BE KNOWN AS

NEXT OF KIN Kathleen Sullivan
ADDRESS 187 Commonhead rd G34
RELATONSHIP Mother
TEL. Nos.

DATE OF BIRTH 7.12.72
AGE 24
RELIGION RC
MENSTRUAL CYCLE LMP 2/7.
PARA
URINALYSIS * NAD.

G.P. AND ADDRESS
DR. Goldie
Eastmoss HC

ALLERGIES: VOLTAROL

CHEMICAL DEPENDANCY: —
PROSTHESIS: —

BASELINE RECORDS

HEIGHT	5'10"
WEIGHT	12st
B.P.	
TEMP.	36.8°
PULSE	
RESPIRATION	20
DENTURES	Nil

SOCIAL CIRCUMSTANCES

OCCUPATION: Insurance
LIVES WITH: Boyfriend
TYPE OF HOUSE: 1st floor flat

SUPPORTING SERVICES: —

STORAGE OF VALUABLES: RETURNED ✓

STORAGE OF DRUGS: RETURNED ✓

REASON FOR ADMISSION	PAST MEDICAL HISTORY	CURRENT DRUG THERAPY
abdominal pain constant since last admission worsening this evening with associated vomiting	Lap chole April 1996 Appendectomy March 1996 Tonsilectomy July 1993 several admissions with c/o abdominal pain	LOSEC DF118 maxalon

ASSESSMENT re issued

CONSULTANT COOKE

0280470

...MENT

SAFETY AND COMFORT	BREATHING & CIRCULATION	MAINTAINING BODY TEMPERATURE	EATING & DRINKING	MOBILITY
maintains own	no problems.	maintains own.	normal diet. occassional alcohol	fully mobile

PERSONAL HYGIENE	ELIMINATION	SLEEP	COMMUNICATION (INCLUDING FEARS & ANXIETIES)
Daily bath/ shower ✓ SKIN CONDITION	no problems.	sleeps well.	

DATE	No.	PROBLEM	AIM	INTERVENTION	SIGNATURE	EVALUATION	DISC

			AIM	INTERVENTION	SIGNATURE	EVALUATION	DISC

DATE	No	EVALUATION/NURSING NOTES	SIGNATURE
12.10.97.		Settled O/A	
		9/w reviews by medical staff.	
		Morphine 10mgs & Stemetil 12.5mgs IM at 4.55am.	
		IV fluids commenced, urinary output satisfactory.	
		Morphine 10mg IM. 10.20am	
		seen by Ref doctor allowed oral fluids discontinued	
		for some 4 fluids continue continues to complain	
		of pain & nausea IM analgesia to be cancelled	
		& oral analgesia prescribed. Vomited x1 vomit	
		satisfactory abpt good	
		Morphine 10mg IM @ 2pm with Stemetil 12.5mg	
		care as planned	
		Stemetil 12.5 milligrams given intramuscularly at 7.30pm to	
		relieve nausea with some effect. Vomited x1	
		complaining of abdominal pain. Unable to tolerate oral	

Glasgow Royal Infirmary
University NHS Trust

Nursing Notes

Name: [illegible] | Hospital Nos: | Ward: 60

Date	Problem No.s	Nursing Notes / Evaluation	Signature
13.10.97		analgesia:	
		Morphine Sulphate 10 milligrams given intramuscularly	
		at 7.40pm with good effect	mmorgan
		Morphine sulphate 10mgs given I.M at 11.50PM	
14.10.97		Slept well. Vomited small amount x1	
		IV fluids as charted. Declined for oral fluids	[illegible]
		Morphine, supp IM & Stemetil 12.5mg IM at 7am	
		care as planned.	
		Continues to complain of abdominal pain.	
		Seen by Professor Cooke - commenced on rectal	
		indomethacin suppositories. No further opiates.	
		No nausea or vomiting.	
		Discussed oral fluids. Intravenous infusion continues	mmorgan
		as prescribed.	
		Husband spoken to by medical staff.	mm
	PM	Complained of pain this PM, given DF118 @ 8.10 orally.	
		Indomethacin Supps @ 6pm - 100 mgs PR.	
		S/B Mr Simon, to treat conservatively till able for	
		Investigations	
		All other care as planned	C. Cam
		I.V fluids continue. Family spoken to by SHO	CBarker
15.10.97		Slept well	
		DF118 as prescribed. % nausea given Stemetil with effect.	
		IV fluids maintained	dmcclung
	AM	IV's discontinued, all care as planned. - Fluid + Diet commenced.	

026M69

Name: [redacted] Hospital No.: [redacted] Ward:

Date	Problem No.s	Nursing Notes / Evaluation	Signature
15-10-92	7pm	wishes to take an irregular discharge. Advised to stay in ward but does not wish to do so. Seen by medical staff and discharged	mmorg

...lasgow Royal Infirmary

...oblem / Aims

D. Sullivan

Date of Birth

Ward No's

12.10.97 A) Potential for fluid & electrolyte imbalance due to...	To maintain hydration	Nursing Intervention A) Administer intravenous fluids as prescribed by doctor	Signature
a) Operative procedure	Electrolytes within normal limits	B) Maintain accurate record of intake & output	
b) Anaesthetic	Increase appetite & promote healthy/balanced diet	C) If necessary, administer antiemetics as prescribed & monitor effect with patient	
c) Nausea & Vomiting		D) Dietary restrictions...	
B) Loss of appetite due to surgery		12.10.97 NBM 15/10 free fluids	
		...appetite and ... dietary intake	

GLASGOW ROYAL INFIRMARY UNIVERSITY S TRUST

PROBLEMS / AIMS

NAME: D Sullivan HOSPITAL NUMBER: WARD:

DATE	NO	PROBLEM	AIM	NURSING INTERVENTIONS	SIGNATURE	EVAL. DATE	DISC. DATE
2.10		Patient requires assistance when moving due to	To minimise the risk of injury to patient and staff To promote patient comfort	Ascertain patient's weight Ascertain patient's height Assess and document patient's weight bearing ability Assess and document patient's dependence on nursing staff to mobilise Encourage patient to mobilise within own capabilities Observe for and document any changes in patient's circumstances			

oblems / Aims

me D. Sullivan | Date of Birth | Ward Bed 60

dr	No	Problem	Aim	Nursing Intervention	Signature	Evaluation Date	Rec Date
12-10-97		Has high temperature. Feels hot and uncomfortable and unable to restore normal temperature because	To help restore normal temperature (specify) and comfort	a. Reduce amount of clothing worn in bed and assist in choosing suitable attire and appropriate bedclothes. b. Ensure fluid intake of at least (specify) in 24 hours. c. Use of fan. d. Position in well ventilated environment. e. Tepid sponge if temperature exceeds and follow set guidelines as per procedure manual. f. Accurately record and monitor body temperature (frequency) 4°	DMAA	OG	

...gow Royal Infirmary

Problems / Aims

PAIN – INFUSION PUMP

Name Deborah Sullivan | Date of Birth | Ward No:s 35

Date	No.	Problem	Aim	Nursing Intervention	Signature	Date Evaluation Date	Date Disc Date
12.10.97		Pain	To monitor & relieve pain Patient will state she is comfortable	A) Ask patient to report to nursing staff when she is in pain B) Administer prescribed analgesia & monitor effect C) Inform medical staff if analgesia is ineffective	DSullivan		

PATIENT NAME D. Sullivan
RESULTS

Date	Normal
WCC	4-11
Hb	M 13-18 F 11.5-16.5
Plts	150-400
Na	135-145
K	3.5-5.0
Cl	97-107
Bic	23-30
Ur	2.5-8.0
Cr	40-130
Gluc	<11.0
Amyl	70-200
Ca	2.2-2.6
Ca	2.2-2.6
PO4	0.7-1.4
T/P	62-82
Alb	35-55
Glb	22-33
Bil	3-22
ALP	80-280
AST	12-48
ALT	5-55
GGT	11-51
LDH	230-525
	<150
CRP	<10
ESR	
APTT	~~35-50~~ 32-44
PT	~~13-18~~ 12-16
TCT	~~6-9~~ 10-13
H+	35-45
pO2	12-15
pCO2	4.4-5.6
HCO3	

GLASGOW ROYAL INFIRM

964876K
SULLIVAN F/S
DEBORAH 07/12/1972
1/1 160 MAIN STREET
BAILLIESTON
G69 6AH

HOSPITAL GRI WARD 60 CONSULTANT COOKE

I.V. THERAPY
PRESCRIPTION SHEET

No H1206 JMcC/914240

PLEASE WRITE OVER WHITE LETTERS

	DATE	FLUID (USE BLOCK LETTERS) / ADDITIVE DRUG	Vol. (ml) / Dose (mg)	Route of Admin.	Dur. of Admin.	SIGNATURE	Serial No. Batch No.	Time Begun	Given By / Added By
A	12/10	(N) SALINE	500	IV	4hr		9711 9BS	12.15 AM	
B	12/10	5% DEXTROSE	500	IV	4hr		97122 BN	4.20	
C	12/10	5% DEXTROSE	500	IV	4hr		9711 9BN	8.30 a	
D	12/10	N Saline	500	IV	4hr		9711 9BS	1 M	
E	13/10	5% Dextrose	500	IV	4°		97F10 BN 08/99	6 p	
F	13/10	N Saline	500	IV	4°		97H2 8BN	10.10 AM	
G	14/10	5% DEXT 20 KCl	500	IV	4H		97F0 4BN	2.25 PM	
H	14/10	(N) Saline	500	IV	4H		97H2 8BN	6.10 PM	
I	14/10	5% Dextrose	500	IV	4°		97011 BN	11 10AM	
J	14/10	N Saline	500	IV	4°		9719 BS	5	
K	14.10	5% Dextrose	500	IV	4°		97I 10BN	11.50	
L	15/10	(N) SALINE 20 KCl	500	IV	4hr		97915 BN	3.50	
M	15/10	5% DEXTROSE	500	IV	4hr		97E 10BN	8.10 am	
N									
O									

RATE OF FLOW (Drops/Min.) = **VOL. OF FLUID (ml) x 15** / Duration (Mins.) (1ml = 15 drops)

6.62

Approximate Rate for 500 ml.

1 hr. = 120 Drops/min. 6 hr. = 22 Drops/min.
4 hr = 30 Drops/min. 8 hr. = 15 Drops/min.

SHEET NO .....

HOSPITAL

PRESCRIPTION SHEET No.

REGULAR PRESCRIPTIONS – INJECTIONS

Pharmacy Use		Date Started	MEDICINE (Block Capitals)	DOSE	ROUTE	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times	Prescribers Signature (Full)	DISCONTINUED: Date	Signed
	A	12/10/97	MORPHINE	10mg	IVI												13/10/97	
	B	12/10/97	STEMETIL	12.5mg	IM													
	C		~~MORPHINE~~	10mg	IM												14/10	
	D																	
	E																	
	F																	
	G																	

REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

		13/10/97	DIHYDROCODEINE	30mg-60mg	ORAL	4-6hrly PRN pain										
	J		~~DICLOFENAC~~													
	K	14/10/97	INDOMETHACIN	100mg	PR		✓					✓			I. Brown	
	L	15/10/97	LOSEC	20mg	PO		✓								SDD	
	M															
	N															
	O															
	P															
	R															
	S															
	T															
	V															

ONCE ONLY PRESCRIPTIONS

DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN
13/10/97	10.40pm	PARACETOMOL	II	PO	~~SMITH~~	~~SMITH~~	10.40pm
14/10/97	~~22.30~~ 09.00	INDOMETHACIN	100mg	PR	I. Brown	SD Clark	09.20am

DIET

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

KNOWN MEDICINE 1. Voltarol.

WARD	NAME OF PATIENT	AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
[illegible]	[illegible] **964876K**					

HOSPITAL

MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

REGULAR PRESCRIPTIONS

DATE	6 a.m.	8 a.m.	10 a.m.	12 m.d.	2 p.m.	4 p.m.	6 p.m.	10 p.m.	12 m.n.	OTHER TIMES	COMMENTS ON DISCREPANCIES
13/10/97	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	A at 12 Noon / B 7.30 pm A at 4.55am B at 4.55am A 10.30am B3 4pm B2 6.2pm
14/10/97	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	C at 7.40pm 98 C & B at 11.50pm
15/10	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	C & B at 6.30pm K @ 3pm H at 3pm H (8.0 g/s) + B 5.10pm B & H at 4.20pm
	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	
	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	
	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	
	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	

NAME: 964876K SULLIVAN F/S DEBORAH 07/12/1972 1/1 140 MAIN STREET

UNIT NUMBER:

WARD: 60

KEY: CODE LETTER CIRCLED E.G. (A) = MEDICINE REFUSED AND MEDICAL STAFF INFORMED

CODE LETTER SCORED E.G. A = PATIENT ABSENT

YOU MUST USE A BALLPOINT PEN AND FULLY C[illegible]MPLETE THIS FORM OR THE PRESCRIPTION WILL NOT BE DISPEN

GLASGOW ROYAL INFIRMARY
G4 OSF TEL 0141-211-400[illegible]

CONFIDENTIAL

[illegible]MEDIATE DISCHARGE LETTER AND [illegible]ICINE PRESCRIPTION FORM
To be completed for every discharge and inter specialty transfer

69766

Dear Doctor..... [illegible] .....

[illegible]ES
964876K
SULLIVAN F/S
DEBORAH 07/12/1972
1/1 160 MAIN STREET
BAILLIESTON
G69 6AH

Diagnosis (inc, cause of injury)

1 Non specific abdominal pain 4 .....
2 ..... 5 .....
3 ..... 6 .....

Procedures

1 ..... Date..... 3 ..... Date .....
2 ..... Date ..... 4 ..... Date .....

Type of Admission			
WL/ARRANGED		DAY CASE	
EMERGENCY	✓	INTERNAL TRANSFER	
		TRANSFER FROM OTHER HOSPITAL	

DOA 2/2/97
CONSULTANT Mr St Yrjon
WARD 60
DATE OF DISCHARGE/DEATH 3/10/97
TRANSFERRED TO WARD 62 DATE 3/10

FOLLOW UP ARRANGEMENTS

Clinic ..... Date.....			GP	YES	NO
Home Help	YES	NO	Meals on Wheels	YES	NO
District Nurse	YES	NO	OTHER		

PROCEDURES PERFORMED BY OTHER SPECIALITIES

Procedure	Specialty	Consultant	Date
1.....	.....	.....	.....
2.....	.....	.....	.....

Medicine	Form	Dose	Frequency	Duration	Days Supplied	PHARMACY TO COMPLETE Quantity, Strength, Brand

COMMENTS (Information given to patients, investigating pending, pharmacy, medicine sensitivities, etc)

No Follow up.

Doctor's Name..... [illegible] Signature..... Page No 1129 Date..... Pharmacist.....

White Copy - GP Pink Copy - Case Notes Blue Copy - Pharmacy Yellow Copy -Coding

0159369

Glasgow Royal Infirmary

Profile / Careplan for 24 / 72 hour stay

HC 2nd Nurse – S/N McGinn
Waterow – 7

DATE OF ADMISSION 2/10/97	TIME 8.25 pm	WARD 60	TYPE OF ADMISSION (EMERGENCY) / PLANNED / TRANSFER FROM : OTHER				ADMITTING NURSE KD

SURNAME / FORENAME / ADDRESS	964876K SULLIVAN F/S DEBORAH 07/12/1972 1/1 160 MAIN STREET BAILLIESTON G69 6AH	DATE OF BIRTH 7/12/72	MENSTRUAL CYCLE	ALLERGIES	BASELINE RECORDS
		AGE 24	PARA	VOLTAROL	HEIGHT 5'10"
		RELIGION	URINALYSIS MSSU ✓ + PROTEIN Large Ketones	CHEMICAL DEPENDANCY /	WEIGHT 11½st
		G.P. AND ADDRESS Goldie Easterhouse HC 7710781		PROSTHESIS /	B.P. 110/80
TEL. Nos. 7713401					TEMP. 36.8
					PULSE 88
					RESPIRATION
					DENTURES —

WISHES TO BE KNOWN AS	SOCIAL CIRCUMSTANCES		STORAGE OF VALUABLES	STORAGE OF DRUGS
NEXT OF KIN Kathleen	OCCUPATION Claims Handler.	SUPPORTING SERVICES		
ADDRESS ~~Sfx~~ 187 Commonhead Rd Easterhouse	LIVES WITH fiancé			
RELATIONSHIP Mother.	TYPE OF HOUSE		RETURNED	RETURNED
TEL.Nos. 771 3743				

REASON FOR ADMISSION	PAST MEDICAL HISTORY	CURRENT DRUG THERAPY
5 day hx of epigastric + RUQ pain radiating to back Associated vomiting	Appendicectomy '96 Lap cholecystectomy '96 Numerous admissions since	Maxalon Losec

PATIENTS NAME [illegible] CONSULTANT [illegible]

ASSESSMENT

SAFETY AND COMFORT	BREATHING & CIRCULATION	MAINTAINING BODY TEMPERATURE	EATING & DRINKING	MOBILITY
Self care. Perfudine 100mg + stemetil 12.5mg IM A+E	No problems (smokes <10 c.p.d.)	No problems	Normal diet (social alcohol)	Independent

PERSONAL HYGIENE	ELIMINATION	SLEEP	COMMUNICATION (INCLUDING FEARS & ANXIETIES)
Independent	No problems	No problems	No problems

SKIN CONDITION Healthy

PRE-OPERATIVE CARE PLAN

DATE	No.	PROBLEM	AIM	INTERVENTION	SIGNATURE	EVALUATION	DISC.
		PREPARATION OF PATIENT FOR THEATRE	PATIENT WILL BE CORRECTLY PREPARED FOR OPERATIVE PROCEDURE	A) EXPLAIN PROCEDURE/SEQUENCE OF EVENTS TO PATIENT B) NIL BY MOUTH FROM: C) SKIN PREPARATION: D) BOWEL PREPARATION E) BATH/SHOWER F) COMPLETE PRE-OPERATIVE CHECK LIST G) PREMEDICATION			
		UNABLE TO MAINTAIN OWN SAFETY WHILE ANAESTHETISED/ MEDICATED	TO MINIMISE THE RISK OF INJURY	A) ENSURE COTSIDES ARE IN POSITION UNTIL THE PATIENT IS FULL AWAKE B) PROVIDE PATIENT WITH NURSE CALL SYSTEM TO ENSURE HE/SHE HAS THE MEANS TO SUMMON ASSISTANCE C) NURSE PATIENT IN A POSITION WHICH CAN BE EASILY OBSERVED			

DATE	No.	PROBLEM	AI	INTERVENTION	SIGNATURE	EVALUATION	DISC

DATE	No.	EVALUATION/NURSING NOTES	SIGNATURE
2/10/97		Settled following IM analgesia in A+E	
		IV fluids commenced 4°, fasting	KD enrol
3/10/97		~~Pethidine 100mgs im at 12mn. & 4am Stemetil 12.5mgs im at 4am~~ 6AM	
		Stemetil 12.5mg given IM at 4am.	
		IV fluids continue, running behind time as vomiting positional	
		HNPU ✓	
		Slept for long periods. no vomiting overnight	SUMARA
am		Seen by Mr Anderson, for ultrasound today	
		Pethidine 100mg IM at 11.25am	KD enrol
		Ultrasound — gIAD	
		IV fluids continue, remain fasting	
		Urinary output satisfactory.	
		For transfer to ward 6	IC

Glasgow Royal Infirmary
University NHS Trust

Nursing Notes

Name: D. SULLIVAN | Hospital Nos: | Ward: 62

Date	Problem No.s	Nursing Notes / Evaluation	Signature
	pm	IV fluids continue 125mls/hr.	
		Pethidine 100mgs given IM at 4.30pm & 8.45 pm.	
		To be sent to Homeopathic hospital if pethidine has not been required.	
		Stemetil given at 8.45pm.	O'Maellan.
4:10:97		Settled overnight. Appeared to sleep for long periods.	
		Pethidine 100mg I.M at 02.45 for abdominal pain.	
		Stemetil 12.5mg given I.M at 06.45. No vomiting.	
		I.V fluids continue 4° as prescribed.	Whitmie.
		Passing good volumes urine.	Whitmie.
		Nil orally.	Whitmie
		Observations: P: 81 T: 36° BP: 129/85 [redacted] at 06°°	
		Pethidine 100mg I.M at 0645 for pain	Whitmie
	am.	Mobile around ward this morning.	
		Recommenced to free fluids.	
		Has not required analgesia.	
		Debbie's mother contacted ward and would like to speak.	
		with Doctor on Monday as is not happy for her to return.	
		to Homeopathic hospital.	
		IV fluids maintained at 125mls per hour.	Afrasa.
	2nd pm	Venflon tissued, Doctor to be informed.	
	pm	Pethidine 100mgs given IM at 3.05pm	Chen
		Pethidine 100mgs and Stemetil 12.5mgs IM at 7.35pm	
		IV fluids discontinued, Venflon removed, managing free fluids well	
		Debbie and Debbies mother are unhappy about Debbie going back to the homopathic hospital.	
		Observations satisfactory. Charted. Patient vomited 100mls at 7pm	Chen.

0280

Name: D. Sullivan | Hospital Nos. | Ward 62

Date	Problem No.s	Nursing Notes / Evaluation	Signature
5:10:97		Fluid balance: Intake: 2875 Output: 2,150 at 12 MN	
		Pethidine 100mg I.M at 2340 for pain, with good effect.	
		Passing good volumes urine.	
		Mum complaining nausea.	
		Allowed free fluids.	
		Observations: P:70 T:36 BP:109/60 at 0600	J Mitchell
		Pethidine 100mg I.M at 0630 for pain.	
		Stemetil 12.5mg given I.M at 0630 for nausea. Vomited x1	
		50mls.	J Mitchell
	pm.	Self caring this morning.	
		Allowed free fluids & diet	
		Pethidine now discontinued with regards to transfer to homeopathic hospital who won't take her whilst on pethidine. Now prescribed co-codamol for pain.	
		Observations @ 2pm.	D Hodgie
	pm.	Vomited x3 during the evening. - medical staff informed.	
		Tramadol 100mgs IM given as one off, Stemetil also given.	
		Remains on fluid and diet.	
		Observations satisfactory.	D Macillan
6:10:97		Fluid balance: Intake: 650 Output: 2450 at 12 MN.	
		Co-codamol taken for pain.	
		Tramadol 100mg I.M given at 0420 as once off, with good effect.	
		Announcing of nausea.	
		Observations: R: 70 T: 36 at 0600.	

Glasgow Royal Infirmary
University NHS Trust

Nursing Notes

Name: DEBORAH SULLIVAN | Hospital Nos. | Ward: 62

Date	Problem No.s	Nursing Notes / Evaluation	Signature
6:10:97		Allowed fluid + diet.	Initials
	AM.	VERY UNSETTLED THIS AM. WASHED INDEPENDANTLY.	
		VOMIT X 200mls X 2. STEMETIL GIVEN AS PRESCRIBED @ 11.15am.	
		TRAMADOL 50mg GIVEN @ 12 MIDDAY WITH LITTLE EFFECT.	
		S/B RESIDENT & WRITTEN UP FOR IV FLUIDS 4°. COMMENCED AS	
		CHARTED.	
		AWAITING FURTHER REVIEW OF ANALGESIA.	K Deacy.
		PETHIDINE 100mgs GIVEN IM @ 14-35pm	K Deacy
6.10.97	Pm.	Appears slightly more settled this evening although she appeared flushed.	
		Managed small amount of light diet. Intravenous fluids continuing 4hly.	
		Observations stable	N Gallagher
7.10.97		Fluid balance : intake : 1700 output 3300 at 12MN.	
		Pethidine 100mg given IM at 23^{30} with good effect. IM	
		Stemetil also given as prescribed.	
		IV fluids continue 4 hourly, passing urine well.	
		300 mls vomit late last night.	
		Allowed fluid and diet.	Initials
		Observations at 6am : P-74 . BP 121/81 ; Temp - 36.7°C ; $Sa0_2$ 98% air	Initials
		PETHIDINE 100mg GIVEN IM @ 11.35am WITH GOOD EFFECT	K. Deacy
		IV FLUIDS CONTINUE 4°.	
		NO FURTHER VOMITING THIS AM.	
		OBSERVATIONS STABLE. WASHED INDEPENDANTLY	K. Deacy
	PM.	IV fluids continue 4°.	
		Pethidine 100mgs IM given at 5^{25} pm. Oral analgesia as	
		prescribed. To be reviewed by gastro-intestinal doctors then	
		homeopathic Dr. L. Reid will review.	D Maclellan.

0280469

Name: Deborah Sullivan | Hospital Nos: | Ward: 62

Date	Problem No.s	Nursing Notes / Evaluation	Signature
7/10/97		Complaining of severe pain, JHO informed.	
		PETHIDINE 100mg given IM at 10.50pm with settling effect.	
8/10/97		IV fluids maintained at 125ml/sper hour	
		fairly settled overnight.	S. Mallett
	am	Settled morning. Self caring with personal hygiene.	
		Seen by Mr Anderson. IV fluids discontinued and for	
		discharge home today. No transpot required. Discharge	
		medications ordered. No follow-up required.	LM^cFarlane

Glasgow Royal Infirmary
University NHS Trust

Problems / Aims

Name	Deborah Sullivan	Hospital Nos.		Ward Nos.	60		

Date	No.	Problem	Aim	Nursing Intervention	Signature	Evaluation Date	Disc Date
2/10/97	1	Pain	Alleviate same	Administer analgesia as prescribed; note effects & liase with medical staff Assist to obtain comfortable position in bed	KD	9/10	

Glasgow Royal Infirmary
University NHS Trust

Problems / Aims

Name	Deborah Sullivan	Hospital Nos.	Ward Nos.	60

Date	No.	Problem	Aim	Nursing Intervention	Signature	Evaluation Date	Disc Date
2/10/17	(2)	Fluid & electrolyte imbalance	ensure electrolytes within normal limits; maintain hydration	Administer IV fluids as prescribed 4°.	KD	n/a	
				Observe output / intake			
				Daily restrictions:			
			2/10	FAST			

FORM PS1 10/90

HOSPITAL PRESCRIPTION SHEET No.

REGULAR PRESCRIPTIONS – INJECTIONS

Charge by Use		Date Started	MEDICINE (Block Capitals)	DOSE	ROUTE	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times	Prescribers Signature (Full)	DISCONTINUED: Date	Signed
	A	2/10	Pethidine	100mg	IM		4-6 hrly PRN										5/10	HK
	B	2/10	Stemetil	12.5mg	IM		6-8hly PRN											
	C																	
	D																	
	E																	
	F																	
	G																	

REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

	H	2/10	LOSEC OMEPRAZOLE	20mg 2 capsules	PO		✓									Logan		
	J	4/10	Ranitidine	2 tabs	O		4-6°	PRN	pain	✓								
16x 8 TABS	K	5/10	co-codamol															
	L																	
	M																	
	N																	
	O																	
	P																	
	R																	
	S																	
	T																	
	V																	

ONCE ONLY PRESCRIPTIONS

DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN
5/10		Tramadol	100mg	IM	Logan	Martin	6.45 pm
~~5/10~~ 5/10		Temazepam	10mg	PO	Logan	Initials	12 MN
5/10		Tramadol	50mg	IM	Logan	Initials	04.20
5/10	12pm	TRAMADOL	100mg	IM		[illegible]	12 MIDDAY
5/10		OLANZAPINE	10mg	IM		[illegible] MSister	4.35
6/10		Pethidine	100mg	IM	Logan	Initials	23.30
7/10	11.30	PETHIDINE	150mg	IM	[illegible]	[illegible]	11.35 pm
7/10		PETHIDINE	100mg	IM		[illegible]	5.25 pm
11/10		Pethidine	100mg	IM	Logan	[illegible]	10.50 pm

DIET

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

KNOWN MEDICINE: 1. VOLTAROL

WARD		AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
62	964876K SULLIVAN F/S	IVAD			964876K	MR ANDERSON

HOSPITAL

MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

DATE	REGULAR PRESCRIPTIONS: 6 a.m.	8 a.m.	10 a.m.	12 m.d.	2 p.m.	4 p.m.	6 p.m.	10 p.m.	12 m.n.	OTHER TIMES	COMMENTS ON DISCREPANCIES
2/10/97	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Aat 12am
3/10/97		H								A+B 4pm	A at 11:25 am KK BAC Dose Taken A at 4:30 pm on 8:45 pm
4/10/97		H						J		A A B	B at 0245 A at 3:05 pm 4h B at 0245 A+B at 7:35 pm 4h A at 0645 A at 2340
5/10/97		H		K @ 12 midday	K- 5pm	B- 6:45 pm		OK- 10pm		A B	A at 0630 B at 0630
6/10/97		H K		BC 11:15 AM				K at 9 pm			B at 2330
7/10/97		H K			BC 2:30 pm			J K- 9pm			
8/10/97		H								K @ 7:10am	KGEMC

NAME: **964876K** SULLIVAN F/S
DEBORAH 07/12/1972
1/1 160 MAIN STREET

UNIT NUMBER: 964876K

WARD: ~~Leo~~ 67

KEY: CODE LETTER CIRCLED E.G. (A) = MEDICINE REFUSED AND MEDICAL STAFF INFORMED
CODE LETTER SCORED E.G. ~~A~~ = PATIENT ABSENT

FORM MR1 10/90

Glasgow Royal Infirmary

Problems / Aims

Name: Deborah Sullivan

Ward No: 60

Date	No	Problem	Aim	Date of Plan	Nursing Intervention	Signature
2/10/97	3	Nausea / Vomiting due to..	To promote patient comfort & relieve nausea / vomiting		a) Position patient where he/she can be easily observed, with nurse call system to hand b) Position in bed to maintain comfort N.B. If airway at risk - left lateral position with suction apparatus to hand c) Provide emesis bowl & ensure patient privacy d) Offer mouthwashes to freshen mouth e) Stay with patient during vomiting action	VR

oblems / Aims

Deborah Sullivan

60

	Problem	Aim	Nursing Intervention	Signature
2/10/94	Has high temperature feels hot and uncomfortable and unable to restore normal temperature because	To help restore normal temperature (specify) and comfort	a. Reduce amount of clothing worn in bed and assist in choosing suitable attire and appropriate bedclothes. b. Ensure fluid intake of at least (specify) 2l IVI in 24 hours. c. Use of fan. d. Position in well ventilated environment. e. Tepid sponge if temperature exceeds ^ and follow set guidelines as per procedure manual. f. Accurately record and monitor body temperature (frequency) 4°	VSR. AC

C VENFLO.1

Patient name Deborah Sullivan | Hosp Number 60

Date	No	Problem	Aim	Intervention	Signature	Review date	
2/10/97	5	Venflon in-situ: potential for local and systemic infection.	Minimise the risk. Detect early.	Ask patient to report any pain, swelling or discharge at venflon site. Inspect cannula site 4 hly. Inform medical staff of any inflammation, discharge or dysfunction. Record venflon site condition - see below. Review with medical staff the need for cannula and need to change cannula. Maintain a dry dressing at insertion site.	VSR	9/6	

Review date	Day	Inflammation at site 0 <1 1-2 2-3 >3 cms	Discharge & Amount Blood/Serous Pus + ++ +++	Comment	Medical staff informed	Signature	Date whe removed. Signature
4/10/97	1	<3	++	Venflon lossed			Rhea 6-10-97
8/10/97	2			revited L) arm.			
	3						
	4						
	5						

GLASGOW ROYAL INFIRMARY UNIVERSITY TRUST
PROBLEMS / AIMS

NAME: Deborah Sullivan HOSPITAL NUMBER: WARD: 60

DATE	NO	PROBLEM	AIM	NURSING INTERVENTIONS	SIGNATURE	EVAL. DATE	DISC. DATE
2/10/97		Patient requires assistance when moving due to Fully mobile	To minimise the risk of injury to patient and staff To promote patient comfort	Ascertain patient's weight Ascertain patient's height Assess and document patient's weight bearing ability Assess and document patient's dependence on nursing staff to mobilise Encourage patient to mobilise within own capabilities Observe for and document any changes in patient's circumstances	VR		

PATIENT NAME

RESULTS

Date	Normal	2/10
WCC	4-11	10
Hb	M 13-18 F 11.5-16.5	12.9
Plts	150-400	290
Na	135-145	137
K	3.5-5.0	4
Cl	97-107	100
Bic	23-30	24
Ur	2.5-8.0	2.1
Cr	40-130	75
Gluc	<11.0	4.1
Amyl	70-200	190
Ca	2.2-2.6	
Ca	2.2-2.6	
PO4	0.7-1.4	
T/P	62-82	
Alb	35-55	
Glb	22-33	
Bil	3-22	
ALP	80-280	
AST	12-48	
ALT	5-55	
GGT	11-51	
LDH	230-525	
	<150	
CRP	<10	
ESR		
APTT	~~35-50~~ 24.4	
PT	~~13-18~~ 12.1-16	
TCT	~~6-9~~ 10.1-13	
H+	35-45	
pO2	12-15	
pCO2	4.4-5.6	
HCO3		

GLASGOW ROYAL INFIRMARY

DATE OF BIRTH | HOSPITAL No.
FIRST NAME Deborah | SURNAME O'Sullivan
ADDRESS | SEX / MARITAL STATUS
ADDRESS | OCCUPATION
HOSPITAL | WARD/DEPT | CONSULTANT

I.V. THERAPY PRESCRIPTION SHEET

0159486

PLEASE WRITE OVER WHITE LETTERS

	DATE	FLUID (USE BLOCK LETTERS) / ADDITIVE DRUG	Vol (ml). / Dose (mg)	Route of Admin.	Dur. of Admin.*	SIGNATURE	Serial No. / Batch No.	Time Begun	Given By / Added By
A	2/10	5% Dextrose	500	IV	4		97110 BN	9.00 pm	
B	2/10	N/Saline	500	IV	4		97H2 8BN	4.50 AM	
C	2/10	5% Dextrose	500	IV	4		97110 BN	11.10	
	3/10	(N) SALINE	500	IV	4hr		97H 28B	3.40	
E	3/10	5% DEXTROSE	500	IV	4hr		97I1 OBN	9.35 pm	
F	3/10	5% DEXTROSE	500	IV	4hr		97110 BN	1.45 AM	
G	3/10	N-Saline	500	IV	4	Logan	97I 19BS	05 40	
H	3/10	5% Dextrose 20 mmol KCl	500	IV	4	Logan	97C 24BK	10.35	
I	3/10	5% Dextrose	500	IV	4	Logan	97I 10BN	9.30 PM	
J									
K									
L									
M									
N									
O									

DISC

RATE OF FLOW (Drops/Min.) = **VOL.OF FLUID (ml) x 15** / Duration (Mins.) (1ml = 15 drops)

6.62

Approximate Rate for 500 ml.

1 hr. = 120 Drops/min. | 6 hr. = 22 Drops/mir
4 hr. = 30 Drops/min. | 8 hr. = 15 Drops/mir

SHEET NO .....

DEBORAH
SULLIVAN

PATIENT ID LABEL

TEMPERATURE, PULSE, RESPIRATION AND BLOOD PRESSURE CHART

0160240

1994

DATE	2/10	3/10	4/10	4/10	5/10	6/10	7/10	8/10						
POST-OP DAY						6th								

TEMPERATURE

F	C
107.6	42
105.8	41
104	40
102.2	39
100	38
98.4	37
96.8	36
95	35

PULSE / RESPIRATION

200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10

350 340 330 320 310 300 290 280 270 260 250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10

Weight								
No. of Stools		0	00			0		

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GLASGOW ROYAL INFIRMARY
UNIVERSITY NHS TRUST

Deborah Sullivan

GRI ward 62

PATIENT I.D. LABEL

24hr. FLUID BALANCE CHART (including Blood)
12mn - 12mn

F/light diet

Date 8.10.97

INTAKE 3500				TIME	UTT OUTPUT 3490			
CODE LETTER OR DESCRIPTION OF INTAKE	ORAL ml.	I.V. ml.	OTHER		URINE	GASTRIC	OTHER	COMMENTS
		125 125		1				
		125 250		2				
'I'		125 375		3				
		125 500		4				
		125 625		5				
		125 750		6				
'J'		125 875		7				
		125 1000		8				
		125 1125		9				
				10				
		DISC		11				
				12				
				1				
				2				
				3				
				4				
				5				
				6				
				7				
				8				
				9				
				10				
				11				
				12				
				12mn.				

TOTAL INTAKE = mls.

TOTAL OUTPUT = mls.

APPROXIMATE MEASURES:- TUMBLER = 200mls. ORDINARY CUP = 150 mls. FEEDING CUP = 175mls. SOUP BOWL = 250r

0150394

GLASGOW ROYAL INFIRMARY UNIVERSITY NHS TRUST

I.V. THERAPY
PRESCRIPTION SHEET

Deborah
SULLIVAN

PATIENT ID LABEL

0159486

	DATE	FLUID (USE BLOCK LETTERS) / ADDITIVE DRUG	Vol (ml). / Dose (mg)	Route of Admin.	Dur. of Admin.*	SIGNATURE	Serial No. / Batch No.	Time Begun	Given B / Added E
A	6/10/97	(N) saline	5W	IV	4°		97H 28RN	12.10 pm	DMae KDonc
B	6/10/97	5% dextrose	5W	IV	4°		97122 BM	16.15	Rcox MHall
C	6/10/97	5% dextrose	5W	IV	4°		97I 10BM	8.20 pm	AC MGalla
D	6/10/97	(N) saline	5W	IV	4°		97119 BS	12.25 am	MGal MHall
E	6/10/97	5% dextrose	5W	IV	4°		97122 BN	4.30 am	MGal F Mack
F	6/10/97	5% dextrose	5W	IV	4°		97I 22BN	12 NOON	K Donc
G	7/10/97	N/Saline	500	IV	4°		97I 08/99 19BN	19.05	Craig DG
H	"	5% Dextrose	500	IV	4°		97122 BN	11.30 pm	MGal Emac
I	"	5% Dextrose	500	IV	4°		97122 BN	3.30 am	MGal F Mack
J	"	N/Saline	500	IV	4°		97119BS	7.30 am	Rcox MGal
K									
L									
M									
N									
O									

DISCONTINUED

RATE OF FLOW (Drops/Min.) = VOL.OF FLUID (ml) x 15 / Duration (Mins.)

6.62 (1ml = 15 drops)

Approximate Rate for 500 ml.

1 hr. = 120 Drops/min. 6 hr. = 22 Drops/min.

4 hr. = 30 Drops/min. 8 hr. = 15 Drops/min.

SHEET NO .....

GLASGOW ROYAL INFIRMARY
UNIVERSITY NHS TRUST

Deborah Sullivan.
GRI WD62

24hr. FLUID BALANCE CHART (including Blood)
12mn - 12mn

Date 7:10:97 PATIENT I.D. LABEL

F/ Light diet INTAKE 2700 TIME UTT. OUTPUT 3300

CODE LETTER OR DESCRIPTION OF INTAKE	ORAL ml.	I.V. ml.	OTHER	TIME	URINE	GASTRIC	OTHER	COMMENTS
		125 -		1				
		125 250		2	200.			
		125 375		3				
'D'		125 500		4	300			
		125 625		5				
		125 750		6	300			
		125 875		7				
'E' Breakfast	250	125		8	250			
Tea	150	125		9				
Juice + Tea	350	125		10	UTT			
		125		11	300			
'F' Soup + MILK	300	125		12	300			
TEA	100	125		1	140			
TEA	200	125		2	220		VOMIT	x 300
		125		3	250			
		125		4	130			
Soup REFUSED	—	125		5	110			
		OFF NIL		6	200			
		125		7	160			
		125		8	80			
TEA	150	125		9	250			
		125		10				
'H'		125		11				
		125	2000	12				
	1500	2000		12mn.	3190		300	

TOTAL INTAKE = 3500 mls. TOTAL OUTPUT = 3490 mls.

APPROXIMATE MEASURES:- TUMBLER = 200mls. ORDINARY CUP = 150 mls. FEEDING CUP = 175mls. SOUP BOWL = 250n

0159394

DAILY SUMMARY OF FLUID BALANCE

DATE OF BIRTH HOSPITAL NO
FIRST NAME Deborah SURNAME
ADDRESS SEX MARITAL STATUS
ADDRESS Nuwan OCCUPATION
HOSPITAL WD/DEPT CONSULTANT

0187497

PLEASE WRITE OVER WHITE LETTERS

DATE	INTAKE				OUTPUT			
	ORAL	I.V.	OTHER	TOTAL	URINE	GASTRIC	OTHER	TOTAL
IAN 2/10/97		500.		500.	?			?
3:10:97	-	2000	-	2000	1500	300		1800
4/10/97	1,000			~~3,875~~	2,050		100	2,150
5:10:97	650	-	-	650	1800 1450	650		2450.
6:10:97	1200	1500	-	2700	2200		vomit 1100	3300
7.10.97	1500	2000		3500	3190		vomit 300	3490

Deborah Sullivan

PROFESSIONAL NURSE

Waterlow Pressure Sore Prevention and Treatment Policy

If scores in table, add total. Several scores per category can be used.

Build/weight for height	*	Skin type Visual risk area	*	Sex Age	*	Special risks	*
Average	0	Healthy	0	Male	1	Tissue malnutrition	*
Above average	1	Tissue paper	1	Female	2		
Obese	2	Dry	1	14-49	1	e.g. Terminal cachexia	8
Below average	3	Oedematous	1	50-64	2	Cardiac failure	5
		Clammy (Temp)	1	65-74	3	Peripheral vascular disease	5
Continence	*	Discoloured	2	75-80	4	Anaemia	2
Complete/ catheterised	0	Broken/spot	3	81+	5	Smoking	1
Occasional incontinence	1	Mobility	*	Appetite	*	Neurological deficit	*
Incontinent of faeces only	2	Fully	0	Average	0	e.g: Diabetes, MS, CVA, motor/sensory, paraplegia	4-6
Doubly incont.	3	Restless/fidgety	1	Poor	1		
		Apathetic	2	N.G tube/fluids only	2	Major surgery/trauma	*
		Restrictive	3	NBM/anorexic	3	Orthopaedic - below waist, spinal	5
		Inert/traction	4			On table > 2 hours	5
		Chairbound	5			Medication	*
						Cytotoxics, high dose steroids, anti inflammatory	4

Score 10+ at risk
15+ high risk
20+ very high risk

BritCair supporting education in Wor

Remember: ... ge often starts prior to admission, in casualty. A seated patient is also at risk. ... W...

ASSESSMENT: (See over) If a patient falls into any of the risk categories preventative nursing is required. A combination of good nursing techniques and preventative aids will definitely be necessary

Prevention:
Preventative aids:

Special mattress/bed:
10+ Overlays or specialist foam mattresses
15+ Alternating pressure overlays, mattresses and bed systems.
20+ Bed systems: Fluidised, bead, low air loss and alternating pressure mattresses.
Note: Preventative aids cover a wide spectrum of specialist features. Efficacy in the 20+ area should be judged on the basis of independent evidence.

Cushions
No patient should sit in a wheelchair without some form of cushioning. If nothing else is available, use the patient's pillow.
10+ 4" Foam cushion
15+ Specialist gel and/or foam cushion
20+ Cushion capable of adjustment to suit individual patient

Bed Clothing:
Avoid using plastic draw sheets, incontinence pads and tightly tucked in sheets/sheet covers, especially when using specialist bed and mattress overlay systems.
Duvet - plus vapour permeable cover

Nursing Care:
General: Frequent changes of position, lyi...
Use of pillows?
Pain: Appropriate pain control
Nutrition: High protein, vitamins, minerals
Patient handling: Correct lifting technique
Hoists
Monk ey Pole
Transfer devices
Patient comfort Aids: Real sheepskins
Bed cradle
Operating table: 4" cover plus adequate protection
Theatre/A&E trolley
Skin care: General hygiene, NO rubbing
Correct lifting and positioning
Cover with an appropriate dressin...

If treatment is required, first remove pressure

Wound Classification

Blanching hyperaemia	STAGE 1	Is the wound RED?	no → yes	Semi permeable film, hydrocolloid sheet
Non-blanching hyperaemia	STAGE 2	Is the wound RED, clean but not healed?	no → yes	Hydrocolloid, alginate, hydrogel, silicone polymer fo...
Ulceration progresses	STAGE 3	Is wound YELLOW/infected/inflamed	no → yes	Alginate, hydrogel, hydrocolloid
Ulceration extends	STAGE 4	Infected?	no → yes	Alginate ribbon or rope, non-adherent typical antimi... dressing, polysaccharide paste
Infective necrosis	STAGE 5	Is wound black/necrotic?	no → yes	Debride – surgical excision, hydrocolloid, hydrogel, ... treatment

BritCair - Division of CV Laboratories Limited, ALDERSHOT, Tel: (0252) 333314. Subsidiary of MERCK & Co., Inc., Rahway, NJ, USA.

ITE	SCORE	STAGE OF SORE	INTERVENTIONS	SIGNATURE	RE... D...
8.10.97					

Glasgow Royal Infirmary University NHS Trust

Patient Profile

PN D. Constantine

DATE OF ADMISSION 13/5/97 | TIME 6.40pm | WARD 29 | CONSULTANT Mr Crawford | TYPE OF ADMISSION EMERGENCY / PLANNED / TRANSFER FROM

Patients Name
Address **964876K**
SULLIVAN F/S
DEBORAH 07/12/1972
1/1 160 MAIN STREET
BAILLIESTON
G69 6AH
Telephone No.
Wishes to be known a

Next of Kin
Address KATHLEEN
187 COMMONHEAD RD
Telephone No. 771-3793
Relationship MOTHER

Hospital No.

Ansaphoned and Dates

Date of Birth AGE 24

Single (Married) Divorced Separated Widowed

Religious Denomination

Valuables None

Returned
Ward
Finance Office

Clothing Listed YES/NO

Identification Band YES/NO

G.P.
Address DR GADDIE
EASTERHOUSE Ulk
Telephone No.

Next of Kin
Address
Telephone No.
Relationship

Relatives Notified of Admission Mother present o/a (Yes/No)

Patient Spoken to by Doctor?

Relatives Spoken to by Doctor?

Future Appointments

Diagnosis Dates
HEAD INJURY

ALLERGIC TO
~~NKA~~
Voltarol

OPERATIVE PROCEDURE
1415 ⇒ CT scan normal.

REASON FOR ADMISSION Accidental clash of heads on Sunday. Vomited intermittently since. Headache not relieved by paracetamol. Admitted for neurological observations.

PAST MEDICAL HISTOR
Cholycystectomy - April 96
Appendicectomy
Tonsillectomy - July 93

PATIENTS PERCEPTION OF ILLNESS
Anxious

SOCIAL CIRCUMSTANCES	SUPPORTING SERVICES
LIVES WITH Flat mate	None
DEPENDANTS	
TYPE OF HOUSE	
OCCUPATION Works in Insurance claims	

CURRENT DRUG THERAPY
Losec 20mgs OM

DISCHARGE PLAN	EXPECTED DATE	CHEMICAL DEPENDANCY	PATIENTS OWN DRUGS	
		None	RETURNED	STORED IN WARD

PATIENT INFORMED YES/NO — RELATIVES INFORMED YES/NO

SERVICE	NEEDED	ORDERED	SIGNATURE	DATE
TRANSPORT	Family will collect			14/5
DISTRICT NURSE	/			
SOCIAL WORKER	/			
OPD	OPT script. ✓ Codeine Phosphate			
DISCHARGE DRUGS				
CLOTHING	—			
OTHER	HIWC			

HEALTH EDUCATION

COMPLETED BY — DATE

Glasgow Royal Infirmary
University NHS Trust

9648768K
SULLIVAN F/S
DEBORAH 07/12/1972
1/1 160 MAIN STREET
BAILLIESTON
G69 6AH

P
B
f Living

Completed by: OB Date: 13/5/97

Name

Ward No:s 29

Safety and Comfort - Including Assessment of Pain

↓ headache o/a

Breathing and Circulation

no obvious problems identified o/a

B.P. Pulse

Respiration

Maintaining Body Temperature

Temperature

self regulating

Eating and Drinking

Dentures

Standard diet

Weight

Mobility

Independent ✓

Dependent

Aids Required

Personal Hygiene

Self care

Skin Condition

Norton/Other Score:

Eliminating

Urinalysis

No problems identified

Sleeping

No problems identified

Communications - Includes Fears / Anxieties

No fears expressed

Glasgow Royal Infirmary
University NHS Trust

964876K
SULLIVAN F/S
DEBORAH 07/12/1972
1/1 160 MAIN STREET
BAILLIESTON
G69 6AH

Nursing Notes

Name

Ward 29

Date	Problem No.s	Nursing Notes / Evaluation	Signature
13/5/97	1	Alert and orientated - neurological observations satisfactory.	
	2	Headache c/o - analgesia as prescribed.	
	3	No vomiting since admission.	EBra
14.5.97	3.	Vomited x 3, adviced against smoking. 1. Remains alert & orientated. All care as plan.	Kanlykson
am		S/B Mr Crew Paed: 2/3 symptoms persists. Commenced on Codeine Phosphate for pain relief. For CT scan later today.	
12md		S/B Dr Grehan - CT normal. For discharge as per plan.	

0280468

Glasgow Royal Infirmary
Problems / Aims

Name			Hospital Nos.		Ward Nos. 29			
Date	**No.**	**Problem**	**Aim**	**Nursing Intervention**	**Signature**	**Evaluation Date**	**Ditch Date**
13/5/97	1	Potential problem	Early detection & recognition of signs.	* Monitor patient as per ward protocol			
		Deteriorating concious level due to		1/2 Hrly			
		head injury. risk of intra cranial bleed.		1 Hrly			
				2 Hrly	W M Smith	daily	
				4 Hrly			
				Specify above.			
				using Glasgow coma scale and chart.			
				* Inform Dr of changes since admission.			
				* Other—			
	2	Headache associated with head injury.	Patient comfort.	* Assist patient to adopt a comfortable			
				position.			
				*Give prescribed analgesia monitor	W M Smith	daily	14/5 D
				effect & discuss with Dr.			
				* Promote a quiet enviroment.			
				* Other—			

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G69 6AH

Glasgow Royal Infirmary
Problems / Aims

Name | Hospital Nos. | Ward Nos. 29

Date	No.	Problem	Aim	Nursing Intervention	Signature	Evaluation Date	Disch Date
13/5/97	3	Nausea / vomiting due to:	To promote patient comfort.	*Place patient where he can be seen.			
				*Ensure patient has nurse call system within reach.			
				*Provide privacy.	MMSmith	daily	
				*Remain with patient during episode.			14/5/97
				*Reasure.			
				* Test vomit, note ammount& document.			
				* If airway at risk place pt in recovery position and have suction aparatus ready.			

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GLASGOW ROYAL INFIRMARY
OBSERVATION CHART

DATE: 13/5/97 14th

TIME: 6 AM | 8 | 10 | 2 PM | 10 | 10

COMA SCALE

Eyes open	Spontaneously	4
	To speech	3
	To pain	2
	None	1
Best verbal response	Orientated	5
	Confused	4
	Inappropriate Words	3
	Incomprehensible Sounds	2
	None	1
Best motor response	Obey commands	6
	Localise pain	5
	Flexion to pain	4
	Extension to pain	3
	None	2

Eyes closed by swelling = C

Endotracheal tube or tracheostomy = T

Usually record the best arm response

Pupil scale (m.m.): 1 2 3 4 5 6 7 8

Blood pressure and Pulse rate: 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10

Respiration: 40 39 38 37 36 35 30

Temperature °C: 40 39 38 37 36 35 34 33 32 31 30

PUPILS

right	Size	5 4 4 4 4 3
	Reaction	+ + + + + +
left	Size	5 4 4 4 4 3
	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

HOSPITAL

PRESCRIPTION SHEET No.

REGULAR PRESCRIPTIONS – INJECTIONS

Pharmacy Use		Date Started	MEDICINE (Block Capitals)	DOSE	ROUTE	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times	Prescribers Signature (Full)	DISCONTINUED: Date	Signed
	A	13/5/97	PAR COCODAMOL	500mg	PO		✓	✓			✓							
	B																	
	C																	
	D																	
	E																	
	F																	
	G																	

REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

	H	13/5/97	PAR CO CODAMOL	500mg (4-6 HOURLY FOR PAIN)	ORAL		✓								Horlicks		
	J																
	K																
	L	14/5/97	CODEINE PHOSPHATE	30mg	O	✓				✓			✓		MJS		
	M																
	N																
	O																
	P																
	R																
	S																
	T																
	V																

ONCE ONLY PRESCRIPTIONS

DIET

DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN
13/5/97	6pm	COCODAMOL	2 TABS	ORAL	W Smith	W Smith	6pm

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

KNOWN MEDICINE 1.

WARD		AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
29.	964876K SULLIVAN F/S DEBORAH 07/12/1972					

HOSPITAL
MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

REGULAR PRESCRIPTIONS																								COMMENTS ON DISCREPANCIES
DATE	6 a.m.		8 a.m.		10 a.m.		12 m.d.		2 p.m.		4 p.m.		6 p.m.		10 p.m.		12 m.n.		OTHER TIMES					
21/8/07	Initial		H	Initial	Initial		V	Initial	Initial		Initial		Initial		Initial		Initial		H	Initial				H @ 10.40pm

NAME: Deborah Sullivan.

UNIT NUMBER:

WARD: 29.

KEY: CODE LETTER CIRCLED E.G. (A) = MEDICINE REFUSED AND MEDICAL STAFF INFORMED

CODE LETTER SCORED E.G. X = PATIENT ABSENT

Patient Name. Deborah Sullivan

Welcome to Ward 39

We organize patient care using a system called **Named Nursing**. This is to enable you to have your own nurse and her associates who will look after you from admission to discharge. If you or your relatives have any questions you will be directed to them. We hope that this will make your stay in hospital easier for you.

Your Named Nurse is :

SIN Tracey

Your Associate Nurses are :

Ward Sister

Sr Boardman

Glasgow Royal Infirmary
Problems / Aims

9
F

Name: Deborah Sullivan | Date of Birth | Ward No.s: 39 | Date

Date	No.	Problem	Aim	Nursing Intervention	Signature	Evaluation Date	Disc Date
16/1/97	1	A) Potential for fluid & electrolyte imbalance due to...	To maintain hydration	A) Administer intravenous fluids as prescribed by doctor 4°			
		a) Operative procedure	Electrolytes within normal limits	B) Maintain accurate record of Intake & output			
		b) Anaesthetic	Increase appetite & promote healthy/balanced diet	C) If necessary, administer antiemetics as prescribed & monitor effect with patient	BStacy	on going	
		c) Nausea & Vomiting		D) Dietary restrictions... Ice / hr	BStacy		
		B) Loss of appetite due to surgery		Free fluids	Eightbay	01/9	
				E) [illegible] appetising meals & observe dietary intake			
				F) Check ventilon site 4°	BStacy	daily	

Glasgow Royal Infirmary

Problems / Aims

Name: Deborah Sullivan | Date of Birth: | Ward No: 39

Date	No	Problem	Aim	Nursing Intervention	Signature
16/1/97	(2)	Nausea / Vomiting due to..	To promote patient comfort & relieve nausea / vomiting	A) Position patient where he/she can be easily observed, with nurse call system to hand B) Position in bed to maintain comfort (N.B. If airway at risk left lateral position with suction apparatus to hand) C) Provide emesis bowl & ensure patient privacy D) Offer mouthwashes to freshen mouth E) Stay with patient during vomiting period & provide	

Glasgow Royal Infirmary

Problems / Aims

Name: Deborah Sullivan | Date of Birth: | Ward No's: | Date:

Date	No	Problem	Aim	Nursing Intervention	Signature	Date achieved
16/1/97	(3)	Pain ~~following surgical procedure~~	Patient will state she is comfortable	A) Nurse patient in comfortable position B) Administer analgesia as prescribed by doctor & monitor effect with patient C) If analgesia is ineffective, notify doctor & review prescription	BStirling	0/9

w Royal Infirmary

s / Alms

Deborah Sullivan | Hospital No. | Ward No. 39

Problem	Aim	Nursing Intervention	Signature	Evaluation Date	Review Date
Unable to attend to own hygiene associated due to weakness & discomfort following operation	To maintain a standard of hygiene which is acceptable to the patient	A) Post operative wash & mouthwash B) Offer mouthwash / water to brush teeth C) Specific daily hygiene requirements: Daily bath/shaver	BSHeg	9/9	

GLASGOW ROYAL INFIRMARY UNIVERSITY NHS TRUST
PROBLEMS / AIMS

NAME: Deborah Sullivan HOSPITAL NUMBER: WARD:

DATE	NO	PROBLEM	AIM	NURSING INTERVENTIONS	SIGNATURE	EVAL. DATE	DISC. DATE
9/1	(5)	Patient requires assistance when moving due to ... fully mobile	To minimise the risk of injury to patient and staff To promote patient comfort	Ascertain patient's weight Ascertain patient's height Assess and document patient's weight bearing ability Assess and document patient's dependence on nursing staff to mobilise Encourage patient to mobilise within own capabilities Observe for and document any changes in patient's circumstances	BStaig	on going	

JL

	ABILITY		WHEN MOVING IN BED		NURSES	MANOEUVRE WHEN MOVING FROM CHAIR / COMMODE		NURSES	REQUIRED TO ASSIST WITH MOBILISING	(✓)	COMMODE (✓)	(✓)
	Able to weight bear and balance	✓	Australian Hold			Front Hold			Handling Sling			
HEIGHT 5'10	Able to weight bear and balance with equipment		Anterior Hold			Side Hold			Turning Disc			
WEIGHT 10st 12	**Specify Equipment**: (eg. Zimmer)		Rolling			Through Arm Hold			Hoist			
	Weight bears but unstable (eg. Dizzy)		Turning						**Specify Hoist Type**			
	Specify :								Pat Slide			
	Unable to weight bear								Easy Slide			
	No.of Nurses required to assist when mobilising								Rollboard			
									Slip Sheets			

Patient name Deborah Sullivan Hosp Number

Date	No	Problem	Aim	Intervention	Signature	Review date	
23-1-97		Venflon in-situ; potential for local and systemic infection.	Minimise the risk. Detect early.	Ask patient to report any pain, swelling or discharge at venflon site. Inspect cannula site 4 hly. Inform medical staff of any inflammation, discharge or dysfunction. Record venflon site condition - see below. Review with medical staff the need for cannula and need to change cannula. Maintain a dry dressing at insertion site.			

Review date	Day	Inflammation at site 0 <1 1-2 2-3 >3 cms	Discharge & Amount Blood/Serous Pus + ++ +++	Comment	Medical staff informed	Signature	Date when removed / Signature
24-1-97	1	<1	Blood +	Dr informed & venflon rested.	✓		
26/1/97	2	1-2cm		venflon removed Dr informed		SSimpson	
	3						
	4						
	5						

PATIENT NAME Deborah Sullivan GRI Wd 39

RESULTS

Date	Normal	16/01/97	17/01/97					
WCC	4-11	5-8	4·7					
Hb	M 13-18 F 11.5-16.5	12·7	12·0					
Plts	150-400	200	161					
Na	135-145	140						
K	3.5-5.0	3·8						
Cl	97-107	102						
Bic	23-30	23						
Ur	2.5-8.0	1·7						
Cr	40-130	65						
Gluc	<11.0	4·3						
Amyl	70-200	150						
Ad Ca	2.2-2.6							
Ca	2.2-2.6							
PO4	0.7-1.4							
T/P	62-82							
Alb	35-55							
Glb	22-33							
Bil	3-22	15						
ALP	80-280							
AST	12-48	29						
ALT	5-55							
GGT	11-51							
DH	230-525							
CK	<150							
CRP	<10	22						
ESR								
APTT	33-50							
PT	13-18							
TCT	6-9							
H+	35-45							
pO2	12-15							
pCO2	4.4-5.6							
HCO3								

~~4°~~ ~~Daily~~ 4° Daily

TEMPERATURE, PULSE, RESPIRATION AND BLOOD PRESSURE CHART

Deborah Sullivan

PATIENT ID LABEL

0160240 Jan'96

DATE	16	17	18	19th	20th	21st	22nd	23rd	24	25	26	27		
POST-OP DAY														

TEMPERATURE

F	C
107.6	42
105.8	41
104	40
102.2	39
100	38
98.4	37
96.8	36
95	35

PULSE / RESPIRATION

200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10

350 340 330 320 310 300 290 280 270 260 250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10

Weight														
No. of Stools	1	0	1	0	0	0	1	0	0	1	0			

GLASGOW ROYAL INFIRMARY UNIVERSITY NHS TRUST

Deborah
Sullivan

PATIENT ID LABEL

I.V. THERAPY
PRESCRIPTION SHEET

0159486

	DATE	FLUID (USE BLOCK LETTERS) / ADDITIVE DRUG	Vol (ml). / Dose (mg)	Route of Admin.	Dur. of Admin.*	SIGNATURE	Serial No. / Batch No.	Time Begun	Given / Added
A	24/1/97	(W) SALINE	500	IV	4	[signature]	97A0 28F	2.40 pm	[signature]
B	24/1/97	5% DEXTROSE	500	IV	4	[signature]	96K0 2BH	5.40 pm	[signature]
C	24/1/97	5% DEXTROSE	500	IV	4	[signature]	96K 22BH	03.30	[signature]
D	27/1/97	(M) SALINE	500	IV	4	[signature]	97A 14BX	07.30	[signature]
E	27/1/97	5% DEXTROSE	500	IV	4	[signature]	96K 22BH	4.30 pm	[signature]
F	27/1/97	5% Dextrose	500	IV	6	[signature]	96K22 BH	45 22	[signature]
G	27/1	(N) SALINE	500	IV	6	[signature]	97A 14BX	0500	[signature]
H	28/1	5% DEXTROSE	500	IV	6	[signature]			
I									
J									
K									
L									
M									
N									
O									

RATE OF FLOW (Drops/Min.) = **VOL.OF FLUID (ml) x 15** / Duration (Mins.)

6.62 (1ml = 15 drops)

Approximate Rate for 500 ml.

1 hr. = 120 Drops/min. | 6 hr. = 22 Drops/min.

4 hr. = 30 Drops/min. | 8 hr. = 15 Drops/min.

SHEET NO .....

Name Deborah Sullivan Hos. Number

Date	No	Problem	Aim	Intervention	Signature	Review date	
18/1/97		Venflon in-situ; potential for local and systemic infection.	Minimise the risk. Detect early.	Ask patient to report any pain, swelling or discharge at venflon site. Inspect cannula site 4 hly. Inform medical staff of any inflammation, discharge or dysfunction. Record venflon site condition - see below. Review with medical staff the need for cannula and need to change cannula. Maintain a dry dressing at insertion site.	akanawes akanawes akanawes akanawes akanawes	Daily	

Review date	Day	Inflammation at site 0 <1 1-2 2-3 >3 cms	Discharge & Amount Blood/Serous Pus -l- -l-l- -l-l-l-	Comment	Medical staff informed	Signature	Date when removed / Signature
18/1/97	1	0	0	no swelling redness or discomfort		akanawes	
19/1/97	2	IV fluids	Discontinued				
	3						
	4						
	5						

GLASGOW ROYAL INFIRMARY
UNIVERSITY NHS TRUST

DEBORAH SULLIVAN GRI WD 61

PATIENT I.D. LABEL

24hr. FLUID BALANCE CHART (including Blood)
12mn - 12mn

Date 27.1.97

	INTAKE 1675			TIME	OUTPUT 1000			
CODE LETTER OR DESCRIPTION OF INTAKE	ORAL ml.	I.V. ml.	OTHER		URINE	GASTRIC	OTHER	COMMENTS
				1Am.	150			
				2	200 100	300		
Tea	150	500		3	300			
				4				
				5	400	50		Bile
				6				
B/Fast Refused				7	200	50		Bile
				8				
Tea	150			9				
Tea	150			10	100			
				11				
Lunch	200			12m				
				1	100	500		Feed Stuffs
				2	100			
				3				
				4	150			
Dinner	500			5	150	500		Food Stuffs
				6	200			
				7	100			
				8	200			
Tea	150			9	150			
				10	150			7 Bed Pans
F		500		11	50			
				12				
	1300	1000		12mn.	2800	1400		

TOTAL INTAKE = 2300 mls.

TOTAL OUTPUT = 4200 mls.

APPROXIMATE MEASURES:- TUMBLER = 200mls. ORDINARY CUP = 150 mls. FEEDING CUP = 175mls. SOUP BOWL = 250n

0159394

GLASGOW ROYAL INFIRMARY
UNIVERSITY NHS TRUST

Deborah Sullivan
GRI W064

PATIENT I.D. LABEL

24hr. FLUID BALANCE CHART (including Blood)
12mn - 12mn

Date 28/1/97

INTAKE 2300				TIME	OUTPUT 4200			
CODE LETTER OR DESCRIPTION OF INTAKE	ORAL ml.	I.V. ml.	OTHER		URINE	GASTRIC	OTHER	COMMENTS
				1AM	50 50 100			
				2				
				3 30	400			
				4				
				5				
				6				
				7				
				8				
				9				
				10				
				11				
				12				
				1				
				2				
				3				
				4				
				5				
				6				
				7				
				8				
				9				
				10				
				11				
				12				
				12mn.				

TOTAL INTAKE = mls.

TOTAL OUTPUT = mls.

APPROXIMATE MEASURES:- TUMBLER = 200mls. ORDINARY CUP = 150 mls. FEEDING CUP = 175mls. SOUP BOWL = 250n

0159394

DAILY SUMMARY OF FLUID BALANCE

DATE OF BIRTH : HOSPITAL NO
FIRST NAME : SURNAME
ADDRESS : SEX MARITAL STATUS
ADDRESS : OCCUPATION
HOSPITAL : WARD : RELIGION

0187497

PLEASE WRITE OVER WHITE LETTERS

DATE	16/1/97	INTAKE			OUTPUT			
	ORAL	I.V.	OTHER	TOTAL	URINE	GASTRIC	OTHER Vom.+	TOTAL
16/1/97	100	500	Nil	600	80 mls	Nil	← 250	330 mls
17/1/97	270	2500	NIL	2770	1700	NIL	← 450	2150
18/1/97	675	3000		3675	2.850	1400		3,250
19/1/97	525	1500		2025	2350	210		2560
20/1/97	1300	—		1300	1350	700		2050
21/1/97	1475			1475	600	2000		2600
22/1/97	1300			1300	1250	1050		3300
23/1/97	1350	100		1450	1015	1400		2415
24/1/97	650	100		750	550	1200		1750
25/1/97	1300	100		1400	900	1900		2800
26/1/97	75	1600		1675	710	290		1000
27/1/97	1300	1000		2300	2800	1400		4200

GLASGOW ROYAL INFIRMARY

PLEASE WRITE OVER WHITE LETTERS

964876K
SULLIVAN F/S
DEBORAH 07/12/1972
1/1 160 MAIN STREET
BAILLIESTON
G69 6AH

BIOCHEMICAL RESULTS

DATE	20.1									
WCC	5.7									
Hb	13.3									
Plt.	193									
PT										
APPT										
TCT										
Na	137									
K	3.9									
Cl	102									
HCO_3	26									
Urea	2.5									
Creat.	90									
Gluc.										
Amyl.	190									
Adj. Ca										
Ca										
Phosp.										
Total Prot.										
Albumin										
Glob.										
B.J.										
Alk Ph.										
AST										
ALT										
ESR										
G2A										

JMcC/913565 FORM H0002

GLASGOW ROYAL INFIRMARY UNIVERSITY NHS TRUST

Deborah
Sullivan.
Wd.
39
PATIENT ID LABEL

I.V. THERAPY
PRESCRIPTION SHEET

0159486

	DATE	FLUID (USE BLOCK LETTERS) / ADDITIVE DRUG	Vol (ml). / Dose (mg)	Route of Admin.	Dur. of Admin.*	SIGNATURE	Serial No. / Batch No.	Time Begun	Given E / Added
A	16/1/97	N. Saline	500 ml	IV	4°	Omar Chandhri	96L03 B2	11p	
B	16/1/97	5% Dextrose	500 ml	IV	4°	Omar Chandhri	96K 22BH	3.40 am	
C	16/1/97	5% Dextrose 20 mmol KCl	500 ml	IV	4°	Omar Chandhri	96FI 8BD	8.05	
D	16/1/97	N. Saline	500 ml	IV	4°	Omar Chandhri	96L03 B2.	12md	
E	16/1/97	5% Dextrose	500 ml	IV	4°	Omar Chandhri	96K 22BH	5pm	
F	16/1/97	5% Dextrose 20 mmol KCl	500 ml	IV	4°	Omar Chandhri	96F18 BD	8.45 pm	
G	17/01/97	N. SALINE	500 ml	iv	4°	ML Montague	96L03 B2	12.50 am	
H	17/01/97	5% DEXTROSE 20 mmol KCl	500 ml	iv	4°	ML Montague	96FI 8BD	4.55	
I	17/01/97	5% DEXTROSE	500 ml	iv	4°	ML Montague	96K22 BH	9.20	
J	17/01/97	N. SALINE	500 ml	iv	4°	ML Montague	96K 2 8BC	3.50 pm	
K	17/01/97	5% DEXTROSE +20 mmol KCl	500 ml	iv	4°	ML Montague	96K2 1BV	8.45 pm	
L	17/01/97	5% DEXTROSE	500 ml	iv	4°	ML Montague	96K 22BH	1.45 am	
M	17/01/97	N. SALINE +20 mmol KCl	500 ml	iv	4°	ML Montague	96K 14BS	5.50 am	
N	19.1.97	5% DEXTROSE	500	IV	5°	[illegible]	96K2 2BH	11.40 am	
O	19.1.97	5% DEXTROSE 20 mmol KCl	500	IV	5°	[illegible]			

RATE OF FLOW (Drops/Min.) = **VOL.OF FLUID (ml) x.15** / Duration (Mins.)

6.62 (1ml = 15 drops)

Approximate Rate for 500 ml.

1 hr. = 120 Drops/min. | 4 hr. = 30 Drops/min. | 6 hr. = 22 Drops/min. | 8 hr. = 15 Drops/min.

SHEET NO .....

(2)

HOSPITAL

PRESCRIPTION SHEET No.

REGULAR PRESCRIPTIONS – INJECTIONS			DOSE	ROUTE	TIMES FOR ADMINISTRATION										Prescribers Signature (Full)	DISCONTINUED	
Pharmacy Use	Date Started	MEDICINE (Block Capitals)			am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times		Date	Signed
	A																
	B																
	C																
	D																
	E																
	F																
	G																
REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED																	
	H																
	J																
	K																
	L																
	M																
	N																
	O																
	P																
	R																
	S																
	T																
	V																

ONCE ONLY PRESCRIPTIONS			DIET				
DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN
26/1/97		TEMAZEPAM	10mg	oral			23.45
27.1.97		PARACETAMOL	1g	O			02.45
27/1/97		[illegible]	25mg	IM			07.00
27/1/97		TEMAZEPAM	10mg	PO		[illegible]	12.15pm

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

KNOWN MEDICINE 1.

WARD	NAME OF PATIENT	AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
	G6487G4					

(1)

HOSPITAL
PRESCRIPTION SHEET No.

REGULAR PRESCRIPTIONS – INJECTIONS

Pharmacy Use		Date Started	MEDICINE (Block Capitals)	DOSE	ROUTE	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times	Prescribers Signature (Full)	DISCONTINUED: Date	Signed
	A	16/1/97	METHADONE	100mg			PRN										21-1	
	B	16/1/97	STEMETIL	12-5mg	Im		PRN	6-8hrly										
	C	21/1/97	TRAMADOL	50mg	IM		✓											
	D	23.1.97	METOCLOPRAMIDE	10mg	IV.		✓			✓			✓				27/1/97	
	E	23/1/97	TRAMADOL	50mg	Im		PRN pain			4hrly	Mark	4hrly	baking					
	F	27/1/97	ONDANSETRON	4mg	IM		✓					✓						
	G																	

REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

	H	16/1/97	LOSEC OMEPRAZOLE	20mg	oral		✓											
	J	16/1/97	MAXOLON	1 tablet	oral		✓										21.1	
	K	16/1/97	TRAMADOL	50mg	oral		PRN			3-4hrly							27/1	
	L	21.1.97	CLEXANE	40mg	O		✓					✓					28.1	
	M																	
	N																	
	O																	
	P																	
	R																	
	S																	
	T																	
	V																	

ONCE ONLY PRESCRIPTIONS

DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN
1/1/97		ZOFRAN	4mg	IM			8.13
1.1.97		ZOFRAN	4mg	IM			10.05
1/1/97		ZOFRAN	4mg	IM			6.55
1.1.97	7.00pm	BUSCOPAN	20mg	IM			7pm
2/1		Buscopen	20mg	IM			7.40
5/1	11.30am	TRAMADOL	10mg	orm			23.25
28/1/97	10pm	TRAMADOL	10 mg	ORM			22.15
6/1/97		ZOFRAN	4mg	IM			2.45
1/1/97	4.30p	PETHIDINE	75mg	IM			5.10pm
1.1.97		PARACETAMOL	1g	O			9pm
5/1/97		ONDANSETRON	4mg	IM			02.30

DIET

WARD	NAME OF PATIENT	AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
3T	Deb 964876K	7/1	5'4"	10st	964876K	MURRAY ~~MR CARTER~~

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

KNOWN MEDICINE 1. VOLTAROL

MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

REGULAR PRESCRIPTIONS

DATE	6 a.m.	8 a.m.	10 a.m.	12 m.d.	2 p.m.	4 p.m.	6 p.m.	10 p.m.	12 m.n.	OTHER TIMES	COMMENTS ON DISCREPANCIES
25.1.97	D Initial	W Initial	Initial	Initial	C Initial	Initial	Initial	C @ 22 D Initial	Initial	G Initial	E @ 10.35 ARNM Eat 6.45 pm
26.1.97	D	W C SS.						C D @ 23		G	E @ 02.50 D - declined
27.1.97	E @ 05.30	H LC			C F LC			C F @ 23		G	E @ 05.30 D - refused.
28/1		C H F									

NAME: Deborah Sullivan

UNIT NUMBER: 964376

WARD: 61

KEY: CODE LETTER CIRCLED E.G. (A) = MEDICINE REFUSED AND MEDICAL STAFF INFORMED

CODE LETTER SCORED E.G. X = PATIENT ABSENT

FORM MR1 10/90

HOSPITAL

MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

REGULAR PRESCRIPTIONS

DATE	6 a.m.	8 a.m.	10 a.m.	12 m.d.	2 p.m.	4 p.m.	6 p.m.	10 p.m.	12 m.n.	OTHER TIMES	COMMENTS ON DISCREPANCIES
16/1	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	B 10.30pm BS
17/1/97											A at 12.25am KR · A 10.05pm KJ B at 4.45am KR. H refused (J) not given E at 1.40pm
18/1/97											A at 12.30am EC. A at 6.55am KR. A @ 10.55am AR A @ 2pm CW
19/1/97											A at 00.40am A @ 6.25pm A + B at 5.10am A at 10.05pm A @ 10.15am CW A + B @ 2.30pm
20/1											A at 7.00am A @ 10.30am AR. A at 5.35pm A + B @ 10.00pm CW
21/1/97											H, J + K vomited whole - repeated at 8.30am on Dr Rousseau's list B @ 6pm C at 10.30pm
22/1/97											B at 7.40pm (E) - Declined
23/1/97											
24/1/97											E at 5.35pm

NAME: D. Sullivan

UNIT NUMBER: 964876K
SULLIVAN F/S
DE[illegible]IH 07/12/1972

WARD: 29

KEY: CODE LETTER CIRCLED E.G. (A) = MEDICINE REFUSED AND MEDICAL STAFF INFORMED

CODE LETTER SCORED E.G. X = PATIENT ABSENT

FORM MR1 10/90

Patient Name.

Welcome to Ward 39

We organize patient care using a system called **Named Nursing**. This is to enable you to have your own nurse and her associates who will look after you from admission to discharge. If you or your relatives have any questions you will be directed to them. We hope that this will make your stay in hospital easier for you.

Your Named Nurse is : Sin McGinn

Your Associate Nurses are : Team 2

Ward Sister

Glasgow Royal Infirmary University NHS Trust

Profile/Careplan for 24 / 72 hour stay

DATE OF ADMISSION 2/12/96	TIME 0030 hr	WARD 39	TYPE OF ADMISSION EA	EMERGENCY / PLANNED / TRANSFER FROM	OTHER	ADMITTING NURSE G Thomson

SURNAME Sullivan	DATE OF BIRTH 7/12/72.	MENSTRUAL CYCLE	ALLERGIES none	BASELINE RECORDS
FORENAME Deboran	AGE 24	PARA 0		HEIGHT
ADDRESS 160 main street Barrheston	RELIGION RC	URINALYSIS +protein.		WEIGHT
	G.P. AND ADDRESS Dr Goldie Easterhouse HC		CHEMICAL DEPENDANCY / PROSTHESIS	B.P. 110/80.
				TEMP. 36²
TEL Nos. 771 3401				PULSE 66.
WISHES TO BE KNOWN AS				RESPIRATION 22.
				DENTURES

NEXT OF KIN mother Kathleen Sullivan	SOCIAL CIRCUMSTANCES		STORAGE OF VALUABLES	STORAGE OF DRUGS
ADDRESS 187 Commonhead Rd Easterhouse	OCCUPATION Cairns handler.	SUPPORTING SERVICES —		
	LIVES WITH Father			
	TYPE OF HOUSE			
RELATONSHIP mother			RETURNED	RETURNED
TEL. Nos. 771 3743.				

REASON FOR ADMISSION	PAST MEDICAL HISTORY	CURRENT DRUG THERAPY
Abdominal Pain.	Appendicectomy 1996 · Laparascope	Losec.
	- chol. April 1996	maxalon.
	multiple admission to 39.	tramadol.
	Sphincter of odd dysfunction.	Ofnic.
		Cisapride

PATIENTS NAME Deboran Sullivan

CONSULTANT ~~Gordon~~ MMB ~~Hendry~~ 0280470 STANTON

ASSESSMENT

SAFETY AND COMFORT	BREATHING & CIRCULATIC..	MAINTAINING BODY TEMPERATURE	EATING & DRINKING	MOBILITY
~~not orally at present~~ Commenced OF118 :: for abdominal pain .	Smokes 10 per day.	no problems .	nil orally at present .	mobile,

PERSONAL HYGIENE	ELIMINATION	SLEEP	COMMUNICATION (INCLUDING FEARS & ANXIETIES)
independant	no problems .		distressed due to pain .

SKIN CONDITION

DATE	No.	PROBLEM	AIM	INTERVENTION	SIGNATURE	EVALUATION	DISC

DATE	No.	PROBLEM	AIM	INTERVENTION	SIGNATURE	EVALUATION	DISC

DATE	No.	EVALUATION/NURSING NOTES	SIGNATURE
21/12/96		Admitted to ward with abdominal pain. IV commenced. now fasting. urine + protein MSSU sent. Tramadol 100mg & Stemetil 12.5mg im at 11.5am.	CThomson
		Slept well	
		IV fluids maintained	Elghtbody
		reviewed by medical staff allowed oral fluids as able Not to have analgesia containing Codeine analgesia & Stemetil given @ 1pm Asleep most of the day	
		Oral fluid 1pm, analgesia required during the afternoon and evening.	
		Tolerating oral fluids & IV fluids continues	MCowieson.
22/12/96		Tramadol 50mgs + Stemetil 12.5mg im at 1.50am	
		Slept for spells	
		IV fluids maintained	Elghtbody
		Now under care of Miss Finlay, Miss Love. fluids and diet as directed	
		May go home if eating & drinking well, no vomiting & infusion discontinued. Oxytocin started im Tracie complained of pain and nausea	Sisterdenison.

Name: DEBORAH SURRIDGE | Hospital Nos: | Ward:

Date	Problem No.s	Nursing Notes / Evaluation	Signature
22/12/96.		Oral Buscopan and Im Stemetil given with some effect. Refused lunch. Not been for fluids. Zydol 100mgs Im at 12.20pm.	M Meadowcroft
pm.		Remained in bed for most of the afternoon, still appears tired and lethargic. managed light diet at tea time. Still complaining of pain and nausea at times. ?Home on monday.	E. Bishop
23/12/96		Slept for spells inbetween analgesics. Up to shower. Self caring. Seen by Medical staff. No changes. For home tomorrow.	Elythbody QBell
WJB		SJB mr Finlay's team ? For discharge home tomorrow. Taking tramadol 100mgs IM and baufen 400mgs orally For relief of pain - with fair effect. Self Caring mobilising.	SJB
		Still reluctant for diet. Analgesia given as recorded. Transfer to ward 62 today.	M Meadowcroft
24.12.96		Not seen by med staff. Mr Stanton telephoned at home and happy for Deborah to go home - to be seen at clinic 9th Jan. 10.45 am. Has own medication at home.	J Hussey

39

Patient name Deborah Sullivan							
Date 21/12/96	No 1	Problem Ventlon in-situ; potential for local and systemic infection	Hosp Number Aim Minimise the risk. Detect early.	Intervention Ask patient to report any pain, swelling or discharge at ventlon site. Inspect cannula site 4 hly. Inform medical staff of any inflammation, discharge or dysfunction. Record ventlon site condition see below. Review with medical staff the need for cannula and need to change cannula. Maintain a dry dressing at insertion site	Signature Eghrbocs Eghrbocs Eghrbocs Eghrbocs Eghrbocs	Review date D/G D/G D/G D/G D/G

Review date	Day	Inflammation at site 0 <1 1 2 2-3 >3 cms	Discharge & Amount Blood/Serous Pus + ++ +++	Comment	Medical staff informed	Signature	Date whe removed Signatur
	1						

Glasgow Royal Infirmary

Problems / Aims

9
F

Name: Deborah Sullivan | Date of Birth | Ward No.s

Date	No	Problem	Aim	Nursing Intervention	Signature	Date Evaluation Date	Disc Date
21/12/95	2	A) Potential for fluid & electrolyte imbalance due to... a) Operative procedure b) Anaesthetic c). Nausea & Vomiting	To maintain hydration. Electrolytes within normal limits	A) Administer intravenous fluids as prescribed by doctor	Eghrbody	0/9	
				B) Maintain accurate record of Intake & output	Eghrbody	0/9	
			Increase appetite & promote healthy/balanced diet	C) If necessary, administer antiemetics as prescribed & monitor effect with patient	Eghrbody	0/9	
		B) Loss of appetite due to surgery		D). Dietary restrictions..... Fasting	Eghrbody	0/9	
				22/12/96 Fluids and diet	[illegible]		
				E) When [illegible] appetising meals & observe dietary intake			

Patient name Deborah Sullivan | Hosp Number

Date	No	Problem	Aim	Intervention	Signature	Review date
21/12/96	1	Venflon in-situ; potential for local and systemic infection.	Minimise the risk.	Ask patient to report any pain, swelling or discharge at venflon site.	Eghrbaq	01/9
			Detect early.	Inspect cannula site 4 hly.	Eghrbaq	01/9
				Inform medical staff of any inflammation, discharge or dysfunction	Eghrbaq	01/9
				Record venflon site condition see below.	Eghrbaq	01/9
				Review with medical staff the need for cannula and need to change cannula.	Eghrbaq	01/9
				Maintain a dry dressing at insertion site	Eghrbaq	01/9

Review date	Day	Inflammation at site 0 <1 1-2 2-3 >3 cms	Discharge & Amount Blood/Serous + ++ +++ Pus	Comment	Medical staff informed	Signature	Date venflue Sign
	1						
	2						
	3						
	4						

Glasgow Royal Infirmary

Problems / Aims

Name Deborah Sullivan | Date of Birth | Ward No 39 | Date

Date	No	Problem	Aim	Nursing Intervention	Signature	Date evaluation
21/12/96	1	Pain ~~following surgical procedure~~	Patient will state she is comfortable	A) Nurse patient in comfortable position	EJ Hrbacz	
				B) Administer analgesia as prescribed by doctor & monitor effect with patient	EJ Hrbacz	
				C) If analgesia is ineffective, notify doctor & review prescription	EJ Hrbacz	

GLASGOW ROYAL INFIRMARY UNIVERSITY NHS TRUST
PROBLEMS / AIMS

NAME: Deborah Sullivan HOSPITAL NUMBER: WARD:

DATE	NO	PROBLEM	AIM	NURSING INTERVENTIONS	SIGNATURE	EVAL. DATE	DISC DATE
		Patient requires assistance when moving due to Fully Mobile	To minimise the risk of injury to patient and staff To promote patient comfort	Ascertain patient's weight Ascertain patient's height Assess and document patient's weight bearing ability Assess and document patient's dependence on nursing staff to mobilise Encourage patient to mobilise within own capabilities Observe for and document any changes in patient's circumstances			

GLASGOW ROYAL INFIRMARY WARD

PATIENT NAME D.O.B.

RESULTS

Date	Normal							
WCC	4-11							
Hb	M 13-18 F 11.5-16.5							
Plts	150-400							
Na	135-145							
K	3.5-5.0							
Cl	97-107							
Bic	23-30							
Ur	2.5-8.0							
Cr	40-130							
Gluc	<11.0							
Amyl	70-200							
Ad Ca	2.2-2.6							
Ca	2.2-2.6							
PO4	0.7-1.4							
T/P	62-82							
Alb	35-55							
Glb	22-33							
Bil	3-22							
ALP	80-280							
AST	12-48							
ALT	5-55							
GGT	11-51							
LDH	230-525							
CK	<150							
CRP	<10							
ESR								
APTT	33-50							
PT	13-18							
TCT	6-9							
H+	35-45							
pO2	12-15							
pCO2	4.4-5.6							
HCO3								

GLASGOW ROYAL INFIRMARY UNIVERSITY NHS TRUST

I.V. THERAPY PRESCRIPTION SHEET

DEBORAH Collins

PATIENT ID LABEL

0159486

	DATE	FLUID (USE BLOCK LETTERS) / ADDITIVE DRUG	Vol (ml). / Dose (mg)	Route of Admin.	Dur. of Admin.*	SIGNATURE	Serial No. / Batch No.	Time Begun	Given / Added
A	20.12	(N) Saline.	500	IV	4°	M Digby	96420 BK	15 1 am	
B	20.12	5% DEXTROSE	500	IV	4°	M Digby	96J31 BC	9.45 am	
C	20.12	(N) Saline.	500	IV	4°	M Digby	96J31 BC	11.40	
D	20.12	5% DEXTROSE	500	IV	4°	M Digby	96J 3 BC	3.40 pm	
E	21.12	Flo Decolone	500	IV	4	Agree	96J3 IBC	9pm	
F	21.12	(N) Saline	500	IV	4	Agree	96428 BX	10 1 am	
G	21.12	Flo Decolone	500	IV	4	Agree	96J31 BC	5.19 am	
H	22.12	Flo Decolone	500	IV	4	Agree			
I	22.12	(N) Saline	500	IV	4	Agree			
J									
K									
L						STOP			
M									
N									
O									

RATE OF FLOW (Drops/Min.) = **VOL.OF FLUID (ml) x 15** / Duration (Mins.)

6.62 (1ml = 15 drops)

Approximate Rate for 500 ml.

1 hr. = 120 Drops/min. | 6 hr. = 22 Drops/min.

4 hr. = 30 Drops/min. | 8 hr. = 15 Drops/min.

SHEET NO .....

Problem / Need	Goals	Interventions	Evaluation
		Ask patient to inform nurse when pain occurs ACTIVE 24/12/1996 CATHERINE YATES 24/12/1996 CATHERINE YATES Assist patient to adopt a comfortable position ACTIVE 24/12/1996 CATHERINE YATES 24/12/1996 CATHERINE YATES Administer analgesia as prescribed and monitor effect of same with patient ACTIVE 24/12/1996 CATHERINE YATES 24/12/1996 CATHERINE YATES	

Glasgow Royal Infirmary
PATIENT CARE PLAN - WARD62

24/12/1996 TIME: 03:45:46

ent Name .... SULLIVAN, DEBORAH
ient No 964876K
tient DX ..... ABDOMINAL SYMP'S 789
ed Number 000020
Admit Date 23/12/1996
Date of Birth ... 07/12/1972

Patient Age/Sex ... 024/00/17 / Female
Primary/Named Nurse.
Consultant Name.... STANTON
Signature
.....

004DFE

Problem / Need	Goals	Interventions	Evaluation
PROB # 01 24/12/1996 Patient requires assistance when moving CATHERINE YATES	To promote patient comfort and minimise the risk of injury to patient and staff CONTINUING REVIEW: 28/12/1996 SELECTED: 24/12/1996 CATHERINE YATES	Specify patient's weight...NOT DOCUMENTED Specify patient's height... NOT DOCUMENTED ACTIVE 24/12/1996 CATHERINE YATES 24/12/1996 CATHERINE YATES Assess and document weight bearing ability Ensure the use of ... nurses to assist when moving Specify the type of lift required when moving in bed... Specify the type of lift required when moving from chair/ commode... Specify the type of equipment required to assist with moving (Eg. Patslide)	
PROB # 02 24/12/1996 Patient has abdominal pain CATHERINE YATES	Patient will state he/ she is comfortable CONTINUING REVIEW: 28/12/1996 SELECTED: 24/12/1996 CATHERINE YATES	Nurse patient in area of ward which can be easily observed ACTIVE 24/12/1996 CATHERINE YATES 24/12/1996 CATHERINE YATES Provide patient with call bell to ensure he/ she has the means to summon assistance ACTIVE 24/12/1996 CATHERINE YATES 24/12/1996 CATHERINE YATES	

[MORE]

[(c) SASHA CARE INTERNATIONAL, INC. Computer Generated form]

ALLERGIC TO VOLTAROL

HOSPITAL
PRESCRIPTION SHEET No.

REGULAR PRESCRIPTIONS – INJECTIONS

Pharmacy Use		Date Started	MEDICINE (Block Capitals)	DOSE	ROUTE	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times	Prescribers Signature (Full)	DISCONTINUED: Date	Signed
	A	20.12.	TRAMADOL	100mg	IM		8-		12		PRN	PAIN						
	B	20.12.	STEMETIL	12.5mg	IM			10-	12		PRN	N+V						
	C																	
	D																	
	E																	
	F																	
	G																	

REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

	H	20.12.	OMEPRAZOLE	20mg	IV		✓											
	J	~~20.12.~~	~~DIHYDROCODEINE~~	30mg	PO		4-		6		PRN	PAIN					21.12	
	K	21.12.96	Buscopan	20mg	PO			4x daily if reqd.										
	L	21.12.96	Ibuprofen	400mg	PO			6 hourly if reqd.										
	M																	
	N																	
	O																	
	P																	
	R																	
	S																	
	T																	
	V																	

ONCE ONLY PRESCRIPTIONS

DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN

DIET

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1. VOLTAROL	
2.	

KNOWN MEDICINE 1.

WARD	NAME OF PATIENT	AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
30	964876K SMITH, IVAN F/S				964876K	STANTON

HOSPITAL

MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

REGULAR PRESCRIPTIONS

DATE	6 a.m.	8 a.m.	10 a.m.	12 m.d.	2 p.m.	4 p.m.	6 p.m.	10 p.m.	12 m.n.	OTHER TIMES	COMMENTS ON DISCREPANCIES
21/12/96	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	AB at 0130am A at 7.10 am EC K at 3.15 pm A & B @ 4pm W A at 10.30 pm EC
22/12/96						A at 4.10 R	Bat 6pm	A at 10.00 pm EC L at 11.30 pm EC		A	A & B at 1.50 am JN K at 10.40 am Vomited B at 10.50 am A at 7.00 pm LT A at 12.20 pm KS
23/12/96		A at 8.30 am H SB		A & B @ 12.20 pm SA	A at 4.05 pm JM			A @ 10.45 pm Enc		A	A at 4.25 pm EL L at 11 am SB
24/12		H V									

NAME: 964876K SULLIVAN F/S DEBORAH 07/12/1972 1/1 140 MAIN STREET

UNIT NUMBER: 964876K

WARD: 39

KEY: CODE LETTER CIRCLED E.G. (A) = MEDICINE REFUSED AND MEDICAL STAFF INFORMED

CODE LETTER SCORED E.G. A = PATIENT ABSENT

FORM MR1 10/90

YOU MUST USE A BALLPOINT PEN AND FULLY COMPLETE THIS FORM OR THE PRESCRIPTION WILL NOT BE DISPE

Dear Doctor... GOOD

GLASGOW ROYAL INFIRMARY
G4 OSF TEL 0141-211-4000

CONFIDENTIAL

IMMEDIATE DISCHARGE LETTER AND MEDICINE PRESCRIPTION FORM
To be completed for every discharge and inter specialty transfer

46953

964876K
SULLIVAN F/S
DEBORAH 07/12/1972
1/1 160 MAIN STREET
BAILLIESTON
G69 6AH

Diagnosis (inc, cause of injury)
1 CAROTID ABDOMINAL PAIN
2
3
4
5
6

Procedures
1 SYLOTEX SCAN Date 11/12
2 SMALL BOWEL ENEMA Date 17/12
3 Date
4 Date

Type of Admission			
WL/ARRANGED		DAY CASE	
EMERGENCY	✓	INTERNAL TRANSFER	
		TRANSFER FROM OTHER HOSPITAL	

DOA 1/12/12
CONSULTANT MOORE
WARD 61
DATE OF DISCHARGE/DEATH 14/12/12
TRANSFERRED TO WARD ..... DATE .....

FOLLOW UP ARRANGEMENTS
Clinic 2/12 Date .....
Home Help ..... YES NO
District Nurse ..... YES NO
GP ..... YES NO
Meals on Wheels ..... YES NO
OTHER .....

PROCEDURES PERFORMED BY OTHER SPECIALITIES

Procedure	Specialty	Consultant	Date
1			
2			

Medicine	Form	Dose	Frequency	Duration	Days Supplied	PHARMACY TO COMPLETE Quantity, Strength, Brand

COMMENTS (Information given to patients, investigating pending, pharmacy, medicine sensitivities, etc)

Admitted with abdominal pain + for investigation
No abnormality detected.
Continue pain relief problem

...tor's Name KNMC Signature ..... Page No ..... Date 14/12/12 Pharmacist .....

Pink Copy - Case Notes Blue Copy - Pharmacy Yellow Copy - Coding 0159369

YOU MUST USE A BALLPOINT PEN AND FULLY COMPLETE THIS FORM OR THE PRESCRIPTION WILL NOT BE DISPEN

GLASGOW ROYAL INFIRMARY
G4 OSF TEL 0141-211-4000

CONFIDENTIAL

IMMEDIATE DISCHARGE LETTER AND MEDICINE PRESCRIPTION FORM
To be completed for every discharge and inter-specialty transfer

46952

Dear Doctor.....

964876K
SULLIVAN F/S
DEBORAH 07/12/1972
1/1 160 MAIN STREET
BAILLIESTON
G69 6AH

Diagnosis (inc, cause of injury)

1 ABDOMINAL PAIN 4
2 5
3 6

Procedures

1 CT ABDOMEN & PELVIS Date 11.11.11 3 Date
2 CT CHEST SCAN Date 11.11.11 4 Date

Type of Admission			
WL/ARRANGED		DAY CASE	
EMERGENCY	✓	INTERNAL TRANSFER	
		TRANSFER FROM OTHER HOSPITAL	

DOA 5.11.11
CONSULTANT MINISTRY
WARD C1
DATE OF DISCHARGE/DEATH 16.11.11
TRANSFERRED TO WARD: DATE

FOLLOW UP ARRANGEMENTS

Clinic Date
Home Help YES NO
District Nurse YES NO
GP YES NO
Meals on Wheels YES NO
OTHER

PROCEDURES PERFORMED BY OTHER SPECIALITIES

Procedure	Specialty	Consultant	Date
1			
2			

Medicine	Form	Dose	Frequency	Duration	Days Supplied	PHARMACY TO COMPLETE Quantity, Strength, Brand
TRAMADOL	TABLET	50mg	THREE TIMES A DAY		7	(21) Zydol 50mg 134C

COMMENTS (Information given to patients, investigating pending, pharmacy, medicine sensitivities, etc)

admitted yesterday with abdominal pain
blood tests were normal. Small bowel obstruction → NBM
Gastroenterology will review again
No surgical cause is thought to be responsible
for pain which is likely to resolve

Doctor's Name R Hikeen Signature Page No Date Pharmacist S Hems

White Copy - GP Pink Copy - Case Notes Blue Copy - Pharmacy Yellow Copy -Coding

0159369

Glasgow Royal Infirmary University NHS Trust

Profile/Careplan for 24 / 72 hour stay

Waterlow +

DATE OF ADMISSION	TIME	WARD	TYPE OF ADMISSION	EMERGENCY / PLANNED /	TRANSFER FROM	OTHER	ADMITTING NURSE
5/12/96	10 p.m.	3Q					

SURNAME **964876K** SULLIVAN F/S
FORENAME DEBORAH 07/12/1972
ADDRESS 1/1 160 MAIN STREET BAILLIESTON G69 6AH

TEL Nos. 771 3401

WISHES TO BE KNOWN AS

NEXT OF KIN Kathleen Sullivan
ADDRESS 187 Commonhead Rd Glasgow
RELATONSHIP Mother
TEL. Nos. 771 3743

DATE OF BIRTH 7/12/72
AGE ~~23~~ 24
RELIGION R/C
MENSTRUAL CYCLE
PARA
URINALYSIS TRACE MSSUV/Protein
G.P. AND ADDRESS Dr Goldie Easterhouse H/C

ALLERGIES: None known

CHEMICAL DEPENDANCY: /
PROSTHESIS: /

BASELINE RECORDS

HEIGHT	5ft 10"
WEIGHT	10½ st
B.P.	110/70
TEMP.	96.4
PULSE	80
RESPIRATION	
DENTURES	/

SOCIAL CIRCUMSTANCES

OCCUPATION Insurance Clerk
LIVES WITH alone
TYPE OF HOUSE Flat

SUPPORTING SERVICES: /

STORAGE OF VALUABLES: / RETURNED

STORAGE OF DRUGS: / RETURNED

REASON FOR ADMISSION	PAST MEDICAL HISTORY	CURRENT DRUG THERAPY
c/o upper abdo pain Colicky in nature associated nausea and vomiting Recently discharged W39 ~~Q~~ weeks ago.	Appendicectomy Lap chole Dyspepsia Sphincter of Oddie dysfunction, Numerous admissions with similar complaint	DF 118 Propulsid bd ac Maxalon OCP
13.12.96: Small bowel enema		

PATIENTS NAME D. L. Sullivan

CONSULTANT MR. MURRAY 0280470

ASSESSMENT

SAFETY AND COMFORT	BREATHING & CIRCULATION	MAINTAINING BODY TEMPERATURE	EATING & DRINKING	MOBILITY
No c/o pain o/n	No problems smokes 10 /day	Within normal limits	Good appetite V. Occasional Alcohol	Fully.

PERSONAL HYGIENE	ELIMINATION	SLEEP	COMMUNICATION (INCLUDING FEARS & ANXIETIES)
Self Care SKIN CONDITION ✓	Prone to Constipation	Sleeps Well	No problems identified

DATE	No.	PROBLEM	AIM	INTERVENTION	SIGNATURE	EVALUATION	DISC
		See Folder.					

Glasgow Royal Infirmary
University NHS Trust

Nursing Notes

Name: [redacted] | Hospital Nos: | Ward: 61

Date	Problem No.s	Nursing Notes / Evaluation	Signature
		nausea this am. Awaiting review re bowel prep for tomorrow's small bowel enema. Apyrexial this am. Encouraged with diet + fluids. Reviewed by Medical staff. To have sachet of Picolax x1 this afternoon. Now on clear fluids. Please fast from 12mn.	JRobertson
pm.		Settled evening, patient on clear fluids only until 12midnight. To fast thereafter in preparation for enema tommorrow.	
		All care as charted.	AFMorgan
		Pemidine 75mg given intramuscularly at 8.35pm with effect for pain relief.	AFMorgan
13/12/96		Slept for long periods. Morning Zyrtec given about 5am for relief of pain.	A Hunter
am		Settled morning self caring with personal hygiene.	
		Recordings: T 36.5°C, p100	
		Attended for small bowel enema this am.	
		All care as charted	AFMorgan
		Reviewed by Mr Murray, for ? discharge home. JOPD to be arranged for 2 months time and Mr Murray will contact Dr Reilly re homeopathic pain control	
		Complaining of pain Pethidine 75mgs IM @ 20.40 for pain relief	
		Vomited x 2 - Stemetil given as prescribed	
14/12/96		Settled and slept well, no further episodes of vomiting.	A Hunter & Rutherford
		Reviewed by Medical staff - discharged home. JOPD arranged for 2 months.	

Glasgow Royal Infirmary
University NHS Trust

Nursing Notes

Name: Deborah Sullivan | Hospital Nos. | Ward: 39

Date	Problem No.s	Nursing Notes / Evaluation	Signature
6/12/96		Patient vomited approx 200mls bile stained fluid ; c/o pain Stemetil 12.5mg IM + Voltarol 75mg IM @ 3.50 pm. Reviewed by Mr Murray care discussed with Dr Morris to have small bowel enema and Sordex scan arranged to remain in hosp until same performed. IV fluids discontinued. Managing oral fluids c/o pain - RIB Dr Griffin oral analgesia as charted DE 11.5 @ 10.15pm Continues to c/o pain RIB Dr Hart - Buscopan 20mg IM and Diazepam 10mg orally @ 11.45pm	R Tracey
7/12/96		Slept well overnight Reviewed by Mr Murray may go home on pass to return to ward 6 for Cimetidine	R. Tracey
9/12/96		Returned from pass @ 12 MD. Awaiting review by medical staff Seen by Mr Murray. To have Tramadol 50mg TDS for pain orally c/o IM injections & Stemetil Patient counted x3 undigested foodstuff and bile stained fluid. Stemetil 25mgs IM at 5.45pm with poor effect. c/o abdominal pain, med only presently of Voltarol 50mgs orally given with little effect. Medical staff aware will review. Still able to tolerate to sips only Seen Medical staff in context. Voltarol 75mgs IM given at 8.30 p.m. with good effect	C Sullivan

Name: Deborah Sullivan | Hospital Nos: | Ward: 6

Date	Problem No.s	Nursing Notes / Evaluation	Signature
10·9·96		Slept well. Complaining of nausea and vomited small amount. Stemetil 12.5mgs I.M at 5.05 am to relieve same. Tramadol 50mgs orally afterwards, to relieve pain; same vomited back up. Hot pack given to relieve abdominal discomfort until stemetil takes effect.	
	A.M.	Settled morning. Independent with personal hygiene. No complaints of pain or nausea this morning. Seen by m/s For small bowel enema Friday, serotex scan tomorrow. Observations satisfactory.	J Mitchie.
		Vomited after lunch, feeling nauseous, stemetil 12.5mg given and hot pack for pain.	J Mitchie.
		Troubled with abdominal pain. Observed by Sister Mulcahy. Seen by Dr. Rowden. Buscopan 20mgs im @ 4pm with minimal effect. Cathaul to be troubled. Buscopan 20mgs im at 7.30pm with fair effect. Not to have im/iv Opiates.	
11/12/96		Zydol given as prescribed for pain. No requests for pain relief from patient. Hot packs being used for abdominal pain. PA dept for periods overnight. PA for serotex scan today.	
		Showered independantly this morning.	Angela
		Reviewed by medical staff for serotex scan this afternoon, commenced on clear fluids orally following light breakfast.	
		Returned from scan. Paracetamol given for headache.	
		settled evening.	
12/12/96		Slept for long periods. Up to shower this am. Sleeping for long spells. No complaints of	

DATE	No.	PROBLEM	AIM	INTERVENTION	SIGNATURE	EVALUATION	DISC

DATE	No.	EVALUATION/NURSING NOTES	SIGNATURE
5/12/96		Voltarol 75mg IM @ 8.10pm also Pethidine 100mg and	
		Stemetil 12.5mg in A+E dept 9.10pm.	
		SHO Mr Teeter - to have GTN spray and 20mg diazepam	
		To remain fasting overnight IV fluids in progress	K Taylor
6/12/96		Slept for long spells overnight.	
		Pethidine 75mgs given IM @ 0025	K Taylor
		IV fluids running behind schedule.	
		S/B Mr Murray - Reviewed by physicians	
		May have free fluids	SNeil
		Has remained in bed all morning	
		Oral intake poor. IV fluids continue.	
		at present.	
		Complaining of pain. Dr Teeter informed	
		GTN spray given as prescribed	
		? For review by Dr Morris	TM

GLASGOW RO

964876K
SULLIVAN F/S
DEBORAH 07/12/1972
1/1 160 MAIN STREET
BAILLIESTON
G69 6AH

WARD 39

PATIENT NAME D.O.B.

RESULTS

Date	Normal	5.12.96	10/12/96					
WCC	4-11		8.9					
Hb	M 13-18 F 11.5-16.5		12.8					
Plts	150-400		247					
Na	135-145	140	142					
K	3.5-5.0	4.3	3.8					
Cl	97-107	103	107					
Bic	23-30	27	25					
Ur	2.5-8.0	2.2	2.7					
Cr	40-130	76	84					
Gluc	<11.0	5.3						
Amyl	70-200	176						
Ad Ca	2.2-2.6		2.25					
Ca	2.2-2.6		2.15					
PO4	0.7-1.4		0.95					
T/P	62-82		68					
Alb	35-55		41					
Glb	22-33		27					
Bil	3-22		15					
ALP	80-280		130					
AST	12-48		25					
ALT	5-55		21					
GGT	11-51							
LDH	230-525							
CK	<150							
CRP	<10		12					
ESR								
APTT	33-50							
PT	13-18							
TCT	6-9							
H+	35-45							
pO2	12-15							
pCO2	4.4-5.6							
HCO3								

GLASGOW ROYAL INFIRMARY UNIVERSITY NHS TRUST

MS DEBORAH SULLIVAN
DoB: 7/12/1972.

I.V. THERAPY
PRESCRIPTION SHEET

0159486

	DATE	FLUID (USE BLOCK LETTERS) / ADDITIVE DRUG	Vol (ml). / Dose (mg)	Route of Admin.	Dur. of Admin.*	SIGNATURE	Serial No. / Batch No.	Time Begun	Given / Added
A	5/12/96	Hartmanns	500ml	IV	250/hr.		96F17 BM	21[00]	C. hr
B	5/12/96	N.S.	500ml	IV	125/hr		96B80	5am	
C	5.12.96	HARTMANN'S	500	IV	4[0]	M Dick.	96I 12BE	7[30]	3Nel
D	5.12.96	HARTMANN'S.	500	IV	4[0]	M Dick.	96I 12BE	1[30] pm	HDC
E									
F									
G						STOP			
H									
I									
J									
K									
L									
M									
N									
O									

RATE OF FLOW (Drops/Min.) = VOL.OF FLUID (ml) x 15 / Duration (Mins.)

6.62

(1ml = 15 drops)

Approximate Rate for 500 ml.

1 hr. = 120 Drops/min.

4 hr. = 30 Drops/min.

6 hr. = 22 Drops/min.

8 hr. = 15 Drops/min.

SHEET NO .....

Glasgow Royal Infirmary

Problems / Aims

Name D. Sullivan | Data of Birth | Ward No 39 | Date

Date	No	Problem	Aim	Nursing Intervention	Signature	Date Achieved
5/12/96	1	Pain following surgical procedure	Patient will state she is comfortable	A) Nurse patient in comfortable position B) Administer analgesia as prescribed by doctor & monitor effect with patient C) If analgesia is ineffective, notify doctor & review prescription		

Glasgow Royal Infirmary

Problems / Aims

Name D. Sullivan | Date of Birth | Ward No's

Date	No	Problem	Aim	Nursing Intervention	Signature
5/12/96	2	Nausea / Vomiting due to..	To promote patient comfort & relieve nausea /vomiting	A) Position patient where he/she can be easily observed, with nurse call system to hand B) Position in bed to maintain comfort (N.B. If airway at risk - left lateral position with suction apparatus to hand) C) Provide emesis bowl & ensure patient privacy D) Offer mouthwashes to freshen mouth E) Stay with patient during vomiting period & provide	&c

asgow Royal Infirmary

oblems / Aims

9
F

ne	D. Sullivan	Date of Birth	Ward No.s	Date

No.	Problem	Aim	Nursing Intervention	Signature	Evaluation Date	Disc Date
5/12/96 (3)	A) Potential for fluid & electrolyte imbalance due to... a) Operative procedure b) Anaesthetic c) Nausea & Vomiting B) Loss of appetite due to surgery	To maintain hydration Electrolytes within normal limits Increase appetite & promote healthy/balanced diet	A) Administer intravenous fluids as prescribed by doctor B) Maintain accurate record of Intake & output C) If necessary, administer antiemetics as prescribed & monitor effect with patient D) Dietary restrictions..... Fast 5/12 F/F E) When appetite returns, encourage eating; weigh & observe dietary intake	(4)		

Patient name D. Sullivan			Hosp Number				
Date	No	Problem	Aim	Intervention	Signature	Review date	
5/12/96	4	Venflon in-situ; potential for local and systemic infection	Minimise the risk. Detect early.	Ask patient to report any pain, swelling or discharge at venflon site. Inspect cannula site daily. Inform medical staff of any inflammation, discharge or dysfunction Record venflon site condition see below. Review with medical staff the need for cannula and need to change cannula. Maintain a dry dressing at insertion site	SJ		

Review date	Day	Inflammation at site 0 <1 1-2 2-3 >3 cms	Discharge & Amount Blood/Serous + ++ +++ Pus	Comment	Medical staff informed	Signature	Date whe removed Signature
6-12-96	1	0	0	0	—	SNeil	
	2						
	3						
	4						

GLASG..V ROYAL INFIRMARY UNIVERSITY NHS TRUST
PROBLEMS / AIMS

NAME: HOSPITAL NUMBER: WARD:

DATE	NO	PROBLEM	AIM	NURSING INTERVENTIONS	SIGNATURE	EVAL. DATE	DISC DATE
		Patient requires assistance when moving due to ...	To minimise the risk of injury to patient and staff	Ascertain patient's weight			
				Ascertain patient's height			
			To promote patient comfort	Assess and document patient's weight bearing ability			
				Assess and document patient's dependence on nursing staff to mobilise			
				Encourage patient to mobilise within own capabilities			
				Observe for and document any changes in patient's circumstances			

HOSPITAL
PRESCRIPTION SHEET No. 1

REGULAR PRESCRIPTIONS – INJECTIONS

Pharmacy Use		Date Started	MEDICINE (Block Capitals)	DOSE	ROUTE	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times	Prescribers Signature (Full)	DISCONTINUED: Date	Signed
	A	7/12/91	STEMETIL	12.5mg	~~IM~~		8		daily	PRN								
	B	~~9/12/91~~	~~SUBUTAMOL~~															
	C																	
	D																	
	E																	
	F																	
	G																	

REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

	H	5/12/96	GTN Transdermal patch.	5 ~~0.05~~ mg	Transdermal	✓												
	J	5/12/96	Lasix	20mg	PO	✓												
Q	K	5/12/96	Prepulsid CISAPRIDE.	~~20mg~~ 10mg NR	PO													
	L	5/12/96	Maxolon	10mg	PO													
	M	~~5/12/96~~																
	N	6/12	GTN SPRAY	1 puff	SL		PRN		PRN									
	O	~~6/12~~	~~Dihydrocodeine~~	~~30-60mg~~	O						4-6 PRN							
	P																	
	R	9.12	TRAMADOL	50mg	O		✓			✓			✓					
	S	11/12	TAMAZEPAM	10	OD								/					
	T																	
	V																	

ONCE ONLY PRESCRIPTIONS

DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN
5/12/96		GTN Spray	1 dose	SL			10pm
6/12/96		DIAZEPAM	10mg	p.o			10pm
6.12	0020	PETHIDINE	75mg	IM.			
6.12		VOLTAROL	75	IM			3.50 am
6.12		STEMETIL	12.5	IM			3.50 pm
6.12.96		BUSCOPAN	20mg	IM			3.50 pm
6.12.96		DIAZEPAM	10mg	PO			9 pm
9.12.96		VOLTAROL	50mg	ORAL			9 pm
9/12/91	8.30 pm	VOLTAROL	75mg	IM			8.30 pm
10/12/96	4pm	BUSCOPAN	20mg	IM			4 pm
10.12.96	7.30pm	BUSCOPAN	20mg	IM			7.30 pm

DIET

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

KNOWN MEDICINE SENSITIVITIES: 1.

WARD	NAME OF PATIENT	AGE/DOB	HEIGHT/WEIGHT	UNIT NUMBER	CONSULTANT
39	Deborah Sullivan		SULLIVAN DEBORAH 07/12/1972 F/S 44 440 MAIN STREET	964876K	Mr Murray

HOSPITAL
PRESCRIPTION SHEET No. 2

REGULAR PRESCRIPTIONS – INJECTIONS

Pharmacy Use	Date Started	MEDICINE (Block Capitals)	DOSE	ROUTE	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times	Prescribers Signature (Full)	DISCONTINUED: Date	Signed
	A																
	B																
	C																
	D																
	E																
	F																
	G																

REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

	H																	
	J																	
	K																	
	L																	
	M																	
	N																	
	O																	
	P																	
	R																	
	S																	
	T																	
	V																	

ONCE ONLY PRESCRIPTIONS

DIET

DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN
13/12/96	8pm	BUSCOPAN	20mg	IM			18.25
13/12/96	8.45pm	PETHIDINE	75mg	IM			8.50pm

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

KNOWN MEDICINE 1:

WARD	NAME OF PATIENT	AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
	DEBORAH					

HOSPITAL
PRESCRIPTION SHEET No. (3)

REGULAR PRESCRIPTIONS – INJECTIONS

Pharmacy Use	Date Started	MEDICINE (Block Capitals)	DOSE	ROUTE	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times	Prescribers Signature (Full)	DISCONTINUED: Date	Signed
	A																
	B																
	C																
	D																
	E																
	F																
	G																

REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

	H																
	J																
	K																
	L																
	M																
	N																
	O																
	P																
	R																
	S																
	T																
	V																

ONCE ONLY PRESCRIPTIONS — **DIET**

DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN
12-96		PARACETAMOL	1g	O	[illegible]	[illegible]	17:45
12-96		Paracetamol	1g	O	[illegible]	[illegible]	10[illegible]
2/12/96	2.35p	pethidine	75mg	IM	CATP	[illegible]	2.35p

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

KNOWN MEDICINE SENSITIVITIES: 1.

WARD	NAME OF PATIENT	AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
	Deborah Sullivan					Mr. Murray

HOSPITAL

PRESCRIPTION SHEET No. 4

REGULAR PRESCRIPTIONS – INJECTIONS

Pharmacy Use	Date Started	MEDICINE (Block Capitals)	DOSE	ROUTE	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times	Prescribers Signature (Full)	DISCONTINUED: Date	Signed
	A																
	B																
	C																
	D																
	E																
	F																
	G																

REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

	H																
	J																
	K																
	L																
	M																
	N																
	O																
	P																
	R																
	S																
	T																
	V																

ONCE ONLY PRESCRIPTIONS

DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN
12/12/96	4pm	FLOLAN	1 SALINE	IVI	[signature]	[signature]	14.30

DIET

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

WARD	NAME OF PATIENT	AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
	SULLIVAN					MURRAY

KNOWN MEDICINE SENSITIVITIES 1.

HOSPITAL

MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

REGULAR PRESCRIPTIONS

DATE	6 a.m.	8 a.m.	10 a.m.	12 m.d.	2 p.m.	4 p.m.	6 p.m.	10 p.m.	12 m.n.	OTHER TIMES	COMMENTS ON DISCREPANCIES
9/12/96	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	60mg 10:15pm	(B) decreased.
7/12/96											(E) ordered.
9/12/96											(E) at 4:00pm A at 5:45pm
10/12/96											at 5:25am. R → vomited back up. A at 14:00 pm
11/12/96											
12/12/96											
13/12/96										A_1	A_1 @ 20⁻
14/12/96											H - refused

NAME: Deborah Sullivan

964876K
SULLIVAN F/S
DEBORAH 07/12/1972
1/1 160 MAIN STREET
BAILLIESTON

WARD: 39

KEY: CODE LETTER CIRCLED E.G. (A) = MEDICINE REFUSED AND MEDICAL STAFF INFORMED

CODE LETTER SCORED E.G. ✗ = PATIENT ABSENT

FORM MR1 1000

Patient Name D Sullivan

Welcome to Ward 39

We organize patient care using a system called **Named Nursing**. This is to enable you to have your own nurse and her associates who will look after you from admission to discharge. If you or your relatives have any questions you will be directed to them. We hope that this will make your stay in hospital easier for you.

Your Named Nurse is :

SN Strang

Your Associate Nurses are :

Team 2
SN K Renwick (Night)
2 Nell (Day)
SN Mc Ginn

Ward Sister

R Boardman

Glasgow Royal Infirmary University [illegible] Trust

Profile/Careplan for 24 / 72 hour stay

DATE OF ADMISSION	TIME	WARD	TYPE OF ADMISSION	TRANSFER FROM	OTHER	ADMITTING NURSE
14/11/96	11pm	39	EMERGENCY / PLANNED			

SURNAME	964876K SULLIVAN F/S
FORENAME	DEBORAH 07/12/1972
ADDRESS	1/1 160 MAIN STREET BAILLIESTON G69 6AH
TEL Nos.	771 - 3401.
WISHES TO BE KNOWN AS	

DATE OF BIRTH	7.12.72
AGE	23yrs.
RELIGION	RC
MENSTRUAL CYCLE	
PARA	
URINALYSIS	Requested m.ssu 16/11/96
G.P. AND ADDRESS	Dr Goldie Eastenhouse HIC

ALLERGIES	BASELINE RECORDS	
Nil known.	HEIGHT	5'10"
	WEIGHT	
	B.P.	
CHEMICAL DEPENDANCY / PROSTHESIS	TEMP.	
– / –	PULSE	
	RESPIRATION	20.
	DENTURES	Nil

NEXT OF KIN	Kathleen Sullivan.
ADDRESS	187 Commonhead Rd Easterhouse.
RELATONSHIP	Mother.
TEL. Nos.	771 - 3743.

SOCIAL CIRCUMSTANCES		STORAGE OF VALUABLES	STORAGE OF DRUGS
OCCUPATION	Insurance Clerk.		
LIVES WITH	Father.		
TYPE OF HOUSE	1st floor flat.		
SUPPORTING SERVICES	– Nil –	RETURNED ✓	RETURNED

REASON FOR ADMISSION	PAST MEDICAL HISTORY		CURRENT DRUG THERAPY
Abdominal pain & vomiting.	Cholecystectomy	94	Losec 20mg x 1
	Appendicectomy	age.	Maxolon 10mg x 3.
	Pleurisy	91	Paracetamol
			Co-proxamol as Req'd.

PATIENTS NAME Deborah Sullivan

CONSULTANT Fundlay

ASSESSMENT

SAFETY AND COMFORT	BREATHING & CIRCULATION	MAINTAINING BODY TEMPERATURE	EATI DRINKING	MOBILITY
maintains own	no problems smokes 10 cigs/day	maintains own	normal diet occassional alcohol	fully mobile

PERSONAL HYGIENE	ELIMINATION	SLEEP	COMMUNICATION (INCLUDING FEARS & ANXIETIES)
daily bath/shower SKIN CONDITION	frequency micturition suffers constipation	usually sleeps well	

DATE	No.	PROBLEM	AIM	INTERVENTION	SIGNATURE	EVALUATION	DISC

DATE	No.	PROBLEM	AIM	INTERVENTION	SIGNATURE	EVALUATION	DISC

DATE	No.	EVALUATION/NURSING NOTES	SIGNATURE
14.11.96		admitted via casualty, to have NBM & IVT ✓	
		pethidine & maxalon given in A&E department	
		Pethidine ~~12~~ 100mg im 4hrly	
		Pethidine 100mg im 4hrly	
		SB medical staff Dr Mann to be informed of admission	
		allowed free fluids.	
		IV fluids continue intake improves	
		Appreciat All care continues	
		SB Mr Finlay - for pelvic U/S + enema.	
		Pethidine 100mgs IM & Stemetil 12.5mg IM at 2-5pm	
		SB gastroenterologist - will follow up next week when prev. casenotes available & pain settled	

Glasgow Royal Infirmary
University NHS Trust

Nursing Notes

Name: Deborah Sullivan | Hospital Nos.: | Ward: 39

Date	Problem No.s	Nursing Notes / Evaluation	Signature
17/11/96		Pethidine 100mgs given I.M. @ 9.15am.	CAnderson
		SLB Mr Finlay for Bisacodyl Picolax.	
		Given picolax - no result as result	
		still c/o continues Apyrexial	
		Vomited foodstuffs x2 after lunch	
		Pethidine 100mg + Stemetil 12.5mg IM 1.45pm.	
		Vomited foodstuffs after supper. Advised to remain on oral	
		fluids only meantime. Pethidine 100mgs given IM at 5.45pm	
		with effect. No result from Picolax	
		Pethidine 100mg + Stemetil 12.5mgs given	
		at 10pm.	
18/11/96		Pethidine 100mgs + Stemetil 12.5mgs im at 4.15am	
		Settled + slept.	
		I.V. fluids running as charted.	
		NO bowel movement overnight.	
		Pethidine 100mg IM 8.40c	
		Reviewed by Mr Hogan. for further 1/2 sachet Picolax	
		today.	
		Pethidine 100mgs IM + Stemetil 12.5mgs IM at 2.30pm	
		Pethidine 100mgs IM at 6.40p.m.	
		Self caring evening. Mist keen for oral	
		intake.	
		Pethidine 100mg im 10.35pm	
19-11-96		Pethidine 100mg IM @ 2.35am + Stemetil 12.5mgs IM @	
		2.35am	
		Settled + slept. Drank + ate. Passed	

Name: Deborah Sullivan | Hospital Nos: | Id: SA

Date	Problem No.s	Nursing Notes / Evaluation	Signature
15/11/96		Asleep most of the afternoon	
		in fluids continue meantime may be discontinued	
		when drinking enough.	
		Pethidine 100mg given IM @ 8.10 pm	
		Phosphate enema given with fair result.	
		Pethidine 100mgs & IM Stemetil 12.5mg IM @ 12.15 am	
16-11-96		Slept well following analgesia.	
		Urinary output appears low	
		Pethidine 100mgs IM @ 6.55 am	
		Pethidine 100mgs IM & Stemetil 12.5mgs IM at 11am	
iv phyria am		SIB NM Xray for scan today.	
		Urine & stool sample to be obtained for porphyria.	
		Up for shower.	
		Attended Scan - NAD, CXR, AXR - Slight faecal loading	
		oral intake fair - output satisfactory.	
		BOS satisfactory.	
		Vomited toast & tea morning. Lunch.	
		Pethidine 100mgs given IMC 4pm a ~~repeat~~	
		Pethidine 100mg + Stemetil 12.5mg IM 8p	
		Urine & stool samples to be obtained monday for	
		Porphyria - Labs unable to test at w/end.	
		Nausea persists. Taking oral fluids well	
17/11/96		Pethidine 100mg @ 12.10 am with good effect	
		Settled night after analgesia Apyrexial	
		Pethidine 100mg + Stemetil 12.5mg IM at 5.05 am	

Name: Deborah Sullivan | Hospital Nos: | Ward: 62

Date	Problem No.s	Nursing Notes / Evaluation	Signature
19/11/96		Vermudine 10mg & Stemetil 12.5mg at 8.00 pm	
		Removed by Mr Finlay to be replaced	
		back to Mr Stanton.	
		Reviewed by Dr. Morris (Gastro-enterology) Naso-gastric tube	
		inserted and commenced 75 MLS KLEEN-PREP / HOUR as directed.	
		? Lazy bowel. One evening bowels opened x 2 (Faecal	
		fluid only.) Becoming agitated and weepy during	
		visiting. - NG Tube irritating Deborah. Re-assurred and	
		explanation given re - treatment. Mother present and	
		aware of current management.	
		Midazolam 2mgs given IM at 8.45 pm. to settle as prescribed.	
		For transfer to Ward 62 this pm. Mother aware	
20.11.96		IV fluids as charted. Nil orally.	
		Kleen-prep given x 3 75mls hourly via N/G tube.	
		Voltarol p.r. for pain overnight with effect.	E. McMurtle
	am.	Showered and self caring.	
		IV fluids continue 4 hourly. Nil orally	
		Kleen prep 75ml via N.G. tube regularly.	
		Bowels active but same not clear.	
		Bowels not yet clear	C. McDermott
21.11.96		I.V. fluids continue overnight as charted.	
		Settled night.	E. McMurtle
		IV fluids continue venflon needs rested	
		assisting person by medical staff	
		remains on nil orally	C. McDermott
	1pm	N.G. Removed, IV removed. S/B medical staff discharged home.	

Glasgow Royal Infirmary

Problems / Aims

Name: Deborah Sullivan | Date of Birth | Ward No. | Date

Date	No.	Problem	Aim	Nursing Intervention	Signature	Evaluation Date
14/11/96	1	Pain following ~~surgical~~ procedure	Patient will state she is comfortable	A) Nurse patient in comfortable position B) Administer analgesia as prescribed by doctor & monitor effect with patient C) If analgesia is ineffective, notify doctor & review prescription	[signature]	

Glasgow Royal Infirmary

Problems / Aims

Name Deborah Sullivan | Date of Birth | Ward No's 39

Date	No	Problem	Aim	Nursing Intervention	Signature
14/11/96	3	Nausea / Vomiting due to..	To promote patient comfort & relieve nausea /vomiting	A) Position patient where he/she can be easily observed, with nurse call system to hand B) Position in bed to maintain comfort (N.B. If airway at risk - left lateral position with suction apparatus to hand) C) Provide emesis bowl & ensure patient privacy D) Offer mouthwashes to freshen mouth E) Stay with patient during vomiting period & provide support / reassurance	

GC 5 W ROYAL INFIRMARY UNIVERSITY NHS TRUST
PROBLEMS / AIMS

NAME: D Sullivan HOSPITAL NUMBER: WARD: 39

DATE	NO	PROBLEM	AIM	NURSING INTERVENTIONS	SIGNATURE	EVAL. DATE	DISC. DATE
10/11	(4)	Patient requires assistance when moving due to ...	To minimise the risk of injury to patient and staff	Ascertain patient's weight 11st			
				Ascertain patient's height 5ft 10	TMS		
			To promote patient comfort	Assess and document patient's weight bearing ability			
				Assess and document patient's dependence on nursing staff to mobilise			
				Encourage patient to mobilise within own capabilities			
				Observe for and document any changes in patient's circumstances			
				mobile	[signature]		

Name D Sullivan | Date of Birth | Ward No. 39

Date	No.	Problem	Aim	Nursing Intervention	Signature	Evaluation Date	Disc Date
15/11/96	5	A) Potential for fluid & electrolyte imbalance due to... a) Operative procedure b) Anaesthetic c) Nausea & Vomiting B) Loss of appetite due to surgery	To maintain hydration Electrolytes within normal limits Increase appetite & promote healthy/balanced diet	A) Administer intravenous fluids as prescribed by doctor B) Maintain accurate record of intake & output C) If necessary, administer antiemetics as prescribed & monitor effect with patient D) Dietary restrictions... 14/11/96 NBM 15/11/96 Free fluid 16/11 + Diet [illegible] appetising meals & observe dietary intake	TMG TMG TMG TMG TMG DM	0/G 0/G 0/G DK	

GLASGOW ROYAL INFIRMARY UNIVERSITY NHS TRUST

964876K
SULLIVAN F/S
DEBORAH 07/12/1972
1/1 160 MAIN STREET
BAILLIESTON
G69 6AH

PATIENT ID LABEL

I.V. THERAPY PRESCRIPTION SHEET

0159486

	DATE	FLUID (USE BLOCK LETTERS) / ADDITIVE DRUG	Vol (ml). / Dose (mg)	Route of Admin.	Dur. of Admin.*	SIGNATURE	Serial No. / Batch No.	Time Begun	Given / Added
A	15/11	(N) SALINE	500	IV	4°		96J 22BS	12.40 am	
B	15/11	5% DEXTROSE	500	IV	4°		961 18BL	6.05 am	
C	15/11	5% DEXTROSE	500	IV	4		96118 BL	10.25	
D	15/11	(N) SALINE	500	IV	4°		96J2 2BS	2.50 pm	
E	15/11	5% Dextrose	500	IV	4°	R Griffin			
F	15/11	5% Dextrose	500	IV	4°	R Griffin			
G									
H									
I									
J									
K									
L									
M									
N									
O									

RATE OF FLOW (Drops/Min.) = **VOL.OF FLUID (ml) x 15** / Duration (Mins.)

6.62 (1ml = 15 drops)

Approximate Rate for 500 ml.

1 hr. = 120 Drops/min. 6 hr. = 22 Drops/min.

4 hr. = 30 Drops/min. 8 hr. = 15 Drops/min.

SHEET NO .....

	YES	NO
1. Bed available.	✓	
2. Ward informed.	✓	
3. Patient informed.	✓	
4. Patient's relatives informed.	✓	
5. Clothing packed.	✓	
6. Own medication.	Midazolam Vials x5 TO WARD 62	
7. IV antibiotics.		✓
8. Casenotes, X-rays & all documents collated awaiting transfer.	✓	NO X Rays.
9. Transport ordered.	✓	
10. Nurse escort.		✓
VANCARD		✓
ANSAPHONE		✓

Deborah → 62
Sullivan

GLASGOW ROYAL INFIRMARY UNIVERSITY NHS TRUST

I.V. THERAPY
PRESCRIPTION SHEET

D.
SULLIVAN
PATIENT ID LABEL

0159486

	DATE	FLUID (USE BLOCK LETTERS) / ADDITIVE DRUG	Vol (ml). / Dose (mg)	Route of Admin.	Dur. of Admin.*	SIGNATURE	Serial No. / Batch No.	Time Begun	Given E / Added
A	19.11	(N) SALINE	500	IV	2P		96H2 IBL	4P.25	
B	19.11	5% DEXTROSE	500	IV	4P		96H1 9BK	345 PM	
C	19.11	5% DEXTROSE	500	IV	4P		96I18 BL	6P.20	
D	20.11	(N) Saline	100	IV	4		96J0 IBW	12.15 am	
E	20.11	5% Dextrose	100	IV	4		96I17 BB	5am	
F	20.11	5% Dextrose	100	IV	4		96I1 7BB	10.20 am	
G	20.11	(N) Saline	100	IV	4		96I2 5BU	2.40 pm	
H	20/11	5% dextrose	500	IV	4P		96I17 BB	11pm	
I	21/11	(N) Saline	500	IV	4P		96J22 BS	9am	
J	21/11	5% dextrose	500	IV	4P		96I1 7BB	11.45	
K	21/11	(N) Saline	500	IV	4P				
L									
M									
N									
O									

RATE OF FLOW (Drops/Min.) = VOL.OF FLUID (ml) x 15 / Duration (Mins.)

6.62

(1ml = 15 drops)

Approximate Rate for 500 ml.

1 hr. = 120 Drops/min. | 6 hr. = 22 Drops/min.

4 hr. = 30 Drops/min. | 8 hr. = 15 Drops/min.

SHEET NO .....

964876K
SULLIVAN F/S
DEBORAH 07/12/1972
1/1 160 MAIN STREET
BAILLIESTON
G69 6AH
PATIENT ID LABEL

TEMPERATURE, PULSE, RESPIRATION AND BLOOD PRESSURE CHART

Daily

0160240

Nov 1996

DATE	14th	15	16	17	18	19	20th	21st	22nd					
POST-OP DAY	O/A													

TEMPERATURE

F	C
107.6	42
105.8	41
104	40
102.2	39
100	38
98.4	37
96.8	36
95	35

PULSE / RESPIRATION

200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10

350 340 330 320 310 300 290 280 270 260 250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10

Weight															
No. of Stools		1	0	0	01	01	111	111							

GLASGOW ROYAL INFIRMARY **WARD** 39

PATIENT NAME D Sollitt D.O.B.

RESULTS

Date	Normal	15/11						
WCC	4-11	6.5						
Hb	M 13-18 F 11.5-16.5	12.4						
Plts	150-400	191						
Na	135-145	139						
K	3.5-5.0	3.6						
Cl	97-107	105						
Bic	23-30	26						
Ur	2.5-8.0	4.7						
Cr	40-130	80						
Gluc	<11.0							
Amyl	70-200	167						
Ad Ca	2.2-2.6							
Ca	2.2-2.6							
PO4	0.7-1.4							
T/P	62-82							
Alb	35-55							
Glb	22-33							
Bil	3-22	13						
ALP	80-280	135						
AST	12-48	86						
ALT	5-55	114						
GGT	11-51							
LDH	230-525							
CK	<150							
CRP	<10							
ESR								
APTT	33-50							
PT	13-18							
TCT	6-9							
H+	35-45							
pO2	12-15							
pCO2	4.4-5.6							
HCO3								

Patient name Deborah Sullivan Number WD62

Date	No	Problem	Aim	Intervention	Signature	Review date	
20-11-96		Venflon in-situ; potential for local and systemic infection.	Minimise the risk. Detect early.	Ask patient to report pain, swelling or discharge at venflon site. Inspect cannula site daily. Inform medical staff of any inflammation, discharge or dysfunction. Record venflon site condition - see below. Review with medical staff the need for cannula and need to change cannula. Maintain a dry dressing at insertion site.	E. McM.	ongoing	

Review date	Day	Inflammation at site 0 <1 1-2 2-3 >3 cms	Discharge & Amount Blood/Serous Pus + ++ +++	Comment	Medical staff informed	Signature	Date wh removed Signatur
21-11-96	1	0	0			cmedermott	
	2						
	3						
	4						
	5						

PROFESSIONAL NURSE

Waterlow Pressure Sore Prevention and Treatment Policy

Ring sc[illegible]n table, add total. Several scores per category can be used.

ild/weight height	*	Skin type Visual risk area	*	Sex Age	*	Special risks	*
erage	(0)	Healthy	(0)	Male	1	Tissue malnutrition	*
ove average	1	Tissue paper	1	Female	(2)		
ese	2	Dry	1	14-49	(1)	e.g. Terminal cachexia	8
low average	3	Oedematous	1	50-64	2	Cardiac failure	5
ntinence	*	Clammy (Temp)	1	65-74	3	Peripheral vascular disease	5
		Discoloured	2	75-80	4	Anaemia	2
mplete/ ıtheterised	(0)	Broken/spot	3	81+	5	Smoking	1
casional incon- ıence	1	Mobility	*	Appetite	*	Neurological deficit	*
ılly incontinent of ieces	2	Fully	0	Average	0	e.g: Diabetes, MS, CVA, motor/sensory, paraplegia	4 6
ubly Incont.	3	Restless/fidgety	1	Poor	(1)		
		Apathetic	2	N.G tube/fluids only		Major surgery/trauma	*
		Restrictive	3	NBM/anorexic	2	Orthopaedic - below waist, spinal	5
		Incontinent	4		3	On table > 2 hours	5
		Chairbound	5			Medication	*
						Cytotoxics, high dose steroids, anti inflammatory	4

Score 10+ at risk
15+ high risk
20+ very high risk

BritCair supporting education in Wou[illegible]

BritCair WOUND CARE

Remember: tissue damage o[illegible]rs prior to admission, in casualty. A seated patient is also at risk. © Waterlow 92

ASSESSMENT: (See over) If a patient falls into any of the risk categories preventative nursing is required.
A combination of good nursing techniques and preventative aids will definitely be necessary

Prevention:
Preventative aids:
Special mattress/bed: 10+ Overlays or specialist foam mattresses
15+ Alternating pressure overlays, mattresses and bed systems.
20+ Bed systems: fluidised, bead, low air loss and alternating pressure mattresses.
Note: Preventative aids cover a wide spectrum of specialist features. Efficacy in the 20+ area should be judged on the basis of independent evidence.
Cushions: No patient should sit in a wheelchair without some form of cushioning. If nothing else is available, use the patient's pillow.
10+ 4" Foam cushion
15+ Specialist gel and/or foam cushion
20+ Cushion capable of adjustment to suit individual patient
Bed Clothing: Avoid using plastic draw sheets, inco pads and tightly tucked in sheets/sheet covers, especially when using specialist bed and mattress overlay systems.
Duvet - plus vapour permeable cover

Nursing Care:
General: Frequent changes of position, lying or sitting
Use of pillows?
Pain: Appropriate pain control
Nutrition: High protein, vitamins, minerals
Patient handling: Correct lifting technique
Hoists
Monkey Pole
Transfer devices
Patient contact Aids: Heel sheepskins
Bed cradle
Operating table: Theatre/A&E trolley: 4" cover plus adequate protection
Skin care: General hygiene, NO rubbing
Correct lifting and positioning
Cover with an appropriate dressing

If treatment is required, first remove pressure

Wound Classification

Blanching hyperaemia	STAGE 1	Is the wound RED?	no → yes	Semi permeable film, hydrocolloid sheet
Non-blanching hyperaemia	STAGE 2	Is the wound RED, clean but not healed?	no → yes	Hydrocolloid, alginate, hydrogel, silicone polymer foam (deep)
Ulceration progresses	STAGE 3	Is wound YELLOW/infected/inflamed	no → yes	Alginate, hydrogel, hydrocolloid
Ulceration extends	STAGE 4	Infected?	no → yes	Alginate ribbon or rope, non-adherent topical antimicrobial dressing, polysaccharide paste
Infective necrosis	STAGE 5	Is wound black/necrotic?	no → yes	Debride – surgical excision, hydrocolloid, hydrogel, enzymatic treatment

BritCair - Division of CV Laboratories Limited, ALDERSHOT, Tel: (0252) 333114. Subsidiary of MERCK & Co., Inc., Rahway, NJ, USA.

DEBORAH SULLIVAN WD62 Nov 1996

TE	SCORE	STAGE OF SORE	INTERVENTIONS	SIGNATURE	REVIEW DATE
0·11·	4		Mobile independently	E McMurdo	23·11·96

L6H

Glasgow Royal Infirma
PATIENT CARE PLAN - W D62

TE: 20/11/1996 TIME: 04:22:56
atient Name .... SULLIVAN, DEBORAH
atient No 964876
atient DX ..... INVEST ABDOMEN 789
ed Number 000023
dmit Date 20/11/1996
ate of Birth ... 07/12/1972

atient Age/Sex ... 023/11/13 / Female
imary/Named Nurse. ANNE KINSELLA
onsultant Name.... MR STANTON
ignature
.....

04BAE

Problem / Need	Goals	Interventions	Evaluation
PROB # 01 20/11/1996 Potential complications of intravenous infusion ELAINE MCMURTRIE	Prevention or early detection of same CONTINUING REVIEW: 23/11/1996 SELECTED: 20/11/1996 ELAINE MCMURTRIE	Administer fluids as prescribed according to hospital policy Observe flow rate and regulate as per prescription Observe insertion site for signs of pain/ inflammation/ infiltration and report same to doctor Commence fluid balance chart, reporting any imbalance to medical staff	
PROB # 02 20/11/1996 Patient requires assistance when moving ELAINE MCMURTRIE	To promote patient comfort and minimise the risk of injury to patient and staff CONTINUING REVIEW: 23/11/1996 SELECTED: 20/11/1996 ELAINE MCMURTRIE	Specify patient's weight... Specify patient's height... 5FT 10INCHES 20/11/1996 ELAINE MCMURTRIE Assess and document weight bearing ability Ensure the use of ... nurses to assist when moving INDEPENDENT ON ADMISSSION 20/11/1996 ELAINE MCMURTRIE Specify the type of lift required when moving in bed... INDEPENDENT ON ADMISSION 20/11/1996 ELAINE MCMURTRIE	

[MORE]

[(c) SASHA CARE INTERNATIONAL, INC. Computer Generated form]

Problem / Need	Goals	Interventions	Evaluation
		Specify the type of lift required when moving from chair/ commode... INDEPENDENT ON ADMISSION 20/11/1996 ELAINE MCMURTRIE Specify the type of equipment required to assist with moving (Eg. Patslide) SLINGS/SLIP SHEETS/EASISLIDE 20/11/1996 ELAINE MCMURTRIE	
PROB # 03 20/11/1996 Nausea/ vomiting ELAINE MCMURTRIE	To promote patient comfort / relieve nausea/ vomiting CONTINUING REVIEW: 23/11/1996 SELECTED: 20/11/1996 ELAINE MCMURTRIE	Position patient where he/ she can be easily observed with nurse call system to hand Position in bed to maintain comfort (NB If airway is at risk ... left lateral position with suction apparatus to hand) Provide emesis bowl and ensure patient privacy Offer mouthwashes to freshen mouth Stay with patient during vomiting period and provide support/ reassurance Monitor and record amount of gastric loss Test same if appropriate Administer antiemetics as prescribed and monitor effect of same with patient	

[MORE]

PRESCRIPTION SHEET No.

REGULAR PRESCRIPTIONS – INJECTIONS

Pharmacy Use		Date Started	MEDICINE (Block Capitals)	DOSE	ROUTE	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times	Prescribers Signature (Full)	DISCONTINUED: Date	Signed
	A	14/11	PERIDOME	100mg	IM			4.0 PRN			PRN							
	B	14/11	STEMETIL	12.5mg	IM			6-8 PRN			PRN	Nausea						
	C	19/11	MIDAZOLAM	2mg	IM			4-6 PRN										
	D																	
	E																	
	F																	
	G																	

REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

	H	16/11/96	LASIX	20mg	O												
	J	16/11/96	CISAPRIDE	10mg	O												
	K	19/11/96	KLEAN PREP	75ml	PO	Every hour until clear											
max 150 mg in 24 hrs		19/11/96	VOLTAROL	100mg	PR	6-8 hourly											
	M	19/11/96	~~Temazepam~~	10mg	PO								✓			20/11	AMACF
	N	20/11	TEMAZEPAM	20mg	ORAL								✓			AMACF	
	O																
	P																
	R																
	S																
	T																
	V																

ONCE ONLY PRESCRIPTIONS

TE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN
19/11		Phosphate enema	X1	PR	R. Griffin		9.30
19/11		Picolax	½ sachet	O	R. Griffin	BSRN	10.30
19/11		Picolax	½ sachet	O	R. Griffin	BSRN	1p
19/11		~~Klean Prep~~					
19/11	6pm	Co-codamol	2 tabs	O	C McDermott	C McDermott	6pm

DIET

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

KNOWN MEDICINE SENSITIVITIES 1. 2.

WARD	NAME OF PATIENT	AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
9	964876K SULLIVAN F/S DEBORAH 07/12/1972				964876K	~~PROF HARRIS~~

HOSPITAL

MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

DATE	REGULAR PRESCRIPTIONS: 6 a.m.	8 a.m.	10 a.m.	12 m.d.	2 p.m.	4 p.m.	6 p.m.	10 p.m.	12 m.n.	OTHER TIMES	COMMENTS ON DISCREPANCIES
15/11/96	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	A@09.25	A+B 4.25am KR A+B at 2.50pm A at 8.10pm SB
16/11/96		H J SM			J JM			J BS		A+B	A+B at 12.15am A@ 6.55am JD A+B at 11AM WMC. A 4pm BS A+B 8p BS
17/11/96		H J BS			D BS		A PM	A+B 10pm KR J PM		A	A at 12.15am EL. A+B 5am KR. A@ 9.15am CA A+B 1.45 BS A at 5.45pm
18/11/96		H J PMC			J BS			J PC		(A)	A+B at 4.15 am EL A 8.45 am BS A@ 6.35 HW A+B at 2.30pm SB. Adm 10pm
19/11/96		H J Asked 20 Dar PC M			L KL			C J K M PMC EMC K	EMC		A AT 0235 C at 8.45pm
20/11/96		H J K. Left 9.15 Ret 10.30. AK	AK		J AK			σ (M) C EMC		L@2.50am (M) = not required KR 2am N@11pm EMC	
21/11/96		H J CMCH			J KR					L@4.10am EMC	

NAME	UNIT NUMBER	WARD	KEY:
964876K SULLIVAN F/S DEBORAH 07/12/1972 1/1 160 MAIN STREET BALLYSTON	964876K	39	CODE LETTER CIRCLED E.G. (A) = MEDICINE REFUSED AND MEDICAL STAFF INFORMED CODE LETTER SCORED E.G. X = PATIENT ABSENT

FORM MR1 10/90

Patient Name. Debbie Sullivan

Welcome to Ward 39

We organize patient care using a system called **Named Nursing**. This is to enable you to have your own nurse and her associates who will look after you from admission to discharge. If you or your relatives have any questions you will be directed to them. We hope that this will make your stay in hospital easier for you.

Your Named Nurse is :

S/N S. BARCLAY.

Your Associate Nurses are :

Ward Sister

SR. BOARDMAN.

Glasgow Royal Infirmary Univers NHS Trust

Wate score 6
NAMED NURSE S/N S. BARCLAY

Profile/Careplan for 24 / 72 hour stay

DATE OF ADMISSION	TIME	WARD	TYPE OF ADMISSION	TRANSFER FROM	ADMITTING NURSE
1.11.96.	12.30AM	39	EMERGENCY / PLANNED / OTHER		M A Mitchell

SURNAME
964876K
SULLIVAN F/S
DEBORAH 07/12/1972
1/1 160 MAIN STREET
BAILLIESTON
G69 6AH

FORENAME

ADDRESS

TEL Nos.

WISHES TO BE KNOWN AS

DATE OF BIRTH 7-12-72	MENSTRUAL CYCLE	ALLERGIES	BASELINE RECORDS
AGE 23.	PARA	NONE KNOWN.	HEIGHT / WEIGHT / B.P. 110/70 / TEMP. / PULSE 80. / RESPIRATION / DENTURES NO
RELIGION R/C.	URINALYSIS M.S.Sed Prot + Bld +	CHEMICAL DEPENDANCY: None. PROSTHESIS: —	
G.P. AND ADDRESS DR JGS. GOWDIE. EASTERHOUSE H/C.			

NEXT OF KIN KATHLEEN SULLIVAN.
ADDRESS 187 COMMONHEAD RD, GLASGOW G.34
RELATONSHIP MOTHER.
TEL. Nos. 771. 3743.

SOCIAL CIRCUMSTANCES		STORAGE OF VALUABLES	STORAGE OF DRUGS
OCCUPATION HANDLER FOR INSURANCE CO LIVES WITH: FATHER. TYPE OF HOUSE	SUPPORTING SERVICES NONE.	none. RETURNED	None. RETURNED

REASON FOR ADMISSION	PAST MEDICAL HISTORY	CURRENT DRUG THERAPY
Admitted with severe abdominal pain nausea & vomiting. Discharged from Wd 61 last week.	APPENDICECTOMY. MARCH 96.	TYLER.
	CHOLE CYSTECTOMY. APRIL "	
	ERCP.	LOSEC.
	SEVERAL PREVIOUS ADMISSIONS.	
? GASTRIC OUTLET OBSTRUCTION.		
? SPHINCTER of ODDI DYSFUNCTION		

PATIENTS NAME [illegible]

CONSULTANT Mr Stuart.

0280470

ASSESSMENT

SAFETY AND COMFORT	BREATHING & CIRCULATION	MAINTAINING BODY TEMPERATURE	EAT & DRINKING	MOBILITY
Nauseous sens. Pain on admission	No Problems. Bruises to forearm	No problems.	Poor appetite. Occasional Vomit.	Fully mobile

PERSONAL HYGIENE	ELIMINATION	SLEEP	COMMUNICATION (INCLUDING FEARS & ANXIETIES)
Attends to own.	Bowels Not Regular	Usually Sleeps well	No problems.

SKIN CONDITION

DATE	No.	PROBLEM	AIM	INTERVENTION	SIGNATURE	EVALUATION	DISC
1.11.96	1	Pain	See Notes				
	2	Nausea & Vomiting.					
	3	Dehydration					
	4	Ven flow.					
	5	Loss of Independence					
	6	Hygiene.					

DATE	No.	PROBLEM	AIM	INTERVENTION	SIGNATURE	EVALUATION	DISC

DATE	No.	EVALUATION/NURSING NOTES	SIGNATURE
1-11-96		Very distressed on admission. Flushed & toxic looking	
		Ophthoxeil at that time.	
	1	Pethidine 75mgs IM. at 12mn +	
	2	Stemetil 12.5 mgs. in ATE.	
	3	I.V. fluids commenced.	
	1	Voltarol 50mgs 100 mgs P.R at 2am.	J M Mitchell
		Settled well thereafter.	
	1	Restressed by pain on awakening 6am 4am	
		Pethidine 100 mgs IM. at +	
	2	Stemetil 12.5 mgs.	J M Mitchell
		Pethidine 100mgs I.M & Stemetil 12.5 mgs given I.M @ 6.55am	C Anderson
8.30am WIR		SIB Mr Stuart - to be PR by medical staff - ? for phosphate enema	SB
		Pethidine 100mg IM 12pm + again at 4.40pm	BS
		SOE seeing daff IV fluids continue 4.0 . Remains strong.	
		Seen by Mr Stuart Analgesia reviewed.	

Glasgow Royal Infirmary
University NHS Trust

Nursing Notes

Name: DEBORAH SULLIVAN | Hospital Nos: 9648576K | Ward: 39

Date	Problem No.s	Nursing Notes / Evaluation	Signature
2·11·96.		Complaining of severe abdominal pain. Pavadol given with no effect. Seen by SJ. Voltarol 75 Mgs IM. at 02:30 hrs + Stemetil 12·5 Mgs.	
		IV. fluids Continue. Settled well following analgesia.	
		~~Nausea Vomiting Fears of Peritonitis~~. Aspirex evil last Am.	M Mitchell.
		O/A Mr Stuart - For ~~NBM~~ oral fluids.	BSheng
		Stemetil 12·5mg IM @ 11³⁰ am	
		Self caring. ↳: hygiene	
		IV fluids continue till oral intake improves.	
		Apyrexial. All care continuing.	BSheng
pm		Settled evening.	
	1.	Taking oral analgesia with fair effect.	
	2.	No further nausea / vomiting	
	3	IV Fluids continue ½°. Taking small amount of oral fluid.	
		Apyrexial this evening	SB-S
3·11·96.		Complaining of indigestion, vomited small amount & clear fluid. Reviewed by medical staff & given Losec 20 mg with relief. Slept well. IV fluids continue	
8³⁰ am	W/R	S/B Mr Stuart - now allowed fluids and diet	
		? For discharge home today if patient wants	SB-S
		- IV fluids to be discontinued later	
am		Self caring morning. All care as planned	
	①	No complaining of any pain	
	③	IV fluids discontinued. Venflon removed. Taking fluids and diet.	
		Apyrexial this morning	

Name: Deborah Sillars | Hospital Nos: 9648766K | Age: 39

Date	Problem No.s	Nursing Notes / Evaluation	Signature
3/11/96		For discharge home today - Barium swallow through appointment already given. NO OPD required - already has OPD for January for Mr Finlay.	SB-J

	Results
WBC	4 - 11
RBC	4.50-5.90
HGB	13.5-16.5
HCT	40-50
SCT	33-50
MCV	83-98
MCH	27-32
MCHC	33-36
RDW	11.5-14.5
PLT	150-400
MPV	7.2-11.1
Gran Ct	2.2-7.6
Gran %	40-74
POC	0.7-7.0
T/P	6.2-8.2
Alb	3.5-5.5
Globs	2.2-3.3
BIL	0.3-1.2
ALP	80-250
AST	12-48
ALT	7-55
LDH	270-525
Chl	4150
TCT	4.36
CRP	
HT	7.37-7.43
pO_2	12-15
pCO_2	4.4-5.6
S. HCO_3	
ESR	

DEBORAH SULLIVAN

Glasgow Royal Infirmary

Problems / Aims

Name: DEBORAH O'SULLIVAN | Date of Birth: | Ward No: 89 | Date:

Date	No	Problem	Aim	Nursing Intervention	Signature	Evaluation Date
1-11-96	1	Pain ~~following surgical procedure~~ Duc to.	Patient will state she is comfortable	A) Nurse patient in comfortable position B) Administer analgesia as prescribed by doctor & monitor effect with patient C) If analgesia is ineffective, notify doctor & review prescription		

Glasgow Royal Infirmary

Problems / Aims

Name DEBORAH O' SULLIVAN | Date of Birth | Ward No: 39

Date	No	Problem	Aim	Nursing Intervention	Signature
14.1.96.	2	Nausea / Vomiting due to..	To promote patient comfort & relieve nausea /vomiting	A) Position patient where he/she can be easily observed, with nurse call system to hand B) Position in bed to maintain comfort (N.B. If airway at risk left lateral position with suction apparatus to hand) C) Provide emesis bowl & ensure patient privacy D) Offer mouthwashes to freshen mouth E) Stay with patient during vomiting period & provide	M. A. Mitchell

Glasgow Royal Infirmary

Problems / Aims

9
F

Name DEBORAH O'SULLIVAN | Date of Birth | Ward No.s 39 | Date

Date	No.	Problem	Aim	Nursing Intervention	Signature	Evaluation Date	Disc Date
1/11/96	3	A) Potential for fluid & electrolyte imbalance due to.. a) Operative procedure b) Anaesthetic c) Nausea & Vomiting	To maintain hydration Electrolytes within normal limits Increase appetite & promote healthy/balanced diet	A) Administer intravenous fluids as prescribed by doctor B) Maintain accurate record of Intake & output C) If necessary, administer antiemetics as prescribed & monitor effect with patient D) Dietary restrictions. 1/11/96 - Fast 2/11/96 F. Fluids	Dr A Mitchell M Mitchell M Mitchell		
		B) Loss of appetite due to surgery		E) When appetite returns encourage appetising meals & observe dietary intake.			

D. O'SULLIVAN

WO 39

Patient name			Hosp Number				
Date	No	Problem	Aim	Intervention	Signature	Review date	
1-11-96	4	Venflon in-situ; potential for local and systemic infection.	Minimise the risk. Detect early.	Ask patient to report any pain, swelling or discharge at venflon site. Inspect cannula site daily. Inform medical staff of any inflammation, discharge or dysfunction Record venflon site condition - see below. Review with medical staff the need for cannula and need to change cannula. Maintain a dry dressing at insertion site.	M. A. Mitchell		

Review date	Day	Inflammation at site 0 <1 1-2 2-3 >3 cms	Discharge & Amount Blood/Serous Pus + ++ +++	Comment	Medical staff informed	Signature	Date whe removed Signatur
2/11/96	1						
	2						
	3						
	4						

Glasgow Royal Infirmary

Problems / Aims

Date of Birth

Ward No 39

Name / Date	No	Problem	Aim	Nursing Intervention	Signature	Date Evaluation Date
1.11.96	5	Loss of independence & self esteem due to reliance on nursing staff / family	To restore patient's confidence in him/herself & others	1) Ensure patient is informed of all aspects of care & reasons for it 2) Encourage patient to participate in as many activities of daily living as possible 3) Involve patient in care planning / decision making 4) Educate patient/family re new / initial capabilities 5) Encourage patient to wear own night clothes as soon as possible	M. A. Mulcahy	

...w Royal Infirmary

s / Alms

D.O SULLIVAN

Hospital No.

Ward No. 39

	Problem	Aim	Nursing Intervention	Signature	Evaluation Date	Init. Date
6	Unable to attend to own hygiene unassisted due to weakness & discomfort following operation	To maintain a standard of hygiene which is acceptable to the patient	A) Post operative wash & mouthwash B) Offer mouthwash / water to brush teeth C) Specify daily hygiene requirements...	SN	9/9	

blems / Aims

Debbie Sullivan

Hospital Nos. 3 and No.s 39

No.	Problem	Aim	Nursing Intervention	Signature	Evaluation Date	Disc Date
11-96-7	Risk of development of pressure sore due to	Patient's skin will remain healthy & intact	A) Assess the risk of tissue breakdown using the Waterlow Scale B) Observe pressure points for signs of redness or tissue breakdown C) Keep skin dry & linen wrinkle free D) Change of position Scored (6)	Sar	9/6	

Waterlow Pressure Sore Prevention and Treatment Policy

Ring scores in table, add total. Several scores per category can be used.

	*		*		*		*
age	0	Healthy	0	Male	1		
e average	1	Tissue paper	1	Female	2		*
se	2	Dry	1	14-49	1	e.g. Terminal cachexia	8
w average	3	Oedematous	1	50-64	2	Cardiac failure	5
	*	Clammy (Temp)	1	65-74	3	Peripheral vascular disease	5
		Discoloured	2	75-80	4	Anaemia	2
plete/	0	Broken/spot	3	81+	5	Smoking	1
leterised	1		*		*		*
sional incon-						e.g: Diabetes, MS, CVA, motor/sensory, paraplegia	4 6
nce		Fully	0	Average	0		*
/incontinent of	2	Restless/fidgety	1	Poor	1		
ces		Apathetic	2	N.G tube/Iluids	2	Orthopaedic - below waist, spinal	5
bly incont.	3	Restrictive	3	only	3	On table > 2 hours	5
		Inert/traction	4	NBM/anorexic			*
		Chairbound	5			Cytotoxics, high dose steroids, anti inflammatory	4

Score
15+ high risk
20+ very high risk

BritCair supporting education in Wound Management

FORM 11 1672

	ABILITY		WHEN MOVING IN BED			MANOEUVRE WHEN MOVING FROM CHAIR/ COMMODE		NURSES	REQUIRED TO ASSIST WITH MOBILISING	BED (✓)	CHAIR/ COMMODE (✓)	BATH (✓)
	Able to weight bear and balance		Australian Hold			Front Hold			Handling Sling			
HEIGHT	Able to weight bear and balance with equipment		Anterior Hold			Side Hold			Turning Disc			
WEIGHT	Specify Equipment: (eg Zimmer)		Rolling			Through Arm Hold			Hoist			
	Weight bears but unstable (eg Dizzy)		Turning						Specify Hoist Type			
	Specify :								Pat Slide			
	Unable to weight bear								Easy Slide			
	No of Nurses required to assist when mobilising								Rollboard			
									Slip Sheets			

GLASGOW ROYAL INFIRMARY UNIVERSITY NHS TRUST

I.V. THERAPY
PRESCRIPTION SHEET

DEBORAH
SULLIVAN
WO 39.
PATIENT ID LABEL

0159486

	DATE	FLUID (USE BLOCK LETTERS) / ADDITIVE DRUG	Vol (ml). / Dose (mg)	Route of Admin.	Dur. of Admin.*	SIGNATURE	Serial No. / Batch No.	Time Begun	Given / Added
A	31/10	(N) SALINE	500	2°	IV		96125 BL	12 am	
B	31/10	(N) SALINE	500	2°	IV		961 16BK	3am	
C	31/10	5% DEXTROSE	500	4°	IV		96H29 BP	5.08 am	
D	31/10	5% DEXTROSE	500	4°	IV		96H09 BP	10.40 am	
E	1/11	N. Saline	500	4°	IV	R Griffin	96116 BK	2.55 pm	
F	1/11	5% Dextrose	500	4°	IV	R Griffin	96429 BD	8.30 pm	
G	1/11	5% Dextrose	500	4°	IV	R Griffin	96H 29BP	12.30 am	
H	2/11	(N) SALINE	500	4°	IV		96I 1 6BK	4.38 am	
I	2/11	5% DEX	500	4°	IV		96H 29BP	1130	
J	2/11	5% DEX	500	4°	IV		96H 29 BP.	4.05 pm	
K	2/11/96	N. Saline 0.9%	500	4°	IV		96I16 BK	8.30 pm	
L	2/11/96	5% DexAmp	500	4°	IV		96H 29BP	12.30	
M	2/11/96	5% DexAmp	500	4°	IV		96H1 9BK	4.30 am	
N	2/11/96	(N) SALINE	500	4°	IV				
O	2.11.96	5% DEXTROSE	500	IV	4h				

RATE OF FLOW (Drops/Min.) = **VOL.OF FLUID (ml) x 15** / Duration (Mins.)

6.62 (1ml = 15 drops)

Approximate Rate for 500 ml.
1 hr. = 120 Drops/min.
4 hr. = 30 Drops/min.
6 hr. = 22 Drops/min.
8 hr. = 15 Drops/min.

SHEET NO .....

HOSPITAL
PRESCRIPTION SHEET No.

REGULAR PRESCRIPTIONS – INJECTIONS

Pharmacy Use		Date Started	MEDICINE (Block Capitals)	DOSE	ROUTE	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times	Prescribers Signature (Full)	DISCONTINUED: Date	Signed
	A	31/10/96	~~PETHIDINE~~	~~75mg~~	~~IM~~			4-6	PRN		PRN					~~ATBlair~~	31.10	~~Clarke~~
	B	31/10/96	STEMETIL (PROCHLOPERAZINE)	12.5mg	IM			6-8	PRN		NAUSEA					ATBlair		
	C	31-10-96	PETHIDINE	100mg	IM			4 hrly	prn		PAIN					~~Clarke~~	2-11	Clarke
	D	1/11/96	VOLTAROL	75mg	IM			12°	PRN		PAIN					ATBlair		
	E																	
	F																	
	G																	

REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

	H	31-10-96	DICLOFENAC Na+ Supp.	100mg	PR				✓								
	J	~~31-10-96~~	PARACETAMOL	1g	PO			4-6 hrly								i/m	ATBS
	K	1/11/96	COMPROXAMOL	2TABS	PO			4-6°	PRN		STAT					ATBlair		
	L	2/11/96	LOSEC	20mg	ORAL													
	M																	
	N																	
	O																	
	P																	
	R																	
	S																	
	T																	
	V																	

ONCE ONLY PRESCRIPTIONS

DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN
1/10/96	12 AM	PETHIDINE	75mg	IM	ATBlair	Deborah Sullivan	2356
1/10/96	12 AM	STEMETIL	12.5mg	IM	ATBlair	Deborah Sullivan	2356
1-11-96	01:15	DICLOFENAC Na+	100 mg	PR	[illegible]	Deborah Sullivan	2AM
1-11-96	1600 PM	GAVISCON	10 mls	ORAL	SN	SN	4pm
1-11-96	10 PM	[illegible]	10 mls	O	[illegible]	[illegible]	10 PM
2-11-96	11 pm	OMEPRAZOLE	20mg	oral	[illegible]	[illegible]	11 PM

DIET

DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN

964876K
SULLIVAN F/S
DEBORAH 07/12/1972
1/1 160 MAIN STREET
BAILLIESTON
G69 6AH

WARD		AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
39	AN	23				STUART

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

KNOWN MEDICINE SENSITIVITIES 1.

HOSPITAL

MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

DATE	REGULAR PRESCRIPTIONS: 6 a.m.	8 a.m.	10 a.m.	12 m.d.	2 p.m.	4 p.m.	6 p.m.	10 p.m.	12 m.n.	OTHER TIMES	COMMENTS ON DISCREPANCIES
1/11/96	Initial	Initial	Initial	(H) Initial	Initial	CE 4pm Initial	Initial	J Initial	D Initial	Initial	B 8.C 6.55pm (H) - refused C 12.15, 8.5
2/11/96				B @ 1130 KR	H KR						Kat 5pm SB
2/11/96								K 9pm	SA		BQ 9pm SALLISON
3/11/96	K L	SB									

NAME: DEBORAH SULLIVAN

UNIT NUMBER:

WARD: 39

KEY: CODE LETTER CIRCLED E.G. (A) = MEDICINE REFUSED AND MEDICAL STAFF INFORMED

CODE LETTER SCORED E.G. X = PATIENT ABSENT

FORM MR1 10/90

Pharmacy Department
Glasgow Royal Infirmary

CONFIDENTIAL

Discharge Medicine Order

964876K
SULLIVAN F/S
DEBORAH 07/12/1972
1/1 160 MAIN STREET
BAILLIESTON
G69 6AH

Dear GP,
Your patient was discharged from Ward 61 on 24/10/96
Listed below are the medicines supplied by the Pharmacy Department.
A seven day supply was made unless otherwise stated.

If your require any further details, please contact:
Ward Clinical Pharmacist : FIONA MONTGOMERY
Tel : 0141 211 4000, Page : 2013

Medicines Supplied on Discharge (Admission Drugs and Newly Started Drugs)

Medicine	Form	Dose	Frequency	Duration	Days Supplied	New Drug (✓)	New Dose (✓)	Reason (if known)	Dispensing Details (Pharmacy Only) (Brand, Strength, BN, Quantity)
CO PROXAMOL	TABS	TWO	4-6 hourly PRN	REVIEW	7			PAIN	
MICROGYNON 30	TABS	1	daily as per pack	—		✓		OWN SUPPLY	
CISAPRIDE *	TABS	10mg	tds -30mins before meals	7		✓		REDUCED GASTRIC EMPTYING	

Discontinued Medicines

Medicine	Reason (if known)
PETHIDINE	
OMEPRAZOLE	NO INDICATION FOUND ON INVESTIGATION

Further Information

*CISAPRIDE : commence with 10mg daily increasing to twice daily after two weeks · D/W MR N MURRAY.

☐ Non CRC Tops ☐ Compliance Aid ☐ Large Type ☐ Admin Times

Ordered by: Pharmacist	Date : 24 · 10 · 96	Dispensed by :	Checked by :

Glasgow Royal Infirmary University NHS Trust

Profile/Careplan for 24 / 72 hour stay

Ward 36

NAMED NURSE } S/N BARCLAY.

DATE OF ADMISSION 10/10/96	TIME 2.45 am	WARD 36	TYPE OF ADMISSION: EMERGENCY / PLANNED / TRANSFER FROM / OTHER		ADMITTING NURSE

SURNAME: 964876K SULLIVAN F/S
FORENAME: DEBORAH 07/12/1972
ADDRESS: 1/1 160 MAIN STREET BAILLIESTON G69 6AH

TEL Nos. 0141 771 3401

WISHES TO BE KNOWN AS

DATE OF BIRTH 7/12/72
AGE 23
RELIGION R. C.
MENSTRUAL CYCLE
PARA MSSU 10/10
URINALYSIS ++ ketone non haem blood + Prot.

G.P. AND ADDRESS 531-8170
DR JGS GOLDIE
EASTERHOUSE H-C.
9 AUCHINLEA RD G34.

ALLERGIES: NOTHING KNOWN.

CHEMICAL DEPENDANCY | PROSTHESIS

BASELINE RECORDS

HEIGHT	5'10½
WEIGHT	11st.
B.P.	100/70
TEMP.	36.5°C
PULSE	72
RESPIRATION	16
DENTURES	No.

NEXT OF KIN: KATHLEEN SULLIVAN
ADDRESS: 187 COMMONHEAD RD., GLASGOW G34
RELATONSHIP: MOTHER (AWARE OF ADMISSION).
TEL. Nos. 771 3763

SOCIAL CIRCUMSTANCES

OCCUPATION: INSURANCE CLERK
LIVES WITH: FATHER.
TYPE OF HOUSE: /

SUPPORTING SERVICES: /

STORAGE OF VALUABLES: / RETURNED

STORAGE OF DRUGS: / RETURNED

REASON FOR ADMISSION	PAST MEDICAL HISTORY	CURRENT DRUG THERAPY
Increased abdominal pain, colicky in RUQ radiating to epigastrium and through to back, nausea & vomiting x10 over 24hrs. Diarrhoea for 5 wks	Appendicectomy MARCH 1996.	LOSEC 20mg.
	LAP/CHOLECYSTECTOMY APRIL 1996.	MAXOLON.
	Recurrent ABDOMINAL pain since surgery.	AMOXYCILLIN (SINCE TUES FOR CHEST INFECTION)
	TONSILLECTOMY JULY '93.	
	KNOWN IRRITABLE BOWEL.	
10/10/96 ERCP Amy 168. – SOD. WCC 11·8		
15-10-96 GASTROSCOPY		

PATIENTS NAME DEBORAH SULLIVAN.

CONSULTANT ~~GOLDIE~~

0280470

ASSESSMENT

SAFETY AND COMFORT	BREATHING & CIRCULATION	MAINTAINING BODY TEMPERATURE	EATING & DRINKING	MOBILITY
PETHIDINE 100mg im 2am STEMETIL 12.5mg im 2.15am in A+E	7 cigarettes d/y.	NO problems.	NORMAL DIET. RARE ALCOHOL.	AMBULANT.

PERSONAL HYGIENE	ELIMINATION	SLEEP	COMMUNICATION (INCLUDING FEARS & ANXIETIES)
SELF CARING. SKIN CONDITION INTACT.	Frequency. Diarrhoea for 5/7/52.	—	—

DATE	No.	PROBLEM	AIM	INTERVENTION	SIGNATURE	EVALUATION	DISC
10/10/96	1	PAIN					
	2	FLUID IMBALANCE					
	3	VENFLON	See folder.				
	4	N+V					
	5	L+H					

DATE	No.	PROBLEM	AIM	INTERVENTION	SIGNATURE	EVALUATION	DISC

DATE	No.	EVALUATION/NURSING NOTES	SIGNATURE
10/10/96		Uncomplaining of pain following analgesia + antiemetic in A+E. To remain NBM at present. ? IV fluids to commence. Please obtain stool, mouth sputum for C/S. For Scan in am ? ERCP	HWalsh
			HWalsh.
		Pethidine 100mgs IM + ~~Stemetil~~ 12.5mgs IM at 5-45am	SB. J
WR		SIB Prof Imrie - for ERCP today, for LFT's. consent form signed	
		~~[redacted]~~ checklisted, awaiting theatre.	
11.30 am		Returned from ERCP drowsy but rousable on return.	
	①	Uncomplaining of any pain.	
		BP 110/60 P74 T36.5°c	
	②	IV fluids continue 4°. Remains Fasting.	
		ERCP shows normal pancreatic duct ? SOD - needs quantitative	
		HIDA scan and serum amylase at 1pm to be done	
		~~[redacted]~~ + No diarrhoea - still to obtain a stool specimen	
		Still to obtain a sputum specimen	SB. J

DATE OF REQUEST	SPECIMEN/INVESTIGATION	PREPARATION	DATE COMPLETED	SIGNATURE
10/10/16	MSSU ✓		10/10	[signature]
	STOOL MC&S			
	SPUTUM			
10/10	? U/S	NBM since admission		
	? ERCP.	NBM. since admission.		

DISCHARGE PLAN

ARRANGED		SIGNATURE	DATE
TRANSPORT			
DISTRICT NURSE			
O.P.D.			
DISCHARGE DRUGS			
OTHER			

HEALTH EDUCATION

SIGNATURE DATE

INSTRUCTIONS TO PATIENT

SIGNATURE DATE

OTHER INFORMATION

SIGNATURE DATE

PATIENTS NAME

CONSULTANT

GLASGOW ROYAL INFIRMARY

Form No. H1238.

DATE	NURSING REPORT	SIGNATURE
10/10/96	Pethidine 100mg given IM at 2-5 Gary have now taken over by Mr Murray. May have free fluids and light diet as tolerated to d/c 5mg GTN patch applied.	Ewood.
pm	Pethidine 100mg IM, Stemetil 12.5mg IM @ 6.50pm Oral analgesia to be prescribed. Tolerating oral fluids - IV continues meantime Self caring evening	Mcgaughran. A White KReming
9pm	Vomited (200 mls) foodstuffs - advised to remain on sips orally (Stemetil already given)	
11/10/96.	Pethidine 100mg im 12.50am + Stemetil 12.5mg ims 12.50am. IV fluids continue - reluctant for oral intake due to nausea. Showered with minimal assistance. Aeyroxial. Intravenous pharmacy continues. Tolerating free fluids. Seen by Mr Murray, commenced on intravenous Buscopan, amylase re-checked. Bowels opened x1 - normal formed stool - specimen not sent. Remaine 100mgs IM & Stemetil 12.5mgs IM at 2.25pm Amy 137. SpR Mr. Murray, IV fluids to be discontinued, Remaine discontinued. To commence Cisapride, Diazepam & co-proxamol per pain. Showered dev	Hulston Hulston S Moir S Moir OMichie
pm.	All care as planned. Taking oral fluids fairly well. Vomited x 1 small amount bile. IV fluids discontinued	JMichie

NAME DERMIAH SULLIVAN

CONSULTANT Mr Murray

GLASGOW ROYAL INFIRMARY — Form No. H1238.

DATE	NURSING REPORT	SIGNATURE
11/10/96	ABS satisfactory.	
	Tearful at times - oral analgesia taken tonight	JMichie
12/10/96	Oral analgesia for pain	
	Slept for spells	Eightbells
	SHO Mr Murray. Still vomiting. Ask back	
	to see pt's.	
	Up for shower.	
	Taking oral fluids - Vomited x 2 after	
	each meal.	
	Medication as charted. Apyrexial.	
	Complaining of severe pain, seen by SHO, Buscopan 20mg IM at 3.15pm	JMcG
	SIB Surgical registrar to commence on trinitrate patches	TMC
	for relief of pain	
	For transfer to ward 61 -	
	Requesting pain-killers - coproxamol given as prescribed.	
	Vomited undigested foodstuffs at 9pm.	CTeale
	Oral buscopan and coproxamol administered as prescribed. Patient	
	nauseated, vomited mouthful of foodstuffs	
13/10/96	Intake 1600 output 1600 @ 12 midnight	
12MN	Patient complaining of severe pain in epigastric area and nausea	
	Reviewed by Dr Harrison — Pethidine 75mg IM and stemetil 12.5mg	
	IM @ 12.15 am for relief of pain (prescribed as once only)	
	Settled thereafter and slept well	Allen

NAME Patient Admission Sullivan — CONSULTANT Murray

Glasgow Royal Infirmary
University NHS Trust

Nursing Notes

Name: Deborah Sullivan | Hospital Nos. | Ward 6

Date	Problem No.s	Nursing Notes / Evaluation	Signature
13/10/96		Showered independantly S/B medical staff, prescribed oral pethidine regular. Taking oral fluids with much encouragement. No vomiting this morning. Passing urine.	
		Pethidine 50mgs orally at 11.05 am. Vomited 150mls after lunch (foodstuffs).	A Hunter
		Slept most of afternoon and early evening.	
		Pethidine 50mg orally at 7.10pm No vomiting	M Geddes
14/10/96		Intake 1100 output 1345 @ 12 midnight	
		Pethidine 50 mg orally @ 12.45 am. for relief of pain.	
		Pethidine 50 mg orally @ 5.40 am for relief of pain complaining of severe abdominal pain and nausea ~~pethidine~~ pethidine 75 mgs IM and stemetil 12.5 mgs IM for relief of same.	Glenar
	am.	Showered independently. Remained fasted until seen by medical staff. Now allowed to take normal diet. Given voltarol suppository for pain. Oral pethidine stopped. Resident to arrange Hida scan. To have LFTs checked.	M. Collins
		For hida scan 9am tomorrow. Fast 12MN. requesting night sedation ✓	M Geddes
15.10.96		Appeared to sleep well. Though taste to settle. Fluid balance good.	E Taylor
	am	Attended for hyda scan. Can have fluid + diet.	
		c/o pain on return. Slept after lunch. Ventolin inhaler	M Geddes
		Seen by medical staff. Oral morphine at 2.30pm	
		Pethendine 50mgs orally at 2.40pm. Vomited 600 mls foodstuffs prior to this.	
		3.30pm. Implanted oral analgesic ineffective.	

0280468

Deborah Sullivan | Hospital Nos: | d:

Date	Problem No.s	Nursing Notes / Evaluation	Signature
15/10/96		seen & examined by D. Brown. rel orally	
		IV Fluids commenced Pethidine 100 IM	
		at 3.55pm for endoscopy tomorrow.	IM Comiskey
		Repeated oral analgesia before settling - same given	
		with little effect. Pethidine 100mg IM at 10.05pm EC	
16.10.96		Gaviscon given to relieve heartburn. Slept for short periods	
		Pethidine 100mg IM at 5.15 AM fasting for endoscopy. IV	E Meenan
		fluids continue.	
		Pethidine 100mg IM @ 10.10 am and 2.40 pm	
		c/o nausea, Zofran 4mg IM @ 10.10 am for relief of same.	
		Showered independantly this morning	
		Attended for Gastroscopy @ 11am. Patient very uneasy on	
		return, observations satisfactory.	
		For Ultrasonic examination this afternoon	Allen
		IV. Fluids entire 4°, remains on rel orally	
		Settled evening. IV Fluids continues Attended for U/S this	
		afternoon, which did not show anything abnormal.	A Hunter
		Taking ice only. Passing urine Pethidine 100mg IM @ 7pm	
		Pethidine 100mg IM at 11.8 pm Weeping & in pain ~~Doc~~	
17.10.96		Pethidine 100mg IM at 5.45 AM. Slept between analgesia	E Meenan
		Showered independantly this morning	
		Seen by Mr Murray. Gastroscopy -ve. Possibly for gastric emptying	
		studies. To be reviewed by Dr Morris. May have free fluids.	
		Losec and Pethidine discontinued. Oral analgesia for pain relief	M Geddes
		Ventolin nebulised, requires resting. Dr Brown informed - awaiting same	Allen
		Settled evening. Patient complaining of pain although	

Glasgow Royal Infirmary
University NHS Trust

Nursing Notes

Name: Deborah Sullivan | Hospital Nos. | Ward 61

Date	Problem No.s	Nursing Notes / Evaluation	Signature
17·10·96		oral analgesia had been given S/B Dr. who prescribed once off pethidine. Pethidine 75mg IM @ 7.25pm. Appeared to settle there after. Taking free fluids with little encouragement. Passing good volumes of urine for gastric emptying studies on Tuesday 22nd Oct at 9am	A Hunter
18/10/96		Vomited 250ml fluid. Complaining of terrible pain at Midnight. Pethidine 75mg IM and Maxalon 10mg IM at 12·10am. Settled + slept thereafter. 4 of 9 in 1970, 0 of 3000.	SBell
		Settled most of the morning. Tub bath. S/B medical staff to continue pethidine meantime. Pethidine 75mgs IM @ 10·30pm. Patient states her bowels have not moved for 6 days. Dr asked to prescribe supps ✓ Good constipation result from same	A Hunter
		S/B medical staff, for home on pass until Monday morning. Medication picked up later in evening	J Reuter
19·10·96	17	Returned from pass feeling nauseated & in pain. Dr. informed. Pethidine 75mgs & Maxalon 10mgs IM @ 17.50 for pain & nausea relief. Settled thereafter	Pethidine
		Pethidine 75mgs IM at 10·40pm. Settled fairly well. Pethidine 75mgs IM at 4·20am. Maxalon 10mg with given 4·20am.	SBell
		Showered independantly. S/B medical staff, no change. Vomited 200mls of foodstuff after breakfast. Pethidine 75mgs IM @ 11am. Taking small amounts of diet and fluids. Vomited 400mls after lunch. ? IV fluids c/o pain. Pethidine 75mgs IM at 3·25pm for relief of pain. No supper taken this night. Seen resident. Not for IV fluids at present	A Hunter Infedds

0280469

DEBORAH SULLY Hospital Nos 6

Date	Problem No.s	Nursing Notes / Evaluation	Signature
20/10/96		Complaining of pain. Pethidine 75mgs given IM at 8pm No vomiting Pethidine 75mgs IM at 1.35AM Appeared to sleep well.	MPeddes
21-10-96		Vomited x 1 (brown fluid (trace blood). Maxalon 10mg IM with Pethidine 75mg IM at 6.05AM	EDevlin
		Pethidine 75mgs IM @ 11.10 am for relief of severe abdominal pain Showered independantly this morning Reviewed by medical staff, for Gastric emptying studies tomorrow afternoon. Please fast from 12 midnight in preparation for same. For ? review by Dr David Reilly (Homeopathic doctor) Tolerating fluids and small amount of diet orally continues to complain of nausea - no acute vomiting	
		Remained in bed for most of morning	SReid
		Pethidine 75 mgs IM @ 2.10 pm Maxalon 10mg IM with same Patient vomited 200mls foaul stuff prior to administration of maxalon	SReid
	PM	Vomited x 1 this evening. c/o pain Pethidine 75mgs IM at 6pm Please fast 12mn: for gastric emptying studies tomorrow pm Maxalon 10mg IM with Pethidine 75mg IM at 11.00pm	MPeddes
22.10.96		Pethidine 75mg IM at ~~3.15~~ 3.10AM Slept between analgesia No obvious vomiting	EDevlin
		Pethidine 75mg IM @ 7.15 am + maxalon 10mg IM @ 7.15 am Showered independantly this morning Reviewed by Mr Murray, pethidine discontinued and on no circumstances has patient to be administered pethidine or opoids. MSSU to be obtained and routine ward urinalysis to be undertaken.	
		For review by Dr Morris. For ? home Thursday	SReid

Glasgow Royal Infirmary
University NHS Trust

Nursing Notes

Name: Deborah Sullivan | Hospital Nos: | Ward: 61

Date	Problem No.s	Nursing Notes / Evaluation	Signature
22-10-96		Attended for gastric emptying studies prior to which - awaiting results of same.	
		Observations satisfactory. Seen by Dr Marrs. Further tests to be done. Vomited large amounts foodstuffs IM Maxolon given.	M McConnell
23-10-96		Oral analgesia given prior to settling. Vomited 300mls undigested foodstuffs (purple in colour) at 4.30am. Maxolon 10mg IM given as prescribed. Requesting analgesia + advised there was no more prescribed till 6AM. Slept fairly well. Awaiting urine specimen - Urinalysis - trace of blood, protein. MSSU obtained. No dysuria.	Clarke
		Showered independently this morning.	
		Patient continuing to complain of abdominal pain - Voltarol 100mg supp given for relief of same. Patient stated that bowels moved following this and supposity came with motion.	
		Vomited large amount of foodstuffs following breakfast.	
		Reviewed by Dr Donaldson, Voltarol 50mg prescribed for relief of pain - administered PR @ 1pm	
		Remained in bed for most of morning, mobile to toilet	
		For review by Dr Reilly (Homeopathic consultant)	
		Awaiting review by Mr Murray	Sullivan
	pm	Vomited large amounts of foodstuffs again this evening after after dinner. IM maxolon was given.	Eileen McCampbell
		Requesting night sedation. ✓	
24-10-96		Stay Appeared to sleep well. No vom interp.	Clarke

0280469

Deborah Sullivan | Hospital Nos: [redacted]

Date	Problem No.s	Nursing Notes / Evaluation	Signature
24-10-96 Contd		Shower taken. Seen by Mr Murray. Probably for home later today. SOPD 6 weeks. Discharge drugs ordered. Porphyria screen and urine laxative screen to be done before discharge. Two urine specimens and one stool specimen required. Vomited. X1 Apyrexial	K Prentice

Patient name: DEBORAH SULLIVAN

MN 39.

Date	No	Problem	Desired Outcome/ Aim	Intervention	Signature	Time & date	Date when removed / Signature
10/10/96	(3)	Ventilation site, potential for local and systemic infection	Minimise the risk Detect early	Ask patient to report any pain, swelling or discharge at ventilation site Inspect cannula site Daily Inform medical staff of any inflammation, discharge or dysfunction Record ventilation site condition on bedchart Review with medical staff the need for cannula and need to change cannula Maintain daily dressing at insertion site	[signature]	DLJ	KT.

Review date	Day	Inflammation at site 0 1 1 2 2 3 3 cms	Discharge & Amount Blood/Serous Pus I II III	Comment	Medical staff informed	Signature
10/10/96	1	0	+ SEROUS	RE-SECURED		SMow
12/10						

Glasgow Royal Infirmary

Problems / Aims

Name: DEBORAH SULLIVAN | Date of Birth: | Ward No's: 35 | Date:

Date	No	Problem	Aim	Nursing Intervention	Signature	Evaluation Date
10/10/96	1	Pain ~~following surgical procedure~~	Patient will state she is comfortable	A) Nurse patient in comfortable position B) Administer analgesia as prescribed by doctor & monitor effect with patient C) If analgesia is ineffective, notify doctor & review prescription	[signature]	0/S.

Glasgow Royal Infirmary

Problems / Aims

Name DEBORAH SULLIVAN | Date of Birth [illegible]39 | Ward No's

Date	No	Problem	Aim	Nursing Intervention	Signature
10/10/96	4	Nausea / Vomiting due to..	To promote patient comfort & relieve nausea /vomiting	A) Position patient where he/she can be easily observed, with nurse call system to hand B) Position in bed to maintain comfort (N.B. If airway at risk - left lateral position with suction apparatus to hand) C) Provide emesis bowl & ensure patient privacy D) Offer mouthwashes to freshen mouth E) Stay with patient during vomiting period & provide support / reassurance	

GLASGOW ROYAL INFIRMARY UNIVERSITY NHS TRUST
PROBLEMS / AIMS

NAME: HOSPITAL NUMBER: WARD:

DATE	NO	PROBLEM	AIM	NURSING INTERVENTIONS	SIGNATURE	EVAL. DATE	DISC DATE
12/10		Patient requires assistance when moving due to ...	To minimise the risk of injury to patient and staff To promote patient comfort	Ascertain patient's weight Ascertain patient's height Assess and document patient's weight bearing ability Assess and document patient's dependence on nursing staff to mobilise Encourage patient to mobilise within own capabilities Observe for and document any changes in patient's circumstances Fully Mobile.	KT	01	

D. Sullivan.

Glasgow Royal Infirmary

Problems / Aims

9
F

Name DEBORAH SULLIVAN | Date of Birth | Ward No.s 39

Date	No.	Problem	Aim	Nursing Intervention	Signature	Evaluation Date	Disc Date
10/10/96	2.	A) Potential for fluid & electrolyte imbalance due to... a) Operative procedure b) Anaesthetic c) Nausea & Vomiting	To maintain hydration Electrolytes within normal limits Increase appetite & promote healthy/balanced diet	A) Administer intravenous fluids as prescribed by doctor I.V. Fluids - 4D B) Maintain accurate record of intake & output 2-hrly C) If necessary, administer antiemetics as prescribed & monitor effect with patient	MWatson	9/5.	
		B) Loss of appetite due to surgery		D) Dietary restrictions... 10/10 NBM 10/10 F+D RR/10 FF	KRennie		
				E) Weigh patient daily - small appetising meals & observe dietary intake			

GLASGOW ROYAL INFIRMARY UNIVERSITY NHS TRUST

964876K
SULLIVAN F/S
DEBORAH 07/12/1972
1/1 160 MAIN STREET
BAILLIESTON
G69 6AH

I.V. THERAPY PRESCRIPTION SHEET

0159486

	DATE	FLUID (USE BLOCK LETTERS) / ADDITIVE DRUG	Vol (ml). / Dose (mg)	Route of Admin.	Dur. of Admin.*	SIGNATURE	Serial No. / Batch No.	Time Begun	Given B / Added B
A	10/10/96	(N) SALINE	500	IV	1°	C Haney	96H27 BJ	3.30 a	
B	10/10/96	5% DEXTROSE	500	IV	1°	C Haney	96F19 BX	4.35 am	
C	10/10/96	(N) SALINE	500	IV	4°	C Haney	96H27 BJ	8.45	
D	10/10/96	5% DEXTROSE	500	IV	4°	C Haney	96F19 BX	9.50 a	
E	10/10/96	5% N. Saline	500	IV	4°	R. Griffin	96H27 BJ	1.40 pm	
F	10/10	5% Dextrose	500	IV	4°	R. Griffin	96F19 BX.	4pm	
G	10/10	N. Saline	500	IV	4°	R. Griffin	96H 27BJ	9.30 pm	
H	10/10	5% Dextrose	500	IV	4°	R. Griffin	96F 19Bx	2am	
I	10/10	5% Dextrose	500	IV	5°	R. Griffin	96F19 BX	7am	
J	10/10/96	(N) SALINE	500	IV	4°	C Haney	96H 27BJ	12no	
K	10/10/96	5% DEXTROSE	500	IV	4°	C Haney	96F19 BX.	4.45 pm	
L	11/10	5% Dextrose 20mmol KCl	500	IV	4°	R. Griffin			
M	11/10	N. Saline	500	IV	4°	R. Griffin	D/S/C		
N									
O									

RATE OF FLOW (Drops/Min.) = **VOL.OF FLUID (ml) x 15** / Duration (Mins.)

6.62 (1ml = 15 drops)

Approximate Rate for 500 ml.

1 hr. = 120 Drops/min. | 6 hr. = 22 Drops/min.

4 hr. = 30 Drops/min. | 8 hr. = 15 Drops/min.

SHEET NO .....

HOSPITAL

PRESCRIPTION SHEET No. 1

REGULAR PRESCRIPTIONS – INJECTIONS

Pharmacy Use	Date Started	MEDICINE (Block Capitals)	DOSE	ROUTE	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times	Prescribers Signature (Full)	DISCONTINUED: Date	Signed
	A 10/10/96	PETHIDINE	100mg	IM			6-8			PRN							
	B 10/10/96	STEMETIL	12.5mg	IM			6-8			PRN							
	C 13/10																
	D 13/10																
	E																
	F																
	G																

REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

	H 10/10/96	GTN PATCH	5mg	TRANSDERMAL											FOR 12 HRS		
	I 10/10/96	~~Buscopan~~ Phychrocodrene	30-60mg	O				6°	PRN								
	J 10/10/96	Omeprazole	20mg	O													
	K 10/10/96	Maxalon	10mg	O				8°	PRN								
	L 10/10/96	CIPRAMIDE	10mg	O													
	M 10.10.96	CO-PROXAMOL	2 tabs	O													
	N 10.10.96	DIAZEPAM	5mg	O													
	O 12.10.96	BUSCOPAN	20mg	IM													
	P 12.10.96	GTN PATCH	5mg	TOPICAL													
	S																
	T 13/10/96	~~METHOTREXATE~~ MAXALON	10mg	ORAL				6-8	hrly								
	V 13/10/96																

ONCE ONLY PRESCRIPTIONS

DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN
11/10		Buscapan	40mg	IV	R. Griffin		
11/10		CIPRIDE	10mg	ORAL		~~cancelled~~	
11/10	6.50pm	COPROXAMOL	2 tabs	ORAL		MICHAEL	6.50pm
12/10	2.40am	Co proxamol	2 tabs	Oral		A Bell	2.35am
12/10/96	10:30	BUSCOPAN	20mg	IV			10:30.
12.10.96	3.15pm	BUSCOPAN	20mg	IM			3.15pm
12.10.96	6.10pm	NITROLINGUAL PATCH	5mg	TOPICAL			6.20pm
12/10/96		PETHIDINE	75mg	IM		A Bell	12.15am
12/10/96		STEMITIL	12.5mg	IM		A Bell	12.15am
13/10	6-30am	PETHIDINE	75mg	IM		A Bell	6.30am
13/10	6.30am	STEMITIL	12.5mg	IM			

DIET

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

KNOWN MEDICINE SENSITIVITIES: 1.

WARD	NAME OF PATIENT	AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
39	964876K SULLIVAN F/S	23.	5'10½	11	9648761K	~~Prof~~ MR ~~Dr~~ C MURRAY

HOSPITAL

MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

REGULAR PRESCRIPTIONS

DATE	6 a.m.	8 a.m.	10 a.m.	12 m.d.	2 p.m.	4 p.m.	6 p.m.	10 p.m.	12 m.n.	OTHER TIMES	COMMENTS ON DISCREPANCIES
19.10.96	Initial	Initial	Initial	Initial	Initial	Initial	A+C2 @17.50	Initial	Initial	C2	C2+A2@17.50 C2 at 10.50pm
20/10/96		O J K N AH		K						C2 H2 C2 AH 2AM	C2+A2 at 4.20am C2+A2@11am C2 at 8pm C2@ 3.25pm TR
21/10		J K N2 O2 SM					C			A+ P@11pm A2 C2 C2 2M	C2 at 1.40am SB C@18.00 C2+A2 at 6.05 AM C1@11.10 am C2+A2 at 2.30pm
22-10-96		N2 O2	K				K J 6.45R	K		A C KE 8M	C at 3.10AM C2+A2 at 7.15pm by A at 6.45R
23.10.96		J K N2 O2 SM	K@11R				K2 at 6.5R	K		A EC	A at 4.30AM A@6.25pm
24.10.96		J K N2 O2 SM									N2 at 06 hrs - ordered.

NAME	UNIT NUMBER	WARD	KEY: CODE LETTER CIRCLED E.G. (A) = MEDICINE REFUSED AND MEDICAL STAFF INFORMED CODE LETTER SCORED I
Deborah Sullivan	964876K	61	

HOSPITAL

MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

REGULAR PRESCRIPTIONS

DATE	6 a.m.	8 a.m.	10 a.m.	12 m.d.	2 p.m.	4 p.m.	6 p.m.	10 p.m.	12 m.n.	OTHER TIMES	COMMENTS ON DISCREPANCIES
10/10/96	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	A at 8.45pm B at 8.45pm A at 2.50pm B at 2.50pm
11/10											A+B @ 6.30pm MN A at 12.30 am B at 12.30 am.
12/10											N at 7.30pm
13/10/96											
14/10/96											T @ 12.45 am Tabs 4 on B
15/10/96											A2 @ 2.30pm L2 @ 2.40pm B2 @ 3.50 pm
16/10/96											B2 at 12.15AM SC. A+B at 10am B2 at 5.15AM SC B2 @ 7AM B2 @ 2.20 pm SC.
17/10/96											B2 at 3.45AM N at 7.25pm
18/10/96											A at 12.14AM A & C at 10.30am

NAME

964876K
SULLIVAN F/S
DEBORAH 07/12/1972

UNIT NUMBER

964876K

WARD

61

KEY: CODE LETTER CIRCLED E.G. (A) = MEDICINE REFUSED AND MEDICAL STAFF INFORMED

CODE LETTER SCORED E.G. X = PATIENT ABSENT

FORM MR1 10/90

YOU MUST USE A BALLPOINT PEN AND FULLY COMPLETE THIS FORM OR THE PRESCRIPTION WILL NOT BE DISPEN

GLASGOW ROYAL INFIRMARY
G4 OSF TEL 0141-211-4000

CONFIDENTIAL

IMMEDIATE DISCHARGE LETTER AND MEDICINE PRESCRIPTION FORM

To be completed for every discharge and inter specialty transfer

35364

Dear Doctor.....

FIX ID LABEL TO ALL 4 COPIES

Name Deborah Sullivan
Address 11 160 Mairs Street
Baillieston
G69 6AH
DOB 7/12/72
Unit No 9648761

Diagnosis (inc, cause of injury)

1 Irritable Bowel Syndrome
2
3
4
5
6

Procedures

1 Laparoscopy Date 16/7/96
2 Date
3 Date
4 Date

Type of Admission			
WL/ARRANGED		DAY CASE	
EMERGENCY	✓	INTERNAL TRANSFER	
		TRANSFER FROM OTHER HOSPITAL	

DOA .....
CONSULTANT Cooke
WARD 62
DATE OF DISCHARGE/DEATH .....
TRANSFERRED TO WARD ..... DATE .....

FOLLOW UP ARRANGEMENTS

Clinic ..... Date .....
Home Help YES NO
District Nurse YES NO
GP YES NO
Meals on Wheels YES NO
OTHER .....

PROCEDURES PERFORMED BY OTHER SPECIALITIES

Procedure	Specialty	Consultant	Date
1			
2			

Medicine	Form	Dose	Frequency	Duration	Days Supplied	PHARMACY TO COMPLETE Quantity, Strength, Brand
As per prescription order						

COMMENTS (Information given to patients, investigating pending, pharmacy, medicine sensitivities, etc)

Laparoscopy - negative finding.
Abdominal pain settling.

Doctor's Name MUKAKI Signature MUKAKI Page No 185 Date 17/7/96 Pharmacist .....

White Copy - GP Pink Copy - Case Notes Blue Copy - Pharmacy Yellow Copy -Coding

0159369

Glasgow Royal Infirmary University NHS Trust

Profile/Careplan for 24 / 72 hour stay

62 — Named Nurse: ON Kirsty. Waterlow: +9

DATE OF ADMISSION 12/7/96	TIME 3am	WARD 39	TYPE OF ADMISSION EMERGENCY / PLANNED /	TRANSFER FROM	OTHER	ADMITTING NURSE K Rennie	

SURNAME Sullivan	DATE OF BIRTH 07/12/72	MENSTRUAL CYCLE	ALLERGIES	BASELINE RECORDS
FORENAME Deborah	AGE 23	PARA	None Known.	HEIGHT 5'11"
ADDRESS 160 Main St Bailleston Glasgow.	RELIGION R.C.	URINALYSIS X		WEIGHT 11 Stone
	G.P. AND ADDRESS Goldie Easterhouse HC 7710781 9 Auchinlea Rd		CHEMICAL DEPENDANCY /	B.P. 107/70
TEL Nos. 771 3401			PROSTHESIS /	TEMP. 36.5
WISHES TO BE KNOWN AS				PULSE 64
				RESPIRATION 16
				DENTURES —

NEXT OF KIN Kathleen Sullivan	SOCIAL CIRCUMSTANCES		STORAGE OF VALUABLES	STORAGE OF DRUGS
ADDRESS 181 Commonhead Road Glasgow	OCCUPATION Insurance Co- Claims Handler	SUPPORTING SERVICES None.	—	—
	LIVES WITH Father.			
RELATONSHIP Mother	TYPE OF HOUSE		RETURNED	RETURNED
TEL. Nos. 771 3743				

REASON FOR ADMISSION	PAST MEDICAL HISTORY	CURRENT DRUG THERAPY
sudden onset LUQ colicky pain	Appendicectomy 3/96	Losec 20mg mane.
vomiting / diarrhoea also.	Lap Chole 4/96.	Maxolon 10mg tds
? cause — gastritis.		
?? pancreatic cause		
?? [redacted].		
WCC. 12·5		

PATIENTS NAME DEBORAH O'SULLIVAN

CONSULTANT ~~COOKE~~ 0280470

ASSESSMENT

SAFETY AND COMFORT	BREATHING & CIRCULATION	MAINTAINING BODY TEMPERATURE	EATING & DRINKING	MOBILITY
Fairly settled on admission Pethidine 50mg IM in A+E / Stemetil 12.5mg	No problems smokes 5-10/day.	No problems.	No special diet occasional alcohol	Independent

PERSONAL HYGIENE	ELIMINATION	SLEEP	COMMUNICATION (INCLUDING FEARS & ANXIETIES)
Independent SKIN CONDITION intact	Having Diarrhoea recently	Sleeps well.	No problems.

DATE	No.	PROBLEM	AIM	INTERVENTION	SIGNATURE	EVALUATION	DISC
12/7/96	1	PAIN	see folder.				
	2	Nausea + Vomiting					
	3	Fluid Imbalance					
	4	Version					
	5	Moving + Handling					
	6	Waterbow					
	7	Diarrhoea.					

DATE	No.	PROBLEM	AIM	INTERVENTION	SIGNATURE	EVALUATION	DISC

DATE	No.	EVALUATION/NURSING NOTES	SIGNATURE
12/7/96		Settled onto ward, in no obvious discomfort. Analgesia given in A & E @ 1[55] am.	
		Observations satisfactory.	
		To commence IV fluids NBM. Urinalysis required	
		Written up for IV Zantac tds.	
		~~Await~~ Review in am. To commence oral fluids in am if able, IV ↓	K Rennie
		Removed by medical staff may have 1/2 litre fluids daily no other change in management	RMcCoy
		Pethidine 50 mgs and stemetil 12.5 mgs IM at 10[00] am with good effect	RMcCoy
		Needs encouragement with oral fluids. No episodes of diarrhoea or vomiting	RMcCoy
		Pethidine 50 mgs I.m @ 4.20 pm	cAnderson
		Comfortable evening. Self caring. Fluids taken.	
		Fairly well. I.V. fluids discontinued	C Anderson

Glasgow Royal Infirmary
University NHS Trust

Nursing Notes

Name: Deborah Sullivan | Hospital Nos: | Ward: 59

Date	Problem No.s	Nursing Notes / Evaluation	Signature
12/7/96		Pethidine 50mg IM @ 11.10 pm	
13/7/96		Slept well following analgesia. Oral fluids to be encouraged. Has not passed urine overnight	
		Reviewed by Dr McKee may have fluids and diet. Self caring. Up & about.	
		For transfer to ward 62	
		Transferred to ward 62	
		Venflon remains insitu	
		Pethidine 50mgs IM at 11.10am	
		Pethidine 50mgs given IM @ 3.10 PM	
	Pm.	Taking only small amounts of fluids and diet.	
		vomited x 1 food stuff. venflon remains insitu.	
		Pethidine 50mg given @ 7.10 pm	
14.7.96		Settled and uncomplaining overnight	
		Prescribed oral analgesia. Vomited food stuff x1	
	am	Vomited x 2 food stuff. complaining of abdominal pain.	
		Pethidine 50mg given IM @ 10.50 AM. Stemetil given IM.	
		as ordered. Reviewed.	
		Settled evening.	
		Managing fluids and diet well. All food eaten at supper	
	7pm	c/o pain & nausea, vomited x1. undigested foodstuffs.	
		Pethidine 50mgs & Stemetil 12.5mgs IM at 7.15pm with desired effect.	
15.7.96		Settled and uncomplaining overnight	
		Pethidine 50mg and Stemetil 12.5mgs IM at 6.10 am	
	am	Settled morning. Continues on free fluids only. No pain or vomiting. Oral analgesia	
		given for pain.	

0280469

Name: Deborah Sullivan | Hospital Nos: | Ward:

Date	Problem No.s	Nursing Notes / Evaluation	Signature
	pm	Pethidine 75mgs given IM at	
		Continues on free oral fluids. Vomitted small amount	AF.
		? to begin on IV fluids.	
16.7.96		Pethidine 75mgs at 11.10pm IM with good effect. Not	
		on IV fluids overnight. Fluid intake orally 1150mls	
		Output incorrectly charted. Free fluids.	AGowan
	am	Pethidine 75mgs IM given at	
		Tolerating free fluids fairly well.	
		Complaining that bowels have not moved for number of days, commenced	
		on lactulose.	AF.
		Mobile to day room.	
	p.m.	Complaining of pain Pethidine 75mg at 5.20p.m.	
		For home tomorrow - will arrange own transport.	E. McMahon
		Venflon removed.	
17.07.96		Pain night only	
		Oral analgesia taken	
		? home today	
	am.	Discharged home asap 6/52 Prof Cookes Clinic.	Gmadden AF, S

PROBLEMS / AIMS

NAME: Deborah Sullivan HOSPITAL NUMBER: WARD: 39

DATE	NO	PROBLEM	AIM	NURSING INTERVENTIONS	SIGNATURE	EVAL DATE
12/7/96	6	Patient requires assistance when moving due to ... fully mobile	To minimise the risk of injury to patient and staff To promote patient comfort	Ascertain patient's weight 11 stone Ascertain patient's height 5'11" Assess and document patient's weight bearing ability Assess and document patient's dependence on nursing staff to mobilise Encourage patient to mobilise within own capabilities Observe for and document any changes in patient's circumstances	K Reinmuth	o/c

Glasgow Royal Infirmary

Problems / Aims

Name Deborah O'Sullivan	Hospital Nos.	Ward Nos. 39

Date	No.	Problem	Aim	Nursing Intervention	Signature	Evaluation Date	Disc Date
12/7/96	(7)	Diarrhoea.	Monitor & alleviate	• IV fluids as charted • free oral fluids encouraged when able • accurate record of input/output • administer medication as prescribed • stool charting	KRennet	o/c	

Glasgow Royal Infirmary

Problems / Aims

Name: Deborah O'Sullivan	Date of Birth:	Ward No: 39	Date:

Date	No	Problem	Aim	Nursing Intervention	Signature
12/7/96	2	Nausea / Vomiting due to.. condition	To promote patient comfort & relieve nausea /vomiting	A) Position patient where he/she can be easily observed, with nurse call system to hand B) Position in bed to maintain comfort (N.B. If airway at risk = left lateral position with suction apparatus to hand) C) Provide emesis bowl & ensure patient privacy D) Offer mouthwashes to freshen mouth E) Stay with patient during vomiting period & provide support / reassurance F) Monitor & record amount of gastric loss	K Round

Glasgow Royal Infirmary

Problems / Aims

Name: Deborah O'Sullivan | Hospital No: | Ward No: 39

Name / Date	No	Problem	Aim	Hospital No	Nursing Intervention	Signature	Evaluation Date	Disc Date
12/7/96	3	Potential for fluid & electrolyte imbalance due to: A) Operative procedure B) Nausea & vomiting C) Dietary restrictions	Prevention of same		A) Administer intravenous infusion as prescribed 4° IVI B) Care of intravenous infusion as per hospital standard C) Maintain accurate record of intake & output D) If necessary, administer antiemetic as prescribed & monitor effect with patient E) Specify dietary / fluid restrictions Fast F.F. F.D.	K Renwick o/c C Anderson C Anderson	0/6	12/7 12/7
				13/7/96				

Patient name Deborah O'Sullivan Hosp Number 39

Date	No	Problem	Aim	Intervention	Signature	Review date	
12/7/96	(4)	Venflon in-situ; potential for local and systemic infection.	Minimise the risk. Detect early.	Ask patient to report any pain, swelling or discharge at venflon site. Inspect cannula site 4 hly. Inform medical staff of any inflammation, discharge or dysfunction Record venflon site condition - see below. Review with medical staff the need for cannula and need to change cannula. Maintain a dry dressing at insertion site.	K Rennick O/G		

Review date	Day	Inflammation at site 0 <1 1-2 2-3 >3 cms	Discharge & Amount Blood/Serous Pus + ++ +++	Comment	Medical staff informed	Signature	Date whe removed Signature
13/7/96	1						
	2						
	3						

Problems / Aims

Name Deborah O'Sullivan | Hospital Nos. | Ward No.s 39

Date	No.	Problem	Aim	Nursing Intervention	Signature	Evaluation Date	Disc Date
12/7/96	5	Risk of development of pressure sore due to	Patient's skin will remain healthy & intact	A) Assess the risk of tissue breakdown using the Waterlow Scale B) Observe pressure points for signs of redness or tissue breakdown C) Keep skin dry & linen wrinkle free D) Change of position +9 on admission	K Ramnub - d/c.		

Waterlow Pressure Sore Prevention and Treatment Policy

Ring scores in table, add total. Several scores per category can be used.

	*		*		*		*
Average	0	Healthy	0	Male	1		*
Above average	1	Tissue paper	1	Female	2		
Obese	2	Dry	1	14-49	1	e.g. Terminal cachexia	8
Below average	3	Oedematous	1	50-64	2	Cardiac failure	5
	*	Clammy (Temp)	1	65-74	3	Peripheral vascular disease	5
		Discoloured	2	75-80	4	Anaemia	2
Complete/ catheterised	0	Broken/spot	3	81+	5	Smoking	1
Occasional incontinence	1		*		*		*
Cath/incontinent of faeces	2	Fully	0	Average	0	e.g: Diabetes, MS, CVA, motor/sensory, paraplegia	4-6
Doubly incont.	3	Restless/fidgety	1	Poor	1		
		Apathetic	2	N.G tube/fluids only			*
		Restrictive	3		2		
		Inert/traction	4	NBM/anorexic	3	Orthopaedic - below waist, spinal	5
		Chairbound	5			On table > 2 hours	5
							*
						Cytotoxics, high dose steroids, anti inflammatory	4

BritCair WOUND CARE

Score

15+ high risk

20+ very high risk

BritCair supporting education in Wound Management

FORM H 1572

Glasgow Royal Infirmary

Problems / Aims

Name	Deborah O'Sullivan	Hospital Nos.	Ward Nos.	39

Date	No.	Problem	Aim	Nursing Intervention	Signature	Evaluation Date	Disc Date
12/7/96	1	PAIN ? CAUSE LUQ pain	TO MONITOR AND ALLEVIATE	a) ADMINISTER PRESCRIBED ANALGESIA AND NOTE EFFECT			
		SPECIFY TYPE		b) REPORT INCREASING PAIN TO MEDICAL STAFF	KRemmd o/a		
				c) ASSIST TO ADOPT ACCEPTABLE POSITION IN BED			
				d) IF APPLICABLE OBSERVE FOR ABDOMINAL DISTENTION			

GLASGOW ROYAL INFIRMARY UNIVERSITY NHS TRUST

MS DEBORAH SULLIVAN
DOB: 7/12/1972

I.V. THERAPY
PRESCRIPTION SHEET

PATIENT ID LABEL

0159486

	DATE	FLUID (USE BLOCK LETTERS) / ADDITIVE DRUG	Vol (ml). / Dose (mg)	Route of Admin.	Dur. of Admin.*	SIGNATURE	Serial No. / Batch No.	Time Begun	Given B / Added
A	12-7	(N) SALINE	500	IV	4°	T.K	96E 23BG	3.40 am	KR
B	12-7	5% DEXTROSE	500	IV	4°	T.K	96F03 BN	7.45 am	
C	12-7	(N) SALINE	500	IV	4°	T.K	96E2 38G	11.40 a	A.Wh
D	12-7	5% DEXTROSE	500	IV	4°	T.K	96F 03BN	4.10 p.m	CAnd
E	12-7	(N) SALINE	500	IV	4°	T.K	96E 23BG	8.20 p.m	CAnd
F	12/7	5% Dextrose +20mmol KCl	500	IV	6°	M. Lhan			
G	12/7	5% Dextrose	500	IV	6°	M. Lhan			
H									
I									
J									
K									
L									
M	12-7	(N) SALINE RANITIDINE	100 50mg	IV	1/2°	T.K			
N	12-7	(N) SALINE RANITIDINE	100 50mg	IV	1/2°	T.K			
O	12-7	(N) SALINE RANITIDINE	100 50mg	IV	1/2°	T.K			

RATE OF FLOW (Drops/Min.) = **VOL.OF FLUID (ml) x 15** / Duration (Mins.)

6.62 (1ml = 15 drops)

Approximate Rate for 500 ml.

1 hr. = 120 Drops/min. 6 hr. = 22 Drops/min.

4 hr. = 30 Drops/min. 8 hr. = 15 Drops/min.

SHEET NO .....

DATE	NORMAL RESULTS
WCC	4 – 11
Hb	M 13·0–18·0 F 11·5–16·5
PLAT	150–400
KCCT	33–50
PT	13–18
TCTR	6–9
Na	135–145
K	3·5–5·0
U·L	97–107
[illegible]	23–30
[illegible]	2·5–3·0
[illegible]	40–130
[illegible]	70–200
Adj Ca	2·2–2·6
Ca	2·2–2·6
PO4	0·7–1·4
T.P	62–82
Alb	35–55
Glob	22–33
Bil	3–22
ALP	80–250
AST	12–48
ALT	13–55
LDH	230–525
CK	<150
PCT	<36
CRP	
HT	7·37–7·43
pO_2	12–15
pCO_2	4·4–5·6
HCO_3	
EBE	

ARTERIAL BLOOD GASES

Arterial [illegible] Sittings

Problem / Need	Goals	Interventions	Evaluation
	AILSA A MACKENZIE	(NB If airway is at risk ... left lateral position with suction apparatus to hand)	
		Provide emesis bowl and ensure patient privacy	
		Offer mouthwashes to freshen mouth	
		Stay with patient during vomiting period and provide support/ reassurance	
		Monitor and record amount of gastric loss	
		Test same if appropriate	
		Administer antiemetic as prescribed and monitor effect of same with patient	

Glasgow Royal Infirmary
PATIENT CARE PLAN - WARD62

DATE: 13/07/1996 TIME: 10:54:39
Patient Name .... SULLIVAN, DEBORAH
Patient No 964876
Patient DX ..... ABDOMINAL SYMP'S 789
Bed Number 000009
Admit Date 13/07/1996
Date of Birth ... 07/12/1972

Patient Age/Sex ... 023/07/06 / Female
Primary/Named Nurse. AILSA MACKENZIE
Consultant Name.... PROF COOKE
Signature
.....Mackenzie.....

00439A

Problem / Need	Goals	Interventions	Evaluation
PROB # 01 13/07/1996 Patient has abdominal pain AILSA A MACKENZIE	Patient will state he/ she is comfortable CONTINUING REVIEW: 17/07/1996 SELECTED: 13/07/1996 AILSA A MACKENZIE	Ask patient to inform nurse when pain occurs 13/07/1996 AILSA A MACKENZIE Monitor and record temperature, pulse and respiration (Frequency) Daily 13/07/1996 AILSA A MACKENZIE Administer analgesia as prescribed and monitor effect of same with patient 13/07/1996 AILSA A MACKENZIE Maintain accurate record of intake and output 13/07/1996 AILSA A MACKENZIE Light diet only 13/07/1996 AILSA A MACKENZIE	
# 02 13/07/1996 ent requires assistance moving AILSA A MACKENZIE	To promote patient comfort and minimise the risk of injury to patient and staff CONTINUING REVIEW: 17/07/1996 SELECTED: 13/07/1996 AILSA A MACKENZIE	Specify patient's weight...11 STONE Specify patient's height...5 FEET 11" 13/07/1996 AILSA A MACKENZIE Assess and document weight bearing ability Ensure the use of ... nurses to assist when moving Specify the type of lift required when moving in bed...NOAIDS REQUIRED 13/07/1996 AILSA A MACKENZIE Specify the type of lift required when moving	

[MORE]

[(c) SASHA CARE INTERNATIONAL, INC. Computer Generated form]

Problem / Need	Goals	Interventions	Evaluation
		from chair/ commode...NO AIDS REQUIRED 13/07/1996 AILSA A MACKENZIE Specify the type of equipment required to assist with moving (Eg. Patslide)NO AIDS REQUIRED 13/07/1996 AILSA A MACKENZIE	
# 03 13/07/1996 Flon in situ - Potential for local and systemic infection AILSA A MACKENZIE	To minimise the risk / early detectioh of infection CONTINUING REVIEW: 14/07/1996 SELECTED: 13/07/1996 AILSA A MACKENZIE	Ask patient to report any pain, swelling or discharge at venflon site. Inspect cannulation site 4 hourly Inform medical staff of any inflammation, discharge or dysfunction Record venflon site condition daily noting : A) Inflammation at site 0, <1cm, 1-2cm, 2-3cm, >3cms B) Discharge & Amount (Blood/ Serous, Pus) +, ++, +++ Review with medical staff the need for cannula and need to change cannula daily Maintain a dry dressing at insertion site.	
PROB # 04 13/07/1996 Nausea/ vomiting AILSA A MACKENZIE	To promote patient comfort / relieve nausea/ vomiting CONTINUING REVIEW: 16/07/1996 SELECTED: 13/07/1996	Position patient where he/ she can be easily observed with nurse call system to hand Position in bed to maintain comfort	

[MORE]

Patient name D Sullivan			Hosp Number				
Date	No	Problem	Aim	Intervention	Signature	Review date	
130796		Venflon in-situ; potential for local and systemic infection.	Minimise the risk. Detect early.	Ask patient to report any pain, swelling or discharge at venflon site. Inspect cannula site 4 hly. Inform medical staff of any inflammation, discharge or dysfunction. Record venflon site condition - see below. Review with medical staff the need for cannula and need to change cannula. Maintain a dry dressing at insertion site.	Jn Mackenzie	daily	

Review date	Day	Inflammation at site 0 <1 1-2 2-3 >3 cms	Discharge & Amount Blood/Serous Pus + ++ +++	Comment	Medical staff informed	Signature	Date when removed / Signature
14/7/96	1	—	—	—	~~Sarah~~	Sarah	
15.7.96	2	0'-1	—	venflon issued removed 7am		Sarah	
	3						
	4						
	5						

Debbie Sullivan.

Patient name			Hosp Number				
Date	No	Problem	Aim	Intervention	Signature	Review date	
15.7.96		Venflon in-situ; potential for local and systemic infection. (R) hand.	Minimise the risk. Detect early.	Ask patient to report any pain, swelling or discharge at venflon site. Inspect cannula site 4 hly. Inform medical staff of any inflammation, discharge or dysfunction. Record venflon site condition - see below. Review with medical staff the need for cannula and need to change cannula. Maintain a dry dressing at insertion site.	Rowan.		

Review date	Day	Inflammation at site 0 <1 1-2 2-3 >3 cms	Discharge & Amount Blood/Serous Pus + ++ +++	Comment	Medical staff informed	Signature	Date when removed / Signature
16.7.96	1	—	—	Slightly painful		AC.	Rowan.
	2						
	3						
	4						
	5						

DAILY SUMMARY OF FLUID BALANCE



0187497

PLEASE WRITE OVER WHITE LETTERS

DATE	INTAKE				OUTPUT			
	ORAL	I.V.	OTHER	TOTAL	URINE	GASTRIC	OTHER	TOTAL
12/7/96	1500	2100		3600	1100			1100
13/7/96	1450			1450	1925	650		2575
14/7	1275			1275	1200	800		2000
15/7.	1150.			1150.	7.200.	150.		2100.
16 7.	1600.			1600.	2100			

Pharmacy Department
Glasgow Royal Infirmary

CONFIDENTIAL

Discharge Medicine Order

964876K
SULLIVAN F/S
DEBORAH 07/12/1972
1/1 160 MAIN STREET
BAILLIESTON
G69 6AH

Dear GP,
Your patient was discharged from Ward 62 on 17/7/96
Listed below are the medicines supplied by the Pharmacy Department.
A seven day supply was made unless otherwise stated.

If your require any further details, please contact:
Ward Clinical Pharmacist : HELEN BARCLAY
Tel : 0141 211 4000, Page : 1518

Medicines Supplied on Discharge (Admission Drugs and Newly Started Drugs)

Medicine	Form	Dose	Frequency	Duration	Days Supplied	New Drug (✓)	New Dose (✓)	Reason (if known)	Dispensing Details (Pharmacy Only) (Brand, Strength, BN, Quantity)
OMEPRAZOLE	cap	20mg	in morning	until	7				
CO-PROXAMOL	tab	2	4-6 hly as reqd		7				
METOCLOPRAMIDE	tab	10mg	3 times a day		7	✓			
LACTULOSE	liq	10ml	at night		7	✓			

Discontinued Medicines

Medicine	Reason (if known)

Further Information

☐ Non CRC Tops ☐ Compliance Aid ☐ Large Type ☐ Admin Times

Ordered by :	Date :	Dispensed by :	Checked by :
H Barclay Pharmacist	17/7/96		

HOSPITAL

MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

REGULAR PRESCRIPTIONS

DATE	6 a.m.	8 a.m.	10 a.m.	12 m.d.	2 p.m.	4 p.m.	6 p.m.	10 p.m.	12 m.n.	OTHER TIMES	COMMENTS ON DISCREPANCIES
12/7/96	Initial	H	A&B at 10 AC	K at 11.30	Initial	Initial	Initial	Initial	Initial	Initial	A @ 4.20 p.m CA A @ 11.10 pm CA
13/7/96		H								A at 11.10 am SK. A at 7.15 pm A @ 5.00 pm EC(AC)	
14/7/96		L H								L at 3.10 am SJF AcB at 7.40 pm SK A @ 10.30 a AC 10.30 p EC	
15/7	A B 6.10 am M	H EC			L MS			M AC	A at 11.15 pm AC	L A A SJF	L at 2.50 am SJF A at 5 pm
16/7		H M L AC			M AC			M N L AC			A at 10.55 am A @ 5.20 a.m.
17/7		H M AC									

NAME	UNIT NUMBER	WARD
Deborah O'Sullivan	D.O.B. 7/12/72	39

KEY: CODE LETTER CIRCLED E.G. (A) = MEDICINE REFUSED AND MEDICAL STAFF INFORMED

CODE LETTER SCORED E.G. ✗ = PATIENT ABSENT

FORM MR1 10/90

HOSPITAL

PRESCRIPTION SHEET No.

REGULAR PRESCRIPTIONS – INJECTIONS

Pharmacy Use		Date Started	MEDICINE (Block Capitals)	DOSE	ROUTE	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times	Prescribers Signature (Full)	DISCONTINUED: Date	Signed
		12-7-96	PETHIDINE	75mg 50mg PRN	IM	11° as req					pain							
		12-7-96	STEMETIL	12.5mg	IM	6-8 as req					nausea							
		~~12-7-96~~	RANITIDINE	50mg	IV												12/7	ML
	D																	
	E																	
	F																	
	G																	

REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

		12-7-96	OMEPRAZOLE	20mg	PO	✓												
		12-7-96	GAVISCON	10ml	PO	as req												
		~~12-7~~	RANITIDINE	150mg	PO	✓												
MAX 8 TABS in 24 HRS	L	13/7	COPROPHYLL	2 TABS	O			4-6° PRN										
	M	15/7/96	Mazolan METOCLOPRAMIDE	10mg	O													
	N	16/7	LACTULOSE	10ml	O													
	O	17/7/96	Discharge medicine	1 Box														
	P																	
	R																	
	S																	
	T																	
	V																	

ONCE ONLY PRESCRIPTIONS

DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN
12-7-96	1.45am	PETHIDINE	50mg	IM			1.55am
12-7-96	1.45am	STEMETIL	12.5mg	IM			11
13/7/96	9.45	CO CODAMOL TABS	x2	PO			9.45
17.7.96	1am	Cocodamol	x2	oral			1am

DIET

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

KNOWN MEDICINE SENSITIVITIES 1.

WARD	NAME OF PATIENT	AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
39.	MS DEBORAH SULLIVAN DoB: 7/12/1972					COOKE

MANUAL PATIENT RECORDS

ALL HOSPITAL RECORDS HELD NHSGGC	☐		
ACS	☐		
BEATSON HOSPITAL	☐		
CANNIESBURN HOSPITAL	☐		
DENTAL HOSPITAL	☐		
GARTNAVEL GENERAL HOSPITAL	☐		
GLASGOW ROYAL INFIRMARY (vol 2)	☑		
INVERCLYDE ROYAL HOSPITAL	☐	MATERNITY	☐
NEW VICTORIA ACH	☐		
PRINCESS ROYAL MATERNITY	☐		
QUEEN ELIZABETH UNIVERSITY HOSPITAL	☐	MATERNITY	☐
ROYAL ALEXANDRA HOSPITAL	☐	MATERNITY	☐
ROYAL HOSPITAL FOR CHILDREN	☐		
STOBHILL HOSPITAL	☐		
VALE OF LEVEN	☐	MATERNITY	☐
WEST CARE AMBULATORY HOSPITAL	☐		
WESTERN INFIRMARY RECORDS	☐		

Including:

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

Sullivan Deborah CHI: 0712726128

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No Consent for Sharing Withheld: No

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000

Date of Completion: 13/03/2014

Dr. JJ Langan
Mcglone Practice
Baillieston Health Centre
20 Muirside Road baillieston
Glasgow
G69 7AD

Dear Dr JJ Langan,

Name	CHI	DoB	Address
Deborah Sullivan	0712726128	07/12/1972	6 MUIRHEAD COURT Glasgow G69 7EP

Admitted	Type	Discharged	Destination
13/03/2014 17:12	In Patient	13/03/2014	

Specialty	Consultant	Ward	Telephone
General Surgery	Ms Elzbieta Tolloczko	GRI Ward 67 General Surgery GP Referrals	0141 211 1291

Reason for Admission and Presenting Complaints	Admission Category
	Admission for treatment - Where the patient is expected to be treated for a diagnosed condition not otherwise specified

Diagnosis	Site	Side

Date	Procedures/Interventions/Operations

Clinical Comments: Dear Doctor

This 41 year old lady was admitted to the Surgical Department of the GRI after a fall at home. Complaining of RUQ pain and right side pain. Very tender on palpation over the ribcage on the right side, soft non tender abdomen. CXR: No pneumothorax and no obvious fracture. Impression is musclosketal pain following fall. We have discharged her with analgesia, PPI and Lactulose cover. Thank you for your time.

Kind regards
Dr Sinead Hagan Surgical FY1

Treatments: None recorded.

Follow-up arranged: none

Planned Outpatient Investigations: none

Final Discharge letter to follow: yes

Medication Info:

Allergies:

Height: cm **Weight:** kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment
Co-codamol 30/500 Tablets	Oral	2	tablet(s)	Every 4 - 6 Hours when required	1 Week	
...ofenac 50mg TID PREPACKED ONLY	Oral	50	mg	THREE Times a Day	1 Week	
Lactulose Liq as directed PREPACKED ONLY	Oral	15	ml	Twice a week	1 Week	
Omeprazole Capsules	Oral	40	mg	ONCE a Day	Indefinite	
Tramadol Capsule	Oral	100	mg	Every 4 - 6 Hours when required	1 Week	

Discontinued Medication:

Drug Name	Dose	UOM	Reason

Yours sincerely,
Dr Sinead Hagan1
Doctor

F cription Review

Medications Reviewed by Pharmacist: ,
Dispensed Medications Checked by Pharmacy: ,
Nurse discharging patient: Sinead Hagan, Doctor

Acute Services Division

Centre for Rheumatic Diseases
Wards 14/15
Glasgow Royal Infirmary
84 Castle Street
GLASGOW
G4 0SF

NHS
Greater Glasgow and Clyde

Clinic	27/09/2012
Dictated	27/09/2012
Typed	10/10/2012
Your Ref	
Our Ref	JP/LP

Dr R Madhok	**0141-211-4966 (F) 552-4862**
Dr D McCarey	**0141-211-4965 (F) 552-4862**
Dr S Saunders	0141-232-1029 (F) 552-4862
Prof R D Sturrock	0141-232-0883 (F) 211-4878
Dr M Field	0141-232-0883 (F) 211-0414
Prof I McInnes	0141-232-0883 (F) 211-0414
Out Patient Clinic	0141-211-5551
Receptionist	0141-211-5966
On-call Page	3105

Dr John Langan
Baillieston Health Centre
20 Muirside Road
Glasgow
G69 7AD

Dear Dr Langan

Deborah Sullivan - 07/12/1972 - CHI: 0712726128 - CRN: 10638479K
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

I reviewed Mrs Sullivan back in the Rheumatology Clinic today. Her problems are as follows:

1. **Musculoskeletal:** She continues to have pain in her hands, feet and knees. She says this is intermittent and comes in flares. She has been on Hydroxychloroquine 400 mgs once daily since January. This has made no difference to her joint pain.

   Results from her previous investigations reveal her CRP was normal at 11 with an ESR of 14. Her rheumatoid factor and anti-CCP antibodies are negative. Her ANA is negative. X-rays of her hands and feet are non-erosive.

   On examination today there was no evidence of synovitis. She had tenderness over most of her joints as well as multiple paired tender points throughout paraspinal muscles.

   I do not think there is anything to suggest ongoing active inflammation at present. In view of the fact that Mrs Sullivan has had no benefit from Hydroxychloroquine I have suggested she stops this. If she does have inflammatory arthritis it is certainly mild and would not suggest an increase in immunosuppressant therapy at the present time. I think a lot of her problems may well be related to fibromyalgia. I have given her written information about this today. I would be grateful if you could refer her to physiotherapist locally as I think she would benefit from this.

2. **Gastrointestinal:** She has previously had chronic pancreatitis and a fundoplication. She has chronic pain in her abdomen and takes Tramadol, Paracetamol, Nexium and Fentanyl patches.
3. **Depression:** She says she has quite severe depression and is currently on Duloxetine.
4. **Feet:** This loss of her medial arch is bilaterally and I think would benefit from referral to the podiatrists. I would be grateful if you could refer her to a podiatrist locally for consideration of orthosis.

5. **COPD:**
6. **Cardiovascular risk:** Blood pressure today 112/81.

Investigations:	Full blood count, U's and E's, LFT's, CRP, ESR
Medications:	Duloxetine, Fentanyl patch, Metoclopramide, Nexium, Paracetamol, Tramadol
Follow up:	I have not arranged formal follow up back in the Rheumatology Clinic. We would of course be very happy to see her back should you feels she is developing more active inflammatory arthropathy. I would be grateful if you could refer her to both the podiatrists and the physiotherapists locally. If her bloods from today are abnormal I will let you know

Yours sincerely

Jemma Pringle
ST5

Acute Services Division

NORTH & EAST GLASGOW BREAST UNIT

NHS
Greater Glasgow and Clyde

Stobhill ACH
133 Balornock Road
Glasgow
G21 3UW

Consultants	Secretaries	Contact Details:
Mr D T Hansell	Lorna Macrae	0141 355 1506
Mr K Ogston	Christine McKeown	0141 355 1504
Mrs M MacLean		
	Grace Ross	0141 355 1503
		Fax: 0141 355 1761

BREAST OUT-PATIENT CLINIC STOBHILL

Our Ref: MMCA/GR

Dictated: 11/07/2012
Typed: 06/08/2012

Dr V Mills
McGlone Practice
Baillieston Health Centre,
20 Muirside Road, Baillieston, Glasgow
G69 7AD

Dear Dr Mills

Deborah Sullivan - 07/12/1972 - CHI: 0712726128 - CRN: 10638479K
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

I reviewed Deborah today in Mr Ogston's Breast Clinic at Stobhill ACH. Deborah was referred to us with a lump in the lower aspect of her right breast. Of note, her sister has recently been diagnosed with breast cancer at 45. Deborah also has a paternal aunt who was diagnosed with breast cancer at the age of 30. As you know Deborah is 39 years old and she is a para 1. She breast fed her child. She had her menarche at the age of 15 and her first pregnancy at 27. She is currently on the mini pill. She first noticed the lump in her right breast approximately six weeks ago. She has a past medical history of appendicectomy, cholecystectomy, tonsillectomy and two hernias.

On examination I thought I could feel a ridge of lumpy tissue in the lower aspect of her right breast. This felt benign. I wondered if it was just an area of lumpy glandular tissue. I arranged for Deborah to have an ultrasound carried out and this showed normal appearances and no suspicious features were seen and this was reported as U1. In view of Deborah's family history I think we should arrange for her to have a mammogram carried out and review her on an annual basis. Unfortunately we were unable to perform a mammogram today but she will return to the clinic within the next few weeks to have this done and we will review her back next year.

Yours sincerely

Moyra McArthur
Breast Care Sister

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

Attachments

REFERRAL TO

General Surgery - Breast
GGC General Referral

Glasgow Royal Infirmary
84 Castle Street
Glasgow
G4 0SF

Consultant / receiving practitioner and/or specialty clinic

Hospital and hospital address

Hospital location code: G107H

Email address: -

Urgency of referral URGENT
Date of referral 27-Jun-2012
Date sent 27-Jun-2012

PATIENT DETAILS

Surname	Sullivan
Forename(s)	Deborah
Title	Ms
Sex	Female
Date of birth	07-Dec-1972
CHI no.	0712726128
Area of Residence	-

Patient's address

6 Muirhead Court
BAILLIESTON
GLASGOW
G69 7EP

Contact number(s)

Voice: 07936225898

1010038264260

Unique Care Pathway Number: 1010038264260

REGISTERED GP DETAILS

Name	Dr John Langan		
GMC code	1351886	GP code	05193
Practice name	Baillieston Health Centre (18889)		
Practice code	46216		

Practice address

20 Muirside Road
Baillieston
Glasgow
G69 7AD

Contact number(s)

Voice: 0141-531-8050
Facsimile: 0141-531-8067

REFERRING GP DETAILS

Name	Dr V Mills		
GMC code	7077798	GP code	G85197
Practice name	-		
Practice code	46216		

Practice address

Contact number(s)

-

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: Right breast lump.

Comment:- Dear Doctor

I would very much appreciate your urgent review of this 39 year old lady who found a non tender breast lump on her right breast during self examination 2 weeks ago. She preformed this self examination as her sister aged 45 was recently diagnosed with breast cancer and underwent a double mastectomy. Ms Sullivan has not noticed any skin or nipple changes. She has a daughter aged 13 who was breast feed and she is currently on the progesterone only pill. Of note she also has a paternal aunt who was diagnosed with breast cancer aged 30 and another paternal aunt who was diagnosed with breast cancer at aged 50.

On examination today there was a small hard lump palpable in the inferior aspect of the right breast. There were no skin or nipple changes and there was no palpable lymphadenopathy.

Given this lady's significant family history of breast cancer I would very much appreciate your urgent review to rule out any sinister cause for her right sided breast lump.

Many thanks for your time and consideration.

With kind regards.

Yours sincerely

DR VIRGINIA MILLS
FY2

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Chronic pancreatitis	-	09-Mar-2009	09-Mar-2009
Anxiety with depression	-	12-Oct-2006	12-Oct-2006
Hiatus hernia NOS	moderately large	05-Nov-2004	05-Nov-2004
Dislocation or subluxation of shoulder	Left shoulder	17-Mar-2004	17-Mar-2004
Overdose of drug	Kapake and Tramadol with Diazepam	30-Aug-2002	30-Aug-2002
[D]Abdominal pain	Vomiting	27-Aug-2002	27-Aug-2002
Chronic pancreatitis	-	02-Jul-2002	02-Jul-2002
Constipation	-	02-Jul-2002	02-Jul-2002
Chronic pancreatitis	-	01-Oct-2001	01-Oct-2001
Anxiety states	Chronic	01-Jul-2001	01-Jul-2001
Sexual assault	-	01-Jul-2001	01-Jul-2001
[X]Rape	-	01-Jul-2001	01-Jul-2001
Reflux oesophagitis	-	23-Apr-1999	23-Apr-1999
Diaphragmatic hernia	-	23-Apr-1999	23-Apr-1999
[D]Abdominal pain	Recurrent	27-Mar-1999	27-Mar-1999
Cholelithiasis	-	23-Apr-1996	23-Apr-1996
Acute cholecystitis	-	23-Apr-1996	23-Apr-1996
Urinary tract infection, site not specified	-	01-Jun-1995	01-Jun-1995
[D]Nausea and vomiting	-	01-Feb-1995	01-Feb-1995

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Laparotomy	and open fundoplication	14-Oct-2009	14-Oct-2009
Laparotomy	and open revision of fundoplication	06-Oct-2009	06-Oct-2009
Nissen-fundoplication using abdominal approach		26-Oct-2004	26-Oct-2004
[SO]Sphincter of Oddi	Dysfuntion	14-Nov-1996	14-Nov-1996
Endoscopic retrograde cholangiopancreatography	Major papilla was located in the second part of the duodenum	10-Oct-1996	10-Oct-1996
Excision of gall bladder	-	23-Apr-1996	23-Apr-1996

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Hydroxychloroquine Sulphate Tablets 200 mg	56	56 tablet	2 DAILY	-	11-May-2012	25-Jun-2012
Laxido Orange Oral Powder Sachets Sugar Free	30	30 sachet	1 SACHET AS DIRECTED	-	11-May-2012	25-Jun-2012
Esomeprazole Gastro-resistant Tablets 40 mg	112	112 TABLET	1 Tab Twice daily	-	29-Dec-2011	25-Jun-2012
Tramadol Hydrochloride Capsules 50 mg	224	224 capsule	ONE OR TWO TO BE TAKEN FOUR TIMES A DAY WHEN REQUIRED	-	22-Dec-2011	25-Jun-2012
Temazepam Tablets 10 mg	28	28 tablet	ONE TO BE TAKEN AT NIGHT	-	22-Dec-2011	25-Jun-2012
Diazepam Tablets 5 mg	28	28 tablet	1 Tab Daily	-	22-Dec-2011	22-Jun-2012
Dihydrocodeine Tartrate Tablets 30 mg	168	168 tablet	ONE OR TWO TABLETS TO BE TAKEN THREE OR FOUR TIMES A DAY	-	22-Dec-2011	25-Jun-2012
Metoclopramide Hydrochloride Tablets 10 mg	168	168 TABLET	TAKE ONE THREE TIMES A DAY	-	28-Oct-2011	25-Jun-2012
Lactulose Solution 3.1-3.7 g/5 ml	500	500 ML	THREE 5ML SPOONFULS TO BE TAKEN TWICE A DAY	-	29-Mar-2011	31-May-2012
Granisetron Hydrochloride Tablets 1 mg	112	112 TABLET	1 Tab Twice daily	-	18-Nov-2010	25-Jun-2012
Paracetamol Capsules 500 mg	224	224 CAPS	2 Caps qds	-	18-Nov-2010	25-Jun-2012

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Cerazette Tablets 75 micrograms	84	84 TABLET	ONE TO BE TAKEN EACH DAY	-	26-Jun-2012	26-Jun-2012
Duloxetine Gastro-resistant Capsules 30 mg	28	28 capsule	1 Cap Daily	-	26-Jun-2012	26-Jun-2012
Clarithromycin Tablets 500 mg	10	10 TABLET	ONE TO BE TAKEN TWICE A DAY	-	26-Jun-2012	26-Jun-2012
Duloxetine Gastro-resistant Capsules 60 mg	28	28 capsule	1 Cap Daily	-	01-Jun-2012	26-Jun-2012
Duloxetine Gastro-resistant Capsules 30 mg	28	28 capsule	1 Cap Daily	-	01-Jun-2012	01-Jun-2012
Fentanyl Transdermal						

patches 75 micrograms/hour	10	10 PATCH	apply 1 patch every 72 hours	01-Jun-2012	26-Jun-2012
Transvasin Heat Rub (Cream)	80	80 gram	APPLY AS REQUIRED	11-May-2012	11-May-2012
Anusol-Hc Ointment	30	30 GRAM	APPLY SPARINGLY MORNING AND NIGHT AND AFTER EACH BOWEL MOVEMENT (MAX FOUR TIMES DAILY) FOR UP TO 7 DAYS	11-May-2012	11-May-2012
Cerazette Tablets 75 micrograms	21	21 tablet	ONE TO BE TAKEN EACH DAY	11-May-2012	11-May-2012
Duloxetine Gastro-resistant Capsules 60 mg	28	28 capsule	1 Cap Daily	10-Apr-2012	04-May-2012
Fentanyl Transdermal patches 75 micrograms/hour	10	10 PATCH	apply 1 patch every 72 hours	10-Apr-2012	04-May-2012
Duloxetine Gastro-resistant Capsules 30 mg	28	28 capsule	1 Cap Daily	10-Apr-2012	04-May-2012
Fentanyl Transdermal patches 75 micrograms/hour	10	10 PATCH	apply 1 patch every 72 hours	14-Mar-2012	14-Mar-2012
Duloxetine Gastro-resistant Capsules 60 mg	28	28 capsule	1 Cap Daily	14-Mar-2012	14-Mar-2012
Duloxetine Gastro-resistant Capsules 30 mg	42	42 capsule	1 Cap Daily	14-Mar-2012	14-Mar-2012
Cerazette Tablets 75 micrograms	21	21 tablet	ONE TO BE TAKEN EACH DAY	09-Mar-2012	09-Mar-2012
Hydroxychloroquine Sulphate Tablets 200 mg	60	60 tablet	2 Tabs Daily	09-Feb-2012	09-Mar-2012
Fentanyl Transdermal patches 75 micrograms/hour	10	10 PATCH	apply 1 patch every 72 hours	18-Jan-2012	15-Feb-2012
Duloxetine Gastro-resistant Capsules 30 mg	42	42 capsule	1 Cap Daily	11-Jan-2012	15-Feb-2012
Duloxetine Gastro-resistant Capsules 60 mg	28	28 capsule	1 Cap Daily	11-Jan-2012	15-Feb-2012
Laxido Orange Oral Powder Sachets Sugar Free	56	56 sachet	1 SACHET BD	11-Jan-2012	11-Jan-2012
Anugesic-Hc Cream	30	30 gram	Apply sparingly Twice daily	11-Jan-2012	11-Jan-2012

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		19-Jan-2012
Current smoker:	Smokefree Pharmacy Service	07-Apr-2011
Ex smoker:	priority=2	14-Jan-2009
Current smoker:	Disease: SPICE Basic Health Values, priority=2	23-Oct-2008
Current smoker:	Disease: SPICE Basic Health Values, priority=2	09-May-2006

Clinical warnings

Allergies

Description	Date recorded
Adverse reaction to penicillins	16-Feb-2009

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:No

Social circumstances

Ethnic Origin: (White) British

Signature of referring doctor (or other professional) **Date**

Acute Services Division

NHS
Greater Glasgow and Clyde

Centre for Rheumatic Diseases
Wards 14/15
Glasgow Royal Infirmary
84 Castle Street
GLASGOW
G4 0SF

Clinic	07/06/2012
Dictated	07/06/2012
Typed	16/06/2012
Your Ref	
Our Ref	DM/CB

Dr R Madhok	**0141-211-4966 (F) 552-4862**
Dr D McCarey	**0141-211-4965 (F) 552-4862**
Dr S Saunders	0141-232-1029 (F) 552-4862
Prof R D Sturrock	0141-232-0883 (F) 211-4878
Dr M Field	0141-232-0883 (F) 211-0414
Prof I McInnes	0141-232-0883 (F) 211-0414
Out Patient Clinic	0141-211-5551
Receptionist	0141-211-5966
On-call Page	3105

Dr John Langan
Baillieston Health Centre
20 Muirside Road
Baillieston, Glasgow
G69 7AD

Dear Dr Langan

Deborah Sullivan - 07/12/1972 - CHI: 0712726128 - CRN: 10638479K
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

This patient did not attend her Rheumatology Clinic review appointment. I have sent one further review appointment.

Yours sincerely

DAVID McCAREY
Consultant Rheumatologist

IMMEDIATE DISCHARGE LETTER

NHS Greater Glasgow

GP COPY

First Issued: 03/04/2012 11:18
Printed: 03/04/2012 11:18

Glasgow Royal Infirmary
84 Castle Street
Glasgow
G4 0SF
Telephone : 0141 - 211 - 4000

Admitted: 29/03/2012 **Discharged:** 30/03/2012
Discharged to: Home
Ward: WD65
Consultant: MR CHONG, General Surgery
Hospital No: 10638479K **Date of birth:** 07/12/1972
CHI: 0712726128

REGISTERED GP

Dr JOHN LANGAN
MCGLONE PRACTICE
BAILLIESTON HEALTH CENTRE
20 MUIRSIDE ROAD, BAILLIESTON
GLASGOW

PATIENT

DEBORAH SULLIVAN
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW
LANARKSHIRE

DIAGNOSES **ICD10** **PROCEDURES** **OPCS4**

No diagnoses have been made for this patient

MEDICATION

No medication has been prescribed for this patient

Pharmacy Comments

FOLLOW UP ARRANGEMENTS

Outpatient Clinic	Consultant	Date
No arrangements made		

Outpatient Investigations	Date
No arrangements made	

Community Care	Date	Reason
No arrangements made		

GENERAL COMMENTS

Final discharge letter to follow

Dear Doctor,

This 39 year old lady was admitted on the 29/3/12 with epigastric pain and constipation. Bloods showed mild increase in inflammatory markers. AXR showed faecal loading. Patient was managed with analgesia and laxatives. The patient moved her bowels and the pain settled. The patient was discharged home on the 30/3/12 with no routine follow up planned. There were no changes to the patient's regular medications.

Regards,

Dr A McKay
FY1 Gen Surg

Signed: _____ **Designation:** _____

Contact: Alastair McKay **Pager Number:**

Res: 23/2/12

Centre for Rheumatic Diseases
Wards 14/15
Glasgow Royal Infirmary
84 Castle Street
GLASGOW
G4 0SF

Dr Rajan Madhok	0141-211-4966 (F) 552-4862
Dr David McCarey	**0141-211-4965 (F) 552-4862**
Dr Sarah Saunders	0141-232-1029 (F) 552-4862
Prof R D Sturrock	0141-232-0883 (F) 211-4878
Dr M Field	0141-232-0883 (F) 211-0414
Prof I McInnes	0141-232-0883 (F) 211-0414
Out Patient Clinic	0141-211-5551
Receptionist	0141-211-5966
On-call Page	1105

Ref: DMcC/SRO/10638479K/**CHI No:** 0712726128

Dictated: 20/02/2012
Typed: 22/02/2012

Deborah Sullivan
6 Muirhead Court
Baillieston
Glasgow
G69 7EP

Dear Ms Sullivan

Your GP has written to us to clarify what eyes checks needs to be done while you are on Hydroxychloroquine which was started by Dr Madhok in January. We now generally recommend that an annual appointment with your optician is sufficient in terms of monitoring of your eyes while you continue on this medication. I would therefore recommend that you make an appointment with your local optician for this to be undertaken. It may be that Dr Madhok has also referred you to Glasgow Caledonian University for a further more detailed check. If he has made this referral then it will take a number of months for you to be seen by them and hence I would advise attendance at your optician in the first instance.

I trust that this information is satisfactory.

Your sincerely

David McCarey
Consultant Rheumatologist

Cc Dr Langan, Baillieston Health centre

Centre for Rheumatic Diseases
Wards 14/15
Glasgow Royal Infirmary
84 Castle Street
GLASGOW
G4 0SF

Dr Rajan Madhok	0141-211-4966 (F) 552-4862
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On-call Page	1105

Ref: DMcC/SRO

Dictated: 20/02/2012
Typed: 22/02/2012

Dr John Langan
McGlone Practice
Baillieston Health Centre
20 Muirside Road
Baillieston, Glasgow
G69 7AD

Dear Dr Langan

Deborah Sullivan - 07/12/1972 - CHI: 0712726128 - CRN: 10638479K
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

Many thanks indeed for your letter dated 16.02.12. I am replying on behalf of Dr Madhok who saw this lady in January. It seems from his letter that he had given Deborah an information leaflet on Hydroxychloroquine and it is unclear whether or not she was referred to Glasgow Caledonian University for Ocular Screening.

The current guidelines from The British Society of Rheumatology and Royal College of Ophthalmologists suggest that annual review with an Optician is entirely satisfactory as regards screening for ocular toxicity. I have written o Deborah to clarify that would be our advice. In the meantime if Dr Madhok has referred her to Glasgow Caledonian University then this will provide additional reassurance.

Many thanks indeed for your letter.

Your sincerely,

David McCarey
Consultant Rheumatologist

Centre for Rheumatic Diseases
Wards 14/15
Glasgow Royal Infirmary
84 Castle Street
GLASGOW
G4 0SF

Dr Rajan Madhok	**0141-211-4966 (F) 552-4862**
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Prof I McInnes	0141-232-0883 (F) 211-0414
Out Patient Clinic	0141-211-5551
Receptionist	0141-211-5966
On-call Page	1105

Ref: RM/SRO

Dictated: 19/01/2012
Typed: 25/01/2012

Dr John Langan
McGlone Practice
Baillieston Health Centre
20 Muirside Road
Baillieston, Glasgow
G69 7AD

Dear Dr Langan

Deborah Sullivan - 07/12/1972 - CHI: 0712726128 - CRN: 10638479K
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

Thank you for asking us to see the above named. Deborah is a 39-year-old single mother of a 13-year-old. She is a smoker. Her problems are:

1. **Gastrointestinal:** She was previously under the care of Mr Smith. Current weight is 77kg for a height of 176. Previous diagnosis of chronic pancreatitis secondary to gallstones. As a result of the chronic pancreatitis she has had pain for which she is on opiate based analgesics. Currently she is receiving no follow-up. I have made no assessment of the endocrine or exocrine function of her pancreas.

2. **Musculoskeletal:** She gives a good history of a bilateral, symmetrical, peripheral polyarthropathy. She states that in the mornings her hands are clawed, stiff and swollen. She cannot wear rings. At worst the pain is 10/10 and functional capacity is scored 8/10. Other symptomatic joints include her wrists, knees and feet. She denied any seronegative or connective tissue associations.

   On examination she was well looking. No mucocutaneous abnormality. Cardio-respiratory examination was normal. Abdominal examination not undertaken. No focal, motor or neurological deficit. Cranial nerves intact. Like you I did think that she had swelling of her wrists and over her fore foot bilaterally.

   In the light of this I have asked her to consider the addition of Hydroxychloroquine 400mg daily. She has also been advised that it will take at least 12 weeks for Hydroxychloroquine to give benefit. I did not discuss the ocular toxicity but did give her an AR UK Leaflet on Hydroxychloroquine.

3. **Lifestyle:** Smoker 15 cigarettes per day – advised.

4. **COPD;**

5. **Cardiovascular risk:** BP 115/84

6. **Social:** At home with her 13-year-old daughter.

Investigations: FBC, Biochemistry Profile, ESR & CRP, Autoantibodies including CCP, X-rays.

Drugs: ~~Duloxetine, Dihydrocodeine, Fentanyl Patch, Lactulose, Metoclopramide, Omeprazole, Paracetamol, Tramadol and Lactulose~~ *~~Please consider the addition of Hydroxychloroquine 400mg daily (started 19.01.12).~~*

Next appointment: Rheumatology Outpatient Clinic – 12th April 2012

Yours sincerely

R Madhok
Consultant Physician and Rheumatologist

FINAL DISCHARGE LETTER

Glasgow Royal Infirmary 84 Castle Street, Glasgow G4 0SF 0141-211 4182
2nd Floor Diabetes & Cardiology Wards 4&5

Consultants: Prof. Miles Fisher Dr. Russell Drummond Dr. S. Cleland

Dr John Langan McGlone Practice Baillieston Health Centre, 20 Muirside Road, Baillieston, Glasgow G69 7AD	Deborah Sullivan 6 Muirhead Court Baillieston Glasgow G69 7EP Hospital Number 10638479K CHI Number 0712726128	**Admitted: 19.12.2011** **Discharged: 22.12.2011** **Follow Up:** **Rheumatology Clinic – as already arranged.**
Phone: Copy to:	Phone:	

Main Diagnoses:

1. **Chronic pain.**

Previous/inactive Diagnoses:

1. **Previous alcohol excess.**
2. **Previous cholecystectomy.**

Presenting complaint: This 39 year old lady presented with left sided weakness following increasing her Gabapentin dose from 600mgs t.d.s. to 600mgs q.d.s. for increasing joint pains. There was no history of visual or speech disturbance or of sensory symptoms and no history of head injury.

On examination the patient had normal tone and normal reflexes with 5/5 power in the right upper and lower limbs and 4/5 power in the left upper and lower limbs. Sensation was normal and no abnormality of the cranial nerves was detected. Heart sounds 1 and 2 were normal with no added sounds and chest was clear on auscultation. Abdomen was soft and non tender with normal bowel sounds. The patient remained haemodynamically stable.

Diagnostic tests / procedures and relevant results / treatment and progress:
The patient had an MI screen due to an episode of chest discomfort, however this was negative. CT brain was carried out in view of the left sided weakness and demonstrated no evidence of infarction or haemorrhage.

Gabapentin has been discontinued on the advice of the Rheumatology Team and the patient will be reviewed by Rheumatology as an outpatient.
Esomeprazole has been increased to 40mgs b.d. due to increasing symptoms of dyspepsia.
No significant abnormalities were demonstrated in routine biochemistry on discharge.

Medication on discharge, changes and why

1. **Lactulose 15mls prn.**
2. **Fentanyl patch 75ugs an hour.**
3. **Paracetamol 1G q.d.s.**
4. **Dihydrocodeine 30mgs q.d.s.**
5. **Esomeprazole 40mgs b.d.**
6. **Metachlopramide 10mgs t.d.s.**
7. **Duloxetine 90mgs once daily.**
8. **Diclofenac gel 3% one application b.d.**
9. **Tramadol tablets 50mgs prn.**

Lactulose has been discontinued.

Date:	Signed:	Name:	Position:	Typed:	Ref:
23.12.2011		Dr. S. Gallanagh	FY2	13.1.2012	SG/CMC

EMERGENCY DEPARTMENT
ACUTE ASSESSMENT UNIT GRI
84 CASTLE STREET
GLASGOW
G4 0SF

NHS
Greater Glasgow and Clyde

Dr JOHN LANGAN
BAILLIESTON HEALTH CENTRE
20 MUIRSIDE ROAD BAILLIESTON GLASGOW

G69 7AD

Date : 20 Dec 2011

Dear Dr JOHN LANGAN,

Re: DEBORAH SULLIVAN, 6 MUIRHEAD COURT, BAILLIESTON, GLASGOW, G69 7EP
Date of Birth: 07/12/1972 CHI number: 0712726128

HOSPITAL INFORMATION MISSING Patient attended on the 19 Dec 2011.

The presenting complaint was: **MED REC**

Triage information:	**NUMBENESS IN LEFT ARM STARTED AROUND 2PM TODAY. UP DOSE OF GABAPENTIN ON DOCOTRS ADVICE TO 600MGS. PT HAS RHEUMATOLOGY PROBLEMS, RECENT FLARE UP. ALSO SUFFER PANIC ATTACK AND IS VERY ANXIOUS AT TRIAGE. CO OF CHEST PAIN ON ARRIVEL AT HOSPITAL.**
The following investigations were carried out:	**None**
The A&E diagnosis was:	**NEUROLOGICAL - OTHER NEUROLOGICAL PROBLEM-SPECIFY IN G P LETTER**

The following treatment was given: **None**

At the conclusion of treatment the patient was: **ADMITTED**

Follow-up: **ADMITTED**

Additional information: **None**



Yours sincerely,

KEVIN MCCLOY

ORTHOPAEDICS



Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

Attachments

REFERRAL TO

Trauma & Orthopaedic - Wrist & Hand
GGC General Referral

Consultant / receiving practitioner and/or specialty clinic

Glasgow Royal Infirmary
84 Castle Street
Glasgow
G4 0SF

Hospital and hospital address

Hospital location code: G107H

Email address:

Urgency of referral ROUTINE

Date of referral 01-Sep-2011 **Date sent** 01-Sep-2011

PATIENT DETAILS

Surname	Sullivan
Forename(s)	Deborah
Title	Ms
Sex	Female
Date of birth	07-Dec-1972
CHI no.	0712726128
Area of Residence	-

Patient's address

6 Mulrhead Court
BAILLIESTON
GLASGOW
G69 7EP

Contact number(s)

Voice: 07936225898

101002478646C Unique Care Pathway Number: 101002478646C

REGISTERED GP DETAILS

Name	Dr John Langan		
GMC code	1351886	GP code	05193
Practice name	Baillieston Health Centre (18889)		
Practice code	46216		

Practice address

20 Muirside Road
Baillieston
Glasgow

Contact number(s)

Voice: 0141-531-8050
Facsimile: 0141-531-8067

REFERRING GP DETAILS

Name	Dr. Melanie MacLeod		
GMC code	6163159	GP code	17469
Practice name	McGlone Practice (46216)		
Practice code	46216		

Practice address

Baillieston Health Centre
20 Muirside Road
Baillieston
Glasgow

Contact number(s)

Voice: 0141 531 8050
Facsimile: 0141 531 8067

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: Joint pains

Comment: I'd appreciate your review of this 38 year old lady who has had a few months of joint pains in her wrists, right hip, knee & ankle. She describes morning stiffness with intermittent swelling and at times feels she is actually unable to lift a kettle of tea with her right hand.

On examination she has a mild synovitis of her right wrist and fingers with full range of movement. Both wrists were mildly tender and no other obvious abnormalities in her other joints were noted. Of note recent x-rays of her hands proved to be normal and no obvious abnormalities in x-rays of pelvis. Rheumatoid factoring in fibromyalgia is unfortunately awaited however she does have a mildly positive ANA from blood results.

Of note this lady has suffered a great deal from chronic pancreatitis of which I believe she is on Fentanyl and Dihydrocodeine. She is also suffering from low mood and due to be seen by specialists in this area. In view of the above, I'd appreciate your review. Many thanks.

Yours sincerely

Dr Melanie McLeod

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Chronic pancreatitis	-	09-Mar-2009	09-Mar-2009
Anxiety with depression	-	12-Oct-2006	12-Oct-2006
Hiatus hernia NOS	moderately large	05-Nov-2004	05-Nov-2004
Dislocation or subluxation of shoulder	Left shoulder	17-Mar-2004	17-Mar-2004
Overdose of drug	Kapake and Tramadol with Diazepam	30-Aug-2002	30-Aug-2002
[D]Abdominal pain	Vomiting	27-Aug-2002	27-Aug-2002
Chronic pancreatitis	-	02-Jul-2002	02-Jul-2002
Constipation	-	02-Jul-2002	02-Jul-2002
Chronic pancreatitis	-	01-Oct-2001	01-Oct-2001
Sexual assault	-	01-Jul-2001	01-Jul-2001
[X]Rape	-	01-Jul-2001	01-Jul-2001
Anxiety states	Chronic	01-Jul-2001	01-Jul-2001
Reflux oesophagitis	-	23-Apr-1999	23-Apr-1999
Diaphragmatic hernia	-	23-Apr-1999	23-Apr-1999
[D]Abdominal pain	Recurrent	27-Mar-1999	27-Mar-1999
Cholelithiasis	-	23-Apr-1996	23-Apr-1996
Acute cholecystitis	-	23-Apr-1996	23-Apr-1996
Urinary tract infection, site not specified	-	01-Jun-1995	01-Jun-1995
[D]Nausea and vomiting	-	01-Feb-1995	01-Feb-1995

Past procedures (High and medium priority - all)

Description	Date performed	Date recorded
Laparotomy	14-Oct-2009	14-Oct-2009
Laparotomy	06-Oct-2009	06-Oct-2009
Nissen fundoplication using abdominal approach	26-Oct-2004	26-Oct-2004
[SO]Sphincter of Oddi	14-Nov-1996	14-Nov-1996
Endoscopic retrograde cholangiopancreatography	10-Oct-1996	10-Oct-1996

Excision of gall bladder	23-Apr-1996	23-Apr-1996	

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Lactulose Solution 3.1-3.7 g/5 ml	500	500 ML	THREE 5ML SPOONFULS TO BE TAKEN TWICE A DAY		29-Mar-2011	08-Aug-2011
Esomeprazole Gastro-resistant Tablets 20 mg	56	56 TABS	1 Tab Twice daily	-	18-Nov-2010	12-Aug-2011
Gabapentin Capsules 300 mg	168	168 caps	2 caps tid	-	18-Nov-2010	08-Aug-2011
Granisetron Hydrochloride Tablets 1 mg	34	34 TABS	1 tab Twice daily	-	18-Nov-2010	08-Aug-2011
Paracetamol Capsules 500 mg	224	224 CAPS	2 Caps qds	-	18-Nov-2010	08-Aug-2011

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Imipramine Tablets 25 mg	168	168 tablet	3 BD	-	12-Aug-2011	12-Aug-2011
Dihydrocodeine Tartrate Tablets 30 mg	168	168 TABS	1 or 2 Tabs 3 times daily	-	08-Aug-2011	08-Aug-2011
Piroxicam Gel 0.5 %	112	112 gram	APPLY THINLY TWICE A DAY	-	26-Jul-2011	26-Jul-2011
Transvasin Heat Rub (Cream)	80	80 gram	APPLY AS REQUIRED	-	26-Jul-2011	26-Jul-2011
Cerazette Tablets 75 micrograms	84	84 TABLET	ONE TO BE TAKEN EACH DAY	-	26-Jul-2011	26-Jul-2011
Fentanyl Transdermal patches 75 micrograms/hour	10	10 patch	Apply every 72 hours	-	15-Jul-2011	12-Aug-2011
Tramadol Hydrochloride Capsules 50 mg	224	224 capsule	ONE OR TWO TO BE TAKEN FOUR TIMES A DAY WHEN REQUIRED	-	15-Jul-2011	12-Aug-2011
Imipramine Tablets 25 mg	168	168 tablet	3 BD	-	15-Jul-2011	15-Jul-2011
Diazepam Tablets 5 mg	28	28 tablet	1 Tab Daily	-	15-Jul-2011	12-Aug-2011
Temazepam Tablets 10 mg	28	28 tablet	ONE TO BE TAKEN AT NIGHT	-	15-Jul-2011	12-Aug-2011
Metoclopramide Hydrochloride Tablets 10 mg	90	90 tablet	TAKE ONE THREE TIMES A DAY	-	15-Jul-2011	15-Jul-2011
Tramadol Hydrochloride Capsules 50 mg	224	224 capsule	ONE OR TWO TO BE TAKEN FOUR TIMES A DAY WHEN REQUIRED	-	25-May-2011	20-Jun-2011
Diazepam Tablets 5 mg	28	28 tablet	1 Tab Daily	-	25-May-2011	20-Jun-2011
Imipramine Tablets 25 mg	168	168 tablet	3 BD	-	25-May-2011	20-Jun-2011
Temazepam Tablets 10 mg	28	28 tablet	ONE TO BE TAKEN AT NIGHT	-	25-May-2011	20-Jun-2011
Dihydrocodeine Tartrate Tablets 30 mg	168	168 TABS	1 or 2 Tabs 3 times daily	-	17-May-2011	17-Jun-2011
Fentanyl Transdermal patches 75 micrograms/hour	10	10 patch	Apply every 72 hours	-	28-Apr-2011	07-Jun-2011
Cyclizine Tablets 50 mg	84	84 tablet	ONE TO BE TAKEN THREE TIMES A DAY	-	04-Apr-2011	04-Apr-2011

Metoclopramide Hydrochloride Tablets 10 mg	84	84 tablet	TAKE ONE THREE TIMES A DAY	-	04-Apr-2011	04-Apr-2011
Pyridoxine Hydrochloride Tablets 10 mg	56	56 tablet	1 Tab Daily	-	29-Mar-2011	21-Apr-2011
Diazepam Tablets 5 mg	28	28 tablet	1 Tab Daily	-	29-Mar-2011	21-Apr-2011
Temazepam Tablets 10 mg	28	28 tablet	ONE TO BE TAKEN AT NIGHT	-	29-Mar-2011	21-Apr-2011
Imipramine Tablets 25 mg	168	168 tablet	3 BD	-	29-Mar-2011	21-Apr-2011
Tramadol Hydrochloride Capsules 50 mg	224	224 capsule	ONE OR TWO TO BE TAKEN FOUR TIMES A DAY WHEN REQUIRED	-	29-Mar-2011	21-Apr-2011
Metoclopramide Hydrochloride Tablets 10 mg	60	60 tablet	TAKE ONE THREE TIMES A DAY	-	29-Mar-2011	21-Apr-2011
Fentanyl Transdermal patches 75 micrograms/hour	10	10 patch	Apply every 72 hours	-	03-Mar-2011	29-Mar-2011
Lactulose Solution 3.1-3.7 g/5 ml	500	500 ML	THREE 5ML SPOONFULS TO BE TAKEN TWICE A DAY	-	01-Mar-2011	29-Mar-2011
Dihydrocodeine Tartrate Tablets 30 mg	168	168 TABS	1 or 2 Tabs 3 times daily	-	01-Mar-2011	29-Mar-2011

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:	Smokefree Pharmacy Service	07-Apr-2011
Ex smoker:	priority=2	14-Jan-2009
Current smoker:	Disease: SPICE Basic Health Values, priority=2	23-Oct-2008
Current smoker:	Disease: SPICE Basic Health Values, priority=2	09-May-2006
Never smoked tobacco:	Disease: SPICE Basic Health Values,	18-Jan-2005

Clinical warnings

Allergies

Description	Date recorded
Adverse reaction to penicillins	16-Feb-2009

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

FINAL DISCHARGE LETTER

Glasgow Royal Infirmary 84 Castle Street, Glasgow G4 0SF 0141-211 4182
2nd Floor Diabetes & Cardiology Wards 4&5

Consultants: Prof. Miles Fisher Dr. Russell Drummond Dr. S. Cleland

Dr John Langan McGlone Practice Baillieston Health Centre, 20 Muirside Road, Baillieston, Glasgow G69 7AD Phone: Copy to:	Deborah Sullivan 6 Muirhead Court Baillieston Glasgow G69 7EP Hospital Number 10638479K CHI Number 0712726128 Phone:	**Admitted: 19.12.2011** **Discharged: 22.12.2011** **Follow Up:** Rheumatology Clinic – as already arranged.

Main Diagnoses:

1. **Chronic pain.**

Previous/inactive Diagnoses:

1. **Previous alcohol excess.**
2. **Previous cholecystectomy.**

Presenting complaint: This 39 year old lady presented with left sided weakness following increasing her Gabapentin dose from 600mgs t.d.s. to 600mgs q.d.s. for increasing joint pains. There was no history of visual or speech disturbance or of sensory symptoms and no history of head injury.

On examination the patient had normal tone and normal reflexes with 5/5 power in the right upper and lower limbs and 4/5 power in the left upper and lower limbs. Sensation was normal and no abnormality of the cranial nerves was detected. Heart sounds 1 and 2 were normal with no added sounds and chest was clear on auscultation. Abdomen was soft and non tender with normal bowel sounds. The patient remained haemodynamically stable.

Diagnostic tests / procedures and relevant results / treatment and progress:
The patient had an MI screen due to an episode of chest discomfort, however this was negative. CT brain was carried out in view of the left sided weakness and demonstrated no evidence of infarction or haemorrhage.

Gabapentin has been discontinued on the advice of the Rheumatology Team and the patient will be reviewed by Rheumatology as an outpatient.
Esomeprazole has been increased to 40mgs b.d. due to increasing symptoms of dyspepsia.
No significant abnormalities were demonstrated in routine biochemistry on discharge.

Medication on discharge, changes and why

1. Lactulose 15mls prn.
2. Fentanyl patch 75ugs an hour.
3. Paracetamol 1G q.d.s.
4. Dihydrocodeine 30mgs q.d.s.
5. Esomeprazole 40mgs b.d.
6. Metachlopramide 10mgs t.d.s.
7. Duloxetine 90mgs once daily.
8. Diclofenac gel 3% one application b.d.
9. Tramadol tablets 50mgs prn.

Lactulose has been discontinued.

Date:	Signed:	Name:	Position:	Typed:	Ref:
23.12.2011		Dr. S. Gallanagh	FY2	13.1.2012	SG/CMC

RECEIVING PSYCHIATRIST

Date: Monday 19-Dec-11 **Agency Phone No.**

Patient Name: Deborah Sullivan Sex: F **Date of Birth:** 07-Dec-1972 **Age:** 39 years

Address: 6 Muirhead Court Baillieston **Own Doctor:** Langan,JJ(222)

Surgery: Provider Group

Glasgow

G69 7EP

Home Tel: 0141 771 6310

Case Origin: **Case Number:** 3303196

Caller Name: **Tel:** **Case Priority:** Pr-1-Within-1-hr

Reported Condition: **Receive Time:** **Operator:**

Latest Consultation Details **Consulted By:** Keany,Lisa(249)

Cons. Begin: 9:15 PM

Cons. Finished: 9:31 PM

patient awaiting rheumatology appt next month for joint pain. particularly knees. fingers, wrists and elbows which are affected. patient on gabapentin for this. has had acute flare up over past few days and spoke to gp who increased dose from 600mgs tid to 600mgs qds. following this she was aware of numbness down left arm and this was highlighted in side effects so has sought medical advice. also prone to panic attacks and is quite anxious at present. has possible uti at present and is on trimethoprin. ALLERGIC TO PENICILLIN. JCrooks

Examination Details:

BP 142/82
Power R arm 5/5 Power L arm 2/5. Past pointing
Tone normal both arms, no reduction in sensation either arm
Limping. power 5/5 R leg, 3/5 L leg.
cranial nerves intact

to GRI

HEAD/NECK
Temperature C 37.4

Clinical Codes:

G6... Cerebrovascular disease

Prescription Items:

Diagnosis:

marked weakness L arm and leg
?cause - need to rule out cva - to receiving physicians

Agency Questions and Answers

Agency Comments

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

Attachments

REFERRAL TO

Trauma & Orthopaedic - Wrist & Hand
GGC General Referral

Consultant / receiving practitioner and/or specialty clinic

Glasgow Royal Infirmary
84 Castle Street
Glasgow
G4 0SF

Hospital and hospital address

Hospital location code.
G107H

Email address

Urgency of referral ROUTINE
Date of referral 01-Sep-2011 **Date sent** 01-Sep-2011

PATIENT DETAILS

Surname	Sullivan
Forename(s)	Deborah
Title	Ms
Sex	Female
Date of birth	07-Dec-1972
CHI no.	0712726128
Area of Residence	

Patient's address

6 Muirhead Court
BAILLIESTON
GLASGOW
G69 7EP

Contact number(s)

Voice: 07936225898

101002478646C Unique Care Pathway Number: 101002478646C

REGISTERED GP DETAILS

Name	Dr John Langan		
GMC code	1351886	GP code	05193
Practice name	Baillieston Health Centre (18889)		
Practice code	46216		

Practice address

20 Muirside Road
Baillieston
Glasgow

Contact number(s)

Voice: 0141-531-8050
Facsimile: 0141-531-8067

REFERRING GP DETAILS

Name	Dr. Melanie MacLeod		
GMC code	6163159	GP code	17469
Practice name	McGlone Practice (46216)		
Practice code	46216		

Practice address

Baillieston Health Centre
20 Muirside Road
Baillieston
Glasgow

Contact number(s)

Voice: 0141 531 8050
Facsimile: 0141 531 8067

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: Joint pains

Comment: I'd appreciate your review of this 38 year old lady who has had a few months of joint pains in her wrists, right hip, knee & ankle. She describes morning stiffness with intermittent swelling and at times feels she is actually unable to lift a kettle of tea with her right hand.

On examination she has a mild synovitis of her right wrist and fingers with full range of movement. Both wrists were mildly tender and no other obvious abnormalities in her other joints were noted. Of note recent x-rays of her hands proved to be normal and no obvious abnormalities in x-rays of pelvis. Rheumatoid factoring in fibromyalgia is unfortunately awaited however she does have a mildly positive ANA from blood results.

Of note this lady has suffered a great deal from chronic pancreatitis of which I believe she is on Fentanyl and Dihydrocodeine. She is also suffering from low mood and due to be seen by specialists in this area. In view of the above, I'd appreciate your review. Many thanks.

Yours sincerely

Dr Melanie McLeod

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Chronic pancreatitis	-	09-Mar-2009	09-Mar-2009
Anxiety with depression	-	12-Oct-2006	12-Oct-2006
Hiatus hernia NOS	moderately large	05-Nov-2004	05-Nov-2004
Dislocation or subluxation of shoulder	Left shoulder	17-Mar-2004	17-Mar-2004
Overdose of drug	Kapake and Tramadol with Diazepam	30-Aug-2002	30-Aug-2002
[D]Abdominal pain	Vomiting	27-Aug-2002	27-Aug-2002
Chronic pancreatitis	-	02-Jul-2002	02-Jul-2002
Constipation	-	02-Jul-2002	02-Jul-2002
Chronic pancreatitis	-	01-Oct-2001	01-Oct-2001
Sexual assault	-	01-Jul-2001	01-Jul-2001
[X]Rape	-	01-Jul-2001	01-Jul-2001
Anxiety states	Chronic	01-Jul-2001	01-Jul-2001
Reflux oesophagitis	-	23-Apr-1999	23-Apr-1999
Diaphragmatic hernia	-	23-Apr-1999	23-Apr-1999
[D]Abdominal pain	Recurrent	27-Mar-1999	27-Mar-1999
Cholelithiasis	-	23-Apr-1996	23-Apr-1996
Acute cholecystitis	-	23-Apr-1996	23-Apr-1996
Urinary tract infection, site not specified	-	01-Jun-1995	01-Jun-1995
[D]Nausea and vomiting	-	01-Feb-1995	01-Feb-1995

Past procedures (High and medium priority - all)

Description	Date performed	Date recorded
Laparotomy	14-Oct-2009	14-Oct-2009
Laparotomy	06-Oct-2009	06-Oct-2009
Nissen fundoplication using abdominal approach	26-Oct-2004	26-Oct-2004
[SO]Sphincter of Oddi	14-Nov-1996	14-Nov-1996
Endoscopic retrograde cholangiopancreatography	10-Oct-1996	10-Oct-1996

Excision of gall bladder	23-Apr-1996	23-Apr-1996	

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Lactulose Solution 3.1-3.7 g/5 ml	500	500 ML	THREE 5ML SPOONFULS TO BE TAKEN TWICE A DAY	-	29-Mar-2011	08-Aug-2011
Esomeprazole Gastro-resistant Tablets 20 mg	56	56 TABS	1 Tab Twice daily	-	18-Nov-2010	12-Aug-2011
Gabapentin Capsules 300 mg	168	168 caps	2 caps tid	-	18-Nov-2010	08-Aug-2011
Granisetron Hydrochloride Tablets 1 mg	34	34 TABS	1 tab Twice daily	-	18-Nov-2010	08-Aug-2011
Paracetamol Capsules 500 mg	224	224 CAPS	2 Caps qds	-	18-Nov-2010	08-Aug-2011

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Imipramine Tablets 25 mg	168	168 tablet	3 BD	-	12-Aug-2011	12-Aug-2011
Dihydrocodeine Tartrate Tablets 30 mg	168	168 TABS	1 or 2 Tabs 3 times daily	-	08-Aug-2011	08-Aug-2011
Piroxicam Gel 0.5 %	112	112 gram	APPLY THINLY TWICE A DAY	-	26-Jul-2011	26-Jul-2011
Transvasin Heat Rub (Cream)	80	80 gram	APPLY AS REQUIRED	-	26-Jul-2011	26-Jul-2011
Cerazette Tablets 75 micrograms	84	84 TABLET	ONE TO BE TAKEN EACH DAY	-	26-Jul-2011	26-Jul-2011
Fentanyl Transdermal patches 75 micrograms/hour	10	10 patch	Apply every 72 hours	-	15-Jul-2011	12-Aug-2011
Tramadol Hydrochloride Capsules 50 mg	224	224 capsule	ONE OR TWO TO BE TAKEN FOUR TIMES A DAY WHEN REQUIRED	-	15-Jul-2011	12-Aug-2011
Imipramine Tablets 25 mg	168	168 tablet	3 BD	-	15-Jul-2011	15-Jul-2011
Diazepam Tablets 5 mg	28	28 tablet	1 Tab Daily	-	15-Jul-2011	12-Aug-2011
Temazepam Tablets 10 mg	28	28 tablet	ONE TO BE TAKEN AT NIGHT	-	15-Jul-2011	12-Aug-2011
Metoclopramide Hydrochloride Tablets 10 mg	90	90 tablet	TAKE ONE THREE TIMES A DAY	-	15-Jul-2011	15-Jul-2011
Tramadol Hydrochloride Capsules 50 mg	224	224 capsule	ONE OR TWO TO BE TAKEN FOUR TIMES A DAY WHEN REQUIRED	-	25-May-2011	20-Jun-2011
Diazepam Tablets 5 mg	28	28 tablet	1 Tab Daily	-	25-May-2011	20-Jun-2011
Imipramine Tablets 25 mg	168	168 tablet	3 BD	-	25-May-2011	20-Jun-2011
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Dihydrocodeine Tartrate Tablets 30 mg	168	168 TABS	1 or 2 Tabs 3 times daily	-	17-May-2011	17-Jun-2011
Fentanyl Transdermal patches 75 micrograms/hour	10	10 patch	Apply every 72 hours	-	28-Apr-2011	07-Jun-2011
Cyclizine Tablets 50 mg	84	84 tablet	ONE TO BE TAKEN THREE TIMES A DAY	-	04-Apr-2011	04-Apr-2011

Metoclopramide Hydrochloride Tablets 10 mg	84	84 tablet	TAKE ONE THREE TIMES A DAY	-	04-Apr-2011	04-Apr-2011
Pyridoxine Hydrochloride Tablets 10 mg	56	56 tablet	1 Tab Daily	-	29-Mar-2011	21-Apr-2011
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Metoclopramide Hydrochloride Tablets 10 mg	60	60 tablet	TAKE ONE THREE TIMES A DAY	-	29-Mar-2011	21-Apr-2011
Fentanyl Transdermal patches 75 micrograms/hour	10	10 patch	Apply every 72 hours	-	03-Mar-2011	29-Mar-2011
Lactulose Solution 3.1-3.7 g/5 ml	500	500 ML	THREE 5ML SPOONFULS TO BE TAKEN TWICE A DAY	-	01-Mar-2011	29-Mar-2011
Dihydrocodeine Tartrate Tablets 30 mg	168	168 TABS	1 or 2 Tabs 3 times daily	-	01-Mar-2011	29-Mar-2011

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:	Smokefree Pharmacy Service	07-Apr-2011
Ex smoker:	priority=2	14-Jan-2009
Current smoker:	Disease: SPICE Basic Health Values, priority=2	23-Oct-2008
Current smoker:	Disease: SPICE Basic Health Values, priority=2	09-May-2006
Never smoked tobacco:	Disease: SPICE Basic Health Values,	18-Jan-2005

Clinical warnings

Allergies

Description	Date recorded
Adverse reaction to penicillins	16-Feb-2009

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

FINAL DISCHARGE LETTER

NHS
Greater Glasgow

Glasgow Royal Infirmary
84 Castle Street
Glasgow
G4 0SF
Telephone : 0141 - 211 - 4000

First Issued: 08/04/2011 08:81
Printed: 08/04/2011 08:81

Admitted: 23/03/2011 Discharged: 25/03/2011
Discharged to: Home
Ward: WD63
Consultant: MR C MCKAY, General Surgery
Hospital No: 10638479K Date of birth: 07/12/1972
CHI: 0712726128

REGISTERED GP

Dr JOHN LANGAN
BAILLIESTON HEALTH CENTRE
20 MUIRSIDE ROAD
BAILLIESTON
GLASGOW

PATIENT

DEBORAH SULLIVAN
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW
LANARKSHIRE

DIAGNOSES	ICD10	PROCEDURES	OPCS4
1. Vomiting, 23/03/2011	R11X		
2. Upper abdominal pain, 23/03/2011	R101		

MEDICATION

Drug Name	Format	Route	Dose	Admin Times 8 12 14 18 22	PRN/Comment	Course Length	Quantity Dispensed
Cyclizine	Tab	Oral	50mg		As required for nausea and vomiting. Maximum 8 hourly/three times daily.		21x50mg
Metoclopramide	Tab	Oral	10mg		As required for nausea and vomiting. Maximum 3 times per day.		28x10mg

Pharmacy Comments

no changes to regular medication. Spoke to own GP surgery she is due her normal prescription next week and has all regular medication at home

FOLLOW UP ARRANGEMENTS

Outpatient Clinic	Consultant	Date
No arrangements made		

Outpatient Investigations	Date
No arrangements made	

Community Care	Date	Reason
No arrangements made		

GENERAL COMMENTS

This 38 year old woman was admitted to GRI on 23/03/11 with headaches, vomiting and epigastric pain. She had a recent fall 6 days prior to her admission, sustaining an injury to the right side of her head, and had been vomiting since. CT head on this admission was normal. Her symptoms continued, however she was keen for discharge, and this was agreed with Mr CJ McKay. She was discharged on 25/03/11 with symptomatic relief.

FINAL COMMENTS:

AG/PVT 08 04 11

Nil to add

Yours sincerely

NHS Greater Glasgow

Patient: DEBORAH SULLIVAN D.O.B: 07/12/1972 Hosp. No: 10638479K

Admitted: 23/03/2011 Discharged: 26/03/2011 Printed: 08/04/2011 09:01

GENERAL COMMENTS (continued)

Mr A Giardino
Lister Fellow in General Surgery

Signed: _____ Designation: _____

IMMEDIATE DISCHARGE LETTER

NHS Greater Glasgow

GP COPY

First Issued: 26/03/2011 12:32
Printed:

Glasgow Royal Infirmary
84 Castle Street
Glasgow
G4 0SF
Telephone : 0141 - 211 - 4000

Admitted: 23/03/2011 **Discharged:** 26/03/2011
Discharged to: Home
Ward: WD63
Consultant: MR C MCKAY, General Surgery
Hospital No: 10838479K **Date of birth:** 07/12/1972
CHI: 0712726128

REGISTERED GP

Dr JOHN LANGAN
BAILLIESTON HEALTH CENTRE
20 MUIRSIDE ROAD
BAILLIESTON
GLASGOW

PATIENT

DEBORAH SULLIVAN
8 MUIRHEAD COURT
BAILLIESTON
GLASGOW
LANARKSHIRE

DIAGNOSES	ICD10	PROCEDURES	OPCS4
1. Vomiting, 23/03/2011	R11X		
2. Upper abdominal pain, 23/03/2011	R101		

MEDICATION

Drug Name	Format	Route	Dose	Admin Times 8 12 14 18 22	PRN/Comment	Course Length	Quantity Dispensed
Cyclizine	Tab	Oral	50mg		As required for nausea and vomiting. Maximum 8 hourly/three times daily.		21x50mg
Metoclopramide	Tab	Oral	10mg		As required for nausea and vomiting. Maximum 3 times per day.		28x10mg

Pharmacy Comments

no changes to regular medication. Spoke to own GP surgery she is due her normal prescription next week and has all regular medication at home

FOLLOW UP ARRANGEMENTS

Outpatient Clinic	Consultant	Date
No arrangements made		

Outpatient Investigations	Date
No arrangements made	

Community Care	Date	Reason
No arrangements made		

GENERAL COMMENTS

Final discharge letter to follow

This 38 year old woman was admitted to GRI on 23/03/11 with headaches, vomiting and epigastric pain. She had a recent fall 6 days prior to her admission, sustaining an injury to the right side of her head, and had been vomiting since. CT head on this admission was normal. Her symptoms continued, however she was keen for discharge, and this was agreed with Mr CJ McKay. She was discharged on 25/03/11 with symptomatic relief.

Signed: _____ **Designation:** _____

Contact: Laura Cheung **Pager Number:**

Acute Services Division

DEPARTMENT OF COLOPROCTOLOGY

Glasgow Royal Infirmary
16 Alexandra Parade
Glasgow G31 2ER
0141 211 4000

NHS
Greater Glasgow and Clyde

Clinic	30/11/2010
Dictated	30/11/2010
Typed	30/11/2010
Your Ref	
Our Ref	PGH/ROH
Direct Dial	0141 800 1976
Fax	0141 211 4880

Consultant Surgeons:
Mr I G Finlay
Dr Ruth F McKee
Mr J H Anderson
Professor P G Horgan

Consultant Radiologist:
Dr F W Poon

Consultant Oncologists:
Dr A McDonald
Dr A Waterston

Dr John Langan
Baillieston Health Centre
20 Muirside Road, Baillieston, Glasgow
G69 7AD

Dear Dr Langan

Deborah Sullivan – 07/12/1972 – CHI: 0712726128 – CRN: 10638479K
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

Admitted:	12.11.01
Discharged:	15.11.10
Diagnosis:	Abdominal pain
Procedure:	Conservative therapy

Deborah was admitted with a further episode of abdominal pain. All investigations were normal including CT scan. She was well on discharge.

Yours sincerely

Professor Paul Horgan
Head of University Department of Surgery
Consultant Colorectal Surgeon

SCOTTISH AMBULANCE SERVICE - PATIENT REPORT FORM

CCS INCIDENT No. A A / [illegible] N N N

Last Name SIVILIVAN

First Name DEBORAH

Location 6 MAY PLEAD

[illegible] BB TESTTO N

D of B 8 2 M 2 4 3

Age 34

Sex M X

Date 25 M

Time of Call 13 40

Time at Patient 13

Time Left

AMPDS Code 7 6 0 2

AMPDS Revised

Airway Clear X Suction N/OPA ET LMA Successful ? Y C-spine Injury

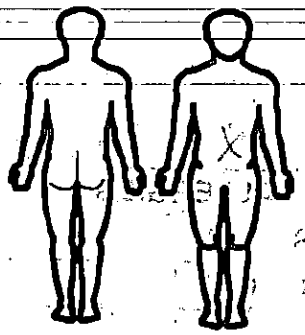
Breathing X Rate X BVM Ventilation Successful ? Y Paralysis Y Fitting

Pulse X Rate V S CPR IV/IO Fluids Successful ? Y ECG

Despite the above unable to

Clear airway Detect breathing Detect pulse X V P U

Injury Site	Wound	#	Pain	Splint	Dressed
Head					
Neck					
Chest					
Women			X		
X					
Arm					
R/Leg					
L/Arm					
L/Leg					



RTA

Trapped

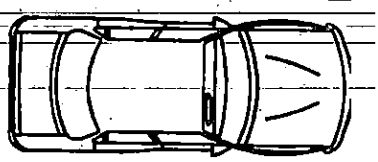
Ejected

M / cyclist

Cyclist

Pedestrian

>20 min. Extricate



Temp. 37.0 °C

PEFR % B. Sugar 5.4 mmol

Allergies PENICILLIN

Medication STEROIDS

Assisted by and Name -

Doctor Y Nurse Other

Time	Pulse	Resp	BP	C / Refill	SpO2 %	GCS	Lpupil	Rpup
1324	116	17	127	FSX	99	E5M	NR	NR
			S Y S	FSN	T	EVM	S	S
			S Y S	FSN		EVM	S	S
			S Y S	FSN		EVM	S	S

Time	Fluid/Drug/Gas	Dose	Unit	Route	Effect	Rhythm	No. Joules	Repeat	Result Rhythm
1342	ENTA	SA		IH	X 0				
					0				
					0				
					0				

Condition at CRINCAS hospital Pulse X Breathing X Conscious X Time at Hospital 1422

History and Additional Information GP URGENT CALL 37 YOF C/O EPIG PAIN (CENTRAL UPPER) SINCE 2000 LAST NIGHT. H/X OF PANCREATITIS. PAIN FEELS LIKE THE PAIN ASSOCIATED WITH PANCREATITIS. PAIN 10/10. SHARP RADIATING TO HER BACK. ENTONOX ADMINISTERED TO GOOD EFFECT. PT C/O COFFEE GROUND VOMIT OF CONSTANT REMAINED STABLE EN ROUTE TO GRI.

PMH: IBS PANCREATITIS GALLSTONES

Working assessment EPIG PAIN EARLIER ? VOMITING

Diagnosis Code O

Crew Name 1 SMITHEWS Grade

Crew Name 2 [illegible]

46216

DR JOHN J LANGAN
DR JUNE GOLDIE
DR MOIRA C M MACLEOD
DR ELAINE E POLLOCK
DR GERARD A MCKAIG
DR JENNIFER DOW
DR JULIE P ELLOR
DR CHRISTINE A WALKER
DR JOHN C MENZIES
DR LIANA MCMILLAN

Baillieston Health Centre
20 Muirside Road
Baillieston
Glasgow G69 7AD
Tel: 0141 531 8050
Fax: 0141 531 8067

Shettleston Health Centre
420 Old Shettleston Road
Glasgow G32 7JZ
Tel: 0141 531 6240
Fax: 0141 531 8067

CHI 0712726128
SULLIVAN Deborah [illegible]
[illegible]
[illegible]

Dr J J Langan [illegible]
[illegible]
12/12/2010 09:21 [illegible]

FAO: Receiving Surgeons

Dear Doctor,

Please could you admit this 37 year old lady who has a 2 day history of severe abdominal pain radiating to her back, associated with coffee-ground vomiting + diarrhoea of black / dark colour.

She has a history of chronic pancreatitis + gallstones. A care summary sheet is attached.

On examination she has a BP of 110/60 and a heart rate of 106 bpm. Her abdomen is very tender, worse in the epigastrium. Temp 38.9°.

Many thanks.

Joseph Simpson
GPST1

GLASGOW ROYAL INFIRMARY

Radiology Report

Patient Name:	SULLIVAN DEBORAH	**Report Date:**	29-May-2010 11:56
Patient ID:	0712726128	**Accession No.:**	G107H13828238
Patient Birth Date:	07-Dec-1972	**Report Status:**	F
Referring Physician:	DR RF MCKEE	**Reason For Study:**	

[Report Summary]
Clinical History : Past history of chronic pancreatitis.
Previous laparoscopic cholecystectomy, appendicectomy, fundoplication etc pain.
[CT Abdomen \T\ pelvis]
CT Abdomen \T\ pelvis :
Contrast enhanced CT scan of abdomen.and pelvis.
The appearances are in keeping with the surgery performed. Non dilated biliary tree. The solid abdominal organs appear normal and in particular, the pancreas appears normal. There is minimal residual inflammatory stranding anteriorly, much less than on last scan dated 11/11/09. A somewhat constipated looking colon and perhaps a little distension of distal small bowel but no hard evidence of established obstruction.
No free fluid in abdomen or pelvis and nil else of note.

Reported by : *DR IS STEWART*

2nd Report by :

Verified by : *DR IS STEWART*

Produced by Carestream Health PACS

Registration

Ms Deborah Sullivan
6 Muirhead Court
BAILLIESTON
GLASGOW
G69 7EP
Telephone: 771 6310 07936225898

Service Code: Permanent
DoB: 07/12/1972
Age: 37

Contact: ?
ContactRelship: ?
Email: ?
CHI Number: 0712726128
NHS Number: 604/72/263
Patient ID: B
Road: 0 Water: 0 FootPath: 0
Occupation:
Marital Status: Unknown
Registered GP: Dr JJ Langan
Registered: 27/05/2002
Confirmed: 31/05/2002
Records Received: 14/08/2002
BMI: 0.0
Height: 0 m
Weight: 0 kg
BP: 130/84
Parity: 0
Gravida: 0
SCI-DC Consent Given: Yes

Repeat Medication

Drug/Preparation	Quantity/Dose/Frequency	Intervals				
		Start	Last	Pres.	Review	CMS Int.
Granisetron TABS 1MG	34 1 tab Twice daily	15/07/2010	20/10/2010	17d.	52w.	w.
Gabapentin CAPS 300MG	168 caps 2 caps tid	15/07/2010	20/10/2010	28d.	52w.	w.
Paracetamol CAPS 500MG	224 2 Caps qds	15/07/2010	20/10/2010	28d.	52w.	w.
Esomeprazole TABS 20MG	56 1 Tab Twice daily	05/01/2009	20/10/2010	17d.	52w.	w.

Adverse Reactions

Read Code	Description
TJ00.	Adverse reaction to penicillins

Clinical / User Marker

Date Recorded	Start Date	Priority	Description	Modifier
14/10/2009	None	High	Laparotomy	
Freetext:	and open fundoplication			
06/10/2009	None	High	Laparotomy	
Freetext:	and open revision of fundoplication			
09/03/2009	None	High	Chronic pancreatitis	
16/02/2009	None	High	Adverse reaction to penicillins	
12/10/2006	None	High	Anxiety with depression	
18/01/2005	None	High	Never smoked tobacco	
05/11/2004	None	High	Hiatus hernia NOS	
Freetext:	moderately large			
26/10/2004	None	High	Nissen fundoplication using abdominal approach	
17/03/2004	None	High	Dislocation or subluxation of shoulder	

Freetext: Left shoulder

30/08/2002	None	High	Overdose of drug	
Freetext: Kapake and Tramadol with Diazepam				
27/08/2002	None	High	[D]Abdominal pain	
Freetext: Vomiting				
02/07/2002	None	High	Chronic pancreatitis	
02/07/2002	None	High	Constipation	
01/10/2001	None	High	Chronic pancreatitis	
01/07/2001	None	High	[X]Rape	
01/07/2001	None	High	Anxiety states	Chronic
01/07/2001	None	High	Sexual assault	
23/04/1999	None	High	Diaphragmatic hernia	
23/04/1999	None	High	Reflux oesophagitis	
27/03/1999	None	High	[D]Abdominal pain	Recurrent
14/11/1996	None	High	[SO]Sphincter of Oddi	
Freetext: Dysfuntion				
10/10/1996	None	High	Endoscopic retrograde cholangiopancreatography	
Freetext: Major papilla was located in the second part of the duodenum				
23/04/1996	None	High	Acute cholecystitis	
23/04/1996	None	High	Cholelithiasis	
23/04/1996	None	High	Excision of gall bladder	
01/06/1995	None	High	Urinary tract infection, site not specified	
01/02/1995	None	High	[D]Nausea and vomiting	

Screening

15/06/2009	**Cervical Screening$$**	Cervical smear: negative	
Repeat after an Interval - 36 Months		Do not send recall letter	Do not send result letter
05/10/2005	**Cervical Screening$$**	Cervical smear: negative	
Repeat after an Interval - 36 Months		Do not send recall letter	Do not send result letter

Priority Clinical / User Marker

Date Recorded	Start Date	Priority	Description	Modifier
14/10/2009	None	High	Laparotomy	
Freetext: and open fundoplication				
06/10/2009	None	High	Laparotomy	
Freetext: and open revision of fundoplication				
09/03/2009	None	High	Chronic pancreatitis	
16/02/2009	None	High	Adverse reaction to penicillins	
12/10/2006	None	High	Anxiety with depression	

18/01/2005	None	High	Never smoked tobacco	
05/11/2004	None	High	Hiatus hernia NOS	
Freetext:	moderately large			
26/10/2004	None	High	Nissen fundoplication using abdominal approach	
17/03/2004	None	High	Dislocation or subluxation of shoulder	
Freetext:	Left shoulder			
30/08/2002	None	High	Overdose of drug	
Freetext:	Kapake and Tramadol with Diazepam			
27/08/2002	None	High	[D]Abdominal pain	
Freetext:	Vomiting			
02/07/2002	None	High	Chronic pancreatitis	
02/07/2002	None	High	Constipation	
01/10/2001	None	High	Chronic pancreatitis	
01/07/2001	None	High	[X]Rape	
01/07/2001	None	High	Anxiety states	Chronic
01/07/2001	None	High	Sexual assault	
23/04/1999	None	High	Diaphragmatic hernia	
23/04/1999	None	High	Reflux oesophagitis	
27/03/1999	None	High	[D]Abdominal pain	Recurrent
14/11/1996	None	High	[SO]Sphincter of Oddi	
Freetext:	Dysfuntion			
10/10/1996	None	High	Endoscopic retrograde cholangiopancreatography	
Freetext:	Major papilla was located in the second part of the duodenum			
23/04/1996	None	High	Acute cholecystitis	
23/04/1996	None	High	Cholelithiasis	
23/04/1996	None	High	Excision of gall bladder	
01/06/1995	None	High	Urinary tract infection, site not specified	
01/02/1995	None	High	[D]Nausea and vomiting	

Acute Prescriptions

Drug/Preparation	Quantity/Dose/Frequency	Date
Dihydrocodeine Tartrate TABS 30MG	168 1 or 2 Tabs 3 times daily	20/10/2010
Fentanyl 75 Micrograms/Hour PATCH	10 apply 1 patch every 72 hours	14/10/2010
Tramadol Hydrochloride CAPS 50MG	224 1 or 2 Caps up to qds prn	14/10/2010
Imipramine Hydrochloride TABS 25MG	168 3 Tabs Twice daily	14/10/2010
Temazepam TABS 10MG	28 dispense fortnightly 1 Tab At night	14/10/2010

Diazepam TABS 5MG	28 1 Tab Daily	14/10/2010
Fentanyl 75 Micrograms/Hour PATCH	10 apply 1 patch every 72 hours	20/09/2010
Tramadol Hydrochloride CAPS 50MG	224 1 or 2 Caps up to qds prn	20/09/2010
Imipramine Hydrochloride TABS 25MG	168 3 Tabs Twice daily	20/09/2010
Temazepam TABS 10MG	28 dispense fortnightly 1 Tab At night	20/09/2010
Diazepam TABS 5MG	28 1 Tab Daily	20/09/2010
Dihydrocodeine Tartrate TABS 30MG	168 1 or 2 Tabs 3 times daily	13/09/2010
Fentanyl 75 Micrograms/Hour PATCH	10 apply 1 patch every 72 hours	23/08/2010
Tramadol Hydrochloride CAPS 50MG	224 1 or 2 Caps up to qds prn	23/08/2010
Imipramine Hydrochloride TABS 25MG	168 3 Tabs Twice daily	23/08/2010
Temazepam TABS 10MG	28 dispense fortnightly 1 Tab At night	23/08/2010
Diazepam TABS 5MG	28 1 Tab Daily	23/08/2010
Dihydrocodeine Tartrate TABS 30MG	168 1 or 2 Tabs 3 times daily	11/08/2010
Fentanyl 75 Micrograms/Hour PATCH	10 apply 1 patch every 72 hours	27/07/2010
Diazepam TABS 5MG	28 1 Tab Daily	27/07/2010
Temazepam TABS 10MG	28 dispense fortnightly 1 Tab At night	27/07/2010
Imipramine Hydrochloride TABS 25MG	168 3 Tabs Twice daily	27/07/2010
Tramadol Hydrochloride CAPS 50MG	224 1 or 2 Caps up to qds prn	27/07/2010
Dihydrocodeine Tartrate TABS 30MG	168 1 or 2 Tabs 3 times daily	15/07/2010
Erythromycin Ec CAPS 250MG	112 1 Cap 4 times daily	15/07/2010
Metoclopramide Hydrochloride TABS 10MG	84 1 tab tds half hour before meal	15/07/2010
Diclofenac Sodium SUPPS 50MG	56 1 to be inserted Twice daily	15/07/2010
Bisacodyl TABS 5MG	60 1 or 2 Tabs At night	15/07/2010
Tramadol Hydrochloride CAPS 50MG	224 1 or 2 Caps up to qds prn	30/06/2010
Diazepam TABS 5MG	28 1 Tab Daily	30/06/2010
Fentanyl 75 Micrograms/Hour PATCH	10 apply 1 patch every 72 hours	30/06/2010
Temazepam TABS 10MG	28 dispense fortnightly 1 Tab At night	30/06/2010
Imipramine Hydrochloride TABS 25MG	168 3 Tabs Twice daily	30/06/2010

Dihydrocodeine Tartrate TABS 30MG	168 1 or 2 Tabs 3 times daily	18/06/2010
Varenicline Tartrate Initiation Pack 11 X 0.5mg 14 X 1mg TABS	1 Take as directed Dispense weekly	18/06/2010
	To be signed up to pharmacy support unless receiving GP or group support	
Erythromycin Ec TABS 250MG	84 1 Tab 3 times daily	11/06/2010
Imipramine Hydrochloride TABS 25MG	168 3 Tabs Twice daily	03/06/2010
Temazepam TABS 10MG	28 dispense fortnightly 1 Tab At night	03/06/2010
Tramadol Hydrochloride CAPS 50MG	224 1 or 2 Caps up to qds prn	03/06/2010
Diazepam TABS 5MG	28 1 Tab Daily	03/06/2010
Fentanyl 75 Micrograms/Hour PATCH	10 apply 1 patch every 72 hours	03/06/2010
Dihydrocodeine Tartrate TABS 30MG	168 1 or 2 Tabs 3 times daily	19/05/2010
Imipramine Hydrochloride TABS 25MG	168 3 Tabs Twice daily	06/05/2010
Temazepam TABS 10MG	28 dispense fortnightly 1 Tab At night	06/05/2010
Tramadol Hydrochloride CAPS 50MG	224 1 or 2 Caps up to qds prn	06/05/2010
Diazepam TABS 5MG	28 1 Tab Daily	06/05/2010
Fentanyl 75 Micrograms/Hour PATCH	10 apply 1 patch every 72 hours	06/05/2010
Dihydrocodeine Tartrate TABS 30MG	168 1 or 2 Tabs 3 times daily	22/04/2010
Fentanyl 75 Micrograms/Hour PATCH	10 apply 1 patch every 72 hours	07/04/2010
Diazepam TABS 5MG	28 1 Tab Daily	07/04/2010
Tramadol Hydrochloride CAPS 50MG	224 1 or 2 Caps up to qds prn	07/04/2010
Temazepam TABS 10MG	28 dispense fortnightly 1 Tab At night	07/04/2010
Imipramine Hydrochloride TABS 25MG	168 3 Tabs Twice daily	07/04/2010
Dihydrocodeine Tartrate TABS 30MG	168 1 or 2 Tabs 3 times daily	24/03/2010
Fentanyl 75 Micrograms/Hour PATCH	5 apply 1 patch every 72 hours	24/03/2010
Temazepam TABS 10MG	28 dispense fortnightly 1 Tab At night	15/03/2010
Tramadol Hydrochloride CAPS 50MG	224 1 or 2 Caps up to qds prn	15/03/2010
Diazepam TABS 5MG	28 1 Tab Daily	15/03/2010
Fentanyl 75 Micrograms/Hour PATCH	5 apply 1 patch every 72 hours	15/03/2010
Imipramine Hydrochloride TABS 25MG	168 3 Tabs Twice daily	15/03/2010
	50mg nocte for 1 week, 50mg nocte 35mg am for 1 week then 50mg bd thereafter	

Temazepam TABS 10MG	28 dispense fortnightly 1 Tab At night	10/02/2010
Tramadol Hydrochloride CAPS 50MG	224 1 or 2 Caps up to qds prn	10/02/2010
Diazepam TABS 5MG	28 1 Tab Daily	10/02/2010
Fentanyl 75 Micrograms/Hour PATCH	3 apply 1 patch every 72 hours	10/02/2010
Imipramine Hydrochloride TABS 25MG	168 3 Tabs Twice daily	10/02/2010
	50mg nocte for 1 week, 50mg nocte 35mg am for 1 week then 50mg bd thereafter	
Fentanyl 75 Micrograms/Hour PATCH	3 apply 1 patch every 72 hours	04/02/2010
Fentanyl 75 Micrograms/Hour PATCH	5 apply 1 patch every 72 hours	14/01/2010
Temazepam TABS 10MG	28 dispense fortnightly 1 Tab At night	14/01/2010
Imipramine Hydrochloride TABS 25MG	168 3 Tabs Twice daily	14/01/2010
	50mg nocte for 1 week, 50mg nocte 35mg am for 1 week then 50mg bd thereafter	
Diazepam TABS 5MG	28 1 Tab Daily	14/01/2010
Tramadol Hydrochloride CAPS 50MG	224 1 or 2 Caps up to qds prn	14/01/2010
Fentanyl 75 Micrograms/Hour PATCH	5 apply 1 patch every 72 hours	07/01/2010
Fentanyl 75 Micrograms/Hour PATCH	5 Apply 1 patch every 72 hours	23/12/2009
Diazepam TABS 5MG	28 1 Tab Daily	23/12/2009
Tramadol Hydrochloride CAPS 50MG	200 1 or 2 Caps up to qds prn	22/12/2009
Imipramine Hydrochloride TABS 25MG	168 3 Tabs Twice daily	17/12/2009
	50mg nocte for 1 week, 50mg nocte 35mg am for 1 week then 50mg bd thereafter	
Temazepam TABS 10MG	28 dispense fortnightly 1 Tab At night	17/12/2009
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	09/12/2009
Tramadol Hydrochloride CAPS 50MG	200 1 or 2 Caps up to qds prn	27/11/2009
Diazepam TABS 5MG	28 1 Tab Daily	27/11/2009
Temazepam TABS 10MG	28 dispense fortnightly 1 Tab At night	20/11/2009
Dihydrocodeine Tartrate TABS 30MG	56 1 or 2 Tabs prn or every 6 hours	20/11/2009
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	18/11/2009
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	02/11/2009

Imipramine Hydrochloride TABS 25MG	168 3 Tabs Twice daily	02/11/2009
	50mg nocte for 1 week, 50mg nocte 35mg am for 1 week then 50mg bd thereafter	
Tramadol Hydrochloride CAPS 50MG	200 1 or 2 Caps up to qds prn	28/10/2009
Diazepam TABS 5MG	28 1 Tab Daily	23/10/2009
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	19/10/2009
Temazepam TABS 10MG	28 dispense fortnightly 1 Tab At night	19/10/2009
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	01/10/2009
Diazepam TABS 5MG	14 1 Tab Twice daily	30/09/2009
Imipramine Hydrochloride TABS 25MG	168 3 Tabs Twice daily	30/09/2009
	50mg nocte for 1 week, 50mg nocte 35mg am for 1 week then 50mg bd thereafter	
Tramadol Hydrochloride CAPS 50MG	200 1 or 2 Caps up to qds prn	30/09/2009
Diazepam TABS 5MG	14 1 Tab Daily	25/09/2009
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	17/09/2009
Diazepam TABS 5MG	15 1 or 2 Tabs every 4 hours	17/09/2009
Temazepam TABS 10MG	28 dispense fortnightly 1 Tab At night	10/09/2009
Diazepam TABS 5MG	15 1 or 2 Tabs every 4 hours	10/09/2009
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	03/09/2009
Tramadol Hydrochloride CAPS 50MG	200 1 or 2 Caps up to qds prn	03/09/2009
Imipramine Hydrochloride TABS 25MG	168 3 Tabs Twice daily	03/09/2009
	50mg nocte for 1 week, 50mg nocte 35mg am for 1 week then 50mg bd thereafter	
Diazepam TABS 5MG	15 1 or 2 Tabs every 4 hours	03/09/2009
Diazepam TABS 5MG	15 1 or 2 Tabs every 4 hours	28/08/2009
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	20/08/2009
Metoclopramide Hydrochloride Sf SYRUP 5MG/5ML	200 10 ml uo to 4 times daily	17/08/2009
Temazepam TABS 10MG	28 dispense fortnightly 1 Tab At night	13/08/2009
Co-Simalcite Sf 125mg/500mg In 5ml SUSP	500 10 ml 3 times daily	10/08/2009
Tramadol Hydrochloride CAPS 50MG	200 1 or 2 Caps up to qds prn	10/08/2009
Imipramine Hydrochloride TABS 25MG	168 3 Tabs Twice daily	10/08/2009
	50mg nocte for 1 week, 50mg nocte 35mg am for 1 week then 50mg bd thereafter	

Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	06/08/2009
Erythromycin Ec TABS 250MG	5 DAYS 2 Tabs 4 times daily	05/08/2009
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	24/07/2009
	dispense 1 patch every 3 days please	
Imipramine Hydrochloride TABS 25MG	84 3 Tabs At night	24/07/2009
	50mg nocte for 1 week, 50mg nocte 35mg am for 1 week then 50mg bd thereafter	
Diazepam TABS 5MG	15 1 or 2 Tabs every 4 hours	17/07/2009
Temazepam TABS 10MG	28 dispense fortnightly 1 Tab At night	16/07/2009
Tramadol Hydrochloride CAPS 50MG	200 1 or 2 Caps up to qds prn	16/07/2009
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	09/07/2009
	dispense 1 patch every 3 days please	
Imipramine Hydrochloride TABS 25MG	63 1 Tab As directed	09/07/2009
	50mg nocte for 1 week, 50mg nocte 35mg am for 1 week then 50mg bd thereafter	
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	26/06/2009
	dispense 1 patch every 3 days please	
Tramadol Hydrochloride CAPS 50MG	200 1 or 2 Caps up to qds prn	22/06/2009
Temazepam TABS 10MG	28 dispense fortnightly 1 Tab At night	19/06/2009
Fluoxetine CAPS 20MG	56 1 Cap As directed	15/06/2009
	make appt for next supply	
Imipramine Hydrochloride TABS 10MG	84 1 Tab As directed	15/06/2009
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	11/06/2009
	dispense 1 patch every 3 days please	
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	29/05/2009
	dispense 1 patch every 3 days please	
Tramadol Hydrochloride CAPS 50MG	200 1 or 2 Caps up to qds prn	29/05/2009
Co-Simalcite Sf 125mg/500mg In 5ml SUSP	500 10 ml 3 times daily	29/05/2009
Temazepam TABS 10MG	28 dispense fortnightly 1 Tab At night	22/05/2009
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	14/05/2009
	dispense 1 patch every 3 days please	
Tramadol Hydrochloride CAPS 50MG	200 1 or 2 Caps up to qds prn	07/05/2009

Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours dispense 1 patch every 3 days please	01/05/2009
Metoclopramide Hydrochloride TABS 10MG	28 1 Tab max tid Take as required	01/05/2009
Co-Simalcite Sf 125mg/500mg In 5ml SUSP	500 10 ml 3 times daily	01/05/2009
Vapour-Permeable Adhesive Film Dressing With Absorbent Pad Alldress 10cmx10cm	30	17/04/2009
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours dispense 1 patch every 3 days please	17/04/2009
Temazepam TABS 10MG	28 dispense fortnightly 1 Tab At night	16/04/2009
Tramadol Hydrochloride CAPS 50MG	200 1 or 2 Caps up to qds prn	15/04/2009
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	08/04/2009
Fluoxetine CAPS 20MG	112 2 Caps In the morning make appt for next supply	08/04/2009
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	27/03/2009
Dihydrocodeine Tartrate TABS 30MG	100 1 Tab every 4 to 6 hours	25/03/2009
Tramadol Hydrochloride CAPS 50MG	200 1 or 2 Caps up to qds prn	25/03/2009
Temazepam TABS 10MG	28 dispense fortnightly 1 Tab At night	19/03/2009
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	09/03/2009
Temazepam TABS 10MG	14 1 Tab At night	02/03/2009
Tramadol Hydrochloride CAPS 50MG	200 1 or 2 Caps up to qds prn	02/03/2009
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	20/02/2009
Erythromycin Ethylsuccinate TABS 500MG	28 1 Tab 4 times daily	16/02/2009
Gabapentin CAPS 300MG	168 caps 2 Caps 3 times daily	16/02/2009
Temazepam TABS 10MG	14 1 Tab At night	16/02/2009
Tramadol Hydrochloride CAPS 50MG	200 1 or 2 Caps up to qds prn	09/02/2009
Granisetron TABS 1MG	60 1 Tab Twice daily	09/02/2009
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	03/02/2009
Omeprazole CAPS 20MG	56 2 Caps Daily	03/02/2009
Temazepam TABS 10MG	14 1 Tab At night	03/02/2009

Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	19/01/2009
Gabapentin CAPS 300MG	168 caps 2 Caps 3 times daily	19/01/2009
Fluoxetine CAPS 20MG	112 2 Caps In the morning make appt for next supply	19/01/2009
Temazepam TABS 10MG	14 1 Tab At night	19/01/2009
Tramadol Hydrochloride CAPS 50MG	200 1 or 2 Caps up to qds prn	12/01/2009
Granisetron TABS 1MG	60 1 Tab Twice daily	12/01/2009
Erythromycin Ethylsuccinate TABS 500MG	28 1 Tab 4 times daily	08/01/2009
Temazepam TABS 10MG	14 1 Tab At night	05/01/2009
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	31/12/2008
Tramadol Hydrochloride CAPS 50MG	100 1 or 2 Caps up to qds prn	31/12/2008
Granisetron TABS 1MG	20 1 Tab Twice daily	31/12/2008
Gabapentin CAPS 300MG	168 caps 2 Caps 3 times daily	31/12/2008
Temazepam TABS 10MG	14 1 Tab At night	22/12/2008
Granisetron TABS 1MG	20 1 Tab Twice daily	15/12/2008
Tramadol Hydrochloride CAPS 50MG	100 1 or 2 Caps up to qds prn	15/12/2008
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	11/12/2008
Granisetron TABS 1MG	20 1 Tab Twice daily	04/12/2008
Metoclopramide Hydrochloride TABS 10MG	84 1 Tab 3 times daily	04/12/2008
Tramadol Hydrochloride CAPS 50MG	100 1 or 2 Caps up to qds prn	04/12/2008
Temazepam TABS 10MG	14 1 Tab At night	04/12/2008
Gabapentin CAPS 300MG	168 caps 2 Caps 3 times daily	02/12/2008
Granisetron TABS 1MG	20 1 Tab Twice daily	26/11/2008
Dihydrocodeine Tartrate TABS 30MG	100 tabs 1 or 2 Tabs up to qds prn	26/11/2008
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	26/11/2008
Temazepam TABS 10MG	14 1 Tab At night	19/11/2008
Dihydrocodeine Tartrate TABS 30MG	100 tabs 1 or 2 Tabs up to qds prn	11/11/2008
Gabapentin CAPS 300MG	112 caps 2 Caps 3 times daily	11/11/2008
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	07/11/2008
Fluoxetine CAPS 20MG	112 2 Caps In the morning make appt for next supply	07/11/2008

Granisetron TABS 1MG	20 1 Tab Twice daily	07/11/2008
Dihydrocodeine Tartrate TABS 30MG	100 1 or 2 Tabs up to qds prn	30/10/2008
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	23/10/2008
Gabapentin CAPS 300MG	112 2 Caps 3 times daily	23/10/2008
Temazepam TABS 10MG	28 1 Tab At night	23/10/2008
Dihydrocodeine Tartrate TABS 30MG	100 1 or 2 Tabs up to qds prn	16/10/2008
Granisetron TABS 1MG	20 1 Tab Twice daily	16/10/2008
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	06/10/2008
Dihydrocodeine Tartrate TABS 30MG	100 1 or 2 Tabs up to qds prn	06/10/2008
Temazepam TABS 10MG	14 1 Tab At night	06/10/2008
Gabapentin CAPS 300MG	112 2 Caps 3 times daily	26/09/2008
Temazepam TABS 10MG	14 1 Tab At night	22/09/2008
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	22/09/2008
Fentanyl Matrix 50 Micrograms/Hour PATCH	5 Apply every 72 hours	10/09/2008
Gabapentin CAPS 300MG	112 2 Caps 3 times daily	02/09/2008
Temazepam TABS 10MG	14 1 Tab At night	02/09/2008
Gabapentin CAPS 300MG	56 1 Cap As directed	27/08/2008
Fentanyl Matrix 50 Micrograms/Hour PATCH	5 Apply every 72 hours	25/08/2008
Fluoxetine CAPS 20MG	60 2 Caps Daily	18/08/2008
Gabapentin CAPS 300MG	56 1 Cap Twice daily	18/08/2008
Cyclizine TABS 50MG	84 1 Tab 3 times daily	18/08/2008
Temazepam TABS 10MG	14 1 Tab At night	18/08/2008
Fentanyl Matrix 25 Micrograms/Hour PATCH	5 Apply every 72 hours	18/08/2008
Cilest TABS	6OP 1 Tab As directed	17/07/2008
Co-Amoxiclav 250mg/125mg TABS	21 1 Tab 3 times daily	27/06/2008
Fluoxetine CAPS 20MG	112 2 Caps In the morning make appt for next supply	27/06/2008
Clarithromycin TABS 500MG	14 1 Tab Twice daily	13/06/2008
Prochlorperazine Maleate TABS 5MG	84 1 Tab 3 times daily	01/05/2008
Pethidine TABS 50MG	112dips weekly 1 Tab 4 times daily	01/05/2008

Pethidine TABS 50MG	50 1 Tab 4 times daily	18/04/2008
Pethidine TABS 50MG	16 1 or 2 Tabs 4 times daily	04/04/2008
Diprobase Pump Dispenser CREAM	500ML Apply As directed	04/04/2008
Pethidine TABS 50MG	16 1 or 2 Tabs 4 times daily	02/04/2008
Pethidine TABS 50MG	50 1 or 2 Tabs 4 times daily	26/03/2008
Pethidine TABS 50MG	50 1 or 2 Tabs 4 times daily	19/03/2008
Pethidine TABS 50MG	50 1 or 2 Tabs 4 times daily	11/03/2008
Fluoxetine CAPS 20MG	112 2 Caps In the morning make appt for next supply	05/03/2008
Pethidine TABS 50MG	50 1 or 2 Tabs 4 times daily	05/03/2008
Senna TABS 7.5MG	60 2 Tabs At night	05/03/2008
Cefalexin CAPS 250MG	20 1 Cap 4 times daily	05/03/2008
Pethidine TABS 50MG	50 1 or 2 Tabs 4 times daily	27/02/2008
Pethidine TABS 50MG	50 1 or 2 Tabs 4 times daily	20/02/2008
Pethidine TABS 50MG	25 1 or 2 Tabs 4 times daily	18/02/2008
Pethidine TABS 50MG	50 1 or 2 Tabs 4 times daily	12/02/2008
Clarithromycin TABS 500MG	14 1 Tab Twice daily	18/01/2008
Tramadol Hydrochloride CAPS 50MG	56 1 or 2 Caps every 4 to 6 hours	18/01/2008
Senna TABS 7.5MG	60 2 Tabs At night	18/01/2008
Erythromycin Ethylsuccinate TABS 500MG	28 1 Tab 4 times daily	31/12/2007
Amoxicillin CAPS 500MG	21 1 Cap 3 times daily	19/12/2007
Cilest TABS	6OP 1 Tab As directed	19/12/2007
Cilest TABS	1 op 1 Tab As directed	26/11/2007
Movelat GEL	100 Apply 3 times daily	03/10/2007
Fluoxetine CAPS 20MG	60 2 Caps In the morning make appt for next supply	11/09/2007
Cilest TABS	3 op 1 Tab As directed	11/09/2007
Morphine Sulphate TABS 10MG	42 2 Tabs 3 times daily	11/07/2007
Morphine Sulphate TABS 10MG	50 2 Tabs 3 times daily	26/06/2007
Cilest TABS	3 op 1 Tab As directed	26/06/2007
Gabapentin CAPS 100MG	200 1 Cap 3 times daily	15/06/2007
Cilest TABS	1 op 1 Tab As directed	30/05/2007
Scheriproct OINT	30 Apply Twice daily	04/05/2007

Scheriproct SUPPS	12 1 to be inserted Daily	04/05/2007
Fluoxetine CAPS 20MG	60 2 Caps In the morning	04/05/2007
	make appt for next supply	
Fluoxetine CAPS 20MG	60 2 Caps In the morning	21/03/2007
	make appt for next supply	
Amoxicillin CAPS 500MG	30 1 TAB THREE TIMES DAILY.	31/01/2007
Ibuprofen TABS 200MG	84 1 Tab 3 times daily	31/01/2007
Cefalexin CAPS 500MG	21 1 Cap 3 times daily	12/01/2007
Penicillin V TABS 250MG	5 DAYS 2 Tabs 4 times daily	04/01/2007
Fluoxetine CAPS 20MG	112 2 Caps In the morning	20/12/2006
Cilest TABS	6OP 1 Tab As directed	20/12/2006
Fluoxetine CAPS 20MG	112 2 Caps In the morning	16/11/2006
Cilest TABS	6OP 1 Tab As directed	16/11/2006
Fluoxetine CAPS 20MG	56 2 Caps In the morning	05/10/2006
Diprobase Pump Dispenser CREAM	500ML Apply As directed	24/08/2006
	ok per Dr Goldie	
Cilest TABS	6OP 1 Tab As directed	20/07/2006
Fluoxetine CAPS 20MG	112 2 Caps In the morning	20/07/2006
Diprobase Pump Dispenser CREAM	500ML Apply As directed	20/07/2006
Hydrocortisone OINT 1%	30 Apply Twice daily	20/07/2006
Fluoxetine CAPS 20MG	112 2 Caps In the morning	09/05/2006
Senna TABS 7.5MG	100 2 Tabs At night	24/01/2006
Amoxicillin CAPS 500MG	5days 1 TAB THREE TIMES DAILY	14/12/2005
Morphine Sulphate Sf Oral Unit Dose Vial 5ml 10MG/5ML	20 5 ml AS DIR FOR BREAKTHROU	17/10/2005
	per Dr Clipston-to make appointment for next supply	
Buprenorphine 52.5 Micrograms/Hour PATCH	5 APPLY EVERY 3 DAY	07/10/2005
	Per Dr Clipston-to make appointment for next supply	
Morphine Sulphate Sf Oral Unit Dose Vial 5ml 10MG/5ML	20 5 ml AS DIR FOR BREAKTHROU	07/10/2005
	per Dr Clipston-to make appointment for next supply	
Morphine Sulphate Sf Oral Unit Dose Vial 5ml 10MG/5ML	20 5 ml AS DIR FOR BREAKTHROU	30/09/2005
Buprenorphine 52.5 Micrograms/Hour PATCH	5 APPLY EVERY 3 DAY	21/09/2005
Morphine Sulphate Sf Oral Unit Dose Vial 5ml 10MG/5ML	20 5 ml AS DIR FOR BREAKTHROU	21/09/2005
Buprenorphine 52.5 Micrograms/Hour PATCH	5 APPLY EVERY 3 DAY	09/09/2005

Morphine Sulphate Sf Oral Unit Dose Vial 5ml 10MG/5ML	20 5 ml AS DIR FOR BREAKTHROU	09/09/2005
Fluoxetine CAPS 20MG	168 1 Cap In the morning	19/08/2005
Buprenorphine 52.5 Micrograms/Hour PATCH	5 APPLY EVERY 3 DAY	08/08/2005
Morphine Sulphate Sf Oral Unit Dose Vial 5ml 10MG/5ML	20 5 ml AS DIR FOR BREAKTHROU	08/08/2005
Buprenorphine 52.5 Micrograms/Hour PATCH	5 APPLY EVERY 3 DAY	02/08/2005
Morphine Sulphate Sf Oral Unit Dose Vial 5ml 10MG/5ML	20 5 ml AS DIR FOR BREAKTHROU	02/08/2005
Buprenorphine 52.5 Micrograms/Hour PATCH	3 patches APPLY EVERY 3 DAY	26/07/2005
Morphine Sulphate Sf Oral Unit Dose Vial 5ml 10MG/5ML	20 mls 5 ml AS DIR FOR BREAKTHROU	26/07/2005
Morphine Sulphate Sf Oral Unit Dose Vial 5ml 10MG/5ML	20 5 ml AS DIR FOR BREAKTHROU	15/07/2005
Buprenorphine 52.5 Micrograms/Hour PATCH	3 APPLY EVERY 3 DAY	15/07/2005
Metoclopramide Hydrochloride TABS 10MG	30 1 Tab As directed	22/06/2005
Metoclopramide Hydrochloride TABS 10MG	30 1 Tab As directed	20/05/2005
Fluoxetine CAPS 20MG	56 1 Cap In the morning	05/05/2005
Amoxicillin CAPS 500MG	30 1 Cap 3 times daily	05/05/2005
Diazepam TABS 5MG	14 1 Tab At night	16/02/2005
Cilest TABS	6op 1 Tab As directed	18/01/2005
Diazepam TABS 10MG	28 1 Tab At night	18/01/2005
Metronidazole GEL 0.75%	1 Apply As directed	18/01/2005
Lactulose Oral SOLN 3.35G/5ML	500ml 10 ml Twice daily	18/01/2005
Amoxicillin CAPS 500MG	15 1 Cap 3 times daily	18/01/2005
Metoclopramide Hydrochloride TABS 10MG	30 1 Tab As directed	18/01/2005
Tramadol Hydrochloride Sf Soluble TABS 50MG	112 1 or 2 Tabs 4 times daily	30/12/2004
Diazepam TABS 10MG	14 1 Tab Daily	30/12/2004
Tramadol Hydrochloride Sf Soluble TABS 50MG	112 1 or 2 Tabs 4 times daily	08/12/2004
Diazepam TABS 10MG	14 1 Tab Daily	08/12/2004
Metoclopramide Hydrochloride TABS 10MG	30 1 Tab Daily	08/12/2004
Fluoxetine CAPS 20MG	28 1 Cap In the morning	11/11/2004
Diazepam TABS 10MG	14 1 Tab Daily	11/11/2004

Tramadol Hydrochloride Sf Soluble TABS 50MG	112 1 or 2 Tabs 4 times daily	11/11/2004
Tramadol Hydrochloride CAPS 50MG	224 1 or 2 Caps 4 times daily	15/07/2004
Diazepam TABS 5MG	14 1 Tab At night	15/07/2004
Fluoxetine CAPS 20MG	112 2 Caps Twice daily	15/07/2004
Chloramphenicol Eye OINT 1%	5 DAYS Apply 4 times daily	17/06/2004
Tramadol Hydrochloride CAPS 50MG	224 1 or 2 Caps 4 times daily	17/06/2004
Diazepam TABS 5MG	14 1 Tab At night	17/06/2004
Hyoscine Butylbromide TABS 10MG	168 2 Tabs 3 times daily	17/06/2004
Omeprazole TABS 20MG	56 1 Tab Twice daily	18/05/2004
Dihydrocodeine Tartrate TABS 30MG	100 1 or 2 Tabs Take as required	18/05/2004
Cefalexin CAPS 250MG	15 1 Cap 3 times daily	02/04/2004
Dihydrocodeine Tartrate TABS 30MG	100 1 or 2 Tabs Take as required	01/04/2004
Diclofenac Sodium Ec TABS 50MG	84 1 Tab 3 times daily	16/03/2004
Metoclopramide Hydrochloride TABS 10MG	30 tabs 1 Tab Daily	26/02/2004
Dihydrocodeine Tartrate TABS 30MG	100 1 or 2 Tabs Take as required	19/02/2004
Dihydrocodeine Tartrate TABS 30MG	100 1 or 2 Tabs Take as required	03/02/2004
Dihydrocodeine Tartrate TABS 30MG	100 1 or 2 Tabs Take as required	20/01/2004
Cefalexin CAPS 500MG	28 1 Cap 4 times daily	10/09/2003
Gaviscon Sf Aniseed LIQ	500 10 ml Take as required	04/09/2003
Co-Codamol 30mg/500mg Effervescent TABS	100 1 or 2 Tabs Take as required	04/09/2003
Xyloproct OINT	30 Apply Twice daily	13/06/2003
Omeprazole TABS 20MG	56 1 Tab Twice daily	29/05/2003
Fluoxetine CAPS 20MG	112 2 Caps Twice daily	28/04/2003
Omeprazole TABS 20MG	56 1 Tab Twice daily	28/04/2003
Senna TABS 7.5MG	28 1 Tab At night	28/04/2003

Last Encounter

Dr JSM Dow

Date: 12/11/2010

severe abdo pain, vomiting dark diarhoea. can't manage to surgery. hist pancreatitis. for house call

Last 4 Clinical Notes

Date	Clinical Notes
12/11/2010	severe abdo pain, vomiting dark diarhoea. can't manage to surgery. hist pancreatitis. for house call
20/10/2010	rx gmk
14/10/2010	says run off meds on sunday no more til 20/11/10
29/09/2010	incapacity form done

CONSULTANT
Dr Ruth F McKee

GLASGOW ROYAL INFIRMARY
84 CASTLE STREET, GLASGOW G4 0SF

Telephone No. 0141-211-4000
Ext.

ADMITTED	DISCHARGED	WARD	AGE	HOSPITAL NUMBER
28/05/2010 Emergency	03/06/2010	65	07/12/1972	10638479

DISPOSAL
Home

FOLLOW UP
Stobhill

NAME AND ADDRESS
Deborah Sullivan
1 Camp Road
Glasgow G69 6QR

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS	I.S.C. CODE
1. Undiagnosed abdominal pain -	
2.	
3.	
4.	
5.	
6.	

DISTRIBUTION OF LETTERS

Dr MacKinnon
Baillieston Health Centre
20 Muirside Road
Glasgow G69 7AD

Mr J Smith
Consultant Surgeon
Stobhill Hospital
Glasgow
G21 2UW

OPERATION	CODE
1.	
2	
3	

17/06/2010

This girl was once more admitted as an emergency with upper abdominal pain and vomiting. She certainly did seem to vomit several times each day during her admission. She was treated conservatively and eventually felt well enough to be discharged home.

Yours sincerely,

Dr Ruth F McKee
Consultant Colorectal Surgeon

Dr Ruth F McKee

05181

Oesophageal Manometry/24 hour ph metry. Book in:
Mon:9am,11am,1.30pm,3pm.
Tues:9am, 11am,1.30pm,3pm,3.15pm
Wed:9am,10.45am,1.30pm3pm,,3.30pm.
Thurs:9am,

ision

Directorate

jery
)BHILL

Stobhill Hospital
133 Balornock Road
GLASGOW
G21 3UW

NHS
Greater Glasgow and Clyde

Secretary: Mrs Eileen Mitchell
Direct Line: 0141 201 3785

Mr J S Smith's Out Patient Clinic

27/4/10
3.15

Clinic 25/02/2010
Typed 01/03/2010
Our Ref JSS/EM

Sister Shona Thomson
Motility Nurse Specialist
Ward 32
Glasgow Royal Infirmary
84 Castle Street
Glasgow
G4 0SD

Copy to:

Dr John Langan
Baillieston Health Centre
20 Muirside Road
Baillieston
Glasgow
G69 7AD

Dear Shona

Deborah Sullivan ~ 07/12/1972 ~ CHI: 0712726128 ~ CRN: 10638479K
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

I wonder if you could see this young woman for me. She has had several Nissen's fundoplications in order to try and stop her getting reflux. The last procedure we performed was an anterior wrap and she has now come back saying she is no better. I am not sure whether this is functional or true bile and acid reflux and would be grateful if you could perform pH and motility studies to see what they show. I will review her in my clinic with the results following completion of your tests.

With many thanks,

Yours sincerely

Mr John S Smith
Consultant Surgeon

CONSULTANT
Dr Ruth F McKee

GLASGOW ROYAL INFIRMARY

84 CASTLE STREET, GLASGOW G4 0SF

Telephone No. 0141-211-4000
Ext.

ADMITTED	DISCHARGED	WARD	AGE	HOSPITAL NUMBER
05/03/2010 Emergency	13/03/2010	65	07/12/1972	10638479

DISPOSAL
Home

FOLLOW UP
none

NAME AND ADDRESS
Deborah Sullivan
1 Camp Road

Glasgow G69 6QR

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS

	I.S.C. CODE
1. Undiagnosed abdominal pain -	
2.	
3.	
4.	
5.	
6.	

DISTRIBUTION OF LETTERS

Dr MacKinnon
Baillieston Health Centre
20 Muirside Road
Glasgow G69 7AD

Mr J Smith
Cons Surgeon
Stobhill Hospital
Balornock Road
Glasgow

OPERATION	CODE
1.	
2.	
3.	

09/04/2010

This young woman who is well known to the Royal Infirmary in that she has had previous pancreatitis and a previous fundoplication as well as a cholecystectomy was admitted as an emergency. She once again had the complaint of abdominal pain and vomiting. The vomiting seemed to settle very soon after admission and was not a significant problem although she did complain bitterly of symptoms of heartburn and on going abdominal pain. She eventually felt well enough to be discharged home on the 13/03/2010. She has an appointment for a gastrografin swallow at Stobill Hospital in a few days time and is already being seen for follow-up there.

Yours sincerely,

Dr Ruth F McKee
Consultant Colorectal Surgeon

Dr Ruth F McKee

05181

Acute Services Division

Surgery and Anaesthetic Directorate

Department of General Surgery
OUTPATIENTS CLINIC - STOBHILL

Mr J S Smith's Out Patient Clinic

Stobhill Hospital
133 Balornock Road
GLASGOW
G21 3UW

Secretary: Mrs Eileen Mitchell
Direct Line: 0141 201 3785

NHS
Greater Glasgow and Clyde

Clinic 25/02/2010
Typed 01/03/2010
Our Ref JSS/EM

Dr John Langan
Baillieston Health Centre
20 Muirside Road, Baillieston, Glasgow
G69 7AD

Dear Dr Langan

Deborah Sullivan ~ 07/12/1972 ~ CHI: 0712726128 ~ CRN: 10638479K
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

I saw this lady in clinic today. She is really no better since we performed the anterior wrap and she is still refluxing and vomiting. It is difficult to know whether this is functional or truly a result of dysfunction in her upper GI tract. For this reason I am going to get her a barium swallow and a barium meal and I am also going to repeat her pH and motility studies to see what they show.

Yours sincerely

Mr John S Smith
Consultant Surgeon

Acute Services Division

Surgery and Anaesthetic Directorate

Department of General Surgery
OUTPATIENTS CLINIC - STOBHILL

Mr J S Smith's Out Patient Clinic

Stobhill Hospital
133 Balornock Road
GLASGOW
G21 3UW

Greater Glasgow and Clyde

Secretary: Mrs Eileen Mitchell
Direct Line: 0141 201 3785

Clinic 25/02/2010
Typed 01/03/2010
Our Ref JSS/EM

Sister Shona Thomson
Motility Nurse Specialist
Ward 32
Glasgow Royal Infirmary
84 Castle Street
Glasgow
G4 0SD

Copy to:

Dr John Langan
Baillieston Health Centre
20 Muirside Road
Baillieston
Glasgow
G69 7AD

Dear Shona

Deborah Sullivan ~ 07/12/1972 ~ CHI: 0712726128 ~ CRN: 10638479K
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

I wonder if you could see this young woman for me. She has had several Nissen's fundoplications in order to try and stop her getting reflux. The last procedure we performed was an anterior wrap and she has now come back saying she is no better. I am not sure whether this is functional or true bile and acid reflux and would be grateful if you could perform pH and motility studies to see what they show. I will review her in my clinic with the results following completion of your tests.

With many thanks,

Yours sincerely

Mr John S Smith
Consultant Surgeon

WEST OF SCOTLAND PANCREATICO-BILIARY UNIT

GLASGOW ROYAL INFIRMARY

MR C R CARTER
MR C J MCKAY
MR E J DICKSON

Tel: 0141 211 5129
0141 211 1168
0141 800 1977
Fax: 0141 232 0701

Glasgow Royal Infirmary
16 Alexandra Parade
Glasgow
G31 2ER

Switchboard: 0141 211 4000

e-mail:
secretary: h.Falconer@ggc.scot.nhs.uk
angela.patrick@ggc.scot.nhs.uk
Deborah.clarkson@ggc.scot.nhs.uk

Ref: RN/HF

Dictated: 28/01/2010
Typed: 10/02/2010

Dr John Langan
Baillieston Health Centre
20 Muirside Road, Baillieston, Glasgow
G69 7AD

Dear Dr Langan

Deborah Sullivan - 07/12/1972 - CHI: 0712726128 - CRN: 10638479K
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

Admitted: 11/11/09
Discharged: 13/11/09

Diagnosis: Chronic pancreatitis

This 36-year-old lady with a past history of open laparotomy in October 2004 following a Nissan fundoplication and cholecystectomy in 2006 was admitted through A&E complaining of severe abdominal pain radiating through to back. CT abdomen was conducted showing some inflammatory change behind laparotomy scar and no free fluid. She was managed conservatively with analgesia and IV fluids. The patient was discharged with her pain improving. The patient is planned for an outpatient MRI.

Yours Sincerely,

Rozh Noel
Lister Fellow in General Surgery

Sullivan Deborah 10638479K
DOB: 07/12/1972 WARD 6

DATE OF OPERATION 06/10/2009

MR J S SMITH

OPERATION: Re-do Nissen's fundoplication.

PROCEDURE: The abdomen was opened through the previous incision excising the stretched scar. On entering the abdominal cavity we were able to dissect the adhesions from the back wall of the wound. This allowed us to free up the colon and also to identify the liver and stomach. The adhesions to the stomach and liver were freed to allow us to gain access to the hiatus. It was quite obvious that there was a failure of the wrap with the wrap having slipped back through the posterior part of the stomach at the posterior window. We therefore elevated the oesophagus, freed this up in order to put in two sutures to close the crura behind the oesophagus. This tightened up the hiatus and should stop her developing further para oesophageal hernia. Secondly as the adhesions were such to the posterior part of the stomach it was felt impossible to perform a posterior wrap and therefore an anterior wrap was created suturing the redundant floppy stomach onto the right crus giving a 120° wrap anteriorly. Hopefully this will stop the patient's symptoms.

JSS/AS DICTATED & TYPED – 07 OCTOBER 2009

Freetext: moderately large

26/10/2004	None	High	Nissen fundoplication using abdominal approach	
17/03/2004	None	High	Dislocation or subluxation of shoulder	
Freetext:	Left shoulder			
30/08/2002	None	High	Overdose of drug	
Freetext:	Kapake and Tramadol with Diazepam			
27/08/2002	None	High	[D]Abdominal pain	
Freetext:	Vomiting			
02/07/2002	None	High	Chronic pancreatitis	
02/07/2002	None	High	Constipation	
01/10/2001	None	High	Chronic pancreatitis	
01/07/2001	None	High	[X]Rape	
01/07/2001	None	High	Anxiety states	Chronic
01/07/2001	None	High	Sexual assault	
23/04/1999	None	High	Diaphragmatic hernia	
23/04/1999	None	High	Reflux oesophagitis	
27/03/1999	None	High	[D]Abdominal pain	Recurrent
14/11/1996	None	High	[SO]Sphincter of Oddi	
Freetext:	Dysfuntion			
10/10/1996	None	High	Endoscopic retrograde cholangiopancreatography	
Freetext:	Major papilla was located in the second part of the duodenum			
23/04/1996	None	High	Acute cholecystitis	
23/04/1996	None	High	Cholelithiasis	
23/04/1996	None	High	Excision of gall bladder	
01/06/1995	None	High	Urinary tract infection, site not specified	
01/02/1995	None	High	[D]Nausea and vomiting	

Screening

15/06/2009	**Cervical Screening$$**	Cervical smear: negative	
Repeat after an Interval - 36 Months		Do not send recall letter	Do not send result letter
05/10/2005	**Cervical Screening$$**	Cervical smear: negative	
Repeat after an Interval - 36 Months		Do not send recall letter	Do not send result letter

Priority Clinical / User Marker

Date Recorded	Start Date	Priority	Description	Modifier
14/10/2009	None	High	Laparotomy	
Freetext:	and open fundoplication			
06/10/2009	None	High	Laparotomy	
Freetext:	and open revision of fundoplication			
09/03/2009	None	High	Chronic pancreatitis	

Pethidine TABS 50MG	50 1 or 2 Tabs 4 times daily	19/03/2008
Pethidine TABS 50MG	50 1 or 2 Tabs 4 times daily	11/03/2008
Fluoxetine CAPS 20MG	112 2 Caps In the morning make appt for next supply	05/03/2008
Pethidine TABS 50MG	50 1 or 2 Tabs 4 times daily	05/03/2008
Senna TABS 7.5MG	60 2 Tabs At night	05/03/2008
Cefalexin CAPS 250MG	20 1 Cap 4 times daily	05/03/2008
Pethidine TABS 50MG	50 1 or 2 Tabs 4 times daily	27/02/2008
Pethidine TABS 50MG	50 1 or 2 Tabs 4 times daily	20/02/2008
Pethidine TABS 50MG	25 1 or 2 Tabs 4 times daily	18/02/2008
Pethidine TABS 50MG	50 1 or 2 Tabs 4 times daily	12/02/2008
Clarithromycin TABS 500MG	14 1 Tab Twice daily	18/01/2008
Tramadol Hydrochloride CAPS 50MG	56 1 or 2 Caps every 4 to 6 hours	18/01/2008
Senna TABS 7.5MG	60 2 Tabs At night	18/01/2008
Erythromycin Ethylsuccinate TABS 500MG	28 1 Tab 4 times daily	31/12/2007
Amoxicillin CAPS 500MG	21 1 Cap 3 times daily	19/12/2007
Cilest TABS	6OP 1 Tab As directed	19/12/2007
Cilest TABS	1 op 1 Tab As directed	26/11/2007
Movelat GEL	100 Apply 3 times daily	03/10/2007
Fluoxetine CAPS 20MG	60 2 Caps In the morning make appt for next supply	11/09/2007
Cilest TABS	3 op 1 Tab As directed	11/09/2007
Morphine Sulphate TABS 10MG	42 2 Tabs 3 times daily	11/07/2007
Morphine Sulphate TABS 10MG	50 2 Tabs 3 times daily	26/06/2007
Cilest TABS	3 op 1 Tab As directed	26/06/2007
Gabapentin CAPS 100MG	200 1 Cap 3 times daily	15/06/2007
Cilest TABS	1 op 1 Tab As directed	30/05/2007
Scheriproct OINT	30 Apply Twice daily	04/05/2007
Scheriproct SUPPS	12 1 to be inserted Daily	04/05/2007
Fluoxetine CAPS 20MG	60 2 Caps In the morning make appt for next supply	04/05/2007
Fluoxetine CAPS 20MG	60 2 Caps In the morning make appt for next supply	21/03/2007
Amoxicillin CAPS 500MG	30 1 TAB THREE TIMES DAILY	31/01/2007

Buprenorphine 52.5 Micrograms/Hour PATCH	5 APPLY EVERY 3 DAY	02/08/2005
Buprenorphine 52.5 Micrograms/Hour PATCH	3 patches APPLY EVERY 3 DAY	26/07/2005
Morphine Sulphate Sf Oral Unit Dose Vial 5ml 10MG/5ML	20 mls 5 ml AS DIR FOR BREAKTHROU	26/07/2005
Morphine Sulphate Sf Oral Unit Dose Vial 5ml 10MG/5ML	20 5 ml AS DIR FOR BREAKTHROU	15/07/2005
Buprenorphine 52.5 Micrograms/Hour PATCH	3 APPLY EVERY 3 DAY	15/07/2005
Metoclopramide Hydrochloride TABS 10MG	30 1 Tab As directed	22/06/2005
Metoclopramide Hydrochloride TABS 10MG	30 1 Tab As directed	20/05/2005
Amoxicillin CAPS 500MG	30 1 Cap 3 times daily	05/05/2005
Fluoxetine CAPS 20MG	56 1 Cap In the morning	05/05/2005
Diazepam TABS 5MG	14 1 Tab At night	16/02/2005
Cilest TABS	6op 1 Tab As directed	18/01/2005
Diazepam TABS 10MG	28 1 Tab At night	18/01/2005
Metronidazole GEL 0.75%	1 Apply As directed	18/01/2005
Lactulose Oral SOLN 3.35G/5ML	500ml 10 ml Twice daily	18/01/2005
Amoxicillin CAPS 500MG	15 1 Cap 3 times daily	18/01/2005
Metoclopramide Hydrochloride TABS 10MG	30 1 Tab As directed	18/01/2005
Tramadol Hydrochloride Sf Soluble TABS 50MG	112 1 or 2 Tabs 4 times daily	30/12/2004
Diazepam TABS 10MG	14 1 Tab Daily	30/12/2004
Tramadol Hydrochloride Sf Soluble TABS 50MG	112 1 or 2 Tabs 4 times daily	08/12/2004
Diazepam TABS 10MG	14 1 Tab Daily	08/12/2004
Metoclopramide Hydrochloride TABS 10MG	30 1 Tab Daily	08/12/2004
Diazepam TABS 10MG	14 1 Tab Daily	11/11/2004
Tramadol Hydrochloride Sf Soluble TABS 50MG	112 1 or 2 Tabs 4 times daily	11/11/2004
Fluoxetine CAPS 20MG	28 1 Cap In the morning	11/11/2004
Tramadol Hydrochloride CAPS 50MG	224 1 or 2 Caps 4 times daily	15/07/2004
Diazepam TABS 5MG	14 1 Tab At night	15/07/2004
Fluoxetine CAPS 20MG	112 2 Caps Twice daily	15/07/2004
Chloramphenicol Eye OINT 1%	5 DAYS Apply 4 times daily	17/06/2004
Tramadol Hydrochloride CAPS 50MG	224 1 or 2 Caps 4 times daily	17/06/2004

Diazepam TABS 5MG	14 1 Tab At night	17/06/2004
Hyoscine Butylbromide TABS 10MG	168 2 Tabs 3 times daily	17/06/2004
Omeprazole TABS 20MG	56 1 Tab Twice daily	18/05/2004
Dihydrocodeine Tartrate TABS 30MG	100 1 or 2 Tabs Take as required	18/05/2004
Cefalexin CAPS 250MG	15 1 Cap 3 times daily	02/04/2004
Dihydrocodeine Tartrate TABS 30MG	100 1 or 2 Tabs Take as required	01/04/2004
Diclofenac Sodium Ec TABS 50MG	84 1 Tab 3 times daily	16/03/2004
Metoclopramide Hydrochloride TABS 10MG	30 tabs 1 Tab Daily	26/02/2004
Dihydrocodeine Tartrate TABS 30MG	100 1 or 2 Tabs Take as required	19/02/2004
Dihydrocodeine Tartrate TABS 30MG	100 1 or 2 Tabs Take as required	03/02/2004
Dihydrocodeine Tartrate TABS 30MG	100 1 or 2 Tabs Take as required	20/01/2004
Cefalexin CAPS 500MG	28 1 Cap 4 times daily	10/09/2003
Gaviscon Sf Aniseed LIQ	500 10 ml Take as required	04/09/2003
Co-Codamol 30mg/500mg Effervescent TABS	100 1 or 2 Tabs Take as required	04/09/2003
Xyloproct OINT	30 Apply Twice daily	13/06/2003
Omeprazole TABS 20MG	56 1 Tab Twice daily	29/05/2003
Fluoxetine CAPS 20MG	112 2 Caps Twice daily	28/04/2003
Omeprazole TABS 20MG	56 1 Tab Twice daily	28/04/2003
Senna TABS 7.5MG	28 1 Tab At night	28/04/2003

Last Encounter

Dr GA McKaig

Date: 10/02/2010

rpt meds, dispensed 10 fentanyl patches

Acute Prescriptions:

Temazepam - TABS 10MG	1 Tab - At night	28 dispense fortnightly
Tramadol Hydrochloride - CAPS 50MG	1 or 2 Caps - up to qds prn	224
Diazepam - TABS 5MG	1 Tab - Daily	28
Fentanyl - 75 Micrograms/Hour PATCH	apply 1 patch - every 72 hours	3
Imipramine Hydrochloride - TABS 25MG	3 Tabs - Twice daily	168

Last 4 Clinical Notes

WEST OF SCOTLAND PANCREATICO-BILIARY UNIT

GLASGOW ROYAL INFIRMARY

MR C R CARTER
MR C J MCKAY
MR E J DICKSON

Tel: 0141 211 5129
0141 211 1168
0141 800 1977
Fax: 0141 232 0701

e-mail:
secretary: h.Falconer@ggc.scot.nhs.uk
angela.patrick@ggc.scot.nhs.uk
Deborah.clarkson@ggc.scot.nhs.uk

Glasgow Royal Infirmary
16 Alexandra Parade
Glasgow
G31 2ER

Switchboard: 0141 211 4000

Ref: RN/HF

Dictated: 28/01/2010
Typed: 10/02/2010

Dr John Langan
Baillieston Health Centre
20 Muirside Road, Baillieston, Glasgow
G69 7AD

Dear Dr Langan

Deborah Sullivan - 07/12/1972 - CHI: 0712726128 - CRN: 10638479K
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

Admitted: 11/11/09
Discharged: 13/11/09

Diagnosis: Chronic pancreatitis

This 36-year-old lady with a past history of open laparotomy in October 2004 following a Nissan fundoplication and cholecystectomy in 2006 was admitted through A&E complaining of severe abdominal pain radiating through to back. CT abdomen was conducted showing some inflammatory change behind laparotomy scar and no free fluid. She was managed conservatively with analgesia and IV fluids. The patient was discharged with her pain improving. The patient is planned for an outpatient MRI.

Yours Sincerely,

Rozh Noel
Lister Fellow in General Surgery

46216

DR JOHN J LANGAN
DR JUNE GOLDIE
DR MOIRA C M MACLF
DR ELAINE E POLLOC
DR GERARD A MCKA
DR JENNIFER DOW
DR JULIE P ELLOR
DR CHRISTINE A WALKI
DR LIANA MCMILLAN

Baillieston Health Centre
20 Muirside Road
Baillieston
Glasgow G69 7AD
Tel: 0141 531 8050
Fax: 0141 531 8067

Shettleston Health Centre
420 Old Shettleston Road
Glasgow G32 7JZ
Tel: 0141 531 6240
Fax: 0141 531 8067

11/11/-9

Dear [illegible]

The lady has chronic pancreatit. JL

[illegible] - [illegible] 6/oct/2014

She complains of pain in the abdomen - the abdomen is soft and she will since when.

O/E [illegible]

CVS P = 124/- BP 110/80

RS



I would like might have had a PTC

would be grateful if you would see her

Yours faithfully

I enclose her records + [illegible]

OESOPHAGO-GASTRIC UNIT

Mr G Fullarton
Mr C K MacKay
Mr M J Forshaw

Secretary: Ayshea Spence
Tel: 0141 211 4293
Fax: 0141 211 4991
Email: Ayshea.Spence@ggc.scot.nhs.uk

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Switchboard: 0141 211 4000

PG/LM

Date Dictated: 04/08/2009
Typed: 13/08/2009

Dr John Langan
Baillieston Health Centre
20 Muirside Road, Baillieston, Glasgow
G69 7AD

Dear Dr Langan

Deborah Sullivan - 07/12/1972 - CHI: 0712726128 - CRN: 10638479K
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

Admission: **22.07.09.**
Discharge: **24.07.09.**
Diagnosis: **Constipation**
Management: **Conservative**

Deborah has a past history of pancreatitis and has previously had pseudocysts drained. She came in with abdominal pain. Abdominal film showed faecal loading. We performed a CT scan, this showed that a chest infection may well be the cause of her recent illness. She was reviewed by the Respiratory Physicians who did not feel she required any further investigation. She was allowed home when she was eating and drinking.

Yours sincerely

Paul Glen
Specialist Registrar

Oesophageal Manometry/24 hour ph metry. Book in:
Mon:9am,11am,1.30pm,3pm.
Tues:9am, 11am,1.30pm,3pm,3.15pm
Wed:10.45am,1.30pm,3pm,3.30pm.
Thurs:9am,

17/3/09 next available 9am

sion

Directorate

ry
BHILL

Stobhill Hospital
133 Balornock Road
GLASGOW
G21 3UW

NHS
Greater Glasgow and Clyde

Mr J S Smith's Out Patient Clinic

Secretary: Mrs Eileen Mitchell
Direct Line: 0141 201 3785

Clinic 18/12/2008
Typed 19/12/2008
Our Ref SK/EM

Sister Shona Thomson
Endoscopy Nurse Specialist
Ward 32
Glasgow Royal Infirmary
84 Castle Street
Glasgow
G4 0SD

Dear Shona

Deborah Sullivan ~ 07/12/1972 ~ CHI: 0712726128 ~ CRN: 10638479K
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

This young woman is presently waiting for manometry and pH studies but does not appear to have received an appointment. I am not sure if Mr Smith's initial referral has reached you but would be grateful if you could arrange for these investigations to be carried out in the near future.

Kind regards.

Yours sincerely,

Mr Segun Komolafe
Specialist Registrar

Acute Services Division

Surgery and Anaesthetic Directorate

Department of General Surgery
OUTPATIENTS CLINIC - STOBHILL

Mr J S Smith's Out Patient Clinic

Stobhill Hospital
133 Balornock Road
GLASGOW
G21 3UW

Secretary: Mrs Eileen Mitchell
Direct Line: 0141 201 3785

NHS
Greater Glasgow and Clyde

Clinic 18/12/2008
Typed 19/12/2008
Our Ref SK/EM

Sister Shona Thomson
Endoscopy Nurse Specialist
Ward 32
Glasgow Royal Infirmary
84 Castle Street
Glasgow
G4 0SD

Dear Shona

Deborah Sullivan ~ 07/12/1972 ~ CHI: 0712726128 ~ CRN: 10638479K
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

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Kind regards.

Yours sincerely,

Mr Segun Komolafe
Specialist Registrar

Immediate Discharge and Medicine Prescription Form - Confidential

Glasgow Royal Infirmary
Glasgow G4 0SF
Telephone: 0141 211 4000

Ref. No: 081486

Name of GP: Lugton
Surgery/Health Centre: Bishopbriggs H C

Fix ID label to all 4 copies

Patient: Sullivan
Address: 11 Rifkind Court

Post Code: G69 7EP
DOB: 1/1/77 Unit no: 100384791C
Weight: CHI no: 0712776178

Ward: 60 Tel:
Consultant: McKee
Named Nurse:
Specialty: Acute Surgery
Admission date: 7/3/09
Mode of admission: Elective ☐ Emergency ☑ Transfer ☐
Source of Admission: A&E
Discharge date: 9/3/09

NURSE TO COMPLETE

Out Patient appointment date:
Diagnosis informed (circle) Patient Relative
Circle support services set up:
District Nurse Home Help Health Visitor
Oncology referral Hospice: day care OR home care
Discharge address if not home:

WARD USE ONLY

Medication Rec. on Ward by:
Checked against kardex:
Issued by: Date:
Signature of Recipient:

All known drug sensitivities / adverse reactions:

Reason for Admission, Diagnosis	Treatment, Investigations, Operations	Complications
	Chemoprevention Cisplatin (Carboplatin)	Nil

New Drug	New Dose	MEDICINE	Form	Dose	TIMES FOR ADMINISTRATION: am 8	md 12	pm 2	pm 6	pm 10	Other times	Course length
		Amlodipine	O	1g	/	/	/		/		
		Ranitidine	O	300mg	/			/	/		
		Ventolin	O	60mg	/					PRN	
		Diazepam	O	5mg	/	/		/	/		
		Nicotinell	O	15MTH	/	/		/	/	PRN QID.	GP r/v
		Aspirin	O	1mg	/				/	o/d.	

PHARMACY USE ONLY

Clinical Pharmacy Check ☐ Professional Check ☐

Quantity supplied	Dispensing Details
	50 x 500mg x 4/7
	42 x 100mg x 7
	14 x 20mg x 7
	30 x 50mg x 7
	28 x 15mg x 7
	14 x 1mg x 7

Dispensed by: Date: / /
Checked by:

Non-childproof containers required: Yes ☐ No ☐
Medicine compliance aids required: Yes ☐ No ☐
Specify:

Medication Collected by:

Medicines Discontinued	Reason if known e.g. side effect	Other Information

Prescribers name: Signature: Date 9/3/09
Designation: Pager number: 3237

White copy - GP, Pink copy - Case Notes, Blue copy - Pharmacy, Yellow copy - Patient

You must use a ballpoint pen and fully complete this form or the prescription will not be dispensed

Back

CRIS: 5302813 Patient Details Address GP

Hospital No SG03130984 20339127X

Chi No. 2304426247

Surname ROONEY

Forenames MARY

DoB 23/04/1942 Female

Film Location G107HW17

224 CARDOWAN ROAD
GLASGOW
LANARKSHIRE
G32 6QR

Search Enquire Result Log off

Attended	Ward	Referrer
08/03/2009 @ 1056	G107HW60	DR RF MCKEE

Verified Report

Clinical History : Right loin and right iliac fossa pain. Positive urinalysis. Marginally elevated CRP 31. Exclude obstruction.

Reported	Typed	Verified
By: DR I KHAN On: 08/03/2009 At:	By: DR I KHAN On: 08/03/2009 At: 1216	By: DR I KHAN On 08/03/2009 At: 1216

Verified Report

US Abdomen :

The liver, though normal in size, shows increased echogenicity in keeping with fatty infiltration. No focal liver lesions seen. No stones seen within the gallbladder and pancreatic head visualized is normal. The CBD, though, is dilated measuring approximately 1 cms. Spleen is within normal limits.

The right kidney measures approximately 12 cms and has a 2.5 x 2.6 x 2.4 cms simple cyst at its lower pole. The left kidney measures 9.6 cms approximately and shows loss of cortex. Bladder was empty and could not be assessed. No free fluid seen within the abdomen/pelvis.

Reported	Typed	Verified
By: DR I KHAN On: 08/03/2009 At:	By: DR I KHAN On: 08/03/2009 At: 1216	By: DR I KHAN On 08/03/2009 At: 1216

Back Log off

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RECEIVING SURGEON

Date: Saturday 7-Mar-09 **Agency Phone No.**

Patient Name: Deborah Sullivan **Sex:** F **Date of Birth:** 07-Dec-1972 **Age:** 36 years

Address: 6 Muirhead Ct Baillieston **Own Doctor:** Langan,JJ(222).

Surgery: Provider Group

Glasgow

G69 7EP

Home Tel: 0141 771 6310

Case Origin: **Case Number:** 2430335

Caller Name: **Tel:** **Case Priority:** Pr 1-Within 1 hr

Reported Condition: **Receive Time:** **Operator:**

Latest Consultation Details **Consulted By:** Rigg,Douglas(CC) **Cons. Begin:** 11:38 AM **Cons. Finished:** 11:47 AM

Pain since 6 am vomiting since midnight -
GP- hx pancreatitis 2nd to gall stones. Some issue with bile duct destruction. Complicated laparotomy.
Been unwell this week with grumbling abdo pains. Overnight ~midnight ^^central abdo pain. Radiating through to back & L shoulder. Vomiting ++. Unable to take meds due to vomit.
Bowels OK.

Examination Details:

Acutely tender abdomen, especially centrally. Guarding, rebound.

HEAD AND NECK
Temperature 36.10.C

LUNGS
Respiration rate 16

HEART
Pulse 102
Pulse character Rhythm regular
Systolic BP 110
Diastolic BP 84

Refer surgeons GRI

Clinical Codes:

R090. [D]Abdominal pain

Prescription Items:

Diagnosis:

Acute abdomen -> needs surgical review.

Agency Questions and Answers

Agency Comments

Mr IG Finlay
Department of Coloproctology

04/09/2008	10/09/2008	60	07/12/1972	10638479
Emergency				

Home

Deborah Sullivan
6 Muirhead Court
Baillieston
Glasgow G69 7EP

none

Other unspecified - Chronic abdominal pain, unknown aetiology

Dr Langan
Baillieston Health Centre
20 Muirside Road
Baillieston G69 7AD

06/10/2008

Deborah was admitted on the above date with self-limiting exacerbation in her chronic abdominal pain. A CT of her abdomen and pelvis was performed during this admission and no significant abnormality detected and in particular the pancreas was of normal morphology.

After a period of fasting Deborah felt her symptoms were much improved and she was discharged on 10.9.08. No plans for follow up under Mr Finlay have been made.

Kind regards.

Yours sincerely,

Mr Ian Jenkins
Specialist Registrar

Mr IG Finlay
Consultant Colorectal Surgeon

CONSULTANT
Mr IG Finlay
Department of Coloproctology

GLASGOW ROYAL INFIRMARY
84 CASTLE STREET, GLASGOW G4 0SF

Telephone No. 0141-211-4000
Ext.

ADMITTED	DISCHARGED	WARD	AGE	HOSPITAL NUMBER
02/02/2008 Emergency	03/02/2008	60	07/12/1972	10638479

DISPOSAL
Home

FOLLOW UP
with Mr Carter

NAME AND ADDRESS
Deborah Sullivan
1 Camp Road
Baillieston
Glasgow G69 6QR

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS

	I.S.C. CODE
1.	
2.	
3.	
4.	
5.	
6.	

DISTRIBUTION OF LETTERS

Dr Langan
Baillieston Health Centre
20 Muirside Road
Baillieston G69 7AD

OPERATION	CODE
1.	
2.	
3.	

29/02/2008

This lady who attends Mr Carter was admitted with epigastric pain. This settled with conservative measures and she was discharged home the following day.

She already has an appointment to see Mr Carter in the near future.

Yours sincerely,

Mr Chris Rodger
Specialist Registrar

Mr IG Finlay
Consultant Colorectal Surgeon

05181

Immediate Discharge and Medicine Prescription Form - Confidential

Glasgow Royal Infirmary
Glasgow G4 0SF
Telephone: 0141 211 4000

Ref. No: 035371

NHS Greater Glasgow and Clyde

To Doctor: Langan
Surgery: Millbrook Health Centre

Fix ID label to all 4 copies

10638479K
SULLIVAN F
DEBORAH 07/12/1972
1 CAMP ROAD
BAILLIESTON
GLASGOW G69 6QR
CHI-0712726128

t Code:
t no:
CHI no:

Ward: 60 Tel: 01412115060
Consultant: finlay
Named Nurse:
Specialty: Acute Surgical Receiving
Admission date: 02/02/18
Mode of admission: Elective ☐ Emergency ☐ Transfer ☐
Source of Admission
Discharge date: / /

FOLLOW-UP ARRANGEMENTS

Clinic appointment made:
Yes ☐ No ☐ To follow ☑
Clinic name: Mr Carter
Date: 14/2/18
Non-childproof containers required: Yes ☐ No ☐
Medicine compliance aids required: Yes ☐ No ☐
Specify:

Reason for Admission, Diagnosis	Treatment, Investigations, Operations	Complications
? ischaemic colitis	Bld (N) AXR CXR IV Fluids	

All known drug sensitivities / adverse reactions:

MEDICINE	Form	Dose	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 8	pm 10	Other times	Course length	New Drug	New Dose

No charge

Medicines Discontinued	Reason if known e.g. side effect	Other Information

Doctor's name: Signature: Date: / /
Doctor's grade: Pager number:

PHARMACY USE ONLY

Clinical/Professional Pharmacist check:

No. of days supply	Dispensing Details

Dispensed by: Date: / /
Checked by:
Medication Collected by: (Messenger)

WARD USE ONLY

Medication Rec. on Ward by:
Checked against kardex:
Issued by:
Date Issued:
Signature of Recipient:

White copy - G.P. Pink copy - Case Notes Blue copy - Pharmacy Yellow copy - Patient

You must use a ballpoint pen and fully complete this form or the prescription will not be dispensed

SCOTTISH AMBULANCE SERVICE - PATIENT REPORT FORM

CCS INCIDENT No.

Last Name

First Name

Location

Age

Sex

D of B

Date

Time of Call

Time at Patient

Time Left

AMPDS Code

AMPDS Revised

Airway Clear | Suction | N/OPA | ET | LMA | Successful ? | C-spine Injury

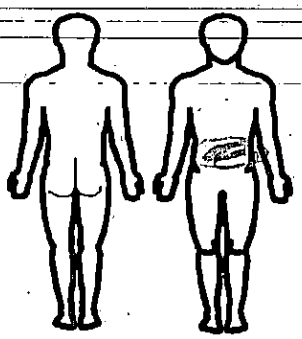
Breathing | Rate | BVM | Ventilation | Successful ? | Paralysis | Fitting

Pulse | Rate | CPR | IV/IO | Fluids | Successful ? | ECG

Despite the above unable to

Clear airway | Detect breathing | Detect pulse

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



RTA

Trapped

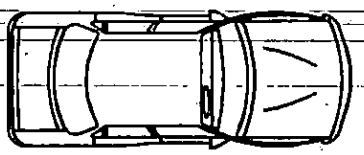
Ejected

M / cyclist

Cyclist

Pedestrian

>20 min. Extricate



Allergies

Medication

Assisted by and Name -

Doctor | Nurse | Other

Temp. °C

PEFR % B. Sugar mmol

Time	Pulse	Resp	BP	C / Refill	SpO2 %	GCS	Lpupil	Rpupil

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

Condition at hospital Pulse Breathing Conscious Time at Hospital

History and Additional Information

Working assessment

Diagnosis Code

Crew Name 1 Grade

Crew Name 2 Grade

Call No: 2042029	**Date:** 02/02/2008 10:56	**NHS 24 No:** 5416079
Patients Name: Deborah Sullivan	**D.O.B.** 07/12/1972 **Age:** 35 years	**Callers Name:** Deborah **Relationship:**

Address Today: 1 Camp Road Baillieston Glasgow	**Home Address if different** 1 Camp Road Baillieston Glasgow
Post Code: G69 6QR	**Post Code:** G69 6QR
Phone Number: 0141 771 6310	**Call Type:** Home Visit Within 1 Hr
Name of GP: Langan,JJ(222)	**Time Call Received at NHS 24:** 02/02/2008 10:44:43
Surgery: 222 Baillieston HC / Shettleston HC	**Time Details Received at GEMS:** 02/02/2008 10:56:18
Practice Number:	**Time Patient Arrived:**
Fax Number: 0141 531 8067	**Consultation Start time:**
ed Dial: 056L	**Consultation End time:**

Dispatched To: KIT9

Clinical Information

WORSENING PANCREATITIS PAIN SEE AVClinical summary created by: (Nurse Advisor) (Glasgow) [02/02/2008 10:56:06]
SEVERE ABDO PAIN FOR 6/24 WORSENING AND HAS CHRONIC PANCREATITIS. PAIN VERY SEVERE THIS MORNING, FEVERISH, UPPER ABDO PAIN RADIATING THROUGH TO BACK, VOMITING, HAS TAKEN TRAMADOL AND MORPHINE WITH NO EFFECT. ALSO HAS MORPHINE PATCH. VERY DISTRESSED. GP HOME VISIT 2 HOURS.

Examination Results:

Clinicians Notes

Prescription Items:

Clinical Code/s:

ormational Outcome:

Referral: Consulting Clinician:

↑ Abd. pain | vomiting since yesterday Ayr 35yrs
Tramadol 7.30am today 20mg ✕
Hb 9 | WCC 13 | Plt 13 | CRP Awaited
Dr Jack
Ayr

Ayr cholecystectomy 1998
+
Complications
Pancreatitis
Δ Pancreatitis Rpt bloods 1 12-5 pm
Refer Rec Surg ASAP GRE
✕ Reds. pain worse with taking MORPH. NB ✕

FINAL DISCHARGE LETTER

Glasgow Royal Infirmary 84 Castle Street, Glasgow G4 0SF 0141 211 4405

Ward 43

Consultants: Dr Chalmers

Dr C Langan
Baillieston Health Centre
20 Muirside Road
Baillieston
Glasgow
G69 7AD

Ms Deborah Sullivan
1 Camp Road
Baillieston
Glasgow
G69 6QR

CHI: 0712726128
DOB: 07/12/1972

Admitted: 10/10/2007
Estimated Discharge:
Discharged: 11/10/2007
Transferred:

Main Diagnoses:

1. Headache
2. Chest pain
3. Epigastric pain

Previous/inactive Diagnoses:

1. Functional abdominal pain – patient relates to this as chronic pancreatitis
2. Previous EOR requiring Fundoplication

Presenting complaint:

Examination:

Diagnostic tests/ procedures and relevant results:

Examination revealed epigastric tenderness. Asked for Oplgles on several occasions.
Floods including Troponin and Urinalysis were normal
Reassessed and discharged home

Progress:

Results awaited/ further action:

Medication on discharge (changes in bold):

No change

Date: 18/10/2007 **Signed:** Dr Fernandez **Position:** ST1

North Glasgow Neck Lump Clinic
Glasgow Royal Infirmary
16 Alexandra Parade
GLASGOW
G31 2ER
Fax No: 0141 211 1211

DEPARTMENT OF OTOLARYNGOLOGY AND HEAD AND NECK SURGERY

Consultants

Mr B Irvine	0141 211 1668
Mr K MacKenzie	0141 211 1659
Mr G W McGarry	0141 211 1660
Mr O J Hilmi	0141 211 1661

Dr Tough
Baillieston Health
Centre
20 Muirside Road
Baillieston
G 69 7AD

08/02/2007

Dear Doctor

Deborah Sullivan Date of Birth 07/12/1972 CHI 0712726128 Post Code G 69 6QR

Attended the North Glasgow Neck Lump Clinic today with a 6 week history

of odynophagia

Examination of the Oral cavity showed no abnormality

Examination of the larynx and pharynx showed no abnormality

Neck Examination Revealed No Palpable mass

clinical impression:- Reactive

No Investigation was organised :-

Pt describing multiple URTI's in last 6 weeks, nil specific to be found

Outcome: Follow up opd - Mr Hilmi

Yours sincerely

Mr Omar Hilmi
Consultant Otolaryngologist

The above results represent clinical +/- Ultrasound findings only, where a biopsy has been taken the result will be given at the follow up clinic

19/2/07 10638479

DR CHARLES LANGAN
DR JOHN J LANGAN
DR JUNE GOLDIE
DR MOIRA C M MACLEOD
DR ELAINE E POLLOCK
DR GERARD A MCKAIG
DR JENNIFER DOW
DR JULIE P ELLOR
DR CHRISTINE A WALKER

46216

Baillieston Health Centre
20 Muirside Road
Baillieston
Glasgow G69 7AD
Tel: 0141 531 8050
Fax: 0141 531 8067

Shettleston Health Centre
420 Old Shettleston Road
Shettleston
Glasgow G32 7JZ
Tel: 0141 531 6240
Fax: 0141 531 6212

JE/AG

15 January 2007

Department of Ear, Nose & Throat
Glasgow Royal Infirmary
16 Alexandra Parade
Glasgow G31 2ER

URGENT APPOINTMENT

Dear Doctor

DEBORAH SULLIVAN – D.O.B. 07.12.72 CHI NO 6128
1 CAMP ROAD, GARROWHILL, GLASGOW G69 6QR

This 34 year old lady presented one week ago with a sore throat and on examination she was found to have evidence of pharyngitis with a purulent exudate and marked cervical lymphadenopathy. She has returned today complaining of persistent throat discomfort but she reports that her throat has been sore persistently over the last 6 months with her symptoms becoming increasingly severe. She states that she developed enlarged glands 4 weeks ago and she has been unable to eat solids since then. She reports that her weight has dropped by a 1½ stone over the last 6 months. She is a smoker but denies any history of alcohol excess. She has had problems with depression for some time and has a degree of agoraphobia.

On examination today her throat looked reasonably normal in appearance but she has very marked bilateral cervical lymphadenopathy. I have sent her for a throat swab and checked a glandular fever screen but I am very concerned given the persistent nature of her symptoms, her history of weight loss and her marked lymphadenopathy.

I see that she has a past history of chronic pancreatitis which she states is due to gallstones and she also underwent Nissen fundoplication back in 2004. A copy of her repeat medication is attached and she is also taking Fluoxetine 40mgs daily along with the combined oral contraceptive pill.

Yours sincerely

JULIE P ELLOR

p.s. I discussed this lady with the on call SHO today who advised me that an urgent referral for a clinic review was the most appropriate action to take with this lady.

[redacted]

Registration

Deborah Sullivan
1 Camp Road
GARROWHILL
GLASGOW
G69 6QR
Telephone:
Contact: ?
ContactRelship: ?
Email: ?
CHI Number 0712726128

[redacted]
DoB: 07/12/1972
Age: 34

Repeat Medication

Drug/Preparation	Quantity/Dose/Frequency	Start	Last	Interval Prea.	Review
Buprenorphine 52.5 Microgrems/Hour PATCH	5 Apply APPLY EVERY 3 DAY	05/01/2006	05/01/2007	28	52
Morphine Sulphate Sf Oral Unit Dose Vial 5ml 10MG/5ML	20 TWENTY 5 ml AS DIR FOR BREAKTHROU	05/01/2006	05/01/2007	28	52
Metoclopramide Hydrochloride TABS 10MG	30 1 Tab As directed	09/09/2005	05/01/2007	28	26
Paracetamol TABS 500MG	168 2 Tabs every 4 to 6 hours	13/07/2005	19/12/2006	28	26
movicol Sachets	60 1 sachet Twice daily	13/07/2005	19/12/2006	28	26
Tramadol Hydrochloride CAPS 50MG	224 1 or 2 Caps 4 times daily	18/01/2005	19/12/2006	28	26
Omeprazole TABS 40MG	28 1 Cap in the morning	08/12/2004	19/12/2006	28	26

Adverse Reactions

Read Code	Description

Priority Clinical / User Marker

Date Recorded	Start Date	Priority	Description	Modifier
12/10/2006	None	High	Anxiety with depression	
18/01/2005	None	High	Never smoked tobacco	
05/11/2004	None	High	Hiatus hernia NOS	
Freetext:	moderately large			
26/10/2004	None	High	Nissen fundoplication using abdominal approach	
17/03/2004	None	High	Dislocation or subluxation of shoulder	
Freetext:	Left shoulder			
30/08/2002	None	High	Overdose of drug	
Freetext:	Kapake and Tramadol with Diazepam			
27/08/2002	None	High	[D]Abdominal pain	
Freetext:	Vomiting			
02/07/2002	None	High	Chronic pancreatitis	
02/07/2002	None	High	Constipation	
01/10/2001	None	High	Chronic pancreatitis	
01/07/2001	None	High	[X]Rape	

From: [redacted]

North Glasgow University Hospitals
Division

LISTER DEPARTMENT OF SURGERY

UPPER GASTROINTESTINAL UNIT

PROFESSOR C W IMRIE
MR W R MURRAY
MR R C STUART
MR R CARTER
MR C MCKAY
MR K ROBERTSON

(Tel: 0141 800 1977)
(Fax: 0141 552 3229)
e-mail: c.j.mckay@clinmed.gla.ac.uk
Secretary: deborah.clarkson@northglasgow.scot.nhs.uk

Glasgow Royal Infirmary
16 Alexandra Parade
Glasgow G31 2ER
Switchboard: 0141 211 4000

NHS Greater Glasgow

CM/DC/20964876r

24 January 2006

Dr Tough
Baillieston Health Centre
20 Muirside Road
Baillieston
Glasgow
G69 7AD

Dear Dr Tough

Re: Deborah Sullivan, 07.12.1972
1 Despard Gardens, Glasgow, G32 0RX

Admitted:	**08.01.2006**	**Discharge:**	10.01.2006
Diagnosis:	Chronic Abdominal Pain		
Procedure:	None		

Deborah was admitted again with abdominal pain. She has a history of GI dysmotility and chronic abdominal pain syndrome. Her symptoms settled within a couple of days and I have not arranged routine follow-up in the clinic.

Yours sincerely

C McKAY
Senior Lecturer/Consultant Surgeon

POSITIVE ABOUT DISABLED PEOPLE

IMMEDIATE DISCHARGE LETTER 352682

NORTH GLASGOW UNIVERSITY HOSPITALS DIVISION

NHS Greater Glasgow

GLASGOW ROYAL INFIRMARY
GLASGOW G31 2ER
Tel: 0141-211 4000

PATIENT IDENTIFICATION

Dr LORRAINE [illegible]
2096487ER
7/12/1972

FIX ID LABEL TO ALL 4 COPIES

DATES

ADMISSION 6/4/06
DISCHARGE 10/4/06
TRANSFER TO
RE-ADMISSION
DEATH

GP IDENTIFICATION

Dr A TOUGH
Sallmston Health Centre

OTHER DISTRIBUTION

MEDICAL IDENTIFICATION

WARD GO
CONSULTANT Dr. MCKAY (BLOCK CAPITALS)
CONTACT Dr. CLARK (BLOCK CAPITALS)

PRESENTING COMPLAINT(S)

Abdo pain + vomiting

ADMISSION

DAY CASE ☐ ARRANGED ☐ EMERGENCY ☐ TRANSFER ☐

ACTIVE DIAGNOSIS/PROBLEMS/OPERATIONS

1) Chronic pancreatitis
2) Panic pain
3)
4)
5)
6)

INACTIVE DIAGNOSIS/PROBLEMS

1)
2)
3)

INFORMATION GIVEN TO PATIENT (SPECIFY)

THE PATIENT WAS DISCHARGED ON THE MEDICATION TREATMENT DETAILED BELOW. RECOMMENDED DURATION OF TREATMENT IS FROM THE DATE OF DISCHARGE. WHERE TREATMENT IS INDEFINITE, A SEVEN DAY COURSE HAS BEEN DISPENSED.

MEDICINE	FORM	DOSE	TIMES OF ADMINISTRATION 8am	10am	12pm	2pm	6pm	10pm	DURATION	PHARMACY TO COMPLETE QUANTITY, STRENGTH, BRAND
No change to regular meds										

FOLLOW-UP REVIEW

HOSPITAL OP YES/NO
SPECIFY.....
GP SURGERY YES/NO
SPECIFY.....

CARE ARRANGEMENTS
NONE ☐
SWD ☐
DISTRICT NURSE ☐
OTHER.....

DRESSING/SUNDRIES SUPPLIED TO PATIENT

PRODUCT	SIZE	NUMBER ISSUED
		Signature:-

COMMENTS:

Signed ..... Page No. 1

(Prescriber) SHO : SpR : CONS (please tick)

White Copy GP Pink Copy Case Notes Yellow Copy Retain in Ward Blue Copy Pharmacy

NORTH GLASGOW UNIVERSITY HOSPITALS DIVISION

HOME PLAN

NHS Greater Glasgow

Hospital GRI Phone Number 0141 211 3660

20964876R
SULLIVAN F
DEBORAH 07/12/1972
1 Despard Gardens
GLASGOW G32 0RX
CHI-0712726128

Ward 60 Phone Number

Consultant Mr McKay Named Nurse SIN JOHNS

Discharge Date 10/1/06

ADMISSION DETAILS

Date of Admission 8/1/06 Admission Ward 60

Reason for Admission / Treatment Abdominal pain + vomiting
Abdo U/S - Normal

MEDICATION

You have been given a [ ] day supply of medication. Please ensure that you read the labels of the medication you have been given and take your drugs as prescribed.

You will / will not require a further supply of this medication.

Please contact your GP within a week if you require a further supply of medication.

FOLLOW UP

You will / will not require follow up at the hospital

You have an appointment for

1. Follow up as prev arranged on _____ (day) _____ (date)
2. _____ on _____ (day) _____ (date)

You will receive a return appointment through the post for

1. _____ in _____ weeks time
2. _____ in _____ weeks time
3. _____ in _____ weeks time

Transport will / will not be arranged

SPECIAL INSTRUCTIONS / ADVICE

Contact your GP or ward for advice if there are any problems.

If you should have a problem with this discharge plan please do not hesitate to contact the w within 24 hours.

Patient / Carer Signature _____

Named / Associate Nurse Signature _____

GRI job no 93999 / 1

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST

Medical In Confidence Inpatient/Day Case Record

NHS Greater Glasgow

I/A/D/C

Patient Identification

Patient CRN 20964876R	Provider SGC04 Hosp GRI
Surname MIS SULLIVAN	Patient's Address
First Forename DEBORAH	1 Despard Gardens
Second Forename	
Previous Surname	GLASGOW
Date of Birth 07 Dec 1972	Postcode G32 0RX
Sex F / Marital Status S	Tel No:
NOK Details KATHLEEN MOTHER	GP Details A TOUGH BAILLIESTON HEALTH CENT 20 MUIRSIDE ROAD BAILLIESTON

Episode Management

Spell/Care Package ID	Ward WD60*GR	Admission Date/Time 08 Jan 06 04:55
Speciality/Discipline (Code + Text National) GENERAL SURGERY		Admission Type 36
Significant Facility OTHE		Admission Reason 11
Consultant Code		Admission/Transfer From 11
Consultant Name MR C MCKAY		Admission/Transfer From – Location
Management of Patient	Patient Category NHS	GP Referral Letter No.
Waiting List Guarantee Exception Code	Waiting List Date	Waiting List Type NWL

General Clinical

Main Diagnosis – ICD 10

Other Condition – ICD 10 – 2

4

5

6

Main Operation/Procedure

Other 2

Other 3

Other 4

Date Main Operation

Clinician Responsible

Date (OPP2)

Clinician Responsible (2)

Date (OPP3)

Clinician Responsible (3)

Date (OPP4)

Clinician Responsible (4)

Development data

Chronic Sick/Disabled ☐ Clinical Problem of Spell/Care Package

Lifestyle Risk Factors 1 2

Outcome Measures 1 2

Dependency/Severity Measures 1 2

SCOTTISH AMBULANCE SERVICE - PATIENT REPORT FORM

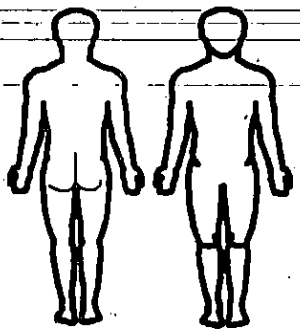
CCS INCIDENT No. 1613966

Last Name: Sullivan
First Name: Deborah
Location: Despard Garden / Sandyhills
Age: 33
Sex: X
D of B: 07/12/72

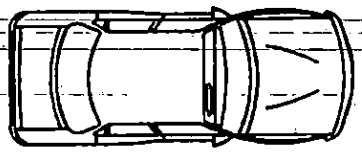
Date: 08/05
Time of Call: 0025
Time at Patient: 0033
Time Left: 0047
AMPDS Code:
AMPDS Revised:

Airway Clear [X] Suction [ ] N/OPA [ ] ET [ ] LMA [ ] Successful ? [ ] C-spine Injury [ ]
Breathing [X] Rate [X] BVM [ ] Ventilation [ ] Successful ? [ ] Paralysis [ ] Fitting [ ]
Pulse [X] Rate [X] CPR [ ] IV/IO [ ] Fluids [ ] Successful ? [ ] ECG [ ]
Despite the above unable to
Clear airway [ ] Detect breathing [ ] Detect pulse [ ] [X] [ ] [ ] [ ]

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



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



Temp. [ ] °C
PEFR [ ] % B. Sugar [ ] mmol

Allergies: Voltarol
Medication: WITHPT
Assisted by and Name -
Doctor [ ] Nurse [ ] Other [ ]

Time	Pulse	Resp	BP	C / Refill	SpO2 %	GCS	Lpupil	Rpupil
0049	R82	20	115/89					

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

Condition at C211 hospital Pulse [X] Breathing [X] Conscious [X] Time at Hospital [ ]

History and Additional Information: GP urgent call upgraded to 999 call by NHS 24. 9/M Adult Female 9/o abdo pain ongoing pancreatic problem. Given antiemetic by GP & taken oramorph 5mg (2hr last pm) Pain started lunchtime today D&V today.

Working assessment: Abdo Pain
Diagnosis Cod

Crew Name 1: Lennon Grade [ ]
Crew Name 2: McWilliams Grade [ ]

CONSULTANT
Mr P Horgan
Department of Coloproctology

GLASGOW ROYAL INFIRMARY
84 CASTLE STREET, GLASGOW G4 0SF

Telephone No. 0141-211-4000
Ext.

ADMITTED	DISCHARGED	WARD	AGE	HOSPITAL NUMBER
08/03/2005 Emergency	12/03/2005	60	07/12/1972	20964876

DISPOSAL
Irregular Discharge

FOLLOW UP
SOPD

NAME AND ADDRESS
Deborah Sullivan
8 Rhindmuir Court

Glasgow G69 6BN

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS

	I.S.C. CODE
1. Undiagnosed abdominal pain -	
2.	
3.	
4.	
5.	
6.	

DISTRIBUTION OF LETTERS

Dr Tough
Baillieston Health Centre
20 Muirside Road
Glasgow G69 6LH

OPERATION	CODE
Other	
Observation	
2.	
3.	

06/04/2005

This lady was admitted with diarrhoea and vomiting accompained with abdominal pain. Recent investigations were normal and she was put back on diet. She took her on regular discharge on 12 March.

Yours sincerely,

05181

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST

Medical In Confidence Inpatient/Day Case Record

NHS Greater Glasgow

I/A/D/C

Patient Identification

Patient CRN 20964876R	Provider SGC04 Hosp GRI
Surname MIS SULLIVAN	Patient's Address
First Forename DEBORAH	8 Rhindmuir Court
Second Forename	Baillieston
Previous Surname	GLASGOW
Date of Birth 07 Dec 1972	Postcode G69 6BN
Sex F / Marital Status S	Tel No:
NOK Details KATHLEEN MOTHER	GP Details A TOUGH BAILLIESTON HEALTH CENT 20 MUIRSIDE ROAD BAILLIESTON

Episode Management

Spell/Care Package ID	Ward WD60*GR	Admission Date/Time 26 Jul 04 17:05
Speciality/Discipline (Code + Text National) GENERAL SURGERY		Admission Type 36
Significant Facility OTHE		Admission Reason 11
Consultant Code		Admission/Transfer From 10
Consultant Name MR R STUART		Admission/Transfer From – Location
Management of Patient	Patient Category NHS	GP Referral Letter No.
Waiting List Guarantee Exception Code	Waiting List Date	Waiting List Type NWL

General Clinical

Main Diagnosis – ICD 10

Other Condition – ICD 10 – 2

4

5

6

Main Operation/Procedure

Other 2

Other 3

Other 4

Date Main Operation

Clinician Responsible

Date (OPP2)

Clinician Responsible (2)

Date (OPP3)

Clinician Responsible (3)

Date (OPP4)

Clinician Responsible (4)

Development data

Clinical Problem of Package

Lifestyle Risk Factors 1 2

Outcome Measures 1 2

Dependency/Days in Ward

Dr. M.P. McKENNA
Dr. C.E. LANGAN
Dr. JOHN J. LANGAN
Dr. JUNE GOLDIE
Dr. MOIRA C.M. MacLEOD
Dr. ELAINE E. POLLOCK
Dr. G.A. McKAIG
Dr. J. DOW
Dr. J.P. ELLOR

Baillieston Health Centre
20 Muirside Road
Baillieston,
Glasgow G69 7AD
Tel: 0141-531 8050

Shettleston Health Centre
420 Old Shettleston Road
Glasgow G32 7JZ
Tel: 0141-531 6240

Dear L

26/7/04

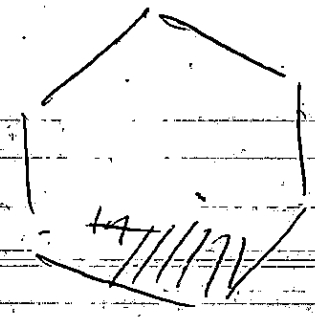
Thx for seeing Deborah Sillars
17/12/72 who has had sepsis over abdomen
pain for the past 2 weeks.

- No urinary symptoms.
- LMP 2/52 ago (on OCP).
- No anticipation. Loose BM each day.

PMH Chronic pancreatitis (gall stones)
cholecystectomy '96
appendicectomy.

SH - tramadol (diazepam 5mg prn)
- losec
- maxolon

O/E P 90 BP 120/84
RS -
CVS -
Abdo -



14/11/17 tender et
grading & reload
BS part

Impè Santu Adrien
? cave

Thanking for your advice
& Sad

NHS
Greater Glasgow

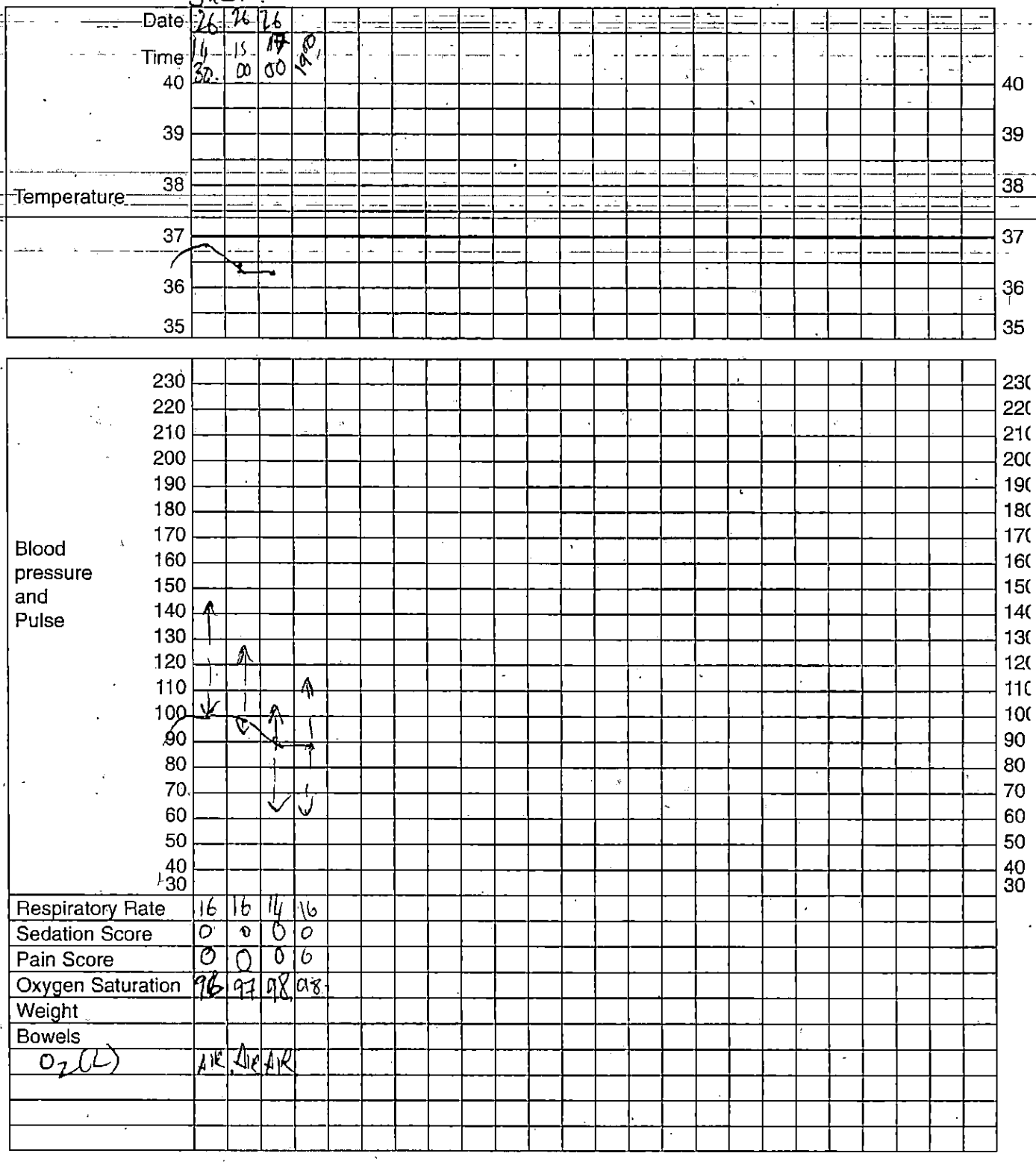
North Glasgow University Hospitals Division

Glasgow Royal Infirmary

Observations and Pain Score

(12)

P A&E No: 038036/04
DEBORAH SULLIVAN
8 Rhindmuir Court
Baillieston
GLASGOW
07/12/72
CRN: 20964876F



SEDATION SCORE

0 = *awake*

S = *normal sleep*

1 = *drowsy, easy to rouse: eyes open to speech or light shake*

2 = *only to vigorous shaking*

PAIN SCORE

0 = *no pain at rest, no pain on movement*

1 = *no pain at rest, slight pain on movement*

2 = *intermittent pain at rest, moderate pain on movement*

3 = *continuous pain at rest, severe pain on movement*

LISTER DEPARTMENT OF SURGERY

UPPER GASTROINTESTINAL UNIT

PROFESSOR C W IMRIE
MR W R MURRAY
MR R C STUART
MR R CARTER
MR C MCKAY

(Tel: 0141 800 1977)
(Fax: 0141 552 3229)
e-mail: c.j.mckay@clinmed.gla.ac.uk
Secretary: deborah.alexander@northglasgow.scot.nhs.uk

Glasgow Royal Infirmary
16 Alexandra Parade
Glasgow G31 2ER
Switchboard: 0141 211 4000

CM/DA/20964876

Dict: 9 June 2004
Typed: 10 June 2004

Dr Tough
Baillieston Health Centre
20 Muirside Road
Baillieston
G69 7AD

Dear Dr Tough

Re: Deborah Sullivan, 07.12.1972
8 Rhindmuir Court, Baillieston, G69 6BN

Admitted: 26.05.2004 **Discharge:** 29.05.2004
Diagnosis: GI Dysmotility
Procedure: None

Deborah was re-admitted with a further attack of abdominal pain. She has a history of sphincter of oddi dysfunction and DI dysmotility. On this occasion her pain was mainly situated in her right loin and for this reason arranged an abdominal ultrasound scan. This was normal and other than avoiding opiate analgesia we have little further to offer Deborah at this time.

She was discharged as her pain was settling and I have not arranged routine follow-up.

Yours sincerely

Colin McKay
Senior Lecturer/Consultant Surgeon

IMMEDIATE DISCHARGE LETTER

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST

NHS Greater Glasgow

GLASGOW ROYAL INFIRMARY
GLASGOW G31 2ER
Tel: 0141-211 4000

PATIENT IDENTIFICATION

20964876R
SULLIVAN
DEBORAH F
07/12/1972
8 Rhindmuir Court
GLASGOW
G69 6BN

FIX ID LABEL

DATE

ADMISSION 26/5
DISCHARGE 29/5
TRANSFER TO Hom
RE-ADMISSION
DEATH

GP IDENTIFICATION

OTHER DISTRIBUTION

MEDICAL IDENTIFICATION

WARD 60
CONSULTANT Dr. Prof Imrie (BLOCK CAPITALS)
CONTACT Dr. METVEN (BLOCK CAPITALS)

PRESENTING COMPLAINT(S)

ADMISSION
DAY CASE ☐ ARRANGED ☐ EMERGENCY ☑ TRANSF

ACTIVE DIAGNOSIS/PROBLEMS/OPERATIONS

1) Constipation
2)
3)
4)
5)
6)

INACTIVE DIAGNOSIS/PROBLEMS

1) Chronic pancreatitis
2)
3)

INFORMATION GIVEN TO PATIENT (SPECIFY)

THE PATIENT WAS DISCHARGED ON THE MEDICATION TREATMENT DETAILED BELOW. RECOMMENDED DURATION OF TREATMENT IS FROM THE DATE OF DISCHARGE. WHERE TREATMENT IS INDEFINITE, A SEVEN DAY COURSE HAS BEEN DISPENSED.

MEDICINE	FORM	DOSE	TIMES OF ADMINISTRATION 8am	10am	12pm	2pm	6pm	10pm	DURATION	PHARMACY TO COMPLETE QUANTITY, STRENGTH, BRAND
medication	as	per	discharge							

FOLLOW-UP REVIEW

HOSPITAL OP YES/NO
SPECIFY.....
GP SURGERY YES/NO
SPECIFY.....

CARE ARRANGEMENTS
NONE ☐
SWD ☐
DISTRICT NURSE ☐
OTHER.....

DRESSING/SUNDRIES SUPPLIED TO PATIENT

PRODUCT	SIZE	NUMBER ISSUED
		Signature:-

COMMENTS:

Signed ..... Page No. 1/2

(Prescriber) SHO : SpR : CONS (please tick)

White Copy - GP Pink Copy - Case Notes Yellow Copy - Retain in Ward Blue Copy - Pharmacy 0518

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST

HOME PLAN

NHS Greater Glasgow

Hospital GRI Phone Number

Phone Number 211274

0964876R
SULLIVAN F
DEBORAH 07/12/1972
8 Rhindmuir Court
GLASGOW
G69 6BN

Ward 60

Consultant Mr Nicholl Named Nurse

Discharge Date 29/5/04

ADMISSION DETAILS

Date of Admission 27/5/04 Admission Ward 60

Reason for Admission / Treatment abdo pain
Hydro. USS. NAD

MEDICATION

You have been given a 5 day supply of medication. Please ensure that you read the labels of the medication you have been given and take your drugs as prescribed.

You will / will not require a further supply of this medication.

Please contact your GP within a week if you require a further supply of medication.

FOLLOW UP

You will / will not require follow up at the hospital

You have an appointment for

_____ on _____ (day) _____ (dat

_____ on _____ (day) _____ (

You will receive a return appointment through the post for

_____ in _____ w

1. _____ in _____

2. _____ in _____

3. _____

Transport will / will not be arranged

SPECIAL INSTRUCTIONS / ADVICE

If you should have a problem with this discharge plan please do not hesit within 24 hours.

Patient / Carer Signature D E Sullivan

Named / Associate Nurse Signature D McCartney

GRI job no. 97

Patient Identification

Patient CRN	20964876R
Surname	MIS SULLIVAN
First Forename	DEBORAH
Second Forename	
Previous Surname	
Date of Birth	07 Dec 1972
Sex	F
Marital Status	S
NOK Details	KATHLEEN MOTHER

Patient's Address	8 Rhindmuir Court Baillieston GLASGOW
Postcode	G69 6BN
Tel No:	
GP Details	A TOUGH BAILLIESTON HEALTH CENT 20 MUIRSIDE ROAD BAILLIESTON

Episode Management

Spell/Care Package ID	Ward WD60*GR	Admission Date/Time 27 May 04 00:01
Specialty/Discipline (Code + Text National) GENERAL SURGERY		Admission Type 36
Significant Facility OTHE		Admission Reason 11
Consultant Code		Admission/Transfer From 12
Consultant Name PROF C IMRIE		Admission/Transfer From – Location
Management of Patient	Patient Category NHS	GP Referral Letter No.
Waiting List Guarantee Exception Code	Waiting List Date	Waiting List Type NWL

General Clinical

Main Diagnosis – ICD 10	
Other Condition – ICD 10 – 2	
3	
4	
6	

Main Operation/Procedure

			Date Main Operation
			Clinician Responsible
Other 2			Date (OPP2)
			Clinician Responsible (2)
Other 3			Date (OPP3)
			Clinician Responsible (3)
Other 4			Date (OPP4)
			Clinician Responsible (4)

Development data

Chronic Sick/Disabled ☐ Clinical Problem of Spell/Care Package

Lifestyle Risk Factors 1

Outcome Measures 1

Dependency/Severity Measures 1

2

Royal Infirmary
16 Alexandra Parade
GLASGOW G31 2ER

DIGESTIVE DISEASES DIRECTORATE
Upper Gastrointestinal Unit

Switchboard: 0141 211 4000
Direct Dial: 0141 211 4293
Fax No: 0141 211 4991

Professor C W Imrie
Mr W R Murray
Mr R C Stuart
Mr R C Carter
Mr C J McKay

Professor Imrie's Surgical Clinic

Dr C E Langan
Baillieston Health Centre
20 Muirside Road
Baillieston
G69 7AD

CWI/JB/0964876K

Dict: 10/02/2003
Typed: 18/02/2003

Dear Dr Langan

Deborah Sullivan (07/12/1972)
8 Rhindmuir Court Glasgow G69 6BN

This lady failed to appear at the Clinic on 10th February 2003. It is not intended that we send her a further appointment.

Kind regards.

Yours sincerely

C W Imrie
Consultant Surgeon
Honorary Professor

0964876K

Nexium

Inter Department
Surgery
Upper Gastrointestinal
Unit
Professor C W Imrie
Mr W R Murray
Mr R C Stuart
Mr C R Carter
Mr C J McKay

CWI/hd
6 January 2003

Mon
10/2/03
9.20
file

Dr C E Langan
Baillieston Health Centre
20 Muirside Road
GLASGOW
G69 7AD

Dear Charles

DEBORAH SULLIVAN 7.12.72
GRI ~~0965976K~~ 0964876K
8 RHINDMUIR COURT BAILLIESTON GLASGOW G69 6BN

I certainly remember Debbie Sullivan very well. Most of her gut problems are functional from my memory and I would have reckoned that all opiate drugs would exacerbate her problem rather than help it. She tends to be very manipulative in terms of drugs and tries to dictate her own therapy. I feel sure it would be best if she was re-assessed in the next few weeks and will therefore arrange for her appointment.

Kind regards
Yours sincerely

C W Imrie
Consultant Surgeon
Honorary Professor

Dr. M.P. McKENNA
Dr. C.E. LANGAN
Dr. JOHN J. LANGAN
Dr. M.C. McGLONE
Dr. JUNE GOLDIE
Dr. MOIRA C.M. MacLEOD
Dr. ELAINE E. POLLOCK
Dr. G.A. McKAIG
Dr. J. DOW

46216

Baillieston Health Centre
20 Muiraide Road
Baillieston,
Glasgow G69 7AD
Tel: 0141-531 6060

Shettleston Health Centre
420 Old Shettleston Road
Glasgow G32 7JZ
Tel: 0141-531 6240

CEL/AG

20 December 2002

Professor C W Imrie
Glasgow Royal Infirmary
16 Alexandra Parade
Glasgow G31 2ER

Dear Professor Imrie

DEBORAH SULLIVAN – D.O.B. 07.12.72 - GRI NO: 0964876K
6 RHINDMUIR COURT, BAILLIESTON, GLASGOW G69 6BN

I would be grateful if you would be kind enough to see Deborah who apparently does not hold a review appointment as she left the ward after her last admission in October (photocopy enclosed) without telling the nursing staff. You will remember her long and difficult history. Unfortunately she was recently admitted to Stobhill Hospital under the care of Mr Hansell with an exacerbation of her chronic problem. His immediate discharge summary suggests that a CT scan was negative and an ultrasound of abdomen was negative and that upper GI endoscopy suggested hiatus hernia. In contrast to your management she was started on MST tablets and Sevredol for break through pain and was discharged home on this. She requested ongoing medication of this nature but when I reviewed her today on the 19th December 2002 she was quite comfortable and in view of your previous opinion as to the potential for morphine dependency I declined to prescribe for the MST and Sevredol and reverted to 50 Tramadol per month with paracetamol which from September until this more recent admission seemed to have been more than sufficient pain control. She still poses a significant management dilemma and I would be grateful for your continuing input.

With kind regards.

Yours sincerely

C.E.LANGAN

CONSULTANT

GLASGOW ROYAL INFIRMARY

84 CASTLE STREET, GLASGOW G4 0SF

Telephone No. 0141-211-4000 Ext.

Professor C W Imrie

ADMITTED	DISCHARGED	WARD	AGE	HOSPITAL NUMBER
06/10/02	07/10/02	60	07/12/72	0964870K

DISPOSAL (Emergency admission)

Home

FOLLOW UP

No SOPD

NAME AND ADDRESS

Deborah Sullivan
6 Muirhead Court
Baillieston
Glasgow
G69 7EP

transferred out

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS

		I.S.C. CODE
1.	Epigastric and left upper quadrant pain	
2.	?Pancreatitis	
3.		
4.		
5.		
6.		

DISTRIBUTION OF LETTERS

Dr A Tough
Baillieston Health Centre
20 Muirside Road
GLASGOW
G69 7AD

OPERATION	CODE
1. None	
C x-ray –no free air	
2.	
3.	

Dear Doctor

Mrs Sullivan was admitted under Professor Imrie's care in Glasgow Royal Infirmary. She presented with epigastric and left upper quadrant pain with a query diagnosis of pancreatitis. She had a previous cholecystectomy and claimed to be suffering from recurrent pancreatitis as well. During an earlier evaluation Professor Imrie's team found that she is more likely to suffer from morphine dependency than chronic pancreatitis. During her stay in hospital the pain improved with conservative treatment and she was discharged one day after admission. The reason for the pain is at present still unknown. No specific follow up date was given as she left without informing the nursing staff.

Yours sincerely

JAN BARNARD
Specialist Registrar to Professor Imrie

Dict 25/10/02
Typed 28/10/02

c:dis 28oct 2002.jb / 9

off our list ?

NORMAL		NO ACTION	✓
SPEAK TO GP		MAKE APP	
- 4 NOV 2002			
URG ACTION			
DOVECOTE		COLLECT SCRIPT	
SUMMARY		REPEAT	

NORMAL		NO ACTION/FILE	
SPEAK TO GP		MAKE APP	
- 1 NOV 2002			
FULL NOTES	✓	COLLECT SCRIPT	
COMPUTER		REPEAT	

0159806

CONSULTANT
Mr JH Anderson
Department of Coloproctology

GLASGOW ROYAL INFIRMARY
84 CASTLE STREET, GLASGOW G4 0SF

Telephone No. 0141-211-4000
Ext.

ADMITTED	DISCHARGED	WARD	AGE	HOSPITAL NUMBER
24/12/02 Emergency	24/12/02	60	07/12/72	9848708K

DISPOSAL
Home

FOLLOW UP
none

NAME AND ADDRESS
Deborah Sullivan
8 Rhindmuir Court
Glasgow G69 6BN

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS	I.S.C. CODE
1. Acute pancreatitis -	
2.	
3.	
4.	
5.	
6.	

DISTRIBUTION OF LETTERS
Dr Tough
Baillieston Health Centre
20 Muirside Road
Glasgow G69 7AD

OPERATION	CODE
1.	
2.	
3.	

14/01/03

This 30 year old lady who has a past history of pancreatitis attended as an emergency with sudden upper abdominal pain having drunk two glasses of wine. On examination she was tender in her epigastrium, however serum amylase was normal. After a short period of analgesia and intravenous rehydration her symptoms and signs resolved and she was able to tolerate diet. She was allowed home on the evening of 24 December 2002 and no surgical review has been arranged.

Yours sincerely,

Mr JH Anderson
Consultant Colorectal Surgeon

Mr JH Anderson
Consultant Colorectal Surgeon

0159806

CONSULTANT ~~Professor C W Imrie~~

GLASGOW ROYAL INFIRMARY
84 CASTLE STREET, GLASGOW G4 0SF

Telephone No. 0141-211-4000
Ext. 4293

ADMITTED	DISCHARGED	WARD	AGE	HOSPITAL NUMBER
06/10/02	07/10/02	60	07/12/72	0964876K

DISPOSAL (Emergency admission)
Home

FOLLOW UP
No SOPD

NAME AND ADDRESS
Deborah Sullivan
6 Muirhead Court
Baillieston
Glasgow
G69 7EP

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS	I.S.C. CODE
1. Epigastric and left upper quadrant pain	
2. ?Pancreatitis	
3.	
4.	
5.	
6.	

DISTRIBUTION OF LETTERS
Dr A Tough
Baillieston Health Centre
20 Muirside Road
GLASGOW
G69 7AD

OPERATION	CODE
1. None	
C x-ray –no free air	
2.	
3.	

Dear Doctor

Mrs Sullivan was admitted under Professor Imrie's care in Glasgow Royal Infirmary. She presented with epigastric and left upper quadrant pain with a query diagnosis of pancreatitis. She had a previous cholecystectomy and claimed to be suffering from recurrent pancreatitis as well. During an earlier evaluation Professor Imrie's team found that she is more likely to suffer from morphine dependency than chronic pancreatitis. During her stay in hospital the pain improved with conservative treatment and she was discharged one day after admission. The reason for the pain is at present still unknown. No specific follow up date was given as she left without informing the nursing staff.

Yours sincerely

JAN BARNARD
Specialist Registrar to Professor Imrie

Dict 25/10/02
Typed 28/10/02

c:dis 28oct 2002.jb / 9

0159806

Greater Glasgow Primary Care NHS Trust
Our ref: DB/DF/T-1520435

Your ref: 0964876K

If 'phoning ask for: Dr Brown

Department of Liaison Psychiatry
Ward 4
Royal Infirmary
84 Castle Street
GLASGOW
G4 0SF

DIRECT DIAL: 0141 211 4417

NHS
Greater Glasgow

30 August 2002

Consultant Physician
Ward 31
Glasgow Royal Infirmary

Dear Colleague

RE: DEBORAH SULLIVAN D.O.B. 07.12.72
6 MUIRHEAD COURT, BAILLIESTON, GLASGOW G69 7EP

Thank you for referring this 29 year old woman to the Liaison Psychiatry Service following her overdose of 120 Kapake and 40 Tramadol with Diazepam. I saw her in Ward 31 on 9 August 2002. She had made a good recovery from a medical point of view. She told me that she began thinking about taking an overdose earlier the previous Monday and with this in mind had arranged childcare for her 3½ year old daughter. Her Fiancée stayed the night with her following his return from work and after he went to bed she stayed downstairs, wrote notes to her family and then took the tablets. She told me she lay on the couch covered with a blanket and fell asleep. She denies remembering any events after this until wakening in hospital being sick. She told me that she wished to kill herself as she had felt terrible since being raped in April last year. However, although initially after waking she regretted being alive, when I saw her she intended to move on and make no further attempts on her life.

There have been a number of distressing events over the past year or so. As noted above, she stated she was raped last April and despite a police investigation no charges have been brought against anyone. Following this, she was seen at Auchinlea House by one of the Community Psychiatric Nurses and a referral was made to John Doyle, Clinical Psychologist, whom she saw on four occasions. She found this beneficial, but felt she would be more relaxed with a female psychologist and so a referral was put in place but she has, as yet, heard nothing. Around that time she was prescribed what she described as strong painkillers by her GP for chronic pancreatitis, but adjusted the prescription from 6 to 60. When she informed her GP of this he removed her from his list. However, he also prescribed Prozac at a dose of 40mg a day which she has felt some benefit from. This year her daughter has required heart surgery, although was previously considered entirely well. She has made a good recovery from this. Deborah told me that she last worked in May of last year but resigned due to feeling under too much pressure.

I note from a brief review of her medical notes that Deborah has been admitted to hospital on a number of occasions with abdominal pain, and at one time attracted a diagnosis of chronic pancreatitis. However, there is a possibility that she has become rather dependent on Opiate painkillers for what may be a functional illness. She has been seen in the past by Professor Imrie and Dr David Reilly of the Homeopathic Hospital.

Deborah appeared as an overweight, relaxed woman who was distressed at times during the interview. She described a number of depressive symptoms including poor appetite, disturbed sleep pattern and poor concentration as well as a feeling of shame since being raped. She told me she had become increasingly socially withdrawn over the past year. However, she denied ongoing suicidal ideation.

POSITIVE ABOUT DISABLED PEOPLE

In view of the fact that Deborah felt she benefited from Psychology input in the past, I felt it would be worthwhile chasing up the referral to a female psychologist which was apparently made last year. I have also contacted the CPN Service at Auchinlea House to ask that Deborah be given some extra support over the next few weeks following quite a serious overdose. In addition, we discussed methods of coping should she feel like taking a further overdose. I shall see her on one occasion in my out-patient clinic for review.

Yours sincerely

DEBORAH BROWN
SPECIALIST REGISTRAR IN PSYCHIATRY

copy: Dr J J Langan, Baillieston Health Centre, 20 Muirside Road, GLASGOW G69 7AD
CPN Service, Auchinlea House

CONSULTANT
J F MacKenzie

GLASGOW ROYAL INFIRMARY
84 CASTLE STREET, GLASGOW G4 0SF

Telephone No. 0141-211-4000
Ext.

ADMITTED	DISCHARGED	WARD	AGE	HOSPITAL NUMBER
6.8.02	9.8.02	4	7.12.72	0964876K

DISPOSAL
Home

NAME AND ADDRESS
Deborah Sullivan
6 Muirhead Road
Glasgow
G69 7EP

FOLLOW UP
None

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS

	ICD
Overdose (120 Kapake 500mg, 40 Tramadol 50 mg plus ?Diazepam)	
1. Opiate dependence	
claims to have chronic pancreatitis	
2. (disputed by Professor Imrie)	
3.	
4.	
5.	
AM/GA/28.8.02	
6.	

DISTRIBUTION OF LETTERS
Dr A Tough
Baillieston Health Centre
20 Muirside Road
Glasgow
G69 7AD

OPERATION	CODE
1	
2	
3	

History: This lady was admitted to Glasgow Royal Infirmary on 6.8.02 after an overdose. She has an extensive past history of abdominal pain. She has claimed she has chronic pancreatitis but this has been disputed by Professor Imrie's team who feel she is an Opiate dependent. She apparently had been struck off her GP's list one week previously and is also well known to Stobhill Hospital with multiple presentations of abdominal pain.

Examination: Her pulse was 115 beats per minute, blood pressure was 130/80. Abdominal examination was unremarkable. She complained of pain on palpation but had no guarding or rebound. Other examination was unremarkable. She was admitted for investigation and treatment of a suspected overdose.

Her Paracetamol levels were 2.44, silicate levels were undetectable. Her full blood count showed a haemoglobin of 13.6, white cell count 26, U's and E's were normal, LFTs' showed AST of 34, ALT 41 and gamma GT 174 otherwise normal. CRP was less than 6, INR was 1.2, APTT 40.

She was started on IV fluids, IV Maxolon and IV Parvolex as per protocol. She responded well to treatment and her repeat LFTs', coagulation screen and post Parvolex were normal.

She regretted her overdose and was referred to the psychiatric team, who felt she was not actively suicidal. She was therefore discharged on 9.8.02.

Adrian McElholm
Senior House Officer

Checked by
Consultant Physician

0159606

Lister Department of Surgery
Department of Upper GI & Hepato-Pancreaticobiliary Surgery

Professor C W Imrie
Mr W R Murray
Mr R C Stuart
Mr C R Carter
Mr C J McKay

2nd Floor
Queen Elizabeth Building
Glasgow Royal Infirmary
16 Alexandra Parade
Glasgow
G31 2ER

Tel: 0141 211 5129
Fax: 0141 211 4991
e-mail:rcarter@clinmed.gla.ac.uk
secretary:Frances.Lyall@northglasgow.nhs.scot.uk

Date: May 15, 2002
Ref: HK/FL/0964876

Dr Tough
Baillieston Health Centre
20 Muirside Rd
Glasgow
G69 7AD

Dear Dr Tough

Re: Deborah Sullivan, 7/12/72
160 Main St, Glasgow G69

Admission: 10/5/02
Discharge: 13/5/02
Diagnosis: Abdominal pain

Your patient was admitted under the care of Mr Carter with abdominal pain. She was treated conservatively and the pain soon settled. She was discharged back into your care. We have not made formal arrangements to see her again, though know doubt Deborah will let us know if she has a problem.

Yours sincerely

Mr H Kasem
Clinical Lecturer in Surgery

CONSULTANT

GLASGOW ROYAL INFIRMARY
84 CASTLE STREET, GLASGOW G4 0SF

Telephone No. 0141-211-4000
Ext.
4293

~~Professor C W Imrie~~

ADMITTED	DISCHARGED	WARD	AGE	HOSPITAL NUMBER
02/01/02	03/01/02	62	07.12.72	0964876K

DISPOSAL (Emergency admission)

Home

FOLLOW UP

SOPD

NAME AND ADDRESS

Deborah Sullivan
160 Main Street
BAILLIESTON
GLASGOW
G69 6AH

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS	I.S.C. CODE
1. Abdominal pain	
2.	
3.	
4.	
5.	
6.	

DISTRIBUTION OF LETTERS

Dr A Tough
Baillieston Health Centre
20 Muirside Road
BAILLIESTON
GLASGOW
G69 6AH

OPERATION	CODE
1. none	
2.	
3.	

Dear Doctor

Deborah was admitted with further exacerbation of pain. As you know she has had significant problems with her use of analgesics, but again the pain settled very quickly and she was allowed home. She already has an appointment for review at Professor Imrie's clinic.

Yours sincerely

C K McKAY
Specialist Registrar in Upper GI Surgery
To Professor C W Imrie

Dict 16/01/02
Typed 21/01/02

c:jan21 2002dis.cmk / 8

0159806

DR MIKE BASLER

PAIN MANAGEMENT CLINIC

Secretary 211 4621
Fax 211 4622
e.mail gri.pain@northglasgow.scot.nhs.uk

Clinic 1 Tuesday am 211 5463
Day Bed Unit Monday pm 211 5478

Dr Townsley
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9NT

MB/SL/0964876

05 September 2001

Dear Dr Townsley

Deborah Sullivan (7.12.72)
6 Muirhead Court Glasgow G69 7EP

This lady failed to keep an appointment at the Pain Management Clinic today. Due to pressure on clinic appointments I have not reappointed her but will be happy to review her should she be reappointed.

Best wishes

Yours sincerely

Mike Basler
Consultant in Anaesthesia and Pain Management

DR MIKE BASLER

PAIN MANAGEMENT CLINIC

Secretary 211 4621
Fax 211 4622
e.mail gri.pain@northglasgow.scot.nhs.uk

Clinic 1 Tuesday am 211 5463
Day Bed Unit Monday pm 211 5478

Dr Townsley
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9NT

MB/SL/0964876

10 July 2001

Dear Dr Townsley

Deborah Sullivan (7.12.72)
6 Muirhead Court Glasgow G69 7EP

The above named patient failed to attend the Pain Management Clinic today. As you know, there is tremendous pressure on Pain Management Clinic appointments but looking at your referral letter it is probably useful that I arrange to see this woman again since she seems to be using increasing medical resources for less and less benefit.

I have arranged a further appointment.

Best wishes

Yours sincerely

Mike Basler
Consultant in Anaesthesia and Pain Management

0964816

Hospital use only	Clinic day	date time	hospital	GP112

Hospital	ROYAL INFIRMARY	Routine ☐	Soon ☐ Urgent ☐
Clinic	PAIN CLINIC	CHI No.	
Consultant		Hospital No.	
		Dr TOWNSLEY	
Patient Details		NEWHILLS MEDICAL PRACTICE	
Surname	SULLIVAN	EASTERHOUSE HEALTH CENTRE	
First Names	DEBORAH	9 AUCHINLEA ROAD	
Date of Birth	07.12.72	GLASGOW	
Address	6 MUIRHEAD COURT	G34 9HQ	
	BAILLIESTON GLASGOW	Practice No. 46451	
Postal Code	G69 7EP	Telephone No: 0141 531 8151	FAX: 531 8167
Telephone No.	771 – 3401		

Date 12 April 2001

I would be grateful for your opinion and advice on the above named patient. A brief outline of history, symptoms and signs is given below:

10.7.01

Dear Doctor

I would be grateful if you could see this young lady who has been attending us for some time now with abdominal pains. She also attends Professor Imrie at Glasgow Royal Infirmary. The background diagnosis is one of probable chronic pancreatitis thought initially to be related to gallstones. She has had her gall bladder removed in 1996 and had an appendicectomy in the same year. Her blood results have always been reasonably normal, she herself is overweight. There is a family history of abdominal pains, her mother has a very similar history as has her sister. She has a young daughter just over 2 years old. Things settled down a little bit when she was pregnant but since then she has had multiple attendances at hospital and ourselves – both routine and emergency with abdominal pains and has also been seen by the Emergency services several times. She has had various regimes of bowel preparations, Lactulose, Fybogel and enemas to see if that improved her pain, she also had a variety of different analgesics including MST and most recently she has been taking Dihydrocodeine Continus 90mg twice daily but augmenting that with Pethidine tablets 100mg when required. We have found when she has not had regular medication she is an even more frequent user of the Emergency services and has been admitted to Hospital and seen on a regular basis there also.

In summary, this is a 28 year old girl with chronic abdominal pain which although helped by Opioid analgesics they have the side effect of constipating her which leads to more pain. I would be grateful for your assessment and advice as to what we can do to try and control both this lady's pain and her use of strong analgesics.

Kind regards.

Yours sincerely

Route now NBR RI

26/07/01

Dr A. Townsley
Dict. 10.04.01 AT/EG

F:\Ref 2001\Deborah Sullivan 07.12.72 Pain clinic AT.doc

CONSULTANT

GLASGOW ROYAL INFIRMARY

84 CASTLE STREET, GLASGOW G4 0SF

Telephone No. 0141-211-4000
Ext. 4293

Professor C W Imrie

ADMITTED	DISCHARGED	WARD	AGE	HOSPITAL NUMBER
12.4.01	14.4.01	60	7.12.72	0964876K

DISPOSAL: Home

FOLLOW UP: SOPD

NAME AND ADDRESS:
Deborah Sullivan
1/1 160 Main St
Baillieston
G69 6AH

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS

	I.S.C. CODE
1. Recurrent abdominal pain	
2.	
3.	
4.	
5.	
6.	

DISTRIBUTION OF LETTERS:
Dr J Goldie
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HY

OPERATION	CODE
1.	
2.	
3.	

This young woman was admitted for the umpteenth time with abdominal pain and this settled with conservative management. She has clearly a major gut dysfunction problem and a repeat of an abnormal gastric emptying study was arranged and has again shown that she has abnormal gastric emptying.

It is my belief that most of her symptoms are attributable to her dysfunctional gut and whether one calls this an irritable bowel syndrome or not, it certainly fits this general pattern. The most useful drugs in her therapy are probably prokinetic drugs such as Maxolon and Domperidone. The provision of analgesics is probably not greatly helpful for her and may even be counterproductive.

C W Imrie
Consultant Surgeon
Honorary Professor
CWI/hd 8.5.01

0159806

Glasgow Royal Infirmary
16 Alexandra Parade
Glasgow
G31 2ER

LISTER DEPARTMENT OF SURGERY

UPPER GASTROINTESTINAL UNIT

PROF C W IMRIE
MR W R MURRAY
MR R C STUART
MR R C CARTER
MR C J MCKAY

Tel: 0141 211 4872
Fax: 0141 211 4991

e-mail:r.c.stuart@clinmed.gla.ac.uk
secretary: Alison.Glen@northglasgow.scot.nhs.uk

HK/AG/0964876

11 December 2001

Dr Tough
Baillieston Health Centre
20 Muirside Road
Glasgow
G69 7AD

Dear Dr Tough

Deborah Sullivan 7.12.72
160 Main Street, Glasgow, G67 7AD

Admitted:	4/11/01
Discharged:	4/11/01
Admission:	Emergency
Diagnosis:	Epigastric pain
Procedure:	Nil
Follow up:	Nil

Deborah Sullivan was again admitted with epigastric pain to the Royal Infirmary. Unfortunately on this occasion she only stayed for a few hours following which she self discharged. I have not arranged any follow up although I am sure she has follow up in place with our Pancreatic Team.

Yours sincerely

Hassan Kasem
Clinical Lecturer in Surgery

LISTER DEPARTMENT OF SURGERY

UPPER GASTROINTESTINAL UNIT

Professor C W Imrie
Mr W R Murray
Mr R C Stuart
Mr C R Carter
Mr C J McKay

Tel: 0141 211 4293
Fax: 0141 211 4991
e-mail: clemimrie@hotmail.com
Secretary: Hilary.Dyer@northglasgow.scot.nhs.uk

CWI/hd
29 October 2001

Dr A Tough
Baillieston Health Centre
20 Muirside Road
GLASGOW
G69

Dear Dr Tough

DEBORAH SULLIVAN 7.12.72
GRI 0964876K
6 MUIRHEAD COURT GLASGOW G69 7EP

Date of Admission: 3.9.01 Date of Discharge 4.9.01

This lady has been diagnosed with chronic pancreatitis for some time. She has had multiple admissions for epigastric pain and she takes long term opiates. This is certainly causing constipation which is actually exacerbating the problem. We allowed her home on Movicol after her pain had settled but still encouraged her to come off all analgesics.

Yours sincerely

C MacKay
Specialist Registrar in Upper GI Surgery

LISTER DEPARTMENT OF SURGERY

UPPER GASTROINTESTINAL UNIT

Professor C W Imrie
Mr W R Murray
Mr R C Stuart
Mr C R Carter
Mr C J McKay

Tel: 0141 211 4293
Fax: 0141 211 4991
e-mail: clemimrie@hotmail.com
Secretary: Hilary.Dyer@northglasgow.scot.nhs.uk

CM/hd
19 October 2001

Dr A Tough
Baillieston Health Centre
20 Muirside Road
GLASGOW
G69 7AD

Dear Dr Tough

DEBORAH SULLIVAN 7.12.72
GRI 0964876K
160 MAIN ST GLASGOW G69 6AH

Date of Admission: 3.9.01 Date of Discharge: 5.9.01

Diagnosis: Flare up of chronic pancreatitis

This lady was admitted under the care of Mr Stuart with acute onset of upper abdominal pain radiating through to her back. She has a history of chronic pancreatitis caused by gallstones. She has had a cholecystectomy and sees Professor Imrie. She was found to be somewhat tender in the epigastrium but her bloods including serum amylase were all normal. Her pain settled with simple conservative management and she was allowed home on 5.9.01 with an out patient appointment to see Professor Imrie.

Yours sincerely

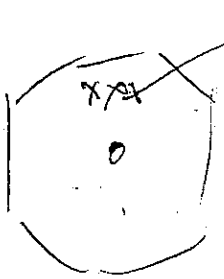
C MacKay
Specialist Registrar in Upper GI Surgery

Dear [illegible]

re Deborah Allen
6 Muellard Crt

The baby has had recent seizures
not what is sense hypomelia syndrome. She walks
Prof Irine. She has had multiple infections
and has had diuretics and effusions are no
effect. Ulcer around the pin and wet dressing
antibiotics and trouble with. Thrushing despite
IM Nystatin she has not settled and I feel
she requires hospital admission to settle her.

O/E Well [illegible] Rate BS Rhd T 37.2°C.



Many thanks for seeing her

[illegible]

LISTER DEPARTMENT OF SURGERY

UPPER GASTROINTESTINAL UNIT

Professor C W Imrie
Mr W R Murray
Mr R C Stuart
Mr C R Carter
Mr C J McKay

Tel: 0141 211 4293
Fax: 0141 211 4991
e-mail: clemimrie@hotmail.com

CWI/hd
13 March 2001
Surgical Clinic

Dr J Goldie
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HY

Dear Dr Goldie

DEBORAH SULLIVAN 7.12.72
GRI 0964876K
6 MUIRHEAD COURT BAILLIESTON GLASGOW G69 7EP

I saw Deborah Sullivan once again at my clinic on 12th March. She continues to complain of nausea and occasional vomiting. This problem is almost certainly resulting from a global dysmotility problem which was manifest by delayed gastric emptying on a Nuclear Medicine scan carried out almost five years ago. She also suffers from constipation and really has a whole series of problems which are largely related to this entity.

I gave her a letter by hand requesting that you put her on Maxolon 10 mg three times a day and I will review her again as an out-patient in a few weeks' time.

She was recently in hospital complaining of abdominal pain but I do not think there is a great necessity for her to be an in-patient with this problem which has also resulted in her losing time at work to an extraordinary degree over the last few years.

Kind regards
Yours sincerely

C W Imrie
Consultant Surgeon
Honorary Professor

P.S. A further gastric emptying study has been arranged.

SCOTTISH AMBULANCE SERVICE **PATIENT REPORT FORM** INCIDENT No.

PATIENT NAME
PATIENT ADDRESS
SEX M
D.O.B.

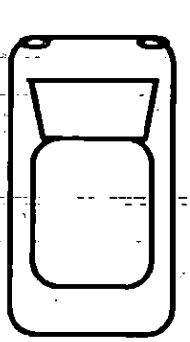
TYPE OF INCIDENT

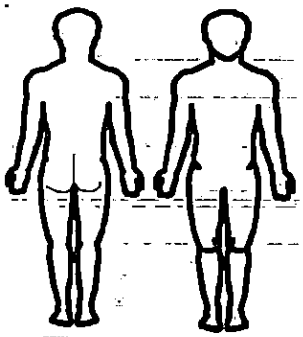
Trauma
Assault
Cardiac Arrest
Other Collapse
DSH
IHT
Obstetric
Other X

TRAUMA INCIDENTS

RTA
Cyclist
M/Cyclist
Pedestrian
Ejected
Trapped
>20 mins. Extricate
Helmet Worn
Seat Belt Worn

Home
Work
Leisure
Burns
Drowning
Fall < 2 mtr.
Fall > 2 mtr.
Head Injury
Poisoning
Other





■ Damaged Area/ Burns %
? Fracture X Laceration

■ Damaged Area ▶ Point of Impact X Position of Patient

INJURY / ILL.

Acute Abdo.
Breathlessness
Chest Pain
Other Cardiac
Convulsions
C.V.A.
DSH O/dose
Haemorrhage
Hypoglycaemia
Other

PRIMARY SURVEY

Treatment prior to arrival Y N
By whom
Duration of treatment / CPR
Airway Clear Obstructed
Breathing Y N
ılation - Pulse Y N
ɔility- Alert Y N
Vocal Stimuli Y N
Pain Stimuli Y N
Unresponsive Y N
Vomited Y N
Fitting Y N
Knocked Out Y N

INITIAL ACTIONS

Airway
Pharyngeal Airway Y N
Tracheal Tube Y N
Laryngeal Mask Y N
Size •
Successful ? Y N
Breathing
O2 Flow rate %
Mask Type
IPPV
Circulation Success
Cannulation Size Side Site -full
1 Y N
2 Y N

A.M.P.L.E.

Allergies (See reverse for coding)
1 2 3 4 5 6 7 8 9
Medication
SEE LETTER
Past Medical History
SEE LETTER
PANCREATITIS
Last Eaten
Events Preceding Incident

OBSERVATIONS

Time	Breathing R.R.	Breathing SpO2 %	Circulation Pulse	Circulation Blood Pressure	Capillary Refill Norm	Capillary Refill Delay	Pupils Left Size (C N D)	Pupils Left React Y/N	Pupils Right Size (C N D)	Pupils Right React Y/N	Glasgow Coma Score E	M	V	Total
1492	20		120	110	80									

TREATMENTS

Time	Presenting Condition	Defib. (Joules)	Fluid / Drug	Batch / Box No.	Dose	Route	Result e.g. Pulse,Asys,VF,Other

COMMENTS / ADDITIONAL INFORMATION

SEE LETTER

(Affix Rhythm Strip Here)

CREW 1
CREW 2
MEDICAL STAFF
INCIDENT LOCATION

SIGNATURE (Crew 1 or 2)

CONDITION ON ARRIVAL AT HOSPITAL
Conscious X Pulse
Breathing X No Vital Signs

DESTINATION HOSPITAL

DATE OF CALL
TIME OF CALL
TREATMENT COMMENCED
TIME LEFT SCENE
TIME ARRIVED HOSPITAL

HOSPITAL USE ONLY

Dr A. Cole
Easterhouse Health Centre
9 Auchinlea Rd
Glasgow
G34 9HQ

Re Deborah Sullivan
7/12/72
6 Muirhead Court
Glasgow

Hosp No 964876K.
8/12/.

Dear Doctor.

Thanks for seeing Deborah who has been seen three times by visiting GEMs doctors this week and given intramuscular analgesics and antiemetic. She has been vomiting, complaining of severe abdominal pain + diarrhoea.

pink/see sheet.

Medication includes Sparamol, Dihydrocodeine and increasingly frequent use of pethidine tablets

O/E Distressed Temp 100 Pulse 140/80 T 36.8.
Mottling rash cheeks.
Abdom. No guarding tender.
BS ✓.

Impression Pancreatitis or Cholecystitis

Thanks for seeing her

yours sincerely

AC

CONSULTANT

Mr IG Finlay

Department of Coloproctology

GLASGOW ROYAL INFIRMARY

84 CASTLE STREET, GLASGOW G4 0SF

Telephone No. 0141-211-4000
Ext.

ADMITTED	DISCHARGED	WARD	AGE	HOSPITAL NUMBER
19/11/2000 emergency	22/11/2000		07/12/1972	964876K

DISPOSAL

Home

FOLLOW UP

none

NAME AND ADDRESS

Deborah Sullivan
1/1 160 Main Street
Baillieston
Glasgow G69 6AH

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS

	I.S.C. CODE
1. Constipation	
2.	
3.	
4.	
5.	
6.	

DISTRIBUTION OF LETTERS

Dr J Goldie
Easterhouse Health Centre
9 Auchinlea Road
Glasgow G34 9QH

OPERATION	CODE
1.	
2	
3.	

12/12/2000

This girl was admitted with a history of abdominal pain and irregular bowel habits, fluctuating between constipation and diarrhoea. On examination, there was evidence of tenderness on the right side of the abdomen. It was felt that the symptoms were most likely related to constipation, secondary to the use of opoid analgesics. The opiates were therefore stopped and phosphate enemas were used with a very good result. This has altered a significant improvement in Mrs Sullivans' symptoms. She has therefore now been discharged home and we have not made any arrangements to review her at the clinic.

Yours sincerely,

Mr O Wright
Specialist Registrar

Mr IG Finlay
Consultant Colorectal Surgeon

0159806

Glasgow Emergency Medical Service

Call Number 324921	Time of Call
Patient's Name DEBORAH SULLIVAN	
Patient's Address 6 MUIRHEAD CRI MID BAILLIESTON	
DoB 7/12/72	
Phone Number	
Caller's Name	
Name of GP GOLDIE	
Surgery	Cipher No. G06521
Call Type C	Call passed
Receptionist	

Symptoms H/O : PANCREATITIS ABDO PAIN & VOMITING
PETHIDINE NOT HELPING

Notes

Pasmin BP 110/80
Chemclav
Allg [structure] terbut
Amoxicillin
Star

△ Acute Pancreatitis

→ Cyclomorphine 10mg IM

Refer to Surgeons AIE GRI

27 yrs

Vomiting failed. RUQ Sharp
Severity. Will be seen sooner than

PMH

Laparoscopic cholecystectomy 1996
Post op. Pancreatitis
Admitted XS ? Acute Pancreatitis
Since

Pethidine
Maxolon
NWC

Car ID	177
Sent to car	Active
Received in car	Job size
Acknowledge in car	Job Status
Arrived at scene	Triggered
Departed scene	
Completed 18:38	

SCOTTISH AMBULANCE SERVICE — **PATIENT REPORT FORM** — INCIDENT No. 1 4741 5

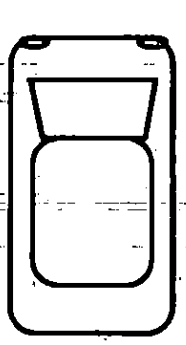
PATIENT NAME: A [illegible] BROADHURST LUCY ANN — SEX M / F X
PATIENT ADDRESS: 6 MURRAY RISE — D.O.B. 07/12/72

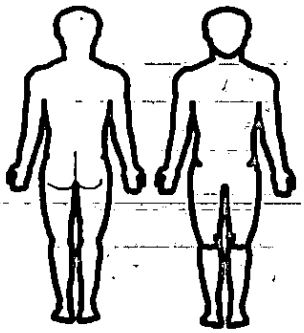
TYPE OF INCIDENT

Trauma	
Assault	
Cardiac Arrest	
Other Collapse	
DSH	
IHT	
Obstetric	
Other	X

TRAUMA INCIDENTS

RTA		Home	
Cyclist		Work	
M/Cyclist		Leisure	
Pedestrian		Burns	
Ejected		Drowning	
Trapped		Fall < 2 mtr.	
>20 mins. Extricate		Fall > 2 mtr.	
Helmet Worn		Head Injury	
Seat Belt Worn		Poisoning	
		Other	





■ Damaged Area ▶ Point of Impact X Position of Patient — ■ Damaged Area/ Burns % # ? Fracture X Laceration

INJURY / ILLNESS

Acute Abdo.	X
Breathlessness	
Chest Pain	
Other Cardiac	
Convulsions	
C.V.A.	
DSH O/dose	
Haemorrhage	
Hypoglycaemia	
Other	

PRIMARY SURVEY

Treatment prior to arrival	Y X	N	
By whom	AMBULANCE		
Duration of treatment / CPR			
Airway	Clear X	Obstructed	
Breathing	Y X	N	
Circulation - Pulse	Y X	N	
Disability- Alert	Y X	N	
Vocal Stimuli	Y X	N	
Pain Stimuli	Y X	N	
Unresponsive	Y	N X	
Vomited	Y X	N	
Fitting	Y	N ✓	
Knocked Out	Y	N X	

INITIAL ACTIONS

Airway			
Pharyngeal Airway	Y	N	
Tracheal Tube	Y	N	
Laryngeal Mask	Y	N	
Size		•	
Successful ?	Y	N	
Breathing			
O2 Flow rate	%		
Mask Type			
IPPV			
Circulation		Success	
Cannulation	Size / Side / Site	-full	
1		Y N	
2		Y N	

A.M.P.L.E.

Allergies (See reverse for coding) NKDA

1	2	3	4	5	6	7	8	9

Medication: PASKIL MTS BEHOTRO [illegible] PARACETAMOL

Past Medical History: PANCREATITIS

Last Eaten: [illegible]

Events Preceding Incident: ACUTE ABDOMINAL PAIN

OBSERVATIONS

Time	Breathing R.R.	Breathing SpO2 %	Circulation Pulse	Circulation Blood Pressure	Capillary Refill Norm	Capillary Refill Delay	Pupils Left Size (C N D)	Pupils Left React Y/N	Pupils Right Size (C N D)	Pupils Right React Y/N	Glasgow Coma Score E	M	V	Total
19:12	18	-	78	110/80			N	Y	N	Y	4	6	5	15

TREATMENTS

Time	Presenting Condition	Defib. (Joules)	Fluid / Drug	Batch / Box No.	Dose	Route	Result e.g. Pulse,Asys,VF,Other

COMMENTS / ADDITIONAL INFORMATION PATIENT HAS ACUTE ABDOMINAL PAIN S/[illegible] GP WHO GAVE PATIENT INJECTION OF CHLORPROMAZINE RELIEF PATIENT FOR A/E SURGEON 8 PANCREATITIS

(Affix Rhythm Strip Here)

CREW 1	[illegible]		M	C	[illegible]	D	Y	C	N				[illegible]					
CREW 2	D.		S	T	C	[illegible]	[illegible]											
MEDICAL STAFF																		
INCIDENT LOCATION	[illegible]		[illegible]															

SIGNATURE (Crew 1 or 2) [illegible]

CONDITION ON ARRIVAL AT HOSPITAL: Conscious X — Pulse — Breathing X — No Vital Signs

DESTINATION HOSPITAL: [illegible] A&E

DATE OF CALL	1	1	1	1	0	0
TIME OF CALL						
TREATMENT COMMENCED						
TIME LEFT SCENE						
TIME ARRIVED HOSPITAL						

HOSPITAL USE ONLY

GENERAL MEDICINE
(Ward 8/9)

Consultant
Professor A R Lorimer

0141 211 4803
0141 211 6126

Dr J Goldie
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HY

ARL/KH/0964876K

Dict: 30.10.00
Typed: 03.11.00

Dear Dr Goldie

Deborah Sullivan (07.12.72)
6 Muirhead Court, Glasgow G69 7EP

I was due to review this lady at clinic but she did not attend.

I note at her last review, the situation seemed to have improved and I have, therefore, not arranged routine review.

Yours sincerely

PROFESSOR A R LORIMER

CONSULTANT
Dr Stanley

GLASGOW ROYAL INFIRMARY
84 CASTLE STREET, GLASGOW G4 0SF

Telephone No. 0141-211-4000
Ext.

ADMITTED	DISCHARGED	WARD	AGE	HOSPITAL NUMBER
12.08.00	14.08.00	8	7.12.72	0964876K

DISPOSAL

Home

FOLLOW UP

MEDICAL OUTPATIENT CLINIC

NAME AND ADDRESS

Deborah Sullivan
6 Muirhead Court
GLASGOW
G69 7EP

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS

	ICD CODE
1. COLLAPSE	
2. PREVIOUS PACREATITIS	
3.	
4.	
5.	
6.	

DISTRIBUTION OF LETTERS

Dr J Goldie
Easterhouse Health Centre
9 Auchinlea Road
GLASGOW GA34 9HY

OPERATION	CODE
1	
2	
3	

CR/LM Typed: 24 August 2000

Dear Dr Goldie

HISTORY: This 27 year old lady was admitted following a history of collapse. The patient herself had no recollection of this event but her sister said that she saw her shaking for approximately 2 minutes. She had also vomited although had not become incontinent. There was no history of tongue biting. In A&E she was feeling improved but had some epigastric discomfort. She had consumed approximately 4 units of alcohol on the night prior to admission but there was no history of her taking any drugs. On further questioning it became apparent that she had had approximately 3 months history of frontal/orbital headache which was not worse in the morning or on bending or straightening.

EXAMINATION: On admission she looked well. She was noted to have a rash over her chin and cheeks which she said tends to develop when she becomes unwell. Fundoscopy revealed pale discs but no evidence of palpable oedema and her neurological examination was otherwise normal. She was apyrexial with blood pressure 117/80 mmHg and pulse 102 beats per minute. Heart sounds were pure with no added sounds and her chest was clear to auscultation. She was noted to have mild epigastric tenderness.

TREATMENT AND PROGRESS: This lady was admitted and a CT scan of head was performed, the verbal report of which showed no abnormality. She was also reviewed by the Surgeons during her admission in relation to her pancreatitis. Her amylase was 90 and it was felt that there was no an acute surgical issue and she was simply treated with IV fluids for this. Apparently her Anti C3D antibody was mildly elevated last year and also immune screen was requested to exclude SLA given her facial rash. Mrs Sullivan made a satisfactory recovery and was fit for discharge on 14.8.00 and she will be reviewed at Professor Lorimer's Medical Outpatient Clinic in due course.

MEDICATION ON DISCHARGE: Nil. Medical during admission included Amitriptyline 75 mg once daily, Losec 20 mg twice daily.

Yours sincerely

Dictated by: C. Reith
Senior House officer

Checked by:
Consultant.....

0159806

DEPARTMENT OF SURGERY

Professor C W Imrie's Clinic
Direct Line 0141 211 4293

Dr J Goldie
Easterhouse Health Centre
9 Auchinlea Road
GLASGOW
G34 9HQ

CWI/HW/964876K

Dict: 18th Sept 2000
Typed: 2nd Oct 2000

Dear Dr Goldie

Deborah (Debbie) Sullivan ~ (07.12.72)
Flat 1/1, 160 Main St., Glasgow G69 6AH

I reviewed Debbie at the Clinic today. Thankfully she is feeling and looking better at the present time and has started Yoga Classes which she thinks is a big help in "getting me more relaxed". She has not had much abdominal discomfort or pain recently and her weight is fairly steady at 84.4 kgs. She does still have episodes of pain which are sometimes accompanied by these strange areas of facial flushing which look somewhat like acne rosacea.

As she is keeping well at present I am discontinuing her attendance at the Outpatient Clinic.

Kind regards.

Yours sincerely

C.W.Imrie
Consultant Surgeon, Honorary Professor

PS. We would be happy to see her back should the need arise.

CONSULTANT

Professor C W Imrie

GLASGOW ROYAL INFIRMARY
84 CASTLE STREET, GLASGOW G4 0SF

Telephone No. 0141-211-4000
Ext.

ADMITTED	DISCHARGED	WARD	AGE	HOSPITAL NUMBER
1. 13/06//00 2. 30/07/00	15/08/00 03/08/00(Emergency	60 Admissions)	07/12/72 27 yrs	9848/96K

DISPOSAL
Home

NAME AND ADDRESS
Deborah (Debbie) Sullivan
1/1, 160 Main Street
Baillieston.
Glasgow
G69 6AH

FOLLOW UP
No SOPD required

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS	I S C CODE
1. Upper Abdominal pain of unknown cause	
2.	
4.	
5.	
6.	

DISTRIBUTION OF LETTERS
Dr J Goldie
Easterhouse Health Centre
9 Auchinlea Road
GLASGOW
G34 9HQ

OPERATION	CODE
1 Conservative management	
2 Conservative management	
3	

Dear Dr

This patient was admitted yet again as an emergency with upper abdominal pain of unknown origin. Her urea and electrolytes were normal and her blood amylase was in the normal range with a marginal rise in WBC to 13.4 and a normal C-reactive protein level of less than 6. Clinically she is always a bit difficult to assess and the cause of this episode of pain is uncertain.

There was another admission on 30 July 2000 to 3 August 2000 with upper abdominal pain of unknown origin. Once again for the third time in 6 weeks, Deborah Sullivan was re-admitted to Glasgow Royal Infirmary with upper abdominal pain and nausea. She was initially treated with intravenous fluids and thereafter kept on a liquid diet. There was no problems with constipation on this occasion. The only abnormalities detected were a marginal rise in temperature at 37.3. Clinically she had some fullness in the upper abdomen. An ultrasound scan revealed no abnormality and there is clearly some concern that she may have an organic pathology but this has not certainly been elucidated and the psychosomatic element is fairly strong in her case. She has been labelled as having a pancreatic problem but there is little substance to this.

Yours sincerely

C W IMRIE
Consultant Surgeon, Honorary Professor

CWI/amb
Dict 09/08/00
Typed 09/08/00

c:dis.cwi/c:aug9dis.cwi 3

0159806

CONSULTANT

GLASGOW ROYAL INFIRMARY
84 CASTLE STREET, GLASGOW G4 0SF

Telephone No. 0141-211-4000
Ext.

Professor C W Imrie

ADMITTED	DISCHARGED	WARD	AGE	HOSPITAL NUMBER
1. 13/06//00 2. 30/07/00	15/06/00 03/08/00(Emergency Admissions)	60	07/12/72 27 yrs	964876K

DISPOSAL

Home

FOLLOW UP

No SOPD required

NAME AND ADDRESS

Deborah (Debbie) Sullivan
1/1, 160 Main Street
Baillieston.
Glasgow
G69 6AH.

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS	I.S.C. CODE
1. Upper Abdominal pain of unknown cause	
2.	
4.	
5	
6.	

DISTRIBUTION OF LETTERS

Dr J Goldie
Easterhouse Health Centre
9 Auchinlea Road
GLASGOW
G34 9HQ

OPERATION	CODE
1. Conservative management	
2. Conservative management	
3	

Dear Dr

This patient was admitted yet again as an emergency with upper abdominal pain of unknown origin. Her urea and electrolytes were normal and her blood amylase was in the normal range with a marginal rise in WBC to 13.4 and a normal C-reactive protein level of less than 6. Clinically she is always a bit difficult to assess and the cause of this episode of pain is uncertain.

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Yours sincerely

CWI/amb
Dict 09/08/00
Typed 09/08/00

C W IMRIE
Consultant Surgeon, Honorary Professor

c:dis.cwi/c:aug9dis.cwi 3

0159806

LISTER DEPARTMENT OF SURGERY

UPPER GI TEAM

Professor C W Imrie
Mr W R Murray
Mr R C Stuart
Mr C R Carter
Mr C J McKay
Mr A Buter (Locum)

0141 211 4872
0141 211 4991

KG/CM/964876

26 July 2000

Dr Goldie
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34

Dear Dr Goldie

Deborah Sullivan (7.12.72)
1/1, 160 Main Street, Baillieston, Glasgow, G69 6AH

Admitted: 22 July 2000
Discharged: 23 July 2000
Diagnosis: Non specific abdominal pain
Treatment: Conservative management

This 27 year old lady presented with sudden onset of abdominal pain radiating to her right shoulder. During her admission she had a normal ultrasound scan of her abdomen and all her blood tests were normal. The pain settled during her stay in Ward 60 and she was discharged home. I have not made any follow up arrangements but would be happy to see her again should she develop further symptoms.

Yours sincerely

K Gardiner
SHO

TEST 24hr pH
DATE 13/06/00
TIME 1.30pm
LAST 9.30am
DNA

SURGERY

Royal Infirmary
16 Alexandra Parade
Glasgow G31 2ER

Pancreatic Clinic

Switchboard: 0141 211 4000
Direct Dial: 0141 211 4293
Fax Number: 0141 211 4991

Sister Cate Buchanan
GI Unit
Ward 32
Glasgow Royal Infirmary

CO'S/JRM/964876K

Dict 18 Oct 1999
Typed 19 Oct 1999

Repeat 1/12

Dear Cate

Deborah Sullivan (7.12.72)
1/1, 160 Main Street, Baillieston, Glasgow G69 6AH

I would be very grateful if you could send this young lady an appointment for oesophageal pH and manometric studies. She has had numerous investigations for upper abdominal pain. Her gallbladder was removed several years ago and her most recent endoscopy in April of this year showed Grade I oesophagitis and a small hiatus hernia. My impression is that she may very well have significant gastro-oesophageal reflux. She is helicobacter pylori negative.

Kind regards

Yours sincerely

C O'SULLIVAN
Specialist Registrar

Date signed 21.10.....

HQS
accredited by the
Health Quality Service

DEPARTMENT OF SURGERY

Professor C W Imrie's Pancreatic Clinic

Dr J Goldie
Easterhouse Health Centre
9 Auchinlea Road
GLASGOW
G34 9HQ

CWI/JRM/964876B

Dict 3 April 2000
Typed 7 April 2000

Dear Dr Goldie

Deborah Sullivan (7.12.72)
1/1, 160 Main Street, Baillieston G69 6AH

Review of Deborah Sullivan on 3.4.00 (together with her mother and her own daughter of 16 months) revealed that she is keeping reasonably well.

1. Her constipation is well controlled with Lactulose and occasional Movicol.
2. The irritable bowel problem in terms of pain has not been major for some time. I think it would be helpful if you would prescribe a few Pethidine tablets for her to have at home as this might well minimise the risk of unncessary call-outs. It would be a wise suggestion that she perhaps have a maximum of eight 50 mg tablets.
3. The question of her gastro-oesophageal reflux problem was not resolved with oesophageal manometry procedure on 1.3.00 as there was a technical failure and the procedure is to be repeated.
4. Her facial skin rash seems to be better controlled.

Her weight is 85.1 kilos which is heavier than she thought she was. I do not think she needs to have a regular follow-up at my clinic although there is an outside chance something may have to be done about her oesophageal problem should this become worse.

Kind regards

Yours sincerely

C W IMRIE
Consultant Surgeon

Date signed.....

DEPARTMENT OF SURGERY

Professor C W Imrie's Pancreatic Clinic

0141 211 4293
0141 211 4991

Sister Cate Buchanan
GI Unit
Ward 32
Glasgow Royal Infirmary

CO'S/JRM/964876K

Dict 18 Oct 1999
Typed 19 Oct 1999

Dear Cate

Deborah Sullivan (7.12.72)
1/1, 160 Main Street, Baillieston, Glasgow G69 6AF

I would be very grateful if you could send this / an appointment for oesophageal pH and manometric studies [illegible] has had numerous investigations for upper abdominal pain. Her gallbladder was removed several years ago and her most recent endoscopy in April of this year showed Grade I oesophagitis and a small hiatus hernia. My impression is that she may very well have significant gastro-oesophageal reflux. She is helicobacter pylori negative.

Kind regards

Yours sincerely

C O'SULLIVAN
Specialist Registrar

Date signed .....

DNA 20/12/99

DEPARTMENT OF SURGERY

Professor C-W Imrie's Pancreatic Clinic

0141 211 4293
0141 211 4991

Dr G Goldie
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

CO'S/JRM/964876K

Dict 18 Oct 1999
Typed 19 Oct 1999

Dear Dr Goldie

Deborah Sullivan (7.12.72)
1/1, 160 Main Street, Baillieston, Glasgow G69 6AH

The above young lady attended the clinic today. She still complains of upper abdominal discomfort which radiates up into her chest and through to her back. It is worse at night. She gets some relief with Omeprazole. I endoscoped her in April of this year, finding her to have Grade I oesophagitis and a small hiatus hernia. I think she needs oesophageal pH and manometric studies performed and will make arrangements for this to be done. We will see her following this.

Kind regards

Yours sincerely

C O'SULLIVAN
Specialist Registrar

Date signed .....

GLASGOW ROYAL INFIRMARY
84 CASTLE STREET, GLASGOW G4 0SF

Ext.

~~Professor Imrie's patient~~

ADMITTED	DISCHARGED	WARD	AGE	HOSPITAL NUMBER
09/08/99	11/08/99	60	07/12/1972	964876K

DISPOSAL: Home

FOLLOW UP: NO SOPD REQUIRED

NAME AND ADDRESS:
Deborah Sullivan
1/1, 160 Main Street
Baillieston
GLASGOW
G69 6AH

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS	I.S.C. CODE
1. CONSTIPATION	
2.	
3.	
5.	
6.	

DISTRIBUTION OF LETTERS:
Dr G Goldie
Easterhouse Health Centre
9 Auchinlea Road
GLASGOW
G34 9HQ

OPERATION	CODE
1. nil	
2.	
3.	

Dear Doctor

The above 26 year old lady was admitted acutely under Professor Imrie's service on the 09/08/99 complaining of upper and abdominal pain which was colicky in nature and associated with vomiting. As you recall this young lady had undergone a cholecystectomy in 1996 and had a previous appendicectomy in the same year. Her liver function tests as well as U's and E's and full blood count were all normal. A plain abdominal x-ray showed that she was faecally loaded. She had a good result from a phosphate enema and was discharged 48 hours later. No arrangements have been made for her to be reviewed in the outpatients clinic. We will see her again should the need arise.

Yours sincerely

C O'SULLIVAN
SPECIALIST REGISTRAR
IN UPPER GI SURGERY
c:dis.cos/c:dis22sep.cwi 9

Dict 21/09/99
Typed 22/09/99

0159806

DEPARTMENT OF SURGERY

Professor C W Imrie's Pancreatico-Biliary Clinic

Dr J Goldie
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

CWI/JRM/964876K

Dict 26 April 1999
Typed 5 May 1999

Dear Dr Goldie

Deborah Sullivan (7.12.72)
1/1, 160 Main Street, Baillieston G69 6AH

I gave this young woman a letter by hand requesting you to try her on Domperidone 10 mgs three times daily for gut spasm in the hope that this would alleviate the frequency of her abdominal pain episodes. I certainly do not think that she should be given any opiates. A prescription for Ponstan might well reduce the number of house calls as well if pain does occur.

Her CLO test was negative with regard to helicobacter infection and I have stressed to both mother and patient that we have turned up no serious pathology.

It is good that she is now attending the Dermatologists with regard to her facial rash which they have diagnosed to be acne rosacea and I trust that this is also a contributory beneficial factor.

Kind regards

Yours sincerely

C W IMRIE
Consultant Surgeon

Date signed .....

GLASGOW ROYAL INFIRMARY
UNIVERSITY N.H.S. TRUST
16 ALEXANDRA PARADE
GLASGOW G31 2ER
0141-211 5016

ENDOSCOPY UNIT

Date:

Out-patient Theatre

G.P.s Name

Consultant:

Address

.....

.....

.....

Dear Doctor

9648/6K
SULLIVAN F/S
DEBORAH 07/12/1972
1/1 160 MAIN STREET
BAILLIESTON
G69 6AH

Name .....

..D.o.B. ..... Hospital No. .....

Address ....

.....

Tel. No. .....

Your patient was treated today in the Endoscopy Unit.

Procedure: ..... was carried out.

Anaesthesia:

- Local Infiltration
- Local Block (Specify)
- Neuroleptanalgesia
- General Anaesthesia
- Diazepam

Analgesia: ..... has been supplied.

Special Precautions. The patient has been warned to seek medical help in the event of: .....

Follow-Up: An appointment has been made at the ..... Clinic on..... at .....

If you have any enquiries please do not hesitate to contact the nursing staff at the above telephone number.

General Comments:

Yours sincerely,

CASE RECORD COPY

0543941

DEPARTMENT OF DERMATOLOGY

Physician in Administrative Charge:
Dr. Angela Forsyth
Tel: 0141 211 4297
Physicians: Fax: 0141 211 4663
Dr. Rebecca E.I. Kerr
Associate Specialist:
Dr Sheila M O'Neill

Dr J Goldie JM/MMS/964876K
Easterhouse Health Centre
9 Auchinlea Road
GLASGOW
G34 9HQ

Dict: 16 April 1999
Typed: 20 April 1999

Dear Dr Goldie

Deborah Sullivan, 07 12 72
1/1, 160 Main Street, Baillieston, G69 6AH

I reviewed this patient in the Dermatology Clinic today.

As you know she has had repeated admissions to hospital with abdominal pain which seems to be accompanied by a facial rash. I saw her on a recent admission to the ward at which point she had a rash which had the appearance of acne rosacea. When I saw her in the clinic today she still had the rash, although she said it had gone away and come back again the previous night when she had had further abdominal pain.

She has had numerous blood tests and the only positive findings have been an elevated Gamma GT and weakly positive antigastric parietal cell antibodies.

We are unsure as to whether her facial rash is related to her abdominal pain and in the first instance she is going to be treated for acne rosacea. I would therefore be very grateful if you could prescribe her Metronidazole 0.75% gel and Oxytetracycline 500 mgs bd.

She will be reviewed at the Consultants Clinical Meeting in three week's time.

Your sincerely

Jennifer May
SHO III

CONSULTANT GLASGOW ROYAL INFIRMARY UNIVERSITY NHS TRUST
84 CASTLE STREET, GLASGOW G4 0SF
Telephone No. 0141-211-4000 Ext. 1168
Professor C W Imrie

ADMITTED	DISCHARGED	WARD	AGE	HOSPITAL NUMBER
27/03/99	30/03/99	60	07/12/1972	964876K

DISPOSAL: Home

FOLLOW UP: SOPD

NAME AND ADDRESS:
Deborah Sullivan
1/1, 160 Main Street
BAILLIESTON
GLASGOW
G69 6AH

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS	I.S.C CODE
1. RECURRENT ABDOMINAL PAIN	
2.	
3.	
4.	
5.	
6.	

DISTRIBUTION OF LETTERS
Dr Goldie
Easterhouse Health Centre
9 Auchinlea Road
GLASGOW
G34

OPERATION	CODE
1. NONE	
2.	
3.	

Dear Dr Goldie

This 26 year old woman presented with a history of further colicky right upper quadrant pain going through to the back. This was associated with nausea and vomiting and constipation. She has had chronic abdominal pain for a number of years and has had a cholecystectomy 2 years ago. Her most recent lupus screen was negative. Rheumatoid factor and ANA tests were negative. There was a suggestion that she had Anti-Gastric Parietal Cell Antibodies on antibody screening.

While she was in hospital a blood test for familial pancreatitis was sent and she was reviewed by the Dermatologists for her face rash. Her intrinsic factor and level was checked but this result is not through as yet. In view of her symptoms she was placed on our waiting list for an upper gastrointestinal endoscopy. Her pain settled and she was discharged with follow up arranged.

Yours sincerely

R WILSON
SENIOR REGISTRAR
c:dis.rw/c:dis9apr.cwi 3

RW/CWI/amb
Dict 08/04/99
Typed 09/04/99

NB Put on waiting list for an Upper GI Endoscopy.

59806

UNIVERSITY DEPARTMENT OF SURGERY

Professor T G Cooke - 211 4870/4871
Mr P Horgan - 211 4871
Mr R Simon - 211 4794
Mr R Stuart - 211 4872

Fax: 0141 552 3229

JK/CM/964876

11 August 1998

Dr Goldie
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34

Dear Dr Goldie

Deborah Sullivan (7.12.72)
1/1, 160 Main Street, Baillieston, Glasgow, G69 6AH

Admitted: 22 July 1998
Discharged: 29 July 1998
Diagnosis: Irritable bowel syndrome
Treatment: Conservative

This lady presented with a 2 week history of lower abdominal pain which is crampy in nature and anorexia and vomiting. She also has a 2 week history of diarrhoea. Her past medical history reveals several such episodes in the past with episodes of abdominal pain and vomiting. I also notice she has a diagnosed problem of her Sphincter-of-Oddi. She was referred to the Gastroenterologists who felt that she probably had a gastrointestinal infection which seems to be resolving. No follow up has been planned.

Yours sincerely

J Kim
SHO

Glasgow Royal
Maternity Hospital
RottenRow
Glasgow G4 ONA

Switchboard 0141 211 5400
Direct Dial
Fax Number

· Glasgow Royal Infirmary ·
· Glasgow Royal Maternity Hospital ·
· Cannicsburn Hospital ·
· Lightburn Hospital · Belvidere Hospital ·

Labour Ward. 23/7/98

Dear Mr Simon

[redacted] A161100

Thankyou for taking Deborah for assessment She is complaining of lower abdominal pain. She has had abdominal pain for many years and had appendicectomy and cholecystectomy. After the cholecystectomy she had continuing problems and was diagnosed with a problem with the sphincter of Oddi. She also has irritable bowel syndrome.
She is currently 23 weeks pregnant and all seems well with the fetus. She was admitted 17/7/98 with lower abdominal pain, frequency, dysuria, vomiting & diarrhoea. She was treated with Augmentin + metadon FBC, U+E were normal. She settled and went home the next day but returned on 22/7/98

She complained she had been to Spain for a week, and had a course of cephalexin for dysuria (no MSU sent as [illegible])

Also complaining of vomiting, loose motions and abdominal pain. There does not seem to be an obstetric cause

Blood U/E, LFT all normal

Thankyou.

Ruth Holman

RUTH HOLMAN
REGISTRAR ON CALL

West Glasgow Hospitals University NHS Trust

Glasgow Homoeopathic Hospital, 1000 Gt Western Road, Glasgow. G12 0NR
Tel No: 0141 211 1623 **Fax No: 0141 211 1610**

Our Ref: DR/JA/945953(9)

Reply to: Dr David Reilly
FRCP MRCGP FFHom

Received: 27th March 1998
Typed: 2nd April 1998

Mr W Murray
Consultant Surgeon
Pancreatic-Biliary Unit
Royal Infirmary
84 Castle Street
Glasgow
G4 0SF

Dear Mr Murray

Re: Deborah Sullivan (7.12.72) 1/1 160 Main Street Baillieston Glasgow. G69 6AH 964876K

Admitted: 9th February 1998 **Discharged: 12th February 1998**

Apologies for the delay, this is an update note on my recent contact with Deborah. She tells me that subsequent to my treatment in February 1997 she had a nine month period of complete remission. As discussed in my letter of November 1997 she then, as you know, relapsed and was re-admitted to the Royal Infirmary. She had not re-approached me because of reticence on her part about being "labelled" as having a psychological difficulty.

However she re-approached me on this occasion and on that basis I was happy to pick-up the trail. I am pleased to say that I have learned as of today (Friday 27th March 1998) that subsequent to that treatment she has again entered a remission for now.

This seems to have been induced once more by some therapeutic encounters with myself and the Homoeopathic Hospital team. This was supplemented by Homoeopathic Baryta carb. It remains to be seen of course just how things develop but it is good that at least for now there is again some improvement. I have emphasised to her that I think it would be appropriate at the next point of relapse that she contacts the Homoeopathic Hospital directly and that we admit her. Perhaps by doing that we might be able to cut short the next relapse.

Yours sincerely

David

Please file.

David Reilly
Consultant Physician and Honorary Senior Lecturer in Medicine

cc: Dr J Goldie Easterhouse Health Centre 9 Auchinlea Road Glasgow. G34 9HQ

West Glasgow Hospitals University NHS Trust

Glasgow Homeopathic Hospital
1000 Great Western Road
Glasgow G12 0NR
Tel: 0141-211-1616
Fax: 0141-211-1610

Our Ref: DR/JC/945953

964876

Dictated: 18/05/98
Typed: 06/05/98

HOMEOPATHY OUTPATIENT CLINIC

Mr W Murray
Consultant Surgeon
Pancreatic-Biliary Unit
ROYAL INFIRMARY
84 Castle Street
GLASGOW G4 0SF

cc: Dr J Goldie
Easterhouse Health Centre
9 Auchinlea Road
GLASGOW
G34 9HQ

Dear Mr ~~Murray~~ Bill

Please file

Deborah SULLIVAN - DOB: 07/12/72
1/1 160 Main Street Baillieston Glasgow G69 6AH

Deborah contacted me for guidance on her heartburn, likely related to her current pregnancy. She has stopped her Losec (I assume because of the pregnancy) and is using Rennies.

It is worse at night and is proving really quite troublesome. She is having to restrict any fluid or food intake from 8.00 pm onwards. Some of the local features and constitutional reactions that she is having suggest that Pulsatilla may help her. I have prescribed this in a 30c 3 times a day until things have settled. If they have not settled within the next 10 days, I have asked her to re-contact me and I will think about the problem afresh.

I also suggested that she raise the head of her bed by a couple of inches by placing the legs on some sort of raise as this, I think, is probably more reliable than being propped up by pillows.

Yours sincerely

David

DAVID REILLY FRCP MRCGP FFHom
Consultant Physician and Honorary Senior Lecturer in Medicine

CONSULTANT
Mr IG Finlay
Department of Coloproctology

GLASGOW ROYAL INFIRMARY UNIVERSITY NHS TRUST
84 CASTLE STREET, GLASGOW G4 0SF

Telephone No. 0141-211-4000
Ext.

ADMITTED	DISCHARGED	WARD	AGE	HOSPITAL NUMBER
28/10/97 Emergency	11/11/97	60	07/12/72	964876K

DISPOSAL
Home

FOLLOW UP
Gastro clinic

NAME AND ADDRESS
Deborah Sullivan
1/1, 160 Main Street
Glasgow G69 6AH

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS	I.S.C. CODE
1. Undiagnosed abdominal pain -	
2.	
3.	
4.	
5.	
6.	

DISTRIBUTION OF LETTERS

Dr Goldie
Easterhouse Health Centre
9 Auchinlea Road
Glasgow G34 9HQ

OPERATION	CODE
1.	
2.	
3.	

02/12/97

This young woman was admitted once again with colicky central abdominal pain. Emergency bloods on admission showed a moderately elevated white count at 11.4 and an amylase of 300. She had a single dilated loop of small bowel in the left side of her abdominal films.

She was treated conservatively and the nausea and vomiting settled. It was decided to repeat barium studies and she underwent a barium enema on 5 November which showed early diverticular disease in the sigmoid colon with no other abnormalities. Her colicky central abdominal pain persisted and a barium swallow and through were repeated. This showed no abnormalities in the upper GI tract with a transit time from mouth to hepatic flexure of two and a half hours. She also underwent an ultrasound of her abdomen on 4 November which failed to reveal any abnormality.

Her symptoms settled on conservative measures and she was advised to avoid cigarette smoking. She was kindly reviewed by a member of Dr MacKenzie's team and I gather arrangements have already been made to see her back at the Gastro Clinic in due course. We have not made formal arrangements to see her back at Mr Finlay's Clinic.

Yours sincerely,

Mr J McCourtney
Specialist Registrar

Mr IG Finlay
Consultant Colorectal Surgeon

159806



West Glasgow Hospitals University NHS Trust

Glasgow Homoeopathic Hospital, 1000 Gt Western Road, Glasgow. G12 0NR
Tel No: 0141 211 1623 Fax No: 0141 211 1610

Febmarch case She

Our Ref: DR/JA/945953(9)

Reply to: Dr David Reilly
FRCP MRCGP FFHom

Hospital No
GRI - 964876K

Received: 31st October 1997
Typed: 20th November 1997

Mr W Murray
Consultant Surgeon
Pancreatic-Biliary Unit
Royal Infirmary
84 Castle Street
Glasgow
G4 0SF

Please file.

GRI Hosp No
964876K.

important

Dear Mr ~~Murray~~ Bill

TEL 771- 3401.

Re: Deborah Sullivan (7.12.72) 1/1 160 Main Street Baillieston Glasgow. G69 6AH

I wanted to let you know that I was approached on the telephone by Debbie's Mum and that I had a long conversation with her. She tells me that after my treatment of Debbie there was a six month period where "she had her daughter back". Apparently Debbie got back to work and was coping well.

There have been two recent relapses and as I write (dictated Friday 31st October 1997) she is in the Royal Infirmary again. I am not sure what is going on of course but I understand she has recently moved in with her boyfriend and there was talk of becoming pregnant. She raised certain needs such as stopping smoking. This went back the loop through her Mum and completed the circle of her Mum back to him. I confronted her Mum fair and square that I thought she was part of the situation of an inter-dependency with Debbie. Debbie cries like a child and her Mum runs. I emphasised to her Mum that this was not necessarily a direct conscious reaction and that like a blush people can have triggered physical responses reflecting inner emotions and stresses. Nevertheless I suggested the situation was quite unhealthy and would need to change.

Similar to the telephone call that I received in the previous deterioration I declined to visit Debbie in the Royal Infirmary through this route of referral. My understanding is that on the last occasion when I offered transfer Debbie declined. I have since learnt from her Mum that the big issue for Debbie is the fear of her situation being labelled as emotional or "loopy". That is Debbie's problem however and she is going to have to get over it and I have made it clear that I am very happy to see her again and work with her but that I require her to be a willing participant and to approach me on an adult basis. I explained to her Mum that any other form of approach such as me running across the city was actually me colluding in the patterns of behaviour and it would not be helpful to Debbie.

I think/

Deborah Sullivan (7.12.72) 1/1 160 Main Street Baillieston Glasgow. G69 6AH

I think it was a helpful call and I am quite sure that in time the situation can be resolved. My own strategy however is that until Debbie is willing and either approaches me directly or is formally re-referred from one of her carers I will just take a watchful brief.

Best wishes.

Yours sincerely

David Reilly
Consultant Physician and Honorary Senior Lecturer in Medicine

cc: D Ramsden JHO to Mr Murray Royal Infirmary 84 Castle Street Glasgow. G4 0SF
Dr J Goldie Easterhouse Health Centre 9 Auchinlea Road Glasgow. G34 9HQ

Professor T G Cooke - 0141 211 4871
Mr P G Horgan - 0141 211 4871
Mr P D Stanton - 0141 211 4794
Mr R C Stuart - 0141 211 4872
Fax - 0141 552 3229

JH/ROH/964876K

27 October 1997

Dr Goldie
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34

Dear Dr Goldie

Deborah Sullivan 7.12.72
1/1, 160 Main Street, Glasgow, B69 6AH

Admitted:	12.10.97	Discharged:	15.10.97
Diagnosis:	Right upper quadrant pain		
Procedure:	None		

The above lady was admitted on 12 October with right upper quadrant pain for which she has had numerous admissions in the past. This seemed to be another episode of her ongoing problem and she was, therefore, treated conservatively. Miss Sullivan took her own discharge on 15 October, feeling that no adequate treatment had been given to her. No arrangements have been made to review her in the clinic.

Yours sincerely

J HARDEN
SHO

T G COOKE
PROFESSOR OF SURGERY

Department of Coloproctology

Consultant Surgeons
Mr J H Anderson
Mr I G Finlay
Dr R F McKee
Consultant Radiologist
Dr F W Poon
Consultant Medical Oncologist 211 4793
Dr M Soukop 552 3229

JHA/HF/964876K

Dict 17.10.97
Typed 22.10.97

Dr Goldie
Easterhouse Health Centre
9 Auchinlea Road
GLASGOW
G34 9NT

Dear Dr Goldie

RE: DEBORAH SULLIVAN, DOB 7.12.72
1/1, 160 MAIN STREET, BAILLIESTON

Admitted: 2.10.97 Discharged: 8.10.97
Diagnosis: Abdominal pain
Operation: None

This 24 year old lady who has a long history of abdominal pain thought to be consequent upon a gastrointestinal motility disorder attended as an emergency with a 5 day history of upper abdominal pain.

On examination she was tender in the epigastrium but apyrexial and well perfused. Full blood count, urea and electrolytes and serum amylase were normal. She was kept in for several days for observation and her symptoms and signs eventually resolved spontaneously. She declined the offer of a transfer to the homeopathic hospital for the opinion of Dr David Reilly, Consultant Physician who had previously attended to her. During her admission she was also seen by Mr Murray, Consultant Upper Gastrointestinal Surgeon to whom she was well known. He felt that there was no indication for endoscopy. Abdominal and pelvic ultrasound scan on 3.10.97 was satisfactory.

She was allowed home on 8.10.97 and no surgical review has been arranged.

Yours sincerely

J H ANDERSON
CONSULTANT COLORECTAL SURGEON Date of signing .....

ACCIDENT AND EMERGENCY UNIT

CG/IG 16th May 1997

Dr J. Goldie
Health Centre
9 Auchinlea Road
EASTERHOUSE
Glasgow G34 9HQ

Dear Dr Goldie **DISCHARGE SUMMARY**

Re: Deborah Sullivan, d.o.b. 7.12.72., Unit No 964876K
1/1 160 Main Street BAILLIESTON G69 6AH

Admitted: 13th May 1997 Discharged: 14th May 1997
Diagnosis: Minor head injury
Investigation: C.T. Scan of head 14th May 1997

This twenty-four year old lady with a complex past medical history of dysfunctional G.I. syndrome was admitted following a minor frontal head injury two days ago. Since then she had complained of severe headache, dizziness, nausea and vomiting, that occurring three days on the day of admission. She was extremely anxious on admission.

Skull X-ray showed no fracture.

She was admitted to Ward 29 for overnight neurological observation and a possible C.T. scan. Her neurological observation was entirely normal, but in view of the history a C.T. scan of her brain was arranged. This was entirely normal and she was reassured and allowed home. No Accident and Emergency follow up has been arranged.

Yours sincerely

C. GRAHAM
S.H.O.III

DEPARTMENT OF SURGERY

Mr W R Murray's Out-Patient Clinic

Dr J Goldie
Easterhouse Health Centre
9 Auchinlea Road
Easterhouse
GLASGOW
G34 9HQ

WRM/JRM/964876K

Dict 4 April 1997
Typed 8 April 1997

Dear Dr Goldie

Deborah Sullivan (7.12.72)
1/1, 160 Main Street, Baillieston G69 6AH

As you know your patient Deborah Sullivan is now under the care and management of Dr David Reilly at the Glasgow Homeopathic Hospital. She did not attend my Surgical Clinic for review and I have not sent further appointments.

Yours sincerely

W R MURRAY
Consultant Surgeon

West Glasgow Hospitals University NHS Trust

Glasgow Homoeopathic Hospital, 1000 Gt Western Road, Glasgow. G12 0NR
Tel No: 0141 211 1623 Fax No: 0141 211 1610

Hosp No
GRI - 9648976K

Our Ref: DR/JA/945953

Reply to: Dr David Reilly
FRCP MRCGP FFHom

Received: 4th February 1997
Typed: 5th February 1997

Mr W Murray
Consultant Surgeon
Pancreatic-Biliary Unit
Royal Infirmary
84 Castle Street
Glasgow
G4 0SF

Please file in GRI notes — important

Dear Mr Murray

Re: Deborah Sullivan (7.12.72) 1/1 160 Main Street Baillieston Glasgow. G69 6AH

Admitted: 27th January 1997 **Discharged: 4th February 1997**

As promised here is a follow-up discharge letter on Deborah. At least for now things have gone remarkably well but of course I think it is better that we err on the side of realism and caution in projecting the future.

She has managed to come off all her drugs and is speaking in discerning terms about her newly developed insight. Her symptoms have settled. On a weekend pass she had some abdominal discomfort and while she thought of reaching for analgesics instead she implemented the relaxation training and breathing exercises that she had been taught and the symptoms settled.

She has been doing some personal writing and study and is trying to address the underlying issues of her self-esteem and her emotions.

I have arranged a follow-up in six weeks but have explained to her that we would be happy to respond immediately to any emergency situation. If this happened it would probably be better that she was admitted here rather than the acute ward but if the latter should happen we could accept transfer.

The one thing that was disturbing her is that she has developed some nightmares of a threatening nature. I encouraged her to see that in fact this was an expression of some of the fear that she had been bottling. Then she readily acknowledged some of these. Apparently she witnessed an attempted murder on her father and had to go to court. She has been threatened that when the convicted man is released from prison he will be out to get her. She has also of course had the childhood violence and fear.

She has constructively spoken with her mother and asked her to help her achieve the goal of greater independence. I have asked Deborah/

Deborah Sullivan (7.12.72) 1/1 160 Main Street Baillieston Glasgow. G69 6AH

I have asked Deborah to continue the Homoeopathic Baryta carb C30, an agent for profound almost infantile anxiety in an adult where there has been a degree of arrested development be it emotionally or physically. I am confident however that the main therapeutic intervention here was the initial consultation followed by the reinforcement programme.

I look forward with interest to seeing how things unfold here and learning whether there has been any lasting benefit or gain from the particular approach I have taken. Thank you for asking me to see Deborah and offering me an opportunity to share her care with you.

Best wishes.

Yours sincerely

David Reilly
Consultant Physician and Honorary Senior Lecturer in Medicine

cc: Dr Ramsden JHO to Mr Murray Royal Infirmary 84 Castle Street Glasgow. G4 0SF
Dr J Goldie Easterhouse Health Centre 9 Auchinlea Road Glasgow. G34 9HQ

CONSULTANT

MR W R MURRAY

GLASGOW ROYAL INFIRMARY
84 CASTLE STREET, GLASGOW C4

Telephone No. 041-552 3535
Ext.

ADMITTED	DISCHARGED	WARD	AGE	HOSPITAL NUMBER
05/12/96 (EMERGENCY RECEIVING WEEK ON)	14/12/96	39	07/12/1972 24 yrs	964876K

DISPOSAL

HOME

FOLLOW UP

SOPD

NAME AND ADDRESS

Deborah Sullivan
1/1, 160 Main Street
Baillieston
Glasgow
G69 6AH

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS	I.S.C. CODE
DIAGNOSIS	
1.	
2.	
3.	
4.	
5.	
6.	

DISTRIBUTION OF LETTERS

MRD

Dr D Reilly
Consultant Physician
Glasgow Homeopathic Hospital
1000 Great Western Road
GLASGOW

OPERATION	CODE
OPERATION	
1.	
2.	
3.	

WRM/AMB/A:DIS18DEC.WRM 5

Dictated WRM: 17/12/96
Typed AMB: 18/12/96

18 December 1996

Dear Dr Reilly

Your patient, Deborah Sullivan, was admitted via the Accident and Emergency Department of Glasgow Royal Infirmary on 05/12/96.

I would be most grateful for your help with this 24 year old lady who I think has a significant gastrointestinal dysfunction disorder.

She has already been admitted on many occasions to Glasgow Royal Infirmary with acute episodes of abdominal pain and has already lost her appendix and her gallbladder. Multiple investigations subsequent to these surgical procedures have failed to reveal ongoing pathology and to me she has the hallmark of a young patient with GI Dysfunction Syndrome. Interestingly her Nuclear Medicine Gastric Emptying Studies show significant delay despite normal gastroscopy, ERCP, small bowel enema and abdominal white cell scans. Her Quantitative HIDA scan (T-max = 10 minutes) does not suggest a significant Sphincter of Oddi Dysfunction component.

This/-

Now attending
Dr Reilly

DNA 21/2/97
DNA 4/4/97

FORM H1514 JJ&C 941793

18 December 1996

RE: DEBORAH SULLIVAN, HOSPITAL NUMBER: 964876K, DOB 07/12/1972, 1/1, 160 MAIN STREET, BAILLIESTON, GLASGOW G69 6AH.

This lady presents a considerable management problem both to her Practitioner and to the Hospital. I fear she may end up with further laparotomies which may not be warranted and I would value your opinion. She has a relevant family history and her mother is genuinely concerned about her progress.

With best wishes.

Yours sincerely

W R MURRAY
CONSULTANT SURGEON
PANCREATICO-BILIARY UNIT
GLASGOW ROYAL INFIRMARY

cc: Dr J Goldie, Easterhouse Health Centre, 9 Auchinlea Road, Glasgow.

cc: Dr J Morris, Consultant Medical Gastro-enterologist, Royal Infirmary, Glasgow.

GENERAL PRACTITIONERS NAME and ADDRESS

DEPARTMENT OF SURGERY

MR I G FINLAY'S GENERAL SURGICAL CLINIC

0141 211 4084
0141 211 4991

Dr Goldie
Easterhouse Health Centre
9 Auchinlea Road
GLASGOW
G34 9HQ

IGF/GG/964876K

Dictated 09/01/97
Typed 12/01/97

Dear Dr Goldie

DEBORAH SULLIVAN (07/12/72)
FLAT 1/1, 160 MAIN STREET, GLASGOW G69 6AH

The above named patient failed to attend the clinic for review. In view of the pressure on our clinic space no further routine review appointment will be sent but if you feel I can be of any further assistance please do not hesitate to get in touch.

Yours sincerely

I G FINLAY
CONSULTANT COLORECTAL SURGEON

MR I G FINLAY 4814

14.11.96 21.11.96 39 7.12.72 964876K

HOME

Deborah Sullivan
1/1, 160 Main Street
Baillieston
G69 6AH

Gastroenterology Clinic

Sphincter of Oddi dysfunction

Dr Goldie
Townhead Health Centre
16 Alexandra Parade
GLASGOW
G31

ERCP

The above patient was admitted as an emergency with abdominal pain and vomiting. As you know, she has had a number of previous investigations for similar symptoms and a diagnosis of sphincter of Oddi dysfunction was made.

On this occasions she complained of right upper quadrant pain which eventually settled on conservative management. Some degree of opiate induced GI stasis is no doubt present, a successful outcome in the longer term is unlikely. On this occasion she responded to Klean Prep and was discharged on 21 November 1996. She is due for review at Dr Morris' Clinic in the near future and we will also be seeing her again in due course.

Yours sincerely

A F Horgan
Specialist Registrar

I G Finlay
Consultant Colorectal Surgeon

AFH/LD
Dict 29 November 1996
Typed 29 November 1996

PROFESSORIAL SURGICAL CLINIC

HW/ROH/964876K

Dict: 28 October 1996
Typed: 30 October 1996

Dr Goldie
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34

Dear Dr Goldie

Deborah Sullivan 7.12.72
1/1, 160 Main Street, Baillieston

This lady has now failed to attend the clinic on two occasions. We have not, therefore, sent her a further appointment but if she develops further problems we would be happy to see her on re-referral.

Yours sincerely

H WARREN
Specialist Registrar

UNIVERSITY DEPARTMENT OF SURGERY

Professor T G Cooke - 0141 211 4871
Mr P D Stanton - 0141 211 4794
Mr R C Stuart - 0141 211 4872
Fax - 0141 552 3229

AT/HF/964876K

26 August 1996 PROFESSORIAL SURGICAL CLINIC

Dr Goldie
Easterhouse Health Centre
9 Auchinlea Road
GLASGOW G34

Dear Dr Goldie

RE: DEBORAH SULLIVAN, DOB 7.12.72
1/1, 160 MAIN STREET, BAILLIESTON

Deborah Sullivan failed to attend the clinic today. I suspect there was a misunderstanding regarding her appointment and therefore I will make arrangements for another to be sent.

Yours sincerely

A TETER
REGISTRAR

DNA 28/10/96

MD/ROH/964876K

Dict: 29 July 1996
Typed: 30 July 1996

Dr J Goldie
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

Dear Dr Goldie

Deborah Sullivan 7.12.72
1/1, 160 Main Street, Baillieston, G69 6AH

Admitted:	12.7.96	Discharged:	16.7.96

Diagnosis: ? Irritable bowel

Procedure: Conservative management

Deborah was admitted with a sudden onset of left upper quadrant colicky pain radiating to the left shoulder. This was associated with vomiting. Appendicectomy in March and laparoscopie cholecystectomy in April of this year were noted.

On presentation her abdomen was soft but tender in the left upper quadrant with no evidence of peritonism. Bloods on presentation demonstrated a white count of 12.5 with normal urea, electrolytes and amylase. She was treated conservatively with intravenous fluid and her pains settled.

She will be reviewed in the outpatient clinic in four weeks. We will keep you informed of her progress.

Yours sincerely

DNA 26/8/96.

M DOWNEY
SHO

Surgery & ERCP
Mr C. W. Imrie
Mr W. R. Murray

Radiology
Dr I. S. Stewart
Dr F. W. Poon

Pathology
Dr A. K. Foulis

Cytology
Dr A. F. Mutch

ROYAL INFIRMARY
GLASGOW
G4 0SF
TELEPHONE: 041-552 3535
Ext 4293/5129
FAX NO: 041-552 6268

Pancreato-Biliary Team

CWI/hd
6 June 1994

Dr Nakshabendi
Registrar
Wards 8 and 9
Royal Infirmary
Glasgow

Dear Dr Nakshabendi

DEBORAH SULLIVAN 7.12.72
HOSPITAL NO 964876

This young patient was referred for an ERCP on the basis that she might well have sphincter of Oddi dysfunction to explain recurrent episodes of right sided upper abdominal pain in the absence of any abnormality detected on routine endoscopy, ultrasound and barium studies.

A copy of the endoscopic report is enclosed and arrangements will be made for the patient to be reviewed at Dr Russell's clinic in the near future.

Yours sincerely

C W Imrie
Consultant Surgeon

c.c. Dr R Russell, Consultant Gastroenterologist, GRI

Consultant Surgeons:
Mr. J.K. Todd
Mr. C.W. Imrie
Mr. I.G. Finlay
Mr. W.R. Murray

9604876K

ROYAL INFIRMARY
GLASGOW
G4 0SF
TELEPHONE 041-552 3535
FAX 041-552 6268

Surgical Unit - Main Building

CWI/HD
16 February 1994

Dr I Nakshabendi
Clinical Research Fellow
Gastroenterology Unit
Royal Infirmary
Glasgow

Dear Dr Nakshabendi

DEBORAH SULLIVAN 7.12.72 187 COMMONHEAD ROAD GLASGOW G34 0DS

Thank you for your letter of 7th February 1994 regarding this patient. It would seem reasonable that an ERCP be carried out and the lady will be contacted in due course for this examination.

Kind regards
Yours sincerely

C W Imrie
Consultant Surgeon

DEPARTMENT OF SURGERY

MR C W IMRIE'S GENERAL SURGICAL CLINIC

0141 211 4293
0141 211 4991

Dr Goldie
Easterhouse Health Centre
9 Auchinlea Road
GLASGOW
G34 9QH

CWI/GG/964876K

Dictated 12/02/96
Typed 17/02/96

Dear Dr Goldie

DEBORAH SULLIVAN (07/12/72)
160 MAIN STREET, GLASGOW G69 6AH

Debbie Sullivan failed to keep her appointment at my clinic on 12/02/96. One further appointment will be sent to her.

Yours sincerely

C W IMRIE
CONSULTANT SURGEON

DEPARTMENT OF SURGERY

Mr C W Imrie's Surgical Clinic

New Tel No 0141 211 4293
New Fax No 0141 211 4991

Dr Goldie
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9QH

JM/hd 964876

Dict 8.1.96
Typed 13.1.96

Dear Dr Goldie

DEBORAH SULLIVAN 7.12.72
160 MAIN ST GLASGOW G69 6AH

This lady is symptomatically much improved but she does complain of occasional constipation. She is much less anxious. I note that she was unable to tolerate Motilium.

We plan to introduce Lactulose on a p.r.n. basis but otherwise have introduced no changes to her present regime as she is so well. I have organised a further review at the clinic in one month's time.

Thank you.

Yours sincerely

J P McGrath FRCSI

DEPARTMENT OF SURGERY

Mr C W Imrie's Outpatient Clinic

New Telephone Number
0141 221 4000

Dr Goldie
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9QH

CWI/JA/964876

Dict 6 November 1995
Typed 7 November 1995

Dear Dr Goldie

DEBORAH SULLIVAN (7.12.72)
160 MAIN STREET, GLASGOW, G69 6AH

This complex young woman has two major gastrointestinal problems which are not being particularly troublesome at the present period.

They are:-

1 delayed gastric emptying
2 reflux oesophagitis

She takes Losec 40 mgs a day and I think that this could be cut to 20 mgs a day and the Maxolon which she reckons has controlled the nausea and symptoms associated with daily gastric emptying might be better replaced by Motilium as a trial period. She is coming back to see me in four weeks and it maybe that we will repeat the nuclear medicine scan as she has felt better in the last six weeks since she broke up the two year relationship that she had with a young man and has felt organically better since that time. It may well be that stress is a considerable factor in Deborah's problem.

Kind regards.

Yours sincerely

C W IMRIE
Consultant Surgeon

Royal Infirmary
84 Castle Street
Glasgow G4 0SF

Switchboard 0141 211 4000
Direct Dial
Fax Number

• Glasgow Royal Infirmary •
• Glasgow Royal Maternity Hospital •
• Cunninghame Hospital •
• Lightburn Hospital • Parkhead Hospital •

RC/CM/964876

2 April 1996

Dr Goldie
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34

c: Mr C W Imrie
Consultant Surgeon
Ward 61
GRI

Dear Dr Goldie

Deborah Sullivan (7.12.72)
160 Main Street, Glasgow, G69 6AH

Admitted: 16 March 1996
Discharged: 20 March 1996
Diagnosis: Appendicitis
Operation: Appendicectomy

Your patient was admitted as an emergency with lower abdominal pain. Deborah is well known to Mr Imrie within the hospital with a long history of colicky abdominal pain and persistent vomiting and has been extensively investigated in the past. On this occasion however her pain was described as completely different to her normal discomfort and she was felt to have signs of right iliac fossa peritonism. A BDCG test was negative and consequently she was taken to theatre and a routine appendicectomy performed. Histology has confirmed foci of acute inflammation consistent with acute appendicitis. She made an uneventful recovery and was fit for discharge on 20.3.96 and no formal follow up has been arranged. It will remain to be seen whether this procedure has any affect on her other gastrointestinal symptoms.

Yours sincerely

R Carter
Senior Registrar

MD/CM/964876

9 May 1996

Dr Goldie
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34

Dear Dr Goldie

Deborah Sullivan (7.12.72)
1/1, 160 Main Street, Baillieston, Glasgow, G69 6AH

Admitted: 23 April 1996
Discharged: 2 May 1996
Diagnosis: Gallstones
Procedure: Laparoscopic cholecystectomy

Deborah attended with right sided abdominal pain 4 weeks following appendicectomy. On presentation her abdomen was soft and tender in the right hand side with marked guarding but no evidence of peritonism. Abdominal ultrasound was performed to exclude the possibility of a collection following the appendicectomy and this demonstrated gallstones within the gallbladder with a normal common bile duct. Liver function tests were carried out which were within normal limits. A decision was taken to proceed to laparoscopic cholecystectomy and this was carried out. She made an uneventful recovery and subsequent pathology of her gallbladder has demonstrated mild inflammatory changes consistent with gallstones. We will review her in the clinic in 6 week's time to reassess her progress.

Yours sincerely

Dr A 13-5-96.

M Downey
SHO

DEPARTMENT OF SURGERY

Professor C W Imrie's Clinic

Dr Goldie
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9QH

FCE/JMC/964876

Dict. 17 June 1996
Typed 21 June 1996

Dear Dr Goldie

DEBORAH SULLIVAN 07.12.72
1/1 160 MAIN STREET BAILLIESTON G69 6AH

This lady failed to attend for her outpatient appointment today following her recent appendicectomy and then laparoscopy cholecystectomy. I trust she is well and I have not arranged to review her but would of course be happy to do so should you feel it necessary.

Yours sincerely

FIONA EATOCK
SHO III

4TH FLOOR MEDICAL UNIT - WARDS 8 + 9
Consultant in Administrative Charge:

PROFESSOR A R LORIMER

Consultants:
DR J F MACKENZIE
DR J M BOULTON-JONES
DR M SOUKOP
DR W F DURWARD

Royal Infirmary
84 Castle Street
Glasgow G4 0SF

Fax No: 0141 552 6126
Direct Lines
Prof Lorimer - 0141 211 4803
Dr MacKenzie - 0141 211 4519

Telephone 041 552 3535

6/11/95 @ 11.20 am

964876

Mr C W Imrie
Consultant Surgeon
Ward 61
G.R.I.

JFMACK/ALN/964876

10 October 1995

Dear Clem

Miss Deborah Sullivan dob 7.12.72
Flat 1/1, 160 Main Street, Baillieston

I enclose a letter of complaint from Deborah Sullivan. ~~Our~~ My approach to her problem has clearly been ineffective and judging by the tone of the letter, it is probably inappropriate for me to continue her care.

Kind regards

Will you see her again?

Yours sincerely

J F MacKenzie
Consultant Physician and Gastroenterologist

cc: Dr J Goldie, Easterhouse Health Centre, 9 Auchinlea Road, Glasgow.

464651

2/

When I have something to eat (and its just not certain foods) I throw up within half an hour. If I don't be sick I suffer severe abdominal pain. Sometimes im sick for weeks on end resulting in me not eating at all in the fear of suffering the pain or sickness.

DR McKenzie has confirmed that I am suffering a severe case of Irritable Bowl Syndrome causing motility disturbance. Dr McKenzie is not "WORRIED" at all about the sickness although to date I have lost 3 stone in weight and have a couple of times woke in the middle of the night choking on my vomit. Dr McKenzie confirmed that my sickness has become a habit as I've been sick for so long and my stomache is simply rejecting the food. The sickness began before I was pre-scribed any codine tablets

1/

MISS DEBORAH E SULLIVAN
160 MAIN ST FLAT 1/1
BAILLIESTON
G69 6AH

GLASGOW ROYAL INFIRMARY UNIVERSITY NHS TRUST
14 SEP 1995
DIRECTOR OF CONTRACTS AND SUPPORT SERVICES

13.9.95

Dear Mr Hume

Hospital No 9648716K

I am presently under the care of Dr McKenzie (GASTRICINTROLOGIST). I have been attending the Glasgow Royal Infirmary for the past two years and have been admitted by my own G.P. at least ten times often being dehydrated, suffering from severe abdominal pain and being violently sick.

I appreciate that I have had numerous endoscopys which were normal. However a Gastric Emptying Study confirmed that my stomache has delayed emptying which I feel contributes to my sickness

however, I appreciate that the coding tablets contributed to my delayed emptying as they slow the bowl down, although, since being off this medication a further Gastric Emptying Study has shown only a 5% increase.

My bowels go from one extreme to the other often being constipated for weeks on end then severe bouts of diarrhoea, but more constipated than anything. I have never had a barium enema or colonoscopy as according to Dr McKenzie this is not required although other Physians and Surgeons (MR IMRIE who I have no complaints against whatsover) confirmed this was necessary

I feel at my wits end as for the past two years I have been told this will all settle down in its own time and two years on I'm suffering the pain and sickness.

Dr McKenzie has prescribed several forms of pain relief which don't take away the pain and more often than not I don't keep the tablets down for being so sick. Dr McKenzie has never seen me is severe pain either when I've been admitted to hospital or took a bad attack in the hospital., The Surgeons who previously looked after me were Marvellous they saw me in pain and relieved it they were concerned and worried about the sickness although I agree I was a bit of a mystery to MR Imirie. Dr McKenzie feels I should lye down in my bed and sip water when the pain comes on although I'm usually rolling about on the floor screaming in agony.

I would most appreciate a second opinion - I understand that my condition is not life threatening although

old and my life is at a complete standstill I cannot plan anything because I don't know what the next day will bring - I now suffer from panic attacks and I've lost weight, from the muscles that support my spine and I have to attend the physiotherapist the pain is very severe and a few times I've been unable to walk.

I just live in hope that someone will resolve this problem and hope you can help in anyway.

I leave for you to consider and await an early reply as you are my last hope.

Yours sincerely

Miss D Cullen

(A VERY DISTRESSED PATIENT)

a few times in despair I've became suicidal and it's only been the my familys (mother, sister, fiancie) support and positive attitude that I've pulled through or I would not be here today. I worry so much that my fiancie will say enough is enough over the past two years has spent many sleepless nights, comforting me and feeling so helpless our relationship has suffered badly. My mother does not keep well and I feel a burden on her the strain and worry show on her face as she also feels so helpless. I have missed alot of time from my work and I live in fear of loosing my job I have a good career and a very understanding boss but who knows how long they will put up with this!

I have no social life, I am 22yrs

DEPARTMENT OF SURGERY

CWI/hd
23 October 1995

Miss Deborah Sullivan
Flat 1/1 160 Main St
Bailliestoon
Glasgow

Dear Miss Sullivan

Arrangements have been made for you to come to my clinic as per the enclosed appointment card. I would be grateful if you could keep that appointment and I would wish to see you myself at that clinic.

Yours sincerely

C W Imrie
Consultant Surgeon

DEPARTMENT OF SURGERY

CWI/hd
23 October 1995

Dr J F MacKenzie
Consultant Physician
Wards 8 and 9
Royal Infirmary
Glasgow

Dear Dr MacKenzie

DEBORAH SULLIVAN 7.12.72
FLAT 1/1 160 MAIN ST BAILLIESTON

Thank you for your letter of 10th October regarding this young woman who is well known to both of us. I will certainly arrange to see her as you suggest and I agree with your view of the overall situation.

Kind regards
Yours sincerely

C W Imrie
Consultant Surgeon

CONSULTANT J A THOMSON

GLASGOW ROYAL INFIRMARY UNIVERSITY NHS TRUST
84 CASTLE STREET, GLASGOW G4 0SF

Telephone No. 0141 211-4000
Ext.

ADMITTED	DISCHARGED	WARD	AGE	HOSPITAL NUMBER
5.9.95	9.9.95	2	7.12.72	964876

DISPOSAL

FOLLOW UP

NAME AND ADDRESS

DEBORAH SULLIVAN
160 MAIN STREET
GLASGOW

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS

		ISC CODE
1.	URINARY TRACT INFECTION	
2.	LONG-STANDING GASTROINTESTINAL PROBLEMS	
3.		
4.		
5.		
6.		

DISTRIBUTION OF LETTERS

DR GOLDIE
9 AUCHINLEA ROAD
GLASGOW

OPERATION	CODE
1	
2	
3	

AG\EF

DICTATED: 13.9.95
TYPED: 14.9.95

This lady, well known to Dr John MacKenzie, was admitted with a 2 day history of left loin pain along with a couple of episodes of vomiting. She gave symptoms suggestive of a urinary tract infection and indeed urinalysis showed the presence of considerable proteinuria. She was treated with Trimethoprim and remained well thereafter. By 8.9.95 she was deemed fit for discharge and will be seen for review presently at the GI Clinic.

MEDICATION ON DISCHARGE: Mebeverine one tab tds, Amitriptyline 25 mg nocte, Omeprazole 20 mg bd and Trimethoprim 200 mg bd.

A GALLAGHER
CAREER REGISTRAR

NE..HILLS MEDICAL PRACTICE

EASTERHOUSE HEALTH CENTRE
9 Auchinlea Road
Easterhouse
Glasgow
G34 9HQ

Tel: 0141-771 0781

Dr A Cole
Dr Fiona Collins
Dr J Goldie
Dr Kristeen Lindsay
Dr I McBain
Dr J Ward

17/7/95

Dear [redacted]

Re Deborah Sillars Age 22
160 Main Street
Bailleston.

This girl attends the gastroenterology clinic for mobille based target she developed sudden onset diarrhoea, severe initially now much better. She has had well over little for the last 4 weeks.

O/E Temp 97°F
Abd - epigastric tenderness
++

GASTROENTEROLOGY

Dr J F MacKenzie's Outpatient Clinic

Direct 0141-304 4968
Fax 0141-552 6126

Dr Goldie
Easterhouse Health Centre
9 Auchinlea Road
GLASGOW
G34 9QH

JFMacK/AG 964876K

Dict 26 June 1995
Typed 28 June 1995

Dear Dr Goldie

DEBORAH SULLIVAN (7.12.72)
187 COMMONHEAD ROAD, GLASGOW, G34 ODS

I reviewed Deborah in the Gastroenterology Clinic today. She has had some pain but this has been affectively relieved by Buscopan. There is still some constipation, diarrhoea and occasional vomiting but overall she feels better although by no means cured at this stage. She has started Amitriptyline and is able to tolerate this and should continue it at least for another two months. I have a given her a wheat/flour restricted diet sheet which may help reduce colonic loading.

Yours sincerely

J F MACKENZIE
Consultant Physician and Gastroenterologist

GASTROENTEROLOGY

Dr J F MacKenzie's Clinic

Direct 0141 304 4968
Fax 0141 552 3126

Dr Goldie
Easterhouse Health Centre
9 Auchinlea Road
GLASGOW
G34 9QH

JFM/ER 964876K

Dict 15 May 1995
Typed 17 May 1995

Dear Dr Goldie

DEBORAH SULLIVAN 7.12.72
187 COMMONHEAD ROAD GLASGOW G34 0DS

I reviewed Deborah in the Clinic today. She has now discontinued her Codeine compounds. She has had one severe bout of pain resulting in her coming to Casualty and Buscopan was effective in relieving this.

On closer questioning it appears that she is still vomiting, has recurrent nausea, has disturbed sleep, nocturia, lethargy and gets quite depressed. I think these are typical features of irritable bowel syndrome and I think she may well respond to Amitriptyline. I suggest we start her on 25mg at night and increasing to 50mg after two weeks.

I will review her in one month.

Yours sincerely

J F McKENZIE
Consultant Gastroenterologist and Physician

GASTROENTEROLOGY

Dr J F MacKenzie's Outpatient Clinic

Direct 0141-30
Fax 0141-55

Dr Goldie
Easterhouse Health Centre
9 Auchinlea Road
GLASGOW
G34 9HQ

JFM/SM/964876

Dictated: 24.04.95
Typed: 27.04.95

Dear Dr Goldie

Deborah Sullivan (7.12.72)
160 Main Street, Glasgow G69 0DS

I saw Deborah Sullivan today. I think she has opiate bowel syndrome. I see that I have in the past suggested that she stop taking Codeine but has continued with this. She used to take Klean-Prep two litres on day one and two litres on day three and she should use Nefopam for her pain.

Kind regards.

Yours sincerely

J F MACKENZIE
Consultant Gastroenterologist

DEPARTMENT OF UROLOGY

WARD 64

MR ROY SCOTT
CONSULTANT IN ADMINISTRATIVE CHARGE
(EXT 5484)

FAX NO. 041 552 7932

RS/JCT/964876

11 April 1995

Dr J Goldie
Easterhouse Health Centre
9 Auchinlea Road
GLASGOW G34 9QH

Dear Dr Goldie

RE: Deborah Sullivan, 160 Main Street, Glasgow, G69 0DS DOB 7.12.72

This lady has been admitted to the day ward on 4 April 1995 and has had a cystoscopy undertaken. There was a minimal cystitis on cystoscopy. The trigone was typical of that area of the bladder found where the derivation of the bladder, ie. the trigone is from the same lining as the vagina. Her bladder was otherwise normal. A simple urethral dilatation was undertaken. We will review her at the clinic in 3 months' time.

Yours sincerely

R Scott
CONSULTANT UROLOGIST

DEPARTMENT OF SURGERY

Mr C W Imrie's General Surgical Clinic

Dr J Goldie
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9NT

AT/DFM/964876K

Dictated:- 27.3.95
Typed:- 30.3.95

Dear Dr Goldie

Deborah Sullivan (7 12 72)
160 Main Street, Glasgow G69 0DS

Deborah was once again seen at our Clinic today in regards to her intractable nausea and vomiting as well as epigastric abdominal pain which she has had now for several months. As you may recall from our last Discharge the exact aetiology of her problem remains elusive. The patient was admitted to Hospital last week with the same problem but it appears to have been related to a urinary tract infection. She was given antibiotics and it resolved. She is scheduled to be followed by Mr. Paterson for a cystoscopy to rule out any genito-urinary disorder that has been contributing to her recurernt history of urinary tract infections as well. It is evident that she has a very low threshold for inducement of nausea.

Mr. Imrie did obtain a radio-labelled gastric meal study on Deborah earlier this month and it did demonstrate a significant reduction of emptying for both liquid and solid phases. In fact, the emptying for solids was greater than 330 minutes. This is despite the fact that the patient is on Cisapride 10mg. t.i.d. Review of her past work-up does indicate that the likelihood of a duodenal ulcer or peptic disease is not a factor causing the delay of this patient's gastric emptying.

On review of the patient's exam today it is noted that she is essentially asymptomatic. Her abdominal examination is unremarkable.

We are going to increase her Cisapride to 10mg. q.i.d. We are also going to ask that we stop the Merbentyl which we note that she has been taking. We have a feeling that this has had some antagonist effect on the Cisapride. We are going to see her back in our Clinic in four weeks. This will also be after the patient has had her cystoscopy. We will continue to keep you abreast as to the management of this patient's problem.

Yours sincerely

ALLEN TETER
REGISTRAR/SHO

CONSULTANT
Mr C W Imrie

GLASGOW ROYAL INFIRMARY
84 CASTLE STREET, GLASGOW C4

Telephone No. 041-552
Ext.

ADMITTED	DISCHARGED	WARD	AGE	HOSPITAL NUMBER
13.2.95	18.2.95	39	7.12.72	964876

DISPOSAL
Home

NAME AND ADDRESS
Deborah Sullivan
160 Main St
Glasgow G69 0DS

FOLLOW UP
Gastric Clinic

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS.

		I.S.C. CODE
1.	Intractable nausea and vomiting	
2.		
3.		
4.		
5.		
6.		

DISTRIBUTION OF LETTERS

Dr Goldie
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34

OPERATION	CODE
1. Upper GI endoscopy	
2.	
3.	

Discharge diagnosis: Rule out bile reflux gastritis with positive CLO test.

Complications: None.

Hospital course: The patient was admitted and treated with anti-emetics initially to help control the nausea and vomiting. She responded favourably to oral Zofrom as well as to intramuscular Stemetil. Laboratory work-up identified no abnormalities apart from a mild elevation in white blood cell count at 10.1 which was thought to be related to her anxiety and the pain she was experiencing. Her urine was completely normal. During the first few days she continued to have some epigastric abdominal pain which prompted the endoscopy on 17th. During the procedure she was noted to have a fair amount of bile in the stomach and mild antral gastritis. Her CLO test was positive. The patient was started on Losec 20 mg once a day in addition to being given Ciproxin 250 mg twice a day. She was also started on Prepulsid 10 mg three times a day. After 24 hours it was noted the patient was not requiring an anti-emetic medicine and she was not vomiting. Her epigastric abdominal pain was relatively unchanged but at the time of discharge it was felt to be manageable with oral pain medications in addition to continuation of the aforementioned medications. Mr Imrie saw the patient and on reviewing the patient's chart in detail it was concluded that the aetiology to this lady's intractable nausea and vomiting remains elusive. She is being followed up by Dr Russell and will be seen in his clinic later this month. We have decided

FORM H1514 JMcC/941793

Mr C W Imrie

to refer the patient to his clinic for assessment. She should continued th aforementioned medications for at least two weeks. From our viewpoint we do not feel that this patient has a surgical condition but would be glad to follow her up if and when she should need our attention.

A Teter S H O
AT/HD

Dict 20.2.95
Typed 22.2.95

GENERAL PRACTITIONERS NAME and ADDRESS

DEPARTMENT OF UROLOGY

WARD 64

MR ROY SCOTT
CONSULTANT IN ADMINISTRATIVE CHARGE
(EXT 5484)

FAX NO. 041 552 7932

RS/JCT/964876

31 January 1995

Dr Goldie
Easterhouse Health Centre
9 Auchinlea Road
GLASGOW G34 9QH

Dear Dr Goldie

RE: Deborah Sullivan, 160 Main Street, Glasgow, G69 0DS DOB 7.12.72

This lady had a flexible cystoscopy undertaken on 27 January 1995. Her bladder and ureteric orifices appeared to be quite normal. We will see her back at the clinic in 2 months' time.

Yours sincerely

R Scott
CONSULTANT UROLOGIST

CONSULTANT

Mr Scott

GLASGOW ROYAL INFIRMARY

84 CASTLE STREET, GLASGOW C4

Telephone No. 041-552 3535 Ext.

5484

ADMITTED	DISCHARGED	WARD	AGE	HOSPITAL NUMBER
2.12.94	7.12.94	39	7.12.72	964876

DISPOSAL

HOME

FOLLOW UP

UDOP

NAME AND ADDRESS

Deborah Sullivan
160 Main Street
GLASGOW
G69 0DS

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS	ISC CODE
1. RIGHT SIDED ABDOMINAL PAIN	
2.	
3.	
4.	
5.	
6.	

DISTRIBUTION OF LETTERS

Dr Goldie
Easterhouse Health Centre
9 Auchinlea Road
GLASGOW G34 9QH

OPERATION	CODE
1 OBSERVATION	
2	
3	

This lady was admitted to the ward with right sided abdominal pain. An intravenous pyelogram was essentially normal. The pain seemed to settle. The patient was obviously constipated. We will see her back at the clinic in approximately one month's time.

Yours sincerely

R Scott
CONSULTANT UROLOGIST

RS/JCT

4 January 1995

FORM H1514 JMcC/941793

MR ISKANDER - DAY SURGERY CLINIC

KH/ER/ 964876K

17 November 1994

Ms D Sullivan
187 Commonhead Road
GLASGOW
G34 0DS

Dear Ms Sullivan

You have been referred to attend the Day Surgery Assessment Clinic. At this visit on Tuesday 6 December you will be seen by the surgeon and liaison nursing staff who will assess your suitability for surgery as a day case. Should this be the case you will be given a date for surgery at this time.

I would be very grateful if you could inform us if this date is unsuitable. Please telephone or write to Mrs Grierson, Day Surgery Secretary, any week day on 041-304-4873 so that we can change this accordingly.

Yours sincerely

KAREN HATTIE
Liaison Day Sister
Day Surgery Dept.

Enc.

DEPARTMENT OF SURGERY

MR C W IMRIE'S CLINIC

Dr Goldie
Easterhouse Health Centre
9 Auchinlea Road
GLASGOW
G34 0DS

CWI/KMcL/964876

dictated: 4 July 1994
typed: 13 July 1994

Dear Dr Goldie

DEBORAH SULLIVAN DOB 7 12 72
187 COMMONHEAD ROAD, GLASGOW G34 ODS

I reviewed this young lady at my clinic on 4.7.94 following a normal ERCP at the request of the Gastroenterologist. It now appears that checking out her history, she probably has an epigastric hernia and on close examination there is a distinct divarication of the recti-muscles immediately after the umbilicus. This requires surgical remedy and I will make the necessary arrangements to carry this out.

Yours sincerely

C W Imrie
Consultant Surgeon

JNSULTANT
MR C W IMRIE

GLASGOW ROYAL INFIRMARY
84 CASTLE STREET, GLASGOW C4

Telephone No. 041-552 3600
Ext.

ADMITTED	DISCHARGED	WARD	AGE	HOSPITAL NUMBER
06/06/94	06/06/94	35	07/12/72	964876

DISPOSAL

Home

FOLLOW UP

Gastroenterology Clinic

NAME AND ADDRESS

Deborah Sullivan
187 Commonhead Road
GLASGOW
G34 0DS

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS	I.S.C. CODE
1. UNEXPLAINED ABDOMINAL PAIN	
2.	
3.	
5.	
6.	

DISTRIBUTION OF LETTERS

Dr Goldie
Easterhouse Health Centre
9 Auchinlea Road
GLASGOW
G34 9HQ

cc Coding Section, MRD

OPERATION	CODE
1. ERCP	
2.	
3.	

SB/GB

29 June 1994

This young lady was referred from the Gastroenterology Department for an ERCP to rule out sphincter of Oddi dysfunction as a cause of her continuing epigastric pain. She underwent an ERCP on the 06/06/94 which revealed a normal biliary and pancreatic ductal system with no evidence of any abnormality at all. There was no evidence to suggest sphincter of Oddi dysfunction and the patient was discharged home that evening and will be followed up by the Gastroenterology Department.

S BHASKAR
SURGICAL REGISTRAR

cc Dr Russell, Consultant Gastroenterologist, Third Floor, QEB, G.R.I.

Date dictated 29/06/94
Date typed 29/06/94

FORM H1514 JMcC/941793

CWI/hd
6 June 1994

Dr Nakshabendi
Registrar
Wards 8 and 9
Royal Infirmary
Glasgow

Dear Dr Nakshabendi

DEBORAH SULLIVAN 7.12.72
HOSPITAL NO 964876

This young patient was referred for an ERCP on the basis that she might well have sphincter of Oddi dysfunction to explain recurrent episodes of right sided upper abdominal pain in the absence of any abnormality detected on routine endoscopy, ultrasound and barium studies.

A copy of the endoscopic report is enclosed and arrangements will be made for the patient to be reviewed at Dr Russell's clinic in the near future.

Yours sincerely

C W Imrie
Consultant Surgeon

c.c. Dr R Russell, Consultant Gastroenterologist, GRI

CWI/HD
16 February 1994

Dr I Nakshabendi
Clinical Research Fellow
Gastroenterology Unit
Royal Infirmary
Glasgow

Dear Dr Nakshabendi

DEBORAH SULLIVAN 7.12.72 187 COMMONHEAD ROAD GLASGOW G34 0DS

Thank you for your letter of 7th February 1994 regarding this patient. It would seem reasonable that an ERCP be carried out and the lady will be contacted in due course for this examination.

Kind regards
Yours sincerely

C W Imrie
Consultant Surgeon

DNA for admission for ERCP
On 18-4-94

H.D.
(Sec.)

MR C W IMRIE

CWI/HD
16 February 1994

Miss Deborah Sullivan
187 Commonhead Road
Glasgow
G34 0DS

Dear Miss Sullivan

You have been referred by Dr Nakshabendi from Dr Russell's Gastroenterology Clinic for an ERCP procedure. This is carried out on a 24 hour admission basis and under intravenous sedation in the X-ray Department.

An endoscope is passed from your mouth down to where the bile duct opens in order to put a tiny plastic tube in the nipple-like structure there and then outline with a contrast which shows up on x-ray both the biliary duct and the pancreatic duct system.

It will probably be several weeks before you are called for this examination.

Yours sincerely

C W Imrie
Consultant Surgeon

Consultant in Charge
R. I. RUSSELL

Consultant
J. F. MacKENZIE

Senior Biochemist
A. DUNCAN

ROYAL INFIRMARY
GLASGOW
G4 0SF
Telephone 041-552 3535

Gastroenterology Unit

DR R I RUSSELL'S GASTROENTEROLOGY CLINIC

Mr C W Imrie
Consultant Surgeon
Ward 35
Royal Infirmary
GLASGOW

IN/MMS/964876K

Dict: 18 January 1994
Typed: 7 February 1994

Dear Mr Imrie

Deborah Sullivan, 7 12 72
187 Commonhead Road, Glasgow, G34 ODS

I would be most grateful if you would review this lady who is complaining of epigastric pain and who has had several endoscopies which were normal, abdominal ultrasound, barium meal and follow through. The working diagnosis is that of irritable bowel syndrome. I would be grateful if you would exclude any possibility of sphincter of Oddi dysfunction and I wonder whether ERCP would be appropriate in her case. I have started her on Merbentyl just now. Currently she is on Omeprazole, Prepulsid, Dihydrocodeine, Buccastem and Metoclopramide. She will be reviewed in Dr Russell's Clinic in due course.

Yours sincerely

I NAKSHABENDI
Clinical Research Fellow

DR R I RUSSELL'S GASTROENTEROLOGY CLINIC

Mr C W Imrie
Consultant Surgeon
Ward 35
Royal Infirmary
GLASGOW

IN/MMS/964876K

Dict: 18 January 1994
Typed: 7 February 1994

Dear Mr Imrie

Deborah Sullivan, 7 12 72
187 Commonhead Road, Glasgow, G34 ODS

I would be most grateful if you would review this lady who is complaining of epigastric pain and who has had several endoscopies which were normal, abdominal ultrasound, barium meal and follow through. The working diagnosis is that of irritable bowel syndrome. I would be grateful if you would exclude any possibility of sphincter of Oddi dysfunction and I wonder whether ERCP would be appropriate in her case. I have started her on Merbentyl just now. Currently she is on Omeprazole, Prepulsid, Dihydrocodeine, Buccastem and Metoclopramide. She will be reviewed in Dr Russell's Clinic in due course.

Yours sincerely

I NAKSHABENDI
Clinical Research Fellow

NO 45

DR R I RUSSELL'S GASTROENTEROLOGY CLINIC

Dr Goldie
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

IN/MMS/964876K

Dict: 18 January 1994
Typed: 7 February 1994

Dear Dr Goldie

Deborah Sullivan, 7 12 72
187 Commonhead Road, Glasgow, G34 ODS

I reviewed this lady with a history of epigastric pain radiating to the back in the clinic today. Her symptoms persisted in spite of her medications which consist of Omeprazole 20 mgs a day, Dihydrocodeine on a prn basis, Buccastem, Metoclopramide and Prepulsid 10 mgs four times a day. She has lost about 2 kilograms in weight since we saw her last in December. Her barium meal and follow through were normal. Upper GI endoscopy was negative and the CLO test was negative as well. It sounds like this lady is suffering from irritable bowel syndrome. However, in view of the persistence of the epigastric pain and radiation to the back I am referring her to Mr Imrie to exclude any possibility of sphincter of Oddi dysfunction. I would be most grateful if you would start her on Merbentyl Hydrochloride 10 mgs three times a day as per my handwritten note.

Yours sincerely

I NAKSHABENDI
Clinical Research Fellow

Dr Collins
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34

RIR/RS/964876

Dictated 31/1/94
Typed 12/2/94

Dr Collins,

Deborah Sullivan (7/12/72)
187 Commonhead Road, Glasgow, G34

This patient had an appointment to attend my Clinic on 31st January, but failed to attend. No further appointment has been sent.

Yours sincerely

R I RUSSELL

Hospital use Only	Clinic	Day Date	Time	Hospital No. 964876	GP112

REQUEST FOR OUT-PATIENT CONSULTATION
THE INFORMATION IN THIS SECTION MUST BE COMPLETED

Appointment Category: Routine ☐ Soon ☐ Urgent ☐

Hospital G.R.I. Date 9.7.93 CHI No. 6 1 2 8 _ _ _ _ _ _

Please arrange for this patient to attend the G/Enterology clinic of Dr/Mr

PARTICULARS OF PATIENT IN BLOCK LETTERS PLEASE

Patient's Surname SULLIVAN Maiden Surname

First Names DEBORAH E. Single/Married/Widowed/Other

Address 187 Commonhead Street, Road Date of Birth 7.12.72

Glasgow G34 0DS Patient's Occupation

Postal Code Contact telephone number

Has the patient attended hospital before? YES/NO If "YES" please state:

Name of Hospital

Year of Attendance Hospital No. 964876

If the patient's name and/or address has/have changed since then please give details:

Can patient attend at short notice? YES/NO

If YES, minimum notice required days

Name, Address and Telephone number of MEDICAL/DENTAL PRACTITIONER

Dr.F.Collins

Please use rubber stamp

DR RUSSELL / ~~MCKENZIE~~
GASTRIC
CLINIC 5

31/1/94

40451

I would be grateful for your opinion and advice on the above named patient. A brief outline of history, symptoms and signs is given below:

Thank you for seeing this young woman who for several years has complained of symptoms suggestive of acid reflux.
No abnormality was seen on barium meal examination and her symptoms were initially helped by H2 Antagonist.
More recently she has been taking Omeprazole 20mgs daily.
In addition she has recurrent episodes of acute tonsillitis and is at present awaiting tonsillectomy.
She was admitted to Surgical Unit of G.R.I. in January of this year with abdominal pain. This was thought to be due to mesenteric-adenitis and she was due to be reviewed at the Clinic, however she did not receive a follow up appointment.

Yours sincerely,

Dr.F.Collins

FC/KM

Diagnosis/provisional diagnosis:

Present drug treatment and potential special hazards:

X-ray (women of childbearing age). Date of first day of L.M.P.

Relevant X-rays available from: No. (if known)

Signature

355-2104

Dd8435631 3/93 15M 13161

DR GOLDIE

AMCL/CM

EASTERHOUSE HEALTH CENTRE
9 AUCHINLEA ROAD
GLASGOW
G34

29/10/93

Dear Dr Goldie

MISS DEBORAH SULLIVAN 07/12/72 Unit No. 964876
187 COMMONHEAD ROAD GLASGOW G34 0DS

I see that this young woman still has ongoing recurrent episodes of epigastric pain. She has no other GI symptoms and to date the only abnormality on examination has been a vague epigastric tenderness and her symptoms are most active. She remains well and has not lost weight. Investigations including an abdominal ultrasound and 2 diagnostic endoscopies have been entirely normal. This girl is complaining bitterly of symptoms. Both she and her mother are very anxious. I reassured them both that there has been no evidence on thorough investigations of a serious intra abdominal pathology.

Meantime after discussion with Mr Anderson we felt it best that we do not simply dismiss Deborah's symptoms out of hand and have asked Dr Russell, Consultant Gastroenterologist to review Deborah for us.

Yours sincerely

Andrew McLean
SHO

)r GOLDIE
) Auchinlea Road
Glasgow

)ear Dr GOLDIE

Regarding your patient: SULLIVAN DEBORAH D.O.B.: 7.12.72 Hosp No: 964876
187 Commonhead Road
GLASGOW
G34 0DS

Your patient was admitted under the care of Professor C. S. McArdle on 5-Oct-1993 and was discharged home on 7-Oct-1993.

)ur diagnosis was as follows:- Epigastric pain
Dyspepsia

Patient to have upper GI endoscopy under Mr Anderson's care.

Yours sincerely

Professor C. S. McArdle
Consultant Surgeon

A. Lannigan
S.H.O.

964876K

SULLIVAN F/S
DEBORAH 07/12/1972 I/P
197 COMMONHEAD ROAD
GLASGOW
041 888

Fundholder Y/N Goldie 46451
Booking date
Consultant firm: McArdle
New Case Y/N Day Case Y/N
Contract no:
Reason for admission: dyspepsia epigastric pain
Routine / Soon / Urgent / Planned / Pending
Available at short notice? Y/N
Phone: Home/Day

Postal
Telephone no:
Home telephone no:
Not Private No:
Additional Information:
Entered by:
Date
Special patient code:

ADMISSION DATE 5.10.93

ADMISSION SOURCE
CFD ref: Routine / Soon / Urgent
A & E self referral
A & E GP referral
GP referral
In-patient referral
Domiciliary visit
Planned
Other hospital

CLINICAL INFORMATION DIAGNOSES (incl relevant History)
(Note side: irrel / L / R / Bil / Mid / Ant / Post / Unspec)
Main:
2
3
4
5
Diagnosis pending? Y/N Date
Reason:

OPERATIONS (Note side: irrel / L / R / Bil / Mid / Ant / Post / Unspec) DATE

Performed by: SURG1	S	SURG 2	ANAE	ASA	URG.

Main: Side:
Comment:
Side:
Side:
Side:
Comment:
Prophylactic Antibiotics:
DVT Prophylaxis:
POSTOPERATIVE COMPLICATIONS: Present / None (see reverse of card)
POINTS FOR REVIEW: Delay / Diagnosis / Management / Complications / Death
Comments:

S = supervised Y / N
ASA code 1—6, none
Urgency: 1 hr / 24hrs / 1—3 wk / elective

DISCHARGE DETAILS

DISCHARGE DATE 7.10.93
DISCHARGE METHOD
- [x] Home
- [ ] Relative / Friend
- [ ] Convalescent home
- [ ] Long term / Terminal care
- [ ] Transfer as in-patient
- [ ] Transfer to other hospital
- [ ] Self discharge
- [ ] Died cause

Drugs on discharge | Dose | Frequency

INFORMATION TO:
Patient: "as diag". Other:
Relative / Friend: "as diag". Other:
Who: Husband / Wife / Son / Daughter / Parents / Mother / Other:
Follow-up: None / 1 wk / 10 days / 2, 4, 6 wks / 2 mnths / Other:

SPECIAL ANALYSIS CODES 1 2 3 4 5 6 7 8 9 10
Special follow up: Y / N Date due
Reason:
Additional Information:
Mr Anderson → Upper GI Endoscopy

Entered by:

(A) Soon

DR Russell

DR GOLDIE

AMCL/CM

EASTERHOUSE HEALTH CENTRE
9 AUCHINLEA ROAD
GLASGOW
G34

29/10/93

Dear Dr Goldie

MISS DEBORAH SULLIVAN 07/12/72 Unit No. 964876
187 COMMONHEAD ROAD GLASGOW G34 0DS

I see that this young woman still has ongoing recurrent episodes of epigastric pain. She has no other GI symptoms and to date the only abnormality on examination has been a vague epigastric tenderness and her symptoms are most active. She remains well and has not lost weight. Investigations including an abdominal ultrasound and 2 diagnostic endoscopies have been entirely normal. This girl is complaining bitterly of symptoms. Both she and her mother are very anxious. I reassured them both that there has been no evidence on thorough investigations of a serious intra abdominal pathology.

Meantime after discussion with Mr Anderson we felt it best that we do not simply dismiss Deborah's symptoms out of hand and have asked Dr Russell, Consultant Gastroenterologist to review Deborah for us.

Yours sincerely

Andrew McLean
SHO

GLASGOW ROYAL INFIRMARY - Department of Surgery

OPERATION RECORD

NAME MISS DEBORAH SULLIVAN | UNIT NO. 964876 | DOB 07/12/72

CONSULTANT Mr J R Anderson | UNIT 60 | DATE 19/10/93

SURGEON Andrew McLean | ASSISTANT Mr J R Anderson C
ANAESTHETIST | ANAESTHETIC Sedation
URGENCY Routine

PRINCIPAL DIAGNOSIS
STOMACH
Normal
LSA 0314400000

PRINCIPAL OPERATION
Diagnostic endoscopy

OPERATIVE FINDINGS AND TECHNIQUES

SEDATION	Midazolam 6mg IV
INSTRUMENT	Pentax FG29X
OESOPHAGUS	Normal
G O JUNCTION	39cm
STOMACH	Normal
PYLORUS	Normal
DUODENUM	First part - normal. Second part - normal.

SUMMARY Normal endoscopy. This lass has recently had an ultrasound examination which is normal. I am unsure of the cause of her pain: She will be seen for review at the clinic in 6 week's time.

c: Goldie
Easterhouse Health Centre
9 Auchinlea Road
Glasgow, G34

GLASGOW ROYAL INFIRMARY - Department of Surgery

To: DR GOLDIE
EASTERHOUSE HEALTH CENTRE
9 AUCHINLEA ROAD
GLASGOW
G34

Admission date: 19/10/93

Discharge date: 19/10/93

Consultant: Mr J R Anderson

Ward: 60

Surname: SULLIVAN Forenames: DEBORAH Number: 964876
D.O.B.: 07/12/72

Address: 187 COMMONHEAD ROAD
GLASGOW
G34 0DS

STOMACH
Normal
LSA 0314400000

Diagnostic endoscopy
Date of operation 19/10/93

No Complications

Normal endoscopy.

Follow up interval: 6 weeks.

John Anderson

Mr J R Anderson
Consultant Surgeon

GLASGOW ROYAL INFIRMARY - Department of Surgery

OPERATION RECORD

NAME MISS DEBORAH SULLIVAN UNIT NO. 964876 DOB 07/12/72

CONSULTANT Mr J R Anderson UNIT 60 DATE 19/10/98

SURGEON Andrew McLean ASSISTANT Mr J R Anderson C
ANAESTHETIST ANAESTHETIC Sedation
URGENCY Routine

PRINCIPAL DIAGNOSIS
STOMACH
Normal
LSA 0314400000

PRINCIPAL OPERATION
Diagnostic endoscopy

OPERATIVE FINDINGS AND TECHNIQUES

SEDATION Midazolam 6mg IV

INSTRUMENT Pentax FG29X

OESOPHAGUS Normal

G O JUNCTION 39cm

STOMACH Normal

PYLORUS Normal

DUODENUM First part - normal. Second part - normal.

SUMMARY Normal endoscopy. This lass has recently had an ultrasound examination which is normal. I am unsure of the cause of her pain. She will be seen for review at the clinic in 6 week's time.

c: Dr Goldie
Easterhouse Health Centre
9 Auchinlea Road
Glasgow, G34

John Anderson

GLASGOW ROYAL INFIRMARY - Department of Surgery

To: DR GOLDIE
EASTERHOUSE HEALTH CENTRE
9 AUCHINLEA ROAD
GLASGOW
G34

Admission date: 13/09/93
Discharge date: 16/09/93
Consultant: Mr J R Anderson
Ward: 39

Surname: SULLIVAN Forenames: DEBORAH Number: 964876
D.O.B.: 07/12/72

Address: 187 COMMONHEAD ROAD
GLASGOW
G34 0DS

STOMACH
dyspepsia
LSA 0305990000

No operation

No Complications

RUQ abdominal pain.
USS - negative
For OP endoscopy

Follow up interval: 2 weeks.

John Anderson

Mr J R Anderson
Consultant Surgeon

Dr Goldie
Easterhouse Health Centre
9 Auchinlea Road
Glasgow

ES/CMCD/964876

4 August 1993

Dear Dr Goldie

Deborah Sullivan 07.12.1972
187 Commonhead Road G34 ODS

This patient was reviewed today at the clinic following her secondary haemorrhage. Both tonsil fossae appear to have healed completely. She has had no further trouble in the past week. She has been discharged.

Yours sincerely

ELEANOR STEWART
SENIOR REGISTRAR

GARTNAVEL GENERAL HOSPITAL
1053 Great Western Road
GLASGOW G12 0YN
GREATER GLASGOW HEALTH BOARD

ADMISSION No.

MISS J A WILSON
CONSULTANT IN CHARGE

PATIENT: Deborah SULLIVAN
ADDRESS: 187 Commonhead Road, GLASGOW G34 0DS
AGE: 20
DATE OF BIRTH: 07.12.1972
HOSP. No. 964876 GRI, 945953 WIG

ADMITTED: 14.07.93
DISCHARGED: 17.07.93

DIAGNOSIS 1st: TONSILLITIS (Code 474.0)
OPERATION 1st: TONSILLECTOMY. (Code F341)

DIAGNOSIS 2nd:
OPERATION 2nd:

DIAGNOSIS 3rd:
OPERATION 3rd:

DIAGNOSIS 4th:
OPERATION 4th:

ES/MWS

CASE SUMMARY

Dr J Goldie
Easterhouse Health Centre
9 Auchinlea Road
GLASGOW
G34 9HQ

Dear Dr Goldie

This patient was admitted to the ENT Unit at Gartnavel General Hospital as noted above and underwent uneventful tonsillectomy on 14.7.93. She will be followed up at G.R.I. as arranged.

Yours sincerely

E STEWART
Senior ENT Registrar

Dr F Collins
Easterhouse Health Centre
9 Auchinlea Road
Glasgow

JW/CMCD/964876

17 May 1993

Dear Dr Collins

Deborah Sullivan 07.12.1972
187 Commonhead Road G34 ODS

Thank you for referring this pleasant young girl. Certainly the severity and frequency of her tonsillitis warrants tonsillectomy and her name has been placed on the waiting list for this procedure to be carried out. She can be admitted on the day of operation as her general health is overall quite good.

I am somewhat concerned however, that her reflux symptoms are such that she requires to be on frequent courses of Omeprazole. I wondered if she might have something like a Barrett's oesophagus which may not show very clearly on a barium swallow but have not taken the liberty of arranging for specialist referral at this time. I will leave this to your own discretion.

Kind regards.

Yours sincerely

JANET A WILSON MD FRCS
CONSULTANT ENT SURGEON

Hospital use Only | Clinic Eyenook N | Day Date | Time | Hospital No. 964876 | 65 01/14

REQUEST FOR OUT-PATIENT CONSULTATION
THE INFORMATION IN THIS SECTION MUST BE COMPLETED

Appointment Category: Routine ☐ Soon ☐ Urgent ☐

Hospital G.R.I. Date 14.4.93 CHI No. 6 1 2 8

Please arrange for this patient to attend the E.N.T. CLINIC clinic of Dr/Mr

PARTICULARS OF PATIENT IN BLOCK LETTERS PLEASE

Patient's Surname SULLIVAN Maiden Surname

First Names DEBORAH Single/Married/Widowed/Other

Address 187 COMMONHEAD ROAD Date of Birth 7.12.72

GLASGOW Patient's Occupation

Postal Code G34 0DS Contact telephone number 771 3743

Has the patient attended hospital before? YES/NO If "YES" please state:

Name of Hospital G.R.I.

Year of Attendance Hospital No. 964876K

If the patient's name and/or address has/have changed since then please give details:

Can patient attend at short notice? YES/NO

If YES, minimum notice required days

Name, Address and Telephone number of MEDICAL/DENTAL PRACTITIONER

DR F COLLINS

Easterhouse [illegible]
9 AUCHINLEE
GLASGOW
G34
Please use rubber stamp

MISS JANET WILSON
E.N.T. DEPT.

Mon 17/5/93 @ 10.30

I would be grateful for your opinion and advice on the above named patient. A brief outline of history, symptoms and signs is given below:

Dear Doctor

Thank you for seeing this patient who has a history of recurrent sore throats with cervical lymphadenopathy. She has had three episodes already this year and I would appreciate your opinion regarding tonsillectomy.

Yours sincerely

DR F COLLINS
FC/AS

Diagnosis/provisional diagnosis:

Present drug treatment and potential special hazards:

X-ray (women of childbearing age). Date of first day of L.M.P.

Relevant X-rays available from: No. (if known)

Signature

365-2104

Dr Goldie
Easterhouse Health Centre
9 Auchinlea Road
GLASGOW

18-JAN-93

Dear Dr Goldie

Regarding your patient:

SULLIVAN Deborah D.O.B.: 07-DEC-72 No: 964876
187 Commonhead Road
Glasgow
G34

Your patient was admitted under the care of Prof. C.S. McArdle
06th January 1993 and was discharged home on 09th January 1993.

Our diagnosis was as follows:
Abdominal pain [D]

A full explanation was given.

Follow up is planned for 4 week(s)

Yours sincerely

Prof. C.S. McArdle
Consultant

Miss J Doughty
Registrar

Dr J A Riddell
Easterhouse Health Centre
9 Auchinlea Road
GLASGOW G34

HWG/SC/964876K

18th May, 1989

Dear Dr Riddell

re: Deborah Sullivan 187 Commonhead Road Glasgow G34
DOB 7 12272

Thank you for referring this patient to us. The main problem of course is tiredness and lack of energy for four or five months. Most of the other complaints were forgotten and her mother kept prompting her about them. She is in the middle of her highers at present and appears to be working hard. I believe she has lost ten pounds in the last month by being at weight watchers and has been on the contraceptive pill for a year to regulate her periods. You have checked full blood count, ESR, thyroid function tests and chest x-ray and they were all normal.

Clinically she was fit, euthyroid with no thyroid tissue palpable or glands. Pulse was 80 regular, B.P. 110/88. the remainder of the physical examination including fundi was totally normal. During the interview her mother kept saying how anxious she was about her child and it is clear that the mother is much more anxious about the problem than the young girl herself. I suspect that this is a stress related phenomenon or related to the pill. When her highers stop in about two weeks time it should be clear which is the problem.

I have not arranged to review her again.

Yours sincerely

H Gray
Consultant Physician

PAMH

Hospital use Only	Clinic	Day Date	Time	Hospital No.

REQUEST FOR OUT-PATIENT CONSULTATION

Urgent Appo Required

Hospital Glasgow Royal Infmy Date 24.4.89

Please arrange for this patient to attend the Medical Clinic clinic of Dr/Mr .....

PARTICULARS OF PATIENT IN BLOCK LETTERS PLEASE

Patient's Surname SULLIVAN
First Names Deborah
Address 187 Commonhead Road
Glasgow
G33 G34 0DS
Postal Code ..... Telephone Number .....

Maiden Surname .....
Single/Married/Widowed/Other
Date of Birth 7 12 72
Patient's Occupation .....

Has the patient attended hospital before YES/NO if "YES" please state:
Name of Hospital .....
Year of Attendance ..... Hospital No .....
If the patient's name and/or address has/have changed since then please give details:

UNIVERSITY DEPT OF MEDICINE
MEDICAL CLINIC

18/5/89 Thurs. 2.15

Name, Address and Telephone Number of MEDICAL/DENTAL PRACTITIONER

Dr J A Riddell
Easterhouse Health Centre
9 Auchinlea Road
Glasgow G34 9QH
Tel. 041-771 0781

Please use rubber stamp

I would be grateful for your opinion and advice on the above named patient. A brief outline of history, symptoms and signs is given below:

I would appreciate your advice regarding this girl who is causing her mother considerable anxiety.

She gives a history of nausea, occasional vomiting, a feeling of being hot and sweating, with night sweats. She has a slight cough and complains of pains in her legs.

Physical examination reveals nil of note apart from minimal anterior cervical glands.

There is no evidence of any generalised lymphadenopathy and spleen etc., is not palpable.

A chest x-ray is reported as normal, full blood count and ESR normal, thyroid function tests normal.

I reached the conclusion that she was primarily suffering from a minor stress related problem associated with sitting her Highers.

Her mother continues to be very worried regarding her general condition and in these cirucmstances I have sought your further advice.

Diagnosis/provisional diagnosis: .....

JAR/HMMT

Present drug treatment and potential special hazards: .....

X-ray (women of childbearing age). Date of first day of L.M.P. .....

Relevant X-rays available from: ..... No. (If known) .....

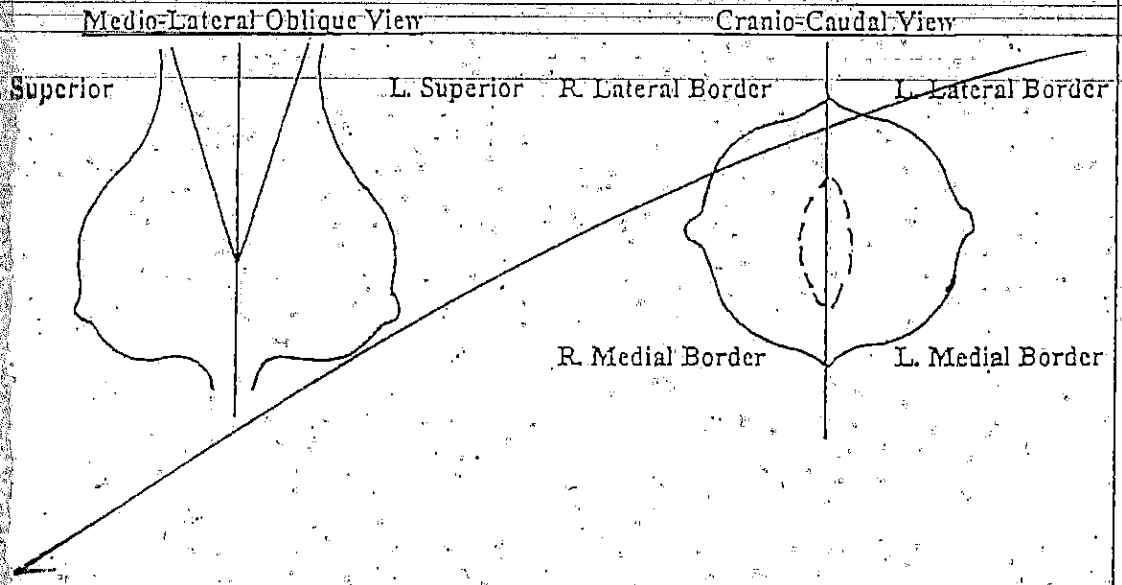
Signature J Alex Riddell

MAMMOGRAM/BREAST ULTRASOUND EXAMINATIONS

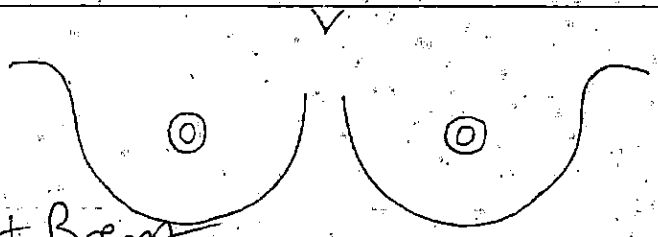
PATIENT DETAILS: Deborah Sullivan 1205416501
(Please attach label) 7/12/72

DATE OF EXAMINATION(S): 11/7/12

PROVISIONAL MAMMOGRAM REPORT



PROVISIONAL BREAST ULTRASOUND REPORT



US Right Breast

Nonel appearines lower right breast.
No inspicous feates
Right UI.

Breast Patients Form

NHS Greater Glasgow and Clyde

Patient: [redacted]
1001047UK F
SULLIVAN 07/12/1972
DEBORAH
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI: 0712728120

GP:

Referred By:

Symptoms:

1. Lump — Tender
2. Pain
3. Discharge
   - Type
   - Site

Site:

1. Right
2. Both
3. Left

4. Other (Specify)
Duration: 5/6 weeks

Age: 34
LMP:

Risk Factors:

Previous History
Family history: Paternal Aunt 30ca b. Sister 45
Age at Menarche: 15
Age at Menopause
Age at first Pregnancy: 27

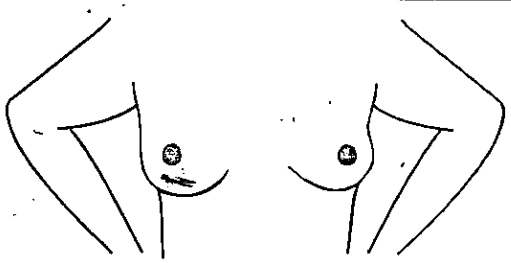
Parity: 1
Breast feed ✓
Use of OCP or HRT: mini pill.
0 None
1 Current
2 Previous

Medical History:

Appendicectomy, Cholecystectomy Tonsillectomy Hernia x 2.

Examination: ridge of lumpy tissue

If lump present specify: Clinical size . cms x . cm
1. Multiple lumps
2. Nipple retraction
3. Deep fixation
4. Skin fixation/ ulceration



Clinical Impression:

1. Benign
2. Unsure
3. Malignant

Investigation Requested:

0 None
1 Mammography
2 Ultrasound
3 MRI
4 FNA
5 Core Biopsy
6 Nipple Smear

Results:

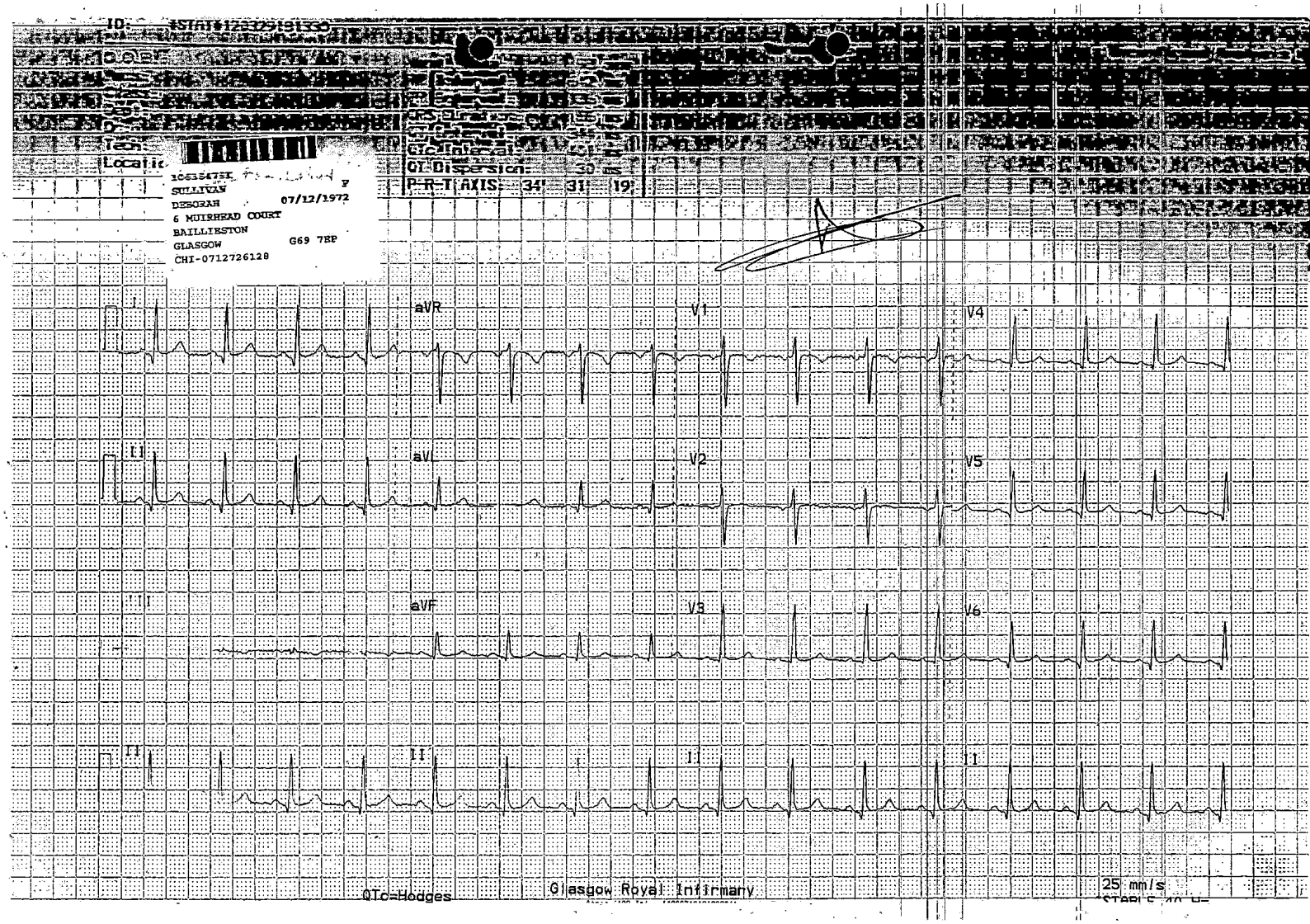
FNA:
Core Biopsy:
Mammograms:
Ultrasound:

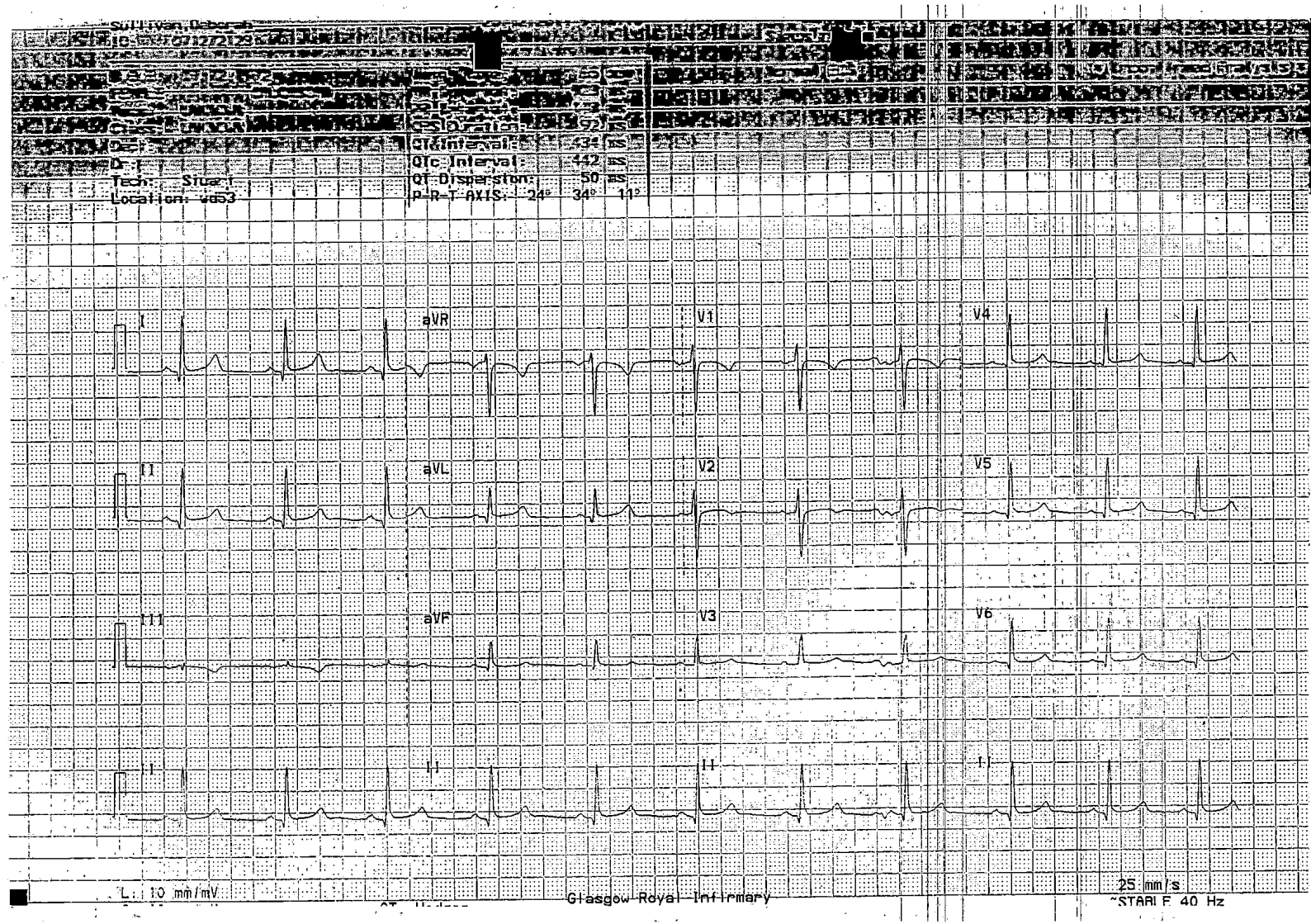
C_1 C_2 C_3 C_4 C_5
Benign/DCIS Invasive Cancer
R_1 R_2 R_3 R_4 R_5

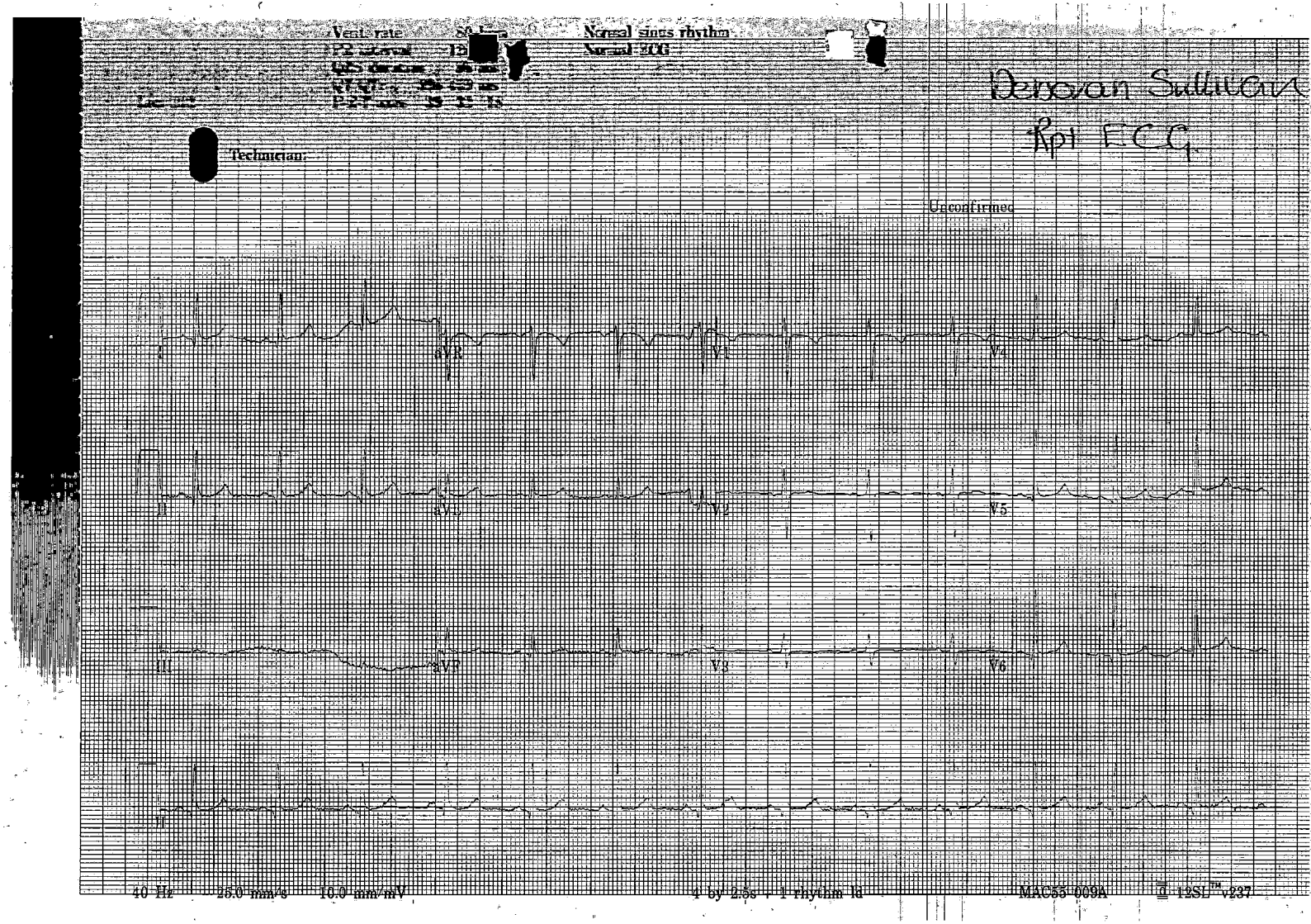
Diagnosis:
Clinician: M Mayle

Outcome:
1. Discharged
2. Review in Months
3. Operation
4. Drug treatment

Date: 11/7/12


ID:
Test:
Locatic
1066547SE
SULLIVAN
DEBORAH
07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW
G69 7EP
CHI-0712726128
QT Dispersion: 30 ms
P-R-T AXIS 34 31 19
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
II
II
II
II
QTc=Hodges
Glasgow Royal Infirmary
25 mm/s


Sullivan, Deborah
ID: 07127129
Tech: Stuart
Location: wd53
QTc Interval: 442 ms
QT Dispersion: 50 ms
P-R-T AXIS: 24° 34° 11°
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
II
II
II
II
10 mm/mV
Glasgow Royal Infirmary
25 mm/s
STABLE 40 Hz



Derrian Sullivan

Rpt ECG

GLASGOW ROYAL INFIRMARY
MEDICAL RECIEVING UNIT

Patient Details
Deborah Sullivan.

Care plan

Date Comm.	Signature	1. Basic care and personal hygiene	Date Disc	Signature
	KC	Independent		
		Bed bath		
		Assisted wash		
		Oral hygiene		
		Pressure care		
		Waterlow if > 15 assess daily		
		2. Mobility		
	KC	Fully independent /-Fully mobile		
		Minimal assistance (give details)		
		Bed rest		
		Dependent (see movement and handling care plan)		
		3.Elimination		
		Independent		
	KC	Commode		
		Urinal/ bed pan		
		Urinary catheter size mls water in balloon		
		Stoma		
		4. Nutrition		
	KC	Normal diet		
		Special diet / modified diet		
		Fasting		
		5. Observations		
	KC	Blood pressure		
	KC	pulse		
	KC	Temperature		
	KC	Respiration		
		FOB'S		
		Daily weights		
		BM's		
	KC	Fluid balance		
		6.Technical care		
		IV infusion		
		Monitor		
		Oxygen therapy state percentage:		
		Nebuilsers		
		IV access: YES		
	KC	Venflon site: (R) arm		
		Date inserted: 20/12/11		
		Venflon colour: PINK.		
		Others:		
		7. Specimens / investigations		
Signature of nurse KC			Date: 20/12/11	

ID: #STAT#101112155013

ID: #STAT#101112155013

Vent. Rate:	96 bpm
RR Interval:	620 ms
PR Interval:	136 ms
QRS Duration:	88 ms
QT Interval:	358 ms
QTc Interval:	421 ms
QT Dispersion:	56 ms
P-R-T AXIS:	57° 50° 31°

Normal ECG

106384751
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

I aVR V1 V4

II aVL V2 V5

III aVF V3 V6

II II II II

L: 10 mm/mV

GLASGOW ROYAL INFIRMARY

25 mm/s

North Glasgow Biochemistry & Immunology ** LIVE **
Patient enquiry ---- Express results

Reg	Name	D.o.B.	Sex	Loc.
10638479K	SULLIVAN DEBORAH	07.12.72	F	ROYAL 65

Specimen N,10.3531868.C Type Specimen
Collected 28.05.10 16:29 A.Diag

.....U&E.....		T Prot	68		
Sodium	139	Alb	35	.....Mg.....	
Potassium	4.2	Globulin	33	Mg++	0.91
Chloride	106	.....Bone.....		.....Amylase.....	
Urea	3.8	A Phos	73	Amylase	66
Creat	55	T Prot	68		
eGFR	>60	Alb	35		
.....LFTs.....		Globulin	33		
Bili	7	Calcium	2.41		
AST	18	Ad Cal	2.55		
ALT	21	Phos	1.36		
G-GT	+ 47	.....CRP.....			
A Phos	73	CRP	1.9		

Quit \ Earlier req \ Later req \ ED \ LD
B--k \ PHoned comment <B> ..

Glasgow Royal Haematology ** LIVE **
Patient enquiry ---- Express results

Reg	Name	D.o.B.	Sex	Loc.
10638479K	SULLIVAN DEBORAH	07.12.72	F	R65

Specimen R,10.5195513.F Type Blood
Collected 28.05.10 16:29 A.Diag

.....FBC.....

WBC	8.0
Hb	118
Hct	0.353
MCV	86.9
Plts	252
NEUT	4.9
LYMPH	2.7
MONO	0.4
EOS	0.01
BASO	0.01

Quit \ Earlier req \ Later req \ ED \ LD
B \ PHoned comment <B> ..

Glasgow Royal Haematology ** LIVE **
Patient enquiry ---- Express results

Reg	Name	D.o.B.	Sex	Loc.
0638479K	SULLIVAN DEBORAH	07.12.72	F	R65

Specimen R,10.5195514.T Type Blood
Collected 28.05.10 16:29 A.Diag

.....C/Screen.....

PT	12
PT C Ratio	1.0
APTT	31
APTT Ratio	0.9
TCT	12
TCT Ratio	0.9

C/Screen N.B. Revised normal ranges.
This report does not include any comment on the platelet count.

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

Esophageal manometry report

SULLIVAN, DEBORAH

Gender:	Female	Investigation nr:	01
Date of birth:	07/12/1972	Hospital:	Royal Infirmary - Glasgow
Patient number:	0712726128	Investigator:	SN C MACKENZIE
Investigation date:	27/04/2010	Referred by:	MR SMITH

NHS Greater Glasgow

LES station results

LES upper border	41.0 cm
LES lower border	44.0 cm
LES length	3.0 cm

LES relaxation overview

	#	%	Normals
% Complete LES relaxations	10	100 %	90-100 %
% Partial LES relaxations	0	0 %	0-10 %
% Absent LES relaxations	0	0 %	0 %

LES resting pressures - Mean

#	P1	P2	P3	P4	P5	P6	P7	P8	Avg	Normals		Duration (s)
1	*	-	-	-	-	-	-	7	7	6-25	mmHg	44.3 s
2	*	-	-	-	-	-	3	-	3	6-25	mmHg	60.7 s
3	*	-	-	-	-	7	-	-	7	6-25	mmHg	52.0 s
4	*	-	-	-	8	-	-	-	8	6-25	mmHg	58.9 s
5	*	-	-	4	-	-	-	-	4	6-25	mmHg	73.1 s
6	*	-	7	-	-	-	-	-	7	6-25	mmHg	75.1 s
7	*	4	-	-	-	-	-	-	4	6-25	mmHg	75.5 s
8	10	-	-	-	-	-	-	-	10	6-25	mmHg	52.7 s
Avg	10	4	7	4	8	7	3	7	6	6-25	mmHg	
Max	10	4	7	4	8	7	3	7	6	6-25	mmHg	

Average of LES relaxations

	P1	Normals	
Percentage relaxation	100	90-100	%
Residual pressure	-1		mmHg
Duration	7.0	5-10	s

Esophageal motility results

Average calculations for 1 swallow(s) [Dry swallow]

	P8	P7	P6	P5	P4	Average	Normals	
Peak amplitude	49	63	116	149	84	93	30-160	mmHg
Contraction duration	1.8	3.0	3.6	4.7	3.2	3.3	2-6	s

Onset velocity(P8-P4)	2.80	cm/s
Peak velocity(P8-P4)	2.70	cm/s

Average calculations for 9 swallow(s) [Wet swallow 5 ml]

	P8	P7	P6	P5	P4	Average	Normals	
Peak amplitude	41	50	97	119	60	74	30-160	mmHg
Contraction duration	2.5	2.5	3.2	4.3	3.3	3.2	2-6	s

Onset velocity(P8-P4)	2.98	cm/s
Peak velocity(P8-P4)	3.00	cm/s

	#	%	Normals
% Peristaltic contractions	8	80 %	80-100 %
% Simultaneous contractions	0	0 %	0-20 %
% Retrograde contractions	0	0 %	0 %
% Non transmitted contractions	0	0 %	0-20 %
% Dropped contractions	0	0 %	
% Interrupted contractions	2	20 %	

Oesophageal manometry report

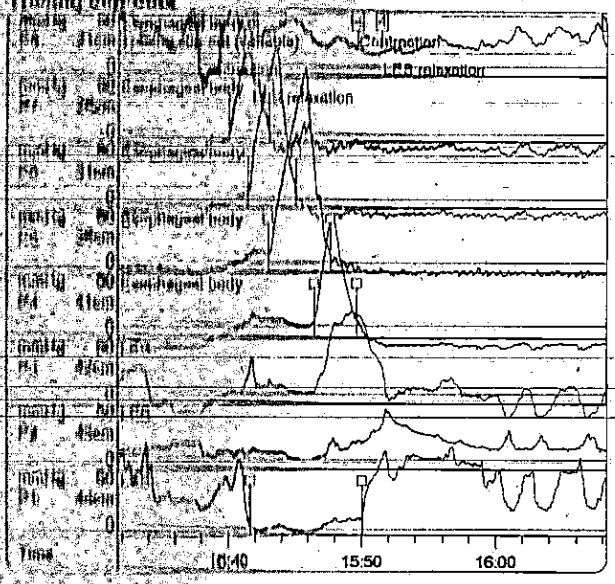
SULLIVAN, DEBORAH

Gender: Female
Date of birth: 07/12/1972
Patient number: 0712720120
Investigation date: 27/04/2010

Investigation nr: 01
Hospital: Royal Infirmary - Glasgow
Investigator: SN C MACKENZIE
Referred by: MR SMITH

NHS Greater Glasgow

Tracing of results



Investigation conclusion

Clinical problem post fundoplication.
Intubation via **right** nare. Serial number of oesophageal manometry catheter.
Technical difficulties encountered during intubation- none.

Procedure: Manometric evaluation of oesophageal function

Description: Manometric procedure included Dent silicone 8 channel catheter. Distilled degassed water was perfused through each channel at a rate of 0.6 ml /min. A series of ten x 5ml water bolus induced swallows were evaluated.

Oesophageal peristalsis was **normal.**

The mean lower oesophageal sphincter pressure was 6 **mmhg**, referenced to stomach pressure.

The lower oesophageal relaxation reflex was **normal.**

The mean oesophageal contractions were **74 mmHg**.

Trace clipping shows peristaltic contraction.

Interpretation:
Oesophageal function was evaluated with perfused manometry. Peristaltic pressures and rates were **normal** for dry and water swallows. The lower oesophageal sphincter **did** relax on multiple swallows. Normal oesophageal study. Clinical correlation, follow-up by Mr J Smith.

Reported by:Sr S Thomson

Nurse Practitioner Clinical G I Physiology.

Patient Name: **SULLIVAN, DEBORAH**

Patient ID: **0712726128**

Date of Birth: **07/12/1972**

Physician: **WINTER, DR JACK**

Ref. Physician: **Smith, Mr J S**

Technician: **MacKENZIE, CAROLE**

Date of Test: 27/04/2010

Time of Test: 10:04

Off pH Study

Reason for Study:
PROBE AT 36CM.

User Comments:
NORMAL OESOPHAGEAL ACID EXPOSURE OFF MEDICATION.

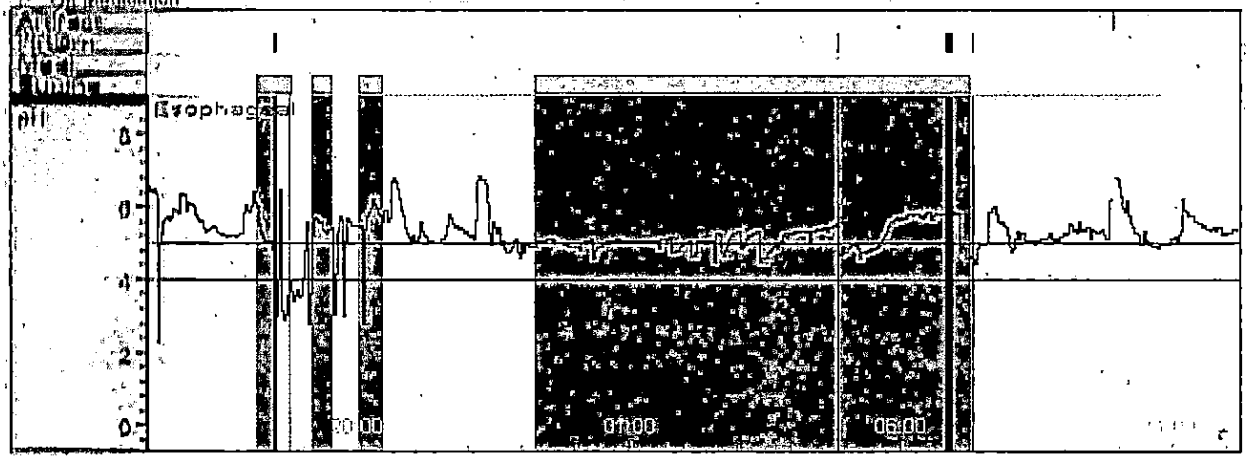
Indications for Test

- [ ] Heartburn
- [ ] Chest Pain
- [ ] Nausea
- [ ] Hoarseness
- [ ] Dysphagia
- [x] Post-Fundoplication
- [ ] Sore Throat
- [ ] Wheezing
- [ ] Chronic Cough
- [ ] Throat Clearing
- [ ] Acid Regurg
- [ ] Post-Myotomy

- [ ] On Medication
- [x] Off Medication

Last PPI Dose
NEXIUM 40MGS DAILY.

Dose



Reflux Table - Oesophageal

	Total	Upright	Supine	Meal	PostPr	PrePra	HrtBrn
Duration of Period (d,hh: mm)	20:08	10:45	09:23	02:56	07:24	09:48	00:13
Number of Refluxes	36	30	6	25	11	0	2
Number of Long Refluxes>5 (min)	0	0	0	0	0	0	0
Duration of longest reflux (min)	2	2	1	2	1	0	0
Time pH <4 (min)	14	11	4	10	4	0	1
Fraction Time pH <4 (%)	1.2	1.7	0.6	5.8	0.9	0.0	4.8
Area (H+) (h*mmol/L)	0.21625	0.11886	0.09737	0.08616	0.06934	0.06074	0.00665
Normalized Area (H+) (h*mmol/L)	0.25776	0.26534	0.24906	0.70494	0.22488	0.14873	0.63885

NormalFraction Time pH < 4 at 95th Percentile. Total 4.5% Upright 8.4% Supine 3.5%
Jamieson JR, Stein HJ, DeMeester TR, et al: Ambulatory 24-HR Esophageal pH Monitoring: American Journal of Gastroenterology Vol 87

Patient Name: SULLIVAN, DEBORAH Patient ID: 0712726128 Date of Test: 27/04/2010

DeMeester Table - Oesophageal

	Score
Duration (d hh: mm: ss)	20:08
Number of Refluxes	2.9
Number of Long Refluxes	0.3
Longest Reflux	0.4
Fraction Time pH <4 (Total)	0.8
Fraction Time pH <4 (Upright)	0.8
Fraction Time pH <4 (Supine)	1.0
Total Score	6.1

Symptom Details Table - Oesophageal

Event	Start Time	End Time	Duration	Reflux Positive
HrtBrn	16:05	16:05	0	no
HrtBrn	18:25	18:28	3	yes
HrtBrn	04:50	04:50	0	no
HrtBrn	06:50	06:56	6	no
HrtBrn	07:19	07:19	0	no
Total HrtBrn: 5				1 of 5

DeMeester Score-Oesophageal

Total score = 6.1 , DeMeester normals less than 14.72 (95th percentile)

SAP Table - Oesophageal

	Total	Meal	Supine	Upright	PrePra	PostPr
HrtBrn	71.7	0.0	82.2	11.5	0.0	89.0
ChestP	0.0	0.0	0.0	0.0	0.0	0.0

SI Table - Oesophageal

	Total	Meal	Supine	Upright	PrePra	PostPr
HrtBrn	20.0	n/a	33.3	0.0	0.0	100.0
ChestP	n/a	n/a	n/a	n/a	n/a	n/a

SAP Details Table - Oesophageal

	Total		
	S+	S-	SAP
HrtBrn-R+	1.0	18.0	71.7
HrtBrn-R-	12.0	574.0	
ChestP-R+	0.0	19.0	0.0
ChestP-R-	0.0	586.0	

The symptom association probability is discussed in B.L.A.M Weusten, J.J.M. Roolofs et al. "The Symptom-Association Probability: An Improved Method for Symptom Analysis of 24 Hour Esophageal pH Data" (Gastroenterology 1994; 107:1741-1745):Referto the pH Reference Manual in the Help Menu.

Signature _____

Accident and Emergency Department
Acute Assessment Unit GRI

A&E No. 11000012888

3 2

Surname:	SULLIVAN	Forename	DEBORAH	Title: MS	
Address:	9 MUIRHEAD COURT BAILLIESTON GLASGOW LANARKSHIRE	Postcode	G69 7EP	CHI No: 0712726128	
		Telephone:	07936 225 898		
Date of Birth:	07.12.72	Sex:	F	Age: 39 yrs	

CHI Number: 0712726128

6

GP Name:	LANGAN JOHN		
Address:	BAILLIESTON HEALTH ... 20 MUIRSIDE ROAD BAILLIESTON GLASGOW	Postcode Telephone:	G69 7AD 01415318050

Next of Kin:	KATHLEEN SULLIVAN		
Relationship:	PARENT		
Address:	187 COMMONHEAD ROAD GLASGOW	Postcode Telephone:	G34 0DS 771 ~~3743~~ 3295 X

Primary Carer:
Date of Attendance: 19.12.11 21:51
Date of Incident:
Presenting Complaint: MED REC

53

Triage: NUMBNESS IN LEFT ARM STARTED AROUND 2PM TODAY, UP DOSE OF GABAPENTIN ON DOCOTRS ADVICE TO 600MGS, PT HAS RHEUMATOLOGY PROBLEMS, RECENT FLARE UP. ALSO SUFFER PANIC ATTACK AND IS VERY ANXIOUS AT TRIAGE. CO OF CHEST PAIN ON ARRIVEL AT HOSPITAL.

Tetanus Cover:

Allergies:

P= 110 BP= 108/72 RR= 19 Sat= 100 BM=

PF= GCS= E M V Total:

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time
	GT					

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Acute Medicine Unit
Glasgow Royal Infirmary
Unitary Patient Record (Part B)

NHS
Greater Glasgow and Clyde

10638479K
SULLIVAN
DEBORAH F
6 MUIRHEAD COURT 07/12/1972
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

Date: Consultant Ward

Ward Review

Plan

Bloods

ECG

CXR

Aspirin + GTN.

Analgesia.

Trop I -ve

D/W Registrar.

Unlikely to be cardiac.

Good response + no evolving ECG changes.

May need MRI tomorrow if concerns about stroke but unlikely due to age.

Please complete where appropriate:

AMT (if >65 years)

CURB Score (if <65 years)

SIRS

DVT Prophylaxis
- indicated ☐
- not indicated ☐

Medicine Reconciliation Form

Source of Information: Patient ☐ / Relative/carer ☐ GP surg ☐ GP computer printout/letter ☐ Patient's own drugs ☐ Other (specify) ECS

Admission Medicines (including OTC, herbal, homeopathic)				Plan for medicines (unless indicated to stop or hold medication should be continued on drug kardex)				
Name	Dose	Freq	Route	Amend	withhold	Stop	continue	Reason for alteration
lactulose	15ml	BD	Po				✓	
Esomeprazole	20mg	BD	Po	✓			X	Dose ↑
Gabapentin	800mg	QDS	Po		✓			
Granisetron (1mg)	1 TAB	BD	Po				✓	
PARACETAMOL (1g)	2 CAPS	QDS	Po				✓	
Fentanyl Patch	75mcg/hr	change 72hrs.					✓	to be changed Thurs 22
Metoclopramide	10mg	TDS	O				✓	
Duloxetine	90mg	OM	O				✓	
Acute Rx Ketoprofen 2.5% gel	TDS					✓		
" Diclofenac 3% gel	Apply	BD					✓	
" 5/12/11 Dihydrocodeine	30-60mg	TDS					✓	Bed regularly
Acute 28/11/11 Tramadol	50mg	PRN					✓	
Allergies/adverse events	Penicillin - RASH.							

List obtained by K McCloy Designation KM

Recently altered/discontinued medicines prioir to admission and reasons why .....

Compliance aid? Y ☐ N ☐ Type..... If, Y Community Pharmacy ..... Phone .....

Senior Medical staff review: Sign ..... Title..... Date and Time .....

Reviewed by pharmacist ..... Date and Time 20/12/11 1155

Comments

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Date 20/12/11 Consultant Ward

Consultant Review (0900) 12W Tmp 36.0.

39 ♀ CHRONIC PAIN
DSH
PRIMARY BREAST CA
LYMPHOEDEMA
EX-SMOKER

? surgery for chronic pain
Doubt (L) sided weakness (L) UL + (L) LL going
Mech cause ? tumour.

O/E Oss dc. CRP 12
(L) UL 4/5 weakness ECG (N)
(but ? effort dependent) T+I wk
(L) LL 4+/5
(N) reflexes.
CN I + II nad.
Chest clear.

INV. (1) (L) sided weakness ? functional
Exclude CVA
(2) LFTs

PLAN . ↑ PPI
. GTN
. WITHHOLD ANTICOAG
? (R) PE

21/12
Estimated Date of Discharge

Print Name Designation
Signature
Date and Time 20/12/11 10.30

Social Circumstances

Name (print): RMitchell Signature: RM Time: 0415 Named Nurse: KCopland.

Religion/Spiritual Belief:		**Occupation:**	**Rm/B:** 5/3
Domestic Arrangements: (please circle)	**Lives;** Alone (Family) Partner House Bound		
Housing: (please circle)	Sheltered Residential Nursing (House) Bungalow Flat (position)		
	Stairs; (Internal) / External		
Carers: (please circle)	~~Cared for by partner / Other~~ ~~Carer for partner / Other~~ ~~Family~~ issues.		
Services: (please circle)	Meals on wheels District Nurse Home Carers CPN Day Hospital		
Personal Belongings: (please circle)	(Clothing Listed) Dentures - ~~Top/Bottom~~ ~~Prosthetics~~ (Policy Explained)		
	Any Valuables If yes - With Patient ☑ Deed Box ☐ Finance Dept ☐		

Smoking History 20 cigs/day for 15 yrs! Alcohol Screen ☐ NIL FAST +ve ☐ -ve ☐

Observations	Temp. 36.3	BP. 127/86	P. 81	RR. 16	SPO2. 100%	MEWS. 0

Functional Assessment

PRE-ADMISSION	ON ADMISSION
Breathing	SpO_2 100% on a/a RR 16/min Not unduly breathless
☐ Breathing Problems Resp Problem Specify: ☐ Domiciliary Oxygen ☐ Domiciliary NEB ☐ Breathless On Exertion	
Circulation	Apyrexial CRT 3sec Well perfused.
☑ No circulatory problems ☐ Problem with circulation (e.g. PVD) specify:	
Safety and Comfort	State orientation / conscious level: GCS 15/15 Pain on admission: Slight joint pain (morphine given A&E)
☐ No Problems with pain Joint pain ☐ Chronic pain specify: Carpenter ☐ Risks to safety (e.g. self harm) specify: Fracture	
Mobility	Moving and Handling Requirements specify: Bed rest advised
☑ Mobile Independently ☐ Problems with mobility specify:	
Personal Hygiene	Basin at bedside.
☑ Independent ☐ Requires Assistance/Aids specify:	
Elimination	Commode. MSU -ve.
☐ No problems new onset incontinence over last 1-2/52 ☐ Problems with elimination specify:	

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Date | Consultant | Ward

PRE-ADMISSION	ON ADMISSION
Sleeping	
☑ No problems sleeping ☐ Problems with sleeping specify: ☐ Use of night sedation specify:	To be assessed.
Communication/Sensory Impairment	
☑ No Problems Communicating ☐ Specify Any Problems ☐ (e.g. Dysphasia, use of hearing aids / glasses):	Communicates freely.
Nutrition	
☑ Normal Diet ☐ Special Diet specify: ☐ Appetite specify: Good ☐ Recent Weight Changes specify: ☐ No Problems Swallowing ☐ Swallowing Difficulties specify:	HS 10st W-12st No weight loss. ☐ **Nutrition Risk Score= (If greater than 10 refer to Dietician.)**

Waterlow Chart

Circle scores in table. Add total. Several scores per catagory can be used.

Build/Weight for Height		Skin Type: Visual Risk Area		Sex: Age	
Average	0	Healthy	0	Male	1
Above Average	1	Tissue Paper / Dry	1	Female	2
Obese	2	Oedematous	1	14 - 49	1
Below Average	3	Clammy (Temp)	1	50 - 64	2
		Discoloured	2	65 - 74	3
		Broken/ Spot	3	75 - 80	4
				81+	5
Continence		**Mobility**		**Appetite**	
Complete/ Catheter	0	Fully	0	Average	0
Occ. Incontinence/ Cath/ Incontinent	1	Restless/ Fidgety	1	Poor	1
Faecally Incontinent	2	Apathetic	2	NG Tub/ Fluids Only	2
Doubly Incontinent	3	Restricted	3	NBM/ Anorexic	3
		Inert/ Traction	4		
		Chairbound	5		

SPECIAL RISKS

Tissue Malnutrition		Neurological Deficit		Medication	
Terminal Cachexia	8	Diabetes MS, CVA,		Cytotoxics	
Cardiac Failure	5	Motor Sensory Paraplegia	4 - 6	High Dose Steroids	4
PVD	5				
Anaemia	2				
Smoker	1				

SCORE	10+ = AT RISK	15+ = HIGH RISK	20+ = VERY HIGH RISK

Pressure Areas	specify:	Skin condition: Intact Waterlow score: 4 Torrance score:

Clinical Notes

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20/12/2011 Nursing
0435 - Pt admitted to ward c (L) weakness + chest pain - Trop <0.04 ECG (N).
- Complaining of ↑ joint pain over last 2/52. Awaiting rheumatology r/v as o/p. Gabapentin ↑ 600mg OOS on 19/12/11. Since complaining of (L) arm/leg weakness.
- MEWS (1). GCS 15/15 PEARL 3+.
(R) arm/leg Normal powers.
Slight weakness (L) arm/leg.
- Given Tramadol, Asparin, 2x5mg IV morphine in A&E. Now only complaining of slight pain.
Pt has fentanyl patch 75 micrograms on (R) arm. due changed 22/12/2011.
- Urinalysis negative on admission
- ?fr MRI
- Settled. Aware bells r/v

(C/N)
(MITCHELL)

Nursing Addit
- patient c/o joint pain
- No Kardex complete
- 1g PO paracetamol given
- medic asked to r/v

—ISW Copland

20/12/11 07[15] CHAN / FYI / NIGHT

ATSP: Analgesia r/v.

Pain: joints both upper limbs.
chest.

Clinical Notes

At home takes dihydrocodeine
Tramadol
Paracetamol
Fentanyl patch
Gabapentin

D/U Slto.

Plan: (1) 2.5 MG Morphine once off
(2) c/o Paracetamol QDS
(3) c/o Dihydrocodeine 30 MG QDS
(4) + Dihydrocodeine 30 MG breakthrough
(5) Fentanyl patch in situ (pt's own)

1169.

20-12-11 12" Nursing.
M2NS 0
Medn to prescribed Qn 2.5g Morphine for pain
Independent c Perisand. Lyginn
Awaits CTHead
Uluck (UN)

20/12/11 CT Brain requested.
C. Moy FY1

20/12/11 13" N.M.
Now crying c pain "all over" M2NS 0
Medics asked to rv pain relief & will do so. Dihydrocodeine prescribed prn however has just had regular dose.
Advised give prn dihydrocodeine
Uluck (SIN)

20/12/11 16" Nursing.
CT Brain booked 21/12/11 @ 09" No risk
Uluck (UN)
16.40.
NURSING :- Patient given analgesia as required details given to WARD (4) Awaiting transfer.
SIN J MacAulay.

Clinical Notes

20/12/11 2030 F41 Review - Pain

Patient in severe pain.
Unchanged to pain at prescription but feels pain is worsening.
Pain in both lower limbs, knees, hips + new sacrum. Lasted 48hrs.
Only been alleviated by morphine.
States cannot take NSAIDs due to hiatus hernia. States can't take ibuprofen
Currently on regular paracetamol, regular dihydrocodeine, diclofenac gel, fentanyl patch + PRN tramadol + morphine. ✱ In last hour has had tramadol + morphine.
Pain team referral has been made.
Pt awaits CT scan as an emergency.
Plan - Add in 30mg PRN dihydrocodeine
- Await pain team referal.
A. Enders F41 #3647

21.12.11 Nursing Night.

Patient still c/o acute and severe pain following std of shift despite pain relief) r/v by medic as above given additional dihydrocodeine with small effect.
Given routine medication at bedtime. Seemed to std to be more comfortable and pain controlled.
Incontinent of urine x (1) assisted. MSA all done.
Repeat urinalysis + MSSU ☐ in ward patient previously on trimethoprim for UTI prior to admission.
awaits CT ☐ awaits pain team ☐.
awaits Neuro appointment ☐.
awoke in each hours c/o acute pain given s/c morphine with immediate effect.

S/N

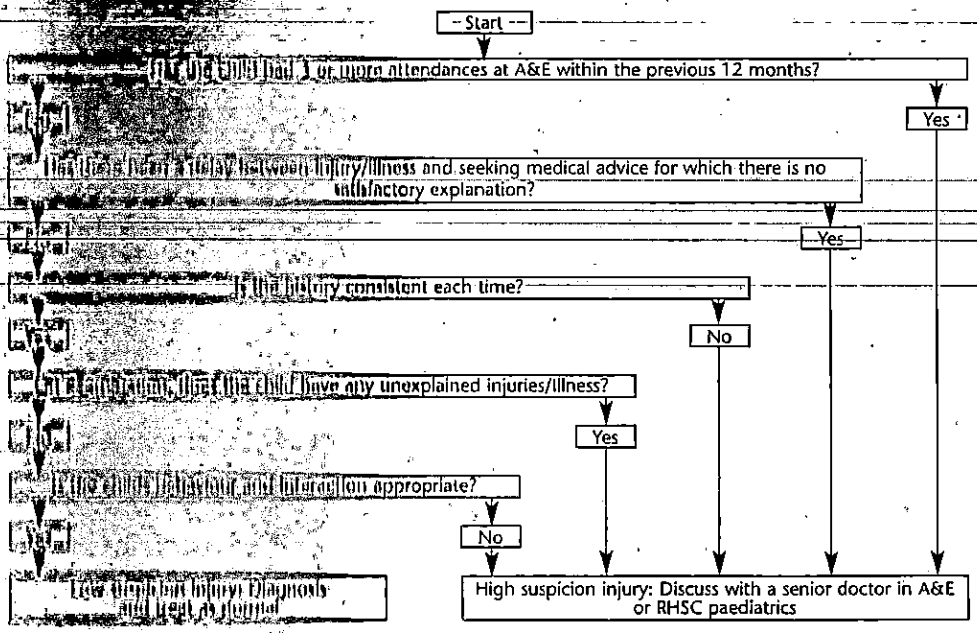
[redacted] Infirmary
[redacted] Record
[redacted] Assessment

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Injury/Illness Flow Chart for all Patients 16 and under

Please tick the appropriate box as you go through the Flow Chart



All Clinical Staff Consider

H.I.Form ☐

Audit Form ☐

Police Consent ☐

Zone 1 AAU Nursing First Assessment

NHS Greater Glasgow and Clyde

Targeted History

Time

A Intact Yes ☐ No ☐

B RR ____ Sa02 ____ Insp 02 (BTS guide) ____
Trachea Central Yes ☐ No ☐
Accessory Muscle Yes ☐ No ☐ CXR Yes ☐ No ☐

C Ventlon Yes ☐ No ☐ Bloods Yes ☐ No ☐ BP ____
HR ____ Reg ☐ Irreg ☐
BCG Yes ☐ No ☐ Cardiac Monitor Yes ☐ No ☐

D GCS ____ Swallow Intact (If approp) Yes ☐ No ☐ BM ____
AMT 7/4. Limb weakness Yes ☐ No ☐

E Urinalysis Prot: ___ Blood ___ Glucose ___ Nitrites ____
Temp ____ Total MEWS on 1st Assess ____

Any other worries? Yes ☐ No ☐ CURB Score (if <65 years)

Urgent Review Required Yes ☐ No ☐
Time Medic Informed ____ Name ____

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Clinical Notes

19/12/11 2260. McCuaig F42 Medicine

39 year old female.
Presented with (L) sided weakness
Started at approximately 1330. ↑ Gabapentin dose from 600mg tds to 600mg qds.
? Taking gabapentin for pain control pd joint pain
↳ has been referred to Rheumatology.
Chronic history of joint pain.

On arrival to hospital chest pain started.
Continuous.
Central tightness
No radiation
Nauseous
Has had previous chest pain 2° to panic attacks but this feels different.

SMHx
Fundoplication
Cholecystectomy
Salt haem
Previous alcohol excess.

FHx
Father MI - 30's

DrugHx
Allergy to penicillin

Social
Ex Smoker

Acute Medicine Unit
Glasgow Royal Infirmary
Unitary Patient Record
(Part A - Acute Assessment)

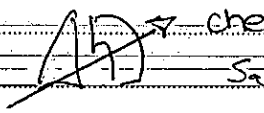
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Clinical Notes

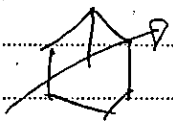
D&TO

O/E A - Patent

B -  chest clear. RR 19 bpm
S_aO_2 100 % air.

C - HS 1+11+0
Pulse 110
BP 109/77

D - GCS 15

E -  SNT.
No distension
BS ✓

No calf tenderness. No swelling.

Neuro:	RUL	LUL	RLL	LLL
Tone	N	N	N	N
			No clonus.	
Power	5	4	5	4
Reflexes	+	middle to elicit	+	+

Improved from GP documented

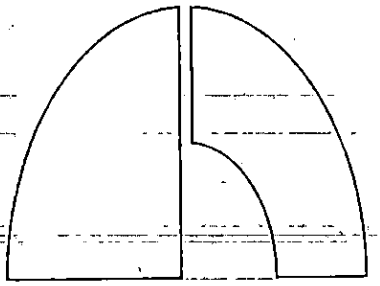
Sensation ↓ T_1/T_2 Normal.

Erythema ab ingrae - @ thigh - ? to self harming.

No spinal tenderness.

Pl. Impression: Need to exclude ACS.
Δ GORD
Side effect of Gabapentin.
Δ Stroke / TIA

X-Ray results



MR D SULLIVAN

6 MUIRHEAD COURT

DAILLIESTON

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ECG findings

sinus rhyth

T wave ↓ III

Haltering aVF

ther investigations

Biochem/Haematology results

Indicate which lab tests have been requested

Haem	19/12	20/12
WCC	14.4	8.1
Hb	131	113
Plat	340	255
MCV	85.8	88.7
Neut	8.0	3.8
DDim		
PT	11	
PTT	32	
TT	13	

Bioch	19/12	20/12
Na+	140	139
K+	4.4	4.2
Cl	108	109
Ur	3.7	3.7
Creat	58	59
Glu		
CRP	16	12
Bil	5	8
AST	21	19
ALT	18	16
GGT	42	35
ALP	75	62
Prot	77	64
Alb	37	32
Glob	40	32
Ca++	2.37	2.32
Amyl	181	
TSH		
FT4		
Tropl	<0.04	<0.04
Chol		
Trig		
Para		
Sal		
S osm		
ABG		
H^+		
P_aCO_2		
P_aO_2		
Bic		
BE		
FiO_2		
Lactate		

Fluids Prescribed in A&E

Drug	
Drug	
Drug	
Drug	
Drug	

Drugs Prescribed in A&E

Drug	
Drug	
Drug	
Drug	
Drug	

Refusal of Treatment

Hereby I declare that I am leaving

*(or taking _____ away from)

the _____ Hospital at my own desire and contrary to the advice of medical staff.

I have had the risks of so doing explained to me, and accept full responsibility for my action.

Signature _____

Witness Date _____

* Delete whichever is inapplicable.

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL

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Date & Time		Signature, Print Name & Designation
21/12/12 10:00	Ward round - A Tindell (FY1) (3rd) Pt more settled than yesterday. Feels is coping with pain better. Has just returned from CT scan. Required 1x S/C morphine overnight. Pain is in both lower limbs + both upper limbs +coccyx. Pain worst in L arm. L arm also numb. Pain is worse in joints but spread throughout limbs. Pt also notes limbs + hands have also been red like sunburn but not localised to joints. She also feels hands, knees + feet are swollen - she can no longer put her rings on. Started in July 2011. Since then gradually improved but flared up over last 2 weeks. Urinary incontinence x 2 yesterday. No bowel incontinence. No dysphagia. No Hx of Raynaud's. No ~~telangiectasia~~ or calcifications in fingers. PMH - Fibromyalgia (mother) Plan - Currently awaits OP rheumatology clinic 19 Jan 2012	

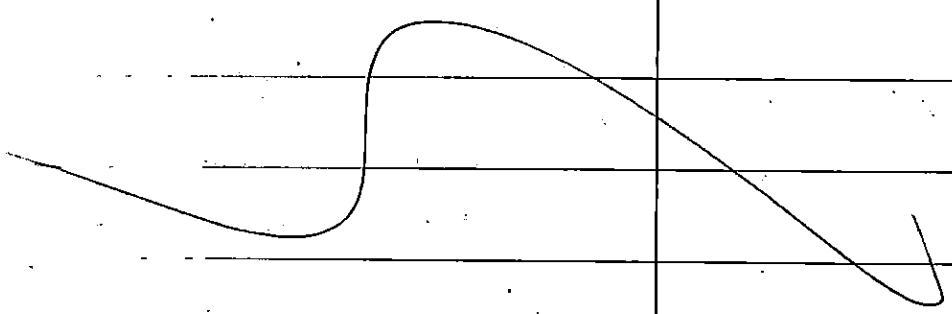
Date & Time		Signature, Print Name & Designation
	O/E - No deformities seen. ↓ use of (L) arm. Gait - dragging (L) leg. ↓ (L) knee flexion. Joints not obviously swollen. No erythema. No calcinosis. No stiffness. (L) hand movement slower than (R). (L) ~~leg~~ hand weaker than (R). Imp - unknown cause for pain (P) - Chase CT scan - Rheumatology referral.	A. Tindell FHI #3647
21/12/11	nursing pm 1120 Patient refusing to attend to personal hygiene this morning Observations as charted - afebrile Tolerating small amounts of diet & fluids Up to sit at bedside this morning Passing urine, bowels not active Analgesia given as prescribed for back pain with little effect. Awaiting to CT head today - patient remains D	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL

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Date & Time		e, Print Name & Designation
	Referral to rheumatology today - awaits c/v D Remains tired + lethargic Awaiting MSSU D No new nursing issues	Dano cU
21/12/11 12[25]	CT Head No evidence of infarct, extra-axial collection or haemorrhage.	A. Tindell FY1 #3647
21/12/11 1440	Discussion to Rheumatology on-call (K. McBride) Hx + Ix discussed. No obvious acute rheumatology issues. Clinic appt 19/01/12 - no chance of this being brought forward. Suggest ~~redet~~ measure anti-CCP level. They will R/v as OP unless any acute issues	A. Tindell FY1 #3647



Date & Time		Signature, Print Name & Designation
22/12/11	NURSING NOTE AMAT 02:45 - OBSERVATION CHARTED MAND O - MEDICATION GIVEN AS PRESCRIBED PATIENT REQUIRED FURTHER PARACETA 30mg DIHYDROCODEINE GIVEN @ 01:30 AM WITH GOOD EFFECT. FENTANYL PATCH DUE (AM) - NO NEW NURSING ISSUES & PLANNING. PATIENT ADVISED SETTLED UNTIL MORNING AS PLANNED. MSSU TO AWAITED	S/N.
26:00	MSSU OBTAINED THE BLOOD SAMPLE SENT FOR U+S.	S/N.
22/12	CT neg. → Home F/U plan in Jan	MJ
22/12/11	Nursing Plan All Care as planned. Up for a bath this am Mobile Analgesia given as prescribed	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL

Date & Time		Signature, Print Name & Designation
	With some effect for discharge home today. Await mum to collect. Obs Stable.	SHO Medicine

GLASGOW ROYAL INFIRMARY

DATE OF BIRTH | HOSPITAL No.
FIRST NAME | SURNAME
ADDRESS | SEX/MARITAL STATUS
ADDRESS | OCCUPATION
HOSPITAL | WD/DEPT | CONSULTANT

CENTRE FOR RHEUMATIC DISEASES

19/1/12

PLEASE WRITE OVER WHITE LETTERS

HISTORY OF PRESENTING COMPLAINTS:

Age 39; right menop; smoker.
→ Chronic pancreatitis — 2° to gallstones

am — fingers stiff mostly
clenched
cannot make fist;
w/o pain
sho;

neck ✓
shoulders ✓
elbows ✓
wrists + pain
hand
hips = 2
knees → cndy
ankles ✓ ? injury

CURRENT DRUG THERAPY:

Tramadol
DHC
Omeprazole
Metoclopramide
Diazepam?

fentanyl patch
Lactulose
Paracetamol

DRUG HISTORY:

Glibenclamide

ALLERGIES:

05196

PAST MEDICAL HISTORY

OP: cholecystectomy
appendix
Bowel ; duodenal ulcer

Med: -

Ncn: -

FAMILY HISTORY

SOCIAL HISTORY

Occupation:

Smoking: 16/day

Alcohol: /

Domestic situation:

lives c daughter = 13yrs

Housing: own

/

Ancillary support:

SYSTEMIC ENQUIRY

Morning stiffness

Uveitis

Conjunctivitis

Raynaud's — Hands — Feet

Dry eyes/Dry mouth

Oral ulceration

Psoriasis/Rash

Photosensitivity

Urethral/Vaginal discharge

G.I.T.

C.V.S.

RESPIRATORY

GENITO-URINARY

C.N.S.

EXAMINATION

HEIGHT: 175.5
WEIGHT: 77
URIN LYSIS:

GENERAL

SKIN:

EYES:

MOUTH:

VASCULITIS:

NAILS:

TOPHI:

NODULES:

HAIR.

ANAEMIA

LYMPHADENOPATHY.

C.V.S.

PULSE

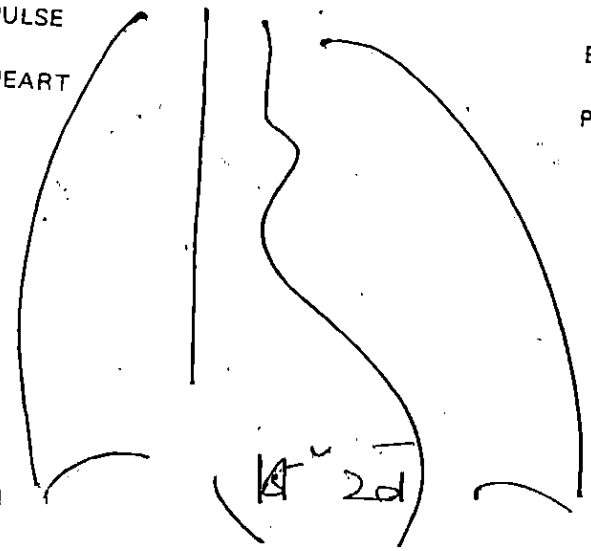
HEART

B.P. 115/84

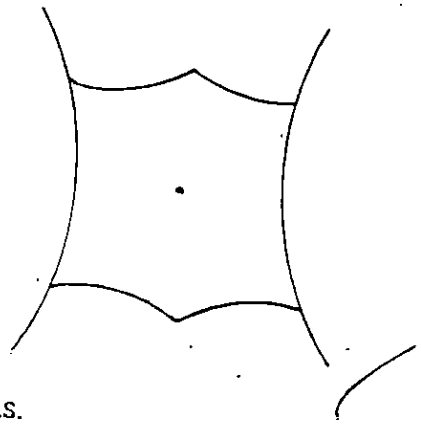
PERIPH. PULSES

R.S.

ABDOMEN



P.R.



C.N.S.

FUNDI:

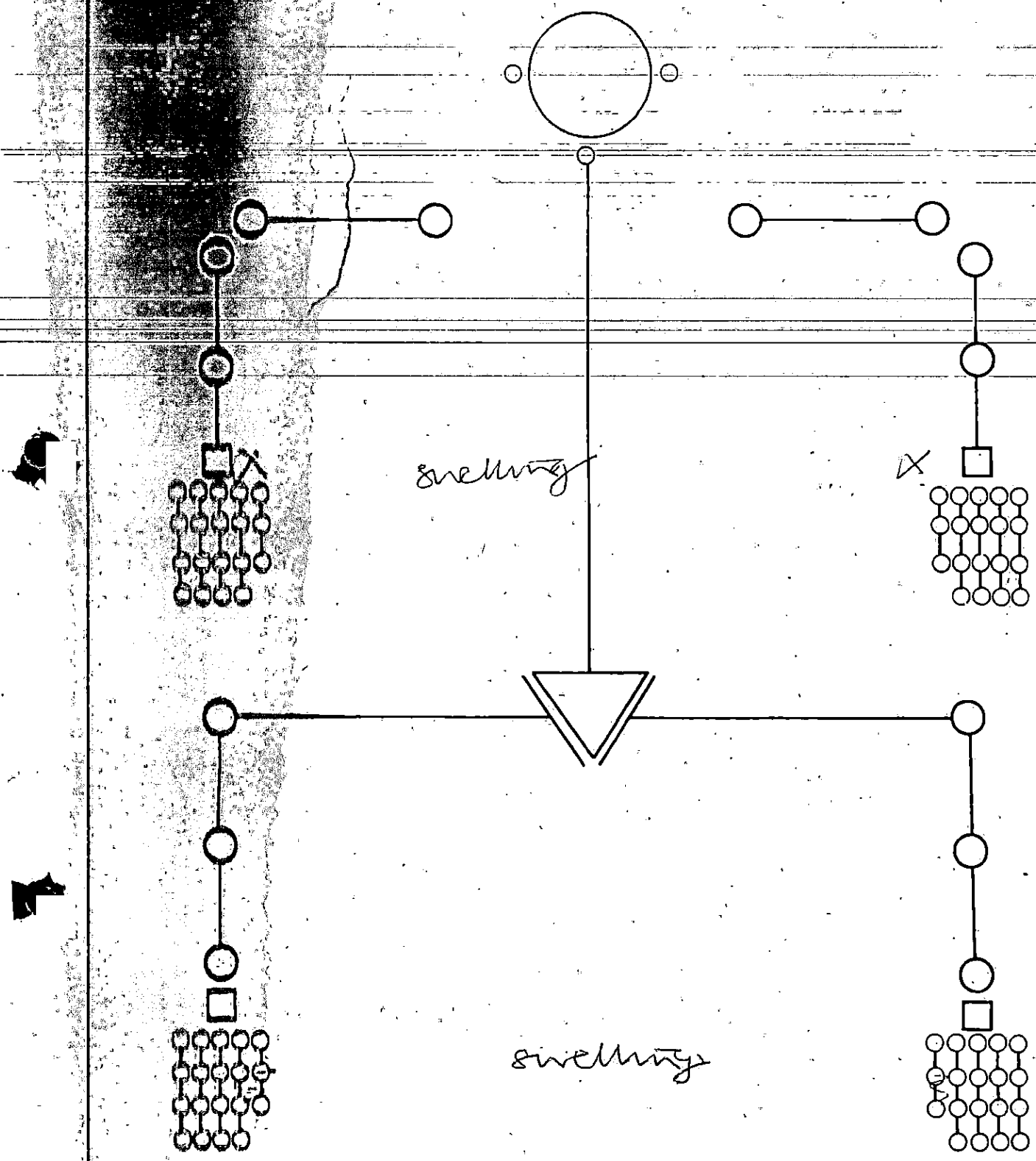
REFLEXES:

CRANIAL NERVES:

SENSATION:

POWER:

MUSCULOSKELETAL



RITCHIE INDEX:

S.L.R.: L. R.

SPONDYLOMETRY:

CHEST EXPANSION:

INITIAL ASSESSMENT:

1) IPA

Gastro

2) Chronic

3) Lyestyle Hdeg

4) CSPD

5) Social

6) CVS risk
115/64

IITIAL MANAGEMENT:

DRUGS:

O.T. :

PHYSIO:

M.S.W.:

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - NURSING

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

Date & Time		Signature, Print Name & Designation
	BD	
27/9/12	LP	
Unit	112	
27-34	81	
	CVP 11 GSR 14	
	CVP - ve RRF - ve Anuria - ve	
	Kerry's notes.	
	Pain - hands, feet, knees	
	Eyes - eyes weeks then L.	
	HCA 4 hourly Sara Jane - No difficulties	
	Tolerated	
	Fluids/Food	
	Nausea	
	Mobilising	
	Weight - patchy.	
	Discharge - Depression	

193443

Accident and Emergency Department
Glasgow Royal Infirmary

A&E No. 12000021311

[redacted]

[redacted] Forename(s) DEBORAH Title: MS

[redacted] Postcode G69 7UP CHI No. 0712726128

Telephone 07926 225 XXX

[redacted] Sex F Age: 39 yrs

[redacted]

[redacted] Postcode G34 7AD

Telephone [redacted]

Next of Kin: [redacted]
Relationship:
Address: [redacted] Postcode G34 9DH
Telephone 7713215

Ward 65.
Bed ready.

Primary Diagnosis:
Date of Admission:
Date of Discharge:
Presenting Complaint: ABDOMINAL

Triage [redacted] Tetanus Cover:

Allergies:

Ht: 164 Wt: 78.5kg BMI: 29 Apgar: 08 DVT=0,1

Pregnancy: Gravida 4 Para 3 Viable 3

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time
17/3/12	Morphine Sulphate	5mg	IV			1900
"	PARACETAMOL	1g				2020

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[redacted]

POPS

Medicine Reconciliation Form

Allergies /adverse reactions

Source of information: Patient ☑ Relative/carer ☐ GP surg ☐ GP computer printout/letter ☐ Patient's own drugs ☑ Other (specify)

Admission (including OTC, herbal, homeopathic)			Plan for medicines (continue all medication unless ticked)			Comments
	Dose	Freq	Amend	Withold (review on d/c)	Stop	Reason for alteration
Temazepam	10mg	nocte				
Fenofibrate	1g	OD				
Duloxetine	90mg	mane				
Amlodipine	10mg	Tid				
Co-codamol	1tbl	mane				
Lactulose	15ml	BD			✓	Commenced rapido
Hydroxychloroquine	400mg	mane				
Diazepam	5mg	mane				
Dihydrocodeine	30mg	QID PRN				
Tramadol	100mg	QID				
Diclofenac 3% gel	1app	PRN				
Fentanyl Patch	75 micrograms		172			Matrifen (12)
Esomeprazole	40mg	BD				

List obtained by Ellen Hibbard Designation pharmacist 3/3/12

Recently altered/discontinued medicines prior to admission and reasons why.....

Compliance aid? Y ☐ N ☐ Type..... If, Y Community Pharmacy ..... Phone .....

Medical staff review: Sign..... Title..... Date and Time.....

Reviewed by pharmacist ..... Date and Time.....

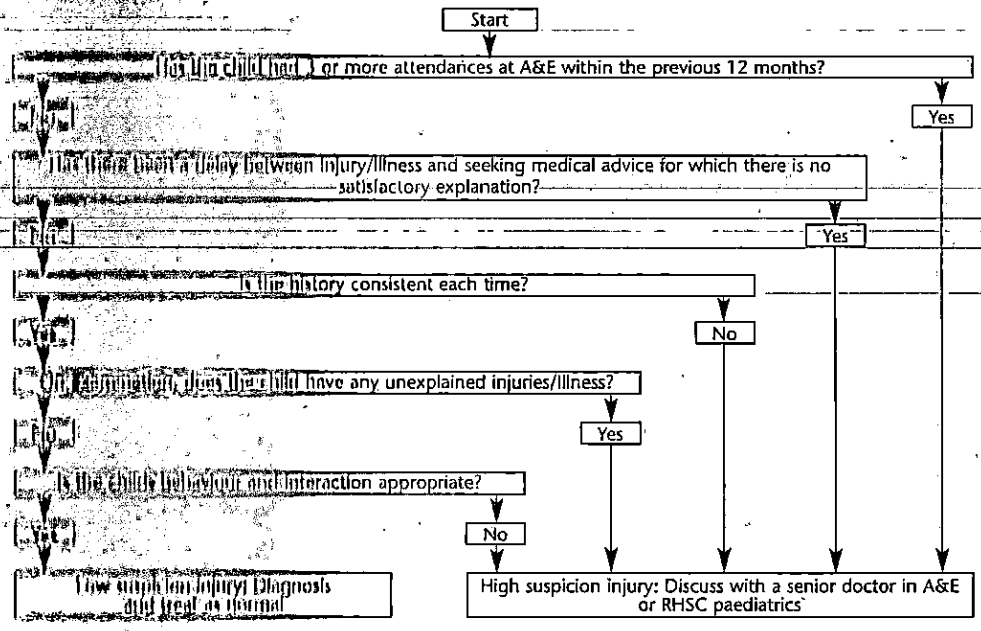
Royal Infirmary
Patient Record
(A&E Assessment)

NHS
Greater Glasgow and Clyde

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SULLIVAN F
DEBORAH 07/12/1972
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BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

Injury/Illness Flow Chart for all Patients 16 and under

Please tick the appropriate box as you go through the Flow Chart



All Clinical Staff Consider

H.I.Form ☐

Audit Form ☐

Police Consent ☐

Clinical Notes

Date 21/3/12 Time 2010 N.KARIM LATI Em

(1) background laparotomy 1996 - subsequent pancreatitis
chronic epigastric pain
recurrent pancreatic pseudocysts - none for several years
? chronic pancreatitis - documented but (N) CT appearances - not on creon
multiple Nissen's fundoplications for hiatus hernia

PC: epigastric pain

HPC: persistent ? severity abdo pain since 0400
not really relieved with tramadol, paracetamol, diclofenac & dihydrocodeine
last passed stool yesterday - (N)
denies urinary symptoms

Please complete where appropriate:

AMT (if >65 years)

CURB Score (if <65 years)

SIRS

Acute Medicine Unit
Glasgow Royal Infirmary
Unitary Patient Record
(Part A - Acute Assessment)

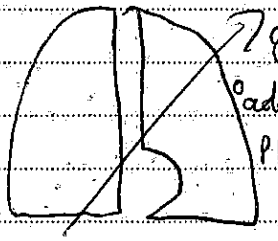
Clinical Notes

o pyrexia
nauseated but not vomiting (keeping fluids down)
no relation to eating

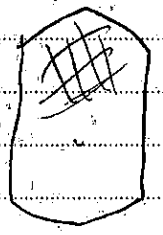
o/e: uncomfortable

T°-36.9°C HR-105 RR-19 BP-121/89 SaO_2-95%OA

HS I+II+0
JVP ↔
calves S+NT
o peripheral oedema



good AE
o added sounds
PN resonant



soft
BS ↑
o masses
tender globally.
↳ worst in epigastrium
Murphy's -ve

ECG: SR 93 bpm
nil acute

urinalysis: NAD

C+R: nil acute

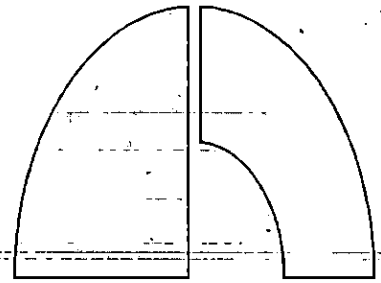
A+R: Faecal loading
nil acute compared to previous

bloods: (N) amylase
WCC-12.4 CRP 26

(P) admit to surgery
analgesia

N. Kamm LATI

X-Ray results



ECG findings

Other investigations

Biochem/Haematology results

Indicate which lab tests have been requested

Haem	29/3	
WCC	12.4	
Hb	119	
Plat	332	
MCV	90.0	
Neut	6.4	
DDim		
PT		
PTT		
TT		

Bioch	29/3	
Na+	141	
K+	4.0	
Cl-	107	
Ur	2.7	
Creat	56.	
Glu		
CRP	26	
Bil	4	
AST	17	
ALT	18	
GGT	41	
ALP	72	
Prot	71	
Alb	36	
Glob	35	
Ca++		
Amyl	83	
TSH		
FT4		
Tropl		
Chol		
Trig		
Para		
Sal		
S osm		
ABG		
H+		
P_aCO_2		
P_aO_2		
Bic		
BE		
FiO_2		
Lactate		

Fluids Prescribed in A&E

Drugs Prescribed in A&E

Refusal of Treatment

Hereby I declare that I am leaving

*(or taking _____ away from)

the _____ Hospital at my own desire and contrary to the advice of medical staff.

I have had the risks of so doing explained to me, and accept full responsibility for my action.

Signature _____

Witness Date _____

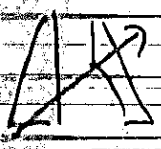
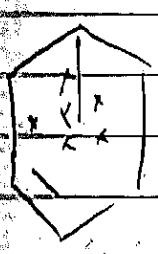
* Delete whichever is inapplicable.

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

Date & Time		Signature, Print Name & Designation
24/4/12 9pm	F11 Clerking McMillan 35F - Cholecystectomy 1995 → pancreatitis with subsequent chronic pain issues - Nissens fundoplication 2005 + 2008. - Under investigation by Mr Smith (Stobhill) last seen 20 - Last CT 2010: No acute pancreatitis, antrum mural thickening. - Under investigation rheumatology for poly arthropathy. PC/ central abdo pain HPC/ Gradual onset central abdo pain at 4am, radiating to back + left shoulder. Colicky lasting few hours. Aggravating factors. Eased on movement. Distended abdo. At worse 10/10 severity. Currently 6/10. Similar episode pain requiring admission ~2 years ago. Nausea since pain onset. No vomiting. Managing SIPS fluids only. Last moved bowels 28/3/12, feels constipated. Tends to be constipated due to regular dihydrocodeine. Takes regular lactulose + PRN Laxido. LUTS.	Cons. D. Chong
	PMH/ Appendicectomy 1995 Depression: long standing. °MI °Angina °COPD °Asthma °DM °Stroke/TIA °Epilepsy Penicillin allergy → Drash.	
	Lives with daughter. Smokes 15-20/day. No alcohol	

		Signature, Print Name & Designation
O/E/	Comfortable at rest alert + orientated Apyraxial 36.9'C	
	1+11+0. HR 90. BP 152/104	
	 Resonant percussion RR 18. Good AE, ↓↓ added SpO2 98% on A.r (Erythematous area lower back RE: scaffold)	
	 Mild abdo distension Prev appendectomy/lap chole/upper laparto ca Tense abdo globally. Maximal epigastric. Tender epigastric. Nil guarding BSV. PR: small amount hard stool.	
	Urinalysis: NAD Bloods: WCC 12.4, CRP 26, otherwise (N) CXR: NAD AXR: Faecal loading. No small bowel ~~obs~~ dilation. Dilated stomach	
IMP/	Constipation 2° opiate use.	
Plan/	Fluids, analgesia + antiemetic. Laxatives Observe overnight.. ? Chronic pain medication R/V / R/V long term laxatives. R Lucas #3233 Micrcas FM1.	
30/3/12	NL CHANG 8:15 AM. Hx reviewed. AP abdo - XRAY showed faecal loading Plan: E+D Review Bloods ~ 3 TSA	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

Date & Time		Signature, Print Name & Designation
21/4/12 22:00	Epigastric SOL long (D. Chong) Hx noted 28yo F Epig pain (- 24 hr) 1/7 Nausea No diarrhoea Wt loss (1 stone) ~ 4/12 Known chronic abdo pain since age 21yr Lap chole 1996 Fundoplication (x2, 2005 | 2009) (Appendicectomy) Pain controlled with Oramorph/Tramadol — last admitted Nov/Dec 2011 No previous upper GI endoscopy (Gen CT abd) — no evidence of acute or chronic pan (+) Current epigastric stabbing pain, sudden onset Grippy pain, intermittent radiates to back & (L) shoulder Worse, progressively worsening Nothing relieves Constant nausea No vomiting No fever/chills Some abdo bloating + Bowels opened yesterday Suffers chronic constipation (on laxatives) No urinary symptoms Other PMHx: Possible Oesophageal dysmotility or Pan - GI dysmotility	(Cons "C")

No recent alcohol

Wakes (occasional) pain

Date & Time		Signature, Print Name & Designation
21/3/12	OA-wl (settled) - Gastritis (OGD 2008)	
	- Depression	fomotren + 10-20/day
		Alcohol - rare
	Ue - In discomfort but otherwise well	
	Obs all ; apyrexial	
	Abdo + Distended	PR (F/E) - hard stool
	Tender RUQ Soft	
	& peritonitis LSK$_2$	
	& masses	
	BS (FF)	
	U&E (n)	
	Urinalysis NAD Bloods WCC (12.4) CRP (26) Amyl 83 LFTs (n)	
	CXR NAD . AXR faecal loading + Gastric distension	
	Imp Chronic abdo pain ? cause - Oesophagitis / Gastritis / CP / Pancreatic Pathology	
	Plan - free fluids as tolerated	
	- Analgesia	
	- Observe	
	- OGD	
	- CT Abdo (new weight loss, ↳ of pancreatitis)	
22/3/12	F. Hamid Reg.	
	Abdo pain radiating to back. nauseous ; wt loss 7 stone.	
	BG. Chr. abdo pain on multiple pain killers	
	Generally Tender [+] no guarding.	PMH. Endo x2
	(R. iliac fossa) Aff. left sided faecal loading.	. A.P ✓ Cholecystectomy Appendicectomy
	Plan . PO4 Enema	GI Dyscondition
	. Scan.	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL

10630479K
SULLIVAN
DEBORAH F
6 MUIRHEAD COURT 07/12/1972
BAILLIESTON
GLASGOW
CHI-0712726120 G69 7EP

Date & Time		Signature, Print Name & Designation
30.7.16 19.10	OD for review	D.McGowan D.M FYI #3143

83949

CHI 0712726128

Glasgow Royal Infirmary

Ward 67

Total Att: 17

12 Mth Att: 0

Title: Ms

SULLIVAN

Deborah

DOB: 07/12/1972 Age: 41y Sex: Female

6 MUIRHEAD COURT
BAILLIESTON
Glasgow
Lanarkshire
G69 7EP
07936226000

Next of kin: SULLIVAN, KATHLEEN
Relationship: Parent
771 3743

GP: JJ Langan
0141 531 8050

Attendance Date: 13/03/2014 Arrival Time: 13:47

Registration Time: 13:47 Date of Incident: 13/03/2014

Major Incident Desc:

Reason for Attendance: rib injury

Nursing Assessment

Alerts: Not Recorded Allergies: Not Recorded Pain Score:

Triage Category: 4 Tetanus up to date/fully immunised:

Presenting Complaint: Gonoral Generally Unwell

Observation Date: 13/03/2014 13:59 Nurse name: Nurse Christopher Bond

Temp	36	C
HR	120	bpm
BP	121/04	mmHg
MAP	103.00	mmHg
RR	10	bpm
SpO2	00	%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: pt fell yesterday onto r side. c/o r sided rib pain. increased pain on inspiration and movement. no urinary or bowel problems. known to have chronic pancreatitis. has taken own analgesia with little effect.

0712726128 07/12/1972 SULLIVAN Deborah

0712726128 07/12/1972 SULLIVAN Deborah

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0712726128 07/12/1972 SULLIVAN Deborah

To be Completed by Clinician		
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

Date	Clinical Notes	
	Seen By	Time Seen

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given
13/2/14	Morphine	2.5mg	IV	16[00]		
3/2/14	Ibuprofen	400mg	PO	16[00]		
13/2	Morphine	2.5mg	IV	17[00]		
13/2	paracetamol	1g	PO	17[00]		

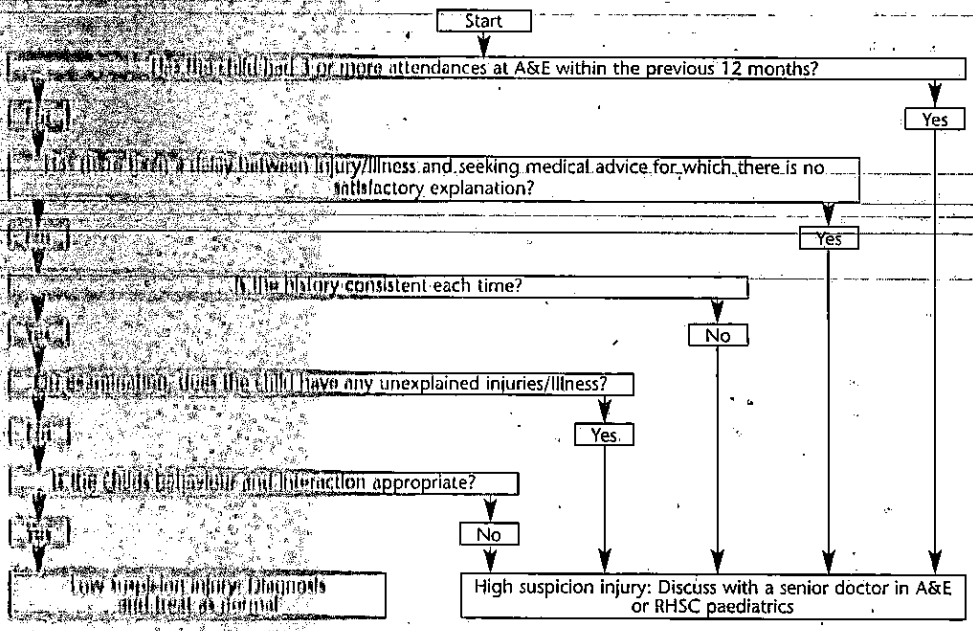
Infirmary
Patient Record
Assessment

NHS
Greater Glasgow and Clyde

0712726128 F
SULLIVAN 07/12/1972
Deborah
6 MUIRHEAD COURT
BAILLIESTON
Glasgow, Lanarkshire
G69 7EP

Injury/Illness Flow Chart for all Patients 16 and under

Please tick the appropriate box as you go through the Flow Chart



All Clinical Staff Consider

H.I.Form ☐

Audit Form ☐

Police Consent ☐

Clinical Notes

PC - abdo pain

HPC - On Friday (6 days ago) Scraped R) side chest/abdo on box
Exp. Then pain RUQ ++
Sharp
↑ on movement + breathing
No nausea Vomit
No bowel change
No cough, No SOBs, No fevers
Previous gallstones + pancreatitis - feels different
Taking tramadol, dihydrocodeine, paracetamol + fentanyl) pc

Please complete where appropriate:

AMT (if >65 years)

CURB Score (if <65 years)

SIRS

80907

Acute Medicine Unit
Glasgow Royal Infirmary
Unitary Patient Record
(Part A - Acute Assessment)

0712726128 F
SULLIVAN
Deborah 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
Glasgow, Lanarkshire
G69 7EP

Clinical Notes

Grade ST

PMH - fundoplication
- pancreatitis
- cholecystectomy
- appendectomy
- tonsillectomy

Meds - omeprazole
- metoclopramide
- gaviscon
- fentanyl patch
- tramadol
- codeine
- paracetamol

SH - lives with daughter
unemployed
- Nonn alcohol
- smokes using electric cig.

O/E
HR 129
BP
Temp
Sats

HS dist. dear Soft tender RUQ + epigastrium

Imp - ? ch. pancreatitis
- ? shunt in CBD
- ? related to trauma

Acute Medicine Unit
Glasgow Royal Infirmary
Unitary Patient Record
(Part A - Acute Assessment)

NHS
Greater Glasgow and Clyde

0712726128
SULLIVAN
Deborah
6 MUIRHEAD COURT
BAILLIESTON
Glasgow, Lanarkshire
G69 7EP
F
07/12/1972

Clinical Notes

Date(s)

antipsy plan - bloods
- analgesia
- CXR
- fluids
- surg referral.

[illegible]

13/3/14 WR PM (McArthur)

Perf. Duodenal ulcer
Pancreatitis
Cholecystectomy
Appendicectomy

- Fall at home
- Complaining of RUQ pain (R) sided pain since
- °SOB. °N+V. °fevers.

2/7 Well.
Obs stable. Apyrexial (Sats 99% Air)

Exam: Musculoskeletal pain

Sore
Tender (R) RUQ

(P) Analgesia
Give voltarol + Co-codamol
PPI cover
Lactulose

Tender ++ on palpation of abdomen (R) side

CXR: No pneumothorax
no obvious obs/#

Form CRF #2481.

Acute Services Division

Nursing Admission & Assessment

1. Admission

NHS Greater Glasgow and Clyde

Name: .....
0712726128
Address SULLIVAN F
Deborah
6 MUIRHEAD COURT 07/12/1972
DoB: .... BAILLIESTON
Glasgow, Lanarkshire
CHI nu G69 7EP

Hospital: GRI	Ward: 67
Date of admission: 13/3/14	Time: 1750
Admitting Consultant: M Forshaw	Admitting Nurse: ECROFT
Expected date of discharge: / /	

1. Patient Details

Preferred name:	Next of Kin (NoK): Kathleen Sullivan
Age: 41	Relationship: Mother
Religion: R/C	NoK Address:
Telephone: 07936225898	
GP: Dr. JJ Langan	NoK Telephone: 0141 237 1145
GP address: Mcglone Practice, Baillieston Health Centre, 20 Muirside Road baillieston, Glasgow, G69 7AD	NoK Aware of admission: ☑ Yes ☐ No
	Consent for information to be given to relatives: ☑ Yes ☐ No
	Nominated family contact:
GP telephone: 5318050	Telephone - Day:
	Telephone - Evening:

Is the patient a carer? ☐ Yes ☐ No If 'Yes' refer to Duty Social Worker if required: ☐ Referred ☐ Not required

Does the patient have an appointed Welfare Guardian / Power of Attorney? ☐ Yes ☐ No ☐ N/A

a. If 'Yes' please provide – Name: ..... Relationship: .....

Contact telephone number: .....

b. If 'Yes' does the patient have an 'Adult with Incapacity Section 47' certificate in place? ☐ Yes ☐ No ☐

If 'No' to 'b' please inform medical staff. Name of doctor informed: .....

2. Presenting Complaint / Diagnosis

Rib pain + Pain on Breathing CXR No#
Fell ~~yesterday~~ 6 days Ago.

Why does the patient think they are in hospital? *Use patients own words:*

3. Allergies (including food allergies)

No known allergies: ☐ PENICILLIN – RASH

4. Observations

Cannard	Waterlow	MUST	Pulse	BP	Resp	SaO_2	Temp
6	4	0	97	122/88	16	99%	36.4

Urinalysis:	AMT4 Score	BM	NEWS Score	Weight Estimated / Actual	Height Estimated / Actual	BMI
Neg Hcu Neg	–	–	1	79	1.78	25

5. Current Medication

Medicines reconciled on admission? ☐ Yes ☐ No

6. Relevant Past Medical History

Chronic Pancreatitis
Fundoplication
Cholecystectomy
Appendicectomy
Tonsilectomy

7. Risk Assessment

MUST

1. Is the patient's BMI:
   > 20 ..... Score 0
   18.5-20 ..... Score 1
   <18.5 ..... Score 2
   Score .....
2. Has the patient had unplanned weight loss in the past 3-6 months?
   < 5% ..... Score 0
   5-10% ..... Score 1
   >10% ..... Score 2
   Score .....
3. If the patient is acutely unwell and there has been or is likely to be no food intake for > 5 days:
   Score = 2

   Not applicable: Score = 0
   Score .....

MUST Score:

If score 1 or more, complete full Nutrition Profile

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

8. Cognitive Impairment

For all patients ≥ 65 years, ask the following 4 AMT questions:

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

If the patient does not answer all questions correctly then refer to medical staff.

AMT Score: ..... out of 4

Name of Doctor informed (if required)

..... Grade .....

9. MRSA Screening / CJD / Healthcare outside Scotland

Will the patient be an inpatient >23 hours? ☐ Yes ☐ No If 'Yes' complete the following section.

1. Has the patient ever had a previous positive MRSA result? ☐ Yes ☑ No ☐ Not known
2. Has the patient been admitted from a Care Home/ institutional setting or another hospital? ☐ Yes ☑ No ☐ Not known
3. Does the patient have a wound / ulcer or invasive device which was present prior to this admission? ☐ Yes ☑ No ☐ Not known

If **'Yes'** to any of the above questions **OR** if the patient is admitted to a 'high impact speciality' e.g. **Orthopaedics, Vascular, Renal Unit, Critical Care – then obtain MRSA Swabs:**

☐ **Nasal** ☐ **Perineum** ☐ **Other - Specify:** ☐ **Patient refused**

CJD: **Has the patient ever been contacted by Public Health and told that they are possibly at risk of CJD:**

☐ Yes ☑ No If 'Yes' contact Infection Control Team. Infection Control Team contacted: ☐

Healthcare outside Scotland

Has the patient been transferred from, or received health care in, a hospital outside of Scotland in the last 12 months:

☐ Yes ☐ No If 'Yes obtain rectal swab and send to microbiologty for CPE screen.

Rectal swab taken ☐ Patient refused ☐

10. Lifestyle

Smoking: EX 3/52

Does the patient smoke? ☐ Yes ☐ No

If 'Yes' how many per day:

Does the patient use nicotine replacement therapy? ☐ Yes ☐ No

Does the patient wish referral to Smoking Cessation Service?

☐ Yes ☐ No If 'Yes', date of referral: / /

Drugs: Does the patient use recreational drugs? ☐ Yes ☐ No If 'Yes' specify:

Alcohol (Men): How often do you have **8** or more drinks on one occasion:

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

If 'Monthly' or more then complete FAST Tool.

Alcohol (Women): How often do you have **6** or more drinks on one occasion:

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

If 'Monthly' or more then complete FAST Tool.

1. Admission Documentation Completed By

Name (Please PRINT): ECRoff	Signature: E Croft
Designation: S/N	Date: 13/3/14

Acute Services Division

Nursing Admission & Assessment

2. Assessment

Hospital: GRI	Ward: G7
Date of Assessment: / /	Time: 1750

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

1. Breathing and Circulation

Breathing:

- ☐ No symptoms or history of respiratory problems
- ☐ Dyspnoeic at rest
- ☑ Dyspnoeic on minimal exertion (Previously)
- ☐ Dyspnoeic on maximum exertion
- ☐ Productive / non-productive cough evident
- ☐ Normally receives oxygen therapy

If 'Yes' provide details:

Circulation:

- ☐ No symptoms
- ☐ Known cardiac or circulatory problems

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

	Initial

2. Communication

Assessment of ability to communicate:

What language does the patient speak?:

English

Interpreter: Required ☐ Not required ☐

If required, provide details and arrangement made:

.....

.....

Does the patient have:

a. Speech difficulties? ☐ Yes ☐ No

b. A learning disability e.g. Down's Syndrome?
☐ Yes ☐ No

If 'Yes' please specify:

.....

If 'Yes' contact Liaison Learning Disability Team.
Liaison Learning Disability Team contacted:
☐ Yes ☐ No

c. A learning difficulty e.g. dyslexia, dyspraxia?
☐ Yes ☐ No

If 'Yes' please specify:

.....

3. Senses

Senses:

Eyesight

- ☑ Normal vision
- ☐ Glasses – ☐ Distance ☐ Reading
- ☐ Prosthesis – ☐ Left ☐ Right
- ☐ Contact lenses
- ☐ Registered blind

Hearing

- ☑ Normal
- ☐ Hearing impaired
- ☐ Hearing aid – ☐ Left ☐ Right

4. Mental Status

Mental Status:

- ☑ Orientated
- ☐ Confused
- ☐ Distressed
- ☐ Aggressive /Abusive
- ☐ Unconcious

Problem Identified: ☐ Yes ☐ No If 'Yes' please describe

	Initial

5. Hydration and Nutrition

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

MUST Score: ..... If score is 1 or more, complete a Nutrition Profile.

Nutition Profile completed ☐ Yes ☐ No
If 'Yes' do not complete sections 5a to 5d.

- **If score is 0, reassess / screen patient in 7 days.**
- **Complete sections 5a to 5d.**

Date of reassessment: / /

5a 1. Food likes / dislikes:

NIL

5a 2. Fluid likes / dislikes:

NIL

5c. Help needed with eating and drinking:
☐ Yes ☑ No
If 'Yes' provide details:

5b. Cultural or religious diet needed e.g. vegetarian, vegan, halal, kosher etc):
☐ Yes ☑ No
If 'Yes' specify diet needed:

5d. Texture Modified Diet needed?
☐ Yes ☑ No
If 'Yes' specify texture: A ☐ B ☐ C ☐ D ☐ E ☐
Thickened Fluids required? ☐ Yes ☐ No
If 'Yes' specify stage required: 1 ☐ 2 ☐ 3 ☐

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial

6. Elimination

Continent:
☐ Bladder
☑ Bowel

Incontinent:
☐ Bladder
☐ Bowel

NHS GGC Stool Chart commenced:
☐ Required ☐ Not required

Long-term urinary catheter in situ? ☐ Yes ☐ No
If 'Yes' – Size: .....fg Make: .....
Date catheter last changed: / /

Continence assessment commenced:
☐ Yes ☐ No ☐ Not applicable

Containment products in use? Please specify:

☑ Bowels regular
☐ Constipated
☐ Diarrhoea / loose stools

Stoma: ☐ Yes ☑ No
If 'Yes' please specify and list appliances used:

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial

7. Personal Hygiene, Oral Health and Skin Assessment

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Personal hygiene:
☑ Self-caring and independent
☐ Requires assistance

Specify assistance if required:

Oral health:
Self-caring and independent ☑ Yes ☐ No
Does the the patient have a sore mouth ☐ Yes ☐ No
Does the patient have a non healing mouth ulcer ☐ Yes ☐ No

If the patient has a sore mouth or non healing mouth ulcer, refer to dentist (See StaffNet for dentist referral pathway) and implement Oral Care Bundle.

Oral Hygiene Care Bundle:
☐ Required ☑ Not required

Dentures:
☑ Not worn
☐ Upper set
☐ Lower set
☐ Full set
☐ Dentures with patient on admission

Skin assessment:
☑ Skin healthy with no evidence of damage
☐ Skin broken ☐ Skin oedematous ☐ Skin discoloured ☐ Skin clammy
If 'Yes' to any of the above, describe skin condition:

Wound Assessment Chart completed: ☐ Yes ☐ No ☐ Not applicable
Pressure ulcer evident: ☐ Yes ☐ No
If 'Yes' please identify Grade and record on Pressure Ulcer record sheet – Grade: .....

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

	Initial

8. Mobility

Patient fully mobile / independent? ☑ Yes ☐ No If 'No' complete Moving and Handling Assessment.
☐ Limited mobility
☐ Mobile with aid – Specify:
☐ Prosthesis – Specify:

Moving and Handling Plan commenced:
☐ Yes ☐ No

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

	Initial

9. Maintaining a Safe Environment

Pain status:
Does the patient have pain? ☑ Yes ☐ No
If 'Yes' record Pain Score on NEWS chart.

What makes their pain better? Please provide brief details:
analgesia

Bed rail assessment completed: ☐ Yes ☑ No

Bed rails required:
☐ Required ☑ Not required

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

	Initial

10. Sleep and Rest

Sleep habits:

☐ Less than 8 hours ☐ Afternoon nap
☐ Morning nap

Sleep difficulties:

☐ None ☐ Disturbed e.g. nocturia, insomnia
☐ Early wakening

Medication required: ☐ Yes ☐ No

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

	Initial

1. Social Circumstances

☐ Employed ☐ Unemployed ☐ Retired
☐ Lives alone
☐ Lives with Family
☐ Friend
☐ Dependants
☐ Other: ☐ Nursing Home ☐ Residential

Current Care / Support arrangements:

☐ Social Services ☐ Unpaid carer e.g. family, friends
☐ Private Carers ☐ None

If support services in place, please provide details:

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

	Initial

12. Privacy, Dignity and Sexuality

Does the patient have issues related to privacy, dignity and/or sexuality that are relevant to admission?

☐ Yes ☐ No

If 'Yes' please provide brief details:

13. Spiritual Care

Is there anything with regard to faith or culture that we can support the patient with during their stay in hospital (e.g. prayer, meditation)?

☐ Yes ☐ No

If 'Yes' please provide brief details:

Is there anything causing the patient a lot of anxiety at the time of admission that staff should be aware of?

☐ Yes ☐ No

If 'Yes' please provide brief details:

Ask the patient:

"Would you like the ward staff to arrange for a Hospital Chaplain to visit you while in hospital?"

☐ Yes ☐ No ☐ Not at this time

If 'Yes' please specify faith group:

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

14. Anticipatory Care
(This section is for patients thought to be in the last year of life, where appropriate and relevant)

Appropriate ☐ Not appropriate ☐

Is the **patient** aware of their:
Diagnosis? ☐ Yes ☐ No
Prognosis? ☐ Yes ☐ No

Is the **patient's family** aware of their:
Diagnosis? ☐ Yes ☐ No
Prognosis? ☐ Yes ☐ No

Preferred place of care:
Home: ☐ Hospital ☐ Hospice ☐

Preferred place of death:
Home: ☐ Hospital ☐ Hospice ☐

Current treatment – please identify (e.g. chemotherapy/ radiotherapy):

Other agencies involved in patient's care – please identify (e.g.) Marie Curie, MacMillan Nurses):

DNACPR order in place: ☐ Yes ☐ No
If 'Yes' are the patient's family and next of kin aware? ☐ Yes ☐ No

15. Admission Assessment Completed By

Name (Please PRINT): ECROFT
Signature: ECroft
Designation: S/N
Date: 13/3/14

Clinical Notes

Date and Time	Notes	Name, Signature and Designation
13/3/14 1800	CLAUDIA ATE of this 41yr old female presenting with R lobar and pain on inspiration. Fell 6 days ago - tripped over a Box.	
	Exam (N) ? Bruising.	
	allow fluid + diet adequate analgesia.	S/N
	Home tomorrow	ECroft
1855	Keen for home tonight	
	Discharged c/c analgesia	
	N-f-U	ECroft S/N

Clinical Notes continue on next page

Name: .....

Address: .....

.....

DoB: .....

CHI number: .....

Affix patient data label

Clinical Notes (continued)

Date and Time	Notes	Name, Signature and Designation

Name: Deborah Sullivan Ward: G7 Date: 13/3/14 Case Record No.:

CARE PLAN

Date Comm.	Signature	1.BASIC CARE AND PERSONAL HYGIENE	Date Disc.	Signature
13/3	EE	Independent		
		Bed bath		
		Assisted wash		
		Oral hygiene		
		Pressure care		
		2.NUTRITION		
13/3	EE	Fasting		
		Normal Diet		
		Special Diet / Modified Diet		
		3.ELIMINATION		
13/3	EE	Independent		
		Commode		
		Bedpan/urinal		
		Urinary Catheter | Size: | Batch No:		
		Type of Material: | H_2O in Balloon:		
		Type of Stoma Appliance:		
		4.MOBILITY		
13/3	EE	Fully Independent/fully mobile		
		Minimal assistance (give details)		
		Dependent (See movement and handling sheet - keep with patient)		
		5.OBSERVATIONS		
13/3	EE	Waterlow daily (if score is over 10+)		
		TPR		
		BP		
		Pain Score		
		Fluid Balance		

CARE PLAN

Date Comm.	Signature	6.TECHNICAL CARE	Date Disc.	Signature
		IV Infusion		
		Monitor		
		Catheter--		
		Oxygen Therapy		
		Nebulisers		
		IV access: ∞ IV cannulae ∞ others		
		7.WOUND CARE		
		8.SPECIMENS/INVESTIGATIONS		
		9.SLEEP		
		10.SPECIAL NEEDS		
		Assess for dysphagia (refer to speech and language therapist)		
		Source/protective isolation (refer to infection Control)		
		Blind/visually impaired		
		Deaf/hard of hearing		
		Anti-embolic stockings		
		Nurse escort when out of ward		
		11.OTHER RELEVANT INFORMATION		
		12.FAMILY/SIGNIFICANT OTHER		

Initial Care Plan seen and agreed by patient: **Yes** ☐ **N/A** ☐

Signature of nurse: E Gould **Date:** 18/3/11

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name	
Address	0712726128 SULLIVAN F Deborah 07/12/1972 6 MUIRHEAD COURT BAILLIESTON Glasgow, Lanarkshire G69 7EP
CHI No.	
DoB	

	Date	Ward
Admitted		
Transferred		
Transferred		

NEWS – NHS Early Warning Score

Physiological Parameter	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

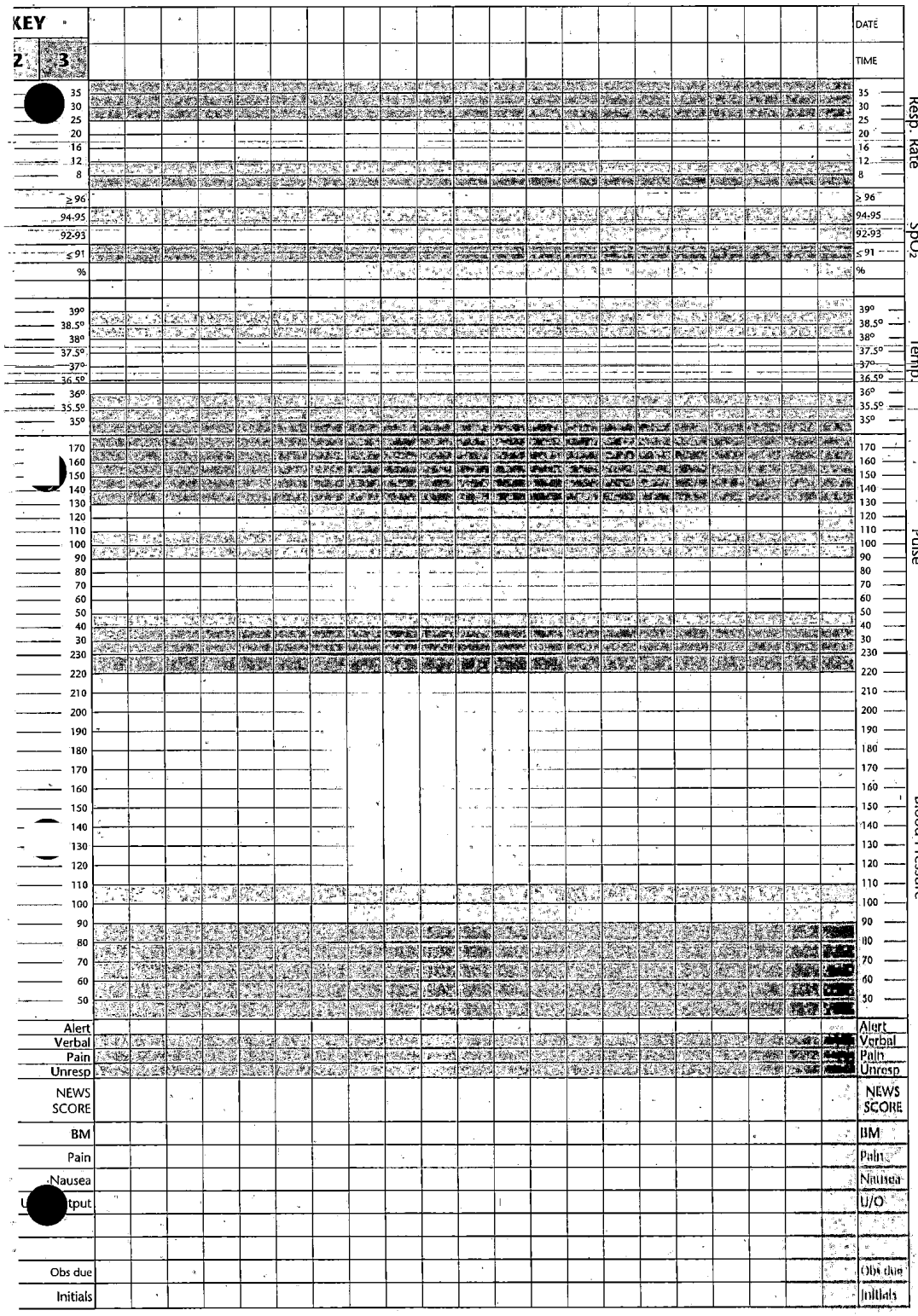
NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1-4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.

DEBORAH SULLIVAN (2)

| | | |


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
Blood Pressure
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Neurological Observations

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

Glasgow Coma Scale

Pupil size (mm)

1
2
3
4
5
6
7
8

Pain Score

Ask the patient to rate his/her pain by choosing a number between 0 and 10. Use the diagram below to assist the patient. If patient's pain is chronic, use generic tool. If patient is unable to communicate, use observational tool.

0	1	2	3	4	5	6	7	8	9	10
No pain	Mild Pain			Moderate Pain			Severe Pain			

Nausea and Vomiting	
0	= None
1	= Mild (*Not distressing – no retching/vomiting*)
2	= Moderate (*Troublesome – occasional retching/vomiting*)
3	= Severe (*Distressing – frequent retching/vomiting*)

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

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: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____

Address _____

Compliance Aid Details _____

Patient consent to share discharge information Y/N

F _____

0712726128

DETAILS

SULLIVAN
Deborah F
07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
Glasgow, Lanarkshire
G69 7EP

Date of Admission: _____

Consultant Name:

Height:

Weight:

Surface area:

Ward:

Name _____

CHI No _____

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
8/3/10	omeprazole	40mg	PO	17.45	S. Haggan	EC	1745

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

_____

_____

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protoc - Authorised Nurses/Midwives Only (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.

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 forms or theophylline).

DATE → 13
MONTH → 3

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

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

Parenteral Drugs : Regular Prescription

| | | |

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

D DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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.

E DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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.

F DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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.

G DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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.

Name _____

CHI No _____

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

_____

_____

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

Warning: Check the As Required and Regular Prescription sections to ensure that the

Notes for Users

FOR PRESCRIBERS:

2. 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 tablets or capsules).

Oral and Other Drugs: Regular Prescription

DATE 13
MONTH 3

| | | |

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

Patient's Own Medicine

BEFORE ADMISSION ☑
NEW DOSE ☐
NEW MEDICATION ☐

M DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

N DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

P DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

R DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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.

Name _____

CHI No _____

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

_____

_____

Midwife Administration by Sympt...atic Relief Policy or other Protoc

Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

Check the As Required and Regular Prescription sections to ensure that the

For Prescribers:

1. Prescribe drugs generically using the approved name, except in circumstances where prescribing by proprietary name is necessary in the interest of patient safety or convenience, or in accordance with prescribing policy of the area of practice. Please print clearly.

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.

S

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

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

T

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

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

V

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

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

W

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

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

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 ☐

X 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 ☐

Y 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 ☐

AA 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 ☐

BB 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.

Name _____

CHI No _____

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

_____

_____

Administration by Symptomatic Relief Policy or other Protocol

Registered Nurses/Midwives Only (Maximum number of doses as per protocol)

Check the As Required and Regular Prescription sections to ensure that the

Notes for Users

For the Doctor:

1. Prescribe drugs generally using the formulary. Note reasons in circumstances where reasonably effective, lower doses of the same drug or an alternative is to be used. Prescribing is timed when giving up the use of

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

DD DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

EE DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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 →

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 ☐

GG DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

HH DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

JJ DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

KK DRUG

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.

Name _____

CHI No _____

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

_____

_____

Nurse/Midwife Administration by Symptomatic Relief Policy or Other Protocols
- Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

Warning: Check the As Required and Regular Prescription sections to ensure that the

[illegible]

All Routes: As Required Prescriptions

																														Patient's Own Medicine
BEFORE ADMISSION ☐	LL	DRUG Tramadol																												For Use Y/N
	DOSE 100mg	ROUTE O	INDICATION Pain																											Qty:
NEW DOSE ☐	PRESCRIBER (PRINT & SIGN) [signature]		MAX.FREQ. QID	DATE: 13/3																										Date:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			STOPPED DATE: INITIALS:																										Assessed by:
					DATE	13/3																								Ordered from Pharm.
					TIME	17																								
					DOSE	100																								
					GIVEN BY	[illegible]																								
BEFORE ADMISSION ☐	MM	DRUG																												For Use Y/N
	DOSE	ROUTE	INDICATION																											Qty:
NEW DOSE ☐	PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE:																										Date:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			STOPPED DATE: INITIALS:																										Assessed by:
					DATE																									Ordered from Pharm.
					TIME																									
					DOSE																									
					GIVEN BY																									
BEFORE ADMISSION ☐	NN	DRUG																												For Use Y/N
	DOSE	ROUTE	INDICATION																											Qty:
NEW DOSE ☐	PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE:																										Date:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			STOPPED DATE: INITIALS:																										Assessed by:
					DATE																									Ordered from Pharm.
					TIME																									
					DOSE																									
					GIVEN BY																									
BEFORE ADMISSION ☐	PP	DRUG																												For Use Y/N
	DOSE	ROUTE	INDICATION																											Qty:
NEW DOSE ☐	PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE:																										Date:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			STOPPED DATE: INITIALS:																										Assessed by:
					DATE																									Ordered from Pharm.
					TIME																									
					DOSE																									
					GIVEN BY																									

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

| | | |

Nutrition Profile

NHS Greater Glasgow and Clyde

Name: SULLIVAN Deborah F Address: 6 MUIRHEAD COURT BAILLIESTON Glasgow, Lanarkshire G69 7EP 0712726128 DoB: 07/12/1972 CHI number: *Affix patient data label*	Date of admission: 13/3/13 Time: 1750 HOSPITAL: GRI Ward: 67

To be recorded within 24 hours of admission*

Height: 1.78 metres Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Weight: 79. kg Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Recent unplanned weight loss: Yes ☐ No ☐

If 'Yes' how much?: kg 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 ☐

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☐

Please state:

Food Allergies: Yes ☐ No ☐ If 'Yes' please state:

Eating likes and dislikes (including appetite):	Drinking likes and dislikes:	Patient NBM Yes ☐ No ☐ If 'Yes' why?:
Appetite Good.		

Are there any contributing factors that may affect food intake such as **physical** (e.g. swallowing difficulties, loose teeth), **physiological** (e.g. nausea), **psychological** (e.g. dementia), **social or environmental**? Yes ☐ No ☐

Please specify all factors:

Is the patient on oral nutritional supplements? Yes ☐ No ☐

If 'Yes' please state:

Is the patient experiencing oropharyngeal swallowing problems (excluding oesophageal issues e.g. GORD, Stricture)? Yes ☐ No ☐

If 'Yes' please complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS). If oesophageal problem present please discuss with medical staff.

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☐

If 'Yes' please state:

Has this patient received written information about inpatient food (e.g. "Food in Hospitals" leaflet)?

Yes ☐ No ☐ Not applicable (received on previous admission) ☐

Profile completed by: Name (PRINT): E CROFT Signature: E Croft Date: 13/3/14

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

Is your patient on the Liverpool Care Pathway (LCP)? Yes ☐ No ☐

If 'Yes' please follow LCP advice as screening for malnutrition may not be appropriate.

Malnutrition Universal Screening Tool ('MUST')

Date	13												
Initials	GO												
Height (see page 1) 1.78 Weight	79												
Oedema or ascites present Y/N	N												
BMI (refer to chart on page 4)	25												

'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. • 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

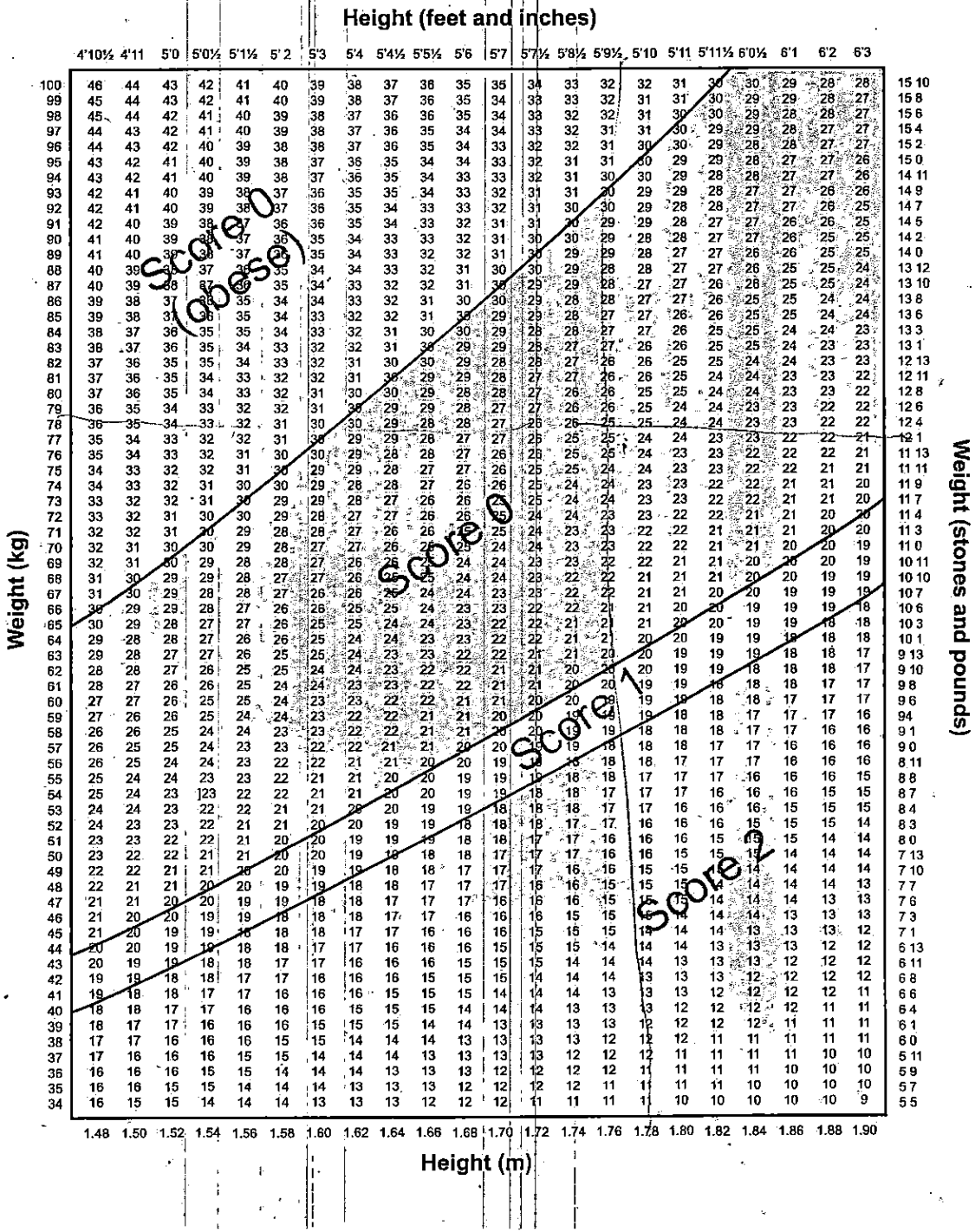
- Provide help and advice on food choices and eating and drinking when necessary.
- Treat underlying conditions and initiate appropriate treatment to relieve symptoms that affect nutritional intake e.g. nausea, vomiting, constipation, diarrhoea and/or pain.
- Refer to dietitian if any specialist advice is required.
- Use a recognised system to identify when equipment or asssistance is required at mealtimes (e.g. red mats, coloured napkins).
- REMEMBER TO CONSIDER YOUR PATIENT'S HYDRATION REQUIREMENTS.
- Ensure Discharge Plan includes most recent 'MUST' Score and any necessary follow-up requirements.

Referral Services		Referred by	Method of referral	Reason for referral
Nutritional Support Team	Date Referred / /			
Dietitian	Date Referred: / /			
Speech and Language Therapy	Date Referred: / /			
Occupational Therapy	Date Referred / /			
Dental Service	Date Referred / /			

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Action discussed with patient / carer	Review date	Name (PRINT) Signature/ Designation
13/3	0	Routine clinical care			SN EC

Step 1 - BMI Score



Step 2 - Weight Loss Score

Weight before weight loss (kg)	Score 0 Wt loss <5%	Score 1 Wt loss 5-10%	Score 2 Wt 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	6.2-12.4 kg	>12.4 kg
126 kg	<6.3	6.3-12.6 kg	>12.6 kg

Weight before weight loss (st/lb)	Score 0 Wt loss <5%	Score 1 Wt loss 5-10%	Score 2 Wt 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

Medical Illustration Services • 233261
STORES ORDER CODE 41850

NHS
Greater Glasgow and Clyde

NATVNS
SCOTLAND

WRI
Surr 0712726128 SULLIVAN F
Fore Deborah 07/12/1972
6 MUIRHEAD COURT
DoB BAILLIESTON
Glasgow, Lanarkshire
Loca G69 7EP

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	2								
Female	2									
Age										
14 -49	1	1								
50 -64	2									
65 - 74	3									
75 - 80	4									
81+	5									
Build/Weight for Height (BMI=weight in Kg/height in m²)										
Average = BMI 20-24.9	0									
Above average = BMI 25-29.9	1	1								
Obese = BMI > 30	2									
Below average = BMI < 20	3									
Continence										
Complete/catheterised	0	0								
Incontinent urine	1									
Incontinent faeces	2									
Doubly incontinent (urine & faeces)	3									
Skin Type - Visual Risks Area										
Healthy	0									
Tissue paper (thin/fragile)	1									
Dry (appears flaky)	1	0								
Oedematous (puffy)	1									
Clammy (moist to touch)/pyrexia	1									
Discoloured (bruising/mottled)	2									
Broken (established ulcer)	3									
Mobility										
Fully mobile	0									
Restless/fidgety	1									
Apathetic (sedated/depressed/reluctant to move)	2	0								
Restricted (restricted by sever pain or disease)	3									
Bedbound (uncooperative/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								
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	0								
Anaemia = Hb < 8	2									
Smoking	1									
Special Risks - Neurological Deficit										
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*	4-6	0								
Special Risks - Surgery/Trauma										
On table > 0 hours	8	0								
Orthopaedic/below waist/spinal (up to 48 hours post op)	5									
On table > 2 hours (up to 48 hours post op)	5									
Special Risks - Medication										
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4	4								
Total Score		4								
Date		13/3								
Initials										
Time										

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

Cli t) Moving and Handling Risk Assessment Form

0712726128 F
SULLIVAN 07/12/1972
Deborah
6 MUIRHEAD COURT
BAILLIESTON
Glasgow, Lanarkshire G69 7EP

Patient's name:	Named nurse:	If Patient is totally independent, tick here and go to date box	Risk: Low / Medium / High

BUILD	
Obese	Tall
Above average	Medium
Average	Short
Below average	

RISK OF FALLS	
High	Low

Problems with comprehension, behaviour, co-operation (specify):

Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):

Transfers (including To/From: Bed; Wheelchair; Commode; Toilet)

HOIST/STANDAID (Specify)	ASSISTANCE	SUPERVISION	INDEPENDENT
Model:	People: 1 2 3	Additional Information:	
Sling type:	Walking aid (specify)		
Sling size:			

Toileting

HOIST/STANDAID	ASSISTANCE	SUPERVISION	INDEPENDENT
	People: 1 2 3	Additional Information:	

Move on / off bed pan

HOIST	MANEOUVRE	ASSISTANCE	SUPERVISION	N/A
	Roll patient	People 1	Additional Information:	
	Monkey pole	People 2		
	Patient bridges	People 3		

Move up / down bed

HOIST	HANDLING AIDS	ASSISTANCE	SUPERVISION	INDEPENDENT
	Sliding sheet	People 1	Additional Information:	
	Monkey pole	People 2		
	Rope ladder	People 3		

Transfer to / from trolley (or bed etc.)

HOIST	HANDLING AIDS	ASSISTANCE	SUPERVISION	INDEPENDENT
	Patslide	People 1	Additional Information:	
	Other	People 2		
	Fabric sliding aid	People 3		

Sit up over side of bed

BED REST	ASSISTANCE	SUPERVISION	INDEPENDENT
	People: 1 2 3	Additional Information (e.g. equipment to be used – swivel cushion):	

Into Bath or Shower

WHICH BATH	HANDLING AID	ASSISTANCE	SUPERVISION	INDEPENDENT
Shower	Shower chair	People 1	Additional Information:	
Variable height bath	Bathing Hoist e.g. Alenti	People 2		
Bed bath	Sling lifting Hoist	People 3		

Walking

NO WALKING	WALKING AID (specify)	ASSISTANCE	SUPERVISION	INDEPENDENT
		People 1	Distanced walked / Additional Information:	
		People 2		
		People 3		

Other Instructions

Recording Symbol:		X	*
Date Assessed:	13/3/14		
Assessor's signature:			
Proposed Review date:	N/A		

05230

Acute Services Division

Hospital / Department GRI

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

Patient name: 0712726128 F SULLIVAN 07/12/1972 Deborah 6 MUIRHEAD COURT BAILLIESTON Glasgow, Lanarkshire G69 7EP

Ward: 67

CHI number: ..... Hospital number .....

Contents

1. Canard Falls Risk Assessment Scoring Form
2. Falls Assessment Care Plan
3. Glossary of terms used in risk assessment

Notes: Risk assessment should be completed within 24 hours of admission to each ward.

Assessment Wards: Risk assessment and care plan should be reviewed weekly.

Continuing Care Wards: Risk assessment and care plan reviewed monthly.

Referral Criteria for Hospital Falls Prevention Co-ordinator

1. Cannard score of 18+.
2. Second or subsequent fall
3. Significant Injury caused by a fall. (Significant Injury defined as any fracture, significant bruising or laceration to head or body.)

The patient should be referred with any of the above criteria.

General Safety Precautions

- Ensure patient has buzzer to hand
- Check patient has the manual dexterity and cognitive ability to operate buzzer
- Place personal items within easy reach
- Keep the bed in lowest position possible (use low bed if available)
- DO NOT leave patients with cognitive impairment unattended on commodes, in toilets, baths and showers.
- Patients with poor mobility, who are known not to ask for assistance, should not be left unattended on commodes, toilets, baths and showers.
- If noted that mobility / transfers are unsafe refer to physio / OT for assessment
- If patient wears glasses, ensure they are clean
- Ensure patient's footwear is adequate
- Lock wheels on all wheelchairs, beds, commodes and trolleys when in use
- Provide adequate lighting at night
- Request medication review if appropriate
- Clean up spills immediately
- Orientate patient to the ward environment

Cannard Falls Risk Assessment

(Must be completed within 24 hours of admission to each ward)

13/3

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						Date: / Ward: 67	Date: / Ward:	Date: / Ward:	Date: / Ward:	Date: / Ward:	Date: / Ward:	Date: / Ward:
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			1						
Sex	Male 1	Female 2				2						
Age	13-59 0	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		1						
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 / chair-bound/ wheel-chair 1		1						
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1						
				TOTAL SCORE		6						
				ACTION(S) TAKEN Enter action code(s) from Care Plan below		1						
SCORE 13+ = HIGH RISK If patient unconscious score as N/A until patient status improves				NURSE SIGNATURE		AO						

Please see back page for glossary of terms relating to the assessment above.

Falls Assessment Care Plan

Please tick all applicable nursing interventions

Action code	NURSING INTERVENTIONS	Date: / Ward:	Date: / Ward:	Date: / Ward:	Date: / Ward:	Date: / Ward:	Date: / Ward:	Date: / Ward:
1	Falls prevention and general safety precautions discussed with patient and family.	✓						
2	Move to more observable area of ward to optimise supervision.							
3	Advise patient they may experience dizziness when they mobilise initially.							
4	Requires assistance with mobilisation.							
5	Observe trip hazard due to invasive lines, drains and catheters.							
6	Do not leave the patient unattended when using commode, toilet, in shower or the bathroom area.							
7	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.							
8	Monitor lying and standing / sitting BP and pulse.							
9	A. Patient requires footwear or podiatry referral. (Date referred: / requested :) B. Request family / carer to provide suitable footwear.							
10	Commence continence assessment, follow Local Guidelines.							
11	Refer to Occupational Therapist.							
12	Select suitable seating (refer to policy).							
13	Non slip mat on chair /floor following advice from therapists.							
14	Refer to Physiotherapist.							
15	Review Transfer techniques.							
16	Request medication review.							
17	Bed/chair monitor in use.							
18	Falls map in use for seven days for patient who has second or subsequent falls.							
19	Bed rails/bumpers to be used (refer to policy).							
20	Patient requires low bed / mattress on the floor (refer to policy.)							
21	Patient requires one to one nursing care.							
22	Refer to Hospital Falls Prevention Co-ordinator (see criteria on front cover).							
23	Other interventions.							

Review Cannard score weekly / monthly as per policy. Enter action code(s) selected in action taken section on Falls Risk Assessment page above.

North Glasgow Hospitals

NHS
Greater Glasgow and Clyde

Patient Label

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

The patient attended GRI Clinic at Rheum

Hospital on No 112 and I would advise a change to drug therapy from

to

or additional therapy of hydroxychloroquine 200mg bd

as detailed below. Full letter to follow.

Additional Comments:

DRUG (print)	DOSE	FREQUENCY	DURATION / REVIEW DATE

Yours Sincerely

Signature:

Name (print) Grade: Ext. No:

White copy to - *G.P.* Pink copy - *File this copy in Case Records*

Patient Profile

North Glasgow Hospitals

NHS Greater Glasgow and Clyde

Ward: 65 **Date:** 29/3/12 **Time:** 2020 (24hr clock)

Please print clearly in BLOCK CAPITALS

Title: MS
Name: Deborah Sullivan
Preferred name:
Address: 6 Muirhead Court
Balliston
Post Code: G69 7EP
☎: 07936725898
DOB: 7/12/77 Age: 34
Hosp. No: 1063814K
Occupation:
Religion:
S.O.S. ☐ date: ☐☐/☐☐/☐☐
Interpretor required: ☐
(specify:)
Lives alone ☐

Consultant: Mr Chang
Named Nurse ①:
Admitting Nurse: S McDonald
Named Nurse ②:
Relatives seen by Doctor ☐

1 NOK/Friend/Contact: Kathleen Sullivan
Address: 187 Lowmoor Rd
☎ Day: 771 3295
☎ Night:
Relationship: Mother
2 NOK/Friend/Contact:
Address:
☎ Day:
☎ Night:
Relationship:
NOK informed of admission ☑
NOK informed by: patient
GP: Dr Flanagan
Address: Balliston HC
☎: 531 8050

REASON FOR ADMISSION

Abdo pain
? cause

Patient's perception of illness:

Diagnosis:

Operation/Treatment:

Relevant PMH: Cholecystectomy
pancreatitis
Pancreatic pseudocysts
Nissen fundoplication
IBS. Reflux

MEDICATION

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

OBSERVATIONS ON ADMISSION

Temperature	36.8	°C
Pulse	89	bpm
BP	152/104	
Resp	98% 18	
Pain Score	9	
Urinalysis		
Waterlow Score	5	
Height	1.80 5ft 10	m
Weight	78 12st 3	kg
Body Mass Index	25	
Blood sugar (if appropriate)		mmols

Allergies Yes ☑ No ☐
details: Penicillin

PERSONAL BELONGINGS

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

00653

Name: Deborah Sullivan Ward: 65 Date: 29/3/12 Case Record No.:

ACTIVITIES OF DAILY LIVING

HOME CIRCUMSTANCES/ SOCIAL SUPPORT

- Lives with family ☑
- Lives alone ☐
- Nursing home ☐
- Residential care ☐
- Elderly/disabled partner ☐
- Family support (specify below) ☐

District Nurse (_____days/week) ☐
(cancelled ☐)
Home help(_____days/week) ☐
(cancelled ☐)
Other services (specify below) ☐

Stairs: Internal ☐ External ☐
Comments:

SMOKING

- Non-smoker ☐
- Smoker: 15-20 per day ☑
- Ex-smoker ☐
- Aware of hospital policy ☐

HYGIENE

Bath ☐ Shower ☑
Requires assistance ☐ Stand up wash ☐
Skin assessment:

Other:

ELIMINATION

- Bowels regular ☑
- Constipated ☐
- Diarrhoea/Loose stools ☐
- Uses aperient ☐
- Has stoma:
  - Colostomy ☐
  - Urostomy ☐
  - Ileostomy ☐

appliances used:

Frequency of micturition ☐
Incontinent: urine/faeces ☐
day/night ☐
stress ☐
No urinary symptoms ☑
Comments:

NUTRITION

Normal menu (includes vegetarian) ☑
Vegan ☐ Child's menu ☐
Halal ☐ Kosher ☐
Refer to Dietician if any below ticked:
Inability to eat/swallow ☐
(refer to speech and language therapist)
Any recent weight changes ☑
Medically related nutrition problems (e.g. diabetes) ☐
Other (specify): Poor appetite

SLEEP

Hours/night Poor sleeper ☑
Medication ☐
details: Temazepam

BREATHING

1. No symptoms ☑
2. Breathless with moderate exercise ☐
3. Breathless with minimal exertion ☐
4. Breathless at rest ☐
5. Uses inhalers ☐

Comments:

MENTAL STATE

- Alert/Orientated ☑
- Confused: day/night ☐
- Anxious/Distressed ☐
- Unconscious ☐
- Other (specify):

SENSES

Glasses: distance ☐
reading ☐
Hearing impaired: left/right ☐
Hearing aid: left/right ☐
Dentures: upper ☐
lower ☐
Communication Difficulties ☐
Other:

MOBILITY (Pre admission)

Mobile without aid ☑
Mobile with aid ☐
(Specify type/side held:)
Furniture walking ☐
Chair Bound ☐
Housebound ☐

RELATIVE PARTICIPATION

PROFILE COMPLETED BY:

(Please print name in block capitals)
SMCDONALD
Signature:
Designation:
Countersigned (if applicable):

ALCOHOL INTAKE

Units/week: nil ☑
less than 14 ☐
14 - 21 ☐
over 21 ☐
(1 unit = 1 measure spirits/half pint beer/ lager/1 glass wine)

OTHER RELEVANT INFORMATION

MDS - fentanyl patch, hyaroxychloroquine Duloxetine, Diazepam, Omeprazole, Granisetron, Lactulose, Metoclopramide paracetamol 4hrly, Temazepam Tramadol.

Fall: - 5
NRS: - 3
MUST: - 0

Date:...../...../..... Ward:.....

MRSA SCREENING:

A: Clinical Risk Assessment (CRA)- for patients >23 hours	YES	NO
1. Has the patient ever had a previous positive MRSA result?	☐	☑
2. Has the patient been admitted from a care home/ institutional setting or another hospital?	☐	☑
3. Does the patient have a wound/ulcer or invasive device which was present prior to admission?	☐	☑

If 'Yes' to any question or if the patient is within (or admitted to) a High Impact Speciality' complete section B ['Not known' = 'No']

*Orthopaedics / Vascular / Renal / Critical Care [please circle]

SWABS TAKEN (✓): Nose ☐
Other(s)..... Perineum ☐
Patient refused ☐

Name: Deborah Sullivan Ward: 6S Date: 29/3/12 Case Record No.:

CARE PLAN

Date Comm.	Signature	1.BASIC CARE AND PERSONAL HYGIENE	Date Disc.	Signature
29/3/12	D	Independent		
		Bed bath		
		Assisted wash		
		Oral hygiene		
		Pressure care		
		2.NUTRITION		
29/3/12	D	Fasting		
30/3	DB	Normal Diet		
		Special Diet / Modified Diet		
		3.ELIMINATION		
29/3/12	D	Independent		
		Commode		
		Bedpan/urinal		
		Urinary Catheter | Size: | Batch No:		
		Type of Material: | H_2O in Balloon:		
		Type of Stoma Appliance:		
		4.MOBILITY		
29/3/12	D	Fully Independent/fully mobile		
		Minimal assistance (give details)		
		Dependent (See movement and handling sheet - keep with patient)		
		5.OBSERVATIONS		
29/3/12	D	Waterlow daily (if score is over 10+)		
		TPR		
		BP		
		Pain Score		
		Fluid Balance		

00499

CARE PLAN

Date Comm.	Signature	6.TECHNICAL CARE	Date Disc.	Signature
		IV Infusion		
		Monitor		
		Catheter		
		Oxygen Therapy		
		Nebulisers		
29/3/12	D	IV access: ∞ IV cannulae ∞ others (D)hand pink		
		7.WOUND CARE		
		8.SPECIMENS/INVESTIGATIONS		
		9.SLEEP		
		10.SPECIAL NEEDS		
		Assess for dysphagia (refer to speech and language therapist)		
		Source/protective isolation (refer to infection Control)		
		Blind/visually impaired		
		Deaf/hard of hearing		
		Anti-embolic stockings		
		Nurse escort when out of ward		
		11.OTHER RELEVANT INFORMATION		
		12.FAMILY/SIGNIFICANT OTHER		

Initial Care Plan seen and agreed by patient: Yes ☐ N/A ☐

Signature of nurse: **Date:** 29/03/12

Name: Deborah Sullivan Ward: 65 Date: 29/3/12 Case Record No.:

CARE PLAN EVALUATION

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

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
29/3/12	2030		Admitted via A+E with Abdo pain, known to Mr McKay with pancreatic pseudocyst.	
		(5)	BP 152/101, other obs stable IV Morphine 10mg IV given in A+E.	
		(2)	Fasting for r/v.	
		(3)	Urinalysis awaited.	
		(4)	Independent. Awaiting r/v.	
	2300		Oral fluids tonight & Fast in am 2 for uls scan. Analgesia given Observe overnight	Wanless
	MN		phosphate enema given - await result	LJ
	0540		Settled following analgesia. Fasting for ? uls this am	
			Bowels moved following enema	Jones
	am	NK	Reviewed by Mr Chang Allow to settle. Allow fluid + diet	Rundell
30/3/12	RMN	(1)	Independently shavelled. all personal hygiene needs attended to by patient	
		(2)	allowed fluid + diet as able. Encouraged oral intake.	
		(3)	voiding urine spontaneously.	
		(4)	Fully mobile.	
		(5)	Observations stable as documented.	
		(6)	IV cyclizine 50mg given for nausea. Oral analesgia given for pain relief. laxatives administered.	
			Nil for Ultrasound as per Mr Chang.	ABell
	WK	PM	D/C home c/c no follow up	Hyde Nurse

Glasgow Royal Infirmary/Western Infirmary

10638479K
SULLIVAN
DEBORAH
CHI-0712726128

NOT TO BE FILED UNTIL DISCHARGE

Name: Unit No.:

Date:		2/9/13	30/3	30/3/13									
Time of Result:		1905	0800	1600									
WCC	4-11	12.4		9.0									
Hb	M - 13-18 F - 11.5-16.5	119		118									
Plat	150-400	332		303.									
Amylase	<100	83	64										
CRP	<10	26	30										
Na+	135-145	141	139										
K+	3-5-50	4	4.2										
Cl-	98-108	107	110										
~~Bic~~ MCHH	21-28		1.01										
Urea	2.5-7.5	~~27~~ 26	2.3										
Creat.	57-113	56	48										
Glucose	3.5-5.5		/										
Bilirubin	3-22	4	8										
AST	<40	17	21										
ALT	<50	18	16										
G-GT	<55	41	38										
Alk. Phos.	40 -150	72	76										
Protein	60-80	71	64										
Albumin	32-45	36	32										
Globulin	22-33	35	32										
Ca	2.1-2.6		2.16										
Adj Ca	2.1-2.6		2.35										
PO4	0.7-1.4		1.11										
PT	9-12		11.4										
APTT	25-37		29.7										
TCT	11-15		13.0										
~~bil~~	~~38-145~~ CK	82											
~~PD2~~	~~42-75~~ Urate	0.17											
PCO2	4.4-5.6												
HCO2	20-28												

Urine: N.I

MIS 238455/GRI/WIG

Patient Observation Chart

NHS Greater Glasgow and Clyde

Name
Address Deborah Sullivan

Hospital No.

DOB

Admitted Date 29/3/12 Ward A+E

Transferred Date _____ Ward _____

Transferred Date _____ Ward _____

Patient Observation Chart Guidelines

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

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

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

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

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

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

Pain Score

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

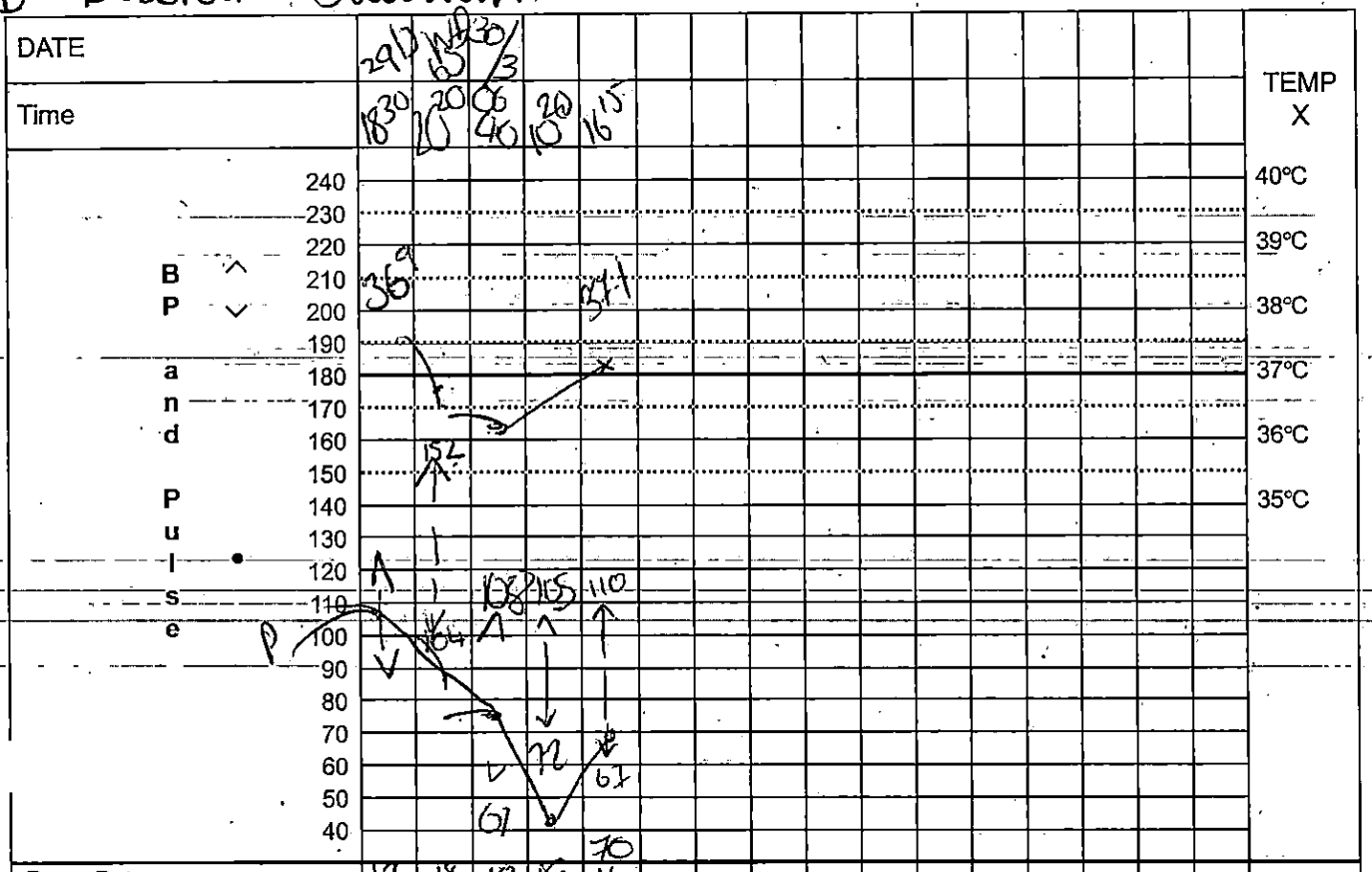
Sedation Score

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

Nausea Score

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

(8) Deborah Sullivan



Resp. Rate	19	18	18	18	16																
Inspiration O_2%	A	Air	Air		A																
SpO_2%	95	98	96	96	97																
Pain Score		1		0																	
Sedation Score		0		0																	
Nausea Score		0		0																	
Blood Glucose	9.3																				
GCS	15																				

MEWS																					
	Resp. Rate	0		0	0	0															
	Pulse	0				0															
	Systolic BP	0				0															
	GCS / AVPU	0				0															
	Urine Output	1				0															
	Temp.	0				0															
	SpO_2%	0				0															
	TOTAL	1		0	0	0															

Modified Early Warning Score (MEWS)

Score	3	2	1	0	1	2	3
Resp. Rate		≤8	9-10	11-20	21-25	26-30	≥31
Pulse		≤40	41-50	51-100	101-110	111-130	≥131
Systolic BP	≤84	85-89	90-100	101-199		>200	
GCS / AVPU	≤8	9-13	14 New agitation or confusion	15 / Alert	Voice	Pain	Unresponsive
Urine	<10mls/hr for 2 hrs	<30mls/hr for 2 hrs					
Temp. (°C)		≤35.0	35.1-35.9	36.0-37.4	37.5-38.5	≥38.6	
SpO_2%	≤87	88-91	92-94	95-100			

GLASGOW ROYAL INFIRMARY

Deborah Sullivan
10638479H

PATIENT ID LABEL

I.V THERAPY
PRESCRIPTION SHEET

No. 05199

	DATE	FLUID (USE BLOCK LETTERS. ADDITIVE DRUG	Vol (ml). Dose (mg)	Route of Admin.*	Dur. of Admin.*	SIGNATURE	Serial No. Batch No.	Time Begun	Given B Added b
A	29/3	Na Cl 0.9%	500	IV	4				
B	29/3	Na Cl 0.9%	500	IV	4				
C	29/3	Dextrose 5% +20mmol KCl	500	IV	4	McLUCCAN			
D									
E									
F									
G									
H									
I									
J									
K									
L									
M									
N									
O									

RATE OF FLOW (Drops/Min.)

6.00

VOL. OF FLUID (ml) x 15 (Duration (Mins.)

(1ml = 15 drops)

Approximate Rate for 500ml.

1 hr. = 120 Drops/min.

4 hr. = 30 Drops/min.

6 hr. = 22 Drops/min.

8 hr. = 15 Drops/min.

SHEET NO

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patient's name: Deborah Sullivan	Ward: 65
Unit number:	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				OWN MEDS ON WARD
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)				
Informed of discharge				
Social work/ Other agencies/Home help				
Physiotherapist				
Occupational Therapist				
Dietician				
Speech and Language Therapist				
Clinical Nurse specialist e.g. Care Home Liaison				
Liaison/ District Nurse/Practice Nurse				
Other discharge items				
Access arrangements (e.g. keys, door entry)				
Patients clothing available for day of discharge				
Valuables e.g. 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:			Date: / /

Adult Peripheral Venous Cannulation (PVC) Chart

Please use 1 chart per PVC

NHS Greater Glasgow and Clyde

PVC Insertion Information

*Ensure the PVC dressing has **date** and **time** of insertion written on it. This implies that appropriate technique has been used for insertion.*

Affix patient label

Name: Deborah Sullivan

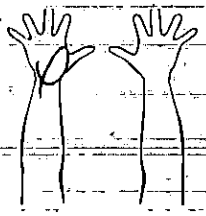
Address:

D.O.B:

CHI number:

Hospital: CRI Ward: 65

L R



Other Site: _____

Date: 29/3/12 (See IV Dressing)

Time: A+E

Reason for Insertion: Routine

Flushed on insertion ☐ (if known) _____

PVC Maintenance Information

Modified V.I.P (Visual Infusion Phlebitis) Score

IV site appears healthy	0	No Phlebitis	Observe Cannula
ONE of the following is evident: - slight pain or redness near site	1	Possible first signs	Observe Cannula
TWO of the following are evident: - pain - redness - swelling	2	Early stage of phlebitis	Re-site Cannula
ALL of the following are evident: - pain - redness - hardening of the surrounding tissue	3	Phlebitis / Thrombophlebitis	Re-site Cannula & Seek Further Advice
As above including: - palpable venous cord	4		
As above including: - pyrexia	5		

Day 1 (24 hours after insertion)

All 5 questions below MUST be answered
The PVC must be monitored at least once per day

1. Continuing clinical indication for PVC?	Yes / No
2. VIP Score?	0
3. PVC Dressing dry & intact?	Yes / No
4. Was PVC dressing renewed?	Yes / No / NA
5. Was PVC Removed?	Yes / No

Removal Reason: _____

Comments/Actions Taken:

Date: 29/3/12 Initials: AMB

Day 2

All 5 questions below MUST be answered
The PVC must be monitored at least once per day

1. Continuing clinical indication for PVC?	Yes / No
2. VIP Score?	☐
3. PVC Dressing dry & intact?	Yes / No
4. Was PVC dressing renewed?	Yes / No / NA
5. Was PVC Removed?	Yes / No

Removal Reason: _____

Comments/Actions Taken:

Date: Initials:

After Day 3 consider removal, if there is still a clinical reason justify rationale for PVC to remain insitu:

Date: Initials:

Day 3

All 5 questions below MUST be answered
The PVC must be monitored at least once per day

1. Continuing clinical indication for PVC?	Yes / No
2. VIP Score?	☐
3. PVC Dressing dry & intact?	Yes / No
4. Was PVC dressing renewed?	Yes / No / NA
5. Was PVC Removed?	Yes / No

Removal Reason: _____

Comments/Actions Taken:

Date: Initials:

Day 4

All 5 questions below MUST be answered
The PVC must be monitored at least once per day

1. Continuing clinical indication for PVC?	Yes / No
2. VIP Score?	☐
3. PVC Dressing dry & intact?	Yes / No
4. Was PVC dressing renewed?	Yes / No / NA
5. Was PVC Removed?	Yes / No

Removal Reason: _____

Comments/Actions Taken:

Date: Initials:

Nutrition Profile

NHS Greater Glasgow and Clyde

Name: Deborah McSullivan	Date of admission: 29/3/12
Address:	Time: 2020
	HOSPITAL: GRI
DoB:	Ward: G5
CHI number:	
Affix patient data label	

To be recorded within 24 hours of admission*

Height: 1.80 metres Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Weight: 78 kg Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Recent unplanned weight loss: Yes ☑ No ☐

If 'Yes' how much?: kg 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 ☐

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☑

Please state:

Food Allergies: Yes ☐ No ☑ If 'Yes' please state:

Eating likes and dislikes (including appetite):	Drinking likes and dislikes:	Patient NBM
poor appetite	nil	Yes ☑ No ☐ If 'Yes' why?:

Are there any contributing factors that may affect food intake such as **physical** (e.g. swallowing difficulties, loose teeth), **physiological** (e.g. nausea), **psychological** (e.g. dementia), **social or environmental**? Yes ☑ No ☐

Please specify all factors: pain, nausea

Is the patient on oral nutritional supplements? Yes ☐ No ☑

If 'Yes' please state:

Is the patient experiencing oropharyngeal swallowing problems (excluding oesophageal issues e.g. GORD, Stricture)? Yes ☐ No ☑

If 'Yes' please complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS). If oesophageal problem present please discuss with medical staff.

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☑

If 'Yes' please state:

Has this patient received written information about inpatient food (e.g. "Food in Hospitals" leaflet)?

Yes ☑ No ☐ Not applicable (received on previous admission) ☐

Profile completed by: Name (PRINT): S MCDONALD Signature: [signature] Date: 29/3/12

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

Is your patient on the Liverpool Care Pathway (LCP)? Yes ☐ No ☐

If 'Yes' please follow LCP advice as screening for malnutrition may not be appropriate.

Malnutrition Universal Screening Tool ('MUST')

Date	29/3/12											
Initials	D											
Height (see page 1) 180 Weight	78											
Oedema or ascites present Y/N	N											
BMI (refer to chart on page 4)	25											

'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. • 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.
- Use a recognised system to identify when equipment or asssistance is required at mealtimes (e.g. red mats, coloured napkins).
- REMEMBER TO CONSIDER YOUR PATIENT'S HYDRATION REQUIREMENTS.
- Ensure Discharge Plan includes most recent 'MUST' Score and any necessary follow-up requirements.

Referral Services		Referred by	Method of referral	Reason for referral
Nutritional Support Team	Date Referred / /			
Dietitian	Date Referred: / /			
Speech and Language Therapy	Date Referred: / /			
Occupational Therapy	Date Referred / /			
Dental Service	Date Referred / /			

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Action discussed with patient / carer	Review date	Name (PRINT) Signature/ Designation
29/3	0	NO Action			

NHS
Greater Glasgow and Clyde

NATVNS
SCOTLAND

WRITE, IMPRINT OR ATTACH LABEL
Surname Sullivan CHI No .....
Forenames Deborah Sex .....
DoB .....
Location .....

ADAPTED WATERLOW PRESSURE AREA RISK ASSESSMENT CHART

More than one score/category can be used: **10+= 'At Risk': 15+= 'High Risk': 20+= 'Very High Risk'**
Complete assessment on admission/1st visit, if there is a change in individuals condition and repeat regularly according to local protocol

Sex										
Male	1									
Female	2	2								
Age										
14 -49	1	1								
50 -64	2									
65 - 74	3									
75 - 80	4									
81+	5									
Build/Weight for Height (BMI=weight in Kg/height in m²)										
Average - BMI 20-24.9	0									
Above average - BMI 25-29.9	1	1								
Obese - BMI > 30	2									
Below average - BMI < 20	3									
Continence										
Complete/catheterised	0	0								
Incontinent urine	1									
Incontinent faecal	2									
Doubly incontinent (urine & faecal)	3									
Skin Type - Visual Risk Area										
Healthy	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								
Restless/fidgety	1									
Apathetic (sedated/depressed/reluctant to move)	2									
Restricted (restricted by sever pain or disease)	3									
Bedbound (unconscious/unable to change position/traction)	4									
Chairbound (unable to leave chair without assistance)	5									
Nutritional Element										
Unplanned weight loss in past 3-6 months										
<5% Score 0, 5-10% Score 1, >10% Score 2	0-2	0								
BMI > 20 Score 0, BMI 18.5-20 Score 1, BMI < 18.5 Score 2	0-2	0								
Patient acutely ill or no nutritional intake > 5 days	2									
Special Risks - Tissue Malnutrition										
Multiple organ failure/terminal cachexia	8									
Single organ failure e.g. cardiac, renal, respiratory	5									
Peripheral vascular disease	5									
Anaemia ∞ Hb < 8	2									
Smoking	1	1								
Special Risks - Neurological Deficit		/								
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*	4-6									
Special Risks - Surgery/Trauma										
On table > 6 hours	8									
Orthopaedic/below waist/spinal (up to 48 hours post op)	5									
On table > 2 hours (up to 48 hours post op)	5									
Special Risks - Medication		/								
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4									
Total Score		5								
Date		2/9/13								
Initials		DO								
Time		21								

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

Acute Services Division

Hospital / Department GRI

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

Patient name: Deborah Sullivan

Ward: 65

CHI number: Unit/Hospital number

Contents

1. Canard Falls Risk Assessment Scoring Form
2. Falls Assessment Care Plan
3. Glossary of terms used in risk assessment

Notes: Risk assessment should be completed within 24 hours of admission to each ward.

Assessment Wards: Risk assessment and care plan should be reviewed weekly.

Continuing Care Wards: Risk assessment and care plan reviewed monthly.

Referral Criteria for Hospital Falls Prevention Co-ordinator

1. Cannard score of 18+.
2. Second or subsequent fall
3. Significant Injury caused by a fall. (Significant Injury defined as any fracture, significant bruising or laceration to head or body.)

The patient should be referred with any of the above criteria.

General Safety Precautions

- Ensure patient has buzzer to hand
- Check patient has the manual dexterity and cognitive ability to operate buzzer
- Place personal items within easy reach
- Keep the bed in lowest position possible (use low bed if available)
- DO NOT leave patients with cognitive impairment unattended on commodes, in toilets, baths and showers.
- Patients with poor mobility, who are known not to ask for assistance, should not be left unattended on commodes, toilets, baths and showers.
- If noted that mobility / transfers are unsafe refer to physio / OT for assessment
- If patient wears glasses, ensure they are clean
- Ensure patient's footwear is adequate
- Lock wheels on all wheelchairs, beds, commodes and trolleys when in use
- Provide adequate lighting at night
- Request medication review if appropriate
- Clean up spills immediately
- Orientate patient to the ward environment

Cannard Falls Risk Assessment

(Must be completed within 24 hours of admission to each ward)

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						Date: 29/3 Ward: 65	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			0						
Sex	Male 1	Female 2				2						
Age	13-59 0	60-70 1	71-80 2	81+ 1		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		1						
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	/						
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed / chair-bound/ wheel-chair 1		1						
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1						
				TOTAL SCORE		5						
				ACTION(S) TAKEN Enter action code(s) from Care Plan below		1						
SCORE 13+ = HIGH RISK If patient unconscious score as N/A until patient status improves				NURSE SIGNATURE								

Please see back page for glossary of terms relating to the assessment above.

Falls Assessment Care Plan

Please tick all applicable nursing interventions

Action code	NURSING INTERVENTIONS	Date: 29/8 Ward: 65	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:
1	Falls prevention and general safety precautions discussed with patient and family.	✓						
2	Move to more observable area of ward to optimise supervision.							
3	Advise patient they may experience dizziness when they mobilise initially.							
4	Requires assistance with mobilisation.							
5	Observe trip hazard due to invasive lines, drains and catheters.							
6	Do not leave the patient unattended when using commode, toilet, in shower or the bathroom area.							
7	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.							
8	Monitor lying and standing / sitting BP and pulse.							
9	A. Patient requires footwear or podiatry referral. (Date referred: / requested :) B. Request family / carer to provide suitable footwear.							
10	Commence continence assessment, follow Local Guidelines.							
11	Refer to Occupational Therapist.							
12	Select suitable seating (refer to policy).							
13	Non slip mat on chair /floor following advice from therapists.							
14	Refer to Physiotherapist.							
15	Review Transfer techniques.							
16	Request medication review.							
17	Bed/chair monitor in use.							
18	Falls map in use for seven days for patient who has second or subsequent falls.							
19	Bed rails/bumpers to be used (refer to policy).							
20	Patient requires low bed / mattress on the floor (refer to policy.)							
21	Patient requires one to one nursing care.							
22	Refer to Hospital Falls Prevention Co-ordinator (see criteria on front cover).							
23	Other interventions.							
		✓						

Review Cannard score weekly / monthly as per policy. Enter action code(s) selected in action taken section on Falls Risk Assessment page above.

Client Specific (Inpatient) Moving and Handling Risk Assessment Form

Patient's name:	Deborah Sullivan	Named Nurse:	SMcDonald	If Patient is totally independent, tick here and go to date box	✓	Risk: Low / Medium / High	

BODY BUILD				Problems with comprehension, behaviour, co-operation (specify):
Obese		Tall	✓	
Above average	✓	Medium		
Average		Short		
Below average				Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
RISK OF FALLS				
High		Low	✓	

Transfers (including To/From: Bed; Wheelchair; Commode; Toilet)

HOIST/STANDAID (specify)	ASSISTANCE	SUPERVISION	INDEPENDENT	
Model:	People: 1 / 2 / 3	Additional Information:		
Sling type:	Walking aid (specify)			
Sling size:				

Toileting

HOIST/STANDAID	ASSISTANCE	SUPERVISION	INDEPENDENT	
	People: 1 / 2 / 3	Additional Information:		

Move on / off bed pan

HOIST	MANOEUVRE	ASSISTANCE	SUPERVISION	N/A	
	Roll patient	People 1	Additional Information:		
	Monkey pole	People 2			
	Patient bridges	People 3			

Move up / down bed

HOIST	HANDLING AIDS	ASSISTANCE	SUPERVISION	INDEPENDENT	
	Sliding sheet	People 1	Additional Information:		
	Monkey pole	People 2			
	Rope ladder	People 3			

Transfer to / from trolley (or bed etc.)

HOIST	HANDLING AIDS	ASSISTANCE	SUPERVISION	INDEPENDENT	
	Patslide	People 1	Additional Information:		
	Other	People 2			
	Fabric sliding aid	People 3			

Sit up over side of bed

BED REST	ASSISTANCE	SUPERVISION	INDEPENDENT	
	People: 1 / 2 / 3	Additional Information (e.g. equipment to be used – swivel cushion):		

Into Bath or Shower

WHICH BATH	HANDLING AID	ASSISTANCE	SUPERVISION	INDEPENDENT	
Shower	Shower chair	People 1	Additional Information:		
Variable height bath	Bathing Hoist e.g. Atenti	People 2			
Bed bath	Sling lifting Hoist	People 3			

Walking

NO WALKING	WALKING AID (specify)	ASSISTANCE	SUPERVISION	INDEPENDENT	
		People 1	Distanced walked / Additional Information:		
		People 2			
		People 3			

Other Instructions

Recording Symbol:	/	X	*
Date Assessed:	29/3/13		
Assessor's signature:			
Proposed Review date:	ongoing		

05230

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

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☑
Date 30/3/12 Name (Print) G Williams
Discharge Prescription Prepared & Reconciled YES ☐
Date _____ Name (Print) _____

Date and time this form prepared: __/__/__ Time: _____ | Sheet No _____ | 2nd Prescription in use 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: M'MICHAEL R Date: 29/3/12

COMMUNITY PHARMACY INFORMATION

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

PATIENT DETAILS

Ho
10638479K
DC SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
De GLASGOW G69 7EP
Cc CHI-0712726128

Height:
Weight:
Surface area:
Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
29/3	PHOSPHATE ENEMA	x1	PR	2330	M'MICHAEL R	Warden	2340

Name Deborah Sullivan
CHI No 0712726128

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

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (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

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

DATE → 3
MONTH → 3

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

A

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☑

DRUG: CLEXANE

DOSE: 40mg | ROUTE: S/C | DATE: 2913

PRESCRIBER (PRINT & SIGN): MCMICCAN.

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

		For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
Other time						
0700-0800						
1200-1400						
1600-1800	8					
2200-2400						
Other time						

B

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

		For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
Other time						
0700-0900						
1200-1400						
1600-1800						
2200-2400						
Other time						

C

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

		For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
Other time						
0700-0900						
1200-1400						
1600-1800						
2200-2400						
Other time						

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

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.

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

D DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

E DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

F DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

G DRUG

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.

Name Deborah Sullivan

CHI No 0712726128

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

Penicillin

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol
– Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

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

Notes for [illegible]

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

Oral and Other Drugs: Regular Prescription

DATE: 29 30
MONTH: 3 3

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

H — BEFORE ADMISSION ☑ — NEW DOSE ☐ — NEW MEDICATION ☐

DRUG: TEMAZEPAM
DOSE: 10mg | ROUTE: ORAL | DATE: 29/3 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): McMILLAN
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

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

J — BEFORE ADMISSION ☑ — NEW DOSE ☐ — NEW MEDICATION ☐

DRUG: ESOMEPRAZOLE G/R
DOSE: 40mg | ROUTE: ORAL | DATE: 29/3 | STOPPED DATE: 31/3 | INITIALS:
PRESCRIBER (PRINT & SIGN): McMILLAN
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

0700-0900: X [illegible]

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

K — BEFORE ADMISSION ☑ — NEW DOSE ☐ — NEW MEDICATION ☐

DRUG: PARACETAMOL
DOSE: 1g | ROUTE: ORAL | DATE: 29/3 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): McMILLAN
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

0700-0900: X [illegible]
1200-1400: X [illegible]
1600-1800: X [illegible]

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

L — BEFORE ADMISSION ☑ — NEW DOSE ☐ — NEW MEDICATION ☐

DRUG: DULOXETINE
DOSE: 90mg | ROUTE: ORAL | DATE: 29/3 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): McMILLAN
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: 90mg

0700-0900: X [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

Oral and Other Drugs: Regular Prescription

DATE → 30
MONTH → 3

Patient's Own Medicine

M — BEFORE ADMISSION ☑ — NEW DOSE ☐ — NEW MEDICATION ☐

DRUG: METOCLOPRAMIDE
DOSE: 10mg | ROUTE: ORAL | DATE: 29/3 | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN): M'MICCAN
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

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

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

N — BEFORE ADMISSION ☑ — NEW DOSE ☐ — NEW MEDICATION ☐

DRUG: CERAZETTE
DOSE: 1 TAB | ROUTE: ORAL | DATE: 29/3 | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN): M'MICCAN
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: Desogestrel 75 microgram

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

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

P — BEFORE ADMISSION ☑ — NEW DOSE ☐ — NEW MEDICATION ☐

DRUG: LACTULOSE
DOSE: 15mls | ROUTE: ORAL | DATE: 29/3 | STOPPED DATE: 30/3 | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN): M'MICCAN
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

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

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

R — BEFORE ADMISSION ☑ — NEW DOSE ☐ — NEW MEDICATION ☐

DRUG: HYDROXYCHLOROQUINE
DOSE: 400mg | ROUTE: ORAL | DATE: 29/3 | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN): M'MICCAN
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.

Name: Deborah Sullivan
CHI No: 0712726128

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

Administration by Symptomatic Relief Policy or other Protocol

Nurses/Midwives Only (Maximum number of doses as per protocol)

Check the As Required and Regular Prescription sections to ensure that the

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

Oral and Other Drugs: Regular Prescription

DATE: 29 30
MONTH: 3 3

| | | |

Oral and Other Drugs: Regular Prescription

DATE → 29 30
MONTH → 3 3

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 ☐

X DRUG: FENTANYL PATCH
DOSE: 75 Microgram/HR | ROUTE: TOPICAL | DATE: 29/3 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): M'MECAN.
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: Warfarin ®

0700-0900: X X X

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

Warning: Check the As Required and Regular Prescription sections to ensure that the

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.

CC

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

DD

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

EE

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FF

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

STOPPED DATE: INITIALS:

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

GG DRUG

DOSE | ROUTE | DATE

STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

HH DRUG

DOSE | ROUTE | DATE

STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

JJ DRUG

DOSE | ROUTE | DATE

STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

KK DRUG

DOSE | ROUTE | DATE

STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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.

Name Deborah Sullivan

CHI No 0712726128

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

Penicillin

Nurse/Midwife Administration by Symptomatic Protocol
- Authorised Nurses/Midwives Only
Warning: Check the As Required and Regular Prescription sections to ensure that the

All Routes: As Required Prescriptions

Patient's Own Medicine

| | | |

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

Name Deborah Sullivan

CHI No. 0712726128

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

Penicillin

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

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☑
Date 20/12/11 Name (Print) K PHILIP

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: KM McCuaig Date: _____

COMMUNITY PHARMACY INFORMATION

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

PATIENT DETAILS

10638479K
SULLIVAN, F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

Height:
Weight:
Surface area:
Ward:

Name Deborah Sullivan
CHI No 0712726128

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

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
19/12	~~ASPIRIN~~	~~300mg~~	~~Po~~	~~2300~~	~~KM McCuaig~~	~~AL~~	~~23.15~~
19/12	CYCLIZINE	50mg	IV	2340	KM McCuaig	AD	00.00
19/12	TRAMADOL	50mg	~~Po~~ Po	2340	KM	AD	00.00
19/12	Aspirin	300mg	PO	23.00	KM	AL	23.45
20/12	MORPHINE	5mg	IV	0100	KM	ML	01.10
20/12	MORPHINE	~~10mg~~ 5mg	IV	0210	KM	ML	02.15
20/12	MORPHINE	2.5mg	IV	0710	JA	RGR	08[illegible]

Nurse/Midwife Administration by Symptomatic Relief Policy (SRP)

- Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

Warning: Check the As Required and Regular Prescription sections to ensure that the

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

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
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 ☐

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.

Name Deborah Sullivan

CHI No 0712726123

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

Penicillin

...Administration by Symptomatic Relief Policy or other Protocol

...Missed Doses/Wdrives Only (Maximum number of doses as per protocol)

...Check the As Required and Regular Prescription sections to ensure that the

Oral and Other Drugs: Regular Prescription

DATE: 20 21 22
MONTH: 12 12 12

H — DRUG: LACTULOSE
DOSE: 15ml | ROUTE: Po | DATE: 19/12 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): KM McCloy
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. | Patient's Own Medicine

J — DRUG: ESOMEPRAZOLE
DOSE: 20mg | ROUTE: Po | DATE: 19/12 | STOPPED DATE: 20/12 | INITIALS:
PRESCRIBER (PRINT & SIGN): KM McCloy
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: GABAPENTIN
DOSE | ROUTE | DATE | STOPPED DATE: | 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: GANISETRON IMG
DOSE: 1 TAB | ROUTE: Po | DATE: 19/12 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): KM McCloy
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.

GRANISETRON
INFORMATION
IN MED
LOCKER
WITH SPECIAL
PLASTIC CHANGE

Note: To discontinue a prescription, initial and date appropriate box ... ction & record reason

Oral and Other Drugs: Regular Prescription

DATE 26 21 22
MONTH 12 12 12

M — DRUG: FENTANYL 75 MCG/HR PATCH
DOSE: 1 patch | ROUTE: TOP | DATE: 20/12 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): CLARK
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: 1 patch every 72 hrs
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time
0700-0900: 2 ✓ ✓ ✓

...ication by Symptomatic Relief Policy (2...
...Narcotics Only (Maximum number of doses as per protocol)
...and Regular Prescription sections to ensure that the
...drug are so important as to avoid prescribing [illegible]

Oral and Other Drugs: Regular Prescription

DATE → 21 22
MONTH → 12 12

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.

S — DRUG: Metoclopramide
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
DOSE: 10 mg | ROUTE: PO | DATE: 20/12 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): C. May
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
0700-0900: ✓ W Pa
1200-1400: 0755 W
1600-1800: X W
2200-2400: ✓

T — DRUG: Duloxetine
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
DOSE: 90 mg | ROUTE: PO | DATE: 20/12 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): C. May
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
0700-0900: ✓ W Pa.
1200-1400: ✓
1600-1800: ✓
2200-2400: ✓

V — DRUG: Diclofenac Gel 3%
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
DOSE: 1 App | ROUTE: PO | DATE: 20/12 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): C. May
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
0700-0900: ✓ (13) (13)
1200-1400: ✓
1600-1800: ✓
2200-2400: ✓ (13) (13)

W — DRUG:
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐
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.

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

X DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

Y DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

AA DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

BB DRUG

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.

Name Deborah Sullivan

CHI No 0712726128

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

Penicillin

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

CC 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 ☐

DD 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 ☐

EE 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 ☐

FF 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.

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

GG DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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.

HH DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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.

JJ DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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.

KK DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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.

Name Deborah Sullivan

CHI No 0712726128

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

Penicillin

Nurse/Midwife Administration by S[illegible]

- Authorised Nurses/Midwives Only

Warning: Check the As Required and Regular Prescription sections to ensure [illegible]

All Routes: As Required Prescriptions

| | | |

| | | |