

ROYAL HOSPITAL

☒

ROYAL INFIRMARY

☐

GLASGOW ROYAL HOSPITAL

☐

MATERNITY

☐

NEW VICTORIA ACH

☐

PRINCESS ROYAL MATERNITY

☐

QUEEN ELIZABETH UNIVERSITY HOSPITAL

☐

MATERNITY

☐

ROYAL ALEXANDRA HOSPITAL

☐

MATERNITY

☐

ROYAL HOSPITAL FOR CHILDREN

☐

STOBHILL HOSPITAL

☐

VALE OF LEVEN

☐

MATERNITY

☐

WEST AMBULATORY CARE HOSPITAL

☐

WESTERN INFIRMARY RECORDS

☒

Including:

BADGERNET

☐

CAREVUE

☐

MEDICAL ILLUSTRATION

☐

METAVISION

☐

PHYSIOTHERAPY

☐

RADIOLOGY

☐

WEST MARC

☐

LABS

☐

E-Facer PATIENT REPORT

Time 15:45 Date 17/12/2010

PATIENT AND INCIDENT DETAILS

Incident number PA003592485.001
 Name MARY WATSON
 Address 28 KENDOO AV
 Patient postcode G15
 Age 56
 Date of birth 06/03/1954
 Gender Female
 Incident location DRUMCHAPPEL H/C: B WING,
 DRUMCHAPPEL H/C KINFARNS
 DRIVE DRUMCHAPPEL GLASGOW
 Incident post code G15 7TS
 Incident type EMG
 Call received 17/12/2010, 14:40
 Call passed 17/12/2010, 14:42
 Crew mobile 17/12/2010, 14:42
 Crew at scene 17/12/2010, 14:55
 Crew left scene 17/12/2010, 15:22
 Receiving hospital and department WEST Western Infirmary Glasgow

TREATMENT REFUSAL FORM

PRIMARY SURVEY

RESPONSE

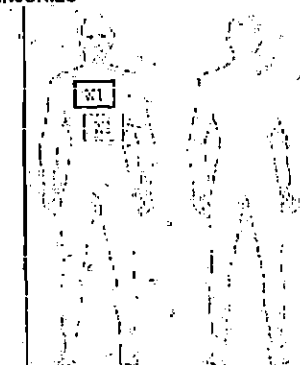
AVPU Alert
 AIRWAY
 Airway assessment Clear
 BREATHING
 Breathing rate Normal
 Respiratory rate

CIRCULATION

Pulse rate Fast
 Cap refill rate

INJURIES

WOUND
 W1 Pain
 W2
 W3
 W4
 P1 No pain relief
 provided
 P2
 P3
 P4



AMPOS

Dispatch code 33004
 Final code 10A01
 T1/T2 Heart Problems / MI
 Chest Pains, Normal Breathing
 35

GCS

Final GCS eye opening Spontaneous
 Final GCS verbal response Orientated
 Final GCS motor response Obeys commands

VITAL SIGNS

Time hr : min	Cap refill (secs)	Peak flow %	Blood sugar mmol / l	Temp °C	SpO2 %	GCS Total	RTS	SEWS	ECG	Pain score
14:05	14	12	141 / 95	32 secs	5.6	34 / 99	15	550	5	NSR
14:50										

AMPLE

Allergies
 Other allergies
 Medication
 Past history
 Last eaten
 Events prior
 SEPTON
 LIST WITH PATIENT
 CERVICAL CIA, BREAST CIA, GALL
 BLADDER REMOVAL
 4 hrs
 10 MIN PERIODS OF PAIN, EVERY
 COUPLE OF HOURS, OVER LAST 2 DAYS

DRUGS, GASES AND PAIN RELIEF

Drug / Gas	Time given	Dose given	Route	Batch No	Pain after
Aspirin					

AMI

History of episode
 Patient symptoms
 Pain character
 Other comments
 Smoker
 Time of onset Central
 Sudden NOT anginal
 NSR

FINAL OBSERVATION AND COMMENTS

Female chest pain onset 12
 days ago 10 min periods
 every couple of hours (GP
 letter) not cardiac chest 12
 lead ok obs ok

Report ID

18ced358-b84e-4976-a158-
 5ce2181ae7c

[illegible]

Watson, Mary
DoB: 06/03/1954

Report Valid On 17/12/10 14:41

Dr Nugent & Partners
Drumchapel Health Centre

Page number 1

Kinfairns Drive

GIS 7TS

0141-211-6100

Registration

Miss Mary Watson
28 kendoon avenue
Glasgow
GLASGOW G15
G15 8AX
Telephone: 944 3074

Service Code: Permanent
DoB: 06/03/1954

Age: 56

Contact: ?

Contact Relationship: ?

Email: ?

CHI Number: 0603546323

NHS Number: S644/7/54/660

Occupation:

Registered GP: Dr SC Lyon

Repeat Consultation: 23/09/2010

Dispensing: No

Marital Status: Unknown

Acute Consultation: 17/12/2010

Repeat Medication

Intervals

Drug/Preparation	Quantity/Dose/Frequency	Start	Last	Pres.	Review	CMS	Int.
Atorvastatin TABS 40MG	56 1 Tab At night	29/09/2009	07/12/2010	56d.	52w.	w.	
Gaviscon Sf Aniseed LIQ	300 15 ml 3 times daily	29/09/2009	07/12/2010	56d.	52w.	w.	
Levothyroxine Sodium TABS 100MICROGRAMS	56 1 Tab In the morning	01/04/2008	07/12/2010	56d.	52w.	w.	
Dihydrocodeine Tartrate TABS 30MG	100 1 Tab qds if req	10/03/2008	07/12/2010	30d.	52w.	w.	
Glyceryl Trinitrate 180 Dose Cfc Free Pump 10g SPRAY 400MCG/DOSE	1 2 Puffs subling prn	06/05/2005	22/11/2010	28d.	52w.	w.	

Adverse Reactions

Read Code	Description
14L..	H/O: drug allergy
TJ0..	Adverse reaction to antibiotics
ADR Description	septrin

Clinical / User Marker

Date Recorded	Start Date	Priority	Description	Modifier
08/12/2003	None	High	Acquired hypothyroidism	
26/06/2002	None	High	Adverse reaction to antibiotics	
Freetext:	septrin			
02/01/2002	None	High	Chest pain	
Freetext:	MI -ve			
30/07/2001	None	High	[D]Chest pain	
12/10/2000	None	High	[D]Chest pain	
16/01/1998	None	High	Chest infection	
11/02/1997	None	High	Alopecia	
21/12/1996	None	High	Lumpectomy of breast	
21/10/1996	None	High	Malign neop of bone, connective tissue, skin and breast	Left

Freetext: BREAST

01/01/1996	None	High	H/O: depression
14/03/1995	None	High	FH: Neoplasm - *
14/03/1995	None	High	H/O: drug allergy
30/09/1991	None	High	Cervical intraepithelial neoplasia
30/09/1991	None	High	No smear - benign hysterectomy
05/12/1985	None	High	[V]Sterilisation
23/10/2010	01/12/2010	Medium	Laparoscopic cholecystectomy
14/03/1995	None	Medium	Health ed. - exercise

Priority Clinical / User Marker

Date Recorded	Start Date	Priority	Description	Modifier
---------------	------------	----------	-------------	----------

08/12/2003	None	High	Acquired hypothyroidism	
26/06/2002	None	High	Adverse reaction to antibiotics	

Freetext: septrin

02/01/2002	None	High	Chest pain	
------------	------	------	------------	--

Freetext: MI -ve

30/07/2001	None	High	[D]Chest pain	
------------	------	------	---------------	--

12/10/2000	None	High	[D]Chest pain	
------------	------	------	---------------	--

16/01/1998	None	High	Chest infection	
------------	------	------	-----------------	--

11/02/1997	None	High	Alopecia	
------------	------	------	----------	--

21/12/1996	None	High	Lumpectomy of breast	
------------	------	------	----------------------	--

21/10/1996	None	High	Malig neop of bone, connective tissue, skin and breast	
------------	------	------	--	--

Left

Freetext: BREAST

01/01/1996	None	High	H/O: depression
------------	------	------	-----------------

14/03/1995	None	High	FH: Neoplasm - *
------------	------	------	------------------

14/03/1995	None	High	H/O: drug allergy
------------	------	------	-------------------

30/09/1991	None	High	Cervical intraepithelial neoplasia
------------	------	------	------------------------------------

30/09/1991	None	High	No smear - benign hysterectomy
------------	------	------	--------------------------------

05/12/1985	None	High	[V]Sterilisation
------------	------	------	------------------

Last Encounter

Dr J McAtear

Date: 17/12/2010

central chest heaviness on and off for past few days. assoc slight SOB on exertion. smoker. cardiac Ix 2002. o/e looks well. chest clear. HSpure. BP130/81. need to exclude cardiac cause. aspirin 300mg chewed 1435hrs. emerg ambulance arranged

Last 4 Clinical Notes

Thank you

J McAtear

Date	Clinical Notes
------	----------------

17/12/2010	central chest heaviness on and off for past few days. assoc slight SOB on exertion. smoker. cardiac Ix 2002. o/e looks well. chest clear. HSpure. BP130/81. need to exclude cardiac cause. aspirin 300mg chewed 1435hrs. emerg ambulance arranged
------------	---

WEST GLASGOW HOSPITALS

50623238H

WATSON

MARY

28 KENDON AVE

GLASGOW

G15 8AX

Hospital No.

06/03/1954

Age

Sex

Dept.

Ward

OUT PATIENT HISTORY

DATE

28/6/64

Dr McClellan
Bone

WT: 65.2 Kg - 10st 4 lb

HT: 1m 51cm - 4ft 11 1/2

Difficulty turning neck as job pain into (L) shoulder

Fell 3 weeks ago - (L) leg gave way

Pain in legs all the way to feet.

Back v. sore of turning stationary.
Worse if walking - need to rest.
Walks leaning forwards.

V. anxious - didn't go for MRT

Hysterectomy age 37. Sp. Ex Cancer

Bowel + bladder problems.

Breast Cancer - (L) arm lymphoedema

- triple therapy

- Dr Evans Beaton

Underactive thyroid

Keeps LTN when out - pres in coronary care.
1 cholesterol.

DATE

HISTORY

(Use other side first)

HL - Main Del. had OP
 Fisher has OP - ankle

2 - Tyrosine
 Anvaratin
 GTN

S/A - Still smoking
 Diet variable
 Milk 1/2 pt/day
 little exercise

Posterior hip tuberosity line

S/E - Angia ~50 gals. 2-3 units.
 Pome & Cuski? - butgut newspaper

7c - ALR 25° B-lab
 AP & hip movement
 Reflexes # Per LV
 No ton muscle bulk

Deser anxiety - MRI at Am of G.

Wrote to Mr. Rance

Caraway

NORTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST
ACCIDENT & EMERGENCY DEPT.
WESTERN INFIRMARY
GLASGOW
G11 6NT
Tel: 0141-211-2304/2409
Fax: 0141-339-3046

CONSULTANTS: Mr W M Tullett
Mr P T Grant
Dr S Perry
NURSE MANAGER: Mr G D Wright



CRN: 50623238H

TREATMENT COPY

PATIENT	Surname WATSON		Forename MARY		Age 50	Date of Birth 06/03/54	Arr Date 20/05/04	Time 20:00	AE Number 020855/04
	Address 28 KENDOOON AVE GLASGOW			Sex Female	Religion Church of Sc	Date of Inc 20/05/04		Time	
				Marital Status Married/	Occupation/School HWIFE	Type of Inc Home	Mode of Arrival By Ambul		
	PC G15 8AX	Tel 944 1246							
G	Name Dr LYON		Address DRUMCHAPEL HEALTH C 80/90 KINFAUNTS DRIV GLASGOW G15 7TS 0141 211 6100				Referred by OTHER		
	Name ARLENE WATSON		Address 28 KENDOOON AVE GLASGOW G15 8AX				Complaint		
EXT	Relat DAUGHTER								
OF	el. No. 944 1246								
ON									

ROAD TRAFFIC ACCIDENT PLACE

DETAILS

HOME ACCIDENT PROBABLE CAUSE

TO BE COMPLETED BY MEDICAL OFFICER AFTER SEEING PATIENT

Dear Doctor,

The above-named patient attended Accident & Emergency Department today.

Diagnosis

X-ray film/ECG shows

Treatment given

Drugs _____ days supply of _____ has been given.

Tetanus Prophylaxis has/has not been administered. TT Course _____ TT Booster _____ HATI _____ (Please Tick)

Would you please arrange _____

DISCHARGE CODES: Please circle

- | | | | |
|--------------|---|-------------------------------------|------------------------|
| 1. Admission | 3. Refer to G.P. | 5. Died | 7. Irregular Discharge |
| 2. Discharge | 4. Transfer to other hospital (see below) | 6. Refer to O.P. Clinic (see below) | 8. D.O.A. |

Ward No. (if admitted)		Transfer to Hospital		Consultant (if admitted)								
Follow-up	Not Arranged	Arranged	To be arranged		IRIS							
Clinic Referred to	AE	Dressings	Hand	Fracture	Ortho	Medical	Surgical	Skin	ENT	Gyn	OHPAT	Others (specify)

Medical Officer's Name (in BLOCK LETTERS)

Signature of Medical Officer

Cons SpR **SHO3** SHO JHO Clin Assist ENP (please circle)

INITIAL VITAL SIGNS

at: (Time) 08.00
HR: 116
BP: 119/69
RR: 16
SaO₂: 96%
Temp: 37.3°
G.C.S.: _____
Signed: ll

[illegible]

PARENTERAL FLUID PRESCRIPTION SHEET

[illegible]

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

REFUSAL TO REMAIN UNDER HOSPITAL CARE

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

Name (print) _____ Signature _____

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

Date _____ Signature _____

(Medical Practitioner)

DISCHARGE DETAILS (NURSING)

Treatment Asp

Signed _____

(Please put initials in box)

Crutches ☐	Return appointment ☐	Advice Card ☐	Medication ☐
Escort to ward ☐	Relatives informed ☐	IRIS ☐	Transport ☐ Time booked _____

Discharged with _____ Admitted / transferred to L.S.M.

Time discharged 22.00 Signed CP

NEUROLOGICAL OBSERVATIONS

[illegible]

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

URINALYSIS

Urobilinogen	Normal	36	33	66	131	
μmol/l	☐	☐	☐	☐	☐	☐
Protein	Neg		Trace	0.30	1	>20
g/mL	☐	☐	☐	☐	+++	++++
pH	5.0	6.0	6.5	7.0	7.5	8.0
	☐	☐	☐	☐	☐	☐
Blood	Neg	Non Hem	Hem	Trace	Small	Mod
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
Specific Gravity	1.000	1.005	1.010	1.015	1.020	1.025
	☐	☐	☐	☐	☐	☐
Ketones	Neg		Trace	0.5	Small	Mod
mmol/L	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
Bilirubin	Neg		Small	+	Mod	Large
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
Glucose	Neg		5.5	Trace	14	28
mmol/L	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
Nitrites	Neg					Positive
	☐	☐	☐	☐	☐	☐
Leucocytes	Neg		Trace	Small	Mod	Large
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
BHCG	+ve					-ve

Signed: _____

Date

20/5/04
 PC - Chest Pain
 29° at lower sternum chest pain
 → back
 Bull No N+V / Smelling
 Slight SOB
 Varying in intensity but always present
 → Previous admission 4 1/2 yrs ago to CCU
 Co - very - runs irregularly / Smoking
 Not on aspirin / Phlebotomy
 on Statin
 PMHx Chest Ca type A
 Ca cervix
 Nil else
 RX Smoker 20 CPD
 Smoky keen Hx
 PMHx Zovir 4 days
 Thyroxine 25mcg
 SE No abuse
 (QE) Pulse 72 - y
 BP 111/70 No murmurs / thrills / rales
 Trunk +
 C=H = Normal
 PMHx Subs = some, not cultured
 Soft non tender
 No lymphadenopathy
 Bil sub - (C=H)
 ECG Sino 100
 Ant Q waves
 General ST Elevation

Date

Large Physical pain but partial relief GTN
 high sub point + buccal GTN
 Ph Admit Aspirin given by paramedics
 Old rules
 Give better 2mg buccal amount
 PMHx ECG shows if better pain
 Nil given
 Cardio Rx
 CVT 100
 CXR on word
 Bloody
 Na 139 Urea 7.3 WCC 11.2
 K 4.5 Creat 87 Hb 12.3
 Cl 109 Plt 187
 21/5/04 Discharge early for relatively asymptomatic
 from for 12 of - v, discharge & start
 Ramipril
 W. Bley

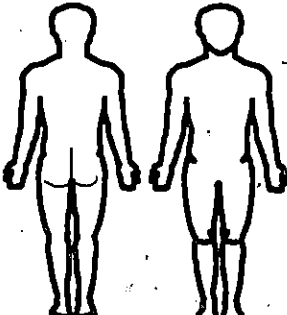
[illegible][illegible]

SCOTTISH AMBULANCE SERVICE - PATIENT REPORT FORM

CCS INCIDENT No.		1085750										Date	190506			
Last Name		WATSON										Time of Call	1906			
First Name		MARY										Time at Patient	1916			
Location	29 KENWOOD RD										Age					
											Sex	M F				
											D of B	060354				
											AMPDS Code	10401				
											AMPDS Revised					

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

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



RTA ☐

Trapped ☐

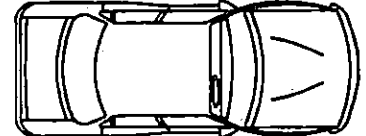
Ejected ☐

M/cyclist ☐

Cyclist ☐

Pedestrian ☐

>20 min. Extricate ☐



Temp. °C

PEFR %

B. Sugar mmol.

Allergies None

Medication WITH PATIENT

Assisted by and Name -

Doctor ☐ Nurse ☒ Other ☐

Time	Pulse	Resp	BP	C / Refill	SpO2 %	GCS	Lpupil	Rpupil
1916	110	20	120/80	F S N		4 5 6	2.5	2.5
			S Y S	F S N		E V M	3.5	3.5
			S Y S	F S N		E V M	3.5	3.5
			S Y S	F S N		E V M	3.5	3.5

Time	Fluid/Drug/Gas	Dose	Unit	Route	Effect	Rhythm	No. Joules	Repeat	Result	Rhythm
1920	ASPIRIN	300mg			+ 0 +					
1920	GABAPENTIN	2mg			+ 0 +					
					- 0 -					
					+ 0 -					

Condition at ☐ hospital Pulse ☒ Breathing ☒ Conscious ☒ Time at Hospital 1957

History and Additional Information 999 - PATIENT WITH CENTRAL CHEST PAIN RADIATING FRONT TO BACK SINCE YESTERDAY. PERSONAL HISTORY OF SAME 3-4 YEARS AGO W/6. FAMILY HISTORY OF SAME HIS CERVICAL + MCAST CA.

Working assessment

Diagnosis Code

Crew Name 1 T. DENNICAN Grade 1

Crew Name 2 R. WATSON Grade 1

ACCIDENT & EMERGENCY DEPT.
WESTERN INFIRMARY
GLASGOW
G11 6NT
Tel: 0141-211-2304/2409

CRN: 623238

Surname WATSON	Forename MARY	Age 47	Date of Birth 06/03/54	Arr Date 01/01/02	Time 16:54	AE Number 000247/02
Address 28 KENDON AVE GLASGOW		Sex Female	Religion Ch. of Scotla	Date of Inc 01/01/02	Time	
PC G15 8AX		Tel 944 9973	Marital Status Married	Occupation/School HWIFE	Type of Inc Other	Mode of Arrival By Ambul
Name Dr LYON			Address DRUMCHAPEL HEALTH C 80/90 KINFAUNTS DRIV GLASGOW G15 7TS 01412116100		Referred by GP	
Name ARLENE WATSON			Address 6 Tallant Terrace GLASGOW G15 7NZ		Complaint	
Relat DAUGHTER			Tel. No. 944 9209			

ROAD TRAFFIC ACCIDENT PLACE

DETAILS

HOME ACCIDENT PROBABLE CAUSE

TRIAGE**TO BE COMPLETED BY MEDICAL OFFICER AFTER SEEING PATIENT**

Dear Doctor,

The above-named patient attended Accident & Emergency Department today.

Diagnosis

X-ray film/ECG shows

Treatment given

Drugs

Tetanus Prophylaxis has/has not been administered.

TT Course

TT Booster

HATI

has been given.

(Please Tick)

Would you please arrange

DISCHARGE CODES: Please circle

1. Admission

3. Refer to G.P.

5. Died

7. Irregular Discharge

2. Discharge

4. Transfer to other hospital (see below)

6. Refer to O.P. Clinic (see below)

8. D.O.A.

Ward No. (if admitted)

Transfer to Hospital

Consultant (if admitted)

Follow-up

Not Arranged

Arranged

To be arranged

Clinic
Referred to

AE

Hand

Fracture

Ortho

Medical

Surgical

Skin

ENT

Gyn

Others (specify)

Medical Officer's Name (in BLOCK LETTERS)

Signature of Medical Officer

Cons

SR

Reg

SHOJHO

Clin Assist

(please circle)

NURSING NOTES

TRIAGE

DATE:

TIME:

CHIEF COMPLAINT:

RELEVANT HISTORY:

PHYSICAL SIGNS

VITAL SIGNS:

TREATMENT AT TRIAGE:

DISPOSITION:

HR:

BP:

RR:

GCS:

TEMP:

1. RESUSCITATION
2. MEDICAL/SURGICAL
3. TRAUMA:
4. OTHER (SPECIFY)

TRIAGE NURSE SIGN

..... PRINT

PT 11

PTT 32

INRO 9

DER FIB 2.46

WCC 10.48

Hb 12.7

PIF 209.

Na⁺ 139

K⁺ 4.1

Cl 107

Bic 27

U 4.7

cr 85

G 5.1

TO BE RECORDED ON ARRIVAL

126/86

T 368

P 81

R 18

BP

O2SA 95%

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION	SIGNATURE	GIVEN BY

CONSULTANT

REG/SHO

JHO

SEEN BY

AT (TIME)

CLINICAL NOTES

KEY TO CLINICAL NOTES

- 1 - HISTORY OF
- 2 - ON EXAMINATION
- 3 - X-RAY FINDINGS
- 4 - TREATMENT GIVEN
- 5 - DISPOSAL
- 6 - NAME OF MEDICAL OFFICER

DATE

4/7/86

Reinstated chest discomfort

Since last

acute intermittent

Cough in waves

Feels sore

No radiation

Went to

? pain worse when walking

now feels as if has burning sensation

Occasional dyspepsia

o Cough / sputum

Normal aged group 2y ago

Sub

the IHD ++

7/5 well

H&S I + II

Chest clear

A&L soft

o DVT / oedema

Note: given on injection by G.P.

ECG. SR. all acute.

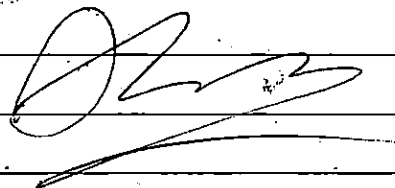
DATE

CLINICAL NOTES

Bloods

CXR

Gua MacLox.



11/1/02

Returned from x-ray.

9:15pm

Gaviscon not really helped pain → still present.

CXR - ↑ (R) hemidiaphragm

fluid in fissures

general ↑ markings

→ to be admitted to LCU.

try buccal sucard for pain → if
no relief → analgesia

for MI screen.

Doe Clerk (STO 1108)

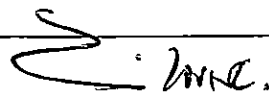
2/1/02. 0950.

Five New. Bin free keen for here.

(N) Cor Arto (for similar pain) ± 3 years ago.

(D) -ve MI screen

See O/P 6/02. ?? → endoscopy



TRIAGE

DATE:

E:

CHIEF COMPLAINT:

RELEVANT HISTORY:

PHYSICAL SIGNS

VITAL SIGNS:

TREATMENT AT TRIAGE:

DISPOSITION:

HR:

BP:

RR:

GCS:

TEMP:

1. RESUSCITATION
2. MEDICAL/SURGICAL
3. TRAUMA:
4. OTHER (SPECIFY)

TRIAGE NURSE

SIGN
PRINT

T. 1 P. 113 R. BP. 182

0.5a 98%

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION	SIGNATURE	GIVEN BY

CONSULTANT

REG/SHO

JHO:

SEEN BY

AT (TIME)

CLINICAL NOTES

KEY TO CLINICAL NOTES

1. HISTORY OF
2. ON EXAMINATION
3. X-RAY FINDINGS
4. TREATMENT GIVEN
5. DISPOSAL
6. NAME OF MEDICAL OFFICER

DATE

20/7/11

Neckline STD

HB - @ breast ca - hyperthy + chemo + Radioactive
lymph nodes but also

- central ca - 8 years ago - mastectomy

- recurrent chest infections

- Gradually worsening @ severe "breast"
pain, post 4/7, worse on coughing -
trough to back

- S.O.B. @ haemoptysis, cough but no spit

- started on amoxicillin last night

Probs - @ above

- recently screened for P.T.E - -VE. V/asea

- Angiogram - 3 yrs ago - been getting chest pain

- 7 previous MI

- @ CVA, @ DM, @ RF, @ TB, @ Epilepsy, @ Senile

Angels - Tenosyn

- OP118

- Ibuprofen

- Amoxicillin

- Metoprolol to Seprin - mouth sweets -

X-ray and other reports to be filed on this side (if the patient is not being admitted)

NAME

May Watson

HOSPITAL

No

623238

AGE

47

PHYS/
SURG

OOFF

DEPT

WARD

L87

IN-PAT
FORM 3IN PATIENT
CONTINUATION HISTORY

DATE

30/7/11

Ph

- Bloods + D-dimers + LFTs + Blood culture

- CXR

- ECG - Sins.

Q in V1, II, aVF

T inversion III

- MI screen

- C/w oral amoxicillin

- Sputum CTB MSS ✓

- Admit L87

Major Sin (S10)

30/7/11 47yrs. Personal PMH and FH
 noted, incl possible prev. (of MI)
 still in stress!

better, less morning signs/sx of DVT.
 Central CP: assoc w breath and some
 postural change. D. ① Long tenderness
 C/S & chest ② Pericardial rub
 Needs MI screen. D - Divers -ve.

Is there any anti-embolism equipment etc?
 ③ if nervous with MI screen -ve

skin

No change of mood

age, prev? MI, risk factors -

ask GP to assess prior to D.



Integrated Care Pathway Chest Pain/Myocardial Infarction

Date: 25/10/98 Ward: WACC



623238
WATSON MAR
28 Halgreen Avenue F
GLASGOW 06/03/5
G15 8AB
G.P. Prac. 40436

Please print details clearly in BLOCK CAPITALS

Patient Details

Name: Mary Watson
Preferred name: _____
Address: 28 Halgreen Avenue
Glasgow
G15 8AB
Phone: 0141 944 7780
D.O.B. 6/3/54 Age: 44
Gender: Female ☒ Male ☐
Hosp.No: 623238
Cons.: JJMcM ☒ JDMcA ☐ JAK ☐ WSH ☐ HJD ☐
Named nurse: K. CURRIE
Associate nurse: _____
Nursing team: Yellow

Admission Date: 25/10/98
Symptom onset time: 18:30
Time of call for help: 18:37
Time at A&E: _____
Time at CCU: _____
Time of first ECG: _____
Time of diagnostic ECG: _____

NB. For all times use 24 hour clock

Diagnosis

• Provisional:
Unstable angina
• Final:

Date	CK	CKMB
<u>26.10.98.</u>	<u>42</u>	

Marital status:
single ☐ married ☐
separated ☐ divorced ☐
living together ☐ widowed ☐
Occupation: Housewife
Retired ☐ Unemployed ☐
Religion: C of S (S.O.S.) ☐
Interpreter required specify: _____
GP: Dr Lynn Drumchapel H/c
Phone: _____

Next of Kin: Arlene Watson
Address: 6 Tallant Terrace
Glasgow
Phone: 0141 944 9209
Relationship: Daughter
Other Contact: _____
Address: _____
Phone: _____
Relationship: _____
Relatives aware of admission ☒

Medication

Not with patient ☐
Stored and receipt given ☐
Taken home ☐

Note: This pathway represents usual practice and variations are expected as clinicians use their own judgement.

Type of Admission

Emergency via A&E ☐
Transfer from other hospital ☐ plus casenotes ☐
Transfer from other ward W8M ☒
Admitted via clinic ☐
Elective ☐
Transfer from day ward ☐
Transferred from Cath Lab ☐
Other (specify): _____

Social History

Smoking History:
Non-smoker ☐
Ex smoker (specify below) ☐
_____ per day for _____ years
Date gave up smoking: _____/_____/_____
Smoker (specify below) ☒
_____ per day for _____ years
Type of tobacco: cigarettes ☐ pipe ☐ cigars ☐

Alcohol Intake (units/week):

nil ☒ less than 14 ☐
14 - 21 ☐ over 21 ☐
(1 unit = 1 measure spirits/half pint beer/ lager/
1 glass wine)

Home Circumstances/Social Support

Lives with family (specify below):

family capable of caring ☒
family incapable/disabled ☐

Lives alone ☐

Family support nearby ☐

Other support (specify below) ☐

No support available ☐

Nursing Home ☐

Residential Care ☐

District Nurse (____ days/week) ☐

(Cancelled ☐)

Home help (____ days/week) ☐

(Cancelled ☐)

Other services ☐

(Specify: _____)

Stairs

Internal ☐

External ☐

Comment: _____

Mobility

Mobile without aid ☒

Mobile with aid ☐

(Specify type/side held: _____)

Furniture walking ☐

Chair Bound ☐

Housebound ☐

Nutrition

Normal menu (includes vegetarian) ☒

Vegan ☐ Halal ☐ Kosher ☐

Refer to Dietitian if any below ticked:

Inability to eat/swallow ☐

Any recent weight changes ☐

BMI >30 ☐

Medically related nutrition problems (e.g. diabetes) ☐

Other (specify): _____

Elimination

Bowels regular ☐

Constipated ☒

Diarrhoea/Loose stools ☐

Frequency of micturition ☐

Incontinent:

urine/faeces

day/night -

Urine - no problems ☐

Has bath/shower at home ☐

Stand-up wash ☐

Sleep

Hours/night ☐

Medication ☐

specify: _____

Observations on Admission

Heart Rate _____ bpm

BP _____

Temperature _____ °C

Waterlow Score _____

Pain Score _____

Height _____ m

Weight _____ kg

Body Mass Index _____

Blood Sugar _____ mmols

Urinalysis:

Trace blood.

Senses

Glasses

Reading. ☒

Hearing impaired: left/right ☐

Hearing aid: left/right ☐

Dentures ☐

Breathing

No symptoms ☐

Symptoms on moderate exertion ☐

Symptoms on minimal exertion ☒

Symptoms at rest ☐

Productive cough ☐

Uses inhalers ☐

Cardiac Related Symptoms

Palpitations ☐

Oedema - site: _____ ☐

Nausea ☐

Vomiting ☐

Other: _____ ☐

Mental State

Alert/Orientated ☒

Confused: day/night ☐

Anxious/Distressed ☒

Other: _____

Personal Belongings

Clothing listed ☐

Clothing taken home ☐

Valuables listed ☐

Valuables taken home ☐

Valuables in hospital safe ☐

Admitting Nurse:

E. L. L. L.

ICP discussed with:

Patient: ☐

Relative ☐

By: _____

Planned Discharge Date:

☐☐☐/☐☐☐/☐☐☐

Integrated Care Pathway
Chest Pain/Myocardial Infarction/
Unstable Angina



623238
WATSON MARY
28 Halgreen Avenue F
GLASGOW 06/03/54
G15 8AB
G.P.Prac. 40436

Date: 25/10/98 Ward: WCCU

Medical Clerking/Admission

Presenting Symptoms

Previous Investigations/ Procedures/Operations	Yes	No	If yes, give details
Coronary angiography	☐	☒	
PTCA	☐	☒	
CABG	☐	☒	
Previous Valve Replacement	☐	☒	
Other vascular	☐	☒	
Cardiac History	Yes	No	If yes, give details
Angina/Unstable angina	☐	☒	
Previous MI	☐	☒	Site: Date:
Previous Thrombolysis	☐	☒	Agent: Date:
Heart failure	☐	☒	
Rheumatic fever	☐	☒	
Valve disease	☐	☒	
Left ventricular hypertrophy	☐	☒	
Arrhythmia	☐	☒	

**Integrated Care Pathway
Chest Pain/Myocardial Infarction/
Unstable Angina**



623238
WATSON MARY
28 Halgreen Avenue F

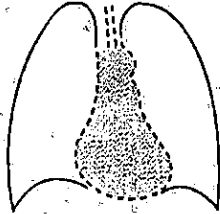
GLASGOW 06/03/54
G15 8AB
G.P.Prac. 40436

Date: 25 / 10 / 98 Ward: WCCU

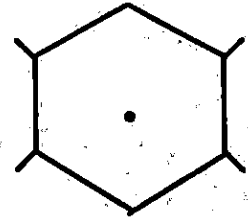
Medical Clerking/Admission (cont.)

Physical Examination (cont.)

Chest:



Abdomen:



Blood Tests ordered (tick if yes) - Please insert results on Secondary Prevention Sheet

- Routine Admission Bloods ☒ (Na, K, U, Cr, Cholesterol, Glucose, FBC)

nat: 140, K: 3.9, BIC: 26, urea: 4.9, creat: 66 CK: 42
GWT: 59

Hb: 12.0 WCC: 10.7, Plt: 249.

Investigations		Comments
ECG	Normal ☐ Abnormal ☒	Specify: Inverted T's V1-V4
Repeat ECG planned (Only after findings from 1st are known) Time: : :	Yes ☒ No ☐	Reason for repeat:
Next day bloods (tick if ordered)	Routine ☒ CK/CKMB ☒ APTT ☒	
Chest X-Ray • heart size (comment) • lung fields (comment)	Yes ☒ No ☐	
Other:		

Treatment	Yes	No	
Thrombolysis for MI: • Agent - SK ☐ tPA ☐ other ☐ (specify: _____) • Dose: _____ • Time: :	☐	☒	If NO, specify reason
Repeat thrombolysis If yes, why: _____	☐	☒	
Aspirin	☒	☐	If NO, specify reason
Beta blocker: • oral ☐ • IV ☐	☒	☐	If NO, specify reason
IV Heparin • Dose: _____	☒	☐	If NO, specify reason
IV GTN/ISDN • Dose: _____	☒	☐	
IV insulin if IDD or Glucose greater than 10	☐	☒	If NO, specify reason
Other (specify): _____	☐		

Summary and Differential Diagnosis

D: Unstable Angina

Immediate Management and Initial Progress

I.V. GTN / Heparin
 Aspirin
 B-Blocker

Admitted by: E. WACKIE (print name in block capitals) E. Wackie (signature)

Designation: _____

**Integrated Care Pathway
Chest Pain/Myocardial Infarction/
Unstable Angina**

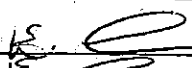
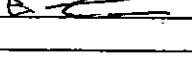
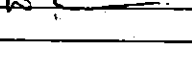
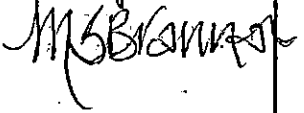
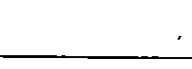
Date: 15/10/98 Ward: Ward



623238
WATSON MARY
28 Halgreen Avenue F
GLASGOW 06/03/54
G15 8AB
G.P.Prac. 40436

Echo Cardiogram - attach to this page

Admission Day

Nursing	Signature	Time	Progress/Evaluation of Care
Patient attached to cardiac monitor/electrodes outwith defib sites		18 ³⁰	Transfer from home medical. Monitoring in sinus bradycardia rate 50 beats. Complaining of a headache. GTM infusing 5mls/0.5mg Heparin infusing 1ml/1000u. 
Observations on admission			
ECG performed			
Venflon in situ			
Pain Score			
Analgesia if required			
Advised to report any pain			
Dr's instructions performed, e.g. thrombolysis, etc.			
Patient informed of named nurse			
CCU information booklet given			
Condition and progress discussed with patient			21 ²⁰ C/O Nausea, IV Metoclopramide 10mg prescribed and administered. Information re stopping smoking given to pt 
Condition and progress discussed with relatives and visiting sheet given			
Hr and Rhythm 1 hourly			
Blood pressure 1-4 hourly			
Temp. 4 hourly			
Accurate Fluid Balance			
IV and dose checked hourly			
Change IV lines 24 hourly			
ECG 2 hours post thrombolysis if applicable			
Patients progress reassessed			
Moving and handling requirements assessed			

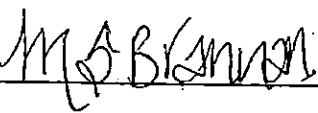
Pharmacy

Confirm drug history		
Review drug therapy:		
• drug changes • drug omissions • drug interactions • IV therapy		
TDM - optimise drugs with narrow therapeutic range		

Night Staff Progress Report

Date: 2/6/10/98

Slept well overnight
IV infusions continue as before
Cardiac monitor displaying sinus rhythm HR 60's-70's

Signature: 

**Integrated Care Pathway
Chest Pain/Myocardial Infarction/
Unstable Angina**

MRS MARY WATSON
28 Halgreen Avenue
GLASGOW
G15 8AB

Date: 26/10/98 Ward: CCU

Admission + 2

Medical	Yes	No	Ward Round/Progress Review
Seen by consultant/deputy	☒	☐	<i>I think she will need a diagnostic cath. - Worsening minor ST-T changes in V₁-V₃ have not changed - different from 1995 but had radiologically same. Wynne is negative. - ? CIA 27/10/98. <i>J. Kennedy</i></i>
CCU daily checklist reviewed	☒	☐	
Record: Blood pressure: <u>116/64</u> Heart rate: <u>79</u> bpm Rhythm: <u>sinus</u> <u>AE</u> <u>other</u>	☒	☐	
Review other treatment (see secondary prophylaxis sheet)	☒	☐	
Condition, progress, treatment, and investigations discussed with patient.	☒	☐	
Management/Plan: • remain in CCU • transfer • discharge	☒	☐	Signature: _____ Print name: _____ Designation: _____ ☐ Cons. ☐ SPR/SR ☐ SHO Time: - ☐ : ☐ : ☐

Additional Comments

Pharmacy	Signature	Time	Comments
Review drug therapy	<i>KL</i>	<i>1840</i>	
TDM	<i>MT</i>		

Admission + 1			
Nursing	Signature	Time	Progress/Evaluation of Care
Assisted wash			See next page
Change electrodes			
Up to sit 1/2 hour			
HR and Rhythm 1 hourly			
BP 4 hourly			
Temp. BD if apyrexial			
Fluid balance assessed			
Check venflon site			
Check rate and dose of IV therapy hourly			
Check IV expiry date 12 hourly and change IV line			
Advise to report chest pain			
Cardiac literature given by named nurse			
Referred to rehab. nurse (only if MI)			
Condition, progress and treatment discussed with patient			
Condition, progress and treatment discussed with relative			
Transfer discussed			
Review venflon sites regularly			

Night Staff Progress Report	Date: / /
------------------------------------	-----------

Signature:

Variations from Pathway				
Code	Variation	Sign	Action	Sign

Integrated Care Pathway Chest Pain/Myocardial Infarction/ Unstable Angina



623238
WATSON
28 Halgreen Avenue MAR
GLASGOW 06/03/5
G15 8AB
G.P. Prac. 40436

Date: 26 11 04 Ward:

Admission + 1

Medical	Yes	No	Ward Round/Progress Review
Seen by consultant/deputy	☒	☐	No further pain No acute B-blockade plc wear off C-TN, continue heparin ↑ metoprolol in patient ETT when stable
CCU daily checklist reviewed	☒	☐	
Record: Blood pressure: 100 / 60 Heart rate: 60 bpm Rhythm: <u>sinus</u> AF other	☐	☐	
Review other treatment (see secondary prophylaxis sheet)	☒	☐	
Condition, progress, treatment, and investigations discussed with patient.	☒	☐	
Management/Plan: • remain in CCU • transfer • discharge	☒	☐	Signature: <u>P. Ne</u> Print name: <u>NEARLY</u> Designation: ☐ Cons. ☐ SPR/SR ☒ SHO Time: - ☐ : ☐ : ☐

Additional Comments

Pharmacy	Signature	Time	Comments
Review drug therapy			
TDM			

Admission + 1				
Nursing	Signature	Time	Progress/Evaluation of Care	
Bed bath	BM	9am	Settled and pain free morning. S/b Dr Nery IV GTN weaned off. To continue IV Heparin for further 24 hours. oral beta blocker increased. Awaiting CK and cholesterol levels for enzyme testing. Venflon dislodged. IV heparin discontinued and commenced on 9c enoxaparin therapy. (Amended) Settled afternoon. C/o feeling shivery and cold @ 1500. Temp 38°C. Blood cultures taken and given paracetamol. S/b Dr Kennedy, priority for angiography tomorrow. Fast from 6am Tea + Toast. Remains pyrexial @ 1800 hrs and feels better than earlier. Mmpk	
Change electrodes				
Up to sit 1/2 hour				
HR and Rhythm 1 hourly				
Blood pressure 1-4 hourly				
Temp. 4 hourly				
BM stix if Diabetic/on Insulin				
Fluid balance				
Review analgesia				
Check venflon site				
Check IV and dose hourly				
Check IV expiry date 12 hourly and change IV line				
Passive limb movements taught				
Advised to report pain				
Condition, progress and treatment discussed with patient	✓	✓		
Condition, progress and treatment discussed with relative				
Night Staff Progress Report			Date: 1/1/2000	
8pm BP 72/53 rechecked 85/53. D/W Dr Quadango. Venflon inserted: IV heparin recommended. metoprolol to be withheld tonight. Settled overnight. IV heparin continues 1,000u/1ml/hr. Observations satisfactory. Tea & toast & medication given at 6am Signature: CWilcox				
Variations from Pathway				
Code	Variation	Sign	Action	Sign

Integrated Care Pathway
Chest Pain/Myocardial Infarction/
Unstable Angina

Date: 27/10/98 Ward: CCU



623238
WATSON MARY
28 Halgreen Avenue F
GLASGOW 06/03/54
G15 8AB
G.P.Prac. 40436

Admission + 2

Medical	Yes	No	Ward Round/Progress Review
Seen by consultant/deputy	☒	☐	27.10.98 Reduce metoprolol to 50mg tid - hypotensive on higher dose. - f CIA today Signature: <u><i>[Signature]</i></u> Print name: <u>KENNEDY</u> Designation: ☒ Cons. ☐ SPR/SR ☐ SHO Time: ☐☐:☐☐☐
CCU daily checklist reviewed	☐	☐	
Record:			
Blood pressure: <u>75/53</u>			
Heart rate: <u>75</u> bpm			
Rhythm: <u>sinus</u>	☐	☐	
<u>AF</u>	☐	☐	
<u>other</u>	☐	☐	
Review other treatment (see secondary prophylaxis sheet)	☐	☐	
Condition, progress, treatment, and investigations discussed with patient.	☐	☐	
Management/Plan:			
• remain in CCU	☒	☐	
• transfer	☐	☐	
• discharge	☐	☐	

Additional Comments

Pharmacy	Signature	Time	Comments
Review drug therapy	<u><i>[Signature]</i></u>	<u>1525</u>	
TDM	<u><i>[Signature]</i></u>		

Admission + 2			
Nursing	Signature	Time	Progress/Evaluation of Care
Assisted wash <i>independant</i>	<i>amacleod</i>		Seen by Dr Kennedy this am. For coronary angiography today. Fasted and consented ✓ Metoprolol & 50mg T10 in view of hypotension last night (amacleod) Missu sent this am ✓
Change electrodes	<i>amacleod</i>		
Up to sit 1/2 hour	<i>amacleod</i>	1.00	
HR and Rhythm 1 hourly			
BP 4 hourly	<i>amacleod</i>	1.00	1500 Patient returned from cath lab. Normal coronary arteries. Uncomplicated procedure. APTT to be checked and sheath to come out later. IV heparin discontinued. pp 128/73
Temp. BD if apyrexial			
Fluid balance assessed			
Check venflon site	<i>amacleod</i>		
Check rate and dose of IV therapy hourly <i>as able</i>	<i>amacleod</i>		D/W Dr Kennedy this pm Patient to remain overnight. Sheath to be removed. (amacleod) Discharge prescription on ward (am)
Check IV expiry date 12 hourly and change IV line	<i>amacleod</i>		
Advise to report chest pain	<i>amacleod</i>	1.00	
Cardiac literature given by named nurse	<i>N/A</i>		
Referred to rehab. nurse (only if MI)	<i>N/A</i>		
Condition, progress and treatment discussed with patient	<i>amacleod</i>		
Condition, progress and treatment discussed with relative			
Transfer discussed			
Review venflon sites regularly			

Night Staff Progress Report	Date: 28/10/98
------------------------------------	-----------------------

Slept well. Sheath removed.
R femoral wound site painful. Given Dihydrocodeine.

Signature: *amacleod*

Variations from Pathway				
Code	Variation	Sign	Action	Sign

**Integrated Care Pathway
Chest Pain/Myocardial Infarction/
Unstable Angina**



623238
WATSON MARY
28 Halgreen Avenue F
GLASGOW 06/03/54
G15 8AB
G.P.Prac. 40436

Date: ____/____/____ Ward: ____

Admission + 3

Medical	Yes	No	Ward Round/Progress Review
Seen by consultant/deputy	☐	☐	
CCU daily checklist reviewed	☐		
Record: Blood pressure: ____/____ Heart rate: ____bpm Rhythm: sinus AF other	☐ ☐ ☐	☐ ☐ ☐	
Review other treatment (see secondary prophylaxis sheet)	☐	☐	
Condition, progress, treatment, and investigations discussed with patient.	☐	☐	
Management/Plan: • remain in CCU • transfer • discharge	☐ ☐ ☐	☐ ☐ ☐	
			Signature: _____ Print name: _____ Designation: ☐ Cons. ☐ SPR/SR ☐ SHO Time: - ☐ ☐ : ☐ ☐

Additional Comments

--	--	--	--

Pharmacy	Signature	Time	Comments
Review drug therapy			
TDM			

Admission + 3

Nursing	Signature	Time	Progress/Evaluation of Care
Basin to wash <i>Independent</i>	<i>am</i>		No complaints this am. R femoral site remains tender. - regular analgesia required For For discharge home today - discharge prescription ✓ (A Macleod)
Review cardiac monitoring			
Review mobilisation <i>off</i>			
Up to sit - gently mobilise <i>fully</i>			
Up to walk pm ✓			
Review BP if:			
BP BD - normotensive ✓			
Temp. BD - if apyrexial			
Review fluid chart <i>//</i>	<i>△</i>		
Advise reporting of chest pain ✓			
Check that cardiac literature/advice given if applicable			
Check that patient referred to rehab. (only if MI)			
Discuss condition, progress and treatment with patient			
Discuss condition, progress and treatment with relative			
Change/remove venflon			

Night Staff Progress Report

Date: / /

Signature:

Variations from Pathway

Code	Variation	Sign	Action	Sign

Name: *Mary Watson*

Ward: 28 Med

Date: 25/10/98

Case Record No.: 623238

CARE PLAN

[illegible]

[illegible]

Integrated Care Pathway
Cardiology Department:
Diagnostic Catheterisation/PTCA/Stent



623238
WATSON MARY
28 Halgreen Avenue F
GLASGOW 06/03/54
G15 8AB
G.P. Prac. 40436

Date of Procedure: 27/10/98 Ward: CCU

Pre-Procedure Checklist

Named nurse: SN E. Curne

Proposed operation: Diagnostic Catheterisation ☒ PTCA ☐ Stent ☐

Nursing: Checklist	Ward			Lab			Comments/Information
	Yes	No	N/A	Yes	No	N/A	
ID band on and correct	☒	☐	☐	☒	☐	☐	
Case notes, Drug Kardex present	☒	☐	☐	☒	☐	☐	
Consent signed	☒	☐	☐	☒	☐	☐	
Fasted from: 6am ☒ other ☐	☒	☐	☐	☒	☐	☐	
Op. site prep.	☒	☐	☐	☒	☐	☐	
IV cannulation	☒	☐	☐	☒	☐	☐	
Tie-back gown on, underwear removed	☒	☐	☐	☒	☐	☐	
Prosthesis, contact lenses removed	☐	☐	☒	☐	☐	☒	
Hearing aid left in	☐	☐	☒	☐	☐	☒	
Dentures in: upper ☐ lower ☐	☐	☒	☐	☐	☒	☐	
Make-up/nail varnish removed	☐	☐	☒	☒	☐	☐	
Jewellery taped/removed, & valuables stored	☒	☐	☐	☒	☐	☐	
Glasses on	☐	☐	☒	☐	☒	☐	
Allergies (specify): <u>Septum</u>	☒	☐	☐	☒	☐	☐	<u>Scabin</u>
Check and specify if patient has: Diabetes ☐ Epilepsy ☐ Asthma ☐	☐	☒	☐	☐	☐	☒	
IV Hydrocortisone given if asthmatic	☐	☐	☐	☐	☐	☒	
Infusions running (specify): <u>IV heparin at 1000 u/ml/h</u>	☒	☐	☐	☒	☐	☒	<u>in 1000 u/ml/h</u>
INR result present	☐	☐	☐	☐	☒	☐	
BM test	☐	☐	☒	☐	☒	☐	
Anticoagulant therapy	☒	☐	☐	☐	☒	☐	
Pre-med given	☐	☒	☐	☐	☐	☐	

Signature:
(Ward) Amadeo

Time:
10⁰⁰

Signature: IC Christie
(Lab)

Time: 2 PM

DATE: 27 10 98

Catheterisation Suite - Procedure

Procedure Events		Comments/Information
Vessel access:	Left Right	
• femoral artery	☐ ☒	
• femoral vein	☐ ☐	
• brachial artery	☐ ☐	
• median basilic vein	☐ ☐	
• subclavian vein	☐ ☐	
• radial artery	☐ ☐	
Procedure		
Left Heart Catheterisation:		
• left ventriculography	☐	
• supra ventriculography	☐	
• aortogram	☐	
• left and right coronary angiography	☒	
• bypass graft angiography	☐	
• renal angiography	☐	
• peripheral angiography	☐	
• other:	☐	
Right Heart Catheterisation:		
• right heart catheterisation	☐	
• right ventriculography	☐	
• pulmonary angio	☐	
• cardiac outputs	☐	
• O ₂ saturation sampling	☐	
• TPL	☐	
Coronary angio	☐	
PTCA - vessels: 1 ☐ 2 ☐ 3 ☐		
Stent - vessels 1 ☐ 2 ☐ 3 ☐		
Operators - 1st: D. MURDOCH 2nd: C. CHURCH		
Complications/Difficulties		
Coronary cannulation:	left ☐ right ☐	
Tortuous vessels	☐	
Angina +/- ECG changes	☐	
VF	☐	
Asystole	☐	
Heart block	☐	
Vasovagal reaction	☐	
Hypertension	☐	
Hypotension	☐	
Vessel dissection	☐	
Vessel occlusion	☐	
MI	☐	
Procedural pain	☐	
Other	☐	
Additional Comments		
Coronary angiogram - no LV. Sheath remains in situ. BP 170/70		
Signature: IC Church		Time: 1440

Integrate Care Pathway
Chest Pain/Myocardial Infarction/
Unstable Angina

Date: 25/10/98 Ward: Ward

623238
 WATSON MARY
 28 Hailgreen Avenue
 GLASGOW G15 8AB
 G.P. Prac. 40436
 06/03/94

Note: On each day enter the appropriate code in box. Sheet to be completed each day only if change in management.

Key to Codes: 1 = yes 2 = no 3 = not required/not appropriate/contraindicated

Daily Checklist (Medical)	Days							Comments
	1	2	3	4	5	6	7	
Symptom Review - does the patient have: • chest pain/discomfort • breathlessness • other (specify in comments section):	2							
Clinical Examination - does the patient have: • signs of heart failure • new murmur	2							
Review of Investigations: • 12 lead ECG • CK/CKMB	1							
Review Parenteral Therapy - does the patient require the following: • Intravenous Heparin • Subcutaneous Heparin • Intravenous GTN/SDN • Intravenous Insulin	1							
New Investigations Ordered: • echocardiogram • exercise ECG • coronary angiogram • other (specify in comments section)								

Note: On each day enter the appropriate code in box:

Key to Codes: 1 = yes 2 = no 3 = not required/not appropriate/contraindicated

CCU/Secondary Prevention:	Day							Comments
	1	2	3	4	5	6	7	
Standard Secondary Prophylaxis • Aspirin • Betablocker	☐	☐	☐	☐	☐	☐	☐	
Selective Secondary Prophylaxis • ACE inhibitor • HMGCoA reductase inhibitor (Statin)	☐	☐	☐	☐	☐	☐	☐	
Echo	☐	☐	☐	☐	☐	☐	☐	
Cardiac Rehabilitation	☐	☐	☐	☐	☐	☐	☐	
Smoking cessation advice given	☐	☐	☐	☐	☐	☐	☐	

CCU Investigations:

Admission Blood Results:

Date	Na	K	U	Creat.	Gluc.	Chol.	Hb	WBC	Plat.	PT	PTT	INR

Date: / /

Initial CK:

CKMB%:

Review of Investigations

12 Lead ECG:

ETT/Bruce/Modified Bruce:

Echo Result:

Cardiac Cath:

Other:

Integrated Care Pathway
Chest Pain/Myocardial Infarction/Unstable Angina
CCU: Medical Transfer/Discharge Summary



623238
WATSON MARY
28 Halgreen Avenue F
GLASGOW 06/03/54
G15 8AB
G.P.Prac. 40436

Date: 25/10/98

CCU Consultant: Dr J.D. McARTHUR ☐ Prof. J.J.V. McMURRAY ☒ Prof. W.S. HILLIS ☐ Dr J.A. KENNEDY ☐ Prof. H.J. DARGIE ☐ Medical Consultant:		Transferred to: Transfer arranged with:	
Admitted: 25/10/98 Transferred: ☐ Discharged: ☐		Follow up appointments arranged/to be arranged by: CCU ☐ Medical ward ☐	
Diagnosis MI: anterior ☐ posterior ☐ inferior ☐ lateral ☐ Q-wave ☐ non Q-wave ☐ LBBB ☐ Unstable angina ☐ Other angina ☐ Undiagnosed ☐ Other (specify):		Other Relevant Conditions (Risk Stratification) 1. VF ☐ 6. Hypertension ☐ 2. LV Dysfunction ☐ 7. Hyperlipidaemia ☐ 3. Heart Failure ☐ 8. Diabetes ☐ 4. Previous MI ☐ 9. Smoker ☐ 5. Prev. PTCA/CABG ☐ 10. AF ☐ Other (specify):	
CK: CKMB%:		Thrombolysis: ☐ SK ☐ rTPA ☐ Not given ☐ Repeat thrombolysis ☐ Trial (specify): ☐ Other (specify):	
Complications (to be completed on discharge): Other:		Discharge Therapy from CCU	
Drug	Dose/Freq.	Drug	Dose/Freq.
Aspirin ☐		Aspirin ☐	
Beta-blocker ☐		Beta-blocker ☐	
Statin ☐		Statin ☐	
ACE inhibitor ☐		ACE inhibitor ☐	
GTN spray/tabs. ☐		GTN spray/tabs. ☐	
LA nitrate ☐		LA nitrate ☐	
Ca ⁺⁺ channel blocker ☐		Ca ⁺⁺ channel blocker ☐	
Other therapy:		Other therapy:	
Actions Pending or Planned		Follow-up Arrangements	
ETT planned?	☐ Yes ☐ No ☐ Already Done	WIG One Stop Secondary Prevention Clinic Yes ☐ No ☐ If NO, give reason:	
If YES, has it been ordered?	☐ Yes ☐ No ☐ Already Done	Follow up appointment: 2 weeks ☐ 4 weeks ☐ 6 weeks ☐ 2 months ☐ 3 months ☐ Other (specify):	
Thallium Scan planned	☐ Yes ☐ No ☐ Already Done	Follow-up Consultant: Prof. J.J.V. McMURRAY ☐ Dr J.D. McARTHUR ☐ Dr J.A. KENNEDY ☒ Prof. W.S. HILLIS ☐ Prof. H.J. DARGIE ☐	
If YES, has it been ordered?	☐ Yes ☐ No ☐ Already Done	Other investigations (specify):	
Angiography planned?	☐ Yes ☐ No ☐ Already Done	Patient in clinical trial Yes ☐ No ☐ If yes, state:	
If YES, has it been ordered?	☐ Yes ☐ No ☐ Already Done		
Seen by Rehab. Nurse?	☐ Yes ☐ No ☐ Already Done		
Risk factors discussed?	☐ Yes ☐ No ☐ Already Done		
Additional information:			

★ If different concentration is required, please use blank IV prescription form

Prescription sheet number _____

This document must be retained

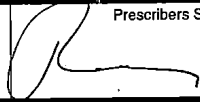
Patients Name MARY WATSON

Hospital LIS Unit Number 623238

Ward L8m D.O.B. 6/3/54

Prescriptions and Administration sheet for medicines given by Syringe/ Infusion Pump
Each Prescription must be completed fully and unambiguously. FULL SIGNATURE TO BE USED

1 Prescription Details (to be completed by DOCTOR before start of therapy)

Medicine(s)	Total amount of drug(s) in syringe/ bag	Diluent	Total Volume in syringe/ bag	Drug Conc'n(s) (mg/ml)	Route	Type	Prescribers Signature
GLYCERYL TRINITRATE	50 mg	5 % Dextrose	500ml	0.1 mg/ ml	IV	infusion pump model:	

2 Flow Rate Details (to be completed by DOCTOR and NURSING STAFF)

Date	Start Time	Drug Dose per hour	Required Flow Rate Setting	Prescribed by	Set by	Checked by
23/10/98	1400	10.0ml	10.0ml			F.ULB
		5.0ml	5.0ml			F.ULB
		5.0ml	5.0ml			F.ULB

3 Preparation Details (to be completed by DOCTOR or NURSING STAFF)

Date	Time	Prepared by	Checked by	Set by	Checked by
23/10	0330		F.ULB		F.ULB
	2045	MBS	AM	MBS	200

4 Administration Check (to be completed)

HOURLY by NURSING STAFF

Date	Time	Volume Remaining	Total Volume Infused	Rate Setting	Checked by	Comments	Date	Time	Volume Remaining	Total Volume Infused	Rate Setting	Checked by	Comments
23/10	0330	500ml	0ml	10ml		Commenced	24/10	0330	472		5ml		
	0400	487	13ml	10ml		5ml 6.0ml		0400	469		5ml		
	0615	480ml	20ml	5ml				0500	463		5		
	0700	477	23ml	5ml				0700	455		5		
	245	430	70	5ml				0800	448		5		
	515	418	82	5ml				1000	440		5		Infusion stopped
	615	413	87	5ml									
	1400	401		5ml		CCM							
	2045	300	0	5mls	MBS	New Infusion							
	2300	290		5mls	MBS								
	1001	283		5mls	MBS								
	0200	275		5mls	MBS								

5 Discontinuation (Sign):

Date: _____ Time: _____

Note: If the 'boost' facility of a syringe driver is used, record this in the 'comments' section

Medical Illustration 98/1883

PRESCRIPTION AND ADMINISTRATION SHEET FOR MEDICINES GIVEN BY SYRINGE PUMP/ INFUSION PUMP - GUIDELINES ON USE

Only appropriately prepared registered nurses may participate in the preparation and administration of medicines given via a syringe pump

THIS FORM IS NOT APPROPRIATE FOR USE IN CERTAIN HIGH DEPENDENCY AREAS

The medicine should be prescribed in the patient's main prescription sheet, cross referenced by annotating the "other prescription sheets in use section". This sheet should be kept in close proximity to the device in use.

Each prescription sheet should be used to record the prescription, preparation and administration details of syringes or infusion bags which are prepared in accordance with the prescription in Section 1 of the form. **IF THE DETAILS IN SECTION 1 REQUIRE TO BE CHANGED A NEW PRESCRIPTION FORM MUST BE USED.**

Signatures must be written out in full in the appropriate spaces.

The form should be completed as follows:

Section 1: Prescription details:

- (i) The prescription must be completed in full by a qualified medical practitioner.
- (ii) "Total Amount of Drug(s)" refers to the total quantity of medicine in micrograms, milligrams or units, placed into the container.
- (iii) If the medicine is further diluted, the diluent must be noted in the "Diluent" space and total volume recorded, ie, medicine + diluent.
- (iv) The final concentration of drug in the syringe/bag should be recorded.
- (v) The Route of Administration, Intravenous or Subcutaneous, must be recorded.
- (vi) The type of infusion device, syringe driver or infusion pump, and the model when selected must be recorded by the doctor or nurse as appropriate.
- (vii) The prescriber must sign the space provided.

Section 2: Flow Rate Details:

- (i) The dose of drug (in microgram or mg/hour) and the resultant initial flow rate (in ml/hour or mm/hour, depending on the device in use) must be prescribed by the Doctor on the "initial rate" line.
- (ii) If the infusion rate is set and started by the prescriber, the "set by" section should also be signed. If this is done by two registered nurses/midwives, both "set by" and "checked by" sections should be signed.
- (iii) Any subsequent alterations in dose and flow rate must be prescribed by the Doctor on the "Change" lines except for prescribed variable dose/sliding scale regimes (see (iv)).
- (iv) When a **"VARIABLE DOSE REGIMES"** (eg sliding scale insulin) has been prescribed, this should be recorded on the "initial rate" line and all changes recorded in the "Comments" section as appropriate.

Section 3: Preparation Details

If the final product (syringe or infusion attached to pump) is prepared by:

- (i) a Qualified Medical Practitioner, then he/she must sign the "prepared by" space, or,
- (ii) a Registered Nurse or Midwife, if calculation or dilution is involved, the preparation of the infusion should be witnessed by another Registered Nurse or Midwife. The "Prepared by/Checked by" and "Set by/Checked by" sections must be signed. Preparation of fresh infusions of the same prescription should be recorded on subsequent lines.

Section 4: Administration Check:

- (i) The infusion must be checked at regular intervals, as indicated on the sheet, during the period that the pump is in use. Each section must be completed in full.
- (ii) The "Comments" section should be used to record observations, include site checks. All unexpected events must be brought to the attention of the Nurse or Doctor in charge.

Section 5: Discontinuation

When the administration is to be discontinued, the prescriber should complete the appropriate sections on the sheet and on the main Kardex prescription sheet. A line should be drawn through each prescription to prevent continued use. Local guidelines for the "Duration of Use" should be followed prior to renewing the syringe/bag.

*** If different concentration is required, please use blank IV prescription form**

Prescription sheet number _____

This document must be retained

Patients Name MARY WATSON

Hospital LIS

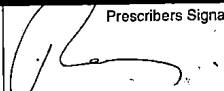
Unit Number 623238

Ward L8med

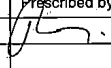
D.O.B. 6-3-54

Prescriptions and Administration sheet for medicines given by Syringe/ Infusion Pump
Each Prescription must be completed fully and unambiguously. FULL SIGNATURE TO BE USED

1 Prescription Details (to be completed by DOCTOR before start of therapy)

Medicine(s)	Total amount of drug(s) in syringe/ bag	Diluent	Total Volume in syringe/ bag	Drug Conc'n(s) (mg/ml)	Route	Type	Prescribers Signature
HEPARIN	25000 units	Neat	25ml	1000 units/ ml	IV	syringe pump model:	

2 Flow Rate Details (to be completed by DOCTOR and NURSING STAFF)

Date	Start Time	Drug Dose per hour	Required Flow Rate Setting	Prescribed by	Set by	Checked by
Initial rate	21/10	1000u	1ml			F.ULG
Change 1						
Change 2						
Change 3						
Change 4						

3 Preparation Details (to be completed by DOCTOR or NURSING STAFF)

Date	Time	Prepared by	Checked by	Set by	Checked by
Initial Prep.	21/10 0330		F.ULG		F.ULG
Rpt. 1	21/10 0445	MGB	EM	MGB	
Rpt. 2					
Rpt. 3					
Rpt. 4					

4 Administration Check (to be completed)

HOURLY by NURSING STAFF

Date	Time	Volume Remaining	Total Volume Infused	Rate Setting	Checked by	Comments	Date	Time	Volume Remaining	Total Volume Infused	Rate Setting	Checked by	Comments
21/10	0330	26ml	0ml	1ml		Commenced	21/10	0345	17ml		1ml		
	0500	24ml	2ml	1ml				0407	16ml		1ml		
	0615	23ml	3ml	1ml				0500	15ml		1		
	0700	22ml	4ml	1ml				0700	13ml		1ml		
	245	15	11ml	1ml	J. Brown			0830	11+		1ml		
	0515	12	14	1ml	J. Brown			1000	10		1ml		
	0615	11	15	1ml	J. Brown			1100	9+		1ml		
	0900	10ml		1ml		0901		1200	Infusion stopped				90 crossapari
	2045	23+		1ml	MGB	New Infusion							
	2300	21		1ml	MGB								
	0100	19		1ml	MGB								
	0200	18		1ml	MGB								

5 Discontinuation

(Sign): _____

Date: _____

Time: _____

Note: If the 'boost' facility of a syringe driver is used, record this in the 'comments' section

Medical Illustration 98/1883

PRESCRIPTION AND ADMINISTRATION SHEET FOR MEDICINES GIVEN BY SYRINGE PUMP/ INFUSION PUMP - GUIDELINES ON USE

Only appropriately prepared registered nurses may participate in the preparation and administration of medicines given via a syringe pump

THIS FORM IS NOT APPROPRIATE FOR USE IN CERTAIN HIGH DEPENDENCY AREAS

The medicine should be prescribed in the patient's main prescription sheet, cross referenced by annotating the "other prescription sheets in use section". This sheet should be kept in close proximity to the device in use.

Each prescription sheet should be used to record the prescription, preparation and administration details of syringes or infusion bags which are prepared in accordance with the prescription in Section 1 of the form. **IF THE DETAILS IN SECTION 1 REQUIRE TO BE CHANGED A NEW PRESCRIPTION FORM MUST BE USED.**

Signatures must be written out in full in the appropriate spaces.

The form should be completed as follows:

Section 1: Prescription details:

- (i) The prescription must be completed in full by a qualified medical practitioner.
- (ii) "Total Amount of Drug(s)" refers to the total quantity of medicine in micrograms, milligrams or units, placed into the container.
- (iii) If the medicine is further diluted, the diluent must be noted in the "Diluent" space and total volume recorded, ie, medicine + diluent.
- (iv) The final concentration of drug in the syringe/bag should be recorded.
- (v) The Route of Administration, Intravenous or Subcutaneous, must be recorded.
- (vi) The type of infusion device, syringe driver or infusion pump, and the model when selected must be recorded by the doctor or nurse as appropriate.
- (vii) The prescriber must sign the space provided.

Section 2: Flow Rate Details:

- (i) The dose of drug (in microgram or mg/hour) and the resultant initial flow rate (in ml/hour or mm/hour depending on the device in use) must be prescribed by the Doctor on the "initial rate" line.
- (ii) If the infusion rate is set and started by the prescriber, the "set by" section should also be signed. If this is done by two registered nurses/midwives, both "set by" and "checked by" sections should be signed.
- (iii) Any subsequent alterations in dose and flow rate must be prescribed by the Doctor on the "Change" lines except for prescribed variable dose/sliding scale regimes (see (iv)).
- (iv) When a "**VARIABLE DOSE REGIMES**" (eg sliding scale insulin) has been prescribed, this should be recorded on the "initial rate" line and all changes recorded in the "Comments" section as appropriate.

Section 3: Preparation Details

If the final product (syringe or infusion attached to pump) is prepared by:

- (i) a Qualified Medical Practitioner, then he/she must sign the "prepared by" space, or,
- (ii) a Registered Nurse or Midwife, if calculation or dilution is involved, the preparation of the infusion should be witnessed by another Registered Nurse or Midwife. The "Prepared by/Checked by" and "Set by/Checked by" sections must be signed. Preparation of fresh infusions of the same prescription should be recorded on subsequent lines.

Section 4: Administration Check:

- (i) The infusion must be checked at regular intervals, as indicated on the sheet, during the period that the pump is in use. Each section must be completed in full.
- (ii) The "Comments" section should be used to record observations, include site checks. All unexpected events must be brought to the attention of the Nurse or Doctor in charge.

Section 5: Discontinuation

When the administration is to be discontinued, the prescriber should complete the appropriate sections on the sheet and on the main Kardex prescription sheet. A line should be drawn through each prescription to prevent continued use. Local guidelines for the "Duration of Use" should be followed prior to renewing the syringe/bag.

Integrated Care Pathway

Prescriptions and Administration sheet for medicines given by Syringe/Infusion Pump

Note: Each prescription must be completed fully and unambiguously, FULL SIGNATURE TO BE USED.
This document must be retained.

Ward: *CCU*



623238
WATSON MARY
28 Halgreen Avenue F
GLASGOW 06/03/54
G15 8AB
G.P. Prac. 40436

1 Prescription Details (to be completed by DOCTOR before start of therapy)

Medicine(s)	Total amount of drug(s) in syringe/bag	Diluent	Total volume in syringe/bag	Drug conc'n(s) (mg/ml)	Route	Type	Prescriber's signature
Heparin	25,000u	Neat	25 ml	1,000u/1ml	IV	Syringe Pump or Infusion Pump Model:	<i>[Signature]</i>

2 Flow Rate Details (to be completed by DOCTOR and NURSING STAFF)

Date	Start Time	Drug Dose per hour	Required Flow Rate Setting	Prescribed by	Set by	Checked by
Initial rate	26/3	100-1u	1ml/hr	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>
Change 1						
Change 2						
Change 3						
Change 4						

3 Preparation Details (to be completed by DOCTOR or NURSING STAFF)

Date	Time	Prepared by	Checked by	Set by	Checked by
Initial prep.	26/3 23:20	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	
Rpt. 1					
Rpt. 2					
Rpt. 3					
Rpt. 4					

4 Administration Check (to be completed HOURLY by NURSING STAFF)

Date	Time	Volume Remaining	Total Volume Infused	Rate Setting	Checked by	Comments	Date	Time	Volume Remaining	Total Volume Infused	Rate Setting	Checked by	Comments
26/3	23:20	24		1ml	<i>[Signature]</i>								
	02:00	22+		1ml	<i>[Signature]</i>								
	04:00	20+		1ml	<i>[Signature]</i>								
	06:10	18+		1ml	<i>[Signature]</i>								
	07:10	17+		1ml	<i>[Signature]</i>								
	08:30	16		1ml	<i>[Signature]</i>								
	09:00	15		1ml	<i>[Signature]</i>								
	10:00	14		1ml	<i>[Signature]</i>								
	11:00	13		1ml	<i>[Signature]</i>								
	13:00	11		1ml	<i>[Signature]</i>								

5 Discontinuation

(Sign):

Date:

Time:

NOTE: If the "BOOST" facility of a syringe driver is used, record this in the "Comments" section.

4 Administration Check (to be completed HOURLY by NURSING STAFF)

[illegible]

5 Discontinuation (Sign):

Date:

Time:

NOTE: If the "BOOST" facility of a syringe driver is used, record this in the "Comments" section.

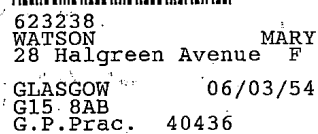
Ward: CCM

Date 26 / 10 / 98

[illegible]

Integrated Care Pathway
CCU - Fluid Balance Chart

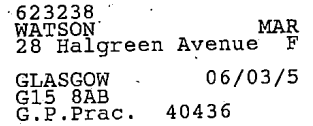
Ward: WCCU Date: 25/10/98



Date: 25/10/98

[illegible]

Integrated Care Pathway CCU - Fluid Balance Chart



Ward: CCU

Date: 27 / 10 / 98

[illegible]

Integrated Care Pathway
CCU - Fluid Balance Chart

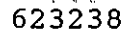
Ward: _____ Date: ____/____/____

D.O.B.: ____/____/____ Age: ____

Ward: _____ Date: ____/____/____

[illegible]

Integrated Care Pathway CCU - Observation Chart



WATSON.

28 Halgreen Avenue

MARY d

GLASGOW

06/03/54

G15 8AB

G.P.Prac. 40436

Date: 25/10/98

Time	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00
TEMPERATURE °C												
Rhythm	SB SL SL SL 58 77 75 69											
Rate	58 77 75 69											
Sat. O ₂	96% on air											
Pain Score	10 7											
PAP	115 70											
PCWP	115 70											
Pedal Pulse	115 70											
Puncture Site	115 70											
Chest Pain	115 70											
Dyspnoea	115 70											

Integrated Care Pathway CCU - Observation Chart

WATSON

28 Hal

28 Halgreen Avenue MARY F

GLASGOW

G15 8AB

G.P. Prac.

06/03/54

Ward: CCN

Date: 26/10/98

G.P. Prac. 40436

Time	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00
TEMPERATURE °C												
BP												
Rhythm	SR	SR	SR	SR								
Rate	75	61	79	66	64							
Sat. O ₂												
Pain Score												
PAP												
PCWP												
Pedal Pulse												
Puncture Site												
Chest Pain												
Dyspnoea												

[illegible]

GLASGOW 06/03/54
G15 8AB
G.P.Prac. 40436

Date: 26/10/98

[illegible]

Integrated Care Pathway CCU - Observation Chart



623238
WATSON
28 Halgreen Avenue F
GLASGOW
G15 8AB
G.P. Prac. 40436
MAR 06/03/5

Ward: CCO

Date: 27/10/98

Time	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00	10:00	11:00	12:00
TEMPERATURE °C	40.0											
	39.5											
	39.0											
	38.5											
	38.0											
	37.5											
	37.0											
	36.5											
	36.0											
	35.5											
BP	200											
	180											
	160											
	140											
	120											
	100											
	80											
	60											
	40											
	20											
Rhythm												
Rate						76						
Sat. O ₂												
Pain Score												
PAP												
PCWP												
Pedal Pulse												
Puncture Site												
Chest Pain												
Dyspnoea												

106

✓

65

106

58

regular
58

Integrated Care Pathway CCU - Observation Chart



623238
WATSON
28 Halgreen Avenue MAR
F

GLASGOW
G15 8AB
G.P. Prac. 40436
06/03/5

Ward: Ccw

Date: 27/10/98

Time	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00
TEMPERATURE °C	40.0											
	39.5											
	39.0											
	38.5											
	38.0											
	37.5											
	37.0											
	36.5											
	36.0											
	200											
BP	180											
	160											
	140											
	120			120				118				
	100			113								
	80											
	60			75								
	40											
	20											
	Rhythm				Regular							
Rate				60				64				
Sat. O ₂												
Pain Score												
PAP												
PCWP												
Pedal Pulse				✓✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	
Puncture Site				✓	✓	✓	✓	✓		Swath out	✓	
Chest Pain				N	N	N	N	no		no	no	
Dyspnoea				N	N	N	N	no		no	no	

[illegible]

GLASGOW 06/03/54
G15 8AB
G.P.Prac. 40436

Date: 28/10/98

[illegible]

Pressure Sore Risk Assessment Documentation Form

Patient Name: Mary Watson

Hospital Number: 623 238

Ward: Caring

Waterlow Risk Assessment		Initials	Date	No.	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Body weight for height:																		
Average	0																	
Above average	1																	
Obese	2																	
Below average	3																	
Continence:																		
Completely catheterised	0																	
Occasionally incontinent	1																	
Cath. incontinence of faeces	2																	
Doubly incontinent	3																	
Skin Type-Visual Risk Areas:																		
Healthy	0																	
Tissue paper/Dry	1																	
Oedematous/Clammy (temp. ↑)	1																	
Discoloured	2																	
Broken spot	3																	
Mobility:																		
Fully	0																	
Restless/Fidgety	1																	
Apathetic	2																	
Restricted	3																	
Inert/Traction	4																	
Chairbound	5																	
Age/Sex:																		
Male/Female	1/2																	
14-49	1																	
50-64	2																	
65-74	3																	
75-80	4																	
80+	5																	
Appetite:																		
Average	0																	
Poor	1																	
N.G. Tubes/Fluids only	2																	
nbm - Anorexic	3																	
Special Risks - Tissue Malnutrition:																		
e.g. Terminal Cachexia	8																	
Cardiac Failure	5																	
Peripheral Vascular Disease	5																	
Anaemia	2																	
Smoking	1																	
Neurological Deficit:																		
e.g. Diabetes, M.S., CVA																		
Motor-sensory Paraplegia	4-6																	
Major Surgery/Trauma:																		
Orthopaedic																		
Below waist, Spinal	5																	
On table > 2 hours	5																	
Medication:																		
Cytotoxics, Highdose steroids	4																	
Anti-inflammatory																		
TOTAL SCORE																		

SCORE: <10 = low risk; 10-14 = at risk; 15-19 = high risk; 20+ = very high risk.

NB: Following patient assessment document intervention in Integrated Care Pathway.



Patient Profile

Ward: L8 Med Date: 28/10/98

Time: 0300 (24hr clock)

Please print clearly in BLOCK CAPITALS

Title: _____
Name: Mary Watson
Preferred name: _____
Address: 28 Halgreen Ave
Glasgow
Post Code: GK8 8AB
Tel: 964 7780
DOB: 06.03.54 Age: 44
Hosp. No: 623238
Occupation: Housewife
Religion: Cof S
S.O.S. ☐ date: ☐☐☐☐☐☐
Interpreter required: ☐
(specify: _____)
Lives alone ☐

1 NOK/Friend/Contact: Arlene Watson
Address: 6 Tallant Terrace
Glasgow
Day: 964 4209
Night: _____
Relationship: Daughter
2 NOK/Friend/Contact: _____
Address: _____
Day: _____
Night: _____
Relationship: _____
NOK informed of admission Present ☒
NOK informed by: _____
GP: Dr Lyon
Address: Drumlapae Health Centre
Tel: _____

MEDICATION

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

PERSONAL BELONGINGS

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

Consultant: Dr Lees
Named Nurse ①: En Higgins
Admitting Nurse: SW Bann
Named Nurse ②: _____
Relatives seen by Doctor ☐

REASON FOR ADMISSION

12 hr history of central leaning
Chest pain - no radiation associated
with shortness of breath, sweating and
nausea.

Patient's perception of illness:

Fair

Diagnosis: MI Screened

EKG - nil acute

CK - -ve 42

Operation/Treatment:

Cardiac Monitoring

IV GTN and Heparin

Relevant PMH: Ca Breast (L) and

Lumpectomy 1996

Hysterectomy 1993

Lymph node clearance - Lymphoedema

02 Sat 98% Air

OBSERVATIONS ON ADMISSION

Temperature: 36.0 °C
Pulse: 84 bpm
BP: 127/83
Resp: 40
Pain Score: 0
Urinalysis: _____
Waterlow Score: _____
Height: _____ m
Weight: _____ kg
Body Mass Index: _____
Blood sugar (if appropriate): _____ mmols
Allergies: Yes ☒ No ☒
details: SEPTICIN

DISCHARGE PLANNING

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

Name: Mary Watson

Ward: L8 med

Date: 25/10/98

Case Record No.: 623238

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: _____

NUTRITION

- Normal menu (includes vegetarian) ☒
- Vegan ☐ Child's menu ☐
- Halal ☐ Kosher ☐
- Refer to Dietitian if any below ticked:
- Inability to eat/swallow ☐
- Any recent weight changes ☐
- Medically related nutrition problems (e.g. diabetes) ☐
- Other (specify): _____

BREATHING

1. No symptoms ☐
2. Breathless with moderate exercise ☐
3. Breathless with minimal exertion ☒
4. Breathless at rest ☐
5. Uses inhalers ☐
- Comments: _____

SMOKING

- Non-smoker ☐
- Smoker: _____ per day ☒
- Ex-smoker ☒ Today
- Aware of hospital policy ☐

HYGIENE

- Bath ☐ Shower ☒
- Requires assistance ☐ Stand up wash ☐
- Skin assessment: _____
- Other: Tubigrip(L) am

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: _____

SLEEP

- Hours/night ☒ 4
- Medication ☐
- details: _____

MENTAL STATE

- Alert/Orientated ☒
- Confused: day/night ☐
- Anxious/Distressed ☒
- Unconscious ☐
- Other (specify): _____

[illegible]

Glasses:	distance	☐
	reading	☒
Hearing impaired:	left/right	☐
Hearing aid:	left/right	☐
Dentures:	upper	☐
	lower	☐

ALCOHOL INTAKE		
Jnits/week:	nil	☒
	less than 14	☐
	14 - 21	☐
	over 21	☐
(1 unit = 1 measure spirits/half pint beer/ lager/1 glass wine)		

Jnits/week:	nil	☒
	less than 14	☐
	14 - 21	☐
	over 21	☐

MOBILITY (Pre admission)	
Mobile without aid	☒
Mobile with aid	☐
(Specify type/side held: _____)	
Furniture walking	☐
Chair Bound	☐
Housebound	☐

Mobile without aid	☐
Mobile with aid	☐
(Specify type/side held: _____)	
Furniture walking	☐
Chair Bound	☐
Housebound	☐

RELATIVE PARTICIPATION	

PROFILE COMPLETED BY: C. BROWN
(Please print name in block capitals)
Signature: [Signature]
Designation: STAFF NURSE
Countersigned (if applicable):

(Please print name in block capitals)

C. Brown

Signature:

Designation: STAFF NURSE

Countersigned (if applicable):

OTHER RELEVANT INFORMATION

Name: Mary Watson

Ward: *Lf med*

Date: 25/10/98

Case Record No.: 62323f

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	
4. Mobility	8. Specimens/Investigations	

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
25/10/98	0500		Admitted via A+E. Fv repeat ECG in 1 hour. Cardiac monitoring commenced and IV GTN and Heparin commenced. Vital signs satisfactory. Anxious +++. Pain free on admission although nausea returning. IV Diamorphine 5mg and Metoclopramide 10mg given in A+E OISS. Discussed with CCU not for admission to CCU. Pain free pain returning. Medical staff informed. Repeat ECG performed. V.	
	0700		Settled and slept for short period. Now pain free. BP 110/70. IV GTN reduced to 5ml/hr.	
		(3)	Uter not passed urine. ECG shows inverted T-waves Leads R1-V3 - discussed with CCU - continue as before.	NR
	1130		Care as planned. Breverities stable. Monitor displaying sinus rhythm. GTN 5ml Heparin 1ml per hour as prescribed. Sb Dr. Leon. Arrhythmia cardiology review. One episode of Chest pain. Relieved by prescribed analgesia.	NR
	1pm		Sb Cardiologist. For transfer to CCU. Arriving CK.	Ellye
	6pm		Settled evening Pain free Continues to monitor in sinus rhythm Dr transfer to CCU	Ellye JB



BP, TPR and Pain Assessment Chart

Name: Mary Watson

Hospital No: 623238

DOB: 06.03.54

Ward: LT Med Consultant: Dr Lee

1. PAIN SCORE 2. SEDATION SCORE 3. NAUSEA SCORE

See reverse for scoring details.

DATE		25/10/98																					
Time		08.00	09.00	10.00	11.00	12.00	13.00	14.00	15.00	16.00	17.00	18.00	19.00	20.00	21.00	22.00	23.00	24.00					
Pain Score		2	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0					
Sedation Score		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0					
Nausea Score		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0					
TEMPERATURE	C°																						
	40																						
	39																						
	38																						
	37																						
	36																						
	35																						
	210																						
	200																						
	190																						
BP	180																						
	170																						
	160																						
	150																						
	140																						
	130																						
	120																						
	110																						
	100																						
	90																						
PULSE	80																						
	70																						
	60																						
	50																						
	40																						
	30																						
	RESPS	21	20	18	17	40																	
	SaO ₂	98	98	97	97	98%																	
	Bowels																						
	RU/TL																						
Drugs																							

1. 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 10 mins after I/V, 1 hour after I/M or oral analgesia.
Sustained pain score of 2 or pain score of 3 requires intervention.

2. 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 intervention.

3. Nausea Score

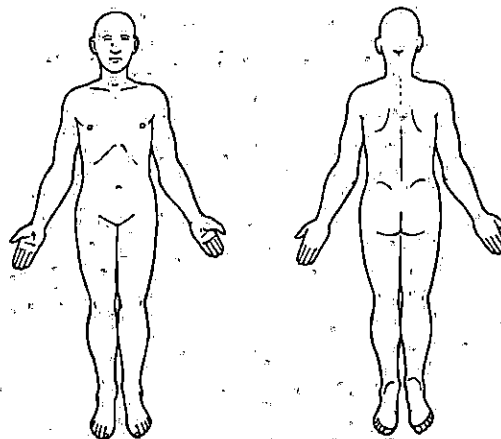
- 0= No nausea
- 1= Mild (No Rx wanted)
- 2= Moderate (Rx required)
- 3= Severe (clinical problem persists despite Rx)

Review 1 hour after Rx. Inform doctor if additional Rx required.

PRESSURE SORE RISK ASSESSMENT

TORRANCE GRADE OF PRESSURE SORE

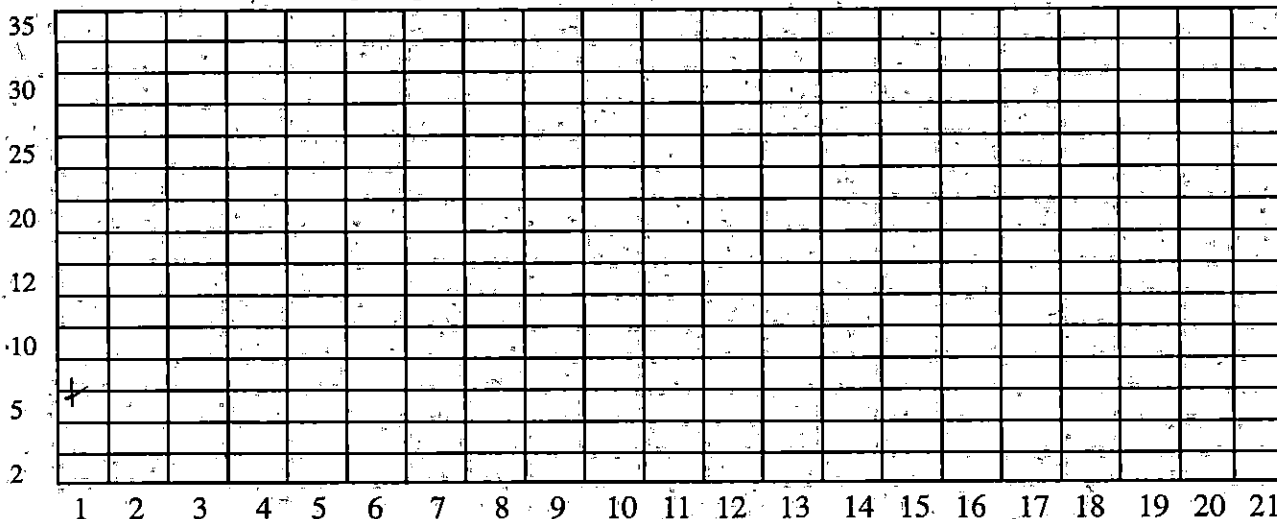
- 0 = no damage
- 1 = blanching hyperaemia
(red area)
- 2 = non-blanching hyperaemia
and/or superficial break
- 3 = ulceration progress through
to meet subcutaneous tissue
- 4 = ulcer extends through fat
to meet underlying muscle
- 5 = damage through muscle
and/or necrotic tissue



DOCUMENT SEVERITY AND SITE OF
PRESSURE DAMAGE ON ABOVE DIAGRAM

NB : ALL NURSING INTERVENTION MUST BE DOCUMENTED IN THE CARE PLAN

▲ Risk Assessment Scoring Graph



Waterlow Assessment

No.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Score	7																				
Date	25/10																				
Initials	JS																				

Build/ Weight for Height	Skin Type (Visual Risk)	Mobility	Sex	Special Risks
Average	0 Healthy	0 Fully	0 Male	1 Tissue Malnutrition e.g.
Above Average	1 Tissue Paper	1 Restless	1 Female	2 Terminal Cachexia
Obese	2 Dry	1 Apathetic	2 14 - 49	1 Cardiac Failure
Below Average	3 Oedematous	1 Restrictive	3 50 - 64	2 Peripheral Vascular Disease
	Clammy (Temp ↑)	1 Inert/Traction	4 65 - 74	3 Anaemia
	Discoloured	2 Chairbound	5 75 - 80	4 Smoking
	Broken Spot	3	81+	5
Appetite	Continence	Major Surgery/Trauma	Medication	
Average	0	0 Orthopaedic	5 Cytotoxics	4
Poor	1 Complete/catheterised	1 Below waist/spinal	5 High dose steroids	4
NG Tube/ Fluids Only	2 Occasional incontinence	2 On operating table > 2hours	5 Anti-inflammatory drugs	4
Nil by mouth	3 Cath/faecal incontinence			
Anorexic	3 Doubly Incontinent			
Score : 10 + AT RISK		Neurological Deficit e.g.		
15 + HIGH RISK		Diabetes, Multiple Sclerosis, CVA, Motor-Sensory Paraplegia		
20 + VERY HIGH RISK				

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			
25 10/98	Initial	H	CA	M	P	Initial	Initial	PR		Initial	MR 14 ⁴⁵		
26 10/98		H	P		W	AK		RT					
27 10/98	ⓐ	H						RT			m 11pm		ⓐ started for cardiac cath
28 10/98		H											ⓐ in bed

NAME
623238
WATSON
MARY

UNIT NUMBER
23238

WARD
L & Med
CW

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

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	am 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times	Date	Signed			
	25/10/98	HEPARIN	2500u / 250u	IV												26/10	SS		
	25/10/98	ST	as directed													26/10	SS		
	C 25/10	DIPLOPHINE	2.5mg - 5.0mg	IV	2-4hrly as reqd												Elkane		
	D 25/10	METOPROLOL	0mg	IV	6-8hrly as reqd												Alao		
	E 26/10	2 METOPROLOL	60mg	SC													Fair		26/10
	F 26/10	HEPARIN	1000u / 100u	IV	Cont												SS		
	G																		

REGULAR PRESCRIPTIONS - OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED																	
DATE	TIME	MEDICINE (Block Capitals)	DOSE	ROUTE	am 6	am 8	am 10	am 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times	Prescribers Signature (Full)	Date	Signed
25/10/98	10:30	TAMOXIFEN	20mg	PO												25/10	SS
25/10/98	10:30	ASPIRIN	150mg	PO												25/10	SS
25/10/98	10:30	PARACETAMOL	1g	PO												25/10	SS
25/10/98	10:30	DIPHENHYDRAMINE	60mg	O												25/10	SS
25/10/98	10:30	BRIVISCOM	10mg	O												25/10	SS
25/10/98	10:30	ASPIRIN	75mg	O												25/10	SS
25/10/98	10:30	METOPROLOL	10mg	O												25/10	SS
25/10/98	10:30	SIMVASTATIN	40mg	O												25/10	SS
25/10/98	10:30	METOPROLOL	100mg	O												25/10	SS
25/10/98	10:30	HEPARIN	10mg	PO												25/10	SS
25/10/98	10:30	HEPARIN	5mg	PO												25/10	SS

ONCE ONLY PRESCRIPTIONS							DIET		PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS									
DATE	TIME	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN		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
25/10/98	0330	HEPARIN	5000u	IV			0330											
25/10/98	0330	METOPROLOL	100mg	O			0330											
26/10/98	10:30	GLUCOSE	100mg	PO			10:30											
26/10/98	10:30	PARACETAMOL	1g	O			10:30											

WARD	AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT	KNOWN MEDICINE SENSITIVITIES
18M	44	6.7.54		623238	UGES.	

WATSON MARY

DATE _____ CLINICAL NO. _____

DN: transfer 20mg od
dihydrocodeine prn

ALL: septrin

SH: liver & daughter
on long term sick
shakes 15/day

Qz: bp 120/80
SR 80/min
Hupre
Chloramphenicol
+ hydrocortisone 10mg
PPAPV
nil odema.

MI
FH: per 600-17 65 MI
MI
6 lbs - nil 1HD.

clear clean
dial NAD.

ONS: ON's vitals
links - hang all 4
tone (2)
p1 11

lung cardiac banding CP in 44 yrs & smoker / FH / can
respiratory.

No acute ECG changes.
AS: oesophageal spasm.

CXR soft AP film
nil focus abn.

Bloods ✓
D. Allen ✓

Plan LBM - (U. nitrostat / heparin)
ELG in 10
pr ECG E. MI screen more
pr ECG if from CP.

J. Moran

WEST GLASGOW HOSPITALS UNIVERSITY NHS TRUST										TREATMENT CARD	
ACCIDENT & EMERGENCY DEPARTMENT										ACCIDENT/EMERGENCY FORM	
ACCIDENT & EMERGENCY DEPARTMENT WESTERN INFIRMARY GLASGOW G11 6NT TEL 0141 211 2304/2409										CPN: 123456	
Forename		Age		Date of Birth		Arr Date		Time		AE Number	
MARY		44		06/03/54		25/10/98		07:00		045416/98	
Sex		Religion		Date of Inc		Time					
Female		Ch of Scotland		25/10/98							
371 1019 Pent Avenue G40U		Married		Occupation/School		Type of Inc		Mode of Arrival		By Transport	
GAB 0447780		Married		WIFE		Other		By Transport			
Address		Referred by									
DRUMCHAPPEL HEALTH CE 80/90 KINFAUNS DRIVE GLASGOW		GP									
ARRENE WATSON DAUGHTER		Address		Complaint							
6 Tallant Terrace GLASGOW G15 7NZ											
BE COMPLETED BY MEDICAL OFFICER AFTER SEEING PATIENT										TRIAGE	
Doctor: <u>Angus</u> (above named patient attended Accident & Emergency Department today.) Initial Complaint: <u>Chest Pain</u> Initial Treatment: <u></u> (above named patient)										TRIAGE TIME 02:01 TRIAGE CATEGORY Category 1	
Discharge Codes (Please Circle) 1. Discharge 2. Refer to G.P. 3. Refer to other hospital (see below) 4. Died 5. Irregular Discharge 6. Refer to O.P. Clinic (see below) 7. DOA											
Transfer to Hospital Consultant (if admitted) LCES											
To be arranged Medical Surgical Skin ENT Gyn Others Specify											
Signature of Medical Officer M. Moran											

TRIAGE

DATE:

TIME:

CHIEF COMPLAINT:

RELEVANT HISTORY:

PHYSICAL SIGNS:

VITAL SIGNS:

TREATMENT AT TRIAGE:

DISPOSITION:

HR:
BP:
RR:
GCS:
TEMP:

1. RESUSCITATION:
2. MEDICAL/SURGICAL:
3. TRAUMA:
4. OTHER (SPECIFY):

TRIAGE NURSE SIGN
..... PRINT

TO BE RECORDED ON ARRIVAL

T_ P_ R_ BP_

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION	SIGNATURE	GIVEN BY
25/10/98	METOCLOPRAMIDE	10mg	(IV)	0155	[Signature]	CE
25/10/98	DANALPHINE	5mg	(IV)	0155	[Signature]	CE

CONSULTANT _____ REG/SHO _____ JHO _____

SEEN BY _____ AT (TIME) _____

CLINICAL NOTES

KEY TO CLINICAL NOTES

- 1 - HISTORY OF
- 2 - ON EXAMINATION
- 3 - X-RAY FINDINGS
- 4 - TREATMENT GIVEN
- 5 - DISPOSAL
- 6 - NAME OF MEDICAL OFFICER

DATE

25/10/98 SP referred.

0230-

(0330 BST)

Hx Ce breast & lymphaden 1996

Ld clearance also -> lymphoedema

as transplan

+ smoker + FHHD.

Today - 4pm. Cermet heavy CP

Ovarian

+ SOB + sweating

While waiting at a stopping centre - not overeating.

10pm - pain worsened

'like being crushed' or 'someone sitting on me'

Ovarian + SOB + sweating + nausea vom.

+ aggr anxi

Swan AIA 300 6mg SP 2 STW Spmg

O2 in ambulance

Diagnosis is AIE.

Now painfree.

PMH: As above

DM chd NK 0 IHD /MI. 1997

hbk 1997 - an

WC 14.6

Hb 12.7

Plt 260

U+E 97

X-Ray & Other Documents to be filed in the patient's notes

NAME

Mary Watson

HOSPITAL

No

AGE

PHYS/
SURG.

LHR

DEPT
WARD

AMAU

IN-PAT
FORM 3IN PATIENT
CONTINUATION HISTORY

DATE

25/10/98 Young 9 with RF's for IHD. Continuing
 0855 history for MI / unstable angina.
 Basal creps on exam & CXR confirms
 Start ACEI* & add diuretic. Would
 Prof McMurtry see please?
 *rampit. ICR LHR
 (LEES, Com)

Glasgow Emergency Medical Services (Centre Name)

Call No: 299443	Date: 08/10/2000 22:43:51	Time of Call:
Patient's Name: WATSON Mary	D.O.B. Age: 06/03/1954	4
Address Today: 28 KENDON AVE MAIN DOOR DRUMCHAPEL GLASGOW	Home Address If different:	
Post Code: G15 8AX	Post Code:	
Phone Number Today: 44 0141 944 1913	Home Phone If different:	
Special Directions to Today's address:		
Callers Name:	Relationship to patient:	
Name of GP: JC Nugent	Practice No: 045	
Surgery: 045 Drumchapel Health Centre 045	Cipher No: G0209 7	
Address:	Fax No: 0141 211 6	
Call Type: OT	Speed Dial:	
Receptionist's Name: ESTRI	Time Passed: 072W	
Time Arrived: 22.53	Time complete: 23.10	
Patient's Complaint: (R) since Friday - no arm discomfort. Pain is constant. Feels breathless pains in chest and neck, feeling weak, feeling clammy, pat is on tamoxifen for 2 yrs Had chest pain few months after surgery for partial mastectomy 2 yrs ago. ? M.I. feels nauseated. Not vomited.		
BP: 130/85	PR: per min 120 regular.	Temp: 36.3°C
Clinical Notes: has had pain since this morning - rt sided going into back - pre- vious m.i. 2 years ago - d/w dr ok to attend <u>Regular medications</u> Tamoxifen * allergy to Septin * Pain in chest x last 48 hrs worse today Worse on inspiration No cough / sputum Leg not painful Pulse 162/min Dyspnoea Chest clear ? Pneumonia ? P.I.S. Defer receiving Physician W.I.		
Treatment:		
Diagnosis Code:		
Referral:		
Seen by Dr: [Signature]	Rota No: 362	Nurse:

100195

36°C

98/1

CRN: 623238

DH TAMOXIFEN 36019 MALE
SH *ALLERGIC TO SEPTICIN
LIVES 2 DAUGHTER
RECEIVES DLA
SMOKES 10-15 CIGS FOR 20 YRS
NEVER DRINKS
FH FATHER + MOTHER 1HD

SYSTEMS CVS + RESP. ITS HIRE

GIT AB PAIN + CONSTIPATION
DUE TO PERVIC 3X
NIL ELSE

CVS NIL OF NOTE

NEURO NIL OF NOTE

LOCO 1997 OSTEOPOROSIS

P SAYS FEELS DEPRESSED
DUE TO ILLNESSES, SY,
+ PREMATURE MENOPAUSE
DOESN'T WANT ANTIDEPRESSANT
WOULD LIKE TO SPEAK TO
PSYCHIATRIST - NO SUICIDAL
IDEATION

EXAM ALERT, ORIENTED. UPSET:
WORRIED ABOUT RECURRENCE
OF CANCER. PYREXIA 37.2°C
O-S ACCOL

CVS PULSE 102, REG.

BP 130/98 SUP LB

APEX UNDISPLACED HS=INTO

O ANKLE OEDSWA

Name		Forename		Age	Date of Birth	Arr Date	Time	AE Number
WATSON		MARY		46	06/03/54	09/10/00	00:14	43864/00
Address		Sex	Religion	Date of Inc		Time		
KENDON AVE ASROW		Female		09/10/00				
15 BAX		Married	WIFE	Occupation/School		Type of Inc		
Tel				Other		Mode of Arrival		
Address		Referred by		Complaint				
LYON		GP						
ARLENE WATSON		616 716						
DAUGHTER		6 Tallant Terrace						
616 716		616 716						
616 716		616 716						
AD TRAFFIC ACCIDENT PLACE		DETAILS						
ME ACCIDENT PROBABLE CAUSE								

BE COMPLETED BY MEDICAL OFFICER AFTER SEEING PATIENT

Doctor, TRIAGE
above-named patient attended Accident & Emergency Department today.
TRIAGE TIME TRIAGE CATEGORY
00:14 Category 2
Diagnosis: (c) Antihypertensive chest pain INITIAL COMPLAINT
Medical Other
ECG shows INITIAL TREATMENT
Treatment given

FILED BY HRIIUNT
has been given.
Prophylaxis has been administered. TT Course TT Booster HATI (Please Tick)
and you please arrange

DISCHARGE CODES Please Circle		1. Admitted		2. Referred to G.P.		3. Died		4. Irregular Discharge	
5. Discharge		6. Transfer to other hospital (see below)		7. Refer to O.P. Clinic (see below)		8. D.O.A.			
9. Transfer to Hospital		10. Consultant (if admitted)		11. To be arranged		12. Other Specify			
Signature of Medical Officer		Signature of Medical Officer		Signature of Medical Officer		Signature of Medical Officer		Signature of Medical Officer	

TRIAGE

DATE:

TIME:

CHIEF COMPLAINT:

RELEVANT HISTORY:

PHYSICAL SIGNS

VITAL SIGNS:

TREATMENT AT TRIAGE:

DISPOSITION:

HR:

BP:

RR:

GCS:

TEMP:

1. RESUSCITATION
2. MEDICAL/SURGICAL
3. TRAUMA
4. OTHER (SPECIFY)

 TRIAGE NURSE _____ SIGN
 _____ PRINT

TO BE RECORDED ON ARRIVAL

T. C. 102 R 96 BP 130/98

G2 96% mair

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION	SIGNATURE	GIVEN BY

CONSULTANT

REG/SNO

JHO

SEEN BY SONIA MACLEOD AT (TIME) 12.0

CLINICAL NOTES

KEY TO CLINICAL NOTES

- 1 - HISTORY OF
- 2 - ON EXAMINATION
- 3 - X-RAY FINDINGS
- 4 - TREATMENT GIVEN
- 5 - DISPOSAL
- 6 - NAME OF MEDICAL OFFICER

CP 10/10/00 GENIS REFERRAL
PC CHESIC PAIN
HR 3/4 HR OF 1 CHEST TIGHTNESS
CONSTANT + RADIATING UP (R)
NECK + THROUGH TO BACK
EXACERBATED BY INSPIRATION
NO CHEST TENDERNESS - ASSOC
SWEATINESS LETHARGY + LOSS
OF APETITE NAUSEA VOMITING
PALPS ANKLE OEDEMA OSYNDOE
MILD DYSNOEA COUGH SPIIT
HAEMORRHOIDS NO WT CHANGE
RECENTLY

PMH 1997 (2) COMPEXION 2
AXILARY CLEARANCE 6/12
MEMO 2 DR DAVIS @ Boc
(APPOINTMENT 10/10/00)
1996 KADICAL HISTORICAL
FOR CA CA (DR DAVIES
STASHILL)

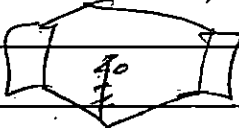
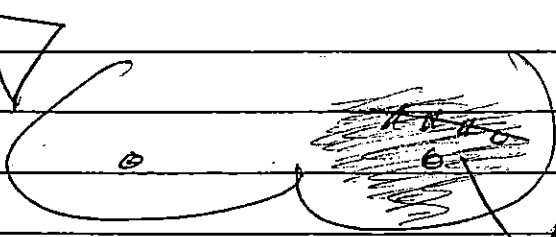
1998 SUSPECTED M.I

CUA HRP OSYNDOE OSYNDOE ODM
ADMITTED 4 15 4 TR

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

NAME	HOSPITAL No.
MARY	
WATSON	AGE
PHY/	DEPT.
SURG.	WARD
SAMPLE	

HISTORY

9/10/00 RESP RATE 20/MIN.
 (N) EXPANSION.
 AIR ENTRY (L) = (R) = (N)
 RON INSP. BASAL CRACKLES
 POREUSION RESONANT.
 (N) VOCAL FREMITUS.
AB SOFT, NON-TENDER
 PARANEDIAL
 SCAR PRESENT
 PUCKERS BS(N)
NECK CN 4 ~~2~~ ~~3~~ CROSSLY
 INTACT.
 ALL 4 LIMBS MOVING.
BREASTS

 NO NODES
 FIRMNESS
 PALPABLE ? SCARRING POST-OP
 ? OVERLYING SKIN
 CHANGES.
LOCO NO LOCAL TENDerness
 OVER CHEST WALL OR
 SPINE.
 TENDER OVER (R) TRAPEZIUS
 MUSCLE.

HISTORY
(Use other side first)

Date

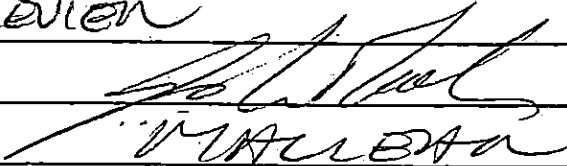
ITIP UNEXPLAINED TINGLING CHEST
TIGHTNESS, RADIATING TO
NECK & NON-SPECIFIC
SYMPTOMS OF CERVICAL &
LOSS OF APPETITE - PYREXIAL

PLAN BLOODS (INCL. BONE)

CXR

EKG

SHO REVIEW


M. ALLEN

SHO 1109.

NAME	HOSPITAL No.
Mary Watson	AGE
PHY/ SURG.	DEPT. WARD

HISTORY

46 ♀ i) Chest Pain

ii) Breathlessness

HPC 3/4 Hx of worsening Ⓜ anterior chest pain
(upper zone Ⓜ Ant Thoracic wall)

- Radiating thro' to back and up Ⓜ side of neck

- No worse on inspiration

- Assoc - Breathlessness (Mild)

- lethargy

- Anorexia (NO Δ WT)

- Been feeling unwell for past 1 wk.

- Haemoptysis / cough

- Appt @ Evans BOC 10/10/00

PMHx 1997 Ⓜ lumpectomy & axillary clearance + 6/12 Chem

1994 Radical Hysterectomy for cervical Ca
(@ Dr Dring Hobhill)

1998 ? MI

CVA^o / PBP^o / A^o / E^o / DM^o / RF^o / TB^o

DHx Saphir Allergy SHx Smokes 10-15 / day (20 yrs)
Tamoxifen

FHx IHD - Father / Mother

HISTORY
(Use other side first)

Date

W Well / Undiscovered
Pyrexial 37.2°C

CVS Pulse 88 reg
MS I + II to
JVP 40

Resp ? RUS (R) upper zone

Tender to palpation both anterior + post chest wall

Bruit oedema

• Fine creps lower zones bilaterally

• Trachea central

Ins Non tender

Breast

No obvious masses

No mass

No axillary nodes

R° K° L° S°

No overlying skin S°

BS - present

PR - NA done

CXR - ? (2) sided lesion / Enlarged Pul vessel

WPR

EKG N.U acute

IMP (1) (R) LFT

(2) ? Bone Met

(3) ? PTE

Plan (1) Admit (8 med)

(2) Analgesia

(3) Tinzaparin Rx dose

(4) Ibuprofen pain

(5) MI Screen in view of PMH + @-dimer

(6) ? Bone Scan / CT chest

(7) ? V/Q

(8) Report CXR

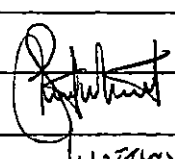
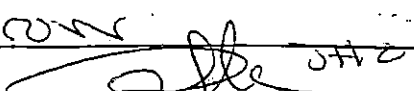
K. Hays
(4336)

1/26
3

NAME	MARY WATSON	HOSPITAL	No
PHYS/	SEMPLER	AGE	
SURG.		DEPT	
		WARD	

IN PATIENT
CONTINUATION HISTORY

IN-PAT
FORM 3

DATE	
9/10/00	Background of @ lumping, radiolucency & dense 1997 parents with 3 deep @ chest pain & mild cough. Prior - not coming any more & ca cervix. Embolized today no chest wall tenderness or signs & legs not. For 1 - dimes ± V/Q & bone scan. On tinzaparin & amoxicillin & ibuprofen. CXR probably not but obtain ap - serial
10/10/00	WR @ Chest pain - resolved (14-56) - tender over ant. aspect of sternum & ribs - ? myalgia ?? metastatic disease @ D-Dimers - One - SpO ₂ - 96% on air - Stop Tinzaparin @ Transfer to 63 → Bone Scan Await CXR report
10/10	Transfer 53  (Watson) Anxious about results - still of Bone scan & V/Q. Still in pain - although analgesia prescribed inadequate - gaps where it "breaks off" have analgesia made analgesics regular. O/S tender over @ chest wall mainly SOB on min exertion V/Q - IVE Bone scan tomorrow  JH

HISTORY
(Use other side first)

W/R PFS-

10/00 Pain responding to analgesia

V/Q - be -

Awaiting bone scan today
chase CXR report.

Will Ilye

2/10/00 Bone scan - remains anxious. Poor renal
conjug. angio & atypical chest pain. Discharge
(calce-mal) sample

1/10/00 Reports from radiology:

15h. Bone scan → (N)

CXR → few areas of atelectasis (seen on old film)

- no new changes

- no evidence of bone involvement

S. David

01/00 - JH10 3380

TRIAGE DATE: TIME: CHIEF COMPLAINT: RELEVANT HISTORY: PHYSICAL SIGNS:

VITAL SIGNS: TREATMENT AT TRIAGE: DISPOSITION:

HR:
BP:
RR:
GCS:
TEMP:

1. RESUSCITATION
2. MEDICAL/SURGICAL
3. TRAUMA:
4. OTHER (SPECIFY)

TRIAGE NURSE SIGN/PRINT

7/12/07
MC 139 Hb 105
K 40 WCC 28.7 - Nph
CL 106 Plt 178 13.65
Hct 32.2 IMR 0.9
WBC 5.2 B/M 1.15
Creat 89
Urea

TO BE RECORDED ON ARRIVAL
T 38 P 110 R 18 BP 79

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION	SIGNATURE	GIVEN BY

CONSULTANT: REG/SHO: JHO:
SEEN BY: AT (TIME):

CLINICAL NOTES

KEY TO CLINICAL NOTES

- 1 - HISTORY OF
- 2 - ON EXAMINATION
- 3 - X-RAY FINDINGS
- 4 - TREATMENT GIVEN
- 5 - DISPOSAL
- 6 - NAME OF MEDICAL OFFICER

8/7/12 PC - SOB, Chest Pain
HPC - 1/2 of Flu like symptoms - General aches + Pain
+ Muscle
Lumbar today + developed SOB and L sided Chest
Pain
° Cough ° Haemoptysis ° Weight
° Calf swelling/Pain/Eggs
° of open travel
PMH
Breast Ca - diagnosed 1996
Cervical Ca - diagnosed 1997
? MI → admitted to CCU angiogram clear
Recent admission 5/12 for similar resp symptoms? Chest
° Ankle ° Ep ° OM
Tx
Transfused? done
Admitted to Septum
Mrs will be discharged
Smoker - 20 day
Nil alcohol

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

NAME	HOSPITAL
MARY	No 623238
WATSON	AGE
PHYSI/SURG. HUNTER	DEPT WARD BA AE

IN-PAT FORM 3

IN PATIENT CONTINUATION HISTORY

DATE	Medical Otho	(46)
PC	SOB	+
	CHEST PAIN	
HPC	Fu like illness	
	- 48 hrs Hx.	No COC
	Drivens / not cold	No Palps
	Aching all over	No cough
	Sore throat	No spib
		No chest pain
	SOB on stairs	
	Little chest pain - dull discomfort in throat -	
	more SOB & chest pain - due to lack	
	Admitted ~ 6/52 for similar resp'y symptoms.	
	here flu-like	
	with (L) ax LN dissects	
	& DXT + ChemRx	
PMH	Breast Ca - Lumpectomy 1996	DH Tamoxifen
	Cervical Ca - Hysterectomy 1993	? 30mg
	Radiant	
	? HI - admitted to cell	°MI
	last year - angio	- Allergic to cephrin
	attending Dr Evans (ChemRx)	
	for check-up on Tues next week	
	°J/TB/RHF/Ep/AGM/DM/CVA/SP	

HISTORY

(Use other side first)

ate

SH Lives $\bar{c}$ 4d 1d - Staff nurse
 Smokes $\approx$ 20/d
 No EtOH - keen to do Zynac
 Pre^v auxiliary nurse

F/H

arm swelling lymphoedema

E

Constitution - uses enemas/suppositories
 of damage - automatically empties at 3-4^o

O/E

Pyrexial 38⁹

Sweaty

VS

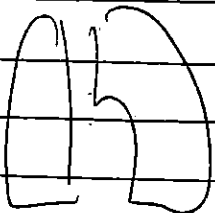
Tachycardic 118

^ocalf swelling
^oSSA

BP 118/79

LL +0 OVP

I

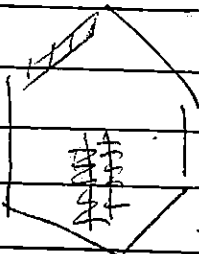


cab on air 96

coarse BS

↓ vocal R bilat ↓ AE

GI



soft
 non-tender

Neuro

Tone

Power

Reflexes

Normal

Full bladder

NAME	HOSPITAL		
MARY	No	623238	
WATSON	AGE		
PHYS/ SURG.	HUNTER	DEPT WARD	8A

IN-PAT
FORM 3

IN PATIENT
CONTINUATION HISTORY

DATE	
	Bloods
	pk 6-9
	wa 139
	w 5.2
	INR 1.0
	K 4
	Cr 89
	D-Dimer Negative
	Cl 106
	CXR
	Shadowing bilat
	esp. R. ht border
	ECG
	sinus
	tachy
	Imp ⁿ
	Viral illness
	± chest infection
	Note prev Ca Br/Cx
	? renal
	Plan Adult → LHM
	• i/v ✓
	• Bloods cultures ✓
	• i/v fluids
	• Amoxycillin + erythromycin
	• Paracetamol
	• Med 2 more
7/12/20	d/w ID
	→ happy to take over
	bed in BC later in pm (S)
	VANCE

HISTORY
(Use other side first)

ate

- 11/2/00 1. Infection - SOB Consider WLS
- Raised R hemidiaphragm / patchy CXR chge ? SOB. review 30 Oct
- went to GP
- treated for community acquired pneumonia
BCs done No response yet
2. Diarrhoea Post 1st dose antibiotic
Stools → CES → 3
3. Anaemia check haemobrics
4. PMH - Breast & Cervical Ca
Anxious understandably
- Offer to ID - if not → 8A

1/2 Transfer to Browne Centre
11/6/00

Problems:

- ① Chest Infection C + axillary clearance
- ② Prev breast Ca - lumpectomy 1996, RTx, chemo
- ③ Cervical Ca - hysterectomy 1993
- ④ admitted October c chest infn.

In W16 6/52 ago c chest infn.
given antibiotics, recovered from this

2/7 ago began to feel unwell.
shivery / sore throat / aches / malaise
° Sweats / shivering episode.
° cough

NAME

HOSPITAL

IN-PAT
FORM 3

Mary Watson No

AGE

IN PATIENT
CONTINUATION HISTORYPHYS/
SURG.DEPT
WARD

DATE

- SOB 2/7

tiredness

on exertion. normal ECG u/d due to ~~asthma~~ (smoker,
asthma in past)

- ° haemoptysis

- same R sided chest ache.

appetite good.

no recent wt loss

chronic post op abdo pain (hindgut neuropathy)

normally ~~usually~~ uses laxatives + enemas to
empty bowels.no sensation of bladder being full ∴ empties
bladder regularly.

6/52 ago; loose stools 2° to antibiotics

1 episode loose bowel motion overnight. Denies
diarrhoea.T_E. T 36.5. O₂ sat 98%.

looks reasonably well.

P 90 reg BP 100/65.

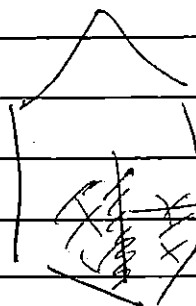
MSITU + 0°M

Chest few crackles @ base

abdo soft

° LICKS

BS active.



midline scar.

some tenderness

HISTORY
(Use other side first)

Jaup

46 ♀ - chest infra likely

* x episode loose bowel motion

Plan

stop CTS incl C-diff if diarrhoea

stop IV antibiotics

reg oral clarithromycin

further blood cts if pyrexial

Na 139 K 4.0 Chl 106 U5.2 Cr 89

Hb 10.5 Wc 25.7 M 13.65 Pl 178 INR 0.9

CXR: elevated @ hemidiaphragm. (A (sus))

probable collapse & some consolidation @ base
~~shading~~ shading @ MZ ? collapse

12/12/20 B93² SEATON

Bilateral exudate in trunks

Very settled

CXR - chgs may be odd

→ Complete 7 days clarithromycin

R/v by ONCOLOGY next week

ASOT

(SEATON)
CWR 4/2/21

NAM

50623238H

WATSON

MARY

28 KENDON AVENUE

GLASGOW

LANARKSHIRE

PHYS/

SURG.

06/03/1954

G15 8AX

CHI-0603546323

AL

F

SE

PT

WARD

IN-PAT
FORM 3IN PATIENT
CONTINUATION HISTORY

DATE

19/5/10

Laparoscopic Cholecystectomy

F. Hain / M. Chang

A. Mcneil (P)

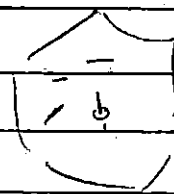
Evidence of recent
inflammation due to mfl-
accumulating effusions at
Caudal of the omentum stuck
to Gall bladder

Hansen technique

Started Lap chole

Suction drain

clip to cavity of
cystic duct



Post op

Can Eat & drink when
fully awake

Nurse Care

J. Hain

474

(Use other side first)

ate

DR A B MACLEAN

MARY WATSON

37

623238

32 KENDON AVENUE, GLASGOW

6.3.54

8.9.91

10.9.91

000031

ABMac/PMS

15 September 1991

Dr Turner
14 Herbyton Avenue
GLASGOW

Dear Dr Turner,

This lady was seen by Dr Hanretty in the Gynaecology Clinic on 9 September 1991 and referred for urgent Colposcopy. Examination at that time showed an area of abnormality on the posterior lip of her cervix and features that I believed were consistent with adenocarcinoma. A biopsy at that time, however, showed CIN although it was not possible to exclude micro-invasive carcinoma. She was therefore admitted and on 9 September 1991 underwent knife-cut cone biopsy, histology of which shows a poorly differentiated squamous carcinoma of the cervix which penetrates to a depth of 11 mm showing a mainly basaloid appearance. There is extensive infiltration of thin walled vascular channels by tumour. There is CIN III of the adjacent surface epithelium but the ectocervical, endocervical and deep resection margins are free from tumour. However, this lady has a Stage IB cervical carcinoma and therefore needs further treatment. I have spoken to Dr Dodgson who has agreed to see this lady with a view to performing radical hysterectomy. I have been in contact with Mrs Watson today i.e. 16 September 1991 explaining to her the outcome of the biopsy and that an appointment has been arranged for her to meet Dr Dodgson this Thursday.

Yours sincerely,

A B MACLEAN

CONSULTANT GYNAECOLOGIST

Copy to: Dr Dodgson, Senior Registrar, Stobhill Hospital, Glasgow
Dr K P Hanretty, Consultant Gynaecologist, Western Infirmary

NHS GREATER GLASGOW AND CLYDE

LAPAROSCOPIC CHOLECYSTECTOMY ICP

Patients details & Hospital no.

50623238H
WATSON ✓
MARY ✓ 06/03/1954 ✓
28 KENDON AVENUE ✓
GLASGOW
LANARKSHIRE G15 8AX
CHI-0603546323

Consultant MC
Named Nurse

D.O.B

Age 56.

Telephone No. 07544 340921

Allergies: ~~sephen~~ - UPS
Religion: swelling

Admission date: 17/3/10
Ward: UOT

Next of Kin

Shirley Watson
0/1 17, Kendon Ave
0141-944-3074
Contact No.
Daughter.
Drumchapel

2nd Next of Kin

Carol McIntosh.
Contact No. 07515 459 746.
Daughter.

G.P Data

Dr. S LYON
DRUMCHAPEL HEALTH CENTRE
80/90 KINFAUNS DRIVE
GLASGOW
G15 7TS

Estimated Discharge Date:

20/5/10

NOTE: This pathway is intended as a guide to the patient's multidisciplinary care management. It represents usual best practice but variations may occur as clinicians use their professional judgement. Any variations which deviate from the pathway must be recorded.

NHS GREATER GLASGOW AND CLYDE

INTEGRATED CARE PATHWAY USERS

[illegible]

Pre-anaesthetic assessment

- ☐ Can climb one flight stairs without stopping
- ☐ Cannot climb one flight stairs without stopping
- ☐ Cannot climb one flight of stairs
- ☐ Cannot lie flat for one hour

NYHA I II III IV
& limiting symptom(s) if

50623238H
WATSON
MARY
28 KENDON AVENUE
GLASGOW
LANARKSHIRE
CHI-0603546323
06/03/1954
G15 8AX

Current Medication

Refer sent at PRHO of Assessment	
please refer PRHO of documents	

Assessed by _____	Date _____	Signature _____
PRHO/Pre-assessment Nurse	Pager# _____	

Examination

General

P 83/min

BP 117/73 mmHg

Temp 36.0°C

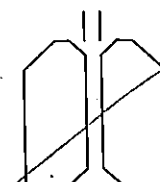
Resp 16/min

Weight ____/kg

Broad Ca - chemo post
cellular Ca - hysterectomy - no problems with CA

Respiratory

Ap 12L
Rel 12L
A/E good throughout



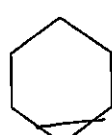
Cardiovascular

Pulse 76 bpm 104
HS I + II + O
Carotid bruit Y ☐ N ☒
Ankle oedema Y ☐ N ☒

Central Nervous System

Abdominal

Soft non-tender
No masses, no organomegaly
BSV PR not u



1st CA

Investigations for anaesthetic assessment (see guidance sheets)

Required	Results
FBC	☒ Y ☐ N Enter on pre-surgery assessment sheet
Ca/LFTs	☒ Y ☐ N Enter on pre-surgery assessment sheet
CXR	☐ Y ☒ N
U&E/G	☒ Y ☐ N Enter on pre-surgery assessment sheet
ECG	☒ Y ☐ N
G&S	☒ Y ☐ N _____ units XM
PFTs	☐ Y ☒ N
Other	

Deep venous thrombosis risk assessment N/A ☐

Low / Medium / High LMWH prescribed Y ☐ N ☐

Kardex completed ☐

Investigations ordered as above ☐

CPromson Admission Sr (1641) 19/3/10

Name _____ PRHO Date _____ Signature _____ Pager# _____

NHS GREATER GLASGOW AND CLYDE

ADMISSION AND PRE-OPERATIVELY

Patient ID: 50623238H
 WATSON F
 MARY 06/03/1954
 28 KENDON AVENUE
 GLASGOW
 LANARKSHIRE G15 8AX
 CHI-0603546323

Date 19/5/10

Multi Disciplinary Plan	Time	Initial	Evaluation
Fasted from 12mn.	✓	AB	
Consent obtained	✓	AB	
Drug Prescription Sheet completed	✓	AB	
U&E, LFT and FBC results in notes	✓	AB	
RESULTS			
Blood group documented in notes			
Documented gall stones (YES/NO)	✓	AB	
ERCP result in notes			
Chest X ray films available if relevant	✓	AB	
ECG available	✓	AB	
DVT prophylaxis prescribed	✓	AB	
Post operative analgesia discussed	✓	AB	
MEWS recorded	✓	AB	
Urinalysis recorded			
Discharge plans discussed	✓	AB	
Relevant agencies for return home contacted – Specify			
Assistance with personal/oral hygiene			
Falls, MUST and P.A risk complete	✓	AB	

NHS GREATER GLASGOW AND CLYDE

POST OPERATIVE PERIOD

Patient Label

Mary
Watson

6.3.54

506232384.

Date

19/5/10

Ward Round/Comments

Daughter informed about patient returned to
the ward. Stilled. H/L/H/dent

19/5/10

07.15 - nil in drain. LF.

Multi Disciplinary Plan	Time	Initial	Time	Initial	Time	Initial	Comments
MEWS recorded	14.55	RH	✓	ng	03 ⁰⁰	LF	
Hourly, two hourly, four hourly	✓	RH	✓	UB	03 ⁰⁰	LF	
Pain score recorded			✓	UB	03 ⁰⁰	LF	
Analgesia given as prescribed			✓	UB	03 ⁰⁰	LF	
Nausea score recorded	✓	RH	✓	UB	03 ⁰⁰	LF	
Anti emetics given as prescribed					n/a	LF	
Dressing checked hourly record	✓	RH	✓	UB	03 ⁰⁰	LF	nil in
MEWS chart							drain 07 ⁰⁰
Urine output assessed	✓	RH	✓	UB	03 ⁰⁰	LF	H.P.U.
Intravenous fluids as prescribed	✓	RH		UB	-	LF	Discontinued
Oxygen given at ...L/L... litres via							
face mask/nasal speculae for							
..... hours					03 ⁰⁰	LF	Discontinued.
Assistance with personal hygiene			N/A	UB	03 ⁰⁰	LF	
Assistance with oral hygiene			N/A	UB			
Oral fluids taken	✓	RH	✓	UB	03 ⁰⁰	LF	
Light diet given			✓	UB	03 ⁰⁰	LF	
Falls, MUST and P.A risk complete	✓	RH					

NHS GREATER GLASGOW AND CLYDE

FIRST POST OPERATIVE DAY

Patient Label

MARY WATSON

5062323BH

6/3/54

0603546323

Date 20/5/10

Ward Round/Comments

W/R - Drain to come out ☒ & redressed. RB

Settled overnight. plan home tomorrow (21.5.10) LF

Multi Disciplinary Plan		Time	Initial	Time	Initial	Time	Initial	Comments
FBC checked	Results							
U&Es checked	Results							
LFT checked	Results							
MEWS 4 hourly		✓	RB			✓	LF	
Pain score recorded		✓	RB			✓	LF	
Nausea score recorded		✓	RB			✓	LF	
Anti emetics given as prescribed		NA	RB			NA	LF	
Wound dressing removed and reapplied as necessary		✓	RB			✓	LF	
Urine output checked		✓	RB			✓	LF	
IV infusion discontinued		✓	RB			✓	LF	
Cannula removed		✓	RB			✓	LF	
Fluids taken		✓	RB			✓	LF	
Diet taken		✓	RB			✓	LF	
Full mobilization encouraged		✓	RB			✓	LF	
Assisted shower/bath given		✓	RB			✓	LF	
Assist with oral hygiene		NA	RB					
Pressure areas checked		✓	RB			✓	LF	
Falls, MUST and P.A risk complete		✓	RB					
Discharge plan checked		✓	RB			✓	LF	
Variance								

21.5.10 Patient discharged home. Stab sites redressed + information given about wounds. Patient stated she had her own analgesia @ home + didn't need any. Letter to be posted out. To return to clinic in 6/52. JWH

NHS GREATER GLASGOW AND CLYDE

SECOND POST OPERATIVE DAY

Patient Label

Date

Ward Round/Comments

[illegible]

NHS GREATER GLASGOW AND CLYDE

DISCHARGE PLAN

Name Unit No

Discharge Address: Home:

Other:

Transport Arrangements		Initials
Will be collected by friends/relatives		
Ambulance required		
Date ordered for: am/pm		
Reference number		
Agencies Arranged (specify)		
Social Worker		
Home Help		
Other		
Other		
Community Nurse Visit Arranged		
Advice given for after Discharge		
Discharge medicines obtained		
Discharge medicines given with advice		
Discharge letter given to patient		
Discharge letter posted to G.P.		
Follow Up Appointment		
Will be reviewed by G.P.		
Appointment will be arranged by consultant		
Appointment arranged by ward		
Appointment given to patient		
Appointment will be posted to patient		

Discharge summary completed by Date

PRESCRIPTION FORM

PATIENT DETAILS						ONCE ONLY AND PREMEDICATION DRUGS						
Name:		Height:		DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF PRESCRIBER	GIVEN BY	TIME GIVEN	
CH:	5062338R F WATSON MARY 06/03/1954 28 KENDOOH AVENUE GLASGOW LANARKSHIRE G15 8AX CHI-0603546323	Weight:		19/5	Sabtenomil neb	Smg	neb	1315	[Signature]	J Campbell	1515	
Hos:		Surface area:										
DOI:		Date of writing discharge prescription: / /										
		Ward: 10										
Admission: 14/8/10												
Consultant Name: BLANCH												
Date and time this form prepared: 14/8/10 Time: / /		Sheet No	2nd Prescription in use									
			Yes or NO									
DRUG SENSITIVITIES												
SEPTIN												
DVT Risk on Admission (SIGN Guideline)												
High ☐ Moderate ☐ Low ☐												
Assessed by: Date: / /												
OTHER CHARTS IN USE												
Insulin ☐			TPN: ☐									
PCA and other infusions ☐			Enteral Nutrition: ☐									
Anticoagulants: Heparin ☐			Oxygen Therapy: ☐									
Oral ☐			Other:									
Topical: ☐												

PATIENT'S NAME:				ADMINISTRATION																											
Parenteral Drugs: Regular Prescription				DATE →																											
				MONTH →																											
A DRUG				Other time																											
DOSE		ROUTE		DATE		DATE:																									
SIGNATURE OF PRESCRIBER				INITIALS:		STOPPED																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																											
FOR PRESCRIBERS USE ONLY				0700-0900																											
				1200-1400																											
				1600-1800																											
				2200-2400																											
				Other time																											
B DRUG				Other time																											
DOSE		ROUTE		DATE		DATE:																									
SIGNATURE OF PRESCRIBER				INITIALS:		STOPPED																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																											
FOR PRESCRIBERS USE ONLY				0700-0900																											
				1200-1400																											
				1600-1800																											
				2200-2400																											
				Other time																											
C DRUG				Other time																											
DOSE		ROUTE		DATE		DATE:																									
SIGNATURE OF PRESCRIBER				INITIALS:		STOPPED																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																											
FOR PRESCRIBERS USE ONLY				0700-0900																											
				1200-1400																											
				1600-1800																											
				2200-2400																											
				Other time																											
D DRUG				Other time																											
DOSE		ROUTE		DATE		DATE:																									
SIGNATURE OF PRESCRIBER				INITIALS:		STOPPED																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																											
FOR PRESCRIBERS USE ONLY				0700-0900																											
				1200-1400																											
				1600-1800																											
				2200-2400																											
				Other time																											

Parenteral Drugs: Regular Prescription				DATE →																											
				MONTH →																											
E DRUG				Other time																											
DOSE		ROUTE		DATE		DATE:																									
SIGNATURE OF PRESCRIBER				INITIALS:		STOPPED																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																											
FOR PRESCRIBERS USE ONLY				0700-0900																											
				1200-1400																											
				1600-1800																											
				2200-2400																											
				Other time																											
F DRUG				Other time																											
DOSE		ROUTE		DATE		DATE:																									
SIGNATURE OF PRESCRIBER				INITIALS:		STOPPED																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																											
FOR PRESCRIBERS USE ONLY				0700-0900																											
				1200-1400																											
				1600-1800																											
				2200-2400																											
				Other time																											
G DRUG				Other time																											
DOSE		ROUTE		DATE		DATE:																									
SIGNATURE OF PRESCRIBER				INITIALS:		STOPPED																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																											
FOR PRESCRIBERS USE ONLY				0700-0900																											
				1200-1400																											
				1600-1800																											
				2200-2400																											
				Other time																											
H DRUG				Other time																											
DOSE		ROUTE		DATE		DATE:																									
SIGNATURE OF PRESCRIBER				INITIALS:		STOPPED																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																											
FOR PRESCRIBERS USE ONLY				0700-0900																											
				1200-1400																											
				1600-1800																											
				2200-2400																											
				Other time																											

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

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

PATIENT'S NAME:				ADMINISTRATION																													
Oral and Other Drugs: Regular Prescriptions				DATE → 2021																													
				MONTH → 55																													
J DRUG <u>AMOXICILLIN</u>				Other time																													
DOSE <u>20mg</u>		ROUTE <u>PO</u>		DATE <u>12/5</u>		DATE: <u>12/5</u>																											
SIGNATURE OF PRESCRIBER <u>[Signature]</u>				INITIALS:		STOPPED		0700-0900		1600																							
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																													
FOR PRESCRIBERS USE ONLY																																	
K DRUG <u>LEVOTHYROXINE</u>				Other time																													
DOSE <u>100mg</u>		ROUTE <u>PO</u>		DATE <u>12/5</u>		DATE: <u>12/5</u>																											
SIGNATURE OF PRESCRIBER <u>[Signature]</u>				INITIALS:		STOPPED		0700-0900		1600																							
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																													
FOR PRESCRIBERS USE ONLY																																	
L DRUG				Other time																													
DOSE		ROUTE		DATE		DATE:																											
SIGNATURE OF PRESCRIBER				INITIALS:		STOPPED		0700-0900																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																													
FOR PRESCRIBERS USE ONLY																																	
M DRUG				Other time																													
DOSE		ROUTE		DATE		DATE:																											
SIGNATURE OF PRESCRIBER				INITIALS:		STOPPED		0700-0900																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																													
FOR PRESCRIBERS USE ONLY																																	

Oral and Other Drugs: Regular Prescriptions				DATE →																													
MONTH →																																	
N DRUG				Other time																													
DOSE		ROUTE		DATE		DATE:																											
SIGNATURE OF PRESCRIBER				INITIALS:		STOPPED		0700-0900																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																													
FOR PRESCRIBERS USE ONLY																																	
P DRUG				Other time																													
DOSE		ROUTE		DATE		DATE:																											
SIGNATURE OF PRESCRIBER				INITIALS:		STOPPED		0700-0900																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																													
FOR PRESCRIBERS USE ONLY																																	
R DRUG				Other time																													
DOSE		ROUTE		DATE		DATE:																											
SIGNATURE OF PRESCRIBER				INITIALS:		STOPPED		0700-0900																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																													
FOR PRESCRIBERS USE ONLY																																	
S DRUG				Other time																													
DOSE		ROUTE		DATE		DATE:																											
SIGNATURE OF PRESCRIBER				INITIALS:		STOPPED		0700-0900																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																													
FOR PRESCRIBERS USE ONLY																																	

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

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

PATIENT'S NAME:		ADMINISTRATION	
Oral and Other Drugs: Regular Prescriptions		DATE	
		MONTH	
T	DRUG	Other time	
DOSE	ROUTE	DATE	
SIGNATURE OF PRESCRIBER		STOPPED DATE:	
		INITIALS:	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		1200-1400	
		1600-1800	
		2200-2400	
		Other time	

FOR PRESCRIBERS USE ONLY			
V	DRUG	Other time	
DOSE	ROUTE	DATE	
SIGNATURE OF PRESCRIBER		STOPPED DATE:	
		INITIALS:	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		1200-1400	
		1600-1800	
		2200-2400	
		Other time	

FOR PRESCRIBERS USE ONLY			
W	DRUG	Other time	
DOSE	ROUTE	DATE	
SIGNATURE OF PRESCRIBER		STOPPED DATE:	
		INITIALS:	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		1200-1400	
		1600-1800	
		2200-2400	
		Other time	

FOR PRESCRIBERS USE ONLY			
X	DRUG	Other time	
DOSE	ROUTE	DATE	
SIGNATURE OF PRESCRIBER		STOPPED DATE:	
		INITIALS:	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		1200-1400	
		1600-1800	
		2200-2400	
		Other time	

Oral and Other Drugs: Regular Prescriptions		DATE	
		MONTH	
Y	DRUG	Other time	
DOSE	ROUTE	DATE	
SIGNATURE OF PRESCRIBER		STOPPED DATE:	
		INITIALS:	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		1200-1400	
		1600-1800	
		2200-2400	
		Other time	

FOR PRESCRIBERS USE ONLY			
AA	DRUG	Other time	
DOSE	ROUTE	DATE	
SIGNATURE OF PRESCRIBER		STOPPED DATE:	
		INITIALS:	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		1200-1400	
		1600-1800	
		2200-2400	
		Other time	

FOR PRESCRIBERS USE ONLY			
BB	DRUG	Other time	
DOSE	ROUTE	DATE	
SIGNATURE OF PRESCRIBER		STOPPED DATE:	
		INITIALS:	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		1200-1400	
		1600-1800	
		2200-2400	
		Other time	

FOR PRESCRIBERS USE ONLY			
CC	DRUG	Other time	
DOSE	ROUTE	DATE	
SIGNATURE OF PRESCRIBER		STOPPED DATE:	
		INITIALS:	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		1200-1400	
		1600-1800	
		2200-2400	
		Other time	

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

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

PATIENT'S NAME:

ADMINISTRATION

**Oral and Other Drugs:
Regular Prescriptions**

DATE →

MONTH →

DD	DRUG			STOPPED INITIALS:
DOSE	ROUTE	DATE	DATE:	
SIGNATURE OF PRESCRIBER			1600-1800	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			2200-2400	
			Other time	

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

FOR PRESCRIBERS USE ONLY

EE	DRUG			STOPPED INITIALS:
DOSE	ROUTE	DATE	DATE:	
SIGNATURE OF PRESCRIBER			1600-1800	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			2200-2400	
			Other time	

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

FOR PRESCRIBERS USE ONLY

FF	DRUG			STOPPED INITIALS:
DOSE	ROUTE	DATE	DATE:	
SIGNATURE OF PRESCRIBER			1600-1800	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			2200-2400	
			Other time	

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

FOR PRESCRIBERS USE ONLY

GG	DRUG			STOPPED INITIALS:
DOSE	ROUTE	DATE	DATE:	
SIGNATURE OF PRESCRIBER			1600-1800	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			2200-2400	
			Other time	

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

FOR PRESCRIBERS USE ONLY

**Oral and Other Drugs:
Regular Prescriptions**

DATE →

MONTH →

HH	DRUG			STOPPED INITIALS:
DOSE	ROUTE	DATE	DATE:	
SIGNATURE OF PRESCRIBER			1600-1800	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			2200-2400	
			Other time	

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

FOR PRESCRIBERS USE ONLY

JJ	DRUG			STOPPED INITIALS:
DOSE	ROUTE	DATE	DATE:	
SIGNATURE OF PRESCRIBER			1600-1800	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			2200-2400	
			Other time	

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

FOR PRESCRIBERS USE ONLY

KK	DRUG			STOPPED INITIALS:
DOSE	ROUTE	DATE	DATE:	
SIGNATURE OF PRESCRIBER			1600-1800	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			2200-2400	
			Other time	

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

FOR PRESCRIBERS USE ONLY

LL	DRUG			STOPPED INITIALS:
DOSE	ROUTE	DATE	DATE:	
SIGNATURE OF PRESCRIBER			1600-1800	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			2200-2400	
			Other time	

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

FOR PRESCRIBERS USE ONLY

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

the "Regular" and "as required" medicines sections should be entered at each administration round to ensure that inadvertent omission or double dosing is avoided.

PATIENT'S NAME:

ADMINISTRATION

All Routes: As Required Prescriptions

MM	DRUG TRAMADOL		DATE:	DATE	12/19/10	12/20/10	12/21/10	12/22/10	12/23/10	12/24/10	12/25/10	12/26/10	12/27/10	12/28/10	12/29/10	12/30/10	12/31/10
	DOSE	ROUTE	INDICATION	STOPPED INITIALS:	TIME	12:00	12:00	12:00	12:00	12:00	12:00	12:00	12:00	12:00	12:00	12:00	12:00
	SIGNATURE OF PRESCRIBER	MAX.FREQUENCY	DATE:	DOSE	50	50	50	50	50	50	50	50	50	50	50	50	50
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			DATE:	GIVEN BY	LF	LF	LF	LF	LF	LF	LF	LF	LF	LF	LF	LF

NN	DRUG COCAINE		DATE:	DATE	12/19/10	12/20/10	12/21/10	12/22/10	12/23/10	12/24/10	12/25/10	12/26/10	12/27/10	12/28/10	12/29/10	12/30/10	12/31/10
	DOSE	ROUTE	INDICATION	STOPPED INITIALS:	TIME	07:20	15:30	20:05	07:10								
	SIGNATURE OF PRESCRIBER	MAX.FREQUENCY	DATE:	DOSE	x2	x2	x2	x2									
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			DATE:	GIVEN BY	LF	LF	LF	LF								

PP	DRUG MORPHINE		DATE:	DATE	12/19/10	12/20/10	12/21/10	12/22/10	12/23/10	12/24/10	12/25/10	12/26/10	12/27/10	12/28/10	12/29/10	12/30/10	12/31/10
	DOSE	ROUTE	INDICATION	STOPPED INITIALS:	TIME	12:00	12:00	12:00	12:00	12:00	12:00	12:00	12:00	12:00	12:00	12:00	12:00
	SIGNATURE OF PRESCRIBER	MAX.FREQUENCY	DATE:	DOSE	1-2mg	1-2mg	1-2mg	1-2mg	1-2mg	1-2mg	1-2mg	1-2mg	1-2mg	1-2mg	1-2mg	1-2mg	1-2mg
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			DATE:	GIVEN BY	LF	LF	LF	LF								

--I	DRUG CYAIZINE		DATE:	DATE	12/19/10	12/20/10	12/21/10	12/22/10	12/23/10	12/24/10	12/25/10	12/26/10	12/27/10	12/28/10	12/29/10	12/30/10	12/31/10
	DOSE	ROUTE	INDICATION	STOPPED INITIALS:	TIME	12:00	12:00	12:00	12:00	12:00	12:00	12:00	12:00	12:00	12:00	12:00	12:00
	SIGNATURE OF PRESCRIBER	MAX.FREQUENCY	DATE:	DOSE	50mg	50mg	50mg	50mg	50mg	50mg	50mg	50mg	50mg	50mg	50mg	50mg	50mg
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			DATE:	GIVEN BY	LF	LF	LF	LF								

SS	DRUG MORPHINE		DATE:	DATE	12/19/10	12/20/10	12/21/10	12/22/10	12/23/10	12/24/10	12/25/10	12/26/10	12/27/10	12/28/10	12/29/10	12/30/10	12/31/10
	DOSE	ROUTE	INDICATION	STOPPED INITIALS:	TIME	12:00	12:00	12:00	12:00	12:00	12:00	12:00	12:00	12:00	12:00	12:00	12:00
	SIGNATURE OF PRESCRIBER	MAX.FREQUENCY	DATE:	DOSE	1-2mg	1-2mg	1-2mg	1-2mg	1-2mg	1-2mg	1-2mg	1-2mg	1-2mg	1-2mg	1-2mg	1-2mg	1-2mg
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			DATE:	GIVEN BY	LF	LF	LF	LF								

	DRUG		DATE:	DATE	12/19/10	12/20/10	12/21/10	12/22/10	12/23/10	12/24/10	12/25/10	12/26/10	12/27/10	12/28/10	12/29/10	12/30/10	12/31/10
	DOSE	ROUTE	INDICATION	STOPPED INITIALS:	TIME												
	SIGNATURE OF PRESCRIBER	MAX.FREQUENCY	DATE:	DOSE													
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			DATE:	GIVEN BY												

VV	DRUG		DATE:	DATE	12/19/10	12/20/10	12/21/10	12/22/10	12/23/10	12/24/10	12/25/10	12/26/10	12/27/10	12/28/10	12/29/10	12/30/10	12/31/10
	DOSE	ROUTE	INDICATION	STOPPED INITIALS:	TIME												
	SIGNATURE OF PRESCRIBER	MAX.FREQUENCY	DATE:	DOSE													
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			DATE:	GIVEN BY												

WW	DRUG		DATE:	DATE	12/19/10	12/20/10	12/21/10	12/22/10	12/23/10	12/24/10	12/25/10	12/26/10	12/27/10	12/28/10	12/29/10	12/30/10	12/31/10
	DOSE	ROUTE	INDICATION	STOPPED INITIALS:	TIME												
	SIGNATURE OF PRESCRIBER	MAX.FREQUENCY	DATE:	DOSE													
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			DATE:	GIVEN BY												

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

Adult Intravenous (IV) Cannulation Care Plan

50623238H
WATSON
MARY
28 KENDON AVENUE
GLASGOW
LANARKSHIRE G15 8AX
CHI-0603546323

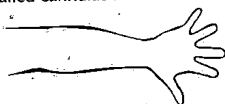
1. Redness, pain or inflammation at insertion site due to phlebitis or local infection
2. Local oedema due to infiltration

3. Bloodstream infection
4. Extravasation

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

Please mark successful cannulation with a number e.g. ① and failed cannulation with an ②

L



R



Emergency IV Access = E
Routine IV Access = R
Radiological Procedure = RP
Nil by Mouth = NBM

Chemotherapy = C
IV Fluids / IV Medicine Administration = IV
Blood = B
Other (Please state)

Not Required = NR
Phlebitis = P
Infiltration = I
Extravasation = E
Other (Please state)

Cannula Number	Date and Time	Inserted by (print name)	Insertion Reason Code	Gauge	Was aseptic technique breached?	Removed by (print name)	Date and Time	Removal Reason Code
①	19/5/10 1030	NICK PAGE	IV	18	Yes* / No			
					Yes* / No			
					Yes* / No			
					Yes* / No			

North Glasgow Hospitals

24 Hour Fluid Balance Chart

Name: <u>MARY WATSON</u>		Case Record No:								Ward: <u>10 EAST</u>		Date: <u>7/5/10</u>				
INPUT (mls)									IN	OUTPUT (mls)					OUT	
TIME HRS (Please delete 1 column)	ORAL	NASO GASTRIC TPN	BLOOD COLLOID PLASMA	IV (1) /	TYPE	IV (2)	IV (3) Drugs	Hourly Total	Cumulative Total	URINE	URINE Cumulative Total	Gastric Aspirate / Vomit	Drain 1		Hourly Total	Cumulative Total
08	24															
09	01															
10	02															
11	03															
12	04															
13	05															
14	06															
15	06															
16	07															
17	08															
18	09															
19	10															
20	11															
21	12															
22	13															
23	14															
24	15															
01	16															
02	17															
03	18															
04	19															
05	20															
06	22															
07	23															
TOTALS										BALANCE				TOTAL OUT MLS		
TOTAL IN MLS																

GUIDELINES FOR RECORDING INTRAVENOUS INFUSIONS ON 24 HOUR FLUID BALANCE CHART

ALL INTRAVENOUS INFUSIONS TO BE RECORDED ON COMPLETION OF INFUSION.

TYPE OF PARENTAL FLUID TO BE RECORDED IN APPROPRIATE COLUMNS:-

BLOOD/COLLOID/PLASMA	
	• RECORD ANY BLOOD OR BLOOD PRODUCTS, e.g. ◆ UNITS OF PACKED BLOOD CELLS ◆ FROZEN PLASMA ◆ GELOFUSINE
IV (1)	• PLEASE RECORD TYPE OF INTRAVENOUS FLUID AND AMOUNT, e.g. ◆ SODIUM CHLORIDE 0.9% ◆ GLUCOSE 5% ◆ RINGER LACTATE
IV (2)	• FOR USE IF MORE THAN ONE INTRAVENOUS INFUSION IN PROGRESS, e.g. CVP LINE
IV (3)	FOR RECORDING INTRAVENOUS DRUGS SUCH AS ANTIBIOTICS. CROSS REFERENCE BY USING THE CODED LETTER OF THE PATIENT'S MEDICATION PRESCRIPTION SHEET, e.g.
	A. 100mls
	• RECORDING INTRAVENOUS PRESCRIPTIONS GIVEN BY SYRINGE DRIVER /INFUSION PUMP, e.g. HEPARIN, INSULIN, DOPAMINE.
	• ADDITIONAL COLUMN FOR USE IF MORE THAN TWO INFUSIONS IN PROGRESS AT ANY ONE TIME

ADAPTED WATERLOW PRESSURE AREA RISK ASSESSMENT CHART

WRITE, IN			
Surname	50623238H WATSON	F	
Forename	MARY 28 KENDON AVENUE GLASGOW	06/03/1954	
DoB	LANARKSHIRE	G15 8AX	
Location ..	CHI-0603546323		

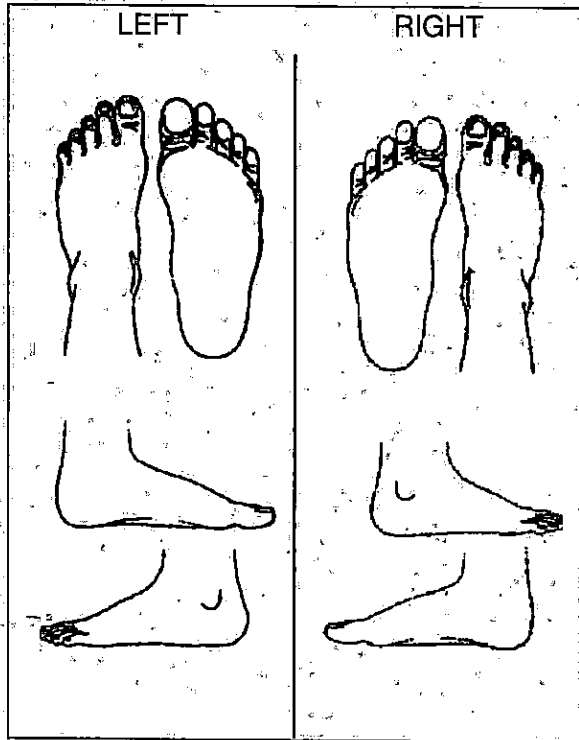
More than one score/category can be used: 10+= 'At Risk': 15+= 'High Risk': 20+= 'Very High Risk' .
Complete assessment on admission/1st visit, if there is a change in individuals condition and repeat regularly according to local protocol

Complete assessment on admission - visit, if there is a change in clinical status to inform the ward team									
Sex									
Male	1								
Female	2	2							
Age									
14 -49	1								
50 -64	2	2							
65 - 74	3								
75 - 80	4								
81+	5								
Build/Weight for Height (BMI=weight in Kg/height in m²)									
Average - BMI 20-24.9	0	0							
Above average - BMI 25-29.9	1								
Obese - BMI > 30	2								
Below average - BMI < 20	3								
Continence									
Complete/catheterised	0	0							
Incontinent urine	1								
Incontinent faeces	2								
Doubly incontinent (urine & faeces)	3								
Skin Type - Visual Risks Area									
Healthy	0	6							
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								
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	0							
Special Risks - Surgery/Trauma									
On table > 6 hours	8								
Orthopaedic/below waist/spinal (up to 48 hours post op)	5	0							
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	0							
Total Score		5							
Date		19/5/19							
initials		AB							
Time		09:00							

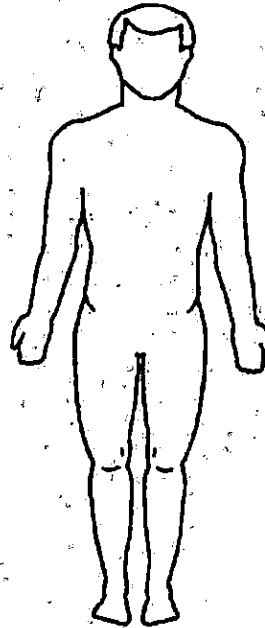
Ensure plan of care is implemented / reviewed for all identified areas of concern.

PRESSURE ULCER RECORD

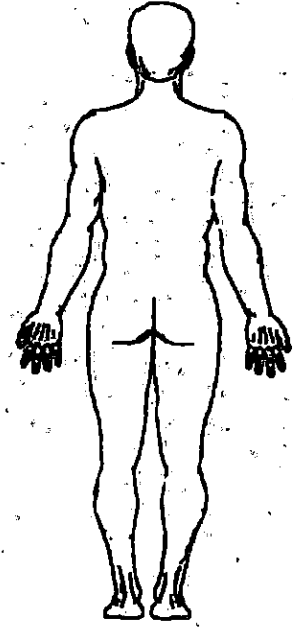
Indicate by circling and numbering all pressure damage on diagrams, then complete box below.
Indicate care plan/wound assessment chart.



Anterior view



Posterior view



SCOTTISH ADAPTED EPUAP PRESSURE ULCER GRADING TOOL

- GRADE 1** Non-blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly on individuals with darker skin.
- GRADE 2** Partial thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents clinically as an abrasion or blister.
- GRADE 3** Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia.
- GRADE 4** Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss.

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

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

Cannard Falls Risk Assessment

Glossary of terms used in risk assessment

SIGHT DEFICIT means patient cannot see well even when wearing glasses or is registered blind.

HEARING DEFICIT means person has hearing problems even with a hearing aid or has hearing problems and does not wear a hearing aid.

BALANCE DEFICIT means person is unable to stand without the support of another person or a walking frame.

MEDICINES FOR SOME MENTAL ILLNESSES include Chlorpromazine (Largactil), Risperidone (Risperdal), Lithium (Camecolit or Priadel), Haloperidol, Chloral hydrate (Welldorm), Clomethiazole (Heminevrin), antidepressants, Diazepam, Lorazepam and Amitriptyline.

CARDIOVASCULAR SYSTEM MEDICATION all antihypertensive medication and inotropes including Captopril, atenolol and many others.

WATER TABLETS (DIURETICS) are such as Bendroflumethiazide, Furosemide and Co-amlofruse.

SEDATIVES / ANALGESIA AT NIGHT include medicines such as Diazepam, Temazepam, Nitrazepam, Chlordiazepoxide and Zopiclone (Zimovane) Morphine PCA, Fentanyl, Tramadol and Oxycodone.

INABILITY TO CO-OPERATE includes failure to use walking aids or putting themselves in situations with a high risk of falling (usually due to mental impairment).

RESTRICTED MOBILITY means the person requires supervision and/or help to walk (i.e. is not safe to walk alone even with an aid).

HESITANT IN INITIATING MOVEMENT means difficulty in starting to walk.

POOR TRANSFER means the person requires help and is not safe to do the following alone - get in or out of bed, on or off a chair, move from chair to standing.

Acute Services Divi:

Hospital / Department

WIG, LOE

Cannard Falls Risk Assessment Pack

Patient name:	50623238H WATSON MARY 28 KENDON AVENUE GLASGOW LANARKSHIRE G15 8AX CHI-0603546323	06/03/1954 P	Unit/Hospital number
Ward:			
CHI number:			

Contents

1. Cannard 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 or mobility problems unattended on commodes, in toilets, baths or 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: 19/5/16	Date:	Date:	Date:	Date:	Date:	Date:
					Ward: 108	Ward:	Ward:	Ward:	Ward:	Ward:	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	0						
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	0					
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed / chair-bound / wheel-chair 1		1					
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1					
TOTAL SCORE					4						
ACTION(S) TAKEN Enter action code(s) from Care Plan below					1, 24						
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

NURSING INTERVENTIONS		Date: 19/5/16	Date:	Date:	Date:	Date:	Date:
		Ward: 108	Ward:	Ward:	Ward:	Ward:	Ward:
Action code							
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	Hip protectors refer to Hospital Falls Co-ordinator.						
24	Other interventions.						

Buzzer
SIGNATURE

Review Cannard score weekly / monthly as per policy. Enter action code(s) selected in action taken section on Falls Risk Assessment page above.

Nutrition Profile

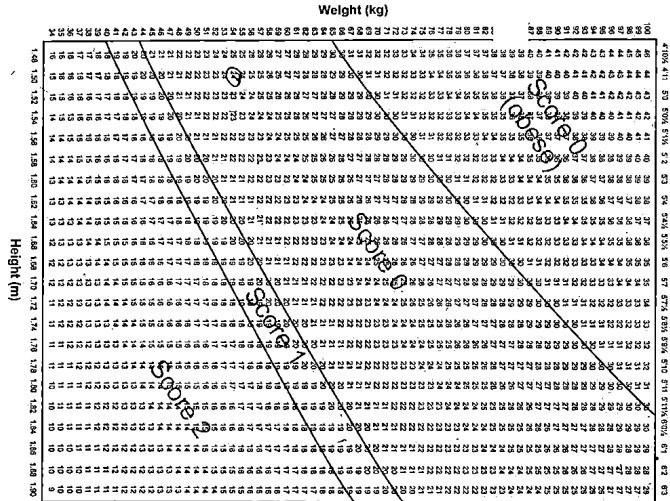
Name:	100623230H WATSON MARY 28 KENNEDY AVENUE GLASGOW LANARKSHIRE G15 8AX CHI-0603546523	Date of admission:	19/5/10
Address:		Time:	0900
DoB:		HOSPITAL:	WIG
CHI number:		Ward:	L10E
Affix patient data label			

To be recorded within 24 hours of admission*	
Height:	4'11" ☒ Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐
Weight:	54 kg/stones ☒ Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐
Recent unplanned weight loss: Yes ☒ No ☐	
If 'Yes' how much?: 1 1/2 kg/stones Over what period of time?: 2-3 weeks/months	
Is there evidence of recent weight loss? due to pain. ☒ Yes ☐ No	
No ☐ Loose clothing ☐ History of reduced food intake/appetite ☐ Swallowing problem ☐	
Eating and drinking likes and dislikes (including appetite and/or NBM status): Normal diet No food allergies	
Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☒	
Please state:	
Are there any contributing factors that may affect food intake such as physical (e.g. swallowing difficulties), physiological (e.g. nausea), psychological (e.g. dementia), social or environmental? Yes ☒ No ☐	
Please specify all factors: Abdo. pain	
Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☒	
Please state:	
Profile completed by: Name (PRINT): G. BROCKMYRE Signature: <i>G. Brockmyre</i> Date: 19/5/10	
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

Step 1 - BMI Score

Height (feet and inches)



Step 2 - Weight Loss Score

Weight (kg)	Weight (stones and pounds)	Weight (kg)	Weight (stones and pounds)	Weight (kg)	Weight (stones and pounds)	Weight (kg)	Weight (stones and pounds)	Weight (kg)	Weight (stones and pounds)
100	15.4	100	15.4	100	15.4	100	15.4	100	15.4
90	13.6	90	13.6	90	13.6	90	13.6	90	13.6
80	11.8	80	11.8	80	11.8	80	11.8	80	11.8
70	10.4	70	10.4	70	10.4	70	10.4	70	10.4
60	9.0	60	9.0	60	9.0	60	9.0	60	9.0
50	7.6	50	7.6	50	7.6	50	7.6	50	7.6
40	6.2	40	6.2	40	6.2	40	6.2	40	6.2
30	4.8	30	4.8	30	4.8	30	4.8	30	4.8
20	3.4	20	3.4	20	3.4	20	3.4	20	3.4
10	2.0	10	2.0	10	2.0	10	2.0	10	2.0
0	0.6	0	0.6	0	0.6	0	0.6	0	0.6

STORES ORDER CODE 41850

VI MEDICAL ILLUSTRATION • NUTRITION & DIET • 12366/01.09.08

[illegible]

Score of Overall Risk of Malnutrition	Action Required
0	LOW RISK - Routine Clinical Care Repeat screening. Hospital AcuteWeekly Hospital RehabilitationMonthly
1	MEDIUM RISK - Observe - Document dietary intake for 3 days on a Food Record Chart. - If no improvement in intake: - Encourage oral intake. - Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. - Repeat screening weekly.
2 or more	HIGH RISK - Treat* - Refer to Dietitian and document food intake for 3 days on a Food Record Chart. - Encourage oral intake. - Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. - Monitor and review Care Plan weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

N.B. Ensure discharge plan includes most recent 'MUST' score and any necessary follow-up requirements.

[illegible]

1 2 3 4 5 6 7 8

Pupil size (mm)

DATE					
Time					
COMAV S C A L E	Eyes open	Spontaneously	4		
		To speech	3		
		To pain	2		
		None	1		
	Oriented		5		
	Confused		4		
	Incomprehensible words		3		
	Incomprehensible sounds		2		
	None		1		
	Obey		5		
Localises		5			
Flexion - withdrawal		4			
Pain - abnormal		3			
Extension to pain		2			
None		1			
TOTAL SCORE					
PUPILS	R	Size Reaction			
	L	Size Reaction			
I M B N O R M A L E Y E S	A	Normal power			
	R	Mild weakness			
	M	Severe weakness			
	S	Spastic flexion			
	L	Extension			
	E	No response			
	G	Normal power			
	S	Mild weakness			
I	Severe weakness				
N	Extension				
O	No response				

NHS
Greater Glasgow
and Clyde

Name _____
Address _____
Hospital No. _____
DOB _____

50623238H
WATSON, F
MARY 06/03/1954
28 KENDON AVENUE
GLASGOW
LANARKSHIRE G15 8AX
CHI-0603546323

Admitted Date 7/5/10 Ward 10E
Transferred Date _____ Ward _____
Transferred Date _____ Ward _____

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

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

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

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

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

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

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.

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

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.

DATE														TEMP
Time														X
B P and P u l s e	240													40°C
	230													39°C
	220													38°C
	210													37°C
	200													36°C
	190													35°C
	180													
	170													
	160													
	150													
	140													
	130													
	120													
	110													
	100													
	90													
80														
70														
60														
50														
40														
Resp. Rate		16	14	16	16	16	16	16	16	20	16	16		
Inspiration O ₂ %		100	100	100	100	100	100	100	100	100	100	100		
SpO ₂ %		100	100	100	100	100	100	100	100	100	100	100		
Pain Score		0	0	0	0	0	0	0	0	0	0	0		
Sedation Score		0	0	0	0	0	0	0	0	0	0	0		
Nausea Score		0	0	0	0	0	0	0	0	0	0	0		
Blood Glucose														
Wound 1														
Wound 2														
Wound 3														
MEWS														
Resp. Rate		0	0	0	0	0	0	0	0	0	0	0		
Pulse		0	0	0	0	0	0	0	0	0	0	0		
Systolic BP		0	0	0	0	0	0	0	0	0	0	0		
GCS / AVPU		0	0	0	0	0	0	0	0	0	0	0		
Urine Output		0	0	0	0	0	0	0	0	0	0	0		
Temp.		0	0	0	0	0	0	0	0	0	0	0		
SpO ₂ %		0	0	0	0	0	0	0	0	0	0	0		
TOTAL		0	0	0	0	0	0	0	0	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	15 /			
Urine	<10mls/hr for 2 hrs	<30mls/hr for 2 hrs	New agitation or confusion	Alert	Voice	Pain	Unresponsive
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			

DATE														TEMP
Time														X
B P and P u l s e	240													40°C
	230													39°C
	220													38°C
	210													37°C
	200													36°C
	190													35°C
	180													
	170													
	160													
	150													
	140													
	130													
	120													
	110													
	100													
	90													
80														
70														
60														
50														
40														
Resp. Rate														
Inspiration O ₂ %														
SpO ₂ %														
Pain Score														
Sedation Score														
Nausea Score														
Blood Glucose														
MEWS														
Resp. Rate														
Pulse														
Systolic BP														
GCS / AVPU														
Urine Output														
Temp.														
SpO ₂ %														
TOTAL														

Calling Criteria

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

Discharge Checklist

Patient's name: 
 Unit number: 50623238H
 CHI number: WATSON
 MARY 06/03/1954
 28 KENDOON AVENUE
 GLASGOW G15 8AX
 CHI-0603546323

Ward: L 10 E

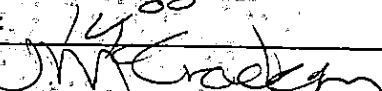
Discharge destination: HOME

Estimated Discharge Date (1) / /

Estimated Discharge Date (2) / /

Final date of discharge: 23/4/10

Checklist

	Yes	N/A	Initials	Comments
Patient informed	☒			
Relative/carer informed	☒			
Others informed: Care Home		☒		
Transport arranged				
Own transport (preferred option)	☒			
Ambulance-1 man/ 2 man am/pm		☒		
Other: Flight, Air ambulance etc.		☒		
Discharge medication				
Discharge prescription completed	☒			
Compliance aids e.g. Dossette Box (involve pharmacist)		☒		
Medication received	☒			
Medication explained to patient and/or relative/carer	☒			
Own medication returned to patient		☒		
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)		☒		
Informed of discharge				
Social work/ Other agencies/Home help		☒		
Physiotherapist		☒		
Occupational Therapist		☒		
Dietician		☒		
Speech and Language Therapist		☒		
Clinical Nurse specialist e.g. Care Home Liaison		☒		
Liaison/ District Nurse/Practice Nurse		☒		
Other discharge items				
Access arrangements (e.g. keys, door entry)	☒			
Patients clothing available for day of discharge	☒			
Valuables e.g. cash		☒		
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: 14:00				
Nurse's signature: 				
Designation: ()				
Date: 23/4/10				

DISCHARGE PLANNING

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

50623238H

WATSON

MARY

06/03/1954

28 KENDON AVENUE

GLASGOW

G15 8AX

CHI-0603546323

Ward: L10V

Date: 13/4/10

Case Record No.:

ACTIVITIES OF DAILY LIVING

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: _____

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)	☐

BREATHING	
1. No symptoms	☒
2. Breathless with moderate exercise	☐
3. Breathless with minimal exertion	☐
4. Breathless at rest	☐
5. Uses inhalers	☐
Comments:	

SMOKING	
Non-smoker	☐
Smoker: <u>15</u> per day	☒
Ex-smoker	☐
Aware of hospital policy	☐

HYGIENE	
Bath ☐	Shower ☒
Requires assistance	☐ Stand up wash ☐
Skin assessment:	
Other:	

ELIMINATION	
Bowels regular	☐
Constipated <i>uses supps</i>	☒
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: <i>Incontinence through surgery</i>	

SLEEP	
Hours/night	☐
Medication	☐
details:	

MENTAL STATE	
Alert/Orientated	☐
Confused: day/night	☐
Anxious/Distressed	☐
Unconscious	☐
Other (specify):	

50623238H

WATSON

MARY

06/03/1954

28 KENDOON AVENUE

GLASGOW

. G15 8AX

CHI-0603546323

Ward: 400

Date: 13/24/0.

Case Record No.:

CARE PLAN

[illegible]

[illegible]

Documentation/nds9/newadmit.doc/sep/98



50623238H

WATSON

MARY

28 KENDON AVENUE

06/03/1954

Ward: L10

Date: 13/4/10

Case Record No.:

GLASGOW

G15 8AX

CHI-0603546323

CARE PLAN EVALUATION

2. Nutrition	5. Observations	9. Sleep
3. Elimination	6. Technical Care	10. Special Needs
4. Mobility	7. Wound Care	11. Other Relevant Information
	8. Specimens/Investigations	

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
13/4/10	00.00		pt admitted today with abdo pain - pt A/W a cholecystectomy in May	
		(5)	ass stable & admissions	
		(8)	A/W USS RT	
			- AUSS is an	
		(11)	pt had 10mg morphine in Att	
			pt pain seems settled on anal	CSL
			A/W falls R/W	CS
14/4/10	01 ¹⁵	11	clo pain. Analgesia given prior to settling down. Further DF 18 30mg given.	
		6	IV fluids commenced 6°	
		3	Voiding urine MSSU RT	P. Kathan
	06 ⁰⁰	9	Settled late. Slept short spells.	
		2	Fluids & diet as able.	
		3/4	Mobilising to toilet. Voiding urine Nil PR.	
		5	Obs stable. Apptaxal. Meas=2. Temp & SpO2 90%.	
		6	IV fluids continue 6°.	
		11	For further R/W today	P. Kathan
14/4/10	12 ²⁵		SIB Mr Clancy	
		2	Fastie for USS	
		5	Observations stable	
		6	IVI to commence	
			Antiemetic given with effect.	
		8	Attended for USS	
			commenced on IV antibiotics.	Theresa
	16 ¹⁰	2	Free fluids	
		3	Passing wind	
		5	Observations stable.	
		6	IVI & IV antibiotics	
		8	Attended for USS.	
			AW further review.	
		11	? for USS guided drainage	
			? for cholecystectomy	
			Patient upset & fearful.	
			appears calmer now - I have	

EVALUATION OF CARE

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
			SPOKEN TO HER at length about her diagnosis.	
			Also, FY2 has spoken to patient at length re treatment.	
15/4/10	0200	(11)	Complaining of pain this evening. Analgesia given with good effect.	Heurme
		(2)	Fluids taken, diet offered but only ate small amount.	
		(3)	Up to toilet, passing urine.	
		(5)	Obs so charted.	
		(6)	IVABX as per code.	
		(8)	? for theatre if pain continues.	
		(9)	Slept for short spells.	Shirley SN HAMILTON
	12MD	1	Independent with personal care. No severe pain. Very fearful. Had low. Morphine long given 11m.	
		2	Fluids & diet as able.	
		3/4	Mobilizing to toilet. Voiding urine.	
		5	Obs stable. Apyrexial. Borderline hypotension C 100/50. Mews = 0.	
		6	IVAB'S continue.	
		11	Seen C ward round. Continue with care as above.	R. Kothan
	1800	11	Seen C ward round. Patient keen for surgery.	
		2	Nil by mouth.	
		3	Voided. Unligated. Food. Voiding urine.	
		6	Commence 10u fluids 40.	
		11	Review tomorrow.	R. Kothan
	1830	11	Patient very fearful & upset. Did not like the way doctor spoke to her. Keen to have surgery done soon. Explained the reasons for not opting for surgery. Calmer now. Will speak to her two daughters who are both nurses.	R. Kothan
16/4/10	0400	9	settled and slept well.	
		2	Fluids taken in small amounts.	
		3	Voiding urine / laxatives given.	
		4	Mobile.	
		5	Observations stable apyrexial.	R. Kothan
		6	IV / + IVABs continue.	IN KROSE
		6	oral analgesia sufficient.	

Name: Mary Watson

Ward: L10E

Date: 16/4/10

506232384
Case Record No.:

CARE PLAN EVALUATION

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

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
16.4.10	17.35	1.	Independent with personal hygiene	
			Patient had a shower this morning.	
		2.	Patient tolerating fluids and diet	
		3.	Voiding urine well + bowels have moved	
		4.	Independently mobile around ward	
		5.	Obs stable as per MEWS.	
		6.	IVI discontinued.	
		11.	Patient is for home when she feels up to it. A/c ^{ERICK} date has been set in May for a lap coil with Mr Clancy.	M. Student Nurse
	18.00		Patient claims abdo is sore after eating dinner, and also swollen	M. Student Nurse
	20.00		90. Eval antibiotics and advised to attempt light diet only at present. Return date 26.5.10.	C. O'Sullivan
	22.00		Complaining of abdo pain, analgesia given as per chart reviewed by FY1 Rami who felt she had indigestion, given 1g.	C. O'Sullivan
17/4/10	3am	(9)	Proposed to have stool	
		(1)	Fluids and diet as per	
		(5)	Stool	
			To return on 26/5/10 for lap coil	
	3am		Cyclizine 50mg IV for nausea and small vomit. Refused in analgesia wants to see if settles after cyclizine stops pain usually settles after vomit.	
	5am		With small vomit, still in pain despite OF18 (60mg) FY1 asked to review	
	1555	1.	Independent with bedside wash this morning.	
		2.	Very little fluid and diet taken - tolerating water.	
		3.	Passing urine spontaneously. Nausea th but no vomiting.	C. O'Sullivan

EVALUATION OF CARE

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
17/4/10		5.	Observations as per MEWS.	
		6.	Declining OC morphine.	
		11.	Unsettled day, nausea and pain following code.	
18/4/10	22 ⁰⁰		Repeat bloods cancelled.	
	20 ⁰⁰	(9)	Appears more settled now, Nausea feeling nauseous earlier.	
		(2)	Managing fluids, not keen for diet.	
		(3)	Up to toilet.	
		(5)	Obs stable.	
	14 ⁴⁵		Bisoprolol 20mg given for pain.	
	12 ⁴⁰	1	Independent with personal care.	
		2	Fluids & Soft diet.	
		3/4	Encourage mobility: Voiding Urine. B/o.	
		5	Obs Stable. Apyrexial. MEWS = 2.	
		11	Seen P ward round. Continue care as before. Oral antibiotics continue. Patient keen to restart IVAB's as a member of staff had mentioned that she may need them restarted. Bloods improving.	R.Kate
	18 ⁰⁰	11	(R) Eye weepy & red looking. Bathed & cleaned.	R.Kate
		(11)	Pain again this evening. Analgesia given with good effect.	
		(2)	Small amounts of F&D taken.	
		(3)	Up to toilet - no new issues.	
		(5)	Obs stable & drowsy.	
		(9)	Appears to have settled & slept well.	Shoreen SNAMILLON
19/4/10	12 ³⁰	1-4	Independent with ADLs.	
		5.	Obs stable as per MEWS. Apyrexial.	
		11.	Seen @ wk.	
			Continue care. Tramadol 100mg given too good effect.	
			Pt crying this AM. IVABs to restart if WCC ↑	
20.4.10	05 ³⁰	2.	Drinking small amounts of water only.	
		3.	Passing urine spontaneously.	
		5.	Observations satisfactory as per MEWS.	
		9.	Appears to have settled and slept well.	

Name: MARY WATSON

Ward: L10E

Date: 20.4.10

Case Record No.:

500232384

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
20.4.10	am		well overnight, no complaints opened	
		11	fluid remains low and oral intake very poor.	
20.4.10	10.50	11	patient unavailable at ward round. No change to current care though - await patient to feel fit for discharge. Has return date for lap. chole.	
		1	Independent.	
		2	Oral intake poor due to nausea	
		3/4	Independent. No issues	
		5	Obs stable as per MEWS	
		6	Still very sore, taking regular paracetamol + tramadol	
		6	C/O nausea: have suggested taking an anti-emetic with other meds.	
21.4.10	am	2.	Tolerating very small amounts only orally.	
		3.	Passing urine. Bowel active - declining laxatives.	
		5.	Observations stable as per MEWS.	
		8.	Wounds show declining WCC and CRP - in view of patient failing to improve - ? change antibiotics.	
		9.	Appears to have settled and sleep well.	
		11.	Continues to have severe pain and nausea. No improvement in how she is feeling over last several days.	
	1630		R/V Mr Kallarchi.	
		8	Will need further scanning to assess empyema. To continue oral antibiotics meantime.	
		5	Obs stable	
			Apyrexial.	

EVALUATION OF CARE

DATE	TIME	No	EVALUATION AND PROGRESS OF CARE	SIGNATURE
22/11/10	06 ⁰⁰	9	Regular oral analgesia for pain relief	Pharmacy
		2	Settled night. Slept well.	
		3/4	Encourage fluids & diet (low fat)	
			Mobile around ward. Voiding urine.	
			Refusing laxatives. Nil PR.	
		5	Obs stable.	
		11	Awaits further RLW. ? Further scans TBA.	R. Kather
	11.45	11	WIR: for repeat AUSS today then for further review.	
		1-4	Independent. No issues	
		5	Obs stable as per MEWS	
		8	For AUSS @ 2pm, fasting	
		11	Pain seems more settled + patient more comfortable today	John
23/11/10	06 ⁰⁰	9	Settled & slept well.	
		2	Fluids & diet as able.	
		3/4	Mobile around ward. Voiding urine. Nil PR.	
		11	Collection now resolved. ? Home soon. Surgery appt 26/11/10.	R. Kather
	15 ⁰⁰		CONFIDENTIAL TV viewing	
		①	Independent with hygiene	
		②	Staircase Dig. No Flushed	
		③	Bringing Urine belt	
		④	Fuller Mobile Around Ward	
		⑤	Seen by the LAXATIVE	
			URGENT REPORT SATISFIED	
			MAN RE DISCHARGED HOME	
			TO RETURN HIS HUSBAND	
			FOR COLIC/STOMACH	
			ON 26th Mon	UMF

Notes for Users

FOR PRESCRIBERS:

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

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

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

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

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

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

6. The following metric unit abbreviations must be used –

Microgram / Nanogram / Units – **Do not abbreviate, write in full**

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

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

OM = oral	ID = intradermal
IM = intramuscular	IL = sublingual
IS = subcutaneous	PR = per rectum
NG = nasogastric	PEG = percutaneous endoscopic gastrostomy
PO = per os	PEJ = percutaneously inserted gastrostomy
NJ = nasojejunostomy	PEJN = percutaneous endoscopic jejunostomy
TOP = topical	ETT = endotracheal
NEB = nebulized	INHAL = inhaled
IV... = intravenous	

Please note - Intrathecal must be written in full.

FOR NURSES

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

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

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

4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

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

PRESCRIPTION FORM

Hospital Name:

PATIENT DETAILS			ONCE ONLY AND PREMEDICATION DRUGS							
Name:  50623238H WATSON MARY CHI-0603546323		Height:	DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF PRESCRIBER	GIVEN BY	TIME GIVEN
Weight:										
Surface area:										
Date of writing discharge prescription: <u> / / </u>										
Ward:										
f-Admission: <u> / / </u>										
Consultant Name:										
Date and time this form prepared: <u> / / </u> Time: <u> : </u>		Sheet No	2nd Prescription in use							
			Yes or NO							
DRUG SENSITIVITIES										
<i>None known</i>										
DVT Risk on Admission (SIGN Guideline)										
High ☐ Moderate ☐ Low ☐										
Assessed by: <u> </u> Date: <u> / / </u>										
OTHER CHARTS IN USE										
Insulin ☐		TPN: ☐								
PCA and other infusions ☐		Enteral Nutrition: ☐								
Anticoagulants: Heparin ☐		Oxygen Therapy: ☐								
Oral ☐		Other: ☐								
Topical: ☐										

PATIENT'S NAME: <u>May Larson</u>		ADMINISTRATION CH 0603546 323 506237384																																																																			
Parenteral Drugs: Regular Prescription		<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%;">DATE</td> <td style="width:5%;">13</td> <td style="width:5%;">14</td> <td style="width:5%;">15</td> <td style="width:5%;">16</td> <td style="width:5%;">17</td> <td style="width:5%;">18</td> <td style="width:5%;">19</td> <td style="width:5%;">20</td> <td style="width:5%;">21</td> <td style="width:5%;">22</td> </tr> <tr> <td>MONTH</td> <td>4</td> <td>4</td> <td>4</td> <td>4</td> <td>4</td> <td>4</td> <td>4</td> <td>4</td> <td>4</td> <td>4</td> </tr> </table>		DATE	13	14	15	16	17	18	19	20	21	22	MONTH	4	4	4	4	4	4	4	4	4	4																																												
DATE	13	14	15	16	17	18	19	20	21	22																																																											
MONTH	4	4	4	4	4	4	4	4	4	4																																																											
A DRUG <u>Cefazolin</u>		<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%;">Other time</td> <td colspan="10"></td> </tr> <tr> <td>0700-0900</td> <td colspan="10"></td> </tr> <tr> <td>1200-1400</td> <td colspan="10"></td> </tr> <tr> <td>1600-1800</td> <td colspan="10"></td> </tr> <tr> <td>2200-2400</td> <td colspan="10"></td> </tr> <tr> <td>Other time</td> <td colspan="10"></td> </tr> </table>		Other time											0700-0900											1200-1400											1600-1800											2200-2400											Other time										
Other time																																																																					
0700-0900																																																																					
1200-1400																																																																					
1600-1800																																																																					
2200-2400																																																																					
Other time																																																																					
DOSE: <u>20mg</u> ROUTE: <u>SLC</u> DATE: <u>13/4/10</u> SIGNATURE OF PRESCRIBER: <u>[Signature]</u> INITIALS: <u>[Initials]</u> ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: <u>every 8 hours</u>		STOPPED DATE: <u>13/4/10</u> INITIALS: <u>[Initials]</u>																																																																			
FOR PRESCRIBERS USE ONLY																																																																					
B DRUG <u>AMOXICILLIN</u>		<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%;">Other time</td> <td colspan="10"></td> </tr> <tr> <td>0700-0900</td> <td colspan="10"></td> </tr> <tr> <td>1200-1400</td> <td colspan="10"></td> </tr> <tr> <td>1600-1800</td> <td colspan="10"></td> </tr> <tr> <td>2200-2400</td> <td colspan="10"></td> </tr> <tr> <td>Other time</td> <td colspan="10"></td> </tr> </table>		Other time											0700-0900											1200-1400											1600-1800											2200-2400											Other time										
Other time																																																																					
0700-0900																																																																					
1200-1400																																																																					
1600-1800																																																																					
2200-2400																																																																					
Other time																																																																					
DOSE: <u>1g</u> ROUTE: <u>IV</u> DATE: <u>14/4/10</u> SIGNATURE OF PRESCRIBER: <u>[Signature]</u> INITIALS: <u>[Initials]</u> ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: <u>every 8 hours</u>		STOPPED DATE: <u>14/4/10</u> INITIALS: <u>[Initials]</u>																																																																			
FOR PRESCRIBERS USE ONLY																																																																					
C DRUG <u>GENTAMICIN</u>		<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%;">Other time</td> <td colspan="10"></td> </tr> <tr> <td>0700-0900</td> <td colspan="10"></td> </tr> <tr> <td>1200-1400</td> <td colspan="10"></td> </tr> <tr> <td>1600-1800</td> <td colspan="10"></td> </tr> <tr> <td>2200-2400</td> <td colspan="10"></td> </tr> <tr> <td>Other time</td> <td colspan="10"></td> </tr> </table>		Other time											0700-0900											1200-1400											1600-1800											2200-2400											Other time										
Other time																																																																					
0700-0900																																																																					
1200-1400																																																																					
1600-1800																																																																					
2200-2400																																																																					
Other time																																																																					
DOSE: <u>10</u> ROUTE: <u>IV</u> DATE: <u>14/4/10</u> SIGNATURE OF PRESCRIBER: <u>[Signature]</u> INITIALS: <u>[Initials]</u> ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: <u>every 8 hours</u>		STOPPED DATE: <u>14/4/10</u> INITIALS: <u>[Initials]</u>																																																																			
FOR PRESCRIBERS USE ONLY																																																																					
D DRUG <u>TACROLIMUS</u>		<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%;">Other time</td> <td colspan="10"></td> </tr> <tr> <td>0700-0900</td> <td colspan="10"></td> </tr> <tr> <td>1200-1400</td> <td colspan="10"></td> </tr> <tr> <td>1600-1800</td> <td colspan="10"></td> </tr> <tr> <td>2200-2400</td> <td colspan="10"></td> </tr> <tr> <td>Other time</td> <td colspan="10"></td> </tr> </table>		Other time											0700-0900											1200-1400											1600-1800											2200-2400											Other time										
Other time																																																																					
0700-0900																																																																					
1200-1400																																																																					
1600-1800																																																																					
2200-2400																																																																					
Other time																																																																					
DOSE: <u>4.5g</u> ROUTE: <u>IV</u> DATE: <u>14/4/10</u> SIGNATURE OF PRESCRIBER: <u>[Signature]</u> INITIALS: <u>[Initials]</u> ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: <u>every 8 hours</u>		STOPPED DATE: <u>14/4/10</u> INITIALS: <u>[Initials]</u>																																																																			
FOR PRESCRIBERS USE ONLY																																																																					

Parenteral Drugs: Regular Prescription		<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%;">DATE</td> <td style="width:5%;"></td> <td style="width:5%;"></td> <td style="width:5%;"></td> <td style="width:5%;"></td> <td style="width:5%;"></td> <td style="width:5%;"></td> <td style="width:5%;"></td> <td style="width:5%;"></td> <td style="width:5%;"></td> <td style="width:5%;"></td> </tr> <tr> <td>MONTH</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>		DATE											MONTH																																																						
DATE																																																																					
MONTH																																																																					
E DRUG		<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%;">Other time</td> <td colspan="10"></td> </tr> <tr> <td>0700-0900</td> <td colspan="10"></td> </tr> <tr> <td>1200-1400</td> <td colspan="10"></td> </tr> <tr> <td>1600-1800</td> <td colspan="10"></td> </tr> <tr> <td>2200-2400</td> <td colspan="10"></td> </tr> <tr> <td>Other time</td> <td colspan="10"></td> </tr> </table>		Other time											0700-0900											1200-1400											1600-1800											2200-2400											Other time										
Other time																																																																					
0700-0900																																																																					
1200-1400																																																																					
1600-1800																																																																					
2200-2400																																																																					
Other time																																																																					
DOSE: ROUTE: DATE: SIGNATURE OF PRESCRIBER: INITIALS: ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:		STOPPED DATE: INITIALS:																																																																			
FOR PRESCRIBERS USE ONLY																																																																					
F DRUG		<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%;">Other time</td> <td colspan="10"></td> </tr> <tr> <td>0700-0900</td> <td colspan="10"></td> </tr> <tr> <td>1200-1400</td> <td colspan="10"></td> </tr> <tr> <td>1600-1800</td> <td colspan="10"></td> </tr> <tr> <td>2200-2400</td> <td colspan="10"></td> </tr> <tr> <td>Other time</td> <td colspan="10"></td> </tr> </table>		Other time											0700-0900											1200-1400											1600-1800											2200-2400											Other time										
Other time																																																																					
0700-0900																																																																					
1200-1400																																																																					
1600-1800																																																																					
2200-2400																																																																					
Other time																																																																					
DOSE: ROUTE: DATE: SIGNATURE OF PRESCRIBER: INITIALS: ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:		STOPPED DATE: INITIALS:																																																																			
FOR PRESCRIBERS USE ONLY																																																																					
G DRUG		<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%;">Other time</td> <td colspan="10"></td> </tr> <tr> <td>0700-0900</td> <td colspan="10"></td> </tr> <tr> <td>1200-1400</td> <td colspan="10"></td> </tr> <tr> <td>1600-1800</td> <td colspan="10"></td> </tr> <tr> <td>2200-2400</td> <td colspan="10"></td> </tr> <tr> <td>Other time</td> <td colspan="10"></td> </tr> </table>		Other time											0700-0900											1200-1400											1600-1800											2200-2400											Other time										
Other time																																																																					
0700-0900																																																																					
1200-1400																																																																					
1600-1800																																																																					
2200-2400																																																																					
Other time																																																																					
DOSE: ROUTE: DATE: SIGNATURE OF PRESCRIBER: INITIALS: ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:		STOPPED DATE: INITIALS:																																																																			
FOR PRESCRIBERS USE ONLY																																																																					
H DRUG		<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%;">Other time</td> <td colspan="10"></td> </tr> <tr> <td>0700-0900</td> <td colspan="10"></td> </tr> <tr> <td>1200-1400</td> <td colspan="10"></td> </tr> <tr> <td>1600-1800</td> <td colspan="10"></td> </tr> <tr> <td>2200-2400</td> <td colspan="10"></td> </tr> <tr> <td>Other time</td> <td colspan="10"></td> </tr> </table>		Other time											0700-0900											1200-1400											1600-1800											2200-2400											Other time										
Other time																																																																					
0700-0900																																																																					
1200-1400																																																																					
1600-1800																																																																					
2200-2400																																																																					
Other time																																																																					
DOSE: ROUTE: DATE: SIGNATURE OF PRESCRIBER: INITIALS: ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:		STOPPED DATE: INITIALS:																																																																			
FOR PRESCRIBERS USE ONLY																																																																					

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

PATIENT'S NAME: <u>May Wilson</u>		5062323871 2110603546223		ADMINISTRATION	
Oral and Other Drugs: Regular Prescriptions		DATE	3	4	5
		MONTH	4	4	4
J DRUG <u>ATORVASTATIN</u>		Other time			
DOSE <u>40mg</u> ROUTE <u>oral</u> DATE <u>13/4/10</u>		0700-0900			
SIGNATURE OF PRESCRIBER <u>[Signature]</u>		1200-1400			
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		1600-1800			
		2000-2400			
		Other time			

K DRUG <u>LEVOthyroxine</u>		Other time			
DOSE <u>100</u> ROUTE <u>oral</u> DATE <u>13/4/10</u>		0700-0900			
SIGNATURE OF PRESCRIBER <u>[Signature]</u>		1200-1400			
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		1600-1800			
		2000-2400			
		Other time			

L DRUG <u>Panethol</u>		Other time			
DOSE <u>2g</u> ROUTE <u>oral</u> DATE <u>13/4/10</u>		0700-0900			
SIGNATURE OF PRESCRIBER <u>[Signature]</u>		1200-1400			
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		1600-1800			
		2000-2400			
		Other time			

M DRUG <u>DIFFERENTIAL</u>		Other time			
DOSE <u>50-60</u> ROUTE <u>P</u> DATE <u>13/4/10</u>		0700-0900			
SIGNATURE OF PRESCRIBER <u>[Signature]</u>		1200-1400			
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		1600-1800			
		2000-2400			
		Other time			

Oral and Other Drugs: Regular Prescriptions		DATE	15	16	17
		MONTH	4	4	4
N DRUG <u>Morco</u>		Other time			
DOSE <u>1 tablet</u> ROUTE <u>P</u> DATE <u>13/4/10</u>		0700-0900			
SIGNATURE OF PRESCRIBER <u>[Signature]</u>		1200-1400			
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		1600-1800			
		2000-2400			
		Other time			

P DRUG <u>SENNA</u>		Other time			
DOSE <u>2 tabs</u> ROUTE <u>P</u> DATE <u>13/4/10</u>		0700-0900			
SIGNATURE OF PRESCRIBER <u>[Signature]</u>		1200-1400			
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		1600-1800			
		2000-2400			
		Other time			

R DRUG <u>Capitolo</u>		Other time			
DOSE <u>10mg</u> ROUTE <u>PO</u> DATE <u>13/4/10</u>		0700-0900			
SIGNATURE OF PRESCRIBER <u>[Signature]</u>		1200-1400			
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		1600-1800			
		2000-2400			
		Other time			

S DRUG <u>OMEPANOLE</u>		Other time			
DOSE <u>20mg</u> ROUTE <u>PO</u> DATE <u>16/4/10</u>		0700-0900			
SIGNATURE OF PRESCRIBER <u>[Signature]</u>		1200-1400			
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		1600-1800			
		2000-2400			
		Other time			

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

PATIENT'S NAME: <u>main Watson SD6232851</u>		CH 060354623		ADMINISTRATION	
Oral and Other Drugs: Regular Prescriptions		DATE	10	11	12
		MONTH	4	5	6
T DRUG <u>Metrondazole</u>		Other time			
DOSE	ROUTE	DATE	DATE:	1200-1400	1600-1800
400	P	15/4/11			
SIGNATURE OF PRESCRIBER		INITIALS:			
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		Other time			

FOR PRESCRIBERS USE ONLY		V DRUG <u>Amoxicillin</u>		Other time	
				0700-0900	
				1200-1400	
				1600-1800	
				2200-2400	
				Other time	

FOR PRESCRIBERS USE ONLY		W DRUG <u>Tramadol</u>		Other time	
				0700-0900	
				1200-1400	
				1600-1800	
				2200-2400	
				Other time	

FOR PRESCRIBERS USE ONLY		V DRUG		Other time	
				0700-0900	
				1200-1400	
				1600-1800	
				2200-2400	
				Other time	

Oral and Other Drugs: Regular Prescriptions		DATE			
		MONTH			
Y DRUG		Other time			
DOSE	ROUTE	DATE	DATE:	1200-1400	1600-1800
SIGNATURE OF PRESCRIBER		INITIALS:			
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		Other time			

FOR PRESCRIBERS USE ONLY		AA DRUG		Other time	
				0700-0900	
				1200-1400	
				1600-1800	
				2200-2400	
				Other time	

FOR PRESCRIBERS USE ONLY		BB DRUG		Other time	
				0700-0900	
				1200-1400	
				1600-1800	
				2200-2400	
				Other time	

FOR PRESCRIBERS USE ONLY		CC DRUG		Other time	
				0700-0900	
				1200-1400	
				1600-1800	
				2200-2400	
				Other time	

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

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs:
Regular Prescriptions

DATE
MONTH

DD DRUG

DOSE ROUTE DATE DATE: STOPPED INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

FOR PRESCRIBERS USE ONLY

EE DRUG

DOSE ROUTE DATE DATE: STOPPED INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

FOR PRESCRIBERS USE ONLY

FF DRUG

DOSE ROUTE DATE DATE: STOPPED INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

FOR PRESCRIBERS USE ONLY

GG DRUG

DOSE ROUTE DATE DATE: STOPPED INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

FOR PRESCRIBERS USE ONLY

Oral and Other Drugs:
Regular Prescriptions

DATE
MONTH

HH DRUG

DOSE ROUTE DATE DATE: STOPPED INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

FOR PRESCRIBERS USE ONLY

JJ DRUG

DOSE ROUTE DATE DATE: STOPPED INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

FOR PRESCRIBERS USE ONLY

KK DRUG

DOSE ROUTE DATE DATE: STOPPED INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

FOR PRESCRIBERS USE ONLY

LL DRUG

DOSE ROUTE DATE DATE: STOPPED INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

FOR PRESCRIBERS USE ONLY

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

PATIENT'S NAME: M. Watson

ADMINISTRATION

All Routes: As Required Prescriptions

MM	DRUG <u>HYDROCODONE</u>	DATE: STOPPED INITIALS: DATE:
DOSE <u>30mg</u>	ROUTE <u>oral</u>	INDICATION <u>Pain</u>
SIGNATURE OF PRESCRIBER <u>[Signature]</u>		MAX. FREQUENCY <u>6</u>
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		

DATE	TIME	DOSE	GIVEN BY
13/10	13:01	30	BK
14/10	01:15	30	RK
14/10	03:40	30	U
14/10	05:15	30	U
14/10	07:30	30	U
14/10	09:00	30	U
14/10	11:30	30	U
14/10	14:00	30	U
14/10	16:30	30	U
14/10	19:00	30	U
14/10	21:30	30	U
15/10	02:00	30	U

NN	DRUG <u>CYCLOZINE</u>	DATE: STOPPED INITIALS: DATE:
DOSE <u>50mg</u>	ROUTE <u>oral</u>	INDICATION <u>N+U</u>
SIGNATURE OF PRESCRIBER <u>HC</u>		MAX. FREQUENCY <u>8</u>
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		

DATE	TIME	DOSE	GIVEN BY
14/10	08:30	50	U
14/10	11:30	50	U
14/10	14:30	50	U
14/10	17:30	50	U
14/10	20:30	50	U
15/10	02:30	50	U

PP	DRUG <u>TRAMADOL</u>	DATE: STOPPED INITIALS: DATE:
DOSE <u>50mg</u>	ROUTE <u>oral</u>	INDICATION <u>Pain</u>
SIGNATURE OF PRESCRIBER <u>[Signature]</u>		MAX. FREQUENCY <u>4-6</u>
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		

DATE	TIME	DOSE	GIVEN BY
14/10	08:30	50	U
14/10	11:30	50	U
14/10	14:30	50	U
14/10	17:30	50	U
14/10	20:30	50	U
15/10	02:30	50	U

DD	DRUG <u>MORPHINE</u>	DATE: STOPPED INITIALS: DATE:
DOSE <u>50mg</u>	ROUTE <u>IV</u>	INDICATION <u>Pain</u>
SIGNATURE OF PRESCRIBER <u>[Signature]</u>		MAX. FREQUENCY <u>1-2</u>
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		

DATE	TIME	DOSE	GIVEN BY
14/10	08:30	50	U
14/10	11:30	50	U
14/10	14:30	50	U
14/10	17:30	50	U
14/10	20:30	50	U
15/10	02:30	50	U

SS	DRUG <u>BUSCAPEN</u>	DATE: STOPPED INITIALS: DATE:
DOSE <u>20mg</u>	ROUTE <u>oral</u>	INDICATION <u>Pain</u>
SIGNATURE OF PRESCRIBER <u>[Signature]</u>		MAX. FREQUENCY <u>4</u>
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		

DATE	TIME	DOSE	GIVEN BY
14/10	08:30	20	U
14/10	11:30	20	U
14/10	14:30	20	U
14/10	17:30	20	U
14/10	20:30	20	U
15/10	02:30	20	U

3	DRUG <u>ONDANSETRON</u>	DATE: STOPPED INITIALS: DATE:
DOSE <u>4mg</u>	ROUTE <u>IV</u>	INDICATION <u>Nausea</u>
SIGNATURE OF PRESCRIBER <u>[Signature]</u>		MAX. FREQUENCY <u>8</u>
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		

DATE	TIME	DOSE	GIVEN BY
14/10	08:30	4	U
14/10	11:30	4	U
14/10	14:30	4	U
14/10	17:30	4	U
14/10	20:30	4	U
15/10	02:30	4	U

VV	DRUG <u>TRAMADOL</u>	DATE: STOPPED INITIALS: DATE:
DOSE <u>50-100mg</u>	ROUTE <u>oral</u>	INDICATION <u>Pain</u>
SIGNATURE OF PRESCRIBER <u>[Signature]</u>		MAX. FREQUENCY <u>4-6</u>
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		

DATE	TIME	DOSE	GIVEN BY
14/10	08:30	50	U
14/10	11:30	50	U
14/10	14:30	50	U
14/10	17:30	50	U
14/10	20:30	50	U
15/10	02:30	50	U

WW	DRUG	DATE: STOPPED INITIALS: DATE:
DOSE	ROUTE	INDICATION
SIGNATURE OF PRESCRIBER		MAX. FREQUENCY
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		

DATE	TIME	DOSE	GIVEN BY

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

Adult Intravenous Cannulation Care Plan

50623238H
WATSON
MARY 06/03/1954 F
28 KENDON AVENUE

GLASGOW G15 8AX
CHI-0603546323

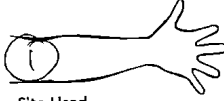
Potential Complications of IV Cannulation

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

Required Interventions

The interventions below are required to minimise the above complications. Those highlighted in bold are necessary to assist in compliance with the Health Protection Scotland (HPS) Peripheral Vascular Catheter (PVC) Care Bundle

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

Cannula Insertion Site		Insertion Reason Codes				Removal Reason Codes			
Please mark successful cannulation with a number e.g. ① and failed cannulation with an ② L  R  Other Site Used _____		Emergency IV Access = E Routine IV Access = R Radiological Procedure = RP Nil by Mouth = NBM		Chemotherapy = C IV Fluids / IV Medicine Administration = IV Blood = B Other (Please state)		Not Required = NR Phlebitis = P Infiltration = I Extravasation = E Other (Please state)			
Cannula Number	Date and Time	Inserted by (print name)	Insertion Reason Code	Gauge	Was aseptic technique breached?	Removed by (print name)	Date and Time	Removal Reason Code	
①	3/4/10	IN ARE	R	P12L	Yes*/No	Dislodged	14/4/10	PL	
					Yes*/No				
					Yes*/No				
					Yes*/No				

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis OBSERVE CANNULA
One of the following is evident: • Slight pain or redness near IV site	1	Possible first signs OBSERVE CANNULA
Two of the following are evident: • Pain • Erythema • Swelling	2	Early stage of phlebitis RESITE CANNULA
All of the following are evident: • Pain along the path of the cannula • Erythema • Induration	3	Mid-stage phlebitis RESITE CANNULA and SEEK FURTHER ADVICE
All of the following are evident and extensive: • Pain along the path of cannula Erythema • Induration • Palpable venous cord	4	Advanced stage of phlebitis or start of thrombophlebitis RESITE CANNULA and SEEK FURTHER ADVICE
All of the following are evident and extensive: • Pain along path of cannula • Erythema • Induration • Pyrexia • Palpable venous cord	5	Advanced thrombophlebitis RESITE CANNULA and SEEK FURTHER ADVICE

(Based on the HPS PVC Care Bundle)

[illegible]

The 'added drugs' should be prescribed in the patient's main prescription sheet, cross referenced by annotating the "other prescription sheets in use" section

24 Hour Fluid Balance Chart

Name: MARY WATSON		Case Record No: 506 23238 H								Ward: L10E		Date: 16/4/10					
TIME HRS (Please delete 1 column)		INPUT (mls)								IN	OUTPUT (mls)						OUT
		ORAL	NASO GASTRIC TPN	BLOOD COLLOID PLASMA	IV (1) /	TYPE	IV (2)	IV (3) Drugs	Hourly Total	Cumulative Total	URINE	URINE Cumulative Total	Gastric Aspirate / Vomit	Drain 1	Hourly Total	Cumulative Total	
08	24																
09	01																
10	02																
11	03																
12	04																
13	05																
14	06																
15	06																
16	07																
17	08																
18	09																
19	10																
20	11																
21	12																
22	13																
23	14																
24	15																
01	16																
02	17																
03	18																
04	19																
05	20																
06	22																
07	23																
TOTALS																	
TOTAL IN MLS											BALANCE			TOTAL OUT MLS			

GUIDELINES FOR RECORDING INTRAVENOUS INFUSIONS ON 24 HOUR FLUID BALANCE CHART

ALL INTRAVENOUS INFUSIONS TO BE RECORDED ON COMPLETION OF INFUSION.

TYPE OF PARENTAL FLUID TO BE RECORDED IN APPROPRIATE COLUMNS:-

BLOOD/COLLOID/PLASMA	• <i>RECORD ANY BLOOD OR BLOOD PRODUCTS, e.g.</i> ◆ UNITS OF PACKED BLOOD CELLS ◆ FROZEN PLASMA ◆ GELOFUSINE
IV (1)	• <i>PLEASE RECORD TYPE OF INTRAVENOUS FLUID AND AMOUNT, e.g.</i> ◆ SODIUM CHLORIDE 0.9% ◆ GLUCOSE 5% ◆ RINGER LACTATE
IV (2)	• <i>FOR USE IF MORE THAN ONE INTRAVENOUS INFUSION IN PROGRESS, e.g. CVP LINE</i>
IV (3)	<i>FOR RECORDING INTRAVENOUS DRUGS SUCH AS ANTIBIOTICS. CROSS REFERENCE BY USING THE CODED LETTER OF THE PATIENT'S MEDICATION PRESCRIPTION SHEET, e.g.</i> A. 100mls • <i>RECORDING INTRAVENOUS PRESCRIPTIONS GIVEN BY SYRINGE DRIVER /INFUSION PUMP, e.g. HEPARIN, INSULIN, DOPAMINE.</i> • <i>ADDITIONAL COLUMN FOR USE IF MORE THAN TWO INFUSIONS IN PROGRESS AT ANY ONE TIME</i>

24 Hour Fluid Balance Chart

0603546323

Name: Mary Watson		Case Record No: 506 232384							Ward: L10E		Date: 15/4/12						
INPUT (mls)									IN		OUTPUT (mls)				OUT		
TIME HRS (Please delete 1 column)	ORAL	NASO GASTRIC TPN	BLOOD COLLOID PLASMA	IV (1) /	TYPE	IV (2)	IV (3) Drugs	Hourly Total	Cumulative Total	URINE	URINE Cumulative Total	Gastric Aspirate /Vomit	Drain 1		Hourly Total	Cumulative Total	
08	24																
09	01																
10	02																
11	03																
12	04																
13	05																
14	06																
15	06																
16	07																
17	08				Commenced												
18	09																
19	10																
20	11	100							100								
21	12																
22	13	100							100								
23	14																
24	15	100						100	400								
01	16																
02	17	SIPS															
03	18				500				900								
04	19																
05	20																
06	22	100						100	1100								
07	23																
TOTALS									TOTAL IN MLS							TOTAL OUT MLS	

TOTAL IN MLS

BALANCE

TOTAL OUT MLS

GUIDELINES FOR RECORDING INTRAVENOUS INFUSIONS ON 24 HOUR FLUID BALANCE CHART

ALL INTRAVENOUS INFUSIONS TO BE RECORDED ON COMPLETION OF INFUSION.

TYPE OF PARENTAL FLUID TO BE RECORDED IN APPROPRIATE COLUMNS:-

BLOOD/COLLOID/PLASMA

IV (1)

IV (2)

IV (3)

- RECORD ANY BLOOD OR BLOOD PRODUCTS, e.g.

♦ UNITS OF PACKED BLOOD CELLS

♦ FROZEN PLASMA

♦ GELOFUSINE

- PLEASE RECORD TYPE OF INTRAVENOUS FLUID AND AMOUNT, e.g.

♦ SODIUM CHLORIDE 0.9%

♦ GLUCOSE 5%

♦ RINGER LACTATE

- FOR USE IF MORE THAN ONE INTRAVENOUS INFUSION IN PROGRESS, e.g. CVP LINE

FOR RECORDING INTRAVENOUS DRUGS SUCH AS ANTIBIOTICS, CROSS REFERENCE BY USING THE CODED LETTER OF THE PATIENT'S MEDICATION PRESCRIPTION SHEET, e.g.

A. 100mls

- RECORDING INTRAVENOUS PRESCRIPTIONS GIVEN BY SYRINGE DRIVER /INFUSION PUMP, e.g. HEPARIN, INSULIN, DOPAMINE.

- ADDITIONAL COLUMN FOR USE IF MORE THAN TWO INFUSIONS IN PROGRESS AT ANY ONE TIME

24 Hour Fluid Balance Chart

Name: <i>Mary Watson.</i>		Case Record No: <i>506232.384</i>							Ward: <i>LOW</i>		Date: <i>14/6/10</i>							
TIME HRS (Please delete 1 column)		INPUT (mls)							IN		OUTPUT (mls)					OUT		
		ORAL	NASO GASTRIC TPN	BLOOD COLLOID PLASMA	IV (1) /	TYPE	IV (2)	IV (3) Drugs	Hourly Total	Cumulative Total	URINE	URINE Cumulative Total	Gastric Aspirate / Vomit	Drain 1		Hourly Total	Cumulative Total	
08	24																	
09	01																	
10	02																	
11	03																	
12	04																	
13	05																	
14	06																	
15	06																	
16	07																	
17	08																	
18	09																	
19	10																	
20	11																	
21	12																	
22	13	<i>Sips.</i>																
23	14																	
24	15																	
01	16																	
02	17																	
03	18																	
04	19																	
05	20																	
06	22																	
07	23																	
TOTALS																		
TOTAL IN MLS											BALANCE			TOTAL OUT MLS				

GUIDELINES FOR RECORDING INTRAVENOUS INFUSIONS ON 24 HOUR FLUID BALANCE CHART

ALL INTRAVENOUS INFUSIONS TO BE RECORDED ON COMPLETION OF INFUSION.

TYPE OF PARENTAL FLUID TO BE RECORDED IN APPROPRIATE COLUMNS:-

BLOOD/COLLOID/PLASMA	• RECORD ANY BLOOD OR BLOOD PRODUCTS, e.g. ♦ UNITS OF PACKED BLOOD CELLS ♦ FROZEN PLASMA ♦ GELOFUSINE • PLEASE RECORD TYPE OF INTRAVENOUS FLUID AND AMOUNT, e.g. ♦ SODIUM CHLORIDE 0.9% ♦ GLUCOSE 5% ♦ RINGER LACTATE • FOR USE IF MORE THAN ONE INTRAVENOUS INFUSION IN PROGRESS, e.g. CVP LINE FOR RECORDING INTRAVENOUS DRUGS SUCH AS ANTIBIOTICS. CROSS REFERENCE BY USING THE CODED LETTER OF THE PATIENT'S MEDICATION PRESCRIPTION SHEET, e.g. A. 100mls • RECORDING INTRAVENOUS PRESCRIPTIONS GIVEN BY SYRINGE DRIVER /INFUSION PUMP, e.g. HEPARIN, INSULIN, DOPAMINE. • ADDITIONAL COLUMN FOR USE IF MORE THAN TWO INFUSIONS IN PROGRESS AT ANY ONE TIME
IV (1)	
IV (2)	
IV (3)	



50623238H

WATSON

MARY

06/03/1954 F

28 KENDON AVENUE

GLASGOW

G15 8AX

CHI-0603546323

North Glasgow Hospitals

24 Hour Fluid Balance Chart

Name:		Case Record No:								Ward: <u>CUA</u>	Date: <u>17/4/10</u>					
		INPUT (mls)							IN	OUTPUT (mls)					OUT	
TIME HRS (Please delete 1 column)	ORAL	NASO GASTRIC TPN	BLOOD COLLOID PLASMA	IV (1) /	TYPE	IV (2)	IV (3) Drugs	Hourly Total	Cumulative Total	URINE	URINE Cumulative Total	Gastric Aspirate / Vomit	Drain I	Hourly Total	Cumulative Total	
08	24															
09	01															
10	02															
11	03															
12	04															
13	05															
14	06															
15	05															
16	07															
17	08															
18	09															
19	10															
20	11	<u>ADAM</u>														
21	12															
22	13															
23	14															
24	15									<u>100</u>					<u>100</u>	
01	16															
02	17															
03	18															
04	19															
05	20															
06	22								<u>500</u>							
07	23															
TOTALS									TOTAL IN MLS		BALANCE			TOTAL OUT MLS		

GUIDELINES FOR RECORDING INTRAVENOUS INFUSIONS ON 24 HOUR FLUID BALANCE CHART

ALL INTRAVENOUS INFUSIONS TO BE RECORDED ON COMPLETION OF INFUSION.

TYPE OF PARENTAL FLUID TO BE RECORDED IN APPROPRIATE COLUMNS:-

BLOOD/COLLOID/PLASMA

IV (1)

IV (2)

IV (3)

- RECORD ANY BLOOD OR BLOOD PRODUCTS, e.g.
 - ♦ UNITS OF PACKED BLOOD CELLS
 - ♦ FROZEN PLASMA
 - ♦ GELOFUSINE
- PLEASE RECORD TYPE OF INTRAVENOUS FLUID AND AMOUNT, e.g.
 - ♦ SODIUM CHLORIDE 0.9%
 - ♦ GLUCOSE 5%
 - ♦ RINGER LACTATE

- FOR USE IF MORE THAN ONE INTRAVENOUS INFUSION IN PROGRESS, e.g. CVP LINE

FOR RECORDING INTRAVENOUS DRUGS SUCH AS ANTIBIOTICS. CROSS REFERENCE BY USING THE CODED LETTER OF THE PATIENT'S MEDICATION PRESCRIPTION SHEET, e.g.

A. 100mls

- RECORDING INTRAVENOUS PRESCRIPTIONS GIVEN BY SYRINGE DRIVER /INFUSION PUMP, e.g. HEPARIN, INSULIN, DOPAMINE.
- ADDITIONAL COLUMN FOR USE IF MORE THAN TWO INFUSIONS IN PROGRESS AT ANY ONE TIME

ADAPTED WATERLOW PRESSURE AREA RISK ASSESSMENT CHART

WRIT
 Surname 5062323BH
 Forename WATSON
 Date of Birth 06/03/1954
 DoB .. MARY
 Address 28 KENDOON AVENUE
 Locality GLASGOW G15 8AX
 CHI-0603546323

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

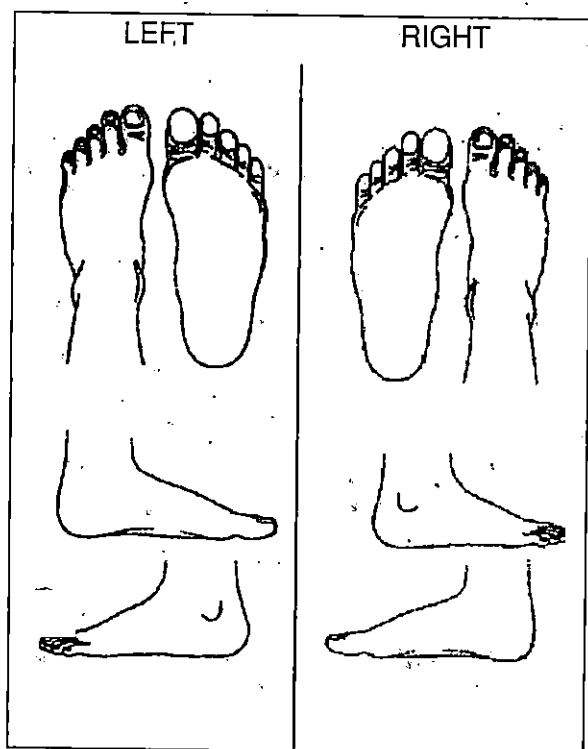
Complete assessment on admission/1st visit, if there is a change in individuals condition and repeat regularly according to local protocol

Sex					
Male	1				
Female	2	0	2		
Age					
14 -49	1	4			
50 -64	2	2	2		
65 - 74	3				
75 - 80	4				
81+	5				
Build/Weight for Height (BMI=weight in Kg/height in m²)					
Average - BMI 20-24.9	0				
Above average - BMI 25-29.9	1	1	1		
Obese - BMI > 30	2				
Below average - BMI < 20	3				
Continence					
Complete/catheterised	0	0	0		
Incontinent urine	1				
Incontinent faeces	2				
Doubly incontinent (urine & faeces)	3				
Skin Type - Visual Risks Area					
Healthy	0	0	0		
Tissue paper (thin/fragile)	1				
Dry (appears flaky)	1				
Oedematous (puffy)	1				
Clammy (moist to touch)/pyrexia	1				
Discoloured (bruising/mottled)	2				
Broken (established ulcer)	3				
Mobility					
Fully mobile	0	0	0		
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	2	2		
BMI > 20 Score 0, BMI 18.5-20 Score 1, BMI < 18.5 Score 2	0-2				
Patient acutely ill or no nutritional intake > 5 days	2				
Special Risks - Tissue Malnutrition					
Multiple organ failure/terminal cachexia	8				
Single organ failure e.g. cardiac, renal, respiratory	5				
Peripheral vascular disease	5				
Anaemia = Hb < 8	2				
Smoking	1	1	1		
Special Risks - Neurological Deficit					
Diabetes/MS/CVA/motor/sensory/paraplegia - Max 6	4-6	0	0		
Special Risks - Surgery/Trauma					
On table > 6 hours	8	0	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	0	0		
Total Score		8	8		
Date		13/4	20/4		
initials		CS	oot		
Time					

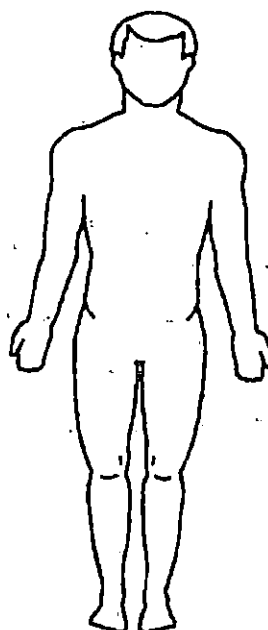
Ensure plan of care is implemented / reviewed for all identified areas of concern.

PRESSURE ULCER RECORD

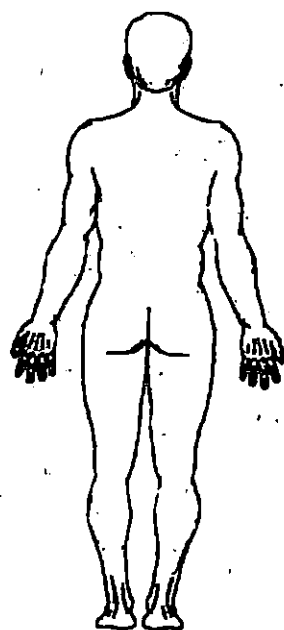
Indicate by circling and numbering all pressure damage on diagrams, then complete box below.
Indicate care plan/wound assessment chart.



Anterior view



Posterior view



SCOTTISH ADAPTED EPUAP PRESSURE ULCER GRADING TOOL

- GRADE 1** Non-blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly on individuals with darker skin.
- GRADE 2** Partial thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents clinically as an abrasion or blister.
- GRADE 3** Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia.
- GRADE 4** Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss.

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

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

Nutrition Profile

Name:	Date of admission: 13/4/10
Address:	Time: 20.00
50623238H WATSON MARY 28 KENDOWN AVENUE GLASGOW G15 8AX CHI number: CHI-0603546323	HOSPITAL: WIG
DoB:	Ward: C10W
Affix patient data label	

To be recorded within 24 hours of admission*	
Height: 4' 11" m ☒ Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐	
Weight: 8' 11" kg/stones ☒ Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐	
Recent unplanned weight loss: Yes ☒ No ☐ Last 12 hours since admission	
If 'Yes' how much?: kg/stones. Over what period of time?: weeks/months	
Is there evidence of recent weight loss? No ☐ Loose clothing ☐ History of reduced food intake/appetite ☒ Swallowing problem ☐	
Eating and drinking likes and dislikes (including appetite and/or NBM status): NBM -	
Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☒ Please state:	
Are there any contributing factors that may affect food intake such as physical (e.g. swallowing difficulties), physiological (e.g. nausea), psychological (e.g. dementia), social or environmental? Yes ☐ No ☒ Please specify all factors: Nausea pain when eating	
Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☒ Please state:	
Profile completed by: Name (PRINT): C. M. A. Signature: [Signature] Date: 13/4/10	

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

Step 1 - BMI Score

Height (feet and inches)

Weight (kg)	40.0	42.0	44.0	46.0	48.0	50.0	52.0	54.0	56.0	58.0	60.0	62.0	64.0	66.0	68.0	70.0	72.0	74.0	76.0	78.0	80.0	82.0	84.0	86.0	88.0	90.0	92.0	94.0	96.0	98.0	100.0
Height (m)	1.40	1.41	1.42	1.43	1.44	1.45	1.46	1.47	1.48	1.49	1.50	1.51	1.52	1.53	1.54	1.55	1.56	1.57	1.58	1.59	1.60	1.61	1.62	1.63	1.64	1.65	1.66	1.67	1.68	1.69	1.70

Step 2 - Weight Loss Score

Weight (stones and pounds)	100 lb	105 lb	110 lb	115 lb	120 lb	125 lb	130 lb	135 lb	140 lb	145 lb	150 lb	155 lb	160 lb	165 lb	170 lb	175 lb	180 lb	185 lb	190 lb	195 lb	200 lb	205 lb	210 lb	215 lb	220 lb	225 lb	230 lb	235 lb	240 lb	245 lb	250 lb
Weight (kg)	14.0	14.5	15.0	15.5	16.0	16.5	17.0	17.5	18.0	18.5	19.0	19.5	20.0	20.5	21.0	21.5	22.0	22.5	23.0	23.5	24.0	24.5	25.0	25.5	26.0	26.5	27.0	27.5	28.0	28.5	29.0

STORES ORDER CODE 41850

VI MEDICAL ILLUSTRATION • NUTRITION & DIET • 12366/01.09.08

[illegible]

Step 1: BMI Score (refer to chart on page 4)									
>20 (>30 = Obese)	0	0							
18.5 - 20	1								
<18.5	2								
Step 2: Weight Loss Score									
Unplanned weight loss in past 3-6 months:									
<5%	0	1							
5-10%	1								
>10%	2								
Step 3: Acute Disease Effect Score									
If patient is acutely ill <u>and</u> there has been or is likely to be no or virtually no food intake for > 5 days.....		6							
Not applicable.....		Score 0							

Step 5: Management Guidelines

Score of Overall Risk of Malnutrition	Action Required
0	LOW RISK - Routine Clinical Care Repeat screening. Hospital AcuteWeekly Hospital Rehabilitation.....Monthly
1	MEDIUM RISK - Observe - Document dietary intake for 3 days on a Food Record Chart. - If no improvement in intake: - Encourage oral intake. - Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. - Repeat screening weekly.
2 or more	HIGH RISK - Treat* - Refer to Dietitian and document food intake for 3 days on a Food Record Chart. - Encourage oral intake. - Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. - Monitor and review Care Plan weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

FOR ALL PATIENTS

- Provide help and advice on food choices and eating and drinking when necessary.
- Treat underlying conditions and initiate appropriate treatment to relieve symptoms that affect nutritional intake . e.g. nausea, vomiting, constipation, diarrhoea and/or pain.
- Refer to dietitian if any specialist advice is required.
- Complete nursing checklist for swallowing difficulties if appropriate.
- Use a recognised system to identify when equipment or assistance is required at mealtimes (e.g. red mats, coloured napkins).

Dietitian	Date: / /	Outcome:
Speech and Language Therapy	Date: / /	Outcome:
Occupational Therapy	Date: / /	Outcome:
Dental Service	Date: / /	Outcome:

[illegible]

N.B. Ensure discharge plan includes most recent 'MUST' score and any necessary follow-up requirements.

Cannard Falls Risk Assessment

Glossary of terms used in risk assessment

SIGHT DEFICIT means patient cannot see well even when wearing glasses or is registered blind.

HEARING DEFICIT means person has hearing problems even with a hearing aid or has hearing problems and does not wear a hearing aid.

BALANCE DEFICIT means person is unable to stand without the support of another person or a walking frame.

MEDICINES FOR SOME MENTAL ILLNESSES include Chlorpromazine (Largactil), Risperidone (Risperdal), Lithium (Camcolit or Priadel), Haloperidol, Chloral hydrate (Welldorm), Clomethiazole (Heminevin), antidepressants.

BLOOD PRESSURE TABLETS include Captopril, atenolol and many others.

WATER TABLETS (DIURETICS) are such as Bendroflumethiazide, Furosemide and Co-amlofruse.

SLEEPING TABLETS include medicines such as Diazepam, Temazepam, Nitrazepam, Chlordiazepoxide and Zopiclone (Zimovane).

INABILITY TO CO-OPERATE includes failure to use walking aids or putting themselves in situations with a high risk of falling (usually due to mental impairment).

RESTRICTED MOBILITY means the person requires supervision and/or help to walk (i.e. is not safe to walk alone even with an aid).

HESITANT IN INITIATING MOVEMENT means difficulty in starting to walk.

POOR TRANSFER means the person requires help and is not safe to do the following alone – get in or out of bed, on or off a chair, move from chair to standing.

Acute Services Divit

Hospital / Department

UCW → UOE W16



Cannard Falls Risk Assessment Pack

PATIENT INFORMATION	
Patient name:	50623238H
WATSON	MARY
Ward:	28 KENDOOM AVENUE
CHI number:	GLASGOW CHI-0603546323
06/03/1954	Q15 8AX
Unit/Hospital number	

Contents

1. Cannard 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.

Assessment Wards: Risk assessment and care plan should be reviewed weekly.

Continuing Care Wards: Mobile and 'at risk' patients should have risk assessment and care plan reviewed monthly.

Cannard Falls Risk Assessment

(Must be completed within 24 hours)

13/4/10

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						DATE	DATE	DATE	DATE	DATE	DATE
						20-4-10					
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			0	0				
Sex	Male 1	Female 2				2	2				
Age	60-70 1	71-80 2	81+ 1			0	0				
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		0	0				
Medication type	Drugs for mental illness 1	Blood pressure / water tablets 1	Sleeping tablets 1	None of these 0		0	0				
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	0	0				
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed bound 1		1	1				
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1	1				
TOTAL SCORE						4	4				
ACTION(S) TAKEN Enter action code(s)						See below	1177				
SCORE 2-8 = LOW, 9-12 = MEDIUM, 13+ = HIGH RISK						NURSE SIGNATURE					
						CL	007				

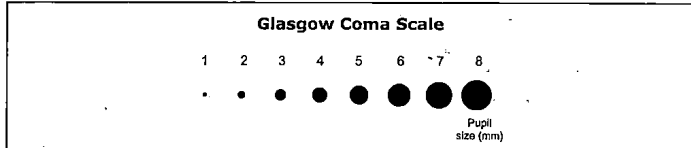
** If you are in any doubt about whether a person's medicine belongs to one of the types listed ask the person or carer or please phone the number on the medicine container and ask the community or hospital pharmacist.
* Please see back page for clarification

Falls Assessment Care Plan

Please tick all applicable nursing interventions

	NURSING INTERVENTIONS	DATE	DATE	DATE	DATE	DATE	DATE
		20-4					
Action code:	LOW, MODERATE AND HIGH RISK						
1	Prevention and general safety precautions discussed with patient and family.	✓	✓				
	MODERATE AND HIGH RISK						
2	Move to more observable area of ward to optimise supervision.						
3	Refer to Physiotherapist.						
4	Refer to Occupational Therapist.						
5	Patient requires footwear or podiatry referral. (Date referred:)						
6	Commence continence assessment						
7	Monitor lying and standing BP and pulse.						
8	Request medication review.						
9	Select suitable seating (refer to policy).						
10	Non-slip mat on chair/floor following advice of OT.						
11	Bed rails/bumpers to be used (refer to policy).						
12	Falls map in use for seven days.						
13	Bed/chair monitor in use.						
14	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.						
15	Patient to be nursed on mattress on the floor (refer to policy.)						
16	Patient requires one to one nursing care.						
17	Other interventions. <i>Burn</i>	✓	✓				
	HIGH RISK ONLY (Score of 13 or over)						
18	Provide hip protectors to patients being discharged to care homes/longterm NHS facilities						
SIGNATURE		CL	007				

Review Cannard score weekly / monthly as per policy.
Enter action code(s) selected in action taken section on Falls Risk Assessment.

[illegible][illegible]

50623238H
WATSON
MARY
28 KENDOOO AVENUE
GLASGOW
CMI-0603546323
06/03/1954
Q15 BAK

Admitted Date 12-1-10 Ward 110E
Transferred Date _____ Ward _____
Transferred Date _____ Ward _____

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

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

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

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

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

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

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.

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

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.

DATE	13/4/18	14/4/18	15/4/18	16/4/18	17/4/18	18/4/18	19/4/18	20/4/18	21/4/18	22/4/18	23/4/18	24/4/18	TEMP X
Time	08:00	09:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	40°C
B P	120/80	120/80	120/80	120/80	120/80	120/80	120/80	120/80	120/80	120/80	120/80	120/80	39°C
a	120	120	120	120	120	120	120	120	120	120	120	120	38°C
n	120	120	120	120	120	120	120	120	120	120	120	120	37°C
d	120	120	120	120	120	120	120	120	120	120	120	120	36°C
P	120	120	120	120	120	120	120	120	120	120	120	120	35°C
u	120	120	120	120	120	120	120	120	120	120	120	120	
s	120	120	120	120	120	120	120	120	120	120	120	120	
e	120	120	120	120	120	120	120	120	120	120	120	120	
Resp. Rate	16	16	16	16	16	16	16	16	16	16	16	16	
Inspiration O ₂ %	98	98	98	98	98	98	98	98	98	98	98	98	
SpO ₂ %	98	98	98	98	98	98	98	98	98	98	98	98	
Pain Score	0	0	0	0	0	0	0	0	0	0	0	0	
Sedation Score	0	0	0	0	0	0	0	0	0	0	0	0	
Nausea Score	0	0	0	0	0	0	0	0	0	0	0	0	
Blood Glucose	7.2	7.2	7.2	7.2	7.2	7.2	7.2	7.2	7.2	7.2	7.2	7.2	

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	15			
Urine	<10mls/hr for 2 hrs	<30mls/hr for 2 hrs	New agitation or confusion	Alert	Voice	Pain	Unresponsive
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			

DATE	13/4/18	14/4/18	15/4/18	16/4/18	17/4/18	18/4/18	19/4/18	20/4/18	21/4/18	22/4/18	23/4/18	24/4/18	TEMP X
Time	08:00	09:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	40°C
B P	120/80	120/80	120/80	120/80	120/80	120/80	120/80	120/80	120/80	120/80	120/80	120/80	39°C
a	120	120	120	120	120	120	120	120	120	120	120	120	38°C
n	120	120	120	120	120	120	120	120	120	120	120	120	37°C
d	120	120	120	120	120	120	120	120	120	120	120	120	36°C
P	120	120	120	120	120	120	120	120	120	120	120	120	35°C
u	120	120	120	120	120	120	120	120	120	120	120	120	
s	120	120	120	120	120	120	120	120	120	120	120	120	
e	120	120	120	120	120	120	120	120	120	120	120	120	
Resp. Rate	16	16	16	16	16	16	16	16	16	16	16	16	
Inspiration O ₂ %	98	98	98	98	98	98	98	98	98	98	98	98	
SpO ₂ %	98	98	98	98	98	98	98	98	98	98	98	98	
Pain Score	0	0	0	0	0	0	0	0	0	0	0	0	
Sedation Score	0	0	0	0	0	0	0	0	0	0	0	0	
Nausea Score	0	0	0	0	0	0	0	0	0	0	0	0	
Blood Glucose	7.2	7.2	7.2	7.2	7.2	7.2	7.2	7.2	7.2	7.2	7.2	7.2	

MEWS

Resp. Rate	0	0	0	0	0	0	0	0	0	0	0	0	
Pulse	0	0	0	0	0	0	0	0	0	0	0	0	
Systolic BP	0	0	0	0	0	0	0	0	0	0	0	0	
GCS / AVPU	0	0	0	0	0	0	0	0	0	0	0	0	
Urine Output	0	0	0	0	0	0	0	0	0	0	0	0	
Temp.	0	0	0	0	0	0	0	0	0	0	0	0	
SpO ₂ %	0	0	0	0	0	0	0	0	0	0	0	0	
TOTAL	0	0	0	0	0	0	0	0	0	0	0	0	

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

Discharge Checklist

Patient's name: 

Unit number: 50623238H
WATSON
MARY 06/03/1954
CHI number: 28 KENDON AVENUE
GLASGOW G15 8AX
CHI-0603546323

Ward: L10

Discharge destination:

Estimated Discharge Date (1) / /

Estimated Discharge Date (2) / /

Final date of discharge : / /

Checklist	Yes	N/A	Initials	Comments
Patient informed				
Relative/carer informed				
Others informed: Care Home				
Transport arranged				
Own transport (preferred option)				
Ambulance-1 man/ 2 man am/pm				
Other: Flight, Air ambulance etc.				
Discharge medication				
Discharge prescription completed				
Compliance aids e.g. Dossette Box (involve pharmacist)				
Medication received				
Medication explained to patient and/or relative/carer				
Own medication returned to patient				
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)				
Informed of discharge				
Social work/ Other agencies/Home help				
Physiotherapist				
Occupational Therapist				
Dietician				
Speech and Language Therapist				
Clinical Nurse specialist e.g. Care Home Liaison				
Liaison/ District Nurse/Practice Nurse				
Other discharge items				
Access arrangements (e.g. keys, door entry)				
Patients clothing available for day of discharge				
Valuables e.g. cash				
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: / /

Discharge Checklist

Patient's name: 
 Unit number: 50623238H
 WATSON F
 MARY 06/03/1954
 CHI number: 28 KENDOON AVENUE
 GLASGOW G15 8AX
 CHI-0603546323

Ward:

Discharge destination:

Estimated Discharge Date (1) / /

Estimated Discharge Date (2) / /

Final date of discharge: / /

Checklist	Yes	N/A	Initials	Comments
Patient informed				
Relative/carer informed				
Others informed: Care Home				
Transport arranged				
Own transport (preferred option)				
Ambulance-1 man/ 2 man am/pm				
Other: Flight, Air ambulance etc.				
Discharge medication				
Discharge prescription completed				
Compliance aids e.g. Dossette Box (involve pharmacist)				
Medication received				
Medication explained to patient and/or relative/carer				
Own medication returned to patient				
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)				
Informed of discharge				
Social work/ Other agencies/Home help				
Physiotherapist				
Occupational Therapist				
Dietician				
Speech and Language Therapist				
Clinical Nurse specialist e.g. Care Home Liaison				
Liaison/ District Nurse/Practice Nurse				
Other discharge items				
Access arrangements (e.g. keys, door entry)				
Patients clothing available for day of discharge				
Valuables e.g. cash				
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: / /

Patient Profile

North Glasgow Hospitals



Ward: U10W Date: 7/4/10 Time: 18³⁰ (24hr clock)

Please print clearly in BLOCK CAPITALS

Title: _____
 Name: _____
 Preferred name: 50623238H
 Address: WATSON F
MARY 06/03/1954
28 KENDON AVENUE
GLASGOW G15 8AX
CHI-0603546323
 Pos: _____
07544340921
 DOB: _____ Age: 56
 Hosp. No: _____
 Occupation: UNEMPLOYED
 Religion: COP
 S.O.S. ☐ date: ☐☐☐☐☐☐
 Interpreter required: ☐
 (specify: _____)
 Lives alone: 1/2 DAUGHTER ☐

Consultant: MR WILSON
 Named Nurse @: S. GIBB
 Admitting Nurse: C. WALKER
 Named Nurse @: _____
 Relatives seen by Doctor ☐

REASON FOR ADMISSION

BUG PAIN + VOMITTING
 Patient's perception of illness: _____
 Diagnosis: _____
 Operation/Treatment: _____
 Relevant PMH: DEPRESSIONS,
HYSTERECTOMY, KNOWN
GALLSTONES

1 NOK/Friend/Contact: ARLENE WATSON
 Address: 1/2 17 ABBOTSMALL AVE
GLASGOW
Day: 0141 944 053
Night: _____
 Relationship: DAUGHTER
 2 NOK/Friend/Contact: DANIELLE WATSON
 Address: A/A
Day: 07966042070
Night: _____
 Relationship: DAUGHTER
 NOK informed of admission: ☒
 NOK informed: _____
 GP: Dr. S LYON
 Address: DRUMCHAPEL HEALTH CENTRE
80/90 KINFAUN'S DRIVE
GLASGOW 211
G15 7TS 6100

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

PERSONAL BELONGINGS
 Clothing listed PT STATES ☐
 Valuables listed NO VALUABLES ☐
 Valuables in ward 0/A ☐
 Valuables in hospital safe ☐

OBSERVATIONS ON ADMISSION

Temperature 35.8 °C
 Pulse 78 bpm
 BP 139 / 72
 Resp 16/A/97%
 Pain Score 0
 Urinalysis _____
 Waterlow Score _____
 Height 4ft 11inc. m
 Weight 95 kg
 Body Mass Index 19
 Blood sugar(if appropriate) _____ mmols
 Allergies Yes ☒ No ☐
 details: SEPTIN

FRS=4
 MUST=2

DISCHARGE PLANNING

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

ACTIVITIES OF DAILY LIVING

50623238H

WATSON

MARY

28 KENDON AVENUE

06/03/1954

G15 8AX

GLASGOW

CHI-0603546323

PLACES/PORTLives 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: _____

NUTRITIONNormal 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): _____

BREATHING1. No symptoms ☒2. Breathless with moderate exercise ☐3. Breathless with minimal exertion ☐4. Breathless at rest ☐5. Uses inhalers ☐

Comments: _____

SMOKINGNon-smoker ☐Smoker: 10-15 per day ☐Ex-smoker ☐Aware of hospital policy ☐**HYGIENE**Bath ☐Shower ☐Requires assistance ☐Stand up wash ☐Skin assessment: PA'S INTACT

Other: _____

ELIMINATIONBowels 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: _____

SLEEPHours/night ☒Medication ☐

details: _____

MENTAL STATEAlert/Orientated ☒Confused: day/night ☐Anxious/Distressed ☐Unconscious ☐

Other (specify): _____

SENSES

Glasses: distance ☐
reading ☒

Hearing impaired: ☐ left/right ☐

Hearing aid: ☐ left/right ☐

Dentures: upper ☒ (N5) (TU)

lower ☐

Communication Difficulties

Other: _____

MOBILITY (Pre admission)

Mobile without aid	
--------------------	--

Mobile with aid

(Specify type/side held: _____)

Furniture walking	
-------------------	--

Chair Bound ☐

Housebound

RELATIVE PARTICIPATION

ALCOHOL INTAKE

Units/week: nil ☒less than 14 ☐

14 - 21

over 21 ☐

(1 unit = 1 measure spirits/half pint beer/
lager/1 glass wine)

PROFILE COMPLETED BY: [REDACTED]

(Please print name in block capitals)

GILIAN WALKER

Signature: AWC

Designation: STAFF NURSE

Countersigned (if applicable):

OTHER RELEVANT INFORMATION

50623238H

WATSON

MARY

28 KENDOON AVENUE

GLASGOW

G15 8AX

CHI-0603546323

Ward: LOW

Date: 7/4/10

Case Record No.:

CARE PLAN

G15 SAX		nature	1.BASIC CARE AND PERSONAL HYGIENE	Date Disc.	Signature
7/6/10	GWR		Independent Bed bath Assisted wash Oral hygiene Pressure care		
7/6/10	GWR		2.NUTRITION Fasting Normal Diet Special Diet / Modified Diet		
7/6/10	GWR		3.ELIMINATION Independent Commode Bedpan/urinal Urinary Catheter Size: Type of Material: Type of Stoma Appliance:		
7/6/10	GWR		4.MOBILITY Fully Independent/fully mobile Minimal assistance' (give details) Dependent (See movement and handling sheet - keep with patient)		
7/6/10	GWR		5.OBSERVATIONS 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		
7/6/10	<i>AW</i>	WSU I		
		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:

Signature of nurse:

AW

Yes ☐ N/A ☐

Date: 07/06/10



50623238H
WATSON
MARY
06/03/1954
28 KENDON AVENUE

Ward: L10W

Date: 7/4/10

Care Record No.:

GLASGOW
CHI-0603546323 G15 8AX

CARE PLAN EVALUATION

2. Nutrition	5. Observations	9. Sleep
3. Elimination	6. Technical Care	10. Special Needs
4. Mobility	7. Wound Care	11. Other Relevant Information
	8. Specimens/Investigations	

DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
7/4/10	1830		Pt admitted to L10W via GP With RUQ pain + vomiting Known gallstones	
		2	Nil by mouth	
		3	WSU requested	
		5	Observations stable	
		11	Awaiting review.	AWAN
		8	? for IV fluids pt requires verdon	AW
	2000	5	Obs stable; B.P 153/92 Medics spoke to patient and made aware that th may be a possibility for cholecystectomy	
		11	For JIF to Centre	AO
8/4/10	0620	9	slept for short spells	
		2	TO remain fasted	
		6	iv fluids continue	
		5	Obs stable	
			no complaints offered	Waller
			? for USS today	(JR)
8/4/10	1350	1.	Pt independent with personal hygiene.	
		2.	Pt unable to eat. Advised about types of food to avoid.	
		3.	Independent with toileting needs.	
		4.	Fully mobile.	
		5.	Observations recorded Apyrexial, BP stable, SpO2 99% on air.	
		6.	Gaviscon + dicyclanide given as prescribed.	
		11.	Pt seen on ward and deemed medically fit for discharge. Scheduled to be operated on in May.	

EVALUATION OF CARE				
DATE	TIME	No.	EVALUATION AND PROGRESS OF CARE	SIGNATURE
			Pt unhappy with this decision.	
8/4/10	18:50		Observations stable.	L. JACKSON
			Discharge letter prepared	
			Pt unwilling to leave ward as feels she is unfit for discharge.	
			Will discuss this with medical staff at ward round tomorrow.	L. JACKSON
	19:15		Pt deemed fit for discharge by medical staff.	
			Has now been discharged	L. JACKSON
			For outpatient cholecystectomy.	

Notes for Users

FOR PRESCRIBERS:

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

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

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

4. When drugs are discontinued, draw a diagonal line through the prescription

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

6. The following metric unit abbreviations must be used –

Milligram = mg Gram = g

Millilitre = ml Millimoles = mmol

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

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

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

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

Please note - Intrathecal must be written in full.

FOR NURSES

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

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

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

4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

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

Hospital Name:

[illegible]

PATIENT'S NAME: <u>MALY WATSON</u>		506232384 0603546323		ADMINISTRATION	
Parenteral Drugs: Regular Prescription		DATE	7		
		MONTH	4		
A	DRUG <u>CLEXPANE</u>	Other time			
DOSE <u>2mg</u>	ROUTE <u>SC</u>	DATE <u>7/11/0</u>	DATE:		
SIGNATURE OF PRESCRIBER 		STOPPED	INITIALS:		
			INITIALS:		
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		2200-2400	☒		
		Other time			
FOR PRESCRIBERS USE ONLY					
B	DRUG	Other time			
DOSE	ROUTE	DATE	DATE:		
SIGNATURE OF PRESCRIBER		STOPPED	INITIALS:		
			INITIALS:		
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		2200-2400			
		Other time			
FOR PRESCRIBERS USE ONLY					
C	DRUG	Other time			
DOSE	ROUTE	DATE	DATE:		
SIGNATURE OF PRESCRIBER		STOPPED	INITIALS:		
			INITIALS:		
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		2200-2400			
		Other time			
FOR PRESCRIBERS USE ONLY					
D	DRUG	Other time			
DOSE	ROUTE	DATE	DATE:		
SIGNATURE OF PRESCRIBER		STOPPED	INITIALS:		
			INITIALS:		
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		2200-2400			
		Other time			
FOR PRESCRIBERS USE ONLY					

Parenteral Drugs: Regular Prescription		DATE			
		MONTH			
E	DRUG	Other time			
DOSE	ROUTE	DATE	DATE:		
SIGNATURE OF PRESCRIBER		STOPPED	INITIALS:		
			INITIALS:		
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		2200-2400			
		Other time			
FOR PRESCRIBERS USE ONLY					
F	DRUG	Other time			
DOSE	ROUTE	DATE	DATE:		
SIGNATURE OF PRESCRIBER		STOPPED	INITIALS:		
			INITIALS:		
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		2200-2400			
		Other time			
FOR PRESCRIBERS USE ONLY					
G	DRUG	Other time			
DOSE	ROUTE	DATE	DATE:		
SIGNATURE OF PRESCRIBER		STOPPED	INITIALS:		
			INITIALS:		
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		2200-2400			
		Other time			
FOR PRESCRIBERS USE ONLY					
H	DRUG	Other time			
DOSE	ROUTE	DATE	DATE:		
SIGNATURE OF PRESCRIBER		STOPPED	INITIALS:		
			INITIALS:		
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		2200-2400			
		Other time			
FOR PRESCRIBERS USE ONLY					

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

PATIENT'S NAME: <u>MARY WATSON</u>		50623238H 0603546323		ADMINISTRATION	
Oral and Other Drugs: Regular Prescriptions		DATE →			
		MONTH →			
J DRUG <u>ATORVASTATIN</u> DOSE <u>40mg</u> ROUTE <u>PO</u> DATE <u>7/4/10</u> SIGNATURE OF PRESCRIBER <u>[Signature]</u> ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		Other time			
		DATE: 0700-0900			
STOPPED		DATE: 1200-1400			
		DATE: 1600-1800			
STOPPED		DATE: 2200-2400			
		Other time			
FOR PRESCRIBERS USE ONLY					
K DRUG <u>TRANSCON</u> DOSE <u>15ml</u> ROUTE <u>PO</u> DATE <u>7/4/10</u> SIGNATURE OF PRESCRIBER <u>[Signature]</u> ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		Other time			
		DATE: 0700-0900			
STOPPED		DATE: 1200-1400			
		DATE: 1600-1800			
STOPPED		DATE: 2200-2400			
		Other time			
FOR PRESCRIBERS USE ONLY					
L DRUG <u>LENOTHYROXINE</u> DOSE <u>100mcg</u> ROUTE <u>PO</u> DATE <u>7/4/10</u> SIGNATURE OF PRESCRIBER <u>[Signature]</u> ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		Other time			
		DATE: 0700-0900			
STOPPED		DATE: 1200-1400			
		DATE: 1600-1800			
STOPPED		DATE: 2200-2400			
		Other time			
FOR PRESCRIBERS USE ONLY					
M DRUG <u>DIMYPRODOINE</u> DOSE <u>100mg</u> ROUTE <u>PO</u> DATE <u>7/4/10</u> SIGNATURE OF PRESCRIBER <u>[Signature]</u> ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		Other time			
		DATE: 0700-0900			
STOPPED		DATE: 1200-1400			
		DATE: 1600-1800			
STOPPED		DATE: 2200-2400			
		Other time			
FOR PRESCRIBERS USE ONLY					

Oral and Other Drugs: Regular Prescriptions		DATE →			
		MONTH →			
N DRUG DOSE ROUTE DATE SIGNATURE OF PRESCRIBER ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		Other time			
		DATE: 0700-0900			
STOPPED		DATE: 1200-1400			
		DATE: 1600-1800			
STOPPED		DATE: 2200-2400			
		Other time			
FOR PRESCRIBERS USE ONLY					
P DRUG DOSE ROUTE DATE SIGNATURE OF PRESCRIBER ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		Other time			
		DATE: 0700-0900			
STOPPED		DATE: 1200-1400			
		DATE: 1600-1800			
STOPPED		DATE: 2200-2400			
		Other time			
FOR PRESCRIBERS USE ONLY					
R DRUG DOSE ROUTE DATE SIGNATURE OF PRESCRIBER ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		Other time			
		DATE: 0700-0900			
STOPPED		DATE: 1200-1400			
		DATE: 1600-1800			
STOPPED		DATE: 2200-2400			
		Other time			
FOR PRESCRIBERS USE ONLY					
S DRUG DOSE ROUTE DATE SIGNATURE OF PRESCRIBER ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		Other time			
		DATE: 0700-0900			
STOPPED		DATE: 1200-1400			
		DATE: 1600-1800			
STOPPED		DATE: 2200-2400			
		Other time			
FOR PRESCRIBERS USE ONLY					

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

PATIENT'S NAME:

ADMINISTRATION

**Oral and Other Drugs:
Regular Prescriptions**

DATE

MONTH

T	DRUG			DATE:
DOSE	ROUTE	DATE	DATE:	INITIALS:
SIGNATURE OF PRESCRIBER				INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				INITIALS:

Other time

0700-0900

1200-1400

1600-1800

2200-2400

Other time

FOR PRESCRIBERS USE ONLY

V	DRUG			DATE:
DOSE	ROUTE	DATE	DATE:	INITIALS:
SIGNATURE OF PRESCRIBER				INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				INITIALS:

Other time

0700-0900

1200-1400

1600-1800

2200-2400

Other time

FOR PRESCRIBERS USE ONLY

W	DRUG			DATE:
DOSE	ROUTE	DATE	DATE:	INITIALS:
SIGNATURE OF PRESCRIBER				INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				INITIALS:

Other time

0700-0900

1200-1400

1600-1800

2200-2400

Other time

FOR PRESCRIBERS USE ONLY

X	DRUG			DATE:
DOSE	ROUTE	DATE	DATE:	INITIALS:
SIGNATURE OF PRESCRIBER				INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				INITIALS:

Other time

0700-0900

1200-1400

1600-1800

2200-2400

Other time

FOR PRESCRIBERS USE ONLY

**Oral and Other Drugs:
Regular Prescriptions**

DATE

MONTH

Y	DRUG			DATE:
DOSE	ROUTE	DATE	DATE:	INITIALS:
SIGNATURE OF PRESCRIBER				INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				INITIALS:

Other time

0700-0900

1200-1400

1600-1800

2200-2400

Other time

FOR PRESCRIBERS USE ONLY

AA	DRUG			DATE:
DOSE	ROUTE	DATE	DATE:	INITIALS:
SIGNATURE OF PRESCRIBER				INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				INITIALS:

Other time

0700-0900

1200-1400

1600-1800

2200-2400

Other time

FOR PRESCRIBERS USE ONLY

BB	DRUG			DATE:
DOSE	ROUTE	DATE	DATE:	INITIALS:
SIGNATURE OF PRESCRIBER				INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				INITIALS:

Other time

0700-0900

1200-1400

1600-1800

2200-2400

Other time

FOR PRESCRIBERS USE ONLY

CC	DRUG			DATE:
DOSE	ROUTE	DATE	DATE:	INITIALS:
SIGNATURE OF PRESCRIBER				INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				INITIALS:

Other time

0700-0900

1200-1400

1600-1800

2200-2400

Other time

FOR PRESCRIBERS USE ONLY

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

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE

MONTH

DD	DRUG			Other time
DOSE	ROUTE	DATE	DATE:	0700-0900
SIGNATURE OF PRESCRIBER			INITIALS:	1200-1400
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			STOPPED	1600-1800
			2200-2400	
			Other time	

FOR PRESCRIBERS USE ONLY

EE	DRUG			Other time
DOSE	ROUTE	DATE	DATE:	0700-0900
SIGNATURE OF PRESCRIBER			INITIALS:	1200-1400
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			STOPPED	1600-1800
			2200-2400	
			Other time	

FOR PRESCRIBERS USE ONLY

FF	DRUG			Other time
DOSE	ROUTE	DATE	DATE:	0700-0900
SIGNATURE OF PRESCRIBER			INITIALS:	1200-1400
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			STOPPED	1600-1800
			2200-2400	
			Other time	

FOR PRESCRIBERS USE ONLY

GG	DRUG			Other time
DOSE	ROUTE	DATE	DATE:	0700-0900
SIGNATURE OF PRESCRIBER			INITIALS:	1200-1400
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			STOPPED	1600-1800
			2200-2400	
			Other time	

FOR PRESCRIBERS USE ONLY

Oral and Other Drugs: Regular Prescriptions

DATE

MONTH

HH	DRUG			Other time
DOSE	ROUTE	DATE	DATE:	0700-0900
SIGNATURE OF PRESCRIBER			INITIALS:	1200-1400
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			STOPPED	1600-1800
			2200-2400	
			Other time	

FOR PRESCRIBERS USE ONLY

JJ	DRUG			Other time
DOSE	ROUTE	DATE	DATE:	0700-0900
SIGNATURE OF PRESCRIBER			INITIALS:	1200-1400
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			STOPPED	1600-1800
			2200-2400	
			Other time	

FOR PRESCRIBERS USE ONLY

KK	DRUG			Other time
DOSE	ROUTE	DATE	DATE:	0700-0900
SIGNATURE OF PRESCRIBER			INITIALS:	1200-1400
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			STOPPED	1600-1800
			2200-2400	
			Other time	

FOR PRESCRIBERS USE ONLY

LL	DRUG			Other time
DOSE	ROUTE	DATE	DATE:	0700-0900
SIGNATURE OF PRESCRIBER			INITIALS:	1200-1400
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			STOPPED	1600-1800
			2200-2400	
			Other time	

FOR PRESCRIBERS USE ONLY

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

Adult Intravenous (IV) Cannulation Care Plan

50623238H
WATSON F
MARY 06/03/1954
28 KENDON AVENUE
GLASGOW G15 8AX
CHI-0603546323

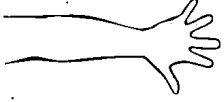
Potential Complications of IV Cannulation

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

Required Interventions

The interventions below are required to minimise the above complications. Those highlighted in bold are necessary to assist in compliance with the Health Protection Scotland (HPS) Peripheral Vascular Catheter (PVC) Care Bundle.

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

Cannula Insertion Site	Insertion Reason Codes						Removal Reason Codes		
Please mark successful cannulation with a number e.g. ① and failed cannulation with an ② L  R  Other Site Used _____	Emergency IV Access = E Routine IV Access = R Radiological Procedure = RP Nil by Mouth = NBM			Chemotherapy = C IV Fluids / IV Medicine Administration = IV Blood = B Other (Please state)			Not Required = NR Phlebitis = P Infiltration = I Extravasation = E Other (Please state)		
	Cannula Number	Date and Time	Inserted by (print name)	Insertion Reason Code	Gauge	Was aseptic technique breached?	Removed by (print name)	Date and Time	Removal Reason Code
	1	7.4.10	NIGHT CO-ORDINATOR	IV	20G	Yes/No			
						Yes*/No			
						Yes*/No			
					Yes*/No				

Modified V.I.P (Visual Infusion Phlebitis) Score

IV site appears healthy	0	No phlebitis OBSERVE CANNULA
One of the following is evident: • Slight pain or redness near IV site	1	Possible first signs OBSERVE CANNULA
Two of the following are evident: • Pain • Erythema • Swelling	2	Early stage of phlebitis RESITE CANNULA
All of the following are evident: • Pain along the path of the cannula • Erythema • Induration	3	Mid-stage phlebitis RESITE CANNULA and SEEK FURTHER ADVICE
All of the following are evident and extensive: • Pain along the path of cannula • Erythema • Induration • Palpable venous cord	4	Advanced stage of phlebitis or start of thrombophlebitis RESITE CANNULA and SEEK FURTHER ADVICE
All of the following are evident and extensive: • Pain along path of cannula • Erythema • Induration • Pyrexia • Palpable venous cord	5	Advanced thrombophlebitis RESITE CANNULA and SEEK FURTHER ADVICE

IV Cannula Monitoring & Recording Chart

(Based on the HPS PVC Care Bundle)

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

N.B. If using a Syringe Driver/Infusion Pump Please Use The 'Prescription And Administration Sheet For Medicines Given By Syringe Driver/Infusion Pump'

Name	Case Record No.
MARY	Age
WATSON.	Sex
	Dept.
Consultant	

PARENTERAL FLUID PRESCRIPTION SHEET

The 'added drugs' should be prescribed in the patient's main prescription sheet, cross referenced by annotating the "other prescription sheets in use" section

[illegible]

24 Hour Fluid Balance Chart

Name: MARTI WATSON		Case Record No: 506232384								Ward: L10W		Date: 7/4/10				
INPUT (mls)									IN	OUTPUT (mls)					OUT	
TIME HRS (Please delete 1 column)	ORAL	NASO GASTRIC TPN	BLOOD COLLOID PLASMA	IV (1) /	TYPE	IV (2)	IV (3) Drugs	Hourly Total	Cumulative Total	URINE	URINE Cumulative Total	Gastric Aspirate / Vomit	Drain 1	Hourly Total	Cumulative Total	
08	24															
09	01															
10	02															
11	03															
12	04															
13	05															
14	06															
15	06															
16	07															
17	08															
18	09															
19	10	ADMITTED TO L10W														
20	11	NBM														
21	12															
22	13															
23	14	venflon inserted 23 ⁰⁰		125					125							
24	15			125					250							
01	16	SIPS		125					375							
02	17			125	NACL				500							
03	18															
04	19															
05	20															
06	22															
07	23															
TOTALS									TOTAL IN MLS		BALANCE			TOTAL OUT MLS		

GUIDELINES FOR RECORDING INTRAVENOUS INFUSIONS ON 24 HOUR FLUID BALANCE CHART

ALL INTRAVENOUS INFUSIONS TO BE RECORDED ON COMPLETION OF INFUSION.

TYPE OF PARENTAL FLUID TO BE RECORDED IN APPROPRIATE COLUMNS:-

BLOOD/COLLOID/PLASMA

IV (1)

IV (2)

IV (3)

- RECORD ANY BLOOD OR BLOOD PRODUCTS, e.g.
 - ♦ UNITS OF PACKED BLOOD CELLS
 - ♦ FROZEN PLASMA
 - ♦ GELOFUSINE
- PLEASE RECORD TYPE OF INTRAVENOUS FLUID AND AMOUNT, e.g.
 - ♦ SODIUM CHLORIDE 0.9%
 - ♦ GLUCOSE 5%
 - ♦ RINGER LACTATE

- FOR USE IF MORE THAN ONE INTRAVENOUS INFUSION IN PROGRESS, e.g. CVP LINE

FOR RECORDING INTRAVENOUS DRUGS SUCH AS ANTIBIOTICS. CROSS REFERENCE BY USING THE CODED LETTER OF THE PATIENT'S MEDICATION PRESCRIPTION SHEET, e.g.

A. 100mls

- RECORDING INTRAVENOUS PRESCRIPTIONS GIVEN BY SYRINGE DRIVER /INFUSION PUMP, e.g. HEPARIN, INSULIN, DOPAMINE.
- ADDITIONAL COLUMN FOR USE IF MORE THAN TWO INFUSIONS IN PROGRESS AT ANY ONE TIME

North Glasgow Hospitals

24 Hour Fluid Balance Chart

Name: <u>Mam Watson</u>		Case Record No: <u>506232-3841</u>								Ward: <u>ICW</u>		Date: <u>7/4/10</u>				
INPUT (mls)									IN	OUTPUT (mls)					OUT	
TIME HRS (Please delete 1 column)	ORAL	NASO GASTRIC TPN	BLOOD COLLOID PLASMA	IV (1) /	TYPE	IV (2)	IV (3) Drugs	Hourly Total	Cumulative Total	URINE	URINE Cumulative Total	Gastric Aspirate / Vomit	Drain 1		Hourly Total	Cumulative Total
08	24															
09	01															
10	02															
11	03															
12	04															
13	05															
14	06															
15	06															
16	07															
17	08															
18	09															
19	10															
20	11															
21	12															
22	13															
23	14															
24	15															
01	16															
02	17															
03	18															
04	19															
05	20															
06	22															
07	23															
TOTALS										BALANCE				TOTAL OUT MLS		

TOTAL IN MLS

BALANCE

TOTAL OUT MLS

GUIDELINES FOR RECORDING INTRAVENOUS INFUSIONS ON 24 HOUR FLUID BALANCE CHART

ALL INTRAVENOUS INFUSIONS TO BE RECORDED ON COMPLETION OF INFUSION.

TYPE OF PARENTAL FLUID TO BE RECORDED IN APPROPRIATE COLUMNS:-

BLOOD/COLLOID/PLASMA	- RECORD ANY BLOOD OR BLOOD PRODUCTS, e.g. ♦ UNITS OF PACKED BLOOD CELLS ♦ FROZEN PLASMA ♦ GELOFUSINE - PLEASE RECORD TYPE OF INTRAVENOUS FLUID AND AMOUNT, e.g. ♦ SODIUM CHLORIDE 0.9% ♦ GLUCOSE 5% ♦ RINGER LACTATE - FOR USE IF MORE THAN ONE INTRAVENOUS INFUSION IN PROGRESS, e.g. CVP LINE FOR RECORDING INTRAVENOUS DRUGS SUCH AS ANTIBIOTICS. CROSS REFERENCE BY USING THE CODED LETTER OF THE PATIENT'S MEDICATION PRESCRIPTION SHEET, e.g. A. 100mls - RECORDING INTRAVENOUS PRESCRIPTIONS GIVEN BY SYRINGE DRIVER /INFUSION PUMP, e.g. HEPARIN, INSULIN, DOPAMINE. - ADDITIONAL COLUMN FOR USE IF MORE THAN TWO INFUSIONS IN PROGRESS AT ANY ONE TIME
IV (1)	
IV (2)	
IV (3)	

ADAPTED WATERLOW PRESSURE AREA RISK ASSESSMENT CHART

WF 
 Su# 50623238H
 WATSON F
 For# MARY 06/03/1954
 28 KENDOOB AVENUE
 Dol# GLASGOW G15 8AX
 Loc# CHI-0603546323

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

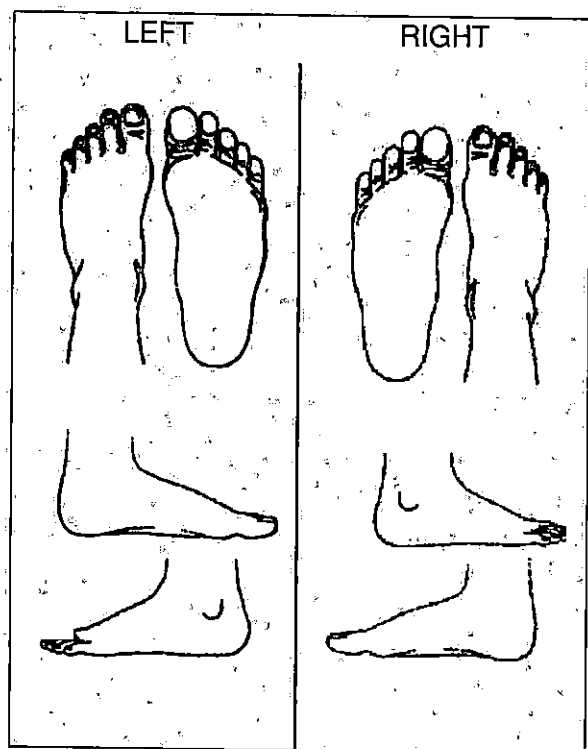
Complete assessment on admission/1st visit, if there is a change in individuals condition and repeat regularly according to local protocol

Sex					
Male	1				
Female	2	2			
Age					
14 -49	1				
50 -64	2	2			
65 - 74	3				
75 - 80	4				
81+	5				
BUILD/Weight for Height (BMI=weight in Kg/height in m²)					
Average - BMI 20-24.9	0	0			
Above average - BMI 25-29.9	1				
Obese - BMI > 30	2				
Below average - BMI < 20	3				
Continence					
Complete/catheterised	0	0			
Incontinent urine	1				
Incontinent faeces	2				
Doubly incontinent (urine & faeces)	3				
Skin Type - Visual Risks Area					
Healthy	0	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				
Restless/fidgety	1	0			
Apathetic (sedated/depressed/reluctant to move)	2				
Restricted (restricted by severe 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				
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	0			
Special Risks - Surgery/Trauma					
On table > 6 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	0			
Total Score		5			
Date		7/4			
Initials					
Time		12			

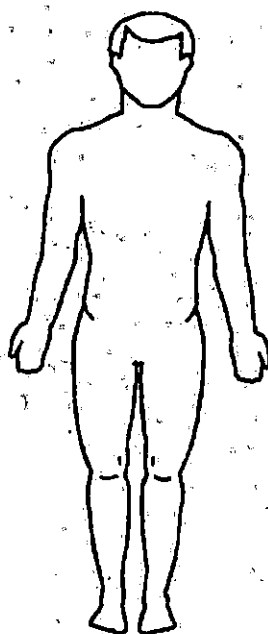
Ensure plan of care is implemented / reviewed for all identified areas of concern.

PRESSURE ULCER RECORD

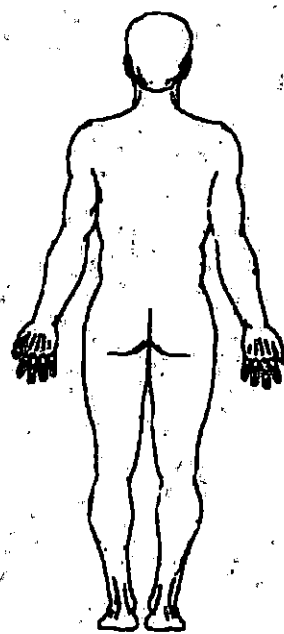
Indicate by circling and numbering all pressure damage on diagrams, then complete box below.
Indicate care plan/wound assessment chart.



Anterior view



Posterior view



SCOTTISH ADAPTED EPUAP PRESSURE ULCER GRADING TOOL

- GRADE 1** Non-blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly on individuals with darker skin.
- GRADE 2** Partial thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents clinically as an abrasion or blister.
- GRADE 3** Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia.
- GRADE 4** Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss.

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

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

Nutrition Profile

Name:	Date of admission: 7/4/10
Address:	Time: 19 ⁰⁰
5062323EN WATSON MAY 28 KEDDOON AVENUE GLASGOW G15 6AX CHI num:	HOSPITAL: WIC
	Ward: L10W
Affix patient data label	

To be recorded within 24 hours of admission*	
Height: 6ft 11in m/ft	Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐
Weight: 95 kg/stones	Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐
Recent unplanned weight loss:	Yes ☒ No ☐
If 'Yes' how much?:	kg/stones. Over what period of time?: weeks/months
Is there evidence of recent weight loss?	
No ☐ Loose clothing ☐ History of reduced food intake/appetite ☒ Swallowing problem ☐	
Eating and drinking likes and dislikes (including appetite and/or NBM status): NBM	
Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☒	
Please state:	
Are there any contributing factors that may affect food intake such as physical (e.g. swallowing difficulties), physiological (e.g. nausea), psychological (e.g. dementia), social or environmental? Yes ☐ No ☒	
Please specify all factors:	
Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☒	
Please state:	
Profile completed by: Name (PRINT): G. Walker Signature: <i>G. Walker</i> Date: 7/4/10	
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

Step 1 - BMI Score

Height (feet and inches)

Weight (kg)		Height (m)	
50	51	1.60	1.61
52	53	1.62	1.63
54	55	1.64	1.65
56	57	1.66	1.67
58	59	1.68	1.69
60	61	1.70	1.71
62	63	1.72	1.73
64	65	1.74	1.75
66	67	1.76	1.77
68	69	1.78	1.79
70	71	1.80	1.81
72	73	1.82	1.83
74	75	1.84	1.85
76	77	1.86	1.87
78	79	1.88	1.89
80	81	1.90	1.91
82	83	1.92	1.93
84	85	1.94	1.95
86	87	1.96	1.97
88	89	1.98	1.99
90	91	2.00	2.01
92	93	2.02	2.03
94	95	2.04	2.05
96	97	2.06	2.07
98	99	2.08	2.09
100	101	2.10	2.11
102	103	2.12	2.13
104	105	2.14	2.15
106	107	2.16	2.17
108	109	2.18	2.19
110	111	2.20	2.21
112	113	2.22	2.23
114	115	2.24	2.25
116	117	2.26	2.27
118	119	2.28	2.29
120	121	2.30	2.31
122	123	2.32	2.33
124	125	2.34	2.35
126	127	2.36	2.37
128	129	2.38	2.39
130	131	2.40	2.41
132	133	2.42	2.43
134	135	2.44	2.45
136	137	2.46	2.47
138	139	2.48	2.49
140	141	2.50	2.51
142	143	2.52	2.53
144	145	2.54	2.55
146	147	2.56	2.57
148	149	2.58	2.59
150	151	2.60	2.61
152	153	2.62	2.63
154	155	2.64	2.65
156	157	2.66	2.67
158	159	2.68	2.69
160	161	2.70	2.71
162	163	2.72	2.73
164	165	2.74	2.75
166	167	2.76	2.77
168	169	2.78	2.79
170	171	2.80	2.81
172	173	2.82	2.83
174	175	2.84	2.85
176	177	2.86	2.87
178	179	2.88	2.89
180	181	2.90	2.91
182	183	2.92	2.93
184	185	2.94	2.95
186	187	2.96	2.97
188	189	2.98	2.99
190	191	3.00	3.01
192	193	3.02	3.03
194	195	3.04	3.05
196	197	3.06	3.07
198	199	3.08	3.09
200	201	3.10	3.11
202	203	3.12	3.13
204	205	3.14	3.15
206	207	3.16	3.17
208	209	3.18	3.19
210	211	3.20	3.21
212	213	3.22	3.23
214	215	3.24	3.25
216	217	3.26	3.27
218	219	3.28	3.29
220	221	3.30	3.31
222	223	3.32	3.33
224	225	3.34	3.35
226	227	3.36	3.37
228	229	3.38	3.39
230	231	3.40	3.41
232	233	3.42	3.43
234	235	3.44	3.45
236	237	3.46	3.47
238	239	3.48	3.49
240	241	3.50	3.51
242	243	3.52	3.53
244	245	3.54	3.55
246	247	3.56	3.57
248	249	3.58	3.59
250	251	3.60	3.61
252	253	3.62	3.63
254	255	3.64	3.65
256	257	3.66	3.67
258	259	3.68	3.69
260	261	3.70	3.71
262	263	3.72	3.73
264	265	3.74	3.75
266	267	3.76	3.77
268	269	3.78	3.79
270	271	3.80	3.81
272	273	3.82	3.83
274	275	3.84	3.85
276	277	3.86	3.87
278	279	3.88	3.89
280	281	3.90	3.91
282	283	3.92	3.93
284	285	3.94	3.95
286	287	3.96	3.97
288	289	3.98	3.99
290	291	4.00	4.01
292	293	4.02	4.03
294	295	4.04	4.05
296	297	4.06	4.07
298	299	4.08	4.09
300	301	4.10	4.11
302	303	4.12	4.13
304	305	4.14	4.15
306	307	4.16	4.17
308	309	4.18	4.19
310	311	4.20	4.21
312	313	4.22	4.23
314	315	4.24	4.25
316	317	4.26	4.27
318	319	4.28	4.29
320	321	4.30	4.31
322	323	4.32	4.33
324	325	4.34	4.35
326	327	4.36	4.37
328	329	4.38	4.39
330	331	4.40	4.41
332	333	4.42	4.43
334	335	4.44	4.45
336	337	4.46	4.47
338	339	4.48	4.49
340	341	4.50	4.51
342	343	4.52	4.53
344	345	4.54	4.55
346	347	4.56	4.57
348	349	4.58	4.59
350	351	4.60	4.61
352	353	4.62	4.63
354	355	4.64	4.65
356	357	4.66	4.67
358	359	4.68	4.69
360	361	4.70	4.71
362	363	4.72	4.73
364	365	4.74	4.75
366	367	4.76	4.77
368	369	4.78	4.79
370	371	4.80	4.81
372	373	4.82	4.83
374	375	4.84	4.85
376	377	4.86	4.87
378	379	4.88	4.89
380	381	4.90	4.91
382	383	4.92	4.93
384	385	4.94	4.95
386	387	4.96	4.97
388	389	4.98	4.99
390	391	5.00	5.01
392	393	5.02	5.03
394	395	5.04	5.05
396	397	5.06	5.07
398	399	5.08	5.09
400	401	5.10	5.11
402	403	5.12	5.13
404	405	5.14	5.15
406	407	5.16	5.17
408	409	5.18	5.19
410	411	5.20	5.21
412	413	5.22	5.23
414	415	5.24	5.25
416	417	5.26	5.27
418	419	5.28	5.29
420	421	5.30	5.31
422	423	5.32	5.33
424	425	5.34	5.35
426	427	5.36	5.37
428	429	5.38	5.39
430	431	5.40	5.41
432	433	5.42	5.43
434	435	5.44	5.45
436	437	5.46	5.47
438	439	5.48	5.49
440	441	5.50	5.51
442	443	5.52	5.53
444	445	5.54	5.55
446	447	5.56	5.57
448	449	5.58	5.59
450	451	5.60	5.61
452	453	5.62	5.63
454	455	5.64	5.65
456	457	5.66	5.67
458	459	5.68	5.69
460	461	5.70	5.71
462	463	5.72	5.73
464	465	5.74	5.75
466	467	5.76	5.77
468	469	5.78	5.79
470	471	5.80	5.81
472	473	5.82	5.83
474	475	5.84	5.85
476	477	5.86	5.87
478	479	5.88	5.89
480	481	5.90	5.91
482	483	5.92	5.93
484	485	5.94	5.95
486	487	5.96	5.97
488	489	5.98	5.99
490	491	6.00	6.01
492	493	6.02	6.03
494	495	6.04	6.05
496	497	6.06	6.07
498	499	6.08	6.09
500	501	6.10	6.11
502	503	6.12	6.13
504	505	6.14	6.15
506	507	6.16	6.17
508	509	6.18	6.19
510	511	6.20	6.21
512	513	6.22	6.23
514	515	6.24	6.25
516	517	6.26	6.27
518	519	6.28	6.29
520	521	6.30	6.31
522	523	6.32	6.33
524	525	6.34	6.35
526	527	6.36	6.37
528	529	6.38	6.39
530	531	6.40	6.41
532	533	6.42	6.43
534	535	6.44	6.45
536	537	6.46	6.47
538	539	6.48	6.49
540	541	6.50	6.51
542	543	6.52	6.53
544	545	6.54	6.55
546	547	6.56	6.57
548	549	6.58	6.59
550	551	6.60	6.61
552	553	6.62	6.63
554	555	6.64	6.65
556	557	6.66	6.67
558	559	6.68	6.69
560	561	6.70	6.71
562	563	6.72	6.73
564	565	6.74	6.75
566	567	6.76	6.77
568	569	6.78	6.79
570	571	6.80	6.81
572	573	6.82	6.83
574	575	6.84	6.85
576	577	6.86	6.87
578	579	6.88	6.89
580	581	6.90	6.91
582	583	6.92	6.93
584	585	6.94	6.95
586	587	6.96	6.97
588	589	6.98	6.99
590	591	7.00	7.01
592	593	7.02	7.03
594	595	7.04	7.05
596	597	7.06	7.07
598	599	7.08	7.09
600	601	7.10	7.11
602	603	7.12	7.13
604	605	7.14	7.15
606	607	7.16	7.17
608	609	7.18	7.19
610	611	7.20	7.21
612	613	7.22	7.23
614	615	7.24	7.25
616	617	7.26	7.27
618	619	7.28	7.29
620	621	7.30	7.31
622	623	7.32	7.33
624	625	7.34	7.35
626	627	7.36	7.37
628	629	7.38	7.39
630	631	7.40	7.41
632	633	7.42	7.43
634	635	7.44	7.45
636	637	7.46	7.47
638	639	7.48	7.49
640	641	7.50	7.51
642	643	7.52	7.53
644	645	7.54	7.55
646	647	7.56	7.57
648	649	7.58	7.59
650	651	7.60	7.61
652	653	7.62	7.63
654	655	7.64	7.65
656	657	7.66	7.67
658	659	7.68	7.69
660	661	7.70	7.71
662	663	7.72	7.73
664	665	7.74	7.75
666	667	7.76	7.77
668	669	7.78	7.79
670	671	7.80	7.81
672	673	7.82	7.83
674	675	7.84	7.85
676	677	7.86	7.87
678	679	7.88	7.89
680	681	7.90	7.91
682	683	7.92	7.93
684	685	7.94	7.95
686	687	7.96	7.97
688	689	7.98	7.99
690	691	8.00	8.01
692	693	8.02	8.03
694	695	8.04	8.05
696	697	8.06	8.07
698	699	8.08	8.09
700	701	8.10	8.11
702	703		

[illegible]

Step 1: BMI Score (refer to chart on page 4)									
>20 (>30 = Obese)	0.								
18.5 - 20	1								
<18.5	2								
Step 2: Weight Loss Score									
Unplanned weight loss in past 3-6 months:									
<5%	0								
5-10%	1								
>10%	2								
Step 3: Acute Disease Effect Score									
If patient is acutely ill <u>and</u> there has been or is likely to be no or virtually no food intake for > 5 days.....	Score 2								
Not applicable.....	Score 0								

Score of Overall Risk of Malnutrition	Action Required
0	LOW RISK - Routine Clinical Care • Repeat screening. Hospital AcuteWeekly Hospital RehabilitationMonthly
1	MEDIUM RISK - Observe • Document dietary intake for 3 days on a Food Record Chart. • If no improvement in intake: - Encourage oral intake. - Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Repeat screening weekly.
2 or more	HIGH RISK - Treat* • Refer to Dietitian and document food intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Monitor and review Care Plan weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

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 dietician if any specialist advice is required.
- Complete nursing checklist for swallowing difficulties if appropriate.
- Use a recognised system to identify when equipment or assistance is required at mealtimes (e.g. red mats, coloured napkins).

Dietitian	Date: / /	Outcome:
Speech and Language Therapy	Date: / /	Outcome:
Occupational Therapy	Date: / /	Outcome:
Dental Service	Date: / /	Outcome:

[illegible]

N.B. Ensure discharge plan includes most recent 'MUST' score and any necessary follow-up requirements.

Cannard Falls Risk Assessment

Glossary of terms used in risk assessment

SIGHT DEFICIT means patient cannot see well even when wearing glasses or is registered blind.

HEARING DEFICIT means person has hearing problems even with a hearing aid or has hearing problems and does not wear a hearing aid.

BALANCE DEFICIT means person is unable to stand without the support of another person or a walking frame.

MEDICINES FOR SOME MENTAL ILLNESSES include Chlorpromazine (Largactil), Risperidone (Risperdal), Lithium (Cancollit or Pridel), Haloperidol, Chloral hydrate (Welldorm), Clomethiazole (Hemineurin), antidepressants, Diazepam, Lorazepam and Amitriptyline.

CARDIOVASCULAR SYSTEM MEDICATION all antihypertensive medication and inotropes including Captopril, atenolol and many others.

WATER TABLETS (DIURETICS) are such as Bendroflumethiazide, Furosemide and Co-amilofruse.

SEDATIVES / ANALGESIA AT NIGHT include medicines such as Diazepam, Temazepam, Nitrazepam, Chlordiazepoxide and Zopiclone (Zimovane) Morphine PCA, Fentanyl, Tramadol and Oxycotin.

INABILITY TO CO-OPERATE includes failure to use walking aids or putting themselves in situations with a high risk of falling (usually due to mental impairment).

RESTRICTED MOBILITY means the person requires supervision and/or help to walk (i.e. is not safe to walk alone even with an aid).

HESITANT IN INITIATING MOVEMENT means difficulty in starting to walk.

POOR TRANSFER means the person requires help and is not safe to do the following alone - get in or out of bed, on or off a chair, move from chair to standing.

Cannard Falls Risk Assessment Pack

Patient name:			
Ward:	50623238H	06/03/1954	
CHI number:	GLASGOW CHI-0603546323	G15 SAX	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 or mobility problems unattended on commodes, in toilets, baths or 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: 7/11	Date:	Date:	Date:	Date:	Date:
					Ward: Low	Ward:	Ward:	Ward:	Ward:	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	0					
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	0				
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed / chair-bound / wheel-chair 1		1				
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1				
TOTAL SCORE					4					
ACTION(S) TAKEN Enter action code(s) from Care Plan below					1, 2, 4					
SCORE 13+ = HIGH RISK If patient unconscious score as N/A until patient status improves					NURSE SIGNATURE	aw				

Please see back page for glossary of terms relating to the assessment above.

Falls Assessment Care Plan

Please tick all applicable nursing interventions

NURSING INTERVENTIONS		Date: 7/11	Date:	Date:	Date:	Date:	Date:
		Ward:	Ward:	Ward:	Ward:	Ward:	Ward:
Action code							
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	Hip protectors refer to Hospital Falls Co-ordinator.						
24	Other interventions.						
SIGNATURE		aw					

Review Cannard score weekly / monthly as per policy. Enter action code(s) selected in action taken section on Falls Risk Assessment page above.

[illegible]

1 2 3 4 5 6 7 8



Pupil size (mm)

DATE									
Time									
COMMA V S C A L E	E	Spontaneously	4						
	Eyes open	To speech	3						Eyes closed by dwelling = C
		To pain	2						
		None	1						
	V	Oriented	5						
		Confused	4						Endocheim tube or tracheostomy = T
		Incomprehensible words	3						
	Best verbal response	Incomprehensible sounds	2						
		None	1						
		Obvys	0						
	M	Localises	5						
		Flexion - withdrawal	4						Usually record the best arm response
Flexion - abnormal		3							
Extension to pain		2							
None		1							
Best motor response									
	TOTAL SCORE								
PUPILS	R	Size							P PERRIES = no reaction c. eyes closed
	L	Reaction							
I M B O O M E N T A L S C A L E	A R M S	Size							
		Reaction							
		Normal power							
		Mild weakness							
		Severe weakness							
	L E G S	Spastic flexion							
		Extension							
		No response							
		Normal power							
		Mild weakness							
I M B O O M E N T A L S C A L E	Severe weakness								
	Extension								
	No response								
I M B O O M E N T A L S C A L E	Reaction								
	Normal power								
I M B O O M E N T A L S C A L E	Mild weakness								
	Severe weakness								
I M B O O M E N T A L S C A L E	Extension								
	No response								
I M B O O M E N T A L S C A L E	Reaction								
	Normal power								
I M B O O M E N T A L S C A L E	Mild weakness								
	Severe weakness								
I M B O O M E N T A L S C A L E	Extension								
	No response								
I M B O O M E N T A L S C A L E	Reaction								
	Normal power								
I M B O O M E N T A L S C A L E	Mild weakness								
	Severe weakness								
I M B O O M E N T A L S C A L E	Extension								
	No response								
I M B O O M E N T A L S C A L E	Reaction								
	Normal power								
I M B O O M E N T A L S C A L E	Mild weakness								
	Severe weakness								
I M B O O M E N T A L S C A L E	Extension								
	No response								
I M B O O M E N T A L S C A L E	Reaction								
	Normal power								
I M B O O M E N T A L S C A L E	Mild weakness								

NHS
Greater Glasgow

Name
Address
50823238H
WATSON
MARY
28 KENDON AVENUE
06/03/1954
GLASGOW
CHI-0603546323
G15 8AX
Hospital No.
DOB

Admitted Date _____ Ward _____
Transferred Date _____ Ward _____
Transferred Date _____ Ward _____

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

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

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

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

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

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

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.

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

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.

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	85-99	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			

Calling Criteria		
Score is 1-3	Increase frequency of patient observations, monitor trends and inform Nurse In Charge.	
Score is 3 in one category	Contact Senior Nurse and increase frequency of patient observations.	
Score is 4 and above or increasing by 2 or more		
Patient's GCS falls by 2 or more		Contact Senior Nurse and increase frequency of patient observations Contact Critical Care Outreach Team.
Any patient whose condition is causing concern		
The Senior Nurse will direct patient care and contact the appropriate medical staff when necessary.		

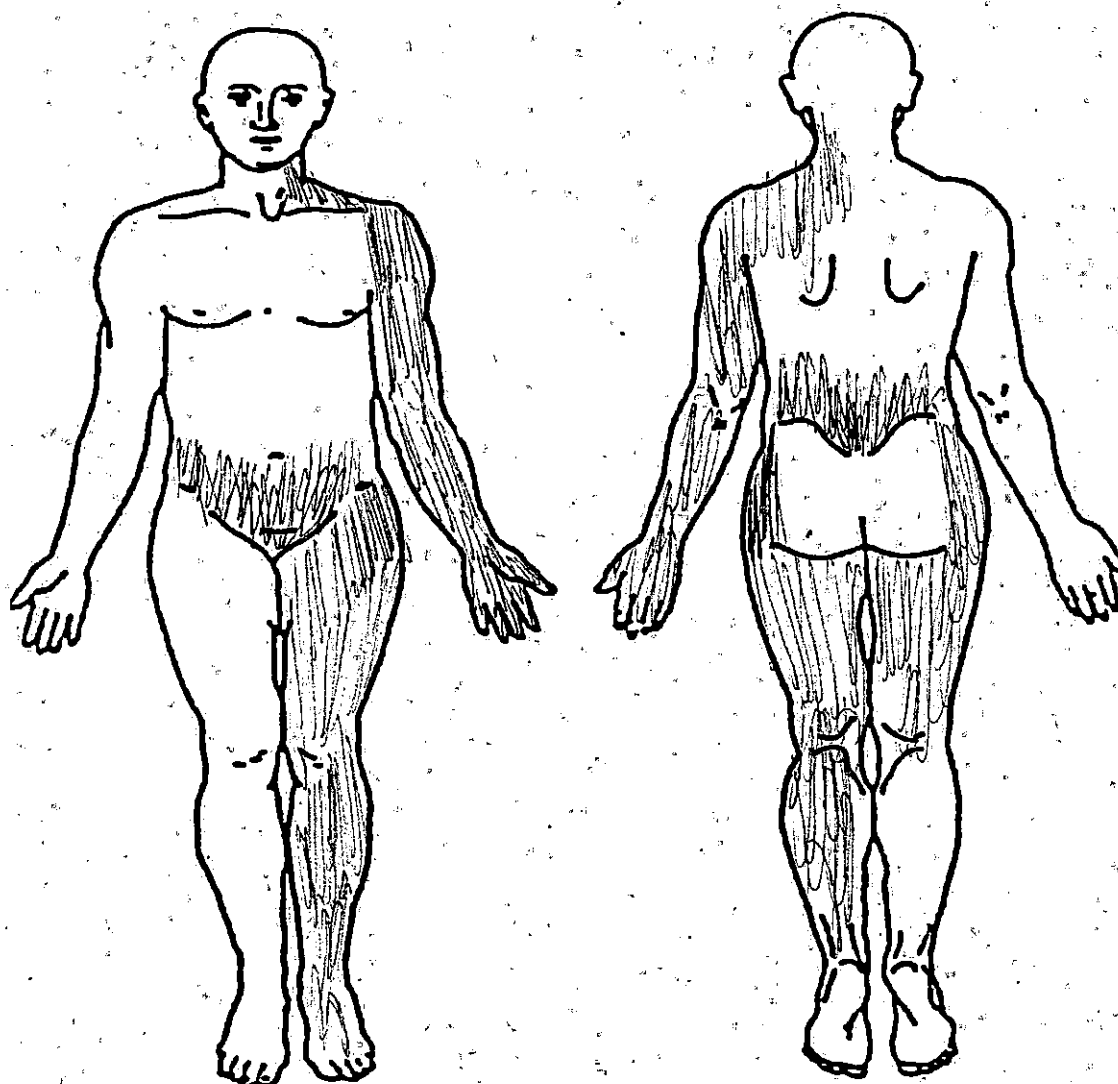
F	50623238H	F
	WATSON	
	MARY 06/03/1954	
	28 KENDON AVE	
	GLASGOW	
	G15 8AX	
		

HOSPITAL	GGM
DATE	17/10/05

Please help us by filling in as much of the following questionnaire as you can.

Don't worry if you find some questions difficult, we will go over all the questions with you on your first visit to the clinic.

We need to know where you have pain. On the drawings below, please shade in the areas where you feel pain. Put an X on the area that hurts the most.



Please answer the following questions.

When did you start having problems with pain? If there was an accident or injury please describe it.

after surgery for Cervical Cancer and Breast cancer

Pain is often very difficult to describe to others. Below is a list of words that people sometimes use when talking about their pain. Please circle any words that you feel describe your pain. You can add other words if you wish.

cutting	<u>pounding</u>	tingling	<u>tiring</u>	deep	
beating	squeezing	<u>throbbing</u>	<u>horrible</u>	stabbing	
<u>burning</u>	pulling	<u>sickening</u>	<u>biting</u>	<u>screaming</u>	
scraping	<u>aching</u>	<u>uncomfortable</u>	cold	tugging	
pricking	cruel	warm	<u>miserable</u>	stretching	
pinching	<u>unbearable</u>	<u>sad</u>	itching	terrible	
stinging	cool	<u>sore</u>	flashing	pressing	
fearful	<u>sharp</u>	jumping	tight	pins and needles	
<u>hot</u>	<u>spreading</u>	punishing	seared	<u>lonely</u>	<u>bad</u>

When do you have your pain?

at all times

Is there anything that makes your pain worse?

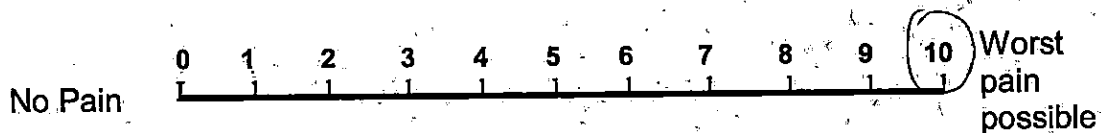
Sometimes

Is there anything that helps your pain?

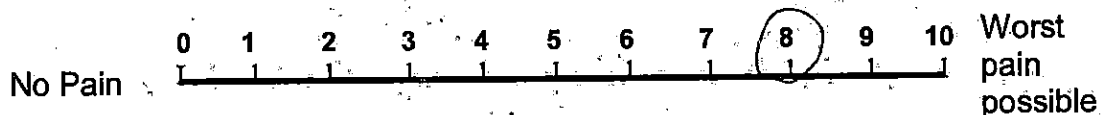
No

Please rate your pain by circling a number on the scales below. This will give us an idea of your pain level on average, at its worst and at its best. The number 0 represents no pain at all, the number 10 represents the worst pain you could possibly have.

Please rate your pain at its **worst** in the past week, by circling a number between 0 and 10 on the scale below



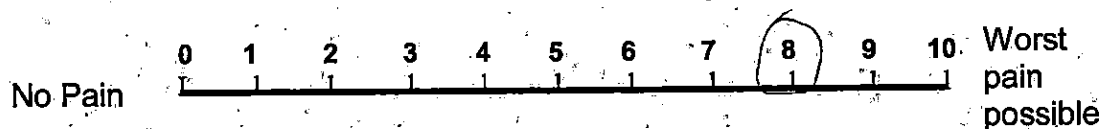
Please rate your pain at its **best** in the past week:



Please rate your pain on the **average** for the past week:



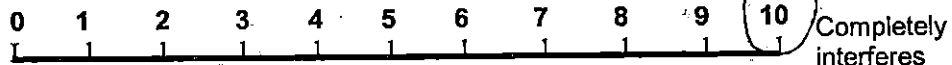
Please rate the pain you have **right now**:



Pain can sometimes interfere with our mood, our sleep, and the ability to do what we want to do. Please rate how much your pain interferes with the following areas of your life, by circling a number between 0 and 10 on the scales below (0 = no interference, 10 = complete interference).

How much does your pain interfere with your **general activity**?

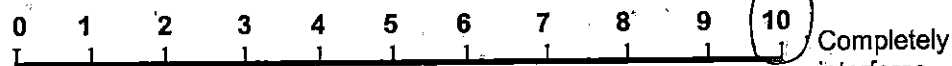
Does
not
interfere



Completely
interferes

How much does your pain interfere with your **mood**?

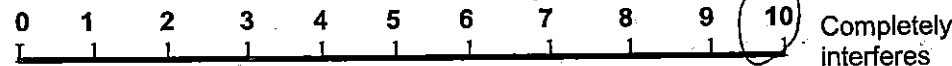
Does
not
interfere



Completely
interferes

How much does your pain interfere with your **walking ability**?

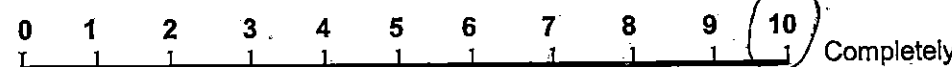
Does
not
interfere



Completely
interferes

How much does your pain interfere with your **normal work**?

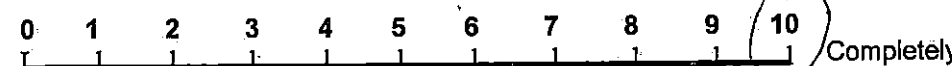
Does
not
interfere



Completely
interferes

How much does your pain interfere with your **relationships with other people**?

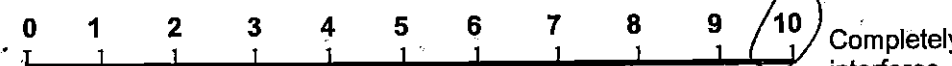
Does
not
interfere



Completely
interferes

How much does your pain interfere with your **sleep**?

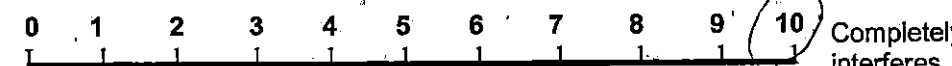
Does
not
interfere



Completely
interferes

How much does your pain interfere with your **enjoyment of life**?

Does
not
interfere



Completely
interferes

Are there any activities (for example hobbies, socialising) you would like to do, which your pain stops you from doing?

Please list all medicines you are taking just now, including doses. If you have a list of medications from your GP please bring that with you.

Name of medication	Dose	Times taken	Does it help?
Thyroxine	50mg	daily	don't know
Colestreal	80mg	daily	" "
Pain Killers	500mg	daily	No

Please list any other medicines you have taken in the past for your pain.

Name of medication	Did it help?	Why did you stop taking it?
Pain Killers	No	No good

Are there any medicines that you are allergic to?

Have you tried any other types of treatment (apart from conventional medicines) for your pain?

Name of treatment	Was it helpful?
No.	

Finally, what do you hope to get from your visit to the pain clinic, and what would you like us to do to help you?

*Better quality of Life
Pain free.*

Thank you very much for completing this questionnaire.

Please bring this completed questionnaire with you when you come to hospital for your Pain Clinic appointment.

CONFIDENTIALITY AND USE OF PATIENT'S INFORMATION

For the purpose of your present and future medical treatment, details of your medical care will be recorded. Some use may be made of this information for research purposes and to indicate the kind of future health services which patients may require; some will be processed on a computer. At all times great care is taken to ensure that high standards of confidentiality are maintained in respect of all information held. The "Data Protection Act 1998" gives you the right of access to any personal information which the Trust may hold about you either in manual records or on its computers. If you wish to apply for access to your data, or if you would like more information about your rights under the Act, you should, in the first instance, contact the Health Records Officer at the hospital.

TAS - HOME

Ward: L8 Med Date: 20/5/04 Time: 10⁴⁵ (24hr clock)

Please print clearly in BLOCK CAPITALS

Title: WRS
 Name: MARY WATSON
 Preferred name: _____
 Address: 28 KENDON AVE
CLASHOL
 Post Code: GL5 8AX
944-1246
 DOB: 6-3-54 Age: 50
 Hosp. No: 50623238H
 Occupation: H/W
 Religion: C/S
 S.O.S. ☐ date: ☐☐☐☐☐
 Interpreter required: ☐
 (specify: _____)
 Lives alone ☐

1 NOK/Friend/Contact: ARLENE WATSON
 Address: A/A
 Day: A/A
 Night: _____
 Relationship: DAUGHTER
 2 NOK/Friend/Contact: _____
 Address: _____
 Day: _____
 Night: _____
 Relationship: _____
 NOK informed of admission ☒
 NOK informed by: PATIENT
 GP: DR LYON
 Address: D/C H.C.

MEDICATION

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

PERSONAL BELONGINGS

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

Consultant: BRODIE
 Named Nurse ①: _____
 Admitting Nurse: E/N McKEENIE
 Named Nurse ②: _____
 Relatives seen by Doctor ☐

REASON FOR ADMISSION

CENTRAL CHEST PAIN
→ BACK
ASSOC. NAUSEA &
DYSPOEA
 Patient's perception of illness:
AWARE OF PROBLEM

Diagnosis: MI SCREEN

Operation/Treatment: _____
IRONONIN LEVEL
CARDIOLOGY REVIEW

Relevant PMH: BREAST CA +
ESophageal CA in 96
HYPERCHOLESTEROL
MI in 03; ANGIO.

OBSERVATIONS ON ADMISSION

Temperature 36.4 °C
 Pulse 97 bpm
 BP 107/76
 Resp 14 982 (A)
 Pain Score 0
 Urinalysis _____
 Waterlow Score 8
 Height _____ m
 Weight _____ kg
 Body Mass Index _____
 Blood sugar(if appropriate) _____ mmols
 Allergies Yes ☐ No ☐
 details: _____

DISCHARGE PLANNING

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

Name: MayWard: L&MedDate: 20/5/04Case Record No: 30623238N**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: _____

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): _____

BREATHING

1. No symptoms ☒
2. Breathless with moderate exercise ☐
3. Breathless with minimal exertion ☐
4. Breathless at rest ☐
5. Uses inhalers ☐
Comments: _____

SMOKING

Non-smoker ☐
Smoker: _____ 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: _____

SLEEP

Hours/night ☒
Medication ☐
details: _____

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: _____

ALCOHOL INTAKE

Units/week: nil ☐
less than 14 ☒
14 - 21 ☐
over 21 ☐
(1 unit = 1 measure spirits/half pint beer/
lager/1 glass wine)

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)

Signature: *H. Her*
Designation: *E.N.*
Countersigned (if applicable):

OTHER RELEVANT INFORMATION

May
Cotton

Ward: L & Hed

Date: 20/5/04

Case Record No.:

50623238H

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
20/5/04	0119		Emergency via 1911 No chest pain Paracetamol 30mg given. Troponin is am.	
21/05/04	0500	(5)	Observations stable as charted.	
		(6)	No complaints of pain.	
		(9)	Slept for short periods.	
		(11)	Patient is quite anxious. Given re-assurance.	
	11:00	(1)	Independently met hygiene needs	
		(2)	Fluid and diet tolerated	
		(3)	Continues on bed rest awaiting	
		(4)	troponin, mobilising to use commode	
		(5)	Observations stable as charted	
			Patient very anxious about blood results, reassurance given.	
	11:40		Troponin negative for discharge via T&S, ventral removed.	

[illegible]

Case Record No.: 50623238H

[illegible]

CARE PLAN				
Date Comm.	Signature	6. TECHNICAL CARE	Date Disc.	Signature
		IV Infusion		
		Monitor		
		Catheter		
		Oxygen Therapy		
		Nebulisers		
20/5	[Signature]	IV access: ∞ IV cannulae ✓ ∞ others		
		7. WOUND CARE		
20/5	[Signature]	8. SPECIMENS/INVESTIGATIONS USU / NAD	21/5/04	
		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:

Signature of nurse: [Signature]

Yes ☐ N/A ☐

Date: 20/03/04

Yes ☐ N/A ☐

Date: 20/03/04

Oxygen Devices and Flow Related | centages

Nasal Cannula

O ₂ Flow Rate (L/min)	1	2	3	4	5	6
Approximate O ₂ concentration (%)	24	28	32	36	40	44

Hudson Face Mask

O ₂ Flow Rate (L/min)	4	6	8	12-15
Approximate O ₂ concentration (%)	40	50	55	65

Venturi Mask

Colour of Venturi Device	Blue	White	Yellow	Red	Green
O ₂ Flow Rate (L/min)	2	4	8	10	15
Approximate O ₂ concentration (%)	24	28	35	40	60

Non-rebreathe masks

An oxygen flow rate of 12-15 litres/minute will provide an oxygen percentage of approximately 95%.

These figures are intended for guidance only. Slight variations may exist between products manufactured by different companies.

Patie Observation Chart (1)

Name Ms. V. V. V.
Address AFFIX
PATIENT
Hospital No. 50623334
DOB 6-3-54

Admitted Date 20/5/04 Ward LE Med
Transferred Date _____ Ward _____
Transferred Date _____ Ward _____

Reference Scoring Chart

Modified Early Warning System Observation Score (MEWS)

Score	3	2	1	0	1	2	3
Pulse		<40	41-50	51-100	101-110	111-130	>131
Resp. Rate		<8	9-14	15-20	21-29	>30	
Temp. (°C)		<35.0	35.1-36.0	36.1-38.0	38.1-38.5	>38.8	
AVPU/GCS	Unresponsive	Pain	Voice	Alert / 15	14	13-9	<8
Urine	<10mls/hr for 2 hrs	30mls/hr for 2 hrs				<300mls in 24hrs	<100mls in 24 hrs
Systolic BP	<70	71-80	81-100	101-199		>200	

If your patient scores 4 or more
If your patient's GCS increases by 2 or more
If your patient's GCS drops by 2 points or more regardless of any other information
Or any patient causing concern to any healthcare professional
Immediately inform your relevant medical staff and contact the Critical Care Outreach Service

Glasgow Coma Scale

Eye opening	Verbal	Motor
4 - spontaneous	5 - orientated	6 - obeys commands
3 - voice	4 - confuse	5 - localises to pain
2 - pain	3 - inappropriate word	4 - normal flexion
1 - none	2 - incomprehensible sound	3 - abnormal flexion
		2 - extension 1 - nil
		1 - nil

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 IV, 1 hour after IM, S/C or oral analgesia.
Sustained pain score of 2 or pain score of 3 requires 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.

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

CON-7

DATE		TEMP	
Time	11:01	40°C	
1	240	39°C	
2	220	38°C	
3	200	37°C	
4	180	36°C	
5	160	35°C	
6	140		
7	120		
8	100		
Pupil size (mm)	118		
Resp. Rate	14		
Inspiration O ₂ %	14		
SpO ₂ %	98		
Pain Score	0		
Sedation Score	0		
Nausea Score	0		

MEWS Scores

[illegible]

HOSPITAL NO.

DATE	TEMP
Time	40°C
• 1	240
	230
• 2	220
B	210
P	200
	190
• 3	180
a	170
d	160
	150
• 4	140
P	130
u	120
i	110
s	100
e	90
	80
• 5	70
• 6	60
• 7	50
• 8	40
Pupil size (mm)	
Resp. Rate	
Inspiration O ₂ %	
SpO ₂ %	
Pain Score	
Sedation Score	
Nausea Score	

NEWS Scores

[illegible][illegible]

PUPILS		R		L		TOTAL SCORE	
		Reaction	Size	Reaction	Size		
E	Spontaneously	4					
C	To speech	3					
O	To pain	2					
M	Open	1					
A	None	1					
V.	Orientated	5					
	Confused	4					
	Best	3					
	Inappropriate words	2					
	Verbal	1					
	Inappropriate sounds	3					
	None	1					
	Obeys	1					
	6						
	Localises	5					
	Reaction - withdrawal	4					
	Best	3					
	Reaction - abnormal	2					
	Extension to pain	1					
	None	1					
	1						

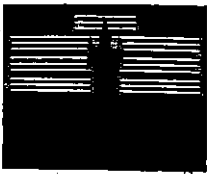
PUPILS		R		L		TOTAL SCORE	
		Reaction	Size	Reaction	Size		
E	Spontaneously	4					
C	To speech	3					
O	To pain	2					
M	Open	1					
A	None	1					
V.	Orientated	5					
	Confused	4					
	Best	3					
	Inappropriate words	2					
	Verbal	1					
	Inappropriate sounds	3					
	None	1					
	Obeys	1					
	6						
	Localises	5					
	Reaction - withdrawal	4					
	Best	3					
	Reaction - abnormal	2					
	Extension to pain	1					
	None	1					
	1						

PUPILS		R		L		TOTAL SCORE	
		Reaction	Size	Reaction	Size		
E	Spontaneously	4					
C	To speech	3					
O	To pain	2					
M	Open	1					
A	None	1					
V.	Orientated	5					
	Confused	4					
	Best	3					
	Inappropriate words	2					
	Verbal	1					
	Inappropriate sounds	3					
	None	1					
	Obeys	1					
	6						
	Localises	5					
	Reaction - withdrawal	4					
	Best	3					
	Reaction - abnormal	2					
	Extension to pain	1					
	None	1					
	1						

PUPILS		R		L		TOTAL SCORE	
		Reaction	Size	Reaction	Size		
E	Spontaneously	4					
C	To speech	3					
O	To pain	2					
M	Open	1					
A	None	1					
V.	Orientated	5					
	Confused	4					
	Best	3					
	Inappropriate words	2					
	Verbal	1					
	Inappropriate sounds	3					
	None	1					
	Obeys	1					
	6						
	Localises	5					
	Reaction - withdrawal	4					
	Best	3					
	Reaction - abnormal	2					
	Extension to pain	1					
	None	1					
	1						

PUPILS		R		L		TOTAL SCORE	
		Reaction	Size	Reaction	Size		
E	Spontaneously	4					
C	To speech	3					
O	To pain	2					
M	Open	1					
A	None	1					
V.	Orientated	5					
	Confused	4					
	Best	3					
	Inappropriate words	2					
	Verbal	1					
	Inappropriate sounds	3					
	None	1					
	Obeys	1					
	6						
	Localises	5					
	Reaction - withdrawal	4					
	Best	3					
	Reaction - abnormal	2					
	Extension to pain	1					
	None	1					
	1						

Eyes closed by dwelling = C		Endocrine all busy or racing/sleepy = 1
Usually record the best arm response		



- Part of North Glasgow University Hospitals NHS Trust

Pressure Sore Risk Assessment Documentation Form

Patient Name: May Watson

Case Record Number: _____

Ward: LG Med

Waterlow Risk Assessment		Initials														
		Date														
		No.	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Body weight for height:	Average 0 Above average 1 Obese 2 Below average 3	0														
Continence:	Completely catheterised 0 Occasionally incontinent 1 Cath. Incontinence of faeces 2 Doubly incontinent 3	0														
Skin type-visual risk areas:	Healthy 0 Tissue paper/dry 1 Oedematous clammy (temp ↑) 1 Discoloured 2 Broken spot 3	0														
Mobility:	Fully 0 Restless/fidgety 1 Apathetic 2 Restricted 3 Inert/traction 4 Chairbound 5	3														
Age/Sex:	Male/Female ½ 14-49 1 50-64 2 65-74 3 75-80 4 80+ 5	2														
Appetite:	Average 0 Poor 1 NG Tube/fluids only 2 nbm - Anorexic 3	0														
Special risks – tissue malnutrition:	eg Terminal cachexia 8 Cardiac failure 5 Peripheral vascular disease 5 Anaemia 2 Smoking 1	1														
Neurological deficit:	Motor-sensory paraplegia 4-6 eg diabetes, MS, CVA															
Major surgery/trauma:	Orthopaedic 5 Below waist, Spinal 5 On table > 2 hours 5															
Medication:	Cytotoxics, High dose steroids 4 Anti-inflammatory															
TOTAL SCORE		8														

Score: <10 = low risk; 10-14 = at risk; 15-19 = high risk; 20+ = very high risk

DAILY PRESSURE AREA SKIN ASSESSMENT CHART

CLASSIFICATION OF PRESSURE DAMAGE (TORRANCE)

Grade one = blanching hyperaemia

Grade two = non blanching hyperaemia/superficial break

Grade three = through to subcutaneous tissue

Grade four = through to underlying muscle

Grade five = through to bone or presence of necrotic tissue

[illegible]

ENSURE ALL ACTION IS DOCUMENTED IN THE NURSING CARE PLAN

Notes for Users

(Maximum number of doses as per protocol)

FOR DOCTORS:

1. Sign your name clearly against each prescription.
2. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date appropriate boxes.
3. If an existing prescription is to be modified, delete existing prescription as described and re-write new instructions in a new section.
4. Use approved names in **BLOCK LETTERS** and use metric doses as follows:

Milligram = mg Gram = g
 Millilitre = ml Microgram: to be written in full.

Fractions of a milligram should be written in micro grams. A zero should be written in front of a decimal point where there is no other figure, e.g. 0.5ml **not** .5ml.

5. Method of administration should be abbreviated as follows:

Intravenous	=	IV	Oral	=	O
Subcutaneous	=	SC	Per rectum	=	PR
Inhalations	=	INH	Topical	=	TOP
Sublingual	=	SL	Nasogastric	=	NG
Intramuscular	=	IM	Vaginal	=	PV
Intradermal	=	ID			

FOR NURSES:

1. The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.
2. Ensure entry is made on administration record each time drug is given. Initial in relevant date column and time row.
3. Check that all drugs prescribed at a certain time are administered.
4. If drug is not administered, enter reason in appropriate box using the undernoted coding system.

Codes for Non-Administration of Drugs

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

PRESCRIPTION FORM

Hospital Name:

PATIENT DETAILS

Name: <u>Mary Watson</u>	Height:
Hospital Number: <u>50623238H</u>	Weight:
DOB: <u>6/13/59</u>	Surface area:
Admission: <u>20, 5, 1</u>	Date of writing discharge prescription: <u> </u>
Intant Name: <u>PROBIE</u>	Ward: <u>LR Med</u>
Date and time this form prepared: <u> </u> <u> </u> <u> </u> Time: <u> </u>	Sheet No <u> </u> 2nd Prescription in use <u> </u> Yes or NO

DRUG SENSITIVITIES

DVT Risk on Admission (SIGN Guideline)

High ☐ Moderate ☐ Low ☐

Assessed by: _____ Date: ____/____/____

OTHER CHARTS IN USE

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

ONCE ONLY AND PREMEDICATION DRUGS

[illegible]

FOR DOCTORS USE ONLY					
M	DRUG <i>LANSOPRAZOLE</i>	Other time			
		☒			
		0700-0900			
		1200-1400			
		1800-1900			
		2200-2400			
		Other time			
SIGNATURE OF DOCTOR: <i>[Signature]</i>	ROUTE <i>o</i>	DATE <i>2/5</i>	DATE:	INITIALS:	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					

FOR DOCTORS USE ONLY									
S		DRUG							
DOSE		ROUTE		DATE:		INITIALS:			
SIGNATURE OF DOCTOR						STOPPED			
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY									
Other time									
0700-0900									
1200-1400									
1600-1800									
2200-2400									
Other time									

The "Regular" and "as required" medicines sections should be checked at each administration round to ensure that medication administration is avoided.

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE

MONTH

T	DRUG			DATE:
	DOSE	ROUTE	DATE	DATE:
SIGNATURE OF DOCTOR				INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				STOPPED

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

FOR DOCTORS USE ONLY

V	DRUG			DATE:
	DOSE	ROUTE	DATE	DATE:
SIGNATURE OF DOCTOR				INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				STOPPED

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

FOR DOCTORS USE ONLY

W	DRUG			DATE:
	DOSE	ROUTE	DATE	DATE:
SIGNATURE OF DOCTOR				INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				STOPPED

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

FOR DOCTORS USE ONLY

X	DRUG			DATE:
	DOSE	ROUTE	DATE	DATE:
SIGNATURE OF DOCTOR				INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				STOPPED

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

FOR DOCTORS USE ONLY

Oral and Other Drugs: Regular Prescriptions

DATE

MONTH

Y	DRUG			DATE:
	DOSE	ROUTE	DATE	DATE:
SIGNATURE OF DOCTOR				INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				STOPPED

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

FOR DOCTORS USE ONLY

AA	DRUG			DATE:
	DOSE	ROUTE	DATE	DATE:
SIGNATURE OF DOCTOR				INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				STOPPED

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

FOR DOCTORS USE ONLY

BB	DRUG			DATE:
	DOSE	ROUTE	DATE	DATE:
SIGNATURE OF DOCTOR				INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				STOPPED

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

FOR DOCTORS USE ONLY

CC	DRUG			DATE:
	DOSE	ROUTE	DATE	DATE:
SIGNATURE OF DOCTOR				INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				STOPPED

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

FOR DOCTORS USE ONLY

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

PATIENT'S NAME:				ADMINISTRATION												
Oral and Other Drugs: Regular Prescriptions				DATE												
				MONTH												
DD	DRUG			Other time												
DOSE	ROUTE	DATE	DATE:	0700-0900												
SIGNATURE OF DOCTOR			STOPPED INITIALS:	1200-1400												
				1600-1800												
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			STOPPED	2200-2400												
				Other time												

FOR DOCTORS USE ONLY																
EE	DRUG			Other time												
DOSE	ROUTE	DATE	DATE:	0700-0900												
SIGNATURE OF DOCTOR			STOPPED INITIALS:	1200-1400												
				1600-1800												
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			STOPPED	2200-2400												
				Other time												

FOR DOCTORS USE ONLY																
FF	DRUG			Other time												
DOSE	ROUTE	DATE	DATE:	0700-0900												
SIGNATURE OF DOCTOR			STOPPED INITIALS:	1200-1400												
				1600-1800												
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			STOPPED	2200-2400												
				Other time												

FOR DOCTORS USE ONLY																
GG	DRUG			Other time												
DOSE	ROUTE	DATE	DATE:	0700-0900												
SIGNATURE OF DOCTOR			STOPPED INITIALS:	1200-1400												
				1600-1800												
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			STOPPED	2200-2400												
				Other time												

FOR DOCTORS USE ONLY															
FOR DOCTORS USE ONLY															

Oral and Other Drugs: Regular Prescriptions				DATE												
				MONTH												
HH	DRUG			Other time												
DOSE	ROUTE	DATE	DATE:	0700-0900												
SIGNATURE OF DOCTOR			STOPPED INITIALS:	1200-1400												
				1600-1800												
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			STOPPED	2200-2400												
				Other time												

FOR DOCTORS USE ONLY																
JJ	DRUG			Other time												
DOSE	ROUTE	DATE	DATE:	0700-0900												
SIGNATURE OF DOCTOR			STOPPED INITIALS:	1200-1400												
				1600-1800												
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			STOPPED	2200-2400												
				Other time												

FOR DOCTORS USE ONLY																
KK	DRUG			Other time												
DOSE	ROUTE	DATE	DATE:	0700-0900												
SIGNATURE OF DOCTOR			STOPPED INITIALS:	1200-1400												
				1600-1800												
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			STOPPED	2200-2400												
				Other time												

FOR DOCTORS USE ONLY																
LL	DRUG			Other time												
DOSE	ROUTE	DATE	DATE:	0700-0900												
SIGNATURE OF DOCTOR			STOPPED INITIALS:	1200-1400												
				1600-1800												
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			STOPPED	2200-2400												
				Other time												

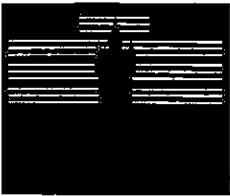
FOR DOCTORS USE ONLY															
----------------------	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

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

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

[illegible]

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



Patient Profile

Ward: Wmed Date: 01/01/02 Time: 2200 (24hr clock)

Please print clearly in BLOCK CAPITALS

Title: MRS
Name: MARY WATSON
Preferred name: _____
Address: 28 Kendoon Ave.
Post Code: G15 8AX
944-9973
DOB: 06/03/54 Age: 47yrs
Hosp. No: 623238
Occupation: UWrite
Religion: C/S
S.O.S. ☐ date: ☐☐☐☐☐☐
Interpreter required: ☐
(specify: _____)
Lives alone ☒

Consultant: Dr Dove
Named Nurse ①: SN Wood
Admitting Nurse: CM Ennes
Named Nurse ②: _____
Relatives seen by Doctor ☐

1 NOK/Friend/Contact: Arlene
Address: 6 Tallant Terr.
Glasgow G15
Day: _____
Night: _____
Relationship: daughter
2 NOK/Friend/Contact: _____
Address: _____
Day: _____
Night: _____
Relationship: _____
NOK informed of admission ☒
NOK informed by: Patience
GP: Dr Lyon
Address: Drumchapel Ulester
Day: _____

Retrosternal chest
discomfort - intermittent
in waves.

Patient's perception of illness: ANORE

Diagnosis: EXCLUDE MI

Operation/Treatment: MI SCREEN (CK)

Relevant PMH: BREAST AND
CERVICAL CA.
HYPOTHYROIDISM.

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

PERSONAL BELONGINGS
Clothing listed ☐
Valuables listed ☐
Valuables in ward ☐
Valuables in hospital safe ☐

OBSERVATIONS ON ADMISSION

Temperature	<u>36.0</u> °C
Pulse	<u>82</u> bpm
BP	<u>153/95</u>
Resp	<u>12.99%</u>
Pain Score	<u>0</u>
Urinalysis	_____
Waterlow Score	_____
Height	_____ m
Weight	_____ kg
Body Mass Index	_____
Blood sugar (if appropriate)	_____ mmols
Allergies	Yes ☐ No ☐
details:	_____

DISCHARGE PLANNING

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

Name: Mary Watson

Ward: C8 Aman

Date: 11/1/02

Case Record No.: 623238

ACTIVITIES OF DAILY LIVING

HOME/RESIDENCE

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: _____

DIET

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): _____

BREATHING

1. No symptoms ☒

2. Breathless with moderate exercise ☐

3. Breathless with minimal exertion ☐

4. Breathless at rest ☐

5. Uses inhalers ☐

Comments: _____

SMOKING

Non-smoker ☐

Smoker: _____ per day ☐

Ex-smoker ☐

Aware of hospital policy ☐

BATHING

Bath ☐ Shower ☐

Requires assistance ☐ Stand up wash ☐

Skin assessment: _____

Other: _____

BOWELS

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: _____

SLEEP

Hours/night ☐

Medication ☐

details: _____

MENTAL STATE

Alert/Orientated ☒

Confused: day/night ☐

Anxious/Distressed ☐

Unconscious ☐

Other (specify): _____

Glasses: distance ☐
 reading ☐
 Hearing impaired: left/right ☐
 Hearing aid: left/right ☐
 Dentures: upper ☐
 lower ☐
 Communication Difficulties ☐
 Other: ☐

Units/week: nil ☐
 less than 14 ☒
 14 - 21 ☐
 over 21 ☐

(1 unit = 1 measure spirits/half pint beer/
 lager/1 glass wine)

Mobile without aid ☒
 Mobile with aid ☐
 (Specify type/side held: _____)
 Furniture walking ☐
 Chair Bound ☐
 Housebound ☐

(Please print name in block capitals)

CANCINNES

Signature: CM Ennes

Designation: SW

Countersigned (if applicable):

Large empty lined area for additional notes or observations.

Name:

Ward:

Date: 1/1/02

Case Record No.: 623238

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	

1/1/02		Admitted via A/E O/A	
		Recordings - satisfactory O ₂ sats 99% on air	
		Painfree For ME screen.	CMGunes
2/1/02	7AM	Slept well Painfree	
		Recordings - stable	CMGunes.
	11AM	Await CK if negative home no reports of chest pain vital signs stable maintaining rectal at present	✓ (C) LENEW100
		OK 81 - discharged home on Dr Cann	

[illegible]

Notes for Users

FOR DOCTORS:

1. Sign your name clearly against each prescription.
2. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date appropriate boxes.
3. If an existing prescription is to be modified, delete existing prescription as described and re-write new instructions in a new section.
4. Use approved names in **BLOCK LETTERS** and use metric doses as follows:

Milligram = mg Gram = g
 Millilitre = ml Microgram; to be written in full.

Fractions of a milligram should be written in micro grams. A zero should be written in front of a decimal point where there is no other figure, e.g. 0.5ml **not** .5ml.

5. Method of administration should be abbreviated as follows:

Intravenous = IV	Oral = O
Subcutaneous = SC	Per rectum = PR
Inhalations = INH	Topical = TOP
Sublingual = SL	Nasogastric = NG
Intramuscular = IM	Vaginal = PV
Intradermal = ID	

1. The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.
2. Ensure entry is made on administration record each time drug is given. Initial in relevant date column and time row.
3. Check that all drugs prescribed at a certain time are administered.
4. If drug is not administered, enter reason in appropriate box using the undernoted coding system.

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

Hospital Name:

PATIENT DETAILS			ONCE ONLY AND PREMEDICATION DRUGS						
Name: MARY WATSON	Height:	DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF DOCTOR	GIVEN BY	TIME GIVEN
Hospital Number: 628238	Weight:	11/01	BUCCAL SUSCALD	2mg	oal	10:00	NO		
DOB: 06 03 54	Surface area:								
if Admission: 01/01/02	Date of writing discharge prescription: 1/1								
Illant Name: DOVER	Ward: L3M								
Date and time this form prepared: 01/01/02 Time: 9:30	Sheet No	2nd Prescription in use							
		Yes or NO							
DRUG SENSITIVITIES									
Septin									
DVT Risk on Admission (SIGN Guideline)									
High ☐ Moderate ☐ Low ☐									
Assessed by: Date: 1/1									
OTHER CHARTS IN USE									
Insulin ☐ TPN: ☐									
PCA and other infusions ☐ Enteral Nutrition: ☐									
Anticoagulants: Heparin ☐ Other: ☐									
Oral ☐									
Topical: ☐									

PATIENT'S NAME:				ADMINISTRATION																									
Parenteral Drugs: Regular Prescription				DATE →																									
				MONTH →																									
A	DRUG			Other time																									
DOSE			ROUTE	DATE	DATE:																								
SIGNATURE OF DOCTOR			INITIALS:		1200-1400																								
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			2200-2400																										
			Other time																										
← FOR DOCTORS USE ONLY →																													
B	DRUG			Other time																									
DOSE			ROUTE	DATE	DATE:																								
SIGNATURE OF DOCTOR			INITIALS:		1200-1400																								
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			1500-1800																										
			2200-2400																										
			Other time																										
← FOR DOCTORS USE ONLY →																													
C	DRUG			Other time																									
DOSE			ROUTE	DATE	DATE:																								
SIGNATURE OF DOCTOR			INITIALS:		1200-1400																								
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			1500-1800																										
			2200-2400																										
			Other time																										
← FOR DOCTORS USE ONLY →																													
D	DRUG			Other time																									
DOSE			ROUTE	DATE	DATE:																								
SIGNATURE OF DOCTOR			INITIALS:		1200-1400																								
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			1500-1800																										
			2200-2400																										
			Other time																										
← FOR DOCTORS USE ONLY →																													

Parenteral Drugs: Regular Prescription				DATE →																									
				MONTH →																									
E	DRUG			Other time																									
DOSE			ROUTE	DATE	DATE:																								
SIGNATURE OF DOCTOR			INITIALS:		1200-1400																								
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			1500-1800																										
			2200-2400																										
			Other time																										
← FOR DOCTORS USE ONLY →																													
F	DRUG			Other time																									
DOSE			ROUTE	DATE	DATE:																								
SIGNATURE OF DOCTOR			INITIALS:		1200-1400																								
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			1500-1800																										
			2200-2400																										
			Other time																										
← FOR DOCTORS USE ONLY →																													
G	DRUG			Other time																									
DOSE			ROUTE	DATE	DATE:																								
SIGNATURE OF DOCTOR			INITIALS:		1200-1400																								
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			1500-1800																										
			2200-2400																										
			Other time																										
← FOR DOCTORS USE ONLY →																													
H	DRUG			Other time																									
DOSE			ROUTE	DATE	DATE:																								
SIGNATURE OF DOCTOR			INITIALS:		1200-1400																								
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			1500-1800																										
			2200-2400																										
			Other time																										
← FOR DOCTORS USE ONLY →																													

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

PATIENT'S NAME:				ADMINISTRATION																										
Oral and Other Drugs: Regular Prescriptions				DATE →																										
				MONTH →																										
T	DRUG			Other time																										
DOSE			ROUTE	DATE	DATE:																									
SIGNATURE OF DOCTOR			STOPPED		INITIALS:																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			1200-1400		1600-1800																									
			2200-2400		Other time																									
← FOR DOCTORS USE ONLY →																														

V	DRUG			Other time																										
DOSE			ROUTE	DATE	DATE:																									
SIGNATURE OF DOCTOR			STOPPED		INITIALS:																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			1200-1400		1600-1800																									
			2200-2400		Other time																									
← FOR DOCTORS USE ONLY →																														

W	DRUG			Other time																										
DOSE			ROUTE	DATE	DATE:																									
SIGNATURE OF DOCTOR			STOPPED		INITIALS:																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			1200-1400		1600-1800																									
			2200-2400		Other time																									
← FOR DOCTORS USE ONLY →																														

X	DRUG			Other time																										
DOSE			ROUTE	DATE	DATE:																									
SIGNATURE OF DOCTOR			STOPPED		INITIALS:																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			1200-1400		1600-1800																									
			2200-2400		Other time																									
← FOR DOCTORS USE ONLY →																														

Oral and Other Drugs: Regular Prescriptions				DATE →																										
				MONTH →																										
Y	DRUG			Other time																										
DOSE			ROUTE	DATE	DATE:																									
SIGNATURE OF DOCTOR			STOPPED		INITIALS:																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			1200-1400		1600-1800																									
			2200-2400		Other time																									
← FOR DOCTORS USE ONLY →																														

AA	DRUG			Other time																										
DOSE			ROUTE	DATE	DATE:																									
SIGNATURE OF DOCTOR			STOPPED		INITIALS:																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			1200-1400		1600-1800																									
			2200-2400		Other time																									
← FOR DOCTORS USE ONLY →																														

BB	DRUG			Other time																										
DOSE			ROUTE	DATE	DATE:																									
SIGNATURE OF DOCTOR			STOPPED		INITIALS:																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			1200-1400		1600-1800																									
			2200-2400		Other time																									
← FOR DOCTORS USE ONLY →																														

CC	DRUG			Other time																										
DOSE:			ROUTE	DATE	DATE:																									
SIGNATURE OF DOCTOR			STOPPED		INITIALS:																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			1200-1400		1600-1800																									
			2200-2400		Other time																									
← FOR DOCTORS USE ONLY →																														

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

LIFE PREPARED FOR THE NATIONAL MEDICAL SOCIETY OF THE UNITED STATES OF AMERICA

PATIENT'S NAME:				ADMINISTRATION																									
Oral and Other Drugs: Regular Prescriptions				DATE →																									
				MONTH →																									
DD DRUG				Other time																									
DOSE ROUTE DATE				DATE:																									
SIGNATURE OF DOCTOR				INITIALS:																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																									
← FOR DOCTORS USE ONLY →																													

EE DRUG				Other time																									
DOSE ROUTE DATE				DATE:																									
SIGNATURE OF DOCTOR				INITIALS:																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																									
← FOR DOCTORS USE ONLY →																													

FF DRUG				Other time																									
DOSE ROUTE DATE				DATE:																									
SIGNATURE OF DOCTOR				INITIALS:																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																									
← FOR DOCTORS USE ONLY →																													

GG DRUG				Other time																									
DOSE ROUTE DATE				DATE:																									
SIGNATURE OF DOCTOR				INITIALS:																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																									
← FOR DOCTORS USE ONLY →																													

HH DRUG				Other time																									
DOSE ROUTE DATE				DATE:																									
SIGNATURE OF DOCTOR				INITIALS:																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																									
← FOR DOCTORS USE ONLY →																													

JJ DRUG				Other time																									
DOSE ROUTE DATE				DATE:																									
SIGNATURE OF DOCTOR				INITIALS:																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																									
← FOR DOCTORS USE ONLY →																													

KK DRUG				Other time																									
DOSE ROUTE DATE				DATE:																									
SIGNATURE OF DOCTOR				INITIALS:																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																									
← FOR DOCTORS USE ONLY →																													

LL DRUG				Other time																									
DOSE ROUTE DATE				DATE:																									
SIGNATURE OF DOCTOR				INITIALS:																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																									
← FOR DOCTORS USE ONLY →																													

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

PATIENT'S NAME:			ADMINISTRATION															
All Routes: As Required Prescriptions																		
MM	DRUG: CO-CODAMOL		STOPPED	DATE:														
	DOSE: 2 TABS																	
	ROUTE: ORAL																	
	INDICATION: PAIN																	
SIGNATURE OF DOCTOR: <i>[Signature]</i>			MAX. FREQUENCY: 3 TABS/24 ⁰		DATE: 2/1/02													
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																		

NN	DRUG:		STOPPED	DATE:														
	DOSE:																	
	ROUTE:																	
	INDICATION:																	
SIGNATURE OF DOCTOR:			MAX. FREQUENCY:		DATE:													
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																		

PP	DRUG:		STOPPED	DATE:														
	DOSE:																	
	ROUTE:																	
	INDICATION:																	
SIGNATURE OF DOCTOR:			MAX. FREQUENCY:		DATE:													
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																		

RR	DRUG:		STOPPED	DATE:														
	DOSE:																	
	ROUTE:																	
	INDICATION:																	
SIGNATURE OF DOCTOR:			MAX. FREQUENCY:		DATE:													
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																		

SS	DRUG:		STOPPED	DATE:														
	DOSE:																	
	ROUTE:																	
	INDICATION:																	
SIGNATURE OF DOCTOR:			MAX. FREQUENCY:		DATE:													
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																		

TRUG	DRUG:		STOPPED	DATE:														
	DOSE:																	
	ROUTE:																	
	INDICATION:																	
SIGNATURE OF DOCTOR:			MAX. FREQUENCY:		DATE:													
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																		

VV	DRUG:		STOPPED	DATE:														
	DOSE:																	
	ROUTE:																	
	INDICATION:																	
SIGNATURE OF DOCTOR:			MAX. FREQUENCY:		DATE:													
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																		

WW	DRUG:		STOPPED	DATE:														
	DOSE:																	
	ROUTE:																	
	INDICATION:																	
SIGNATURE OF DOCTOR:			MAX. FREQUENCY:		DATE:													
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																		

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

1. 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 10 mins after I/V, 1 hour after I/M or oral analgesia.

Sustained pain score of 2 or pain score of 3 requires intervention.

2. 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 intervention.

3. Nausea Score

0 = No Nausea

1 = Mild (No Rx wanted)

2 = Moderate (Rx required)

3 = Severe (clinical problem persists despite Rx)

Review 1 hour after Rx. Inform doctor if additional Rx required.

Name: Mary Watson

Ward: 68
Amman

Date: 11/02

Case Record No.: 623238

CARE PLAN

[illegible]

[illegible]

Yes ☐ N/A ☐

Date: 01/01/02



- Part of North Glasgow University Hospitals NHS Trust

Pressure Sore Risk Assessment Documentation Form

Patient Name: Mary Watson

Case Record Number: 623238

Ward: CGAMAU

Waterlow Risk Assessment		Initials														
		Date														
		No.	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Body weight for height:	Average Above average Obese Below average	0 1 2 3														
Continence:	Completely catheterised Occasionally incontinent Cath. Incontinence of faeces Doubly incontinent	0 1 2 3														
Skin type-visual risk areas:	Healthy Tissue paper/dry Oedematous clammy (temp ↑) Discoloured Broken spot	0 1 1 2 3														
Mobility:	Fully Restless/fidgety Apathetic Restricted Inert/traction Chairbound	0 1 2 3 4 5														
Age/Sex:	Male/Female 14-49 50-64 65-74 75-80 80+	½ 1 2 3 4 5														
Appetite:	Average Poor NG Tube/fluids only nbm - Anorexic	0 1 2 3														
Special risks - tissue malnutrition:	eg Terminal cachexia Cardiac failure Peripheral vascular disease Anaemia Smoking	8 5 5 2 1														
Neurological deficit:	Motor-sensory paraplegia eg diabetes, MS, CVA	4-6														
Major surgery/trauma:	Orthopaedic Below waist, Spinal On table > 2 hours	 5 5														
Medication:	Cytotoxics, High dose steroids Anti-inflammatory	 4														
TOTAL SCORE																

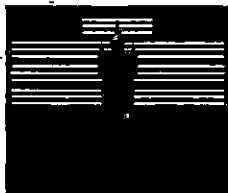
Score: <10 = low risk; 10-14 = at risk; 15-19 = high risk; 20+ = very high risk

CLASSIFICATION OF PRESSURE DAMAGE (TORRANCE)

Grade one	= blanching hyperaemia
Grade two	= non blanching hyperaemia/superficial break
Grade three	= through to subcutaneous tissue
Grade four	= through to underlying muscle
Grade five	= through to bone or presence of necrotic tissue

[illegible]

ENSURE ALL ACTION IS DOCUMENTED IN THE NURSING CARE PLAN



Patient Profile

Ward: L8 MED Date: 30/7/01 Time: _____ (24hr clock)

Please print clearly in BLOCK CAPITALS

Title: MRS
Name: MARY WATSON
Preferred name: _____
Address: 28 KENDRON AVE
Post Code: G15 8AX
Tel: 944 9973
DOB: 06-03-54 Age: 47
Hosp. No: 623238
Occupation: HOUSEWIFE
Religion: COES
S.O.S. ☐ date: ☐☐☐☐☐☐
Interpreter required: ☐
(specify: _____)
Lives alone ☐

Consultant: DR DOVER
Named Nurse ①: J. ANTONELLI
Admitting Nurse: P. COCKAYNE
Named Nurse ②: _____
Relatives seen by Doctor ☐

1 NOK/Friend/Contact: ARLENE WATSON
Address: 6 TALLANT TERR
GLASGOW
Day: 944 9209
Night: _____
Relationship: DAUGHTER
2 NOK/Friend/Contact: _____
Address: _____
Day: _____
Night: _____
Relationship: _____
NOK informed of admission ☐
NOK informed by: _____
GP: LYON
Address: DRUMCHAPEL H/C
Tel: _____

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

PERSONAL BELONGINGS
Clothing listed ☐
Valuables listed ☐
Valuables in ward ☐
Valuables in hospital safe ☐

REASON FOR ADMISSION
4/7 WORKING (R) ANTERIOR
BURNING CHEST PAIN
RADIATING TO BACK
≈ SOB & LOUGH
Patient's perception of illness: _____
Diagnosis: LRTI ON
BACKGROUND OF PREVIOUS
BREAST CA
+ FH OF IHD
Operation/Treatment: _____
D-DIMERS BLOOD CULTURES,
CXR ECG-SR & T INVERSION III
MIS AMOXICILLIN
SPUTUM C&S, MSSU
Relevant PMH: BREAST CA
LUMPECTOMY & CHEMO/RADIO-
THERAPY 1998, CA CAPEC
1993 - RADICAL HYSTERECTOMY
HYPERTENSION ? MI

OBSERVATIONS ON ADMISSION
Temperature 36.4 °C
Pulse 81 bpm
BP 136/91
Resp 97%
Pain Score 0
Urinalysis NAD
Waterlow Score 8
Height _____ m
Weight _____ kg
Body Mass Index _____
Blood sugar(if appropriate) _____ mmols
Allergies Yes ☐ No ☐
details: SEPTIN

DISCHARGE PLANNING

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

Venfon ant ✓ *gr*

ACTIVITIES OF DAILY LIVING

HOME CIRCUMSTANCES:

Lives with family DAUGHTER ☒

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: TRIES TO AVOID STAIRS
DUE TO BREATHLESSNESS

DIET:

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): _____

EXERCISE:

1. No symptoms ☐

2. Breathless with moderate exercise ☐

3. Breathless with minimal exertion ☒

4. Breathless at rest ☐

5. Uses inhalers ☐

Comments: _____

SMOKING:

Non-smoker ☐

Smoker: 4 per day ☒

Ex-smoker ☐

Aware of hospital policy ☒

ALSO USING NICOTINE PATCHES

HYGIENE:

Bath ☐ Shower ☒

Requires assistance ☐ Stand up wash ☐

Skin assessment: INTACT

Other: _____

FLU/MINIBOWEL:

Bowels regular ☐

Constipated ☐

Diarrhoea/Loose stools ☐

Uses aperient ENEMAS, SELF ☐

Has stoma: ADMINISTERING ☐

- Colostomy ☐
- Urostomy ☐
- Ileostomy ☐

appliances used: _____

Frequency of micturition: ☐

Incontinent: urine/faeces ☐

day/night ☐

stress ☐

No urinary symptoms ☐

Comments: _____

SLEEP:

Hours/night POOR SLEEP ☐

Medication PATIENT ☐

details: _____

MENTAL STATE:

Alert/Orientated ☒

Confused: day/night ☐

Anxious/Distressed ☐

Unconscious ☐

Other (specify): _____

Case Record No.: 623238

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
30/7/01	01.45		Pain free on admission. Appended, observations satisfactory. Anxious on admission, reassurance given ttr. To commence oral antibiotics more. For MIS Green and odours. WCU and sputum specimens awaited.	Phelan
	0700		Patient remains very anxious despite reassurance. Given 400mg oral ibuprofen for discomfort. Observations remain stable. Urinalysis NAD. Given further 400mg ibuprofen of waking. JHO informed.	Phelan
	1125		Settled morning Observations satisfactory and discharged Reviewed by medical staff CK negative at 48 Awaiting review by cardiology for possible discharge home. Information leaflet on smoking given by medical staff No other complaints at this time	Phelan

[illegible]

Notes for Users

(Maximum number of doses as per protocol)

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

DOCTOR'S DECLARATION (if required by Local Protocol)

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

Signature: _____ Date: _____

[illegible]

FOR DOCTORS:

1. Sign your name clearly against each prescription.
2. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date appropriate boxes.
3. If an existing prescription is to be modified, delete existing prescription as described and re-write new instructions in a new section.
4. Use approved names in **BLOCK LETTERS** and use metric doses as follows:

Milligram = mg Gram = g
 Millilitre = ml Microgram: to be written in full.

Fractions of a milligram should be written in micro grams. A zero should be written in front of a decimal point where there is no other figure, e.g. 0.5ml not .5ml.

5. Method of administration should be abbreviated as follows:

Intravenous = IV	Oral = O
Subcutaneous = SC	Per rectum = PR
Inhalations = INH	Topical = TOP
Sublingual = SL	Nasogastric = NG
Intramuscular = IM	Vaginal = PV
Intradermal = ID	

FOR NURSES:

1. The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.
2. Ensure entry is made on administration record each time drug is given. Initial in relevant date column and time row.
3. Check that all drugs prescribed at a certain time are administered.
4. If drug is not administered, enter reason in appropriate box using the undernoted coding system.

Codes for Non-Administration of Drugs

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

PREScription FORM

Hospital Name:

PATIENT DETAILS			ONCE ONLY AND PREMEDICATION DRUGS						
Name: MARY WATSON	Height:	DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF DOCTOR	GIVEN BY	TIME GIVEN
Hospital Number: 623238	Weight:								
DOB: 6.3.54	Surface area:								
Admission: 29.7.01	Date of writing discharge prescription: / /								
Attendant Name: DOVER	Ward:								
Date and time this form prepared: / / Time: :	Sheet No:	2nd Prescription in use Yes or NO							
DRUG SENSITIVITIES									
SEPTUM									
DVT Risk on Admission (SIGN Guideline)									
High ☐ Moderate ☐ Low ☐									
Assessed by: Date: / /									
OTHER CHARTS IN USE									
Insulin ☐ TPN: ☐									
PCA and other infusions ☐ Enteral Nutrition: ☐									
Anticoagulants: Heparin ☐ Other: ☐									
Oral ☐									
Topical: ☐									

PATIENT'S NAME:

ADMINISTRATION

Parenteral Drugs: Regular Prescription

DATE

MONTH

A

DRUG

DOSE

ROUTE

DATE

DATE:

SIGNATURE OF DOCTOR

STOPPED

INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time

0700-0900

1200-1400

1600-1800

2200-2400

Other time

FOR DOCTORS USE ONLY

B

DRUG

DOSE

ROUTE

DATE

DATE:

SIGNATURE OF DOCTOR

STOPPED

INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time

0700-0900

1200-1400

1600-1800

2200-2400

Other time

FOR DOCTORS USE ONLY

C

DRUG

DOSE

ROUTE

DATE

DATE:

SIGNATURE OF DOCTOR

STOPPED

INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time

0700-0900

1200-1400

1600-1800

2200-2400

Other time

FOR DOCTORS USE ONLY

D

DRUG

DOSE

ROUTE

DATE

DATE:

SIGNATURE OF DOCTOR

STOPPED

INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time

0700-0900

1200-1400

1600-1800

2200-2400

Other time

FOR DOCTORS USE ONLY

Parenteral Drugs: Regular Prescription

DATE

MONTH

E

DRUG

DOSE

ROUTE

DATE

DATE:

SIGNATURE OF DOCTOR

STOPPED

INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time

0700-0900

1200-1400

1600-1800

2200-2400

Other time

FOR DOCTORS USE ONLY

F

DRUG

DOSE

ROUTE

DATE

DATE:

SIGNATURE OF DOCTOR

STOPPED

INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time

0700-0900

1200-1400

1600-1800

2200-2400

Other time

FOR DOCTORS USE ONLY

G

DRUG

DOSE

ROUTE

DATE

DATE:

SIGNATURE OF DOCTOR

STOPPED

INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time

0700-0900

1200-1400

1600-1800

2200-2400

Other time

FOR DOCTORS USE ONLY

H

DRUG

DOSE

ROUTE

DATE

DATE:

SIGNATURE OF DOCTOR

STOPPED

INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time

0700-0900

1200-1400

1600-1800

2200-2400

Other time

FOR DOCTORS USE ONLY

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

Oral and Other Drugs: Regular Prescriptions				DATE →																					
N	DRUG			DOSE	ROUTE	DATE	DATE: INITIALS:	STOPPED	MONTH →																
	SIGNATURE OF DOCTOR																								
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY									Other time																
									0700-0900																
									1200-1400																
									1500-1800																
									2200-2400																
									Other time																
← FOR DOCTORS USE ONLY →																									
P	DRUG			DOSE	ROUTE	DATE	DATE: INITIALS:	STOPPED	Other time																
	SIGNATURE OF DOCTOR																								
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY									Other time																
									0700-0900																
									1200-1400																
									1500-1800																
									2200-2400																
									Other time																
← FOR DOCTORS USE ONLY →																									
R	DRUG			DOSE	ROUTE	DATE	DATE: INITIALS:	STOPPED	Other time																
	SIGNATURE OF DOCTOR																								
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY									Other time																
									0700-0900																
									1200-1400																
									1500-1800																
									2200-2400																
									Other time																
← FOR DOCTORS USE ONLY →																									
S	DRUG			DOSE	ROUTE	DATE	DATE: INITIALS:	STOPPED	Other time																
	SIGNATURE OF DOCTOR																								
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY									Other time																
									0700-0900																
									1200-1400																
									1500-1800																
									2200-2400																
									Other time																
← FOR DOCTORS USE ONLY →																									

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

PATIENT'S NAME:				ADMINISTRATION																									
Oral and Other Drugs: Regular Prescriptions				DATE																									
				MONTH																									
T	DRUG			Other time																									
				0700-0900																									
DOSE ROUTE DATE				DATE:																									
				1200-1400																									
SIGNATURE OF DOCTOR				INITIALS:																									
				1600-1800																									
				2200-2400																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																									
← FOR DOCTORS USE ONLY →																													
V	DRUG			Other time																									
				0700-0900																									
DOSE ROUTE DATE				DATE:																									
				1200-1400																									
SIGNATURE OF DOCTOR				INITIALS:																									
				1600-1800																									
				2200-2400																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																									
← FOR DOCTORS USE ONLY →																													
W	DRUG			Other time																									
				0700-0900																									
DOSE ROUTE DATE				DATE:																									
				1200-1400																									
SIGNATURE OF DOCTOR				INITIALS:																									
				1600-1800																									
				2200-2400																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																									
← FOR DOCTORS USE ONLY →																													
X	DRUG			Other time																									
				0700-0900																									
DOSE ROUTE DATE				DATE:																									
				1200-1400																									
SIGNATURE OF DOCTOR				INITIALS:																									
				1600-1800																									
				2200-2400																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																									
← FOR DOCTORS USE ONLY →																													

Oral and Other Drugs: Regular Prescriptions				DATE																									
				MONTH																									
Y	DRUG			Other time																									
				0700-0900																									
DOSE ROUTE DATE				DATE:																									
				1200-1400																									
SIGNATURE OF DOCTOR				INITIALS:																									
				1600-1800																									
				2200-2400																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																									
← FOR DOCTORS USE ONLY →																													
AA	DRUG			Other time																									
				0700-0900																									
DOSE ROUTE DATE				DATE:																									
				1200-1400																									
SIGNATURE OF DOCTOR				INITIALS:																									
				1600-1800																									
				2200-2400																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																									
← FOR DOCTORS USE ONLY →																													
BB	DRUG			Other time																									
				0700-0900																									
DOSE ROUTE DATE				DATE:																									
				1200-1400																									
SIGNATURE OF DOCTOR				INITIALS:																									
				1600-1800																									
				2200-2400																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																									
← FOR DOCTORS USE ONLY →																													
CC	DRUG			Other time																									
				0700-0900																									
DOSE ROUTE DATE				DATE:																									
				1200-1400																									
SIGNATURE OF DOCTOR				INITIALS:																									
				1600-1800																									
				2200-2400																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time																									
← FOR DOCTORS USE ONLY →																													

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

PATIENT'S NAME:				ADMINISTRATION																									
Oral and Other Drugs: Regular Prescriptions				DATE																									
				MONTH																									
DD DRUG				Other time																									
DOSE ROUTE DATE				DATE:		0700-0900																							
SIGNATURE OF DOCTOR				INITIALS:		1200-1400																							
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				STOPPED		1600-1800																							
						2200-2400																							
						Other time																							

EE DRUG				Other time																									
DOSE ROUTE DATE				DATE:		0700-0900																							
SIGNATURE OF DOCTOR				INITIALS:		1200-1400																							
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				STOPPED		1600-1800																							
						2200-2400																							
						Other time																							

FF DRUG				Other time																									
DOSE ROUTE DATE				DATE:		0700-0900																							
SIGNATURE OF DOCTOR				INITIALS:		1200-1400																							
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				STOPPED		1600-1800																							
						2200-2400																							
						Other time																							

GG DRUG				Other time																									
DOSE ROUTE DATE				DATE:		0700-0900																							
SIGNATURE OF DOCTOR				INITIALS:		1200-1400																							
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				STOPPED		1600-1800																							
						2200-2400																							
						Other time																							

Oral and Other Drugs: Regular Prescriptions				DATE																									
				MONTH																									
HH DRUG				Other time																									
DOSE ROUTE DATE				DATE:		0700-0900																							
SIGNATURE OF DOCTOR				INITIALS:		1200-1400																							
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				STOPPED		1600-1800																							
						2200-2400																							
						Other time																							

JJ DRUG				Other time																									
DOSE ROUTE DATE				DATE:		0700-0900																							
SIGNATURE OF DOCTOR				INITIALS:		1200-1400																							
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				STOPPED		1600-1800																							
						2200-2400																							
						Other time																							

KK DRUG				Other time																									
DOSE ROUTE DATE				DATE:		0700-0900																							
SIGNATURE OF DOCTOR				INITIALS:		1200-1400																							
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				STOPPED		1600-1800																							
						2200-2400																							
						Other time																							

LL DRUG				Other time																									
DOSE ROUTE DATE				DATE:		0700-0900																							
SIGNATURE OF DOCTOR				INITIALS:		1200-1400																							
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				STOPPED		1600-1800																							
						2200-2400																							
						Other time																							

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

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

_____ I agree that the patient should be treated with the following medication: _____

_____ I agree that the patient should be treated with the following medication: _____

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



BP, TPR and Pain Assessment Chart

Name: MAR/ WATSON.

Case Record No.: 623238

DOB: 06-03-54

Ward: L8 M Consultant: DR DOVER

1. Pain Score

2. Sedation Score

3. Nausea Score

See reverse for scoring details

Date	30/7/01				
Time	09:00:10				
Pain Score	0 1 1				
Sedation Score	0 0 0				
Nausea Score	0 0 0				
Nurse Initials	Re. Re. Re.				
Temperature	C°				
	40				
	39				
	38				
	37				
	36				
	35				
	210				
	200				
	190				
BP	180				
	170				
	160				
	150				
	140				
	130				
	120				
	110				
	100				
	90				
Pulse	80				
	70				
	60				
	50				
	40				
	30				
	RESPS				
	SaO2	97 97 99			
	Bowels				

1. 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 10 mins after I/V, 1 hour after I/M or oral analgesia.

Sustained pain score of 2 or pain score of 3 requires intervention.

2. Sedation Score

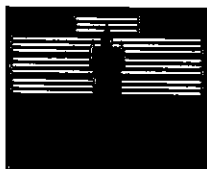
- 0 = Awake, alert, orientated
- 1 = Mild, aroused by verbal stimulus
- 2 = Moderate, aroused by physical stimulus
- 3 = Severe, no response
- S = Normal sleep, easy to rouse

Score 2 or 3 requires intervention.

3. Nausea Score

- 0 = No Nausea
- 1 = Mild (No Rx wanted)
- 2 = Moderate (Rx required)
- 3 = Severe (clinical problem persists despite Rx)

Review 1 hour after Rx. Inform doctor if additional Rx required.



- Part of North Glasgow University Hospitals NHS Trust

Pressure Sore Risk Assessment Documentation Form

Patient Name: MARY WATSON

Case Record Number: 623238

Ward: L8 MED

Waterlow Risk Assessment		Initials														
		Date														
		No.	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Body weight for height:	Average 0 Above average 1 Obese 2 Below average 3															
Continence:	Completely catheterised 0 Occasionally incontinent 1 Cath. Incontinence of faeces 2 Doubly incontinent 3															
Skin type-visual risk areas:	Healthy 0 Tissue paper/dry 1 Oedematous clammy (temp ↑) 1 Discoloured 2 Broken spot 3															
Mobility:	Fully 0 Restless/fidgety 1 Apathetic 2 Restricted 3 Inert/traction 4 Chairbound 5															
Age/Sex:	Male/Female ½ 14-49 1 50-64 2 65-74 3 75-80 4 80+ 5															
Appetite:	Average 0 Poor 1 NG Tube/fluids only 2 nbm - Anorexic 3															
Special risks - tissue malnutrition:	eg Terminal cachexia 8 Cardiac failure 5 Peripheral vascular disease 5 Anaemia 2 Smoking 1															
Neurological deficit:	Motor-sensory paraplegia 4-6 eg diabetes, MS, CVA															
Major surgery/trauma:	Orthopaedic Below waist, Spinal 5 On table > 2 hours 5															
Medication:	Cytotoxics, High dose steroids 4 Anti-inflammatory															
TOTAL SCORE																

Score: <10 = low risk; 10-14 = at risk; 15-19 = high risk; 20+ = very high risk

CLASSIFICATION OF PRESSURE DAMAGE (TORRANCE)

[illegible]

Designed & Produced by Department of Medical Illustration MID Job No. 99/1694

MARY
WATSON

Date: 30/7/01

623238

[illegible]

[illegible]

Page 6 of 8

(Maximum number of doses as per protocol)

DOCTOR'S DECLARATION (if required by Local Protocol)

Signature: _____ Date: _____

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

[illegible]

FOR DOCTORS:

5. Method of administration should be abbreviated as follows:

- | | | | | | |
|---------------|---|-----|-------------|---|-----|
| Intravenous | = | IV | Oral | = | O |
| Subcutaneous | = | SC | Per rectum | = | PR |
| Inhalations | = | INH | Topical | = | TOP |
| Sublingual | = | SL | Nasogastric | = | NG |
| Intramuscular | = | IM | Vaginal | = | PV |
| Intradermal | = | ID | | | |

FOR NURSES:

1. The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.
2. Ensure entry is made on administration record each time drug is given. Initial in relevant date column and time row.
3. Check that all drugs prescribed at a certain time are administered.
4. If drug is not administered, enter reason in appropriate box using the undernoted coding system.

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

Hospital Name:

PATIENT DETAILS			ONCE ONLY AND PREMEDICATION DRUGS						
Name:	Height:	DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF DOCTOR	GIVEN BY	TIME GIVEN
Hospital: 623238 MARY WATSON DOB: 06/03/1954	Weight:	7/12	AMOXICILLIN	500	IV			Emilia	0600
	Surface area:	7/12	CLARITHROMYCIN	500	IV			Emilia	0600
Admission: 7/12/00	Date of writing discharge prescription: ____/____/____								
Attendant Name: PORTER	Ward:								
Date and time this form prepared: ____/____/____ Time: ____:____	Sheet No: _____	2nd Prescription in use Yes or NO							
DRUG SENSITIVITIES									
DVT Risk on Admission (SIGN Guideline)									
High ☐ Moderate ☐ Low ☐									
Assessed by: _____ Date: ____/____/____									
OTHER CHARTS IN USE									
Insulin ☐ TPN: ☐									
PCA and other infusions ☐ Enteral Nutrition: ☐									
Anticoagulants: Heparin ☐ Other: ☐									
Oral ☐									
Topical: ☐									

ADMINISTRATION

Parenteral Drugs: Regular Prescription				DATE																	
				MONTH																	
E	DRUG			DATE:	Other time																
	DOSE	ROUTE	DATE	DATE:	0700-0900																
	SIGNATURE OF DOCTOR			INITIALS:	1200-1400																
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800																
					2200-2400																
					Other time																
FOR DOCTORS USE ONLY																					
F	DRUG			DATE:	Other time																
	DOSE	ROUTE	DATE	DATE:	0700-0900																
	SIGNATURE OF DOCTOR			INITIALS:	1200-1400																
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800																
					2200-2400																
					Other time																
FOR DOCTORS USE ONLY																					
G	DRUG			DATE:	Other time																
	DOSE	ROUTE	DATE	DATE:	0700-0900																
	SIGNATURE OF DOCTOR			INITIALS:	1200-1400																
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800																
					2200-2400																
					Other time																
FOR DOCTORS USE ONLY																					
H	DRUG			DATE:	Other time																
	DOSE	ROUTE	DATE	DATE:	0700-0900																
	SIGNATURE OF DOCTOR			INITIALS:	1200-1400																
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800																
					2200-2400																
					Other time																
FOR DOCTORS USE ONLY																					

he required and, as required medicines, solutions, syringes, etc., to be delivered at such reasonable rates as to enable him to obtain them at a reasonable price.

PATIENT'S NAME:				ADMINISTRATION																							
Oral and Other Drugs: Regular Prescriptions J DRUG <u>Amoxicillin</u> DOSE <u>20mg</u> ROUTE <u>PO</u> DATE <u>7/12</u> SIGNATURE OF DOCTOR _____ ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY _____ DATE <u>7/8</u> MONTH <u>12/12</u> Other time _____ 0700-0900 _____ 1200-1400 _____ 1600-1800 _____ 2200-2400 _____ Other time _____																											
FOR DOCTORS USE ONLY																											
K DRUG <u>Clarithromycin</u> DOSE <u>500mg</u> ROUTE <u>oral</u> DATE <u>7/12</u> SIGNATURE OF DOCTOR <u>[Signature]</u> ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY _____																											
FOR DOCTORS USE ONLY																											
L DRUG <u>ASPIRIN</u> DOSE <u>300mg</u> ROUTE <u>Oral</u> DATE <u>8/12</u> SIGNATURE OF DOCTOR <u>[Signature]</u> ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY _____																											
FOR DOCTORS USE ONLY																											
M DRUG <u>DIFFLAM MONTH WASH</u> DOSE <u>9mg</u> ROUTE <u>gagles</u> DATE <u>8/12</u> SIGNATURE OF DOCTOR <u>[Signature]</u> ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY _____																											
FOR DOCTORS USE ONLY																											

Oral and Other Drugs: Regular Prescriptions N DRUG _____ DOSE _____ ROUTE _____ DATE _____ SIGNATURE OF DOCTOR _____ ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY _____																											
FOR DOCTORS USE ONLY																											
P DRUG _____ DOSE _____ ROUTE _____ DATE _____ SIGNATURE OF DOCTOR _____ ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY _____																											
FOR DOCTORS USE ONLY																											
R DRUG _____ DOSE _____ ROUTE _____ DATE _____ SIGNATURE OF DOCTOR _____ ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY _____																											
FOR DOCTORS USE ONLY																											
S DRUG _____ DOSE _____ ROUTE _____ DATE _____ SIGNATURE OF DOCTOR _____ ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY _____																											
FOR DOCTORS USE ONLY																											

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

PATIENT'S NAME:		ADMINISTRATION	
Oral and Other Drugs: Regular Prescriptions		DATE	
		MONTH	
T	DRUG	Other time	
DOSE	ROUTE	DATE	DATE:
			STOPPED INITIALS:
SIGNATURE OF DOCTOR			
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			

FOR DOCTORS USE ONLY			
V	DRUG	Other time	
DOSE	ROUTE	DATE	DATE:
			STOPPED INITIALS:
SIGNATURE OF DOCTOR			
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			

FOR DOCTORS USE ONLY			
W	DRUG	Other time	
DOSE	ROUTE	DATE	DATE:
			STOPPED INITIALS:
SIGNATURE OF DOCTOR			
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			

FOR DOCTORS USE ONLY			
X	DRUG	Other time	
DOSE	ROUTE	DATE	DATE:
			STOPPED INITIALS:
SIGNATURE OF DOCTOR			
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			

Oral and Other Drugs: Regular Prescriptions		DATE	
		MONTH	
Y	DRUG	Other time	
DOSE	ROUTE	DATE	DATE:
			STOPPED INITIALS:
SIGNATURE OF DOCTOR			
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			

FOR DOCTORS USE ONLY			
AA	DRUG	Other time	
DOSE	ROUTE	DATE	DATE:
			STOPPED INITIALS:
SIGNATURE OF DOCTOR			
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			

FOR DOCTORS USE ONLY			
BB	DRUG	Other time	
DOSE	ROUTE	DATE	DATE:
			STOPPED INITIALS:
SIGNATURE OF DOCTOR			
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			

FOR DOCTORS USE ONLY			
CC	DRUG	Other time	
DOSE	ROUTE	DATE	DATE:
			STOPPED INITIALS:
SIGNATURE OF DOCTOR			
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			

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

Oral and Other Drugs: Regular Prescriptions				DATE	
				MONTH	
HH	DRUG			Other time	
DOSE	ROUTE	DATE	DATE:	0700-0900	
SIGNATURE OF DOCTOR			INITIALS:	1200-1400	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800	
				2200-2400	
				Other time	
FOR DOCTORS USE ONLY					
JJ	DRUG			Other time	
DOSE	ROUTE	DATE	DATE:	0700-0900	
SIGNATURE OF DOCTOR			INITIALS:	1200-1400	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800	
				2200-2400	
				Other time	
FOR DOCTORS USE ONLY					
KK	DRUG			Other time	
DOSE	ROUTE	DATE	DATE:	0700-0900	
SIGNATURE OF DOCTOR			INITIALS:	1200-1400	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800	
				2200-2400	
				Other time	
FOR DOCTORS USE ONLY					
LL	DRUG			Other time	
DOSE	ROUTE	DATE	DATE:	0700-0900	
SIGNATURE OF DOCTOR			INITIALS:	1200-1400	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800	
				2200-2400	
				Other time	
FOR DOCTORS USE ONLY					

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

ADMINISTRATION

All Routes: As Required Prescriptions

[illegible][illegible][illegible][illegible][illegible]

DRUG			STOPPED	DATE:																												
DOSE	ROUTE	INDICATION	INITIALS	TIME																												
SIGNATURE OF DOCTOR	MAX.FREQUENCY			DOSE																												
				GIVEN BY																												
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																																

[illegible][illegible]

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

PATIENT PROFILE

Ward: L8M Date: 07/12/00 Time: 04.00 (24hr clock)

PLEASE PRINT CLEARLY IN BLOCK CAPITALS

Title: Mrs
 Name: Mary Watson
 Preferred name: _____
 Address: 28 Kardon Ave
Glasgow
 Post Code: G15 8AX
 DOB: 06/3/54 Age: 46
 Hosp. No: 623238
 Occupation: H/wife
 Religion: C of S
 S.O.S. ☐ date: ☐☐☐☐☐☐
 Interpreter required: ☐
 (specify language _____)
 Date arranged ☐☐☐☐☐☐
 Lives alone ☐

Consultant: Hunter
 Named Nurse: J. Wilson
 Admitting Nurse: P. Cockayne
 Countersigned: _____
 Relatives seen by Doctor ☐

REASON FOR ADMISSION
48 hour history flu-like symptoms.
Sudden onset of SOB & C. Pain
on @ side.
 Patient's perception of illness:
Good understanding.
 Diagnosis:
? Viral illness / Chest infection.

Operation/Treatment: IV fluids.
Blood cultures
IV abs ✓ CXR ✓
Review.

Relevant PMH: Breast Ca (lumpectomy 1996)
Cervical Ca (hysterectomy 1993)
? MI (1 year ago)
SOB/C. Pain 6 weeks ago.

1 NOK/Friend/Contact: Arlene Watson
 Address: 6 Tallat Terrace
Glasgow
 Day: 944 9209 Night: _____
 Relationship: Daughter
 2 NOK/Friend/Contact: _____
 Address: _____
 Day: _____ Night: _____
 Relationship: _____
 NOK informed of admission ☐
 NOK informed by: _____
 GP: D. Lyon
 Address: Drumchapel HC.
20/90 Kinfans Drive
 Day: _____ Night: _____

OBSERVATIONS ON ADMISSION
 Temperature 37.6 °C
 Pulse 97 bpm
 BP 112 / 67
 Resp NAD
 Pain Score 0
 Urinalysis NAD

Waterlow Score 4
 Height _____ m
 Body Mass Index Sats 96%
 Blood sugar(if appropriate) _____ mmols

MEDICATION
 With patient ☐
 Stored & receipt given ☐
 No medication required ☐
 Taken home ☐
 PERSONAL BELONGINGS
 Clothing listed ☐
 Valuables listed ☐
 Valuables in ward ☐
 Valuables in hospital safe ☐
 House keys held by: _____
 (If req'd)

ALLERGIES Yes ☒ No ☐
 details: SEPTIC

DISCHARGE PLANNING

Boarding	1st	2nd	3rd	Signature	Time	Comments/Information
Informed:						
ward	☐	☐	☐			
patient	☐	☐	☐			
relatives	☐	☐	☐			
Date patient boarded:						
1st:	☐ ☐	☐ ☐	☐ ☐			
2nd:	☐ ☐	☐ ☐	☐ ☐			
3rd:	☐ ☐	☐ ☐	☐ ☐			
EXTERNAL/INTERNAL TRANSFERS						
Transfer destination:						
Planned transfer date: ☐ ☐ ☐ ☐						
Medical consent ☒				<i>[Signature]</i>		
Arranged with receiving area ☐						
Patient informed ☒				<i>[Signature]</i>		
NOK/Contact informed ☒				<i>[Signature]</i>		
Transport: stretcher ☐						
2 hand seat chair ☐				<i>[Signature]</i>		
Escort ☐						
Case notes ☐						
X-rays ☐						
Nursing notes & Drug Form ☐						
Property/Valuables listed ☐						
Catering ☐						
Dietitian ☐						
Physiotherapist ☐						
Occupational therapist ☐						
DISCHARGE CHECKLIST						
Actual discharge date: ☐ ☐ ☐ ☐						
Medical consent ☐						
Date discussed with patient: ☐ ☐ ☐ ☐						
Date discussed with NOK/Contact: ☐ ☐ ☐ ☐						
Transport: own ☐ ambulance ☐						
Ambulance ordered on: ☐ ☐ ☐ ☐						
type:						
District nurse ☐ Liaison nurse ☐						
Home help: ☐ ☐ ☐ ☐ ☐ ☐						
Social work dept. ☐						
Discharge prescription ☐						
Discharge dressings ☐						
Patient information ☐						
Valuables/Cashier ☐						
Physiotherapy ☐						
Out patient appointment: ☐ ☐ ☐ ☐						
Other:						

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: occasional
breathlessness climbing stairs.

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): _____

BREATHING

1. No symptoms ☐
 2. Breathless with moderate exercise ☐
 3. Breathless with minimal exertion ☒
 4. Breathless at rest ☐
 5. Uses inhalers ☐
 Comments: _____

SMOKING

- Non-smoker ☐
 Smoker: 30 per day ☒
 Ex-smoker ☐
 Aware of hospital policy ☒

HYGIENE

- Bath ☐ Shower ☒
 Requires assistance ☐ Stand up wash ☐
 Skin assessment: Good
 Other: _____

ELIMINATION

- Bowels regular ☒
 Constipated ☐
 Diarrhoea/Loose stools ☐
 Uses aperient Micralax ☐
 Has stoma: enemas ☐
 • Colostomy ☐
 • Urostomy ☐
 • Ileostomy ☐
 appliances used: _____
 Frequency of micturition ☐
 Incontinent: urine/faeces ☐
 day/night ☐
 stress ☐
 No urinary symptoms ☐
 Comments: _____

SLEEP

- Hours/night 4 hours ☒
 Medication ☐
 details: _____

MENTAL STATE

- Alert/Orientated ☒
 Confused: day/night ☐
 Anxious/Distressed ☐
 Unconscious ☐
 Other (specify): _____

[illegible]

ALCOHOL INTAKE

Units/week:	nil	☒
	less than 14	☐
	14 - 21	☐
	over 21	☐

(1 unit = 1 measure spirits/half pint beer/
lager/1 glass wine)

MOBILITY (Pre-admission)	
Mobile without aid	☒
Mobile with aid	☐
(Specify type/side held: _____)	
Furniture walking	☐
Chair-Bound	☐
Housebound	☐

[illegible]

PROFILE COMPLETED BY:
(Please print name in block capitals)
P. COLEMAN
Signature: *[Signature]*
Designation: *SN*
Countersigned (if applicable):

OTHER RELEVANT INFORMATION

Name: Mary Watson

Ward: L8 Med.

Date: 07/12/00

Case Record No.: 623238

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
07/12/00	04.00		Admitted to ward with 48 hr history of flu-like symptoms and sudden onset of @ sided chest pain and SOB this morning.	
			Observations on admission - T 37.6°. Obs obs satisfactory.	
			CXR taken, bilateral shadowing evident. Blood cultures taken.	
			c/o IV fluids and IV antibiotics for review in morning. Paracetamol if c/o pain.	
	06.30		Observations - T 37.2°, BP 98/71, HR 119.	
			IVI continuing 4° Medical staff informed.	
	11.15		fairly settled morning. Independent c/o personal hygiene in bathroom area of ward.	
			IV ABs (clarithromycin 500mg) given as charted. Vented on CPD hand dislodged thereafter, resisted in @ hand. Fair diet & fluids taken. IV fluids recommenced at this time. For transfer to Brownlee Institute Gartnavel General later.	
			T: 36.7°C.	
	14.00		Care as per plan - For transfer to Brownlee centre NOK informed.	
			Observations stable.	
			IV crystalloids continue as charted.	
	15.00		IV infusion completed drinking reasonable amount for further crystalloids.	
7/12/00	16.00		TRANSFERRED TO BROWNLEE WARD	
			OBSERVATIONS SATISFACTORY ON ADMISSION.	
	20.00		SEEN BY DR ALGATEL.	
			COMMENCED ON ORAL CLARITHROMYCIN	
			PARACETAMOL 1g TAKEN FOR HEADACHE WITH EFFECT	

EVALUATION OF CARE			
DATE	TIME	EVALUATION AND PROGRESS OF CARE	SIGNATURE
8.12.00	0600	(13) Medication as filed.	
		(14) Settled & encouraging overnight	Michael
8.12.00	1500	5. Discharge instructions given	
		See by Dr. Simon	
		? TALKING INSTRUCTIONS.	
		FOR DISCHARGE HOME. NO FURTHER	
		UP EXERCISE. See in Pharmacy	Michael

Name: May Watson Ward: 68 Med. Date: 07/12/00 Case Record No.: 623238

[illegible]

[illegible]

Signature of nurse:

Date: 07/12/00

Pressure Sore Risk Assessment Documentation Form

Patient Name: Mary Watson

Case Record Number: 623238

Ward: L8 Med.

Waterlow Risk Assessment		Initials														
		Date														
		No.	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Body weight for height:	Average	0														
	Above average	1	0													
	Obese	2														
	Below average	3														
Continence:	Completely catheterised	0														
	Occasionally incontinent	1	0													
	Cath. Incontinence of faeces	2														
	Doubly incontinent	3														
Skin type-visual risk areas:	Healthy	0														
	Tissue paper/dry	1	0													
	Oedematous clammy (temp ↑)	1														
	Discoloured	2														
	Broken spot	3														
Mobility:	Fully	0														
	Restless/fidgety	1	1													
	Apathetic	2														
	Restricted	3														
	Inert/traction	4														
	Chairbound	5														
Age/Sex:	Male/Female	½														
	14-49	1	1													
	50-64	2														
	65-74	3														
	75-80	4														
	80+	5														
Appetite:	Average	0														
	Poor	1	0													
	NG Tube/fluids only	2														
	nbm - Anorexic	3														
Special risks - tissue malnutrition:	eg Terminal cachexia	8														
	Cardiac failure	5	1													
	Peripheral vascular disease	5														
	Anaemia	2														
	Smoking	1														
Neurological deficit:	Motor-sensory paraplegia	4-6	0													
	eg diabetes, MS, CVA															
Major surgery/trauma:	Orthopaedic															
	Below waist, Spinal	5	0													
	On table > 2 hours	5														
Medication:	Cytotoxics, High dose steroids	4	0													
	Anti-inflammatory															
TOTAL SCORE			3													

Score: <10 = low risk; 10-14 = at risk; 15-19 = high risk; 20+ = very high risk

CLASSIFICATION OF PRESSURE DAMAGE (TORRANCE)

[illegible]

Designed & Produced by Department of Medical Illustration MID Job No. 99/1694

Name	Case Record No.
	Age
	Sex
	Dept.
Consultant	

The 'added drugs' should be prescribed in the patient's main prescription sheet, cross referenced by annotating the "other prescription sheets in use" section

0597642

BP, TPR and Pain Assessment Chart

1. 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 10 mins after I/V, 1 hour after I/M or oral analgesia.

Sustained pain score of 2 or pain score of 3 requires intervention.

2. 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 intervention.

3. Nausea Score

- 0 = No Nausea
- 1 = Mild (No Rx wanted)
- 2 = Moderate (Rx required)
- 3 = Severe (clinical problem persists despite Rx)

Review 1 hour after Rx. Inform doctor if additional Rx required.

West Glasgow Hospitals

N.B. If using a Syringe Driver/Infusion Pump Please Use The 'Prescription And Administration Sheet For Medicines Given By Syringe Driver/Infusion Pump'

PARENTERAL FLUID PRESCRIPTION SHEET

The 'added drugs' should be prescribed in the patient's main prescription sheet, cross referenced by annotating the "other prescription sheets in use" section

Name	Case Record No.
MARY WATSON	46
Age	F
Sex	AE
Consultant	HUNTER
Dept.	

Date	FLUID	Volume (mls)	Time to Run	Rate mls/hr	ADDED DRUGS	Quantity	Doctor's Signature	Added by	Start Time (24 hr clock)	Put up	Checked by	Serial/ Batch No
7.12	(N) saline	500ml	4 ⁰		20mmol KCl				09.40			60K2084
	(N) saline	500ml	4 ⁰						11.15			

(Maximum number of doses as per protocol)

DOCTOR'S DECLARATION (if required by Local Protocol)

protocol No.(s) with the following exceptions:

Signature: _____ Date: _____

[illegible]

FOR DOCTORS:

- Fractions of a milligram should be written in micro grams. A zero should be written in front of a decimal point where there is no other figure, e.g. 0.5ml not .5ml.

- | | |
|---------------------------|-------------------------|
| Intravenous = IV | Oral = O' |
| Subcutaneous = SC | Per rectum = PR |
| Inhalations = INH | Topical = TOP |
| Sublingual = SL | Nasogastric = NG |
| Intramuscular = IM | Vaginal = PV |
| Intradermal = ID | |

FOR NURSES:

1. The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.
2. Ensure entry is made on administration record each time drug is given. Initial in relevant date column and time row.
3. Check that all drugs prescribed at a certain time are administered.
4. If drug is not administered, enter reason in appropriate box using the undernoted coding system.

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

Hospital Name: WIG

PATIENT DETAILS			ONCE ONLY AND PREMEDICATION DRUGS							
Name: <u>MARY WATSON</u>	Height:		DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF DOCTOR	GIVEN BY	TIME GIVEN
Hospital Number: <u>623238</u>	Weight:									
DOB: <u>6/3/54</u>	Surface area:									
Date of Admission: <u>9/10/00</u>	Date of writing discharge prescription: <u>1/1/</u>									
Attendant Name: <u>SAMPLE</u>	Ward: <u>LSMAD</u>									
Date and time this form prepared: <u>1/1</u> Time: <u> </u>	Sheet No <u> </u>	2nd Prescription in use <u> </u>								
DRUG SENSITIVITIES <u>* SEPTIN *</u>										
DVT Risk on Admission (SIGN Guideline) High ☐ Moderate ☐ Low ☐ Assessed by: <u> </u> Date: <u>1/1/</u>										
OTHER CHARTS IN USE Insulin ☐ TPN: ☐ PCA and other infusions ☐ Enteral Nutrition: ☐ Anticoagulants: Heparin ☐ Other: ☐ Oral ☐ Topical: ☐										

PATIENT'S NAME: MARY NATON		ADMINISTRATION	
Parenteral Drugs: Regular Prescription		DATE → 9 10 11 12	
		MONTH → 10 11 12	
A	DRUG Finzepran	Other time	
	DOSE: 10500 ROUTE: SC DATE: 9/10/12	0700-0900	
	SIGNATURE OF DOCTOR: R. H. [Signature]	1200-1400	
	STOPPED INITIALS:	1600-1800	
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	2200-2400	
	FOR DOCTORS USE ONLY	Other time	

B	DRUG	Other time	
	DOSE ROUTE DATE	0700-0900	
	SIGNATURE OF DOCTOR	1200-1400	
	STOPPED INITIALS:	1600-1800	
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	2200-2400	
	FOR DOCTORS USE ONLY	Other time	

C	DRUG	Other time	
	DOSE ROUTE DATE	0700-0900	
	SIGNATURE OF DOCTOR	1200-1400	
	STOPPED INITIALS:	1600-1800	
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	2200-2400	
	FOR DOCTORS USE ONLY	Other time	

D	DRUG	Other time	
	DOSE ROUTE DATE	0700-0900	
	SIGNATURE OF DOCTOR	1200-1400	
	STOPPED INITIALS:	1600-1800	
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	2200-2400	
	FOR DOCTORS USE ONLY	Other time	

Parenteral Drugs: Regular Prescription			
		DATE →	MONTH →
E	DRUG	Other time	
	DOSE ROUTE DATE	0700-0900	
	SIGNATURE OF DOCTOR	1200-1400	
	STOPPED INITIALS:	1600-1800	
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	2200-2400	
	FOR DOCTORS USE ONLY	Other time	

F	DRUG	Other time	
	DOSE ROUTE DATE	0700-0900	
	SIGNATURE OF DOCTOR	1200-1400	
	STOPPED INITIALS:	1600-1800	
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	2200-2400	
	FOR DOCTORS USE ONLY	Other time	

G	DRUG	Other time	
	DOSE ROUTE DATE	0700-0900	
	SIGNATURE OF DOCTOR	1200-1400	
	STOPPED INITIALS:	1600-1800	
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	2200-2400	
	FOR DOCTORS USE ONLY	Other time	

H	DRUG	Other time	
	DOSE ROUTE DATE	0700-0900	
	SIGNATURE OF DOCTOR	1200-1400	
	STOPPED INITIALS:	1600-1800	
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	2200-2400	
	FOR DOCTORS USE ONLY	Other time	

Note: To discontinue a prescription, initial and date appropriate boxes and draw a diagonal line through section
 The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs:
Regular Prescriptions

J		DRUG		Amoxycillin		DATE	9	10	11	12												
		DOSE		500mg		ROUTE	O	DATE		9/10/00	STOPPED	DATE:										
		SIGNATURE OF DOCTOR		K. L. J.		INITIALS:																
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																				
		Other time																				

FOR DOCTORS USE ONLY

K		DRUG		TAMOXIFEN		DATE	9	10	11	12												
		DOSE		20mg		ROUTE	O	DATE		9/10	STOPPED	DATE:										
		SIGNATURE OF DOCTOR		J. C.		INITIALS:																
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																				
		Other time																				

FOR DOCTORS USE ONLY

L		DRUG		IBUPROFEN		DATE	9	10	11	12												
		DOSE		400mg		ROUTE	O	DATE		10/10	STOPPED	DATE:										
		SIGNATURE OF DOCTOR		J. C.		INITIALS:																
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																				
		Other time																				

FOR DOCTORS USE ONLY

M		DRUG		PARACETAMOL		DATE	9	10	11	12												
		DOSE		500mg		ROUTE	O	DATE		9/10	STOPPED	DATE:										
		SIGNATURE OF DOCTOR		J. C.		INITIALS:																
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																				
		Other time																				

FOR DOCTORS USE ONLY

Oral and Other Drugs:
Regular Prescriptions

N		DRUG		IBUPROFEN		DATE	11	12														
		DOSE		400mg		ROUTE	O	DATE		11/10/00	STOPPED	DATE:										
		SIGNATURE OF DOCTOR		J. C.		INITIALS:																
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																				
		Other time																				

FOR DOCTORS USE ONLY

P		DRUG				DATE	11	12														
		DOSE				ROUTE		DATE			STOPPED	DATE:										
		SIGNATURE OF DOCTOR				INITIALS:																
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																				
		Other time																				

FOR DOCTORS USE ONLY

R		DRUG				DATE	11	12														
		DOSE				ROUTE		DATE			STOPPED	DATE:										
		SIGNATURE OF DOCTOR				INITIALS:																
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																				
		Other time																				

FOR DOCTORS USE ONLY

S		DRUG				DATE	11	12														
		DOSE				ROUTE		DATE			STOPPED	DATE:										
		SIGNATURE OF DOCTOR				INITIALS:																
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																				
		Other time																				

FOR DOCTORS USE ONLY

Note: To discontinue a prescription, initial and date appropriate boxes and draw a diagonal line through section
The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

DATE 

MONTH 

T				DRUG		Other time	
DOSE		ROUTE		DATE:		0700-0900	
SIGNATURE OF DOCTOR				STOPPED		1200-1400	
						INITIALS:	
						1600-1800	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY						2200-2400	
						Other time	
FOR DOCTORS USE ONLY							

— FOR DOCTORS USE ONLY.

FOR DOCTORS USE ONLY				Other time
V	DRUG			0700-0900
DOSE		ROUTE	DATE	1200-1400
SIGNATURE OF DOCTOR			STOPPED DATE: INITIALS:	1600-1900
				2200-2400
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time
FOR DOCTORS USE ONLY				

- FOR DOCTORS USE ONLY.

FOR DOCTORS USE ONLY					Other time
W	DRUG				0700-0900
DOSE		ROUTE	DATE	DATE:	1200-1400
SIGNATURE OF DOCTOR				STOPPED INITIALS:	1600-1800
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					2200-2400
					Other time

FOR DOCTORS USE ONLY

FOR DOCTORS USE ONLY					
X	DRUG		Other time		
			0700-0900		
			1200-1400		
			1600-1800		
			2200-2400		
DOCTOR		ROUTE	DATE	STOPPED DATE: INITIALS:	Other time
SIGNATURE OF DOCTOR					
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					

FOR DOCTORS USE ONLY.

Oral and Other Drugs: Regular Prescriptions				DATE →
Y	DRUG			MONTH →
				Other time
DOSE		ROUTE	DATE	0700-0900
			STOPPED	1200-1400
SIGNATURE OF DOCTOR				INITIALS:
				1600-1800
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				2200-2400
				Other time

FOR DOCTORS USE ONLY

A_n HUG				Other time: 0700-0900
DOSE	ROUTE	DATE:	STOPPED	1200-1400
SIGNATURE OF DOCTOR				INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time:

- FOR DOCTORS USE ONLY

BB		DRUG		Other time	
DOSE		ROUTE	DATE	STOPPED	DATE:
SIGNATURE OF DOCTOR					INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					Other time

FOR DOCTORS USE ONLY

CC	DRUG			Other time
DOSE		ROUTE	DATE	0700-0900
SIGNATURE OF DOCTOR			STOPPED INITIALS:	1200-1400
				1600-1800
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				2200-2400
				Other time

— FOR DOCTORS USE ONLY

Note: To discontinue a prescription, initial and date appropriate boxes and draw a diagonal line through section. The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

ADMINISTRATION

Oral and Other Drugs:
Regular Prescriptions

DATE →																												
MONTH →																												
DD	DRUG		Other time																									
			0700-0900																									
DOSE	ROUTE	DATE	DATE:																									
SIGNATURE OF DOCTOR			INITIALS:																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			2200-2400																									
			Other time																									
FOR DOCTORS USE ONLY																												

EE	DRUG		Other time																									
			0700-0900																									
DOSE	ROUTE	DATE	DATE:																									
SIGNATURE OF DOCTOR			INITIALS:																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			2200-2400																									
			Other time																									
FOR DOCTORS USE ONLY																												

FF	DRUG		Other time																									
			0700-0900																									
DOSE	ROUTE	DATE	DATE:																									
SIGNATURE OF DOCTOR			INITIALS:																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			2200-2400																									
			Other time																									
FOR DOCTORS USE ONLY																												

GG	DRUG		Other time																									
			0700-0900																									
DOSE	ROUTE	DATE	DATE:																									
SIGNATURE OF DOCTOR			INITIALS:																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			2200-2400																									
			Other time																									
FOR DOCTORS USE ONLY																												

Oral and Other Drugs:
Regular Prescriptions

DATE →																												
MONTH →																												
HH	DRUG		Other time																									
			0700-0900																									
DOSE	ROUTE	DATE	DATE:																									
SIGNATURE OF DOCTOR			INITIALS:																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			2200-2400																									
			Other time																									
FOR DOCTORS USE ONLY																												

JJ	UG		Other time																									
			0700-0900																									
DOSE	ROUTE	DATE	DATE:																									
SIGNATURE OF DOCTOR			INITIALS:																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			2200-2400																									
			Other time																									
FOR DOCTORS USE ONLY																												

KK	DRUG		Other time																									
			0700-0900																									
DOSE	ROUTE	DATE	DATE:																									
SIGNATURE OF DOCTOR			INITIALS:																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			2200-2400																									
			Other time																									
FOR DOCTORS USE ONLY																												

LL	DRUG		Other time																									
			0700-0900																									
DOSE	ROUTE	DATE	DATE:																									
SIGNATURE OF DOCTOR			INITIALS:																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			2200-2400																									
			Other time																									
FOR DOCTORS USE ONLY																												

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

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

PATIENT'S NAME: <u>MARY WATSON</u>				ADMINISTRATION												
All Routes: As Required Prescriptions																
MM	DRUG: <u>ibuprofen</u>			STOPPED DATE: <u>9/10</u>	DATE: <u>9/10</u>											
DOSE: <u>400mg</u>	ROUTE: <u>0</u>	INDICATION: <u>9/10/00</u>		INITIALS: <u>SS</u>	TIME: <u>5:45</u>											
SIGNATURE OF DOCTOR: <u>K. Hays</u>		MAX. FREQUENCY: <u>8°</u>		DATE: <u>9/10/00</u>	DOSE: <u>400mg</u>											
					GIVEN BY: <u>KS</u>											
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																

NN	DRUG: <u>PARACETAMOL</u>			STOPPED DATE: <u>9/10</u>	DATE: <u>9/10</u>											
DOSE: <u>1g</u>	ROUTE: <u>0</u>	INDICATION: <u>PAIN</u>		INITIALS: <u>SS</u>	TIME: <u>10:15</u>											
SIGNATURE OF DOCTOR: <u>H. Lohr</u>		MAX. FREQUENCY: <u>4-6</u>		DATE: <u>9/10/00</u>	DOSE: <u>1g</u>											
					GIVEN BY: <u>KS</u>											
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																

PP	DRUG: <u>Dihydrocodeine</u>			STOPPED DATE: <u>9/10</u>	DATE:											
DOSE: <u>30mg</u>	ROUTE: <u>0</u>	INDICATION: <u>PAIN</u>		INITIALS: <u>SS</u>	TIME:											
SIGNATURE OF DOCTOR: <u>[Signature]</u>		MAX. FREQUENCY: <u>8 hr</u>		DATE:	DOSE:											
					GIVEN BY:											
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																

RR	DRUG: <u>Dihydrocodeine</u>			STOPPED DATE: <u>9/10</u>	DATE:											
DOSE: <u>30mg</u>	ROUTE: <u>0</u>	INDICATION: <u>PAIN</u>		INITIALS: <u>SS</u>	TIME:											
SIGNATURE OF DOCTOR: <u>[Signature]</u>		MAX. FREQUENCY: <u>6-8</u>		DATE: <u>9/10/00</u>	DOSE:											
					GIVEN BY:											
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																

SS	DRUG: <u>MICROLLETTE</u>			STOPPED DATE: <u>9/10</u>	DATE:											
DOSE: <u>1 APP.</u>	ROUTE: <u>PR</u>	INDICATION: <u>CONSTIPATION</u>		INITIALS: <u>SS</u>	TIME:											
SIGNATURE OF DOCTOR: <u>[Signature]</u>		MAX. FREQUENCY: <u>PRN</u>		DATE: <u>9/10/00</u>	DOSE:											
					GIVEN BY:											
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																

TT	DRUG:			STOPPED DATE:	DATE:											
DOSE:	ROUTE:	INDICATION:		INITIALS:	TIME:											
SIGNATURE OF DOCTOR:		MAX. FREQUENCY:		DATE:	DOSE:											
					GIVEN BY:											
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																

VV	DRUG:			STOPPED DATE:	DATE:											
DOSE:	ROUTE:	INDICATION:		INITIALS:	TIME:											
SIGNATURE OF DOCTOR:		MAX. FREQUENCY:		DATE:	DOSE:											
					GIVEN BY:											
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																

WW	DRUG:			STOPPED DATE:	DATE:											
DOSE:	ROUTE:	INDICATION:		INITIALS:	TIME:											
SIGNATURE OF DOCTOR:		MAX. FREQUENCY:		DATE:	DOSE:											
					GIVEN BY:											
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																

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

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

Patient Profile

Ward: L8mod Date: 9-10-00 Time: 5³⁰am (24hr clock)

Please print clearly in BLOCK CAPITALS

Title: MRS
 Name: MARY WATSON
 Preferred name: _____
 Address: 28 KENNEDY AVE
GLASGOW
 Post Code: G15 8AX
 DOB: 6/3/54 Age: 46
 Hosp. No: 623238
 Occupation: HOUSEWIFE
 Religion: C/S
 S.O.S. ☐ date: ☐☐☐☐☐☐
 Interpreter required: ☐
 (specify: _____)
 Lives alone ☐

Consultant: DR SEMPLE
 Named Nurse ①: SIN FOSTER
 Admitting Nurse: SIN STENNET
 Named Nurse ②: _____
 Relatives seen by Doctor ☐

1 NOK/Friend/Contact: ALLENE
 Address: 6 TALLANT TELL
GLASGOW
 Day: 944 1913
 Night: _____
 Relationship: DAUGHTER
 2 NOK/Friend/Contact: _____
 Address: _____
 Day: _____
 Night: _____
 Relationship: _____
 NOK informed of admission ☐
 NOK informed by: PATIENT
 GP: DR LYON
 Address: DRUMCHAPEL HIC
80/90 KILFARNS
 Day: _____
 Night: _____

37 history of warren's
 (Anterior wall chapsin
 associated SOB, hematuria
 and anaemia
 Patient's perception of illness:
aware

Diagnosis: _____
? PE
? CHEST INFECTION

Operation/Treatment: _____
ORAL ANTIBIOTICS
TINIZPRIN

CK 56
 D-dimer negative

Relevant PMH: W. H. Impeccable
+ 6/12 chemo, Hysterectomy
Cervical CA (Dr Dewle
Goodman)

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

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

Temperature 36.2 °C
 Pulse 73 bpm
 BP 120/75
 Resp 98/l
 Pain Score _____
 Urinalysis NAD
 Waterlow Score _____
 Height _____ m
 Weight _____ kg
 Body Mass Index _____
 Blood sugar (if appropriate) _____ mmols
 Allergies Yes ☐ No ☐
 details: *SEPTILIN*

DISCHARGE PLANNING

Boarding	1st	2nd	3rd	Signature	Time	Comments/Information
Informed:						
ward	☐	☐	☐			
patient	☐	☐	☐			
relatives	☐	☐	☐			
Date patient boarded:						
1st:	☐ ☐	☐ ☐	☐ ☐			
2nd:	☐ ☐	☐ ☐	☐ ☐			
3rd:	☐ ☐	☐ ☐	☐ ☐			
Internal Transfers						
Transfer destination:	G3					
Planned transfer date:						
	☐ ☐	☐ ☐	☐ ☐			
Medical consent	☒			WATSON		
Arranged with receiving area	☒			3/11		
Patient informed	☒			Daugh		
NOK/Contact informed	☒					
Transport: stretcher	☐					
2 hand seat chair	☒			LM		
Escort	☐					
ie notes	☒			LM		
X-rays	☐					
Nursing notes & Drug Form	☒			Small		
Property/Valuables listed	☒					
Catering	☐					
Dietitian	☐					
Physiotherapy	☐					
Occupational Therapist	☐					
Speech and Language Therapist	☐					
Discharge Checklist						
Planned discharge date:						
	☐ ☐	☐ ☐	☐ ☐			
Medical consent	☐					
Date discussed with patient:						
	☐ ☐	☐ ☐	☐ ☐			
Date discussed with NOK/Contact:						
	☐ ☐	☐ ☐	☐ ☐			
nsport: own	☐					
ambulance	☐					
Ambulance ordered on:						
	☐ ☐	☐ ☐	☐ ☐			
• type:						
• order no.:						
District nurse	☐					
/Liaison nurse	☐					
Home help:	☐					
Social work dept.	☐					
Discharge prescription	☐					
Discharge dressings	☐					
Patient information	☐					
Valuables/Cashier	☐					
Physiotherapy	☐					
Speech and Language Therapist	☐					
Out patient appointment						
	☐ ☐	☐ ☐	☐ ☐			
Other:						

Name: MARY WATSONWard: CameoDate: 9/10/00

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: _____

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): Alimentary NA
EATING WELL

BREATHING

1. No symptoms ☒
2. Breathless with moderate exercise ☐
3. Breathless with minimal exertion ☐
4. Breathless at rest ☐
5. Uses inhalers ☐
Comments: _____

SMOKING

Non-smoker ☐
Smoker: 10/15 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: _____

SLEEP

Hours/night ☒
Medication ☐
details: poor sleeper - Anxiety

MENTAL STATE

Alert/Orientated ☒
Confused: day/night ☐
Anxious/Distressed ☐
Unconscious ☐
Other (specify): _____

Mobile without aid	☒
Mobile with aid	☐
(Specify type/side held: _____)	
Furniture walking	☐
Chair Bound	☐
Housebound	☐

[illegible]

(Please print name in block capitals)
Karen Stewart
 Signature: _____
 Designation: SN
 Countersigned (if applicable): _____

Units/week: nil ☐
 less than 14 ☐
 14 - 21 ☐
 over 21 ☐

(1 unit = 1 measure spirits/half pint beer/
 lager/1 glass wine)

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or printed text on the paper. The top edge of the paper appears slightly irregular, possibly due to the scanning process or the way it was cut from a binder. The overall appearance is that of a clean, unused piece of stationery.

Name: MARY WATSON

Ward: L8m00

Date: 9/10/00

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	

9/10	6am		An emergency admission of 46yr old lady with chest pain, SOB and tachycardia. OIA upset, scared - given analgesia. Vital signs as recorded. Wound and femoral pain assessed. Atrial fibrillation - for repeating.	
			pt worried at bed -	Recurrent
	1200		As plan. Rest maintained. Observations stable. UMH as prescribed.	
			Awaiting VP scan	Latigoven
	2100	1	Care as plan settled. BP 95/50 - asymptomatic	
		5	Informed by Doctor D-dimer negative. Chest infection.	
		8	No bed in G3 stay + review in am.	
			TO contact stobhill re clinic appointment.	
			Mobile around room	
10/10/00	0700	1	all care as planned.	
		5	VPB remains as 95/52 asymptomatic	
			Uncomplaining	Stobhill
	1030	1	Care as plan settled independent.	
		5	Attended for V/O	
		10	D. Watson asked to organise patient to be reviewed by Dr Gais as inpatient.	
	3pm	1-10	Transferred from L8M - Upset on arrival - reassured given by S. Hunt. The aware of TIF	family

EVALUATION OF CARE			
Date	Time	Notes	Signature
10/10/00	1900	1-10 Case as planned. Observations stable.	J. Miller
11/10/00	6am	Sept well. Uncomplaining.	8/11/00
	12.30	1-10 As planned, all running. Attended for Bone Scan. No more seen for discharge home. probably tomorrow. Discharge letter requested.	Shave
	7pm	1-20 Case as plan. Settled evening. Attended for Bone Scan result.	DM Macarty
12/10/00	6am	Settled + Sept well. Uncomplaining.	8/11/00
	11am	1-20 Case as plan. Independent. S/B Dr Sample for discharge home. Told discharge letter would be approx 1 hr.	
	12noon	Unable to find patient. Phoned daughter - patient had left ward without discharge letter - Family will collect.	DM Macarty

BP, TPR and Pain Assessment Chart

Name: MARY WATSON

Case Record No.: 623 238

DOB: 6/3/54

Ward: 18mer Consultant: ^{DR} ~~Samuel~~

1. Pain Score

2.Sedation Score

3. Nausea Score

See reverse for scoring details

Date	9-10-00	10-10-00.	11-10-00
Time	8 ⁰⁰ AM 10 ⁰⁰ AM 14 ⁰⁰ 15 ⁰⁰ 21 ⁰⁰ 6 ⁰⁰ 11 ⁰⁰ 18 ⁰⁰ 25 ⁰⁰	10 ⁰⁰	
Pain Score	0 0 0 1 0 0 0	0	
Sedation Score	0 0 0 0 0 0 0	0	
Nausea Score	0 0 0 0 6 0 0	0	
Nurse Initials	CMLM DDAP B.Y		
Temperature	C° 40 39 38 37 36 35		
BP	210 200 190 180 170 160 150 140 130 120		
Pulse	110 100 90 80 70 60 50 40 30		
RESPS	20 16 14 16 18 14 16		
SaO2	98 98 98 98 96 98		
Bowels			



- Part of North Glasgow University Hospitals NHS Trust

Pressure Sore Risk Assessment Documentation Form

Patient Name: MARY WATSON

Case Record Number: 623238 Ward: LSmed

Waterlow Risk Assessment		Initials														
		Date														
		No.	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Body weight for height:	Average	0														
	Above average	1														
	Obese	2	0													
	Below average	3														
Continence:	Completely catheterised	0														
	Occasionally incontinent	1														
	Cath. Incontinence of faeces	2	0													
	Doubly incontinent	3														
Skin type-visual risk areas:	Healthy	0														
	Tissue paper/dry	1														
	Oedematous clammy (temp ↑)	1	0													
	Discoloured	2														
	Broken spot	3														
Mobility:	Fully	0														
	Restless/fidgety	1														
	Apathetic	2	3													
	Restricted	3														
	Inert/traction Chairbound	4														
Age/Sex:	Male/Female	1/2														
	14-49	1	2													
	50-64	2														
	65-74	3														
	75-80	4														
Appetite:	Average	0														
	Poor	1														
	NG Tube/fluids only	2	0													
	nbn - Anorexic	3														
Special risks - tissue malnutrition:	eg Terminal cachexia	8														
	Cardiac failure	5														
	Peripheral vascular disease	5	1													
	Anaemia	2														
	Smoking	1														
Neurological deficit:	Motor-sensory paraplegia 4-6 eg diabetes, MS, CVA	6														
Major surgery/trauma:	Orthopaedic															
	Below waist, Spinal On table > 2 hours	5	0													
Medication:	Cytotoxics, High dose steroids	4	0													
	Anti-inflammatory															
TOTAL SCORE			6													

Score: <10 = low risk; 10-14 = at risk; 15-19 = high risk; 20+ = very high risk

CLASSIFICATION OF PRESSURE DAMAGE (TORRANCE)

[illegible]

Designed & Produced by Department of Medical Illustration MID Job No. 99/1694

Name: MARY
WATSON

Ward: 3med Date: 9/10/00 Case Record No.: 623238

CARE PLAN

[illegible]

CARE PLAN

Date Comm.	Signature	6. TECHNICAL CARE	Date Disc.	Signature
		IV Infusion		
		Monitor		
		Catheter		
		Oxygen Therapy		
		Nebulisers		
9/10	LMG	IV access: • IV cannulae • others	11/10	AGB
		7. WOUND CARE		
		8. SPECIMENS/INVESTIGATIONS		
9/10	KS	WOUND NRAD	9/10	LMG
		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: / /

PATIENT PROFILE

Ward: L10W Date: 14/12/97

Time: 1100 (24hr clock)

PLEASE PRINT CLEARLY IN BLOCK CAPITALS

Title: Mrs
Name: Mary Watson
Preferred name: _____
Address: 32 Kendon Ave
Glasgow
Tel: 944 7780 Post Code: G15 8PX
DOB: 06/03/54 Age: 43
Hosp. No: 623238
Occupation: Housewife
Religion: C of S
S.O.S. ☐ date: ☐☐☐☐☐☐☐☐
Interpreter required: ☐
(specify language _____)
Date arranged (☐☐☐☐☐☐☐☐
Lives alone ☐

Consultant: Mr Byrne
Named Nurse: SIN E Smith
Admitting Nurse: SIN Amyke
Countersigned: _____
Relatives seen by Doctor ☐

REASON FOR ADMISSION
12 hr history of LPO pain
and nausea
? Sub Acute Obstruction
? Constipation
Patient's perception of illness:
stomach pain
Diagnosis: _____

1 NOK/Friend/Contact: Arlene Watson
Address: 6 Talont Terrace
Glasgow G15
Day: 944-9209 Night: _____
Relationship: Daughter
2 NOK/Friend/Contact: Elizabeth Woods
Address: 600 Kinfauns Drive
Glasgow
Day: 944 4284 Night: _____
Relationship: Sister
NOK informed of admission ☒
NOK informed by: Patient
GP: Dr Lyon
Address: Drumchapel Health
Centre
Tel: _____

Operation/Treatment: _____
Relevant PMH:
Hysterectomy (L breast lump removed)
axillary clearance 1996 DXT/chemo

MEDICATION
With patient ☐
Stored & receipt given ☐
No medication required ☐
Taken home ☒ (TAMOXIFEN)
PERSONAL BELONGINGS
Clothing listed ☒
Valuables listed ☒
Valuables in ward ☐
Valuables in hospital safe ☐
House keys held by: _____
(If req'd)

OBSERVATIONS ON ADMISSION
Temperature 37.7 °C
Pulse 75 bpm
BP 107/62
Resp 95%
Pain Score _____
Urinalysis _____
Waterlow Score _____
Height _____ m
Body Mass Index _____
Blood sugar (if appropriate) _____ mmols

ALLERGIES Yes ☒ No ☐
details: Septin

Name:

Ward:

Case Record No:

DISCHARGE PLANNING

Boarding	1st	2nd	3rd	Signature	Time	Comments/Information
Informed:						
ward	☐	☐	☐			
patient	☐	☐	☐			
relatives	☐	☐	☐			
Date patient boarded:						
1st:	☐	☐	☐			
2nd:	☐	☐	☐			
3rd:	☐	☐	☐			
EXTERNAL/INTERNAL TRANSFERS						
Transfer destination:						
Planned transfer date:						
Medical consent	☐					
Arranged with receiving area	☐					
Patient informed	☒					
NOK/Contact informed	☐					
Transport: stretcher	☐					
2 hand seat chair	☐					
Escort	☐					
Case notes	☐					
X-rays	☐					
Nursing notes & Drug Form	☐					
Property/Valuables listed	☐					
Catering	☐					
Dietitian	☐					
Physiotherapist	☐					
Occupational therapist	☐					
DISCHARGE CHECKLIST						
Actual discharge date:						
☒ 17/11/2017						
Medical consent	☒					
Date discussed with patient:						
☒ 17/11/2017						
Date discussed with NOK/Contact:						
☒ 17/11/2017						
Transport: own ambulance	☒					
Ambulance ordered on:						
type:						
District nurse ☐ / Liaison nurse ☐						
Home help: ☐						
Social work dept. ☐						
Discharge prescription ☒						
Discharge dressings ☐						
Patient information ☐						
Valuables/Cashier ☐						
Physiotherapy ☐						
Out patient appointment:						
☐						
Other:						

Name: Mary WatsonWard: LOW Case Record No:**ACTIVITIES OF DAILY LIVING**

COMPLETE FOR PATIENTS WHOSE DURATION OF STAY IS IN EXCESS OF 48 HOURS (OR IF RELEVANT)

**HOME CIRCUMSTANCES/
SOCIAL SUPPORT**

Lives with family ☒
 Lives alone ☐
 Elderly/disabled partner ☐
 Able/safe to cook/use appliances y ☐ n ☐
 Type of accommodation: _____

Stairs: Internal ☐ External ☐
 Comments: _____

Nursing home ☐
 Residential care ☐
 Family support (specify below) _____

District Nurse ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
 cancelled ☐)
 Home help ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
 (cancelled ☐)
 Other services (specify below) _____

MOBILITY (Pre admission)

Mobile without aid ☒
 Mobile with aid ☐
 (Specify type/side held: _____)
 Furniture walking ☐
 Chair Bound ☐
 Housebound ☐

ELIMINATION

Bowels regular (specify) _____
 Constipated ☒
 Diarrhoea/Loose stools ☐
 Uses aperient ☐
 Has stoma ☐
 Colostomy ☐ Urostomy ☐
 Ileostomy ☐ Ileal Conduit ☐
 Appliances used: _____

Frequency of micturition ☐
 Incontinent: urine/faeces/both ☐
 day/night ☐
 stress ☐
 Uses incontinence aids ☐
 Type used: _____

No urinary symptoms ☐
 Comments: Bowels last moved 4/7.
ago. Man had enema
14/12/97 with no result.

SLEEP

Hours/night ☒
 Medication ☐
 details: _____

MENTAL STATE

Alert/Orientated ☒
 Confused: day/night ☐
 Anxious/Distressed ☐
 Unconscious ☐
 Aggressive/Abusive ☐
 Other _____

NUTRITION

Normal menu (includes vegetarian) ☒
 Vegan ☐ Child's menu ☐
 Halal ☐ Kosher ☐
 Refer to Dietitian if any below ticked:
 Difficulty with eating/swallowing ☐
 Any recent weight changes ☐
 Medically related nutrition problems (e.g. diabetes) ☐
 Other (specify): _____

BREATHING

1. No symptoms ☒
 2. Breathless with moderate exercise ☐
 3. Breathless with minimal exertion ☐
 4. Breathless at rest ☐
 5. Uses inhalers ☐
 Comments: _____

SMOKING

Non-smoker ☐
 Smoker: 10-15 per day ☒
 Ex-smoker ☐ Stopped: ☐ ☐ ☐ ☐ ☐
 Aware of hospital policy ☒

SENSES

Registered blind ☐

Visually impaired: left/right/both ☐

Glasses: distance ☐
reading ☐

Hearing impaired: left/right/both ☐

Hearing aid: left/right/both ☐

Dentures: upper ☐
lower ☐

Other: _____

ALCOHOL INTAKE

Inappropriate/relevant on admission ☒

Units/week: nil ☐

less than 14 ☐

14 - 21 ☐

over 21 ☐

(1 unit = 1 measure spirits/half pint
beer/lager/1 glass wine)

HYGIENE

Bath ☐

☐ Shower ☐

Stand up wash ☐

Independent ☒

Requires assistance ☐

Skin assessment: _____

Other: _____

RELATIVE PARTICIPATION ☐

PROFILE COMPLETED BY:

(Please print name in block capitals)

AWYLE

Signature: AWYLE

Designation: SIR

Countersigned (if applicable):

Designation: _____

OTHER RELEVANT INFORMATION

Name: Mary WatsonWard: LION Date: 14/12/97

Case Record No:

EVALUATION OF CARE (each shift)

1. Basic Care and Hygiene	5. Movement and Handling	9. Wound Care
2. Nutrition	6. Special Needs	10. Specimens/Investigations
3. Elimination	7. Observations	11. Sleep
4. Mobility	8. Technical Care	

DATE	TIME	No	EVALUATION AND PROGRESS OF CARE	SIGNATURE
14/12/97	0000		Admitted via A+E Yc L.P. Quadrant pain & nausea ? SA Obstruction.	
		(8)	IV/in program	
		(6)	Posting till review by SHO	
			S/B SHO - ? Constipation for lactulose, 1m Valparol, 1x Arachis oil enema.	
		(2)	and can have diet & fluids.	
		(7)	Obs T 37.7°C.	AWY
	0200		Apyrexial at 0200.	
15/12/97	0630	(1)	Settled & slept overnight	
		(8)	IV continues 4hrly	
		(2)	Can have fluids & diet.	
		(7)	Obs Apyrexial	AWY
			Care as planned	AWY
	1500.		S/B MR Byrne for enemas	
		3	phosphate enema given	
		2	monitoring fluids & diet	ESM (ESM)
	1530		Settled evening.	
		(2)	IV discontinued	
		(3)	For phosphate enema.	AWY
16.12.97	0630		Slept well overnight For phosphate enema.	J. GORDON
	13.30.	(1)	Independent in all care.	
		(3)	Phosphate enema given with ^{poor} good results.	
		(7)	Obs satisfactory. Apyrexial ? home tomorrow.	D. Quirk/ J. Trenwick (J. Trenwick)
	2000		Settled evening	
		3	no result from enema	ESM (ESM)
17.12.97	0635		Fair night No bowel movement	J. GORDON

EVALUATION OF CARE

[illegible]

CARE PLAN					
DATE COMM.	SIGNATURE	7. OBSERVATIONS	DATE DISC.	SIGNATURE	
		Waterlow daily (if score is over 10+)			
14/12/97	AJW	TPR 4 times daily			
14/12/97	AJW	BP 4 times daily			
		Pain Score			
14/12/97	AJW	Fluid Balance			
		8. TECHNICAL CARE			
14/12/97	AJW	IV infusion: as per regime			
		Monitor			
		Catheter			
		Oxygen Therapy			
		Nebulisers			
		IV access:			
		• IV cannulae			
		• others			
		9. WOUND CARE			
		10. SPECIMENS/INVESTIGATIONS			
14/12/97	AJW	W.S.O			
		11. SLEEP			

Signature of nurse: AW

Date: 1 4 / 1 2 / 9 7

LOW

HOSPITAL
MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

FIRST SIDE

NAME	MARY WATSON	HOSPITAL No.	
AGE		SEX	F
PHYS. SURG.	Prime	DEPT. WARD	10 W

24HR FLUID BALANCE AND PRESCRIPTION SHEET

DATE FROM

[illegible]

TIME	INTAKE				OUTPUT						
	PARENTERAL		Oral/ Nasogastric	Oral/NG Running Total	URINE	Urine Running Total	SECRETIONS				
	TYPE	AMOUNT					Vomit/ NG ASP	Wound Drain			
08-09											
09-10											
10-											
11-											
12-											
1 p.m.											
2-											
3-											
4-											
5-											
6-											
7-											
8-											
9-											
10-											
11-											
12-											
1 a.m.											
2-											
3-											
4-											
5-											
6-											
07-08											
TOTALS											
TOTAL INTAKE				ml	TOTAL OUTPUT						ml

NAME
HOSPITAL NO.

BALANCE	NEG	POS

ml



BP, TPR and Pain Assessment Chart

Name: Mary Wilson

Hospital No:

DOB: 06/03/54

Ward: 44W Consultant: Mr Byrne

1. PAIN SCORE 2. SEDATION SCORE 3. NAUSEA SCORE

See reverse for scoring details.

DATE		14/12/97				15/12/97				16/12/97											
Time		23	00	01	02					12	05		20								
Pain Score		2								1											
Sedation Score		0								0											
Nausea Score		0								0											
TEMPERATURE	C°																				
	40																				
	39																				
	38																				
	37																				
	36																				
	35																				
	210																				
	200																				
	190																				
BP	180																				
	170																				
	160																				
	150																				
	140																				
	130																				
	120																				
	110																				
	100																				
	90																				
PULSE	80																				
	70																				
	60																				
	50																				
	40																				
	30																				
	RESPS																				
	SaO ₂																				
	Bowels																				

1. 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 10 mins after I/V, 1 hour after I/M or oral analgesia.
Sustained pain score of 2 or pain score of 3 requires intervention.

2. 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 intervention.

3. Nausea Score

- 0= No nausea
- 1= Mild (No Rx wanted)
- 2= Moderate (Rx required)
- 3= Severe (clinical problem persists despite Rx)

Review 1 hour after Rx. Inform doctor if additional Rx required.

TIME	INTAKE				OUTPUT						
	PARENTERAL		Oral/ Nasogastric	Oral/NG Running Total	URINE	Urine Running Total	SECRETIONS				
	TYPE	AMOUNT					Vomit/ NG ASP	Wound Drain			
08-09			100	100							
09-10											
10-											
11-											
12-					PUIT						
1 p.m.											
2-											
3-											
4-											
5-											
6-											
7-											
8-											
9-											
10-											
11-											
12-											
1 a.m.											
2-											
3-											
4-											
5-											
6-											
07-08											
TOTALS											
TOTAL INTAKE				ml	TOTAL OUTPUT						ml

NAME	Mary Watson
HOSPITAL NO.	16-12-97

BALANCE	NEG	POS

ml

IN PAT. FORM **6**

FIRST SID

24HR FLUID BALANCE AND PRESCRIPTION SHEET

DATE FROM

NAME	HOSPITAL No.
	AGE
	SEX
PHYS.	DEPT.
SURG.	WARD

[illegible]

0062444MI

 i, RH

TIME	INTAKE				OUTPUT						
	PARENTERAL		Oral/ Nasogastric	Oral/NG Running Total	URINE	Urine Running Total	SECRETIONS				
	TYPE	AMOUNT					Vomit/ NG ASP	Wound Drain			
08-09											
09-10											
10-											
11-											
12-											
1 p.m.											
2-											
3-											
4-											
5-											
6-											
7-											
8-											
9-											
10-											
11-											
12-											
1 a.m.											
2-											
3-											
4-											
5-											
6-											
07-08											
TOTALS											
TOTAL INTAKE				ml	TOTAL OUTPUT						ml

NAME	Mary Watson
HOSPITAL NO.	15/12/97

BALANCE	NEG	POS

ml

FIRST SIDE

24HR FLUID BALANCE AND PRESCRIPTION SHEET

DATE FROM

NAME	HOSPITAL No.
	AGE
	SEX
PHYS.	DEPT.
SURG.	WARD

[illegible]

TIME	INTAKE				OUTPUT						
	PARENTERAL		Oral/ Nasogastric	Oral/NG Running Total	URINE	Urine Running Total	SECRETIONS				
	TYPE	AMOUNT					Vomit/ NG ASP	Wound Drain			
08-09											
09-10											
10-											
11-											
12-											
1 p.m.											
2-											
3-											
4-											
5-											
6-											
7-											
8-											
9-											
10-											
11-											
12-			Commenced								
1 a.m.											
2-											
3-											
4-		11:25 500									
5-											
6-											
07-08											
TOTALS											
TOTAL INTAKE				ml	TOTAL OUTPUT						ml

NAME	Mary Watson
HOSPITAL NO.	14/12/97

BALANCE	NEG	POS

ml

PATIENT PROFILE

Ward: LOW Date: 6/12/97

Time: (24hr clock)

PLEASE PRINT CLEARLY IN BLOCK CAPITALS

Title: MRS
 Name: Mary Watson
 Preferred name: MARY
 Address: 32 KENDON AVE
GLASGOW
G15 8AX
 Tel: 944 7780 Post Code: _____
 DOB: 6.3.54 Age: 43yrs
 Hosp. No: _____
 Occupation: HOUSEWIFE
 Religion: C/S
 S.O.S. ☐ date: ☐☐☐☐☐☐
 Interpreter required: ☐
 (specify language _____)
 Date arranged ☐☐☐☐☐☐
 Lives alone ☐

Consultant: MR GALLOWAY
 Named Nurse: _____
 Admitting Nurse: M. MORRISON
 Countersigned: _____
 Relatives seen by Doctor ☐

REASON FOR ADMISSION

S.A.O.

Patient's perception of illness:

Pain in stomach &
stomach swollen.
 Diagnosis: Pain in stomach
& feels distended

Operation/Treatment:

Relevant PMH: hysterectomy 1971 for CA
leucopa only 1996 for CA
chemo & radiotherapy May 97

1 NOK/Friend/Contact: Linda Watson
 Address: 6 Talent Terr.
Drumchapel
 Day: 944 9209 Night: _____
 Relationship: DAUGHTER
 2 NOK/Friend/Contact: Carol Watson
 Address: SIA
 Day: _____ Night: _____
 Relationship: _____
 NOK informed of admission ☒
 NOK informed by: patricia's sister
 GP: Dr Scott
 Address: Drumchapel H/C
 Tel: 211 6100

MEDICATION

With patient ☐
 Stored & receipt given ☐
 No medication required ☐
 Taken home ☐
 PERSONAL BELONGINGS
 Clothing listed ☒
 Valuables listed ☒
 Valuables in ward ☐
 Valuables in hospital safe ☐
 House keys held by: daughter
 (If req'd)

OBSERVATIONS ON ADMISSION

Temperature _____ °C
 Pulse _____ bpm
 BP 118 / 80
 Resp _____
 Pain Score _____
 Urinalysis requestal.
 Waterlow Score _____
 Height 4 ft 11 in m
 Body Mass Index _____
 Blood sugar (if appropriate) _____ mmols

ALLERGIES Yes ☐ No ☐
 details: _____

Name:

Ward:

Case Record No:

DISCHARGE PLANNING

Boarding	1st	2nd	3rd	Signature	Time	Comments/Information
Informed:						
ward	☐	☐	☐			
patient	☐	☐	☐			
relatives	☐	☐	☐			
Date patient boarded:						
1st:	☐ ☐	☐ ☐	☐ ☐			
2nd:	☐ ☐	☐ ☐	☐ ☐			
3rd:	☐ ☐	☐ ☐	☐ ☐			
EXTERNAL/INTERNAL TRANSFERS						
Transfer destination:						
Planned transfer date:						
☐ ☐ ☐ ☐						
Medical consent			☐			
Arranged with receiving area			☐			
Patient informed			☐			
NOK/Contact informed			☐			
Transport:stretcher			☐			
2 hand seat			☐			
chair			☐			
Escort			☐			
Case notes			☐			
X-rays			☐			
Nursing notes & Drug Form			☐			
Property/Valuables listed			☐			
Catering			☐			
Dietitian			☐			
Physiotherapist			☐			
Occupational therapist			☐			
DISCHARGE CHECKLIST						
Actual discharge date:						
☒ ☒ ☒ ☒						
Medical consent			☐			
Date discussed with patient:						
☒ ☒ ☒ ☒						
Date discussed with NOK/Contact:						
☐ ☐ ☐ ☐						
Transport: own			☒			
ambulance			☐			
Ambulance ordered on:						
☐ ☐ ☐ ☐						
type:						
District nurse ☐ /Liaison nurse ☐						
Home help: ☐ ☐ ☐ ☐ ☐ ☐						
Social work dept.			☐			
Discharge prescription			☒			
Discharge dressings			☐			
Patient information			☐			
Valuables/Cashier			☐			
Physiotherapy			☐			
Out patient appointment:						
☐ ☐ ☐ ☐						
Other:						

Name: Mary Holson

Ward: AKW

Case Record No:

ACTIVITIES OF DAILY LIVING

COMPLETE FOR PATIENTS WHOSE DURATION OF STAY IS IN EXCESS OF 48 HOURS (OR IF RELEVANT)

HOME CIRCUMSTANCES/ SOCIAL SUPPORT

Lives with family ☒
Lives alone ☐
Elderly/disabled partner ☐
Able/safe to cook/use appliances y ☐ n ☐
Type of accommodation: tenement flat
Stairs: Internal ☐ External ☒
Comments:

Nursing home ☐
Residential care ☐
Family support (specify below)
District Nurse ☐ ☐ ☐ ☐ ☐ ☐ ☐
cancelled ☐
home help ☐ ☐ ☐ ☐ ☐ ☐ ☐
(cancelled ☐
Other services (specify below) ☐

NUTRITION

Normal menu (includes vegetarian) ☒
Vegan ☐ Child's menu ☐
Halal ☐ Kosher ☐
Refer to Dietitian if any below ticked:
Difficulty with eating/swallowing ☐
Any recent weight changes ☐
Medically related nutrition
problems (e.g. diabetes) ☐
Other (specify):

BREATHING

1. No symptoms ☒
2. Breathless with moderate exercise ☐
3. Breathless with minimal exertion ☐
4. Breathless at rest ☐
5. Uses inhalers ☐
Comments:

SMOKING

Non-smoker ☐
Smoker: 10-15 per day ☒
Ex-smoker ☐ Stopped: ☐ ☐ ☐ ☐ ☐
Aware of hospital policy ☒

MOBILITY (Pre admission)

Mobile without aid ☒
Mobile with aid ☐
(Specify type/side held: _____)
Furniture walking ☐
Chair Bound ☐
Housebound ☐

ELIMINATION

Bowels regular
(specify) _____
Constipated ☒
Diarrhoea/Loose stools ☐
Uses aperient ☐
Has stoma ☐
Colostomy ☐ Urostomy ☐
Ileostomy ☐ Ileal Conduit ☐
Appliances used:

Frequency of micturition ☐
Incontinent: urine/faeces/both ☐
day/night ☐
stress ☐
Uses incontinence aids ☐
Type used: occasional urine
incontinence
No urinary symptoms ☐
Comments:

SLEEP

Hours/night varied pattern ☐
Medication ☐
details: lules temazepam

MENTAL STATE

Alert/Orientated ☒
Confused: day/night ☐
Anxious/Distressed ☐
Unconscious ☐
Aggressive/Abusive ☐
Other

Registered

Visually impaired: left/right/both

Hearing impaired: left/right/both

Hearing aid: left/right/both

Dentures: upper
 lower

Other:

Bath

Bath ☐ **Shower** ☐

Stand up wash

Independent

Requires assistance

Skin assessment:

Other:

RELATIVE PARTICIPATION

ALCOHOL INTAKE

Inappropriate/relevant on admission

Units/week: nil
 less than 14
 14 - 21
 over 21

(1 unit = 1 measure spirits/half pint beer/lager/1 glass wine)

PROFILE COMPLETED BY:

(Please print name in block capitals)

Signature: M. Morrison

Designation:

Countersigned (if applicable):

Designation:

OTHER RELEVANT INFORMATION

Name: Mary Watson

Ward: L10W Date: 6/12/97

Case Record No:

EVALUATION OF CARE (each shift)

1. Basic Care and Hygiene	5. Movement and Handling	9. Wound Care
2. Nutrition	6. Special Needs	10. Specimens/Investigations
3. Elimination	7. Observations	11. Sleep
4. Mobility	8. Technical Care	

DATE	TIME	No	EVALUATION AND PROGRESS OF CARE	SIGNATURE
6/12/97	20 ⁴⁵		Emergency admission history of constipation 24 hrs of abdominal pain & distension.	
		8	IVI in situ	
		2	To be fasted	
		7	Recording stable. Family in attendance.	
		6	Morphine 10mg & Stemetil 12.5mg given in A/E	M. Merrick
7-12-97	0700		Fair overnight.	
			All care continues as planned	
		3	Arachis oil enema given - no result. For further phosphate	
			Awaiting WSH	
		7	Obs T 36 P 66 BP 100/40	J. Gordon
	1145		9/13 Mr Gallaway	
		3	For further enemas & oral laxatives	
		7	Obs stable	
		2	Fluids & diet	
	7 ⁴⁰ pm		Morphine 1 for pain Bowel active following enemas	Prof J. IFREY
		2	Fluids & diet taken	
		7	Obs as charted	HERBERT
8-12-97	06 ³⁰		Slept well Uncomplaining	J. Gordon
			9/13 Mr Gallaway Bowel active Pain relief Nocturnal appt	

[illegible][illegible]

Name:

Mary
Hanson

Ward: L10W

Date: 6/12/97

Case Record No:

CARE PLAN

DATE COMM.	SIGNATURE	1. BASIC CARE AND PERSONAL HYGIENE	DATE DISC.	SIGNATURE
6/12	M. Hanson	Independent		
		Bed bath		
		Assisted wash		
		Oral hygiene		
		Pressure care		
6/12/97	JP	2. NUTRITION	7-12	JP
7-12	JP	Fasting		
		Normal Diet		
		Special Diet		
6/12/97	JP	3. ELIMINATION	7-12	JP
7-12	JP	Use of shells		
6/12	M. Hanson	4. MOBILITY (If requires assessment more than once use Individual Movement & Handling Care Plan)		
		Fully independent		
		Independent with supervision		
		Independent with aids: details		
		Partially dependent: see 5 below		
		Fully dependent: see 5 below		
		Other:		
		5. MOVEMENT AND HANDLING		
		Toileting:		
		Bathing:		
		Moving in Bed:		
		Chair transfers:		
		Other:		
		IF A HOIST OR SLING IS USED, PLEASE INDICATE THE TYPE AND SIZE		
		6. SPECIAL NEEDS		
		Assess for dysphagia		

CARE PLAN					
DATE COMM.	SIGNATURE	7. OBSERVATIONS	DATE DISC.	SIGNATURE	
6/12/97		Waterlow daily (if score is over 10+)			
6/12/97		TPR 4 hourly	7.12	[Signature]	
6/12/97		BP 4 hourly	7.12	[Signature]	
6/12/97		Pain Score continuous	7.12	[Signature]	
7.12		Fluid Balance			
		DAILY T, P & B.P.			
8. TECHNICAL CARE					
6/12/97	[Signature]	IV infusion:			
		as prescribed	7.12	[Signature]	
		Monitor			
		Catheter			
		Oxygen Therapy			
		Nebulisers			
		IV access:			
		• IV cannulae			
		• others			
9. WOUND CARE					
10. SPECIMENS/INVESTIGATIONS					
11. SLEEP					

Initial Care Plan seen and agreed by patient: Yes ☐ N/A ☐

Signature of nurse: _____ Date: /

Signature of nurse:

Date: / /

HOSPITAL
MEDICINE RECORDING SHEET No.[illegible]



BP, TPR and Pain Assessment Chart

Name: Mary Watson

Hospital No:

Ward: Acute Consultant: Mr Gilberg

DOB:

1. PAIN SCORE 2. SEDATION SCORE 3. NAUSEA SCORE

See reverse for scoring details.

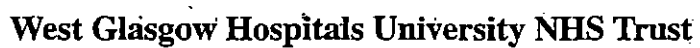
DATE		6/12/07		7-12-97																
Time		9pm		3:00																
Pain Score																				
Sedation Score																				
Nausea Score																				
TEMPERATURE	C°																			
	40																			
	39																			
	38																			
	37																			
	36																			
	35																			
	210																			
	200																			
	190																			
BP	180																			
	170																			
	160																			
	150																			
	140																			
	130																			
	120																			
	110																			
	100																			
	PULSE	90																		
80																				
70																				
60																				
50																				
40																				
30																				
RESPS																				
SaO ₂																				
Bowels																				

TIME	INTAKE				OUTPUT						
	PARENTERAL		Oral/ Nasogastric	Oral/NG Running Total	URINE	Urine Running Total	SECRETIONS				
	TYPE	AMOUNT					Vomit/ NG ASP	Wound Drain			
08-09											
09-10	Solo	500									
10-											
11-											
12-											
1 p.m.											
2-											
3-											
4-											
5-											
6-											
7-											
8-											
9-											
10-											
11-											
12-											
1 a.m.											
2-											
3-											
4-											
5-											
6-											
07-08											
TOTALS											
TOTAL INTAKE				ml	TOTAL OUTPUT						ml

NAME	M. WATSON
HOSPITAL NO.	7.12.97

BALANCE	NEG	POS

ml



FIRST SIDE

24HR FLUID BALANCE AND PRESCRIPTION SHEET

DATE FROM

NAME	HOSPITAL No.
	AGE
	SEX
PHYS.	DEPT.
SURG.	WARD

[illegible]

60 drops per min = 500 ml in 2 hours

0062444MP
URR

TIME	INTAKE				OUTPUT						
	PARENTERAL		Oral/ Nasogastric	Oral/NG Running Total	URINE	Urine Running Total	SECRETIONS				
	TYPE	AMOUNT					Vomit/ NG ASP	Wound Drain			
08-09											
09-10											
10-											
11-											
12-											
1 p.m.											
2-											
3-											
4-											
5-											
6-											
7-											
8-			Commenced								
9-			F								
10-			A								
11-			S								
12-			T								
1 a.m.			I								
2-	NSAL	500	N								
3-			Q								
4-											
5-											
6-	SI-DEX	500			HNPU	—					
07-08											
TOTALS											
TOTAL INTAKE				ml	TOTAL OUTPUT						ml

NAME	Mary Watson
HOSPITAL NO.	6/12/97

BALANCE	NEG	POS

ml



FIRST SIDE

24HR FLUID BALANCE AND PRESCRIPTION SHEET

DATE FROM

60 drops per min = 500 ml in 2 hours

0062444MI
GRB



IN PAT. FORM 6.

FIRST SIDE

NAME	HOSPITAL
MARY	No.
WATSON	AGE
	SEX
PHYS.	DEPT.
SURG.	WARD

24HR FLUID BALANCE AND PRESCRIPTION SHEET

DATE FROM

[illegible]

60 drops per min = 500 ml in 2 hours

6. RH

TIME	INTAKE				OUTPUT						
	PARENTERAL		Oral/ Nasogastric	Oral/NG Running Total	URINE	Urine Running Total	SECRETIONS				
	TYPE	AMOUNT					Vomit/ NG ASP	Wound Drain			
08-09											
09-10											
10-											
11-											
12-											
1 p.m.											
2-											
3-											
4-											
5-											
6-											
7-											
8-											
9-											
10-											
11-											
12-											
1 a.m.											
2-											
3-											
4-											
5-											
6-											
07-08											
TOTALS											
TOTAL INTAKE				ml	TOTAL OUTPUT						ml

NAME
HOSPITAL NO.

BALANCE	NEG	POS

ml

PATIENT NURSING HISTORY

000034

DATE OF ADMISSION <u>8-9-91</u>	TIME <u>4 p.m.</u> WARD <u>99</u>
PATIENTS NAME <u>MARY WATSON</u>	HOSPITAL <u>WESTERN INFIRMARY</u>
ADDRESS <u>32 KENDON AVE</u>	CONSULTANT <u>MCLEAN</u>
<u>GLASGOW</u>	HOSPITAL NO. <u>623238/B</u>
<u>G158AX</u>	G.P. <u>ANNA MORGAN Turner</u>
TELEPHONE NO. <u>/</u>	TELEPHONE NO. <u>4424787</u>
DATE OF BIRTH <u>6/3/54</u> AGE <u>37</u>	OCCUPATION <u>Welfare Assistant</u>
RELIGION <u>/</u>	SACRAMENTS OF THE SICK <u>/</u>
NEXT OF KIN (1) <u>Arlene (daughter)</u>	NEXT OF KIN (2) <u>/</u>
ADDRESS <u>AAA</u>	ADDRESS <u>/</u>
TELEPHONE NO. <u>AAA</u>	TELEPHONE NO. <u>/</u>
RELATIVES NOTIFIED OF ADMISSION <u>✓</u>	CLOTHING LISTED <u>/</u>
PATIENT SPOKEN TO BY CONSULTANT <u>/</u>	PATIENTS OWN DRUGS <u>/</u>
RELATIVES SPOKEN TO BY CONSULTANT <u>/</u>	

SOCIAL CIRCUMSTANCES Lives lic - 4 children, 1 yrs, 17 yrs, 15 & 6 yr
Smokes 10-15 per day
Non-drinker

REASON FOR ADMISSION Arranged? Cone Biopsy

PATIENTS PERCEPTION OF ILLNESS Aware

DIAGNOSIS/OPERATION dx CA - Cone Biopsy - 9th Sept 91

OTHER HEALTH PROBLEMS Lap Ster 1985 PID 1990
Asthmatic

ALLERGIES * COTRIMOX AZOLE *

000035

MAINTAINING A SAFE ENVIRONMENT Alert & Orientated

NUTRITION Normal diet

ELIMINATION Bowels move daily

HYGIENE Clean & well kept on admission

SLEEP No problems

ABILITY Fully mobile

SENSES All senses intact

BREATHING Pt is asthmatic, takes no medication

OTHER RELEVANT INFORMATION LMP August
Para 4 to

DISCHARGE PLANNING: HOME HELP ☐

COMMUNITY NURSE ☐

AMBULANCE ☐

DRESSINGS ☐

CASHIER ☐

MEDICATION ☐

APPOINTMENT ☐

TICK (✓) WHEN ARRANGED

OBSERVATIONS ON ADMISSION

TEMPERATURE 37.1 PULSE 80 RESPIRATIONS _____

BLOOD PRESSURE 110/80 HEIGHT _____ WEIGHT _____

URINALYSIS requested

SIGNATURE OF ADMITTING NURSE S/N R. B. L.

NAME: MARY WATSON

DATE OF ADMISSION: 8-9-91

HOSPITAL: WESTERN INFIRMARY

HOSPITAL NO: 623238/1

DATE	PATIENT PROGRESS REPORT	000036	SIGNATURE
8/9/91	A admitted as arranged for cone biopsy tomorrow. Pt has had toothache for a few days & has been taking analgesia regularly SB medical staff		PB Hand
	Fast from MIDNIGHT		PB Hand
9/9/91	Settled night. prepared for theatre care as plan.		Mr
* 11.45am	Cyclimorph 10mg IM at 12 ²⁵ pm Returned to recovery. General condition satisfactory. No p.bss. Care as per care plan.		* CMNAN
1pm	Returned to ward G9 sleepy but rousable. P.V loss nil Obs satisfactory.		J Hunter
	Has had cyclimorph 10mg IM at 12.15pm Theatre recordings stable P.V. loss as per chart		W Cruckshank
10.9.91	Care as plan. Slept well.		
① 9.40pm	P.V. loss. etc. S/R Dr McLean - discharged & appoint- ment posted out.		W Cruckshank

DATE OF ADMISSION: 8-9-91

HOSPITAL: WESTERN INFIRMARY

HOSPITAL NO.: 623238 / B

[illegible]

DOSE

ROUTE

TIMES FOR ADMINISTRATION

**Prescribers
Signature (Full)**

DISCONTINUED

Pharmacy Use	Date Started	MEDICINE (Block Capitals)
--------------	--------------	---------------------------

Pharmacy Use	Date Started	MEDICINE (Block Capitals)
A	9/5/51	CYCLING RITE
B		
C		
D		
E		
F		
G		

DOSE

ROUTE

TIMES FOR ADMINISTRATION

**Prescribers
Signature (Full)**

DISCONTINUED

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

DATE	HOURS	CO-PROXAMA	2 tabs	0.	E-GITONILIT FOR	PAIN	Grain
	J						
	K						
	L						
	M						
	N						
	O						
	P						
	R						
	S						
	T						
	V						

00038

ONCE ONLY PRESCRIPTIONS

DIET

[illegible]

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. SEPRA	

WARD	NAME OF PATIENT	AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
99	MARY WATSON	37 6/3/54			62 3238/8	MCLEAN.

FORM MR1 10/90

DATE OF ADMISSION: 8/9/91

HOSPITAL NO. 623238/B.

DATE COMM.	BASIC CARE & PERSONAL HYGIENE	DATE DISC.	DATE COMM.	TECHNICAL CARE	DATE DISC.
8/9	DAILY BATH				
				OBSERVATIONS	
	MOBILISATION		8/9	BASLINE WSG	
SR	INDEPENDENT		9.9.91	Wheely b.P. + Pulse	
				WOUND CARE	
	DIET				
8/9	NORMAL DIET				
	BLADDER & BOWEL CARE			SPECIMENS	INVESTIGATIONS
8/9	INDEPENDENT		8/9	WSU	
	SPECIAL NEEDS				

NAME

HOSPITAL

No.

RESUSCITATION AND
BLOOD PRESSURE CHARTIN-PAT
FORM 7

AGE

DIAGNOSIS:

SUGAR

000041

PHYSI

DEPT

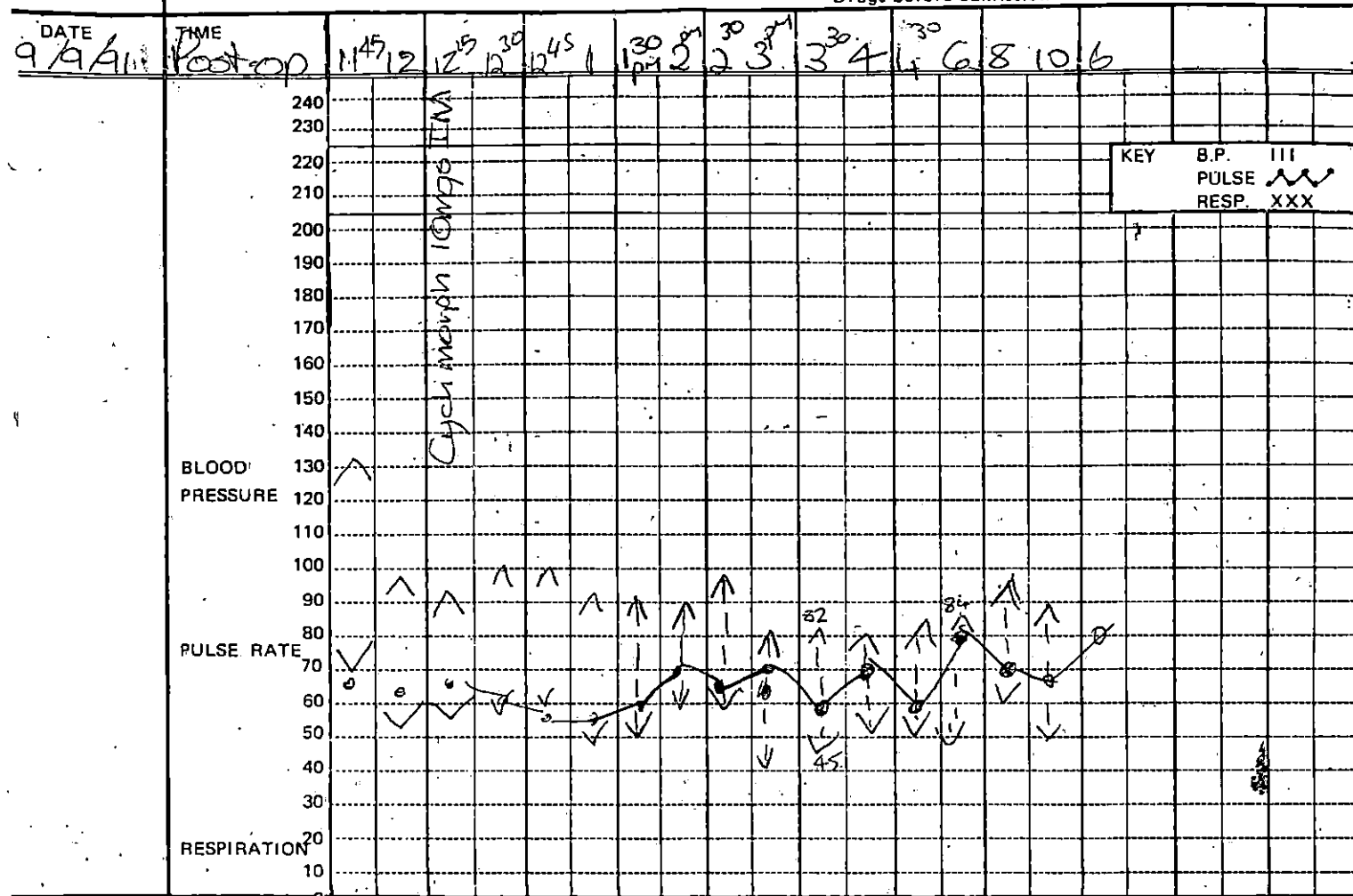
URINE

ALB.

SURG.

WARD

Drugs before admission



INTAKE ml

367

URINE ml

Oxygen Therapy 4 litres

P.V. 1000

N.I.

✓

✓

✓

Slight

N.I.

N.I.

N.I.

Slight

Slight

V. Slight

N.I.

THERAPY

NAME
MARY
WATSON

HOSPITAL W13
No. 623238/B

AGE 37

PHYS/
SURG. MCLEAN

DEPT 94N
WARD 69

RESUSCITATION AND
BLOOD PRESSURE CHART

IN-PAT
FORM 7

DIAGNOSIS:

SUGAR

000042

URINE

ALB.

Drugs before admission

DATE

TIME

8/9/91

9A

BLOOD
PRESSURE

PULSE RATE

RESPIRATION

KEY

B.P.

PULSE

RESP.

III

XXX

240

230

220

210

200

190

180

170

160

150

140

130

120

110

100

90

80

70

60

50

40

30

20

10

0

THERAPY

↓

Temp 37.1

URINE ml

GREATER GLASGOW HEALTH BOARD
WESTERN DISTRICT
FILE IN PART 1 OF CASE RECORD
ADMISSION FORM

CASE RECORD

69
000043

HOSPITAL CODE		CASE REFERENCE No. 000043	
PREVIOUS ATTENDANCE AT THIS HOSPITAL YES/NO		IN/OUTPATIENT	
YEAR 1990			
SURNAME WATSON	MAIDEN NAME CUMMINGS		
FIRST FORENAME MARY	SECOND FORENAME	OTHER INITIALS	
DATE OF BIRTH 6.3.54	SEX 2	MARITAL STATUS 2	
ADDRESS 32 KENDON AVE GLASGOW			
POST CODE G15 8AX	TELEPHONE No.		
FAMILY DOCTOR SURNAME TURNER	INITIALS	G.P. TELEPHONE No.	
ADDRESS 24 MERRYTON AVE GLASGOW			
POSTCODE G15			
ADMISSION DATE OF ADMISSION 8/9/91	WARD No. 69	TIME OF ADMISSION 15.45	
DATE PLACED ON WAITING LIST	ADMITTED/TRANSFERRED FROM 11	TYPE OF ADMISSION 2	
CONSULTANTS SURNAME McLean	PATIENTS RELIGION		
OCCUPATION WELFARE ASST			
HUSBAND'S OCCUPATION (MARRIED WOMAN)/PARENT'S OCCUPATION (CHILD)			
REASON FOR ADMISSION ARRANGED			
PROVISIONAL DIAGNOSIS			
IF ADMISSION IS CONSEQUENCE OF ROAD TRAFFIC ACCIDENT: PLACE		DATE OF INJURY	
DETAILS		TIME OF INJURY	
IF ADMISSION IS CONSEQUENCE OF HOME ACCIDENT: PROBABLE CAUSE			
NEXT OF KIN: NAME ARLENE	RELATIONSHIP DAUGHTER 18	TELEPHONE No. A1A	
ADDRESS S/A		POSTCODE A1A	
OTHER RELATIVE OR FRIEND: NAME	RELATIONSHIP	TELEPHONE No.	
ADDRESS		POSTCODE	
NAME	RELATIONSHIP	TELEPHONE No.	
ADDRESS		POSTCODE	

CODING USED ABOVE

ADMITTED/TRANSFERRED FROM

- | | |
|--------------------------------|----------|
| 1. HOME | 6. |
| 2. OTHER HOSPITAL | 7. |
| 3. OTHER UNIT IN THIS HOSPITAL | 8. OTHER |
| 4. | 9. |
| 5. | |

TYPE OF ADMISSION

- | | |
|---|--|
| 0. DEFERRED ADMISSION | 6. EMERGENCY-HOME ACCIDENT |
| 1. WAITING LIST | (INCLUDES ACCIDENTAL POISONING IN THE HOME) |
| 2. BOOKED CASE | 7. EMERGENCY-OTHER INJURY (INCLUDES ACCIDENTAL |
| 3. TRANSFER | POISONING OTHER THAN IN THE HOME) |
| 4. EMERGENCY-DELIBERATE SELF-INFLICTED INJURY | 8. EMERGENCY-OTHER |
| OR POISONING | (EXCLUDING ACCIDENTAL POISONING) |
| 5. EMERGENCY-ROAD TRAFFIC ACCIDENT | 9. |

DISCHARGE FORM

CONSULTANT IN CHARGE						
DATE OF DISCHARGE		TIME OF DISCHARGE				
HOSPITAL DIVISION OR UNIT		SUB-SPECIALITY CODE		DISCHARGE CODE		
CATEGORY OF PATIENT		TYPE OF FACILITY				
DIAGNOSES PRINCIPAL DIAGNOSIS OTHER CONDITIONS TO BE INDEXED INCLUDE EXTERNAL CAUSE OF INJURY AND TUMOUR TYPE WHERE RELEVANT	1					
	2					
	3					
	4					
	5					
	6					
	7					
	8					
SURGICAL OPERATIONS		DATE	DETAILS			
PRINCIPAL OTHER OPERATIONS AND DIAGNOSTIC PROCEDURES	1					
	2					
	3					
	4					
	5					
	6					

CODING USED ABOVE

HOSPITAL DIVISION OR UNIT ON DISCHARGE OR TRANSFER

(SEE SEPARATE SPECIALITY LIST FOR CODINGS)

SUB-SPECIALITY CODE

(SEE SEPARATE SPECIALITY LIST FOR CODINGS)

TYPE OF FACILITY

- | | |
|----------------------|------------------------------------|
| 1 Ordinary Inpatient | 6 Day Bed Unit |
| 2 | 7 Day Case in Inpatient facilities |
| 3 | 8 Other Day Case |
| 4 | 9 |
| 5 5-day ward | |

CATEGORY OF PATIENT

- 1 Amenity
- 2 Paying
- 3 N.H.S.

DISCHARGE CODE

- 0 'Irregular' - e.g. Self Discharge
- 1 Home
- 2 Convalescent Hospital or Home
- 3 Other Hospital
- 4 Local Authority Care
- 5 Transfer to other speciality in same hospital
- 6 Died (P.M.)
- 7 Died (No P.M.)
- 8 Other

ADMISSION PROFORMA

NAME	Hospital No.
ADDRESS	Date of Birth

000044

A. Q.1 Have you

{has your husband/wife}
{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 Q.2.

Q.2 Are you

{is your husband/wife}
{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:

Q.3 On what date did you

{your husband/wife}
{your mother
{your father }

arrive in the UK?

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

B. Folders or forms should be marked to provide for these entries:

"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.

GREATER GLASGOW HEALTH BOARD



000045

623238/B

WATSON MARY

32 KENDON AVE., F
GLASGOW M

06/03/1954

G15 8AX G.P.Prac.40205

CONSENT

FOR

OPERATION

Dept./Wd.

Phy./Surg.

GA

Dr. McLean

WIG

Hospital

I, Mary Watson of 32 Kendon Ave, GS hereby consent to

* (undergo the submission of my * (child ward) to undergo)

the operation of Cone Biopsy

the nature and purpose of which have been explained to me by

Dr. Smith

I also consent to such further or alternative operative measures as may be found necessary during the course of the above-mentioned operation and to the administration of general, local or other anaesthetics for any of these purposes.

No assurance has been given to me that the operation will be performed by any particular practitioner.

Date 2/9/91 Signed X Mary Watson
(Patient/Parent/Guardian) *

I confirm that I have explained the nature and purpose of this operation to the patient/parent/guardian.

Date 2/9/91 Signed [Signature]
(Medical/Dental * Practitioner)

* DELETE AS APPROPRIATE

ANY DELETIONS, INSERTIONS OR AMENDMENTS TO THIS FORM MUST BE MADE BEFORE THE EXPLANATION IS GIVEN AND THE FORM SUBMITTED FOR SIGNATURE.

GREATER GLASGOW HEALTH BOARD
HOSPITAL RECOVERY ROOM & POST OPERATION FORM

000046

WARD C9 THEATRE C9110 SURGEON Dr Colclough DATE 9 Sept 91

SURNAME Watson AGE 37 UNIT NO. 6232328

OTHER NAMES MARY

DIAGNOSIS

PROPOSED OPERATION Cervix Biopsy

CASE NOTES ☒	IDENTIFICATION BAND ☒
X-RAYS ☒	DENTURES REMOVED ☒
DRUG & NURSING KARDEX ☒	BED CAGE ☒
FLUID CHART ☒	ORTHO. WEDGE ☒
PREMEDICATION ☒ TIME <u>9.30am</u>	INFUSION STAND ☒
ANAESTHETIC AND OPERATION PERMISSION FORM COMPLETED <u>yes</u>	HEARING-AID ☒

I CERTIFY THAT IDENTIFICATION AND DOCUMENTS ARE CORRECT ON LEAVING WARD

SISTER/CHARGE NURSE OR DEPUTIES SIGNATURES [Signature]

RECEPTION/THEATRE

PATIENT'S DOCUMENTATION AND IDENTIFICATION = CORRECT Correct

SISTER/CHARGE NURSE OR DEPUTIES SIGNATURES [Signature]

POST-OPERATIVE INSTRUCTIONS

OPERATION Cervix Biopsy

DRAIN NASO-GASTRIC TUBE

CATHETER PACK

PATIENT POSITION

O₂ THERAPY l/m. By mask for hours.

B.P. HRLY. PULSE HRLY.

POST OP SEDATION SEE KARDEX

DRUGS IN THEATRE

OTHER INSTRUCTIONS:

SURGEONS SIGNATURE [Signature] ANAESTHETIST'S SIGNATURE [Signature]

FLUIDS IN THEATRE.

TIME:

VOLUME

FLUID

ADDITIVES

POST OPERATIVE FLUIDS.

TIME

VOLUME

FLUID

ADDITIVES

Signature

GREATER GLASGOW HEALTH BOARD - WESTERN DISTRICT

ANAESTHETIC
RECORD

000047

PATIENT

Number

Hosp

Age

Sex

Date

ANAESTHETIST

Cons

SR

Reg

SHO

OPERATOR

Cons

SR

Reg

SHO

Other

PROCEDURE

Code

Time Commenced

Duration

Emergency

PRE-OP DISEASE

Resp

Anaemia

Renal

Neurolog

Other

CVS

Endocrine

Hepatic

Muscular

CURRENT DRUGS

PREV. ANAESTH.

Halothane

Complications

PREMEDICATION

Morph

Atropine

Papaveret

Hyosc

Pethidine

Phenergan

Fentanyl

Drop

Diaz

Other

INDUCTION

Thiopentone

Methohexitone

Althesin

Ketamine

Inhalation

Other (spec)

RELAXANT

Sux

dtc

Panc

Alcur

Gall

Other (spec)

Neost

Atrop

MAINTENANCE

N₂O

Hal

Ethrane

Ether

Morphine

Papaveret

Phenop

Other

Methox

Trilene

Cyclo

Pethidine

Fentanyl

Pentaz

TECHNIQUE

Spont

Mask

ETT

Oral

Magill

Tracheos

Circ (cl)

Circ (lk)

IPPV

A'way

Cuff

Nasal

T Pce

Hypotens

Pack

Other

I.V. SITE

R Arm

R Hand

L Leg

Neck

L Arm

L Hand

L Leg

Other

MONITORING

ECG

Pulse

Temp.

CVP line

Art. line

Other

POSITION

Supine

Lithotomy

Lateral

Prone

Other

Hd Up

Hd Down

REG. ANALGESIA

Spinal

Epidural

Bier

Brach Plex

Other

Cath

Site

Amethoc

Priloc

Cinchoc

Bupivac

Lignoc

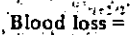
Adren

Other

COMPLICATIONS

NOTES

Sulc 99

[illegible]

HISTORY

DATE

000048

IN-PAT. FORM 1

2/1/12 a/a for cure Bx for CIN 3.

2/12 ago → post coital bleeding → GP
 ↳ polyp → Gyn clinic - Bx at colposcopy
 CIN 3 & 2 ad micr Ca.

Loop beginning August 4/28-32, reg but
 intermenstrual bleeding

para 4 to. 13.4 forceps } Redlands

17 q SVD

ad. Gyn acutely June 90

15 q SVD

lower abd pain - no cause

6 q SVD

found

pink mil d.h. mil, ? allergic to reptin →
 'scabs in mouth' mil also

sh, mother - 15-20/day. fh, mil.

se, mil 1 rate

de, well, ° general signs of disease

CVS, pulse 80 bpm reg

JVP → Hs I + II + 0 @.

Resp trachea - chest clear

Abdo. NAB

Imp A 374 para 4 to & CIN 3 for cure Bx

plan admit, consult GTS.

Smith
 (Smith)

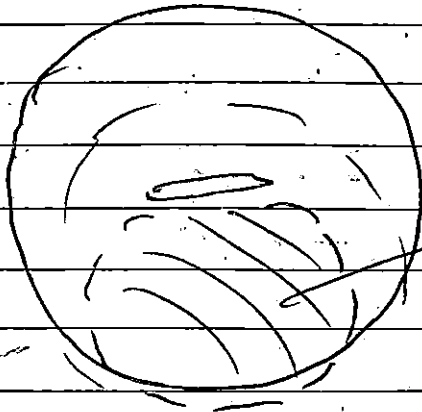
000049

HISTORY

(Use other side first)

Date

9/9/91

CONC BLOPPY
EIAD maxican
D DUTIKexophytic
friable
"tumour"

Above area removed by cone
 2½ cm wide x 2 cm long
 Canal created → tissue
 Sutures x 4 → haemostasis

PR: both uterosacral ligaments obvious
 but cannot detect tumour
 infiltration

? IB cervical carcinoma

may be

GREATER GLASGOW HEALTH BOARD

NAME

Hospital No.

Age

Sex

PHYS/
SURG.

Dept.
Ward

OUT PATIENT
HISTORY

000050

DATE

4/9/91 37 yr old F 2 1/2 miscarriages
P & B

Colt smear yrs ago?

RTT Para 4th - 18. PDA
G. SUDX3

RTT Leg 1985

SH Smokes 15/day

Old nose

Specimen - florid post-
cancer

looks suspicious

? Cervix 1 micro

⇒ Colposcopy

Kuz

PATIENT NURSING HISTORY

000051

DATE OF ADMISSION <u>5/7/90</u>	TIME <u>945pm</u> WARD <u>G-9</u>
PATIENTS NAME <u>Mary Watson</u>	HOSPITAL <u>W.I.G.</u>
ADDRESS <u>32 Kandoon Ave</u>	CONSULTANT <u>RICHARDS</u>
<u>Glasgow.</u>	HOSPITAL NO. _____
<u>615</u>	G.P. <u>DR TURNER</u> <u>221 GERRYTON AVE</u>
TELEPHONE NO. <u>/</u>	<u>Glasgow.</u>
DATE OF BIRTH <u>6/3/55</u> AGE <u>35</u>	TELEPHONE NO. _____
RELIGION <u>C/S.</u>	OCCUPATION <u>Housewife</u>
NEXT OF KIN (1) <u>MISS P. CUMMINGS</u> (SISTER)	SACRAMENTS OF THE SICK _____
ADDRESS <u>335 KINFARNS DR, GLASGOW</u>	NEXT OF KIN (2) _____
TELEPHONE NO. <u>/</u>	ADDRESS _____
RELATIVES NOTIFIED OF ADMISSION <u>YES</u>	TIME _____
PATIENT SPOKEN TO BY CONSULTANT _____	TELEPHONE NO. _____
RELATIVES SPOKEN TO BY CONSULTANT _____	CLOTHING LISTED _____
	PATIENTS OWN DRUGS _____

SOCIAL CIRCUMSTANCES lives with husband + 4 girls

17yrs 16yrs 14yrs 5yrs

REASON FOR ADMISSION acute P.I.D.

PATIENTS PERCEPTION OF ILLNESS inflammation of pelvis

DIAGNOSIS/OPERATION _____

OTHER HEALTH PROBLEMS lap ster 1985

ALLERGIES SEPTIN

000052

MAINTAINING A SAFE ENVIRONMENT

alert & orientated

NUTRITION

normal

ELIMINATION

no problems

HYGIENE

clean, skin intact

SLEEP

usually sleeps well

MOBILITY

up & around

SENSES

intact

BREATHING

mildly asthmatic - takes no medication

OTHER RELEVANT INFORMATION

LMP 2-3/52 ago Para 4+0

DISCHARGE PLANNING: HOME HELP ☐COMMUNITY NURSE ☐AMBULANCE ☐DRESSINGS ☐CASHIER ☐MEDICATION ☐APPOINTMENT ☐

TICK (✓) WHEN ARRANGED

OBSERVATIONS ON ADMISSION

TEMPERATURE

36.9

PULSE

80

RESPIRATIONS

BLOOD PRESSURE

110/76

HEIGHT

WEIGHT

URINALYSIS

SIGNATURE OF ADMITTING NURSE

Shaf

NAME: MARY WATSON

WARD: 69

DATE OF ADMISSION: 5/7/90

HOSPITAL:

HOSPITAL NO.:

000053

DATE	PROBLEM	AIM	EVALUATION DATE	PATIENT PROGRESS REPORT	PLEASE SIGN + DATE EACH ENTRY
			5/7/90	Emergency admission with pelvic inflammatory disease. I.V.I. in progress. I.V. antibiotics commenced. Oral analgesia given. Ashaj.	
			6/7/90	Slept well. I.V.I. continues. MSSU to be obtained. ✓ Ashaj.	
				Settled morning, washed up to sit. Observations satisfactory. NO % Pain. PV Loss very slight.	
					ST/N M Gallacher
				Scan this afternoon shows normal sized uterus. normal Endometrium. thin walled cyst lying above fundus to the R side of the midline. iii described in Dr Hays. intracystic septa. cystic mass. red. I drink. obese machine running.	
			8pm	Early settled evening. observations satisfactory.	
				no complaints of pain.	
			7/7/90	Slept well. PV loss slight.	Ashaj

DATE OF ADMISSION:

HOSPITAL NO.:

[illegible]

00056

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			
3/1/60													
3/2/60													
3/3/60													
3/4/60													
3/5/60													
3/6/60													
3/7/60													
3/8/60													
3/9/60													
3/10/60													
3/11/60													
3/12/60													
3/13/60													
3/14/60													
3/15/60													
3/16/60													
3/17/60													
3/18/60													
3/19/60													
3/20/60													
3/21/60													
3/22/60													
3/23/60													
3/24/60													
3/25/60													
3/26/60													
3/27/60													
3/28/60													
3/29/60													
3/30/60													
3/31/60													

NAME

MARY WATSON

UNIT NUMBER

69

WARD

69

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

CODE LETTER SCORED E.G. X = PATIENT ABSENT

000057

DATE OF ADMISSION: 5-7-90.

HOSPITAL NO. _____

[illegible]

TIME	INTAKE				000059 OUTPUT							
	PARENTERAL		Oral/ Nasogastric	Oral/NG Running Total	URINE	Urine Running Total	SECRETIONS					
	TYPE	AMOUNT					Vomit/ NG ASP	Wound Drain				
08-09	Flagyl?	100.	40	40.								
09-10			150	190.	100.							
10-												
11-												
12-			fish									
1:30pm 0.9% 1 p.m. sodium chloride		500.	✓									
2-												
3-												
4-												
5-	Dextrose 5%	500										
6-												
7-												
8-												
9-												
10-												
11-												
12-												
1 a.m.												
2-												
3-												
4-												
5-												
6-												
07-08												
TOTALS												
TOTAL INTAKE				ml	TOTAL OUTPUT							ml

NAME	Mary Watson
HOSPITAL NO.	6-7-90.

BALANCE	NEG	POS

ml

GREATER GLASGOW HEALTH BOARD

IN-PAT. **6**_A
FORM

000060

FIRST SIDE

24 HR FLUID BALANCE AND PRESCRIPTION SHEET

DATE FROM / /8 to / /8

NAME	HOSPITAL
MARY WATSON	No.
	AGE
	SEX
PHYS.	DEPT.
SURG	WARD
WHITEHEAD	69

[illegible]

OTHER ORDERS

60 drops per min = 500 ml in 2 hours

TIME	INTAKE				OUTPUT						
	PARENTERAL		Oral/ Nasogastric	Oral/NG Running Total	URINE	Urine Running Total	SECRETIONS				
	TYPE	AMOUNT					Vomit/ NG ASP	Wound Drain			
08-09											
09-10											
10-											
11-											
12-											
1 p.m.											
2-											
3-											
4-											
5-											
6-											
7-											
8-											
9-											
10-			Admitted								
11-	Plagyl	100									
12-			180	180							
1 a.m.											
2-	N/saline	500									
3-											
4-											
5-											
6-	Dextrose	500									
07-08											
TOTALS		1100									
TOTAL INTAKE				ml	TOTAL OUTPUT						ml

NAME	MARY WATSON
HOSPITAL NO.	5790

BALANCE	NEG	POS

ml

000061

HOSPITAL

HOSPITAL NUMBER

— 104
— 103
— 102
9
— 101
— 100
— 99
— 98

NAME

MARY
WATSON

HOSPITAL

No.

AGE 35 yrs

PHYS/

SURG.

PROF WHITEHEAD

DEPT

WARD

69.

RESUSCITATION AND
BLOOD PRESSURE CHARTIN-PAT
FORM 7

DIAGNOSIS:

SUGAR

URINE

ALB.

Drugs before admission

000062

DATE TIME

5/6/90 6/7/90 10 2. 6. 10 6 10 2 6 10

BLOOD
PRESSURE

PULSE RATE

RESPIRATION

KEY B.P. III
PULSE 
RESP. XXX

INTAKE ml

URINE ml

36 36 36 36 36 36 36 36 36 36

Temp

36.9
36

THERAPY

Re Mary Watson
32 Kendoon Ave.
Slasgaw 15.
DoB: 6/3/54.

000063

Dr. Katherine J Turner
Dr. Malachy Duffy
22 Merryton Avenue
Drumchapel
GLASGOW
G15 7PU
Tel: 041 944 4944

5/7/90

Dear Receiving Surgeon,

Thankyou for seeing
the above lady who has had
RIF pain since this a.m. On
Examination she is febrile - temp 38°C
Abd is markedly tender in her RIF.
She has had vaginal bleeding with
clots for 7 days (had a normal
period two weeks ago). She is sterilised
185

Yours faithfully,
Katherine Turner

000064

99

GREATER GLASGOW HEALTH BOARD
WESTERN DISTRICT

CASE RECORD

FILE IN PART 1 OF CASE RECORD

ADMISSION FORM

A/E 760744

HOSPITAL CODE 601		CASE REFERENCE No. 623238B	
PREVIOUS ATTENDANCE AT THIS HOSPITAL YES/NO		IN/OUT PATIENT	
SURNAME WATSON		MAIDEN NAME CUMMINGS	
FIRST FORENAME MARY	SECOND FORENAME	OTHER	INITIALS
DATE OF BIRTH 6-3-55 (35)	SEX 2	MARITAL STATUS 2	
ADDRESS 32 BLENDON AVE GLASGOW			
POST CODE G15	TELEPHONE No.		
FAMILY DOCTOR SURNAME BUTLER	INITIALS	G.P. TELEPHONE No.	
ADDRESS 22 MERRILTON AVE			
POST CODE G15	TELEPHONE No.		
ADMISSION: DATE OF ADMISSION 5-7-90	WARD No. 99	TIME OF ADMISSION 1950	
DATE PLACED ON WAITING LIST	ADMITTED/TRANSFERRED FROM	TIME OF ADMISSION	
CONSULTANTS SURNAME	PATIENTS RELIGION C/S		
OCCUPATION H/WIFE			
HUSBAND'S OCCUPATION (MARRIED WOMAN)/PARENT'S OCCUPATION (CHILD)			
REASON FOR ADMISSION SURG (CONJ)			
PROVISIONAL DIAGNOSIS ACUTE PID			
IF ADMISSION IS CONSEQUENCE OF ROAD TRAFFIC ACCIDENT: PLACE		DATE OF INJURY	
DETAILS		TIME OF INJURY	
IF ADMISSION IS CONSEQUENCE OF HOME ACCIDENT: PROBABLE CAUSE			
NEXT OF KIN: NAME MISS P CUMMINGS	RELATIONSHIP SISTER	TELEPHONE No.	
ADDRESS 335 KINFARNS DR		POST CODE G15	
OTHER RELATIVE OR FRIEND: NAME	RELATIONSHIP	TELEPHONE No.	
ADDRESS		POST CODE	
NAME	RELATIONSHIP	TELEPHONE No.	
ADDRESS		POST CODE	

CODING USED ABOVE

ADMITTED/TRANSFERRED FROM

- | | |
|--------------------------------|----------|
| 1. HOME | 6. |
| 2. OTHER HOSPITAL | 7. |
| 3. OTHER UNIT IN THIS HOSPITAL | 8. OTHER |
| 4. | 9. |
| 5. | |

TYPE OF ADMISSION

- | | |
|---|---|
| 0. DEFERRED ADMISSION | 6. EMERGENCY-HOME ACCIDENT
(INCLUDES ACCIDENTAL POISONING IN THE HOME) |
| 1. WAITING LIST | 7. EMERGENCY-OTHER INJURY (INCLUDES ACCIDENTAL
POISONING OTHER THAN IN THE HOME) |
| 2. BOOKED CASE | 8. EMERGENCY-OTHER
(EXCLUDING ACCIDENTAL POISONING) |
| 3. TRANSFER | 9. |
| 4. EMERGENCY-DELIBERATE SELF-INFLICTED INJURY
OR POISONING | |
| 5. EMERGENCY-ROAD TRAFFIC ACCIDENT | |

480000

DISCHARGE FORM

CONSULTANT IN CHARGE					
DATE OF DISCHARGE		TIME OF DISCHARGE			
HOSPITAL DIVISION OR UNIT		SUB-SPECIALITY CODE		DISCHARGE CODE	
CATEGORY OF PATIENT		TYPE OF FACILITY			
DIAGNOSES		1			
PRINCIPAL DIAGNOSIS		2			
OTHER		3			
CONDITIONS		4			
TO BE		5			
INDEXED		6			
INCLUDE EXTERNAL CAUSE OF INJURY AND TUMOUR TYPE WHERE RELEVANT		7			
		8			
SURGICAL OPERATIONS		DATE		DETAILS	
PRINCIPAL		1			
OTHER OPERATIONS AND DIAGNOSTIC PROCEDURES		2			
		3			
		4			
		5			
		6			

CODING USED ABOVE**HOSPITAL DIVISION OR UNIT ON DISCHARGE OR TRANSFER****(SEE SEPARATE SPECIALITY LIST FOR CODINGS)****SUB-SPECIALITY CODE****(SEE SEPARATE SPECIALITY LIST FOR CODINGS)****TYPE OF FACILITY**

- | | |
|---------------------------------|------------------------------------|
| 1 Ordinary Inpatient | 6 Day Bed Unit |
| 2 Convalescent Hospital or Home | 7 Day Case in Inpatient facilities |
| 3 Other Hospital | 8 Other Day Case |
| 4 Local Authority Care | 9 |
| 5 5-day ward | |

CATEGORY OF PATIENT

- | |
|-----------|
| 1 Amenity |
| 2 Paying |
| 3 N.H.S. |

DISCHARGE CODE

- | |
|---|
| 0 'Irregular' - e.g. Self Discharge |
| 1 Home |
| 2 Convalescent Hospital or Home |
| 3 Other Hospital |
| 4 Local Authority Care |
| 5 Transfer to other speciality in same hospital |
| 6 Died (P.M.) |
| 7 Died (No P.M.) |
| 8 Other |

ADMISSION PROFORMA

000065

NAME	Hospital No.
ADDRESS	Date of Birth

A. Q.1 Have you

{has your husband/wife}
{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 Q.2.

Q.2 Are you

{is your husband/wife}
{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:

Q.3 On what date did you

{your husband/wife}
{your mother
{your father }

arrive in the UK?

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

B. Folders or forms should be marked to provide for these entries:

"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.

GREATER GLASGOW HEALTH BOARD
Western Infirmary
Glasgow G11 6NT
Tel: 041-339 8822

000066

MEDICAL
RECORD

IMMEDIATE DISCHARGE LETTER

Dear Dr. unew Date 6/11/97
Your Patient Mary Watson Date of Birth 1/1/57
Address
Hosp. Number 623238
Has been under the care of in Ward G and was
discharged on 1/11/97 with a diagnosis of:—
1. chronic cyst
2.
3.

A full discharge letter will follow. The patient has been discharged on the medication detailed below. The recommended duration of the treatment is shown from the date of discharge. A FIVE DAY supply HAS/HAS NOT* been dispensed by the Hospital.
(*Delete as appropriate).

NOTE TO THE HOSPITAL PRESCRIBER:

1. USE A BIRO PEN AND PRESS FIRMLY.
2. State the number of days that the treatment is to continue from the date of discharge.
3. If the treatment is to be for an indefinite period write "INDEFINITE".
4. If treatment is to be intermittent or irregular give full details.

FOR PHARMACIST

Medicine	Form of Preparation (e.g. Tabs)	Dose	Frequency	Recommended Duration of Treatment from Date of Discharge (Days)	Quantity, Name & Strength Supplied by Pharmacy
Cephalexin	tabs	500mg	OID	5	
metronidazole	tabs	400mg	TD	5	

Drug Sensitivities 1.
2.
3.

PHARMACIST
DATE

OTHER TREATMENT AND COMMENTS (Include Details of Appliances)

A follow-up appointment has been given. ☐
A follow-up appointment is not necessary ☐

DRs. NAME IN BLOCK CAPITALS LESLIE M. STAY WARD G

Yours sincerely

OPEN BEFORE WRITING

DATE: 30.01.90

CLINICAL NOT

30.01.90 with onset 7 days ago.

No cardiac symptoms.

No respiratory symptoms.

01.05. flushed & distressed. not shocked.

pulse rate = 110/min tachycardia.

AS I + II + r2.

no ccf.

Chest clear - no wheeze.

generalised distention of low abdomen.

laparoscopic sterilisation scar (v. small).

no other scars.

abdomen soft. no masses palpable.

Tender to R. lower quad, no rebound.

BS ✓ present.

CNS - grossly intact.

Imp - Gynaecological problem.

Ref. Rauling

5/1/90 G.P. Ref.!

Developed lower abdominal pain a week ago, after starting to bleed heavily pr, 2 weeks after her last normal period. Pains have continued all week, but have become much more severe today. Somewhat anorectic, nauseated, vomited yesterday, but not today. Has been eating this week. Bowels have been moving this week, last moved yesterday, normal bowel movement. No diarrhoea, no blood pr.

No dysuria, some frequency of micturition but? only because have to go to toilet frequently with bleeding.

LMP 2/52 age normal. Periods initially regular, and only last 3-4 days. This week has been flooding, less

ACCIDENT & EMERGENCY DEPARTMENT

GLASGOW

G11 6NT

TEL: 041-339 8822

GREATER GLASGOW HEALTH BOARD

AE No. C/ 760744

ACCIDENT/EMERGENCY FORM

HOSPITAL CODE 601

SURNAME WATSON

FORENAMES MARY

ADDRESS 32 KENDALL AVE, GLASGOW

POSTCODE G15

TELEPHONE No. 635535

DATE OF BIRTH 6.3.55

SEX F

MARITAL STATUS H.W.I.F.E.

RELIGION C.S.

NEXT OF KIN NAME Miss P. Cummings

RELATIONSHIP SISTER

ADDRESS 335 KINFARLS DR., GLASGOW

POSTCODE G15

TELEPHONE No. 615

ACCIDENT/EMERGENCY: DATE OF ATTENDANCE 5.7.90

PREVIOUS ATTENDANCE AT THIS HOSPITAL YES/NO NO

REASON FOR ATTENDANCE URGENT (Gynaecological)

DATE OF INJURY OR ILLNESS 1/52

TIME OF INJURY 8.00

TYPE (CODE) 8

SOURCE OF REFERRAL A.M.B.

GP SELF POLICE OTHER (CODE)

ROAD TRAFFIC ACCIDENT PLACE

DETAILS

HOME ACCIDENT PROBABLE CAUSE

TO BE COMPLETED BY MEDICAL OFFICER AFTER SEEING PATIENT

Dear Doctor, TURNER

The above-named patient attended Accident & Emergency Department today.

Diagnosis Ante P.D.

X-Ray film/ECG shows Admitted to 14 clinic / investigation

Treatment given with sub result pending

Drugs days supply of has been given.

Tetanus Prophylaxis has/has not been administered. TT Course TT Booster HATI (Please Tick)

Would you please arrange

DISCHARGE CODES: Please Circle

1. Admission 3. Refer to G.P. 5. Died 7. Irregular Discharge

2. Discharge 4. Transfer to other hospital (see below) 6. Refer to O.P. Clinic (see below) 8. D.O.A.

Ward No. (if admitted) G9

Transfer to Hospital

Consultant (if admitted) H117.7160

Follow Up Not arranged Arranged To be arranged

Clinic Referred to AE Hand Fracture Ortho Medical Surgical Skin ENT Gyn. Others Specify

Medical Officers Name (in Block Letters) KINGDOM

Signature of Medical Officer

Cons SR Reg SHO/JHO Clin Assist (please circle)

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)					
DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION	SIGNATURE
					000068

CONSULTANT _____ REG/SNO _____ JHO RAVENING

SEEN BY Dr. Ravening AT (TIME) 8:20pm

CLINICAL NOTES

DATE GP Referral letter - NO PHONE CALL

PC. 6 days of "niggling" central abdominal pain. then suddenly much worse today - colicky comes for ~ 10 mins - v. severe then goes away for ~ 1 hr. Associated nausea / no vomiting. Has been having v. heavy vaginal bleeding for 7 days now - not usual period for her. only finished period ~ 2 weeks ago & insists that is usually regular. Not constipated. No diarrhoea. Frequency of urine - no dysuria/nocturia. noticed distension of lower abdomen.

PMH. Laparoscopic sterilisation - 1985. 4 children - eldest = 17. No other operations/illnesses.

drugs none.

social smoker 15/day no alcohol. Lives w husband & children.

TO BE RECORDED ON ARRIVAL
36 P. 100 R. BP. 180/90
Wine { spec gravity 1.000
trace of blood

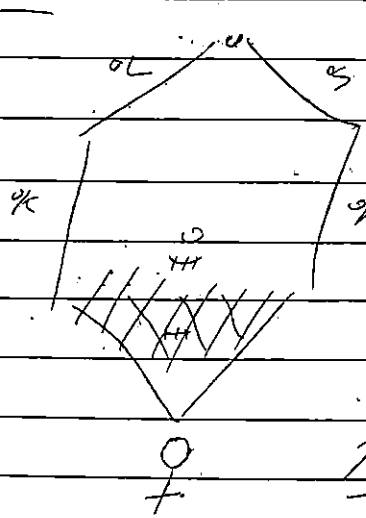
KEY TO CLINICAL NOTES
1 - HISTORY OF
2 - ON EXAMINATION
3 - X-RAY FINDINGS
4 - TREATMENT GIVEN
5 - DISPOSAL
6 - NAME OF MEDICAL OFFICE

NAME	HOSPITAL
<u>MARY WATSON</u>	No.
	AGE
PHYS/ SURG.	DEPT. WARD

IN-PAT
FORM 3

IN PATIENT
CONTINUATION HISTORY

000070

DATE	
	<u>PMH</u> No ops Sterilized 5 yrs ago. No Diabetes, No TB, No Jaundice, Asthma diagnosed 2 yrs ago.
	<u>Drugs</u> Inhaler - not often used. <u>Allergies</u> Cotrimoxazole - 2 month course.
	<u>L.H.</u> Smokes 15/day, occ alcohol, Married, 4 daughters.
	<u>O/E</u> Apyrexial (nb G.P. temp 38°C). Distressed with lower abdominal pain. Tongue moist, no Cx lymphadenopathy Chest clear. St. (R) loin pain.
	<u>Abdo</u>  Soft in lower abdomen. Tender across lower abdomen low down unpropagably as well as in (L) & (R) IF. No rebound. <u>PR</u> Very tender Cx excitation. <u>PV</u> not attempted.
	<u>IMP</u> App+ less likely. Clearview -ve ? PID.
	<u>Plan</u> Refer to Gynaecology.

Stump 260

000071

HISTORY

(Use other side first)

Date

GYNECOLOGY

7/1/90

Age 35 Para 4th started 1985.21⁰⁰

$$\frac{3}{28}$$
 LMP 2-3/52 ago

PV bleeding

 Heavy⁺, began 1/7/90 - unexpected. not postcoital
 Lr abd pain.
pain present each day, now nose⁺ and sticky.

no IM discharge, no dyspareunia.

legs normal, no vomiting. bowels normal

General health normally good. No cervical smear for 5 years

PMHx nil serious.

Allergies to penicillin

SR no dyspnea, normal bowel movement yesterday.

Moved some Lr abd distension.

 % Inspected with Lr abd pain. A little flushed; but temp (N).
 chest clear

ABD



Slight Lr abd distension

Bowel sounds (N). No masses

Lr abd tender - no guarding.

 Pr. Speculum: Some excitation Gx. Pains os - regular.
 No bleeding. No post discharge

Uterus Av tender. Adnexae tender. no masses

TMP Antic PID

Chlamydia -ve

- ectopic extremely unlikely

FBC

✓

U/E/Amplase

✓

Gx sub - C/S + chlamydia. ✓

PHCG ✓

IV fluids Lr Ghty.

Use ceftriaxone/mefenamic acid as no dysuria. Will

need separate Rx if chlamydia present.

J. Taylor REAGAN

NAME May Watson	HOSPITAL No.
	AGE
PHYS/ SURG. WATERFIELD	DEPT. WARD

IN PATIENT
CONTINUATION HISTORY

INPAT
FORM

000072

DATE

- suggest pulse USS if fails to resolve, but
not entirely as quite sure

Jo

ht 146	} Normal
wt 4.6	
urea 2.9	
glucose 5.4	
Amplase 85	

0745

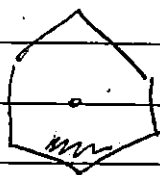
Reviewed.

6/7/90

"feinted" attempted to go to bathroom, accompanied with
hr abd pain. vomited x1 - saliva only.
Has had a stable night. Temp (N)

O/E BP 110/70 pulse (N)

ABD



Mild hr abd tenderness

no rebound

not distended BS normal

no focal signs

no mass felt

PV not repeated.

IMP. No new signs to suggest surgical cause.
Review again at lunchtime & check serum
HCG to validate the negative cleavious. Continue
antibiotics.

Thompson

000073

HISTORY
(Use other side first)

Date

6/7/90. More comfortable today - does not look
distressed. Spontaneous at present.

Abd Soft - only slight suprapubic
tenderness - Abdomen slightly
distended in suprapubic area.

Impression: ~~Abd~~ erect supine abdomen
- Pelvic ultrasound.

Impression: ~~I think~~ seems to be
settling - observe for present.

7/7/90 Temp = 37.2
Abdomen still tender &
distended

Review Monday

JAH

90 well - settled.

Seem satisfactory & stone tomorrow or
today or

