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

NHS
Greater Glasgow and Clyde

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

Date: 24/07/2026
Your Ref: DSAR-20260622-61BA5F
Our Ref: SAR/ACCESS/ CD
Enquiries to: Chrissy
Direct Line: 0141 201 3379
Email: chrissy.davie@nhs.scot

Dear Sir/Madam

Re: Subject Access Request under the General Data Protection Regulation

Patient: RYAN MCCOURT **D.O.B: 19/04/1994**

Thank you for your request received 08TH July 2026 in which you seek a copy of your client's personal information.

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

GLASGOW ROYAL INFIRMARY & STOBHILL HOSPITAL RECORDS

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

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

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

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

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

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

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

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

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

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

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

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

Yours sincerely

Subject Access Request Team

ELECTRONIC PATIENT RECORDS

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

Including:

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

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Stobhill Hospital
133 Balornock Road
Glasgow
Lanarkshire
G21 3UW

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 30/07/2022

Consultant: Dr Neil Dignon

C Howat
Drs Howat legge hunter & newhouse
The Barony Medical Centre
30 Auchinloch Street
Glasgow
Glasgow
G21 4AH

Dear C Howat

Re: **McCourt Ryan** DOB: **19/04/1994** CHI: **1904946291**
7 Freeneuk Lane
Glasgow G72 7JW

Attended on: **30/07/2022 at 15:46 hrs.** Departed on: **at hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
lac to finger - left hand

Nursing Assessment:

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Open Wound of Finger(S) Without Damage to Nail	**Left**	**Finger: Thumb**

Procedures: **1. Wound glue other**

Immunisations: **DipTPV DIP/TET/Polio Vaccine > 10 years**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:

Followup :
Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Rose Dhesi
Nurse

Copies to:
1. C Howat (GP)

School Address:

CHI: 1904946291

Stobhill Hospital

Total Att: **5**

12 Mth Att: **0**

Title: **MR**

MCCOURT **Ryan**

DOB **19/04/1994** Age: **28y** Sex: **Male**

7 Freeneuk Lane
Cambuslang
Glasgow
G72 7JW
07566890731

Next of kin: **MCCOURT, MARY**
Relationship: **Parent**
07878048331

GP: **C Howat**
0141 557 6161

Attendance Date: **30/07/2022** Arrival Time: **15:46**

Registration Time: **15:46** Date of Incident: **30/07/2022**

Major Incident Desc:

Reason for Attendance: **lac to finger - left hand**

Nursing Assessment

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

Triage Category: **0** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **30/07/2022 15:49** Nurse name: **Nurse Rose Dhesi**

Temp		C
HR		bpm
BP	/	mmHg
MAP		mmHg
RR		bpm
SpO2		%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils-Right		Pupils-Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes:

1904946291 19/04/1994 MCCOURT Ryan

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1904946291 19/04/1994 MCCOURT Ryan

RHD ♂ 28yrs Grounds worker.

Date	Clinical Notes
	Seen By RM Dhesi — Time Seen 1640

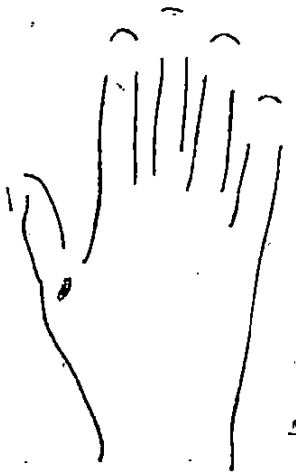
HPC

Helping friend to move a sofa into a van this afternoon (L) hand dragged on sharp edge of van door

C/o wound (L) thumb. Last ATT >10yrs ago

PMH NIL DH NIL NKDA

O/E



1.5cm flap wound palmar aspect (L) thumb as per diagram. Base of wound visible, no exposed underlying structures. No surrounding bruising / swelling Full ROM thumb, no bony tenderness N/V intact.

Dx Laceration (L) thumb.

Rx Clean

Glue + steristrips + dressing
Wound care advice
Advised re signs of infection.
ATT booster

RM Dhesi 1700

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By
30/7	Revaxis	0.5ml	IM	1655	S/C	RM Dhesi

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GLASGOW ROYAL INFIRMARY	☑		
INVERCLYDE ROYAL HOSPITAL	☐	MATERNITY	☐
NEW VICTORIA ACH	☐		
PRINCESS ROYAL MATERNITY	☐		
QUEEN ELIZABETH UNIVERSITY HOSPITAL	☐	MATERNITY	☐
ROYAL ALEXANDRA HOSPITAL	☐	MATERNITY	☐
ROYAL HOSPITAL FOR CHILDREN	☐		
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METAVISION	☐
PHYSIOTHERAPY	☐
RADIOLOGY	☑
WEST MARC	☐
LABS	☐

EMERGENCY DEPARTMENT
GLASGOW ROYAL INFIRMARY
84 CASTLE STREET
GLASGOW
G4 0SF

NHS
Greater Glasgow and Clyde

Dr JAMES MCKINLAY
THE BARONY MEDICAL CENTRE
30 AUCHINLOCH STREET GLASGOW
G21 4AH

Date: 22 Apr 2012

Dear Dr JAMES MCKINLAY,

Re: RYAN MCCOURT, 0/1 427 BILSLAND DRIVE, GLASGOW, G20 9JN
Date of Birth: 19/04/1994 CHI number: 1904946291

Your patient attended Glasgow Royal Infirmary on the 22 Apr 2012.

The presenting complaint was:	**STANDB/JUMPED FROM WINDOW**
Triage information:	**Not recorded**
The following investigations were carried out:	**None**
The A&E diagnosis was:	**** INJURY- NOT ASSAULT** - FRACTURE-CLOSED - SPINE - LUMBAR**
The following treatment was given:	**None**
At the conclusion of treatment the patient was:	**ADMITTED**
Follow-up:	**ADMITTED**
Additional information:	**None**

Yours sincerely,

JOCELYN BRITLIFF
EMERGENCY DEPARTMENT DOCTOR

Department of Trauma & Orthopaedics
Glasgow Royal Infirmary
84 Castle Street
Glasgow G4 0SF

TEL: 0141 211 5838
FAX: 0141 211 4060

NHS
Greater Glasgow and Clyde

DISCHARGE SUMMARY

CONSULTANT: MISS N. JANE MADELEY

ADMITTED:	22/04/2012	WARD:	61
DISCHARGED:	24/04/2012	AGE:	19/04/1994
HOSPITAL NUMBER:	23096429V	CHI NUMBER:	1904946291
DISPOSAL HOME		NAME :	Mr Ryan McCourt
FOLLOW UP		ADDRESS:	0/1 427 Bilsland Drive Glasgow G20 9JN
DISTRIBUTION OF LETTERS : Dr James McKinlay The Barony Medical Centre 30 Auchinloch Street Glasgow G21 4AH			

	FINAL DIAGNOSIS	ICD10		OPERATION	OPCS
1.	L2 fracture		1.		

Dear Dr McKinlay

The above named 18 year old gentleman jumped 30feet from a window onto concrete having lost his keys. He landed on his feet but complained of sudden back pain. He was taken to A&E where imaging was carried out which confirmed comminuted fractures through the superior endplate of L2. There was also slight loss of height of L1 vertebral body. However the posterior elements of the spine were undamaged and we were able to confirm with the spinal injuries unit that this was a stable injury which could be treated with mobilisation as able. In order to facilitate this he was fitted with an airback brace by our Orthotic Department. This enabled him to be mobilised with analgesia. Ryan was made aware that it could take 6-8 weeks for his symptoms to markedly improve but that no further treatment is required. Never at any point did he have any abnormal neurology. He will have follow up in the fracture clinic in due course to make sure his symptoms are settling as expected.

Yours sincerely

JANET McCAUL
Specialist Registrar - Orthopaedics

Department of Trauma & Orthopaedics
Glasgow Royal Infirmary
84 Castle Street
Glasgow
G4 0SF

Telephone: **0141 211 1243**
Fax: **0141 211 4060**
Appointments: **0141 211 4608**

TRAUMA HAND CLINIC

Clinic and dictated: 21/09/2010
Typed: 24/09/2010
Our Reference: GM/HB

Dr James McKinlay
The Barony Medical Centre
30 Auchinloch Street
Glasgow
G21 4AH

Dear Dr McKinlay

Re: Mr Ryan McCourt 19/04/1994; CHI: 1904946291; CRN:23096429V
18 Pinkston Drive Flat 5/6 Glasgow G21 1NP

Diagnosis **Right Bennet's fracture 21 08 10**
Outcome **Return appointment in 4 weeks' time to hand clinic**

This lad attended our fracture clinic today. His mum remained in attendance throughout his clinic appointment.

As previously discussed with Mr Sianos, orthopaedic surgeon, at today's trauma hand meeting. This lad has sustained a right Bennet's fracture during a game of football.

On examination normal colour and sensation appeared to be evident to the limb. Slight swelling is evident over the right thumb with localised tenderness. A right Bennet's cast has been applied today. Advice has been given with regard to cast care and an acceptable level of activity.

Ryan will be further reviewed in 4 weeks' time at the hand clinic for further management. He has a contact telephone number and advised to contact the clinic should any problems or concerns arise.

Yours sincerely,

G McIntyre
STAFF NURSE

Accident and Emergency Department

Glasgow Royal Infirmary

4

NHS
Greater Glasgow and Clyde
Glasgow Royal Infirmary
Glasgow G4 0SF
Tel: 0141 211 4484/4314
Fax : 0141 552 5384

23096429V

A&E No. 09056988

4

Surname	MCCOURT	**Forename**	RYAN	**Title:** MR
Address:	18 PINKSTON DRIVE FLAT 5/6 GLASGOW	**Postcode** **Telephone:**	G21 1NP 07926248213	**CHI No:**1904946291
Date of Birth:	19.04.94	**Sex:**	M	**Age:** 15 yrs

GP Name:	CRON ALISON		
Address:	THE BARONY MEDICAL ... 30 AUCHINLOCH STREET GLASGOW.	**Postcode** **Telephone:**	G21 4AH 0141 557 6161

Next of Kin	MARY MCCOURT		
Relationship:	PARENT		
Address:	18 PINKSTON DRIVE FLAT 5/6 GLASGOW	**Postcode** **Telephone:**	G21 1NP 07926248213
Primary Carer:	ST ROCHS SEC.		

Date of Attendance: 29.09.09 15:25
Date of Incident:
Presenting Complaint: LIMB PROBLEM

Triage IINJURED RT HAND AT COLLEGE USING A STANLEY KINFE ACCIDANTALLY PUT SAME THROUGH 3RD AND 4TH WEB SPACE OF HAND NO ALLERGIES UNSURE IF COVERED FOR ETET TOX DRESSING INSITU ALSO CONCERNED RE OLD WOUND TO RT ARM ? INFECTED

Tetanus Cover:

Allergies:

P= **BP=** / **RR=** **Sat=** **BM=** **Temp=**

PF= **GCS=** E: M: V: Total:

Drugs Prescribed

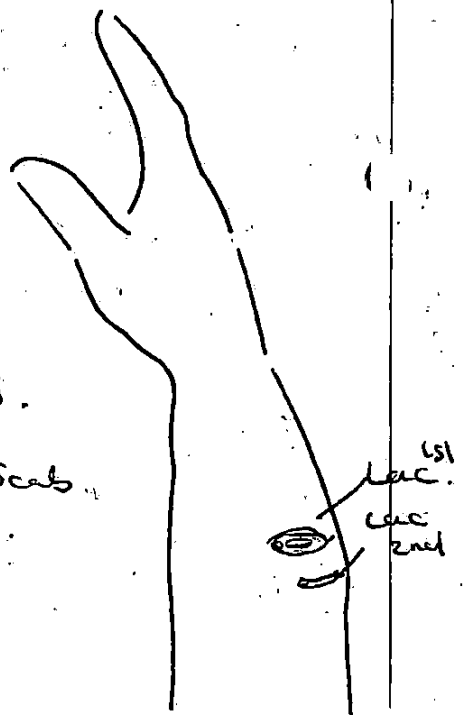
Date	Drug	Dose	Route	Signature	Given By	Time

29/9/09 Verbal Consent to examine

PC ® Forearm & hand **General Notes** ® hand dominant
injury.

HPC ® Forearm. Patient reluctant to divulge ~~injury to~~ mechanism
of injury to ® Forearm. Informative gives that it was caused
by glass and over one week old.

O/E Two lacerations noted at ® Forearm
1st about 1 inch in length. Previously gaping wound, however
now scabbed over. Light pink margin around scabs. Tenderness
felt at wound margin.
Scabs dry and no apparent leakage.
2nd lac about.



PMH - Asthma DH - NIL Allergies - NIL
ATT - unsure
Plan - Soft tissue xray to ® Forearm.
Results - NO FB seen
Plan. - Area dressed - scab well adhered
- Advised patient to shower and wash area well.
- Advised not to pick scabs. Scab will come off as wound heals.

Discharged

23096429V
MCCOURT
RYAN M
19/04/1994
18 PINKSTON DRIVE
FLAT 5/6
GLASGOW G21 1NP
CHI-1904946291

Have you considered Child Protection? (Please Circle)

N/A No Yes (Refer to Child Protection flow chart)

Patient x-rayed

Yes ☐ **No** ☐

Ward No. (*if admitted*)	Transfer to:

Doctor/ENP name (*PRINT*)	Signature of Doctor/ENP
Irene Yardley	Irene Yardley
CON SpR AS MG CA FY2 ENP *(please circle)*	

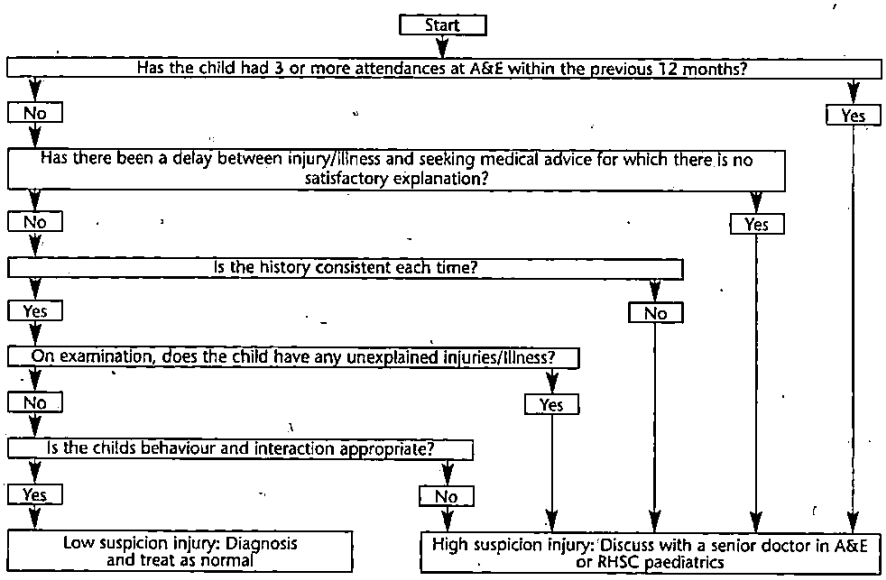
Glasgow Royal Infirmary ED Record

NHS Greater Glasgow and Clyde

23096429V
MCCOURT M
RYAN 19/04/1994
18 PINKSTON DRIVE
FLAT 5/6
GLASGOW G21 1NP
CHI-1904946291

Injury Flow Chart for all Patients 16 and under

Please tick the appropriate box as you go through the Flow Chart



All Clinical Staff Consider

H.I.Form ☐

Audit Form ☐

Police Consent ☐

Clinical Notes

29/9/09

(12) head injury.

Hpc Patient cutting paper with scissors today. Scalpel slipped and entered web space between middle and ring finger. Scarple did not become embedded into hand. Slight bleeding at time of injury.

O/E No bruising or scratches to middle, ring finger or web. Space between both.

Lac < 1 cm to web space between middle and ring finger.

Bony tenderness proximal, middle, distal phalanx of middle and ring finger.

Bony tenderness over MCP joint ring finger.

Patient c/o numbness to distal aspect of ring finger palmer surface.

Soft / sharp sensation test to both middle & ring finger with patients eyes close. Radial, ulna and median nerve intact.

Skin surface ~~is~~ clammy and naturally warm to fingers.

23096429V
MCCOURT M
RYAN 19/04/1994
18 PINKSTON DRIVE
FLAT 5/6
GLASGOW G21 1NP
CHI-1904946291

Clinical Notes

29/9/09

Vascular test. CRF < 2 seconds to both medelle and ring finger.
Movement - Able to flex and extend medelle and ring. activity and resisted.
Plan - xray ® hand to exclude bony injury
Results - no # seen.
Plan - Wound irrigated
- Bandage and, repose dressing
- discussed sign / symptoms of wound infection and seeking medical attention
- Replacement dressing supplied

Irene Yardley RN.

ED
Glasgow Royal Infirmary
Unitary Patient Record

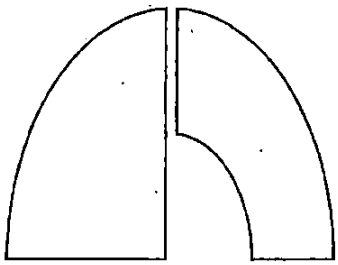
NHS
Greater Glasgow and Clyde

23096429V
MCCOURT M
RYAN 19/04/1994
18 PINKSTON DRIVE
FLAT 5/6
GLASGOW G21 1NP
CHI-1904946291

Clinical Notes

Lac.

X-Ray results



ECG findings

Other investigations

Fluids Prescribed in A&E

Drugs Prescribed in A&E

Refusal of Treatment

Hereby I declare that I am leaving

*(or taking _____ away from)

the _____ Hospital at my own desire and contrary to the advice of medical staff.

I have had the risks of so doing explained to me, and accept full responsibility for my action.

Signature _____

Witness Date _____

* Delete whichever is inapplicable.

23096429V
MCCOURT M
RYAN 19/04/1994
18 PINKSTON DRIVE
FLAT 5/6
GLASGOW G21 1NP
CHI-1904946291

Biochem/Haematology results

Indicate which lab tests have been requested

Haem		
WCC		
Hb		
Plat		
MCV		
Neut		
DDim		
PT		
PTT		
TT		

Bioch		
Na^+		
K^+		
Cl^-		
Ur		
Creat		
Glu		
CRP		
Bil		
AST		
ALT		
GGT		
ALP		
Prot		
Alb		
Glob		
Ca^{++}		
Amyl		
TSH		
FT4		
TropI		
Chol		
Trig		
Para		
Sal		
S osm		
ABG		
H^+		
P_aCO_2		
P_aO_2		
Bic		
BE		
FiO_2		
Lactate		

Department of Orthopaedic Surgery
MISS N. JANE MADELEY

Glasgow Royal Infirmary
84 Castle Street
Glasgow G4 0SF
Tel: 0141 211-5838

Ward Round

W61
Date: 22/04/2012

Mr Ryan McCourt, 0/1 427 Bilsland Drive Glasgow G20 9JN
Hospital No: 23096429V
CHI No: 1904946291

Mr McCourt is a 19 year old boy who jumped 30 feet from a window whilst intoxicated at his 18th birthday party, landed on his feet on the concrete path outside. He was walking when the ambulance services arrived but developed back pain. He was treated with spinal protocols. The spine was cleared. He now has tenderness over L1/2 with no neurological deficit.

On examination today he has normal power, sensation, reflexes throughout his lumbar spine. There are no abnormalities or pain on examination. He has multiple minor grazes but no other injuries. C-spine examination again is not painful. He has a fracture to both L1 and L2 noted on his lumbar film with wedging of L2 with a loss of approximately 4% height. The plan is for CT scan of the lumbar spine, to be flat in bed until this has been done.

Miss N. Jane Madeley, F.R.C.S. (Tr & Orth)
Consultant Orthopaedic Surgeon

This ward round note has not yet been checked by the Consultant.

Department of Orthopaedic Surgery
MISS N. JANE MADELEY

Glasgow Royal Infirmary
84 Castle Street
Glasgow G4 0SF
Tel: 0141 211-5838

This ward round note has not yet been checked by the Consultant.

CT Spine lumbar

Performed	22-Apr-2012 10:48	Received	22-Apr-2012 12:26
Reported	22-Apr-2012 12:00	Order Number	G107H26831914
Status	Final	Source System	MiSys

CT Spine lumbar Final
Ryan McCourt
Clinical History :
Fall from 30 feet. L2 fracture on plain film.

CT Spine lumbar :

CT confirms a comminuted fracture through the superior endplate of the L2 vertebral body with several small fracture fragments lying just anterior to the anterior superior corner of the to the body. The posterior cortex is intact.

There is also slight loss of height of the L1 vertebral body with an irregular cortical outline of the antero-superior corner, suspicious of a further undisplaced fracture.

There is a lucent line running through the inferior articulating processes of the posterior elements of L1 bilaterally. Although the margins do appear relatively corticated, appearances are thought most likely to represent acute avulsion type fractures.

Conclusion:
Fractures of L2 and probably L1 anterior vertebral bodies and inferior articulating process of L1.

Reported by: Dr Ewen Robertson (SpR) and Dr Subra Viswanathan
Verified by: Dr Subra Viswanathan

XR Wrist Rt

Performed	22-Apr-2012 02:25	Received	22-Apr-2012 10:51
Reported	22-Apr-2012 10:22	Order Number	G107H26831725
Status	Final	Source System	MiSys

XR Cervical spine Final
Ryan McCourt
Clinical History :
Jumped 30 feet. Back pain. Wrist tender.

XR Cervical spine : Lateral, AP and open-mouth peg view performed.

An incomplete trauma series. The cervico- thoracic junction is not visible on the lateral projection of either the cervical or thoracic spine radiographs.

However, vertebral alignment is maintained with no prevertebral soft tissue swelling. No evidence of cervical spine fracture.

Code N: No note: No sticky note available. Referrer's interpretation is unknown

XR Thoracic spine :
No evidence of thoracic vertebral malalignment or acute fracture. No para-vertebral soft tissue swelling.

Code N: No note: No sticky note available. Referrer's interpretation is unknown

XR Lumbar spine :
There is loss of height of the L1 and L2 vertebral bodies with a fracture fragment anterior to the antero-superior corner of L2 vertebral body. The posterior vertebral cortices appear intact.

If there is concerning neurology, further imaging is recommended.

Code N: No note: No sticky note available. Referrer's interpretation is unknown

XR Wrist Rt :
No evidence of acute fracture.

Code N: No note: No sticky note available. Referrer's interpretation is unknown

Reported by: Dr Ewen Robertson (SpR)
Verified by: Dr Ewen Robertson (SpR)

XR Thoracic spine

Performed	22-Apr-2012 02:25	Received	22-Apr-2012 10:51
Reported	22-Apr-2012 10:22	Order Number	G107H26831723
Status	Final	Source System	MiSys

XR Cervical spine Final
Ryan McCourt
Clinical History :
Jumped 30 feet. Back pain. Wrist tender.

XR Cervical spine : Lateral, AP and open-mouth peg view performed.

An incomplete trauma series. The cervico- thoracic junction is not visible on the lateral projection of either the cervical or thoracic spine radiographs.

However, vertebral alignment is maintained with no prevertebral soft tissue swelling. No evidence of cervical spine fracture.

Code N: No note: No sticky note available. Referrer's interpretation is unknown

XR Thoracic spine :
No evidence of thoracic vertebral malalignment or acute fracture. No para-vertebral soft tissue swelling.

Code N: No note: No sticky note available. Referrer's interpretation is unknown

XR Lumbar spine :
There is loss of height of the L1 and L2 vertebral bodies with a fracture fragment anterior to the antero-superior corner of L2 vertebral body. The posterior vertebral cortices appear intact.

If there is concerning neurology, further imaging is recommended.

Code N: No note: No sticky note available. Referrer's interpretation is unknown

XR Wrist Rt :
No evidence of acute fracture.

Code N: No note: No sticky note available. Referrer's interpretation is unknown

Reported by: Dr Ewen Robertson (SpR)
Verified by: Dr Ewen Robertson (SpR)

XR Lumbar spine

Performed	22-Apr-2012 02:25	Received	22-Apr-2012 10:51
Reported	22-Apr-2012 10:22	Order Number	G107H26831724
Status	Final	Source System	MiSys

XR Cervical spine Final
Ryan McCourt
Clinical History :
Jumped 30 feet. Back pain. Wrist tender.

XR Cervical spine : Lateral, AP and open-mouth peg view performed.

An incomplete trauma series. The cervico- thoracic junction is not visible on the lateral projection of either the cervical or thoracic spine radiographs.

However, vertebral alignment is maintained with no prevertebral soft tissue swelling. No evidence of cervical spine fracture.

Code N: No note: No sticky note available. Referrer's interpretation is unknown

XR Thoracic spine :
No evidence of thoracic vertebral malalignment or acute fracture. No para-vertebral soft tissue swelling.

Code N: No note: No sticky note available. Referrer's interpretation is unknown

XR Lumbar spine :
There is loss of height of the L1 and L2 vertebral bodies with a fracture fragment anterior to the antero-superior corner of L2 vertebral body. The posterior vertebral cortices appear intact.

If there is concerning neurology, further imaging is recommended.

Code N: No note: No sticky note available. Referrer's interpretation is unknown

XR Wrist Rt :
No evidence of acute fracture.

Code N: No note: No sticky note available. Referrer's interpretation is unknown

Reported by: Dr Ewen Robertson (SpR)
Verified by: Dr Ewen Robertson (SpR)

XR Cervical spine

Performed	22-Apr-2012 02:25	Received	22-Apr-2012 10:51
Reported	22-Apr-2012 10:22	Order Number	G107H26831722
Status	Final	Source System	MiSys

XR Cervical spine Final
Ryan McCourt
Clinical History :
Jumped 30 feet. Back pain. Wrist tender.

XR Cervical spine : Lateral, AP and open-mouth peg view performed.

An incomplete trauma series. The cervico- thoracic junction is not visible on the lateral projection of either the cervical or thoracic spine radiographs.

However, vertebral alignment is maintained with no prevertebral soft tissue swelling. No evidence of cervical spine fracture.

Code N: No note: No sticky note available. Referrer's interpretation is unknown

XR Thoracic spine :
No evidence of thoracic vertebral malalignment or acute fracture. No para-vertebral soft tissue swelling.

Code N: No note: No sticky note available. Referrer's interpretation is unknown

XR Lumbar spine :
There is loss of height of the L1 and L2 vertebral bodies with a fracture fragment anterior to the antero-superior corner of L2 vertebral body. The posterior vertebral cortices appear intact.

If there is concerning neurology, further imaging is recommended.

Code N: No note: No sticky note available. Referrer's interpretation is unknown

XR Wrist Rt :
No evidence of acute fracture.

Code N: No note: No sticky note available. Referrer's interpretation is unknown

Reported by: Dr Ewen Robertson (SpR)
Verified by: Dr Ewen Robertson (SpR)

XR Scaphoid Rt

Performed	21-Sep-2010 00:47	Received	23-Sep-2010 10:15
Reported	23-Sep-2010 09:48	Order Number	G107H25249673
Status	Final	Source System	MiSys

XR Scaphoid Rt Final
Ryan McCourt
Clinical History : Fall onto right hand. ASB tenderness.

XR Scaphoid Rt :

There is a minimally displaced intra-articular fracture of the base of the right thumb metacarpal.

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

Reported by: Dr Jonathan Foley
Verified by: Dr Jonathan Foley

XR Radius & ulna Rt

Performed	29-Sep-2009 17:04	Received	30-Sep-2009 16:56
Reported	30-Sep-2009 16:56	Order Number	G107H13234702
Status	Final	Source System	MiSys

XR Hand Rt Final
Ryan McCourt
Clinical History : Possible glass injury to right forearm 7 days ago ? foreign body, bony tenderness 4th metacarpal phalangeal joint.

XR Hand Rt :

No acute bone or joint injury demonstrated.

XR Foreign body demonstration :

There is no evidence of any radio-opaque foreign body.

Reported by: DR C CAMERON and BLANK CLINICIAN
Verified by: DR C CAMERON

XR Hand Rt

Performed	29-Sep-2009 17:04	Received	30-Sep-2009 16:56
Reported	30-Sep-2009 16:36	Order Number	G107H13234701
Status	Final	Source System	MiSys

XR Hand Rt Final
Ryan McCourt
Clinical History : Possible glass injury to right forearm 7 days ago ? foreign body, bony tenderness 4th metacarpal phalangeal joint.

XR Hand Rt :

No acute bone or joint injury demonstrated.

XR Foreign body demonstration :

There is no evidence of any radio-opaque foreign body.

Reported by: DR C CAMERON and BLANK CLINICIAN
Verified by: DR C CAMERON

XR Foreign body demonstration

Performed	29-Sep-2009 17:04	Received	30-Sep-2009 16:56
Reported	30-Sep-2009 16:36	Order Number	G107H13234703
Status	Final	Source System	MiSys

XR Hand Rt Final
Ryan McCourt
Clinical History : Possible glass injury to right forearm 7 days ago ? foreign body, bony tenderness 4th metacarpal phalangeal joint.

XR Hand Rt :

No acute bone or joint injury demonstrated.

XR Foreign body demonstration :

There is no evidence of any radio-opaque foreign body.

Reported by: DR C CAMERON and BLANK CLINICIAN
Verified by: DR C CAMERON

MANUAL PATIENT RECORDS

ALL HOSPITAL RECORDS HELD NHSGGC	☐		
ACS	☐		
BEATSON HOSPITAL	☐		
CANNIESBURN HOSPITAL	☑		
DENTAL HOSPITAL	☐		
GARTNAVEL GENERAL HOSPITAL	☐		
GLASGOW ROYAL INFIRMARY	☐		
INVERCLYDE ROYAL HOSPITAL	☐	MATERNITY	☐
NEW VICTORIA ACH	☐		
PRINCESS ROYAL MATERNITY	☐		
QUEEN ELIZABETH UNIVERSITY HOSPITAL	☐	MATERNITY	☐
ROYAL ALEXANDRA HOSPITAL	☐	MATERNITY	☐
ROYAL HOSPITAL FOR CHILDREN	☐		
STOBHILL HOSPITAL	☐		
VALE OF LEVEN	☐	MATERNITY	☐
WEST CARE AMBULATORY HOSPITAL	☐		
WESTERN INFIRMARY RECORDS	☐		
Including:			
BADGERNET	☐		
CAREVUE	☐		
MEDICAL ILLUSTRATION	☐		
METAVISION	☐		
PHYSIOTHERAPY	☐		
RADIOLOGY	☐		
WEST MARC	☐		
LABS			

Canniesburn Plastic Surgery Unit
Glasgow Royal Infirmary
Jubilee Building
84 Castle Street
Glasgow
G4 0SF

MR JAMES KIRKPATRICK
CONSULTANT PLASTIC SURGEON

Switchboard: 0141 211 4000
Direct Dial: 0141 211 5777
Ref: DW/RG/23096429V
Clinic: 28 June 2007
Date: 28 June 2007

Dr Cron
The Barony Medical Centre
30 Auchinloch Street
Glasgow
G21 4AH

Dear Dr Cron

Ryan McCourt, DOB 19.04.1994(6291) – Flat 5/6 18 Pinkston Drive, Glasgow G21 1NP

I saw Ryan in clinic today. He is doing very well following an open Salter Harris type II fracture of his right distal phalanx of his thumb. He now has a normal range of movement which is pain free and his thumb is non tender. A new nail is growing in place of the old one and this is not causing him any problems. I have therefore discharged him from our care but would be more than happy to see him again should he run into any problems in the future.

With kind regards

Yours sincerely

Mr Daniel Widdowson
Registrar in Plastic Surgery

Acute Services Division

Canniesburn Plastic Surgery Unit

MISS MARGARET STRICK

The Jubilee Building
The Royal Infirmary
16 Alexandra Parade
GLASGOW G31 2ER
Switchboard : 0141 211 4000
Direct Line: 0141 232 0750

NHS
Greater Glasgow and Clyde

Clinic *07/06/2007*
Dictated *07/06/2007*
Typed *12/06/2007*
Our Ref *RC/CMcC/23096429V*

Dr Alison Cron
The Barony Medical Centre
30 Auchinloch Street
G21 4AH

Dear Dr Cron

Ryan McCourt - 19/04/1994 - CHI: 1904946291 - CRN: 23096429V
18 Pinkston Drive, Flat 5/6, Glasgow, G21 1NP

I reviewed this boy in the Plastic Surgery Hand Clinic today. I am unsure as to why he had come. His mother seems to have thought that he had an appointment for today, however, Miss Strick had requested a review in six weeks not two. There were no new issues today. I have advised him to continue wearing his splint and arranged another appointment for four weeks.

Yours sincerely

R Clark
Registrar

Canniesburn Plastic Surgery Unit

TRAUMA SERVICE DISCHARGE LETTER

Dr. A CRON
THE BARONY MEDICAL CENTRE
30 AUCHINLOCH STREET
GLASGOW

G21 4AH

Cannieburn Plastic Surgery Unit
Jubilee Building
Glasgow Royal Infirmary
84 Castle Street
GLASGOW
G4 0SF
Switchboard: 0141-211 4000
Consultant: Mr J Kirkpatrick

Patient name:	Ryan	MCCOURT	
Hospital Number:	23096429V		
Date of Birth:	19/04/1994	CHI number:	6291
Date of admission:	26/04/2007	Date of surgery:	26/04/2007

Surgery performed:	PERFORMED BY MR CLARK. K-WIRE OF FRACTURE P2 RIGHT THUMB PLUS WASHOUT.
Other info:	TRAPPED LEFT THUMB IN DOOR CAUSING LACERATION AND OPEN DISLOCATION OF RIGHT THUMB.
Follow up clinic:	Mr J Kirkpatrick
Follow up hospital:	Canniesburn
Follow up information:	MR KIRKPATRICK HAND CLINIC IN 4 WEEKS. K-WIRE REMOVAL IN 4 WEEKS. PHYSIO HAND CLINIC NEXT WEDNESDAY.

Yours sincerely,

Printed by Lynn Waters, Trauma Secretary: 22 May 2007

Canniesburn Plastic Surgery Unit
Glasgow Royal Infirmary
Jubilee Building
84 Castle Street
Glasgow
G4 0SF

MR JAMES KIRKPATRICK
CONSULTANT PLASTIC SURGEON

Switchboard: 0141 211 4000
Direct Dial: 0141 211 5777
Ref: JK/RG/230964029V
Clinic: 17 May 2007
Date: 17 May 2007

Dr Cron
The Barony Medical Centre
30 Auchinloch Street
Glasgow
G21 4AH

Dear Dr Cron

Ryan McCourt, DOB 19.04.1994(6291) – Flat 5/6 18 Pinkston Drive, Glasgow G21 1NP

I reviewed Ryan in the Hand Clinic today following treatment on 26 April 2007 for an unstable Salter Harris II open fracture of the distal phalanx of his right thumb. This was treated by washout, repair and k-wire fixation.

On examination today everything is healing satisfactorily and we have removed the k-wire. I think we should protect this for a further two weeks with a splint and we have modified the splint accordingly. The physiotherapists will then mobilise him after this period.

I will see him for review in the Hand Clinic in six weeks.

Yours sincerely

Mr James Kirkpatrick
Consultant Plastic Surgeon

GLASGOW ROYAL INFIRMARY

CLINICAL NOTES

23096429V M
MCCOURT 19/04/1994
RYAN
18 Pinkston Drive
FLAT 5/6
GLASGOW G21 1NP
CHI-1904946291

1/5/07.

9/5/07 DNA.

31/5/07

Returned early

? why

No issues

Review 4/52 as per JK's original instructions

keep splint.

Form 05171

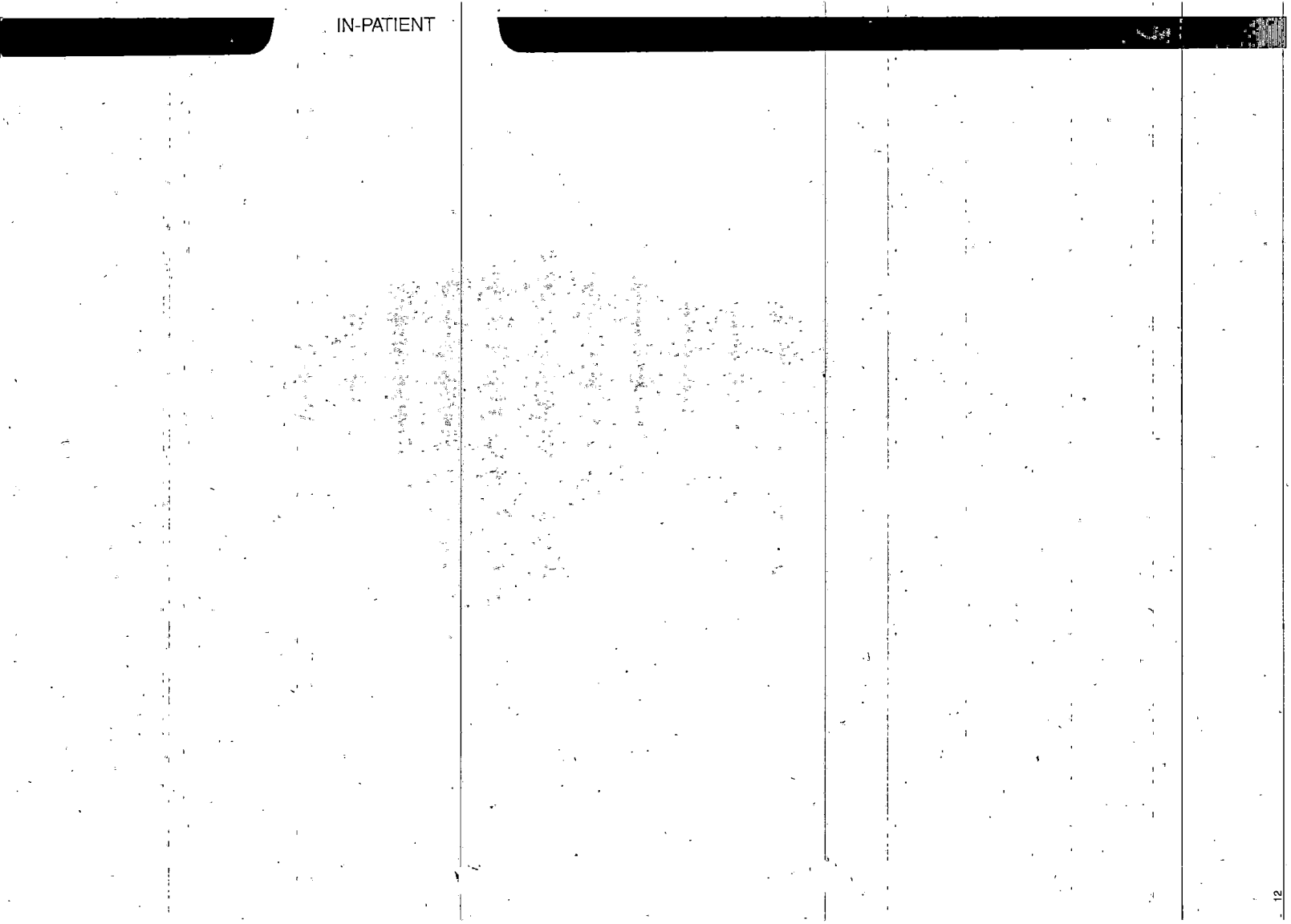
NAME	HOSPITAL
	No
	AGE
PHYS/ SURG.	DEPT WARD

IN-PAT FORM 3

23096429V
MCCOURT
RYAN M Y
19/04/1994
10 Pinkston Drive
FLAT 5/6
GLASGOW
G21 1NP
CHI-1904946291

DATE	28.6.07

00559



NHS Greater Glasgow and Clyde

Canniesburn Plastic Surgery Unit

23096429V
MCCOURT
RYAN M 19/04/1994
18 Pinkston Drive
FLAT 5/6
GLASGOW G21 1NP
CHI-1904946291

23096429V
MCCOURT
RYAN M 19/04/1994
18 Pinkston Drive
FLAT 5/6
GLASGOW G21 1NP
CHI-1904946291

Admission Ward: 49
Date: 26/04/07
Consultant: N Kirkpatrick

Age: 13yr 43kg
Telephone no:

Next of kin: MARY CAIRNS
Relationship: MOTHER
Address:
Phone No. 07926248213
Aware of admission ☐

Presenting Complaint / Procedure:

OPEN # DISLOCATION ~~LEFT~~ RIGHT THUMB

History of Presenting Complaint / Reason for Admission:

13yr ♂, 7^30pm trapped (L) Thumb in huge doors.
laceration + Bone protruding proximal to nail.

Actual Procedure(s) Date(s)

26/4/07
K-wire # P2 thumb + wash out.

Past Medical History:

Asthma - No admissions

Type of Anaesthetic:

GA ☐ LA ☐ Epidural ☐

Sedation ☐ Block ☐

Allergies:

NKDA

PRE-OPERATIVE ASSESSMENT

Assessor: _____ Date: _____ Procedure: _____

Admission Details:

ANAESTHETIC			DETAILS / PROBLEMS
Previous GA	Y ☐	N ☐	
Previous LA	Y ☑	N ☐	No problems
Dentition risk	Y ☐	N ☐	
Dentures	Y ☐	N ☐	
Other risk	Y ☐	N ☐	
Indigestion	Y ☐	N ☐	
Family history of Complications	Y ☐	N ☐	

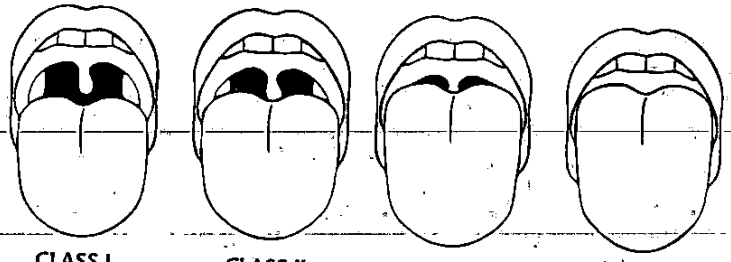
Details of previous surgical procedures:

Airway Assessment:

			Details
Is the thyromental distance less than 6.5cm	YES ☐	NO ☐	
(PAT IL) mouth opening: Can patient insert middle three fingers vertically into their mouth?	YES ☐	NO ☐	
Any limitation of neck movement?	YES ☐	NO ☐	

Anterior / Posterior

Head fixed with chin on chest (extreme flexion)



CLASS I CLASS II CLASS III CLASS IV

ASA status I II III IV

Summary

2 Referred for Anaesthetic Review ☐ _____

PRE-OPERATIVE ASSESSMENT

Cardiovascular			Details
Hypertension	Y ☐	N ☑	
Palpitations	Y ☐	N ☑	
Angina	Y ☐	N ☑	
Heart Attack	Y ☐	N ☑	
Murmur	Y ☐	N ☑	
CCF	Y ☐	N ☑	
PVD	Y ☐	N ☑	
IHD	Y ☐	N ☑	
Other	Y ☐	N ☐	

Respiratory			Details
Tracheostomy	Y ☐	N ☑	
Asthma	Y ☑	N ☐	
Bronchitis	Y ☐	N ☑	
COPD	Y ☐	N ☑	
Cough	Y ☐	N ☑	
Dyspnoea	Y ☐	N ☑	
Wheeze	Y ☐	N ☑	
Other	Y ☐	N ☑	

Exercise Tolerance			Details		
Climbs stairs without stopping	Y ☑	N ☐	Climbs stairs with stopping	Y ☐	N ☐
Cannot climb stairs	Y ☐	N ☐			

Neurological			Details
Stroke	Y ☐	N ☑	
Epilepsy	Y ☐	N ☑	
Neurological Disease	Y ☐	N ☑	
Physical Disability	Y ☐	N ☑	
Other	Y ☐	N ☑	
Alert & Orientated	Y ☑	N ☐	
Depression/Anxiety	Y ☐	N ☑	

Haematological			Details
Bleeding Disorder	Y ☐	N ☑	
Previous DVT	Y ☐	N ☑	
Previous PE	Y ☐	N ☑	
Anaemia	Y ☐	N ☑	

DVT Risk	Details
Risk Factors	

Others			Details
Kidney Disease	Y ☐	N ☑	
Liver Disease / Jaundice	Y ☐	N ☑	
Diabetes	Y ☐	N ☑	
Arthritis	Y ☐	N ☑	
Thyroid problems	Y ☐	N ☑	
Other	Y ☐	N ☑	

PRE-OPERATIVE ASSESSMENT

Alimentary			Details
Weight Loss	Y ☐	N ☐	
Hiatus Hernia	Y ☐	N ☐	
PEG / NG	Y ☐	N ☐	
Swallowing difficulties	Y ☐	N ☐	
Dietary Requirements	Y ☐	N ☐	

Gentourinary			Details
Bowel problems	Y ☐	N ☐	
Urinary problems	Y ☐	N ☐	
Bowel / Urinary aids	Y ☐	N ☐	

Disabilities / Mobility			Details
Limited Mobility	Y ☑	N ☐	
Mobility Aid	Y ☐	N ☐	
Visual Impairment	Y ☐	N ☐	
Hearing Impairment	Y ☐	N ☐	
Other	Y ☐	N ☐	

Drug History	Dosage & Times	Drug	Dosage & Times
PRN PARACETAMOL			

Special needs (e.g. dosette/liquid) _____

Previous (circle) Details _____

Chemotherapy Radiotherapy _____

Social / Lifestyle			Details
Smoking	Y	N ☐	
Alcohol	Y ☐	N ☐	
Chemical dependancy	Y ☐	N ☐	
Religion	Y ☐	N ☐	
Pregnancy	Y ☐	N ☐	Gestation _____ AC/ Weeks LMP _____
Lives Alone	Y ☐	N ☐	Hostel ☐ Nursing Home ☐

Occupation SCHOOLBOY

Patients understanding of illness / procedure _____

Other Relevant details/stairs in house/needle phobia etc. _____

Social Services Y ☐ N ☐ _____

Referral

Physiotherapy	☐	Breast Recon	☐	Other	☐
Social Services	☐	Head and Neck CNS	☐	Details	_____
Speech Therapy	☐	Dietitian	☐		_____

Glasgow Royal Infirmary

General Examination

Temp: 35° Pulse: 64 RR: PERF:- Weight: Height:-

SpO2 98 BP: 147/90 BG: BMI:-

General Observations:

Cardiovascular Examination

Heart sounds HS I+II+0

Normal ☑ Abnormal ☐

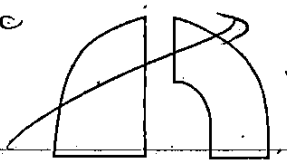
If abnormal describe:-

Rhythm:- Regular

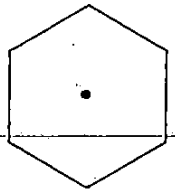
Peripheral Oedema:-

Respiratory Examination

BS Vesicular NAD



Abdominal Examination



Additional Information

RING BLOCK 1% LIGNOCAIN 3·5mls

WASH-OUT ± 300mls (N) SALINE

Reduced

Dressed with INADINE & splinted.

Rpt XR;

Other Examination

(R) Thumb proximal to nail bed exposed bone, Base of nail exposed

Cap Refil <2s, (N) sensation

XR; Slater harris I # of (R) Thumb Distal phalanx

Signature of Assessor:

Pre-assessment Initial Investigations

FBC	☐	INR	☐	Other Investigations	
U's & E's	☐	ECG	☐		
LFT's	☐	Chest X-ray	☐		
Group & save	☐	Photo	☐	MRSA Screen	☐
X-match	☐	Kardex	☐	Echo	☐
Coagulation Screen	☐	Consent	☐	Previous Positive	
HBA1c	☐	OPT	☐	MRSA Y ☐ N ☐	
Glucose	☐				

SHO/SpR Review

Paracetamol + Ibuprofen

Augmentin

Tetanus - UTD

(H) NBM from midnight for review on ward 4900

Rt XR; slightly reduced. Ryan is unwilling to have it reduced again without another reg block would prefer to have one again tomorrow on ward.

Name (print): K Hughes Signature: [signature] Designation: SHO

Date: 25/4/07 Time: 22[00]

Plan /Summary

WR Kirkpatrick

- For theatre today
- Consent
- IV Abx

[signature] Sng

Name (print): Signature: Designation:

Date: Time:

DISCHARGE PLAN

Date of Discharge:

Discharged to:

SERVICES	ON ADMISSION	ON DISCHARGE	INITIAL & DATE
Transport details			
District Nurse			
Social Worker			
McMillan Nurse			
Hospice			
Home Help			

OTHER DISCHARGE ARRANGEMENTS

	YES	NO	N/A	DETAILS	INITIAL & DATE
Discharge Prescription	☐	☐	☐		
District Nurse Letter	☐	☐	☐		
Outpatient Appointment	☐	☐	☐		
Written Advice	☐	☐	☐		
Verbal Advice	☐	☐	☐		
Dressing	☐	☐	☐		

Feeding Pump ☐ Giving Sets ☐ Feed ☐ _____

Other: _____

_____

ON ADMISSION

Safety and Comfort
- ☐ No problems with pain
- ☐ Chronic pain Specify:
- ☐ Risks to safety (e.g. self harm) Specify:

State orientation / conscious level:

Pain on admission:

Mobility
- ☐ Mobile Independently
- ☐ Problems with mobility Specify:

Moving and handling Requirements specify:

Personal Hygiene
- ☐ Independent
- ☐ Requires Assitance /Aids Specify:

Elimination
- ☐ No problems
- ☐ Problems with elimination Specify:

Sleeping
- ☐ No problems sleeping
- ☐ Problems with sleeping Specify:
- ☐ Use of night sedation Specify:

Communication / Sensory Impairment
- ☐ No problems communicating
- ☐ Specify any problems
- ☐ (e.g. Dysphasia, use of hearing aids / glasses):

LABEL

MULTIDISCIPLINARY CLINICAL NOTES

DATE TIME	
26/04	pt emergency adm via A&E following crush injury to (R) thumb venflon & IVABS O/A [signature]
26/4/07 14°°	Returned from theatre alert and orientated. O2 sats ≥98% on room air, BP and HR stable and satisfactory. No IV fluids prescribed, has not passed urine. Pain free, block in theatre. Finger pink, soft, warm, CRT < 3s. No sensation. Hand elevated. Apparently ... 1/7 IV Abx then 5/7 oral. Diet taken. Post-op - physio hand next week for splint and dressing, stitches, K-wire out 4/52. [signature] MORAN
8pm	Settled since return; finger tip (thumb) remains pink, soft, warm, refill < 2s. No sensation as yet thumb and index finger. High elevation continues. Observations stable and satisfactory, apyrexial. [signature]
4/07	Late to settle due to complaints of pain — 30mg DF118, 200mg Ibuprofen and 750mg paracetamol given between 8 - midnight with Hand on high elevation - Thumb medium dark pink in colour, sensation and movement intact. IVAB continue as charted. J MADDEN / J Madden
	27/4/7 w/e Kirkpatrick
	Pt. comfortable Obs: stable, apyrexial
	Plan: 1. (H) today → to complete Abx 2. Clinic r/v 1/52 [signature] (SHO)
	27/04/07 (10:00) R/V on Ward Round this am please read above note. R/V by Physio: Instructions given re: Post. Op Care. Hand Elevated on sling. Observations satisfactory: CSM satisfactory: Home on Oral ABX as per discharge script

[signature] / Amousey PTO

GLASGOW ROYAL INFIRMARY

CLINICAL NOTES

23096429V
MCCOURT M
RYAN 19/04/1994
18 Pinkston Drive
FLAT 5/6
GLASGOW G21 1NP
CHI-1904946291
PATIENT ID LABEL

Cont'd
17/04/07
10:00. Appointment re-made for Physio Hand Clinic on Thursday 03/04/07 @ 09:30am. Card given to Mother.
Dressing to (R) Hand remains dry & Intact. CS [illegible]

17/1/07

Wire sl. [illegible]

→ Removed [illegible]

[illegible] splint [illegible] 2/52

[illegible]

HC 6/52

[illegible]

Form 05171

NHS
Greater Glasgow and Clyde

THEATRE CHECKLIST / CARE PLAN

Unit Number

Name

Address

23096429V
MCCOURT
RYAN M
19/04/1994
18 Pinkston Drive
FLAT 5/6
GLASGOW G21 1NP
CHI-1904946291

DOB

Ward

Date

Allergies NKDA

Breast Implant Consent Record

Current Medication Nil

Past Medical History Nil

Consent Signed

	Ward pre-op	Ward Recovery	Recovery Anaes
Case notes & drug Kardex	X ✓	✓	
Biochem/Haematology Results	No	✓	
ECG	No	✓	
X-Rays	yes	✓	
Identity Band Details	correct.	✓	
Red Allergy Band	NKDA	✓	
Pre-medication	done	✓	
Fasted from	2300 -	25/04 ✓	
Dentures Removed/not Removed	No	loose teeth bottom front	
Caps/crowns/loose teeth = no. and position	No	↑	
Prosthesis removed/not removed/Contact lenses	No.	✓	
Make-up/Nail varnish/jewellery/Body piercing	No.	✓	
Theatre gown and paper pants/underwear rem'd	yes	✓	
Pacemaker	No.	✓	
Inhalers/GTN spray	No.	✓	
Voided Urine	yes	✓	
Subcut Heparin	No	✓	
Ted stockings	No	✓	
Tampon	No	✓	

Signature Ward Nurse [signature]

Signature Recovery Nurse [signature], Reception

Signature Anaesthetic Person

Record of Peri-operative Events

Time	Event	Sign

Record of Sterile Supplies Used

Intra-operative Record Theatre

Date	Time entered anaes room	Time entered theatre	Time left theatre

Base line BP Pulse SpO_2

Anaesthetic
General/local/spinal/IV sedation/other

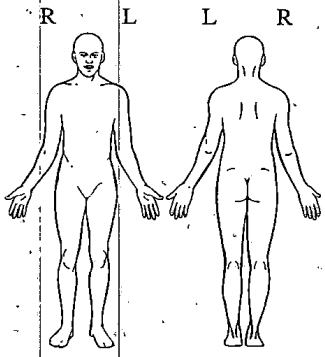
ETT/Nasal/Tracheostomy/LMA size and #

Position Supine/prone/right lateral/left lateral/other
Lithotomy/Jackknife/Trendelenberg/Rev. Trendelenberg

Right arm At side/onboard/across chest/other
Left arm At side/on board/across chest/other

Protection devices Pillows/Padding/GelPads/Other
Warming blanket/Blood warmer

Peripheral IVI	- X
IV Cannula	- C
ECG Electrodes	- □
CVP	- Z
Arterial line	- A
BP cuff	- B
Pulse oximeter	- •
Diathermy pad	- Δ
Core Temp	- C
Flowtron boots	- F
Eyes Taped	- II
Sub Cut Cannula	- Y
Skin condition	- S
Other notes	-



Tourniquet
Arm Left
Leg Right

Inflated _____
Deflated _____
Set _____ mmHg _____

Operation

Anaesthetist | Anaes. Nurse/ODP

Surgeons

Scrub nurse/ODP | Circulating person

Skin preparation

Drains Exudrain/Porges/Corrugated/Glove/other
fr/g

Urinary Catheter g | Intra-op blood loss

Skin closure | Dressings | Packs in situ

Swab/needle and instrument count correct
Scrub person
Circulating person

Throat Pack
In
Out

Incorrect X-ray performed

Discrepancy

Surgeon Sign Witness sign

Specimen and amount
Pathology/Frozen section/Bacteriology/other

Date/Time													
NIBP													
Arterial													
220													
200													
190													
180													
Blood Pressure 170													
160													
150													
140													
130													
120													
Pulse 110													
Rate 100													
90													
80													
70													
60													
50													
40													
30													
20													
10													
0													
SpO_2													
O_2 L/Minute													
Resps													
Temp °C													
CVP													
ECG													
Blood glucose m/mols													
Haemocue g/dl													
Pain Score													
Sed Score													
Nausea													
Urine Vol													
Wound 1*													
Wound 2*													
Wound 3*													
Wound 4*													
Drain 1*													
Drain 2*													
Drain 3*													
Drain 4*													

Procedure Performed

Recovery Nurse

Anaesthetic ty

Keys
Pain score
0 - pain free
1 - slight pain
2 - moderate pain
3 - severe pain
4 - asleep
Sedation score
0 - alert & orientated
1 - normal sleep
2 - drowsy
3 - sedated/difficult to rouse
Nausea score
0 - no nausea/vomiting
1 - mild nausea/vomiting
2 - severe despite Rx
Wound score
0 - dry & intact
1 - slight staining
2 - moderate staining
3 - saturation/pad req.

Total Fluids Administered in Theatre (Recovery Use)

In	
Blood	
Colloid	
Crystalloid	
Total	

Out	
Blood	
Urine	
Other	
Total	

Post-Operative Drugs/Fluids given in Recovery Room

Post-operative & Anaesthetic Instructions

Occurrences in Recovery Room

Signature

On Transfer to Ward

Case Notes/X-rays Prosthesis/Dentures Drugs/Inhalers

Notes

Anaesthetic Record

No. 05148

GLASGOW ROYAL INFIRMARY

PRE-OPERATIVE INSTRUCTIONS:

23096429V M
MCCOURT 19/04/1994
RYAN
18 Pinkston Drive
FLAT 5/6 G21 1NP
GLASGOW
CHI-1904946291

PLEASE WRITE OVER WHITE LETTERS

Place	Date & Time	Premedication	Ordered by	Given by	Time Given

PRE-OPERATIVE ASSESSMENT

WEIGHT: kg HEIGHT: cms AGE 1 3

PREVIOUS ANAESTHESIA / OPERATIONS: [illegible] ⓪ problems.

RECENT DRUG THERAPY: salbutamol PRN

PREVIOUS MAJOR ILLNESS: Asthma

CO-EXISTING CHRONIC DISORDERS:

CVS : IHD Angina Grade: PVD CC F HBP

RS : Asthma (circled) COAD Dyspnoea Grade: Smoking (circled) 5/day

GIS : Reflux Liver Disease Alcohol / Drugs

Diabetes Obesity

CNS : Epilepsy Chronic CNS Chronic Psychiatric

GUS : Renal Failure

ALLERGIES / DRUG REACTIONS: NK

ASA 1 2 3 4 5 E

Acute Physiological State - Clinical Features

HR 90/min	RR	Hb	Na^+
BP 90/50	F_iO_2	WBC	K^+
CVP	P_aO_2	Platelets	Cl^-
PAWP	P_aCO_2	PT / INR	HCO_3
ECG	H^+	KCCT / APPT	Urea
	HCO_3	Blood Group	Creatinine
	CXR		ARF
State of Consciousness:			Glucose

Fasted? Midnight

Dentition: 1 mild loose

Jaw / Neck Mobility: NAD

Anticipated Difficulty with Intubation:

Anaesthesia

Patient's RYAN McCourt

Date: 26/4/07

Site of Injections	L/R Hand / Arm / Foot 20 G
Site of Infusions	L/R Hand / Arm / Foot
Central Venous Site	
Arterial Site	
Cuffed / Uncuffed	Oro / Nasal Tracheal Tube
Size 3	Mask / Laryngeal Mask
HME	Airway Oral / NP
Ventilation: Spontaneous / I.P.P.V.	
Circuit:	Ventilator:
Position: SUPINE	

Intravenous Fluids Blood Warmer ☐

(1) R. Ringer - 500.

Start: ..... Finish: .....

ECG ✓ NIBP ✓ SpO2 ✓ EtCO2 ✓ | FiO2 ✓ EtAA ✓ Temp Disconnect ✓ | CVP IABP PA Cath TOF

Drugs and Fluid given:- Time:- 9:50 10:15 10:40

Fentanyl 50+25 mg
Propofol 130 mg
O2 / Air / Sevo 2-1 / 1.9
Pancuronium 8 mg

	9:50	10:15	10:40
I.V. Fluid Nos.			
VT x f / Pressure			
FiO2	0.5	0.5	0.5
Saturation %	99	99	99
EtCO2	5.8	6.2	6.5
Temperature			
CVP/PCWP			
Urine			
Blood Loss:-			

200 180 160 140 120 100 80 60 40 20

PO2
PCO2
H+
HCO3
K+
THb

REGIONAL ANAESTHESIA

INSTITUTED PRE/POST-OPERATIVELY

DESCRIPTION

DRUG(S) USED	VOLUME / DOSE	NEEDLE SIZE
		INTRODUCER SIZE
		CATHETER SIZE
		DEPTH

OTHER ANAESTHETIC COMMENTS (R) Thumb digital N block given by surgeon with Bupivacaine.

DATE: 26/4/07 THEATRE: 5

OPERATION: (R) thumb reduction, nail bed repair ± K wire fixation.

ANAESTHETIST: C. Falco (J. Hamid - SO) SURGEON: R. Clark.

DURATION:

CONDITION ON LEAVING THEATRE

PATIENT SPEAKS	B.P.	AIRWAY: ☐
RESPONDS TO SPEECH:	HEART RATE	L.MASK ☐
RESPONDS TO STIMULUS:	TEMP. - CORE	E.T.T: ☐
NO RESPONSE	TEMP. - SKIN	I.P.P.V.: ☐
	SHIVERING	

FLUIDS:	IN	OUT	MONITORING
BLOOD		BLOOD	ARTERIAL LINE ☐
COLLOID		URINE	C.V.P. ☐
CLEAR		OTHER	PA. CATH. ☐
TOTAL		TOTAL	URINARY CATH.
			NASO GASTRIC

RECOVERY ROOM INSTRUCTIONS

ANALGESIA: As charted.

OXYGEN: 40% via facemask until fully awake.

FLUIDS: Discontinue IV fluids once present bag is finished please.

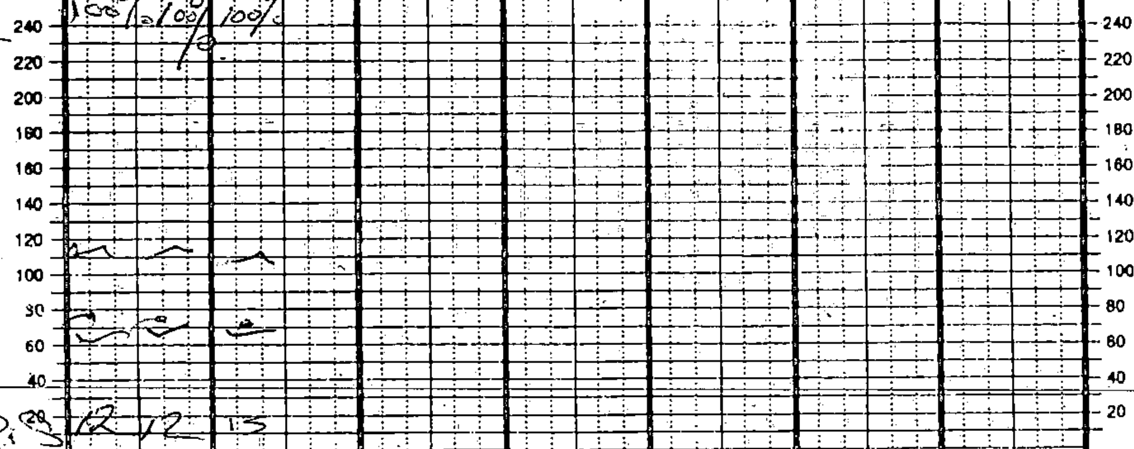
OTHER:

ANAESTHETIST'S SIGNATURE:

DRUGS & ROUTE:

TIME														

TIME	10⁴⁰	10⁵⁵	11¹⁰											
SPO2	100%	100%	100%											



RESP'S	12	12	13											
E.C.G.	SR	SR	SR											
C.V.P.	4L	4L	4L											
PERIPH. TEMP.														
CORE TEMP.														
WOUND CHECK	DRY	DRY	DRY											
URINE VOL.	NPU		NPU											
Drain 1.														
Drain 2.														
Drain 3.	C +ve		+ve											
S	+ve		+ve											
M	+ve		+ve											
P	<3		<3											
T	~		~											

[signature]

I.V. FLUIDS: From theatre

	TIME	
1.		
2.		
3.		
4.		
5.		

Blood Gas Results:

Time F_IO_2
P_aO_2 KPa
P_aCO_2 KPa
H^+
HCO_3
Glucose mmol/l

NURSING NOTES

Time F_IO_2
P_aO_2 KPa
P_aCO_2 KPa
H^+
HCO_3
Glucose mmol/l

North Glasgow Hospitals

NHS Greater Glasgow and Clyde

Intra Operative Count Record

Patient Information
23096429V 19/04/1994
McCOURT
RYAN
8 PINKSTON DR
FLAT 5/6
GLASGOW. G21 1NP.

Anaesthetic Nurse Henderson
Circulating Nurse
Scrub Nurse
Scrub Nurse E RODDEN
1st Count J McDERMOTT.
2nd Count
3rd Count

Consultant Kaufmann
Surgeon Dr CLARK
Anaesthetist Dr MATTHEW
Date 25/04/07
Theatre S
Time in 09.50.
Out 1035.

Procedure Reduction of # R thumb, K-wire - re-implantation of nail.

Total Items Used		Additional Count Items					
Swabs (Raytec)	10						
Abdominal Packs							
Wedgelets							
Blades	2						
Sutures	1						
Hypodermic Needles							
Ligature Reels							

Trays	Tray No	Trays	Tray No
INFECTED W/DISC No SERIAL No S N S274-13 252160 Minor Plastic Set (Canniesburn)			
STERILE 134 C MINI DRIVER B W/DISC No H/W SERIAL No 07:5728 S N S274-3 244604 Minor Plastic Set (Canniesburn)			

Supplementaries	Anaesthetic Equipment

Drains	Packing (Describe & Count)	Catheters

North Glasgow Hospitals

NHS
Greater Glasgow and Clyde

CONSENT TO ANAESTHESIA, OPERATION, INVESTIGATION OR TREATMENT, MEDICAL PHOTOGRAPHY AND RESEARCH

23096429V
Patient MCCOURT
RYAN M
19/04/1994
18 Pinkston Drive
FLAT 5/6
GLASGOW G21 1NP
CHI-1904946291

DATE 26/4/19

Proposed procedure (block capitals) RIGHT THUMB REDUCTION + NAIL BED REPAIR + K-WIRE FIXATION

NOTES ON GUIDANCE FOR CLINICIANS

A patient has the right to grant or withhold consent prior to examination, investigation, treatment or operation. The Doctor/Dentist must give the patient sufficient information, in a way he/she can understand about the proposed procedure, significant side effects and the possible alternatives. The Doctor/Dentist must give the patient enough time to read this form and ask any questions relating to it or their treatment. The patient must be allowed to decide whether he or she will agree to the procedure and they may refuse or withdraw consent to a procedure at any time. The patient's consent to a procedure should be recorded on page two of this form.

Written informed consent is not required for minor procedures, however written consent should be sought for:

i) any procedure that carries a significant risk.

ii) any procedure to be carried out under general anaesthesia, sedation or utilising nerve blockage or regional anaesthesia beyond that provided topically or by simple infiltration.

iii) any procedure which could be considered new, novel or experimental.

iv) any situation where there are implications for "third parties" eg. relatives and insurance companies in relation to genetic studies or HIV testing.

(v) any recording procedure such as photography, video and audio.

For further guidance on "significant risk" see section 5 of the Trust's Policy for Consent to Anaesthesia, Operation, Investigation or Treatment and Medical Photography/video.

TO BE COMPLETED BY CLINICAL PRACTITIONER

The clinician completing this form should have sufficient knowledge of the proposed investigation or treatment in order to provide the patient with the appropriate information.

I HAVE FULLY EXPLAINED: To the patient/parent/guardian/next of kin (delete as appropriate)

1. **The procedure named on this form**
2. **Alternatives which are available**
3. **Significant side effects which may result from the procedure**
4. **The use and implications of medical photography, video/audio recordings, including live video links**
5. **The need to read the patient information leaflet on the use of tissue for medical research and teaching.**

Name (block capitals) Ross Nasso

Signature

Grade/Designation SHO

TO BE COMPLETED BY THE PATIENT/PARENTGUARDIAN/NEXT OF KIN

You should read this form and the notes below carefully. If there is anything you do not understand please ask the doctor for an explanation. The doctor is here to help you and he or she will explain the procedure. If for any reason you are not content with the explanation you are entitled to refuse the procedure. You can ask any questions and ask for more information. If you are happy with this, you understand the procedure and wish to proceed you should sign the form.

Increasingly in modern clinical care, photography and video pictures are used for consultation and teaching purposes. These images will not be used for publication in any form without your specific consent. The procedure may also be observed by other professionals via a live video link.

You may ask for a relative or a friend or a nurse to be present while the doctor explains the procedure and asks you to sign the form.

I AM — The Patient/Parent/Guardian/Next of Kin (delete as appropriate)

I UNDERSTAND — The purpose, benefits and significant risks associated with the procedure which have been explained to me by the doctor named on this form.

That the procedure may not be carried out by the Doctor who has been treating me so far.

That any procedure in addition to that named on this form will only be carried out if it is necessary and in my best interests.

That any photographs, video and audio recordings may subsequently be used for consultation and teaching purposes.

That my identity will not be broadcast if the procedure is observed by other professionals via a live video link.

Students need to learn how to examine patients and see how procedures are done. This is important for the future of health services. You may be asked to give consent to be examined by students during the procedure.

I have been given the opportunity to read the Patient Information Leaflet on the use of Tissue for Medical Research and Teaching and agree that tissue not essential for my diagnosis and future treatment may be used for medical education and ethically approved medical research.

Please tick the appropriate box if you agree or disagree to any of the following:

To the administration of anaesthetics or to sedation if required	Agree ☑	Disagree ☐
To the procedure named on this form	Agree ☑	Disagree ☐
To photography, video and audio recordings, including live video links	Agree ☑	Disagree ☐
To examination by a student during the procedure named on this form under the supervision of the senior clinician undertaking the procedure.	Agree ☑	Disagree ☐
To the use of my tissue in medical education	Agree ☑	Disagree ☐
To the use of my tissue in medical research	Agree ☑	Disagree ☐

Signature	Date	Address
M McCourt	26/4/07	

Name (block capitals)

Notes

GLASGOW ROYAL INFIRMARY

23096429V
MCCOURT
RYAN M
19/04/1994
18 Pinkston Drive
FLAT 5/6
GLASGOW
G21 1NP
CHI-1904946291

DATE 26/4/7

OPERATION

SURGEON R Clark

K-wire # P_2 Ⓡ Thumb + cast [illegible]

very unstable. Wound open ⓒ nailbed

→ K wire across IPJ.

wash 1L saline

Nail removed + glued in place

Post op / High elevation

1/7 IV antibiotics

then oral 1/52

Physio hand clinic next wed - splint + reduce dressing.

K-wire out ⓒ 4 weeks

Hand clinic 4/52. JK.

MATERIAL SENT FOR EXAMINATION

No. 05230

IMMEDIATE DISCHARGE LETTER 411599

NORTH GLASGOW HOSPITALS

NHS Greater Glasgow and Clyde

GLASGOW ROYAL INFIRMARY
GLASGOW G31 2ER
Tel: 0141-211 4000

PATIENT IDENTIFICATION

23096429V
MCCOURT M
RYAN 19/04/1994
18 Pinkston Drive
FLAT 5/6
GLASGOW G21 1NP
CHI-1904946291
~~FIX ID LABEL TO ALL 4 COPIES~~

DATES

ADMISSION 25/4/17
DISCHARGE 27/4/17
TRANSFER TO Home
RE-ADMISSION
DEATH

Dr. A CRON
THE BARONY MEDICAL CENTRE
30 AUCHINLOCH STREET
GLASGOW

G21 4AH

OTHER DISTRIBUTION

MEDICAL IDENTIFICATION

WARD 49
CONSULTANT Dr. Mc Kirdy (BLOCK CAPITALS)
CONTACT Dr. [illegible] (BLOCK CAPITALS)

PRESENTING COMPLAINT(S)

ADMISSION

DAY CASE ☐ ARRANGED ☐ EMERGENCY ☑ TRANSFER ☐

ACTIVE DIAGNOSIS/PROBLEMS/OPERATIONS

1) Right Thumb - Distal Phalynx
2) ~~Open #~~ → K-Wire + Washout
3)
4)
5)
6)

INACTIVE DIAGNOSIS/PROBLEMS

1)
2)
3)

INFORMATION GIVEN TO PATIENT (SPECIFY)

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

MEDICINE	FORM	DOSE	TIMES OF ADMINISTRATION 8am	10am	12pm	2pm	6pm	10pm	DURATION	PHARMACY TO COMPLETE QUANTITY, STRENGTH, BRAND
Penicillin V	PO	500mg	✓		✓		✓	✓	6 Days	
[illegible]										
Flucloxacillin	PO	500mg	✓		✓		✓	✓	6 DAYS	

FOLLOW-UP REVIEW

HOSPITAL OP YES/NO
SPECIFY.....
SURGERY YES/NO
SPECIFY.....
RE ARRANGEMENTS
E ☐
☐
ICT NURSE ☐
.....

DRESSING/SUNDRIES SUPPLIED TO PATIENT

PRODUCT	SIZE	NUMBER ISSUED
		Signature:-

NTS: FU Clin. 1/52

Signed ..... Page No. 1/1

(Prescriber) : SHO : SpR : CONS (please tick)

Pink Copy - Case Notes Yellow Copy - Retain in Ward Blue Copy - Pharmacy 05180

Patient Observation Chart

NHS Greater Glasgow

Name	23096429V MCCOURT M RYAN 19/04/1994
Address	18 Pinkston Drive FLAT 5/6 GLASGOW G21 1NP CHI-1904946291
Hospital No.	
DOB	

Admitted Date _____ Ward _____

Transferred Date _____ Ward _____

Transferred Date _____ Ward _____

Patient Observation Chart Guidelines

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

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

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

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

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

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

Pain Score

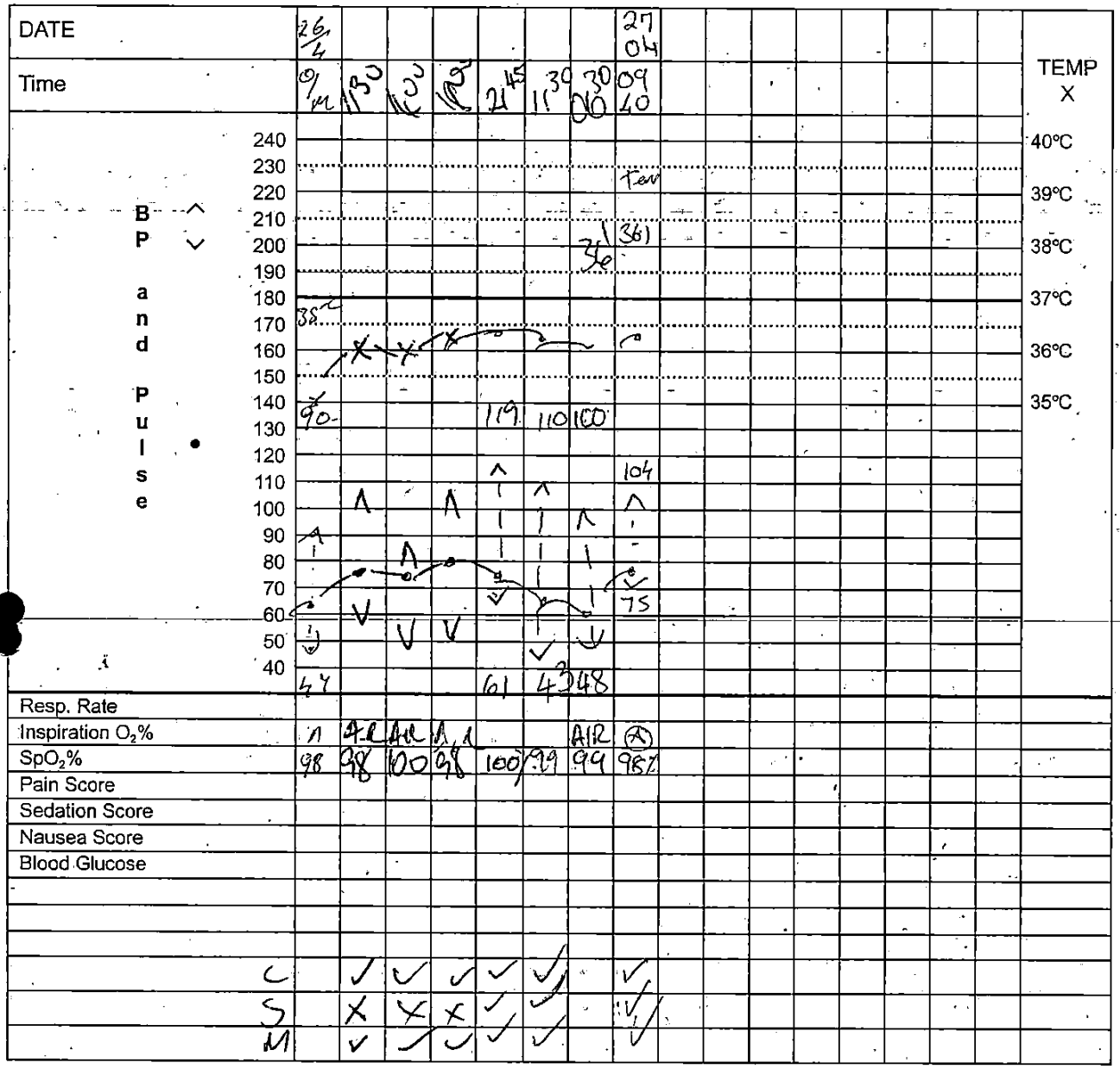
Remember to check scores after pain relief.
Patient asked to report pain at rest and on movement.
0 = No pain at rest or on movement
1 = No pain at rest, slight pain on movement
2 = Intermittent pain at rest, moderate on movement
3 = Continuous pain at rest severe on movement
Review 5 mins after I/V, 1 hour after I/M, S/C or oral analgesia.
Sustained pain score of 2 or pain score of 3 requires intervention.

Sedation Score

0 = Awake, alert, orientated
1 = Mild, aroused by verbal stimulus
2 = Moderate, aroused by physical stimulus
3 = Severe, no response
S = Normal sleep, easy to rouse
Score 2 or 3 requires immediate intervention

Nausea Score

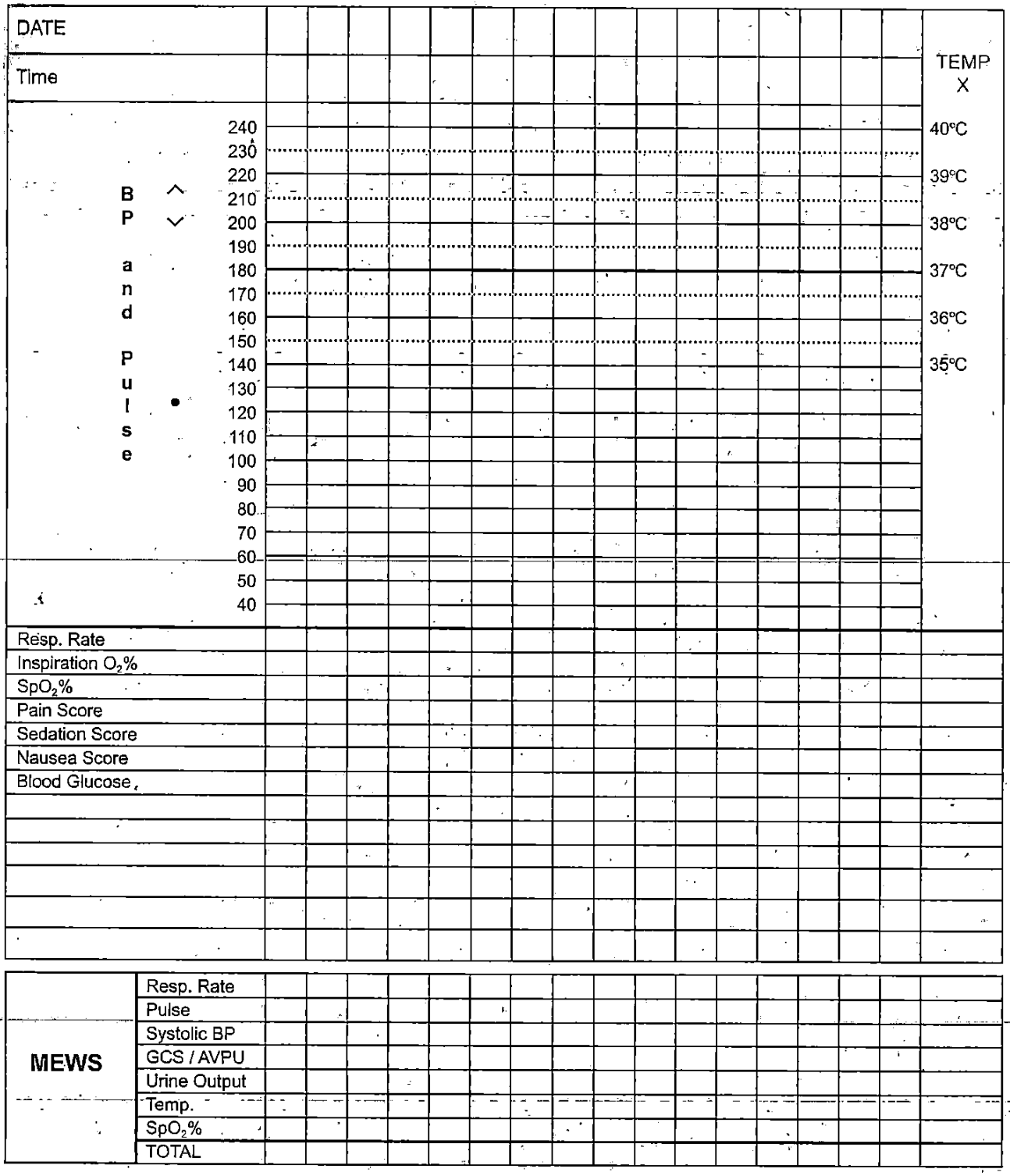
0 = No nausea
1 = Mild (No treatment wanted)
2 = Moderate (Treatment required)
3 = Severe (Clinical problem persists despite treatment)
Review 1 hour after treatment. Inform doctor if additional treatment required.



MEWS	
	Resp. Rate
	Pulse
	Systolic BP
	GCS / AVPU
	Urine Output
	Temp.
	SpO_2%
	TOTAL

Modified Early Warning Score (MEWS)

Score	3	2	1	0	1	2	3
Resp. Rate		≤8	9-10	11-20	21-25	26-30	≥31
Pulse		≤40	41-50	51-100	101-110	111-130	≥131
Systolic BP	≤84	85-89	90-100	101-199		>200	
GCS / AVPU	≤8	9-13	14 New agitation or confusion	15 / Alert	Voice	Pain	Unresponsive
Urine	<10mls/hr for 2 hrs	<30mls/hr for 2 hrs					
Temp. (°C)		≤35.0	35.1-35.9	36.0-37.4	37.5-38.5	≥38.6	
SpO_2%	≤87	88-91	92-94	95-100			



MEWS	
	Resp. Rate
	Pulse
	Systolic BP
	GCS / AVPU
	Urine Output
	Temp.
	SpO_2%
	TOTAL

Calling Criteria

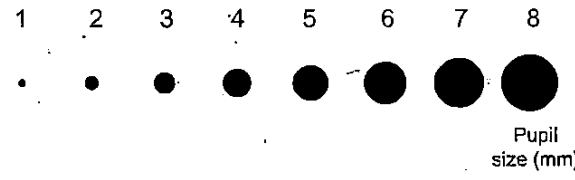
Score is 1-3	Increase frequency of patient observations, monitor trends and inform Nurse in Charge.
Score is 3 in one category	Contact Senior Nurse and increase frequency of patient observations.
Score is 4 and above or increasing by 2 or more Patient's GCS falls by 2 or more Any patient whose condition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

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

Neurological Observation Chart

DATE																			
Time																			
COMA SCALE	E Eyes open	Spontaneously	4																Eyes closed by dwelling = C
		To speech	3																
		To pain	2																
		None	1																
	V Best verbal response	Orientated	5																Endotracheal tube or tracheostomy = T
		Confused	4																
		Inappropropriate words	3																
		Incomprehensible sounds	2																
		None	1																
	M Best motor response	Obeys	6																Usually record the best arm response
		Localises	5																
		Flexion - withdrawal	4																
		Flexion - abnormal	3																
		Extension to pain	2																
		None	1																
		TOTAL SCORE																	
PUPILS	R	Size																	= reacts —no reaction c. eyes closed
		Reaction																	
	L	Size																	
		Reaction																	
LIMB MOVEMENT	ARMS	Normal power																	Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness																	
		Severe weakness																	
		Spastic flexion																	
		Extension																	
		No response																	
	LEGS	Normal power																	
		Mild weakness																	
		Severe weakness																	
		Extension																	
		No response																	

Glasgow Coma Scale



DATE																			
Time																			
COMA SCALE	E Eyes open	Spontaneously	4																Eyes closed by dwelling = C
		To speech	3																
		To pain	2																
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		Extension																	
		No response																	
	LEGS	Normal power																	
		Mild weakness																	
		Severe weakness																	
		Extension																	
		No response																	

Medical Illustration Services, MIS 111948 - Reorder CEDAR 35497

PRESCRIPTION FORM

Hospital Name: ....

PATIENT DETAILS	
Name: 23096429V MCCOURT RYAN M 19/04/1994 18 Pinkston Drive FLAT 5/6 GLASGOW G21 1NP CHI-1904946291	Height:
Hosp	Weight:
D	Surface area:
Date of Admission: ___/___/___	Date of writing discharge prescription: ___/___/___
Consultant Name:	Ward:
Date and time this form prepared: ___/___/___ Time:________	Sheet No .... / 2nd Prescription in use Yes or NO

DRUG SENSITIVITIES

NKDA.

DVT Risk on Admission (SIGN Guideline)

High ☐ Moderate ☐ Low ☐

Assessed by: Date: ___/___/___

OTHER CHARTS IN USE

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

ONCE ONLY AND PREMEDICATION DRUGS

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

PATIENT'S NAME:

ADMINISTRATION

Parenteral Drugs: Regular Prescription

DATE → 26 27 28

MONTH → 4 4 04

A DRUG: Flucloxacillin

DOSE: 1g | ROUTE: IV | DATE: 26/4/7 | STOPPED DATE: | STOPPED INITIALS:

SIGNATURE OF DOCTOR:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

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

B DRUG: Benzylpenicillin

DOSE: 600mg | ROUTE: IV | DATE: 26/4/7 | STOPPED DATE: | STOPPED INITIALS:

SIGNATURE OF DOCTOR:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

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

C DRUG:

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

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

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

D DRUG:

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

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

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 inadvertent omission or double dosing is avoided.

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

E DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

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

F DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

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

G DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

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

H DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

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

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

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE → 26 27
MONTH → 04 04

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

J DRUG: Paracetamol

DOSE: 500mg | ROUTE: PO | DATE: 26/4/07

STOPPED DATE:

SIGNATURE OF DOCTOR:

STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

K DRUG: PARACETAMOL

DOSE: 750mg | ROUTE: PO | DATE: 26/4/07

STOPPED DATE:

SIGNATURE OF DOCTOR:

STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

L DRUG

DOSE | ROUTE | DATE

STOPPED DATE:

SIGNATURE OF DOCTOR

STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

M DRUG

DOSE | ROUTE | DATE

STOPPED DATE:

SIGNATURE OF DOCTOR

STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Oral and Other Drugs: Regular Prescriptions

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 →

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

N DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

P DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

R DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

S DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

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 →

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

T DRUG

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

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

V DRUG

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

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

W DRUG

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

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

X DRUG

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

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Oral and Other Drugs: Regular Prescriptions

DATE →
MONTH →

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

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

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

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 →

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

DD DRUG

DOSE | ROUTE | DATE

STOPPED DATE:

SIGNATURE OF DOCTOR

STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

EE DRUG

DOSE | ROUTE | DATE

STOPPED DATE:

SIGNATURE OF DOCTOR

STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

FF DRUG

DOSE | ROUTE | DATE

STOPPED DATE:

SIGNATURE OF DOCTOR

STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

GG DRUG

DOSE | ROUTE | DATE

STOPPED DATE:

SIGNATURE OF DOCTOR

STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

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

Oral and Other Drugs: Regular Prescriptions

DATE →
MONTH →

HH

DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

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

JJ

DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

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

KK

DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

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

LL

DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

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

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

PATIENT'S NAME:

All Routes: As Required Prescriptions

ADMINISTRATION

MM			STOPPED		
DRUG: Dihydrocodeine			DATE:	DATE	26/4
DOSE: 30mg	ROUTE: O	INDICATION: Pain	INITIALS:	TIME	20:10
SIGNATURE OF DOCTOR: [signature]	MAX.FREQUENCY: 4-6°		DATE: 26/4/17	DOSE	30mg
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				GIVEN BY	JM

NN			STOPPED		
DRUG: Naproxen			DATE:	DATE	26/4/17
DOSE: 250mg	ROUTE: O	INDICATION: Pain	INITIALS:	TIME	20:40
SIGNATURE OF DOCTOR: [signature]	MAX.FREQUENCY: 8°		DATE: 26/4/17	DOSE	250mg
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				GIVEN BY	JD

PP			STOPPED		
DRUG			DATE:	DATE	
DOSE	ROUTE	INDICATION	INITIALS:	TIME	
SIGNATURE OF DOCTOR	MAX.FREQUENCY		DATE:	DOSE	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				GIVEN BY	

RR			STOPPED		
DRUG			DATE:	DATE	
DOSE	ROUTE	INDICATION	INITIALS:	TIME	
SIGNATURE OF DOCTOR	MAX.FREQUENCY		DATE:	DOSE	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				GIVEN BY	

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

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

DATE																										
TIME																										
DOSE																										
GIVEN BY																										

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

DATE																										
TIME																										
DOSE																										
GIVEN BY																										

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

DATE																										
TIME																										
DOSE																										
GIVEN BY																										

WW	DRUG		STOPPED DATE:
DOSE	ROUTE	INDICATION	INITIALS:
SIGNATURE OF DOCTOR		MAX.FREQUENCY	DATE:
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

Nurse/Midwife Administration by Protocol - Authorised Nurses/Midwives Only

(Maximum number of doses as per protocol)

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

DOCTOR'S DECLARATION (if required by Local Protocol)

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

Signature: _____ Date: _____

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

Notes for

FOR DOCTORS:

1. Sign your name clearly against t
2. When drugs are discontinued, c ugh the prescription box, initial and date
3. If an existing prescription is existing prescription as described and r n 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.**
		Units:	**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		

MANUAL PATIENT RECORDS

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

Including:

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

Department of Trauma & Orthopaedics
Glasgow Royal Infirmary
84 Castle Street
Glasgow
G4 0SF

Telephone: **0141 211 1243**
Fax: **0141 211 4060**
Appointments: **0141 211 4608**

TRAUMA HAND CLINIC

Clinic and dictated: 21/09/2010
Typed: 24/09/2010
Our Reference: GM/HB

Dr James McKinlay
The Barony Medical Centre
30 Auchinloch Street
Glasgow
G21 4AH

Dear Dr McKinlay

Re: Mr Ryan McCourt 19/04/1994; CHI: 1904946291; CRN:23096429V
18 Pinkston Drive Flat 5/6 Glasgow G21 1NP

Diagnosis **Right Bennet's fracture 21 08 10**
Outcome **Return appointment in 4 weeks' time to hand clinic**

This lad attended our fracture clinic today. His mum remained in attendance throughout his clinic appointment.

As previously discussed with Mr Sianos, orthopaedic surgeon, at today's trauma hand meeting. This lad has sustained a right Bennet's fracture during a game of football.

On examination normal colour and sensation appeared to be evident to the limb. Slight swelling is evident over the right thumb with localised tenderness. A right Bennet's cast has been applied today. Advice has been given with regard to cast care and an acceptable level of activity.

Ryan will be further reviewed in 4 weeks' time at the hand clinic for further management. He has a contact telephone number and advised to contact the clinic should any problems or concerns arise.

Yours sincerely,

G McIntyre
STAFF NURSE

Fracture Clinic Review Request Form

For completion by doctor requesting follow up

Date of Injury _____

Patient Details

Name _____

Address _____

DOB _____

23096429V
MCCOURT M
RYAN 19/04/1994
18 PINKSTON DRIVE
FLAT 5/6
GLASGOW G21 1NP
CHI-1904946291

LRI No. (Not A&E No) _____
(Addressograph Label)

Diagnosis / Injury

base 1st mc.

Treatment Required

Requires a true Bennett: cast.

3-4 wks.

hand clinic

Anyone to see.

Accident and Emergency Department
Glasgow Royal Infirmary

VOL

17

23096429V

A&E No. 10000053953

4

Surname	MCCOURT	**Forename**	RYAN	**Title:** MR	
Address:	18 PINKSTON DRIVE FLAT 5/6 GLASGOW	**Postcode**	G21 1NP	**CHI No:**	1904946291
		Telephone:	07878048331		
Date of Birth:	19.04.94	**Sex:**	M	**Age:**	16 yrs

CHI Number: 1904946291

GP Name:	CRON ALISON		
Address:	THE BARONY MEDICAL ... 30 AUCHINLOCH STREET GLASGOW	**Postcode**	G21 4AH
		Telephone:	0141 557 6161

Next of Kin	MARY MCCOURT		
Relationship:	PARENT		
Address:	18 PINKSTON DRIVE FLAT 5/6 GLASGOW	**Postcode**	G21 1NP
		Telephone:	07878048331
Primary Carer:	ST ROCHS SEC.		

Date of Attendance: 21.09.10 00:17
Date of Incident:
Presenting Complaint: R HAND INJURY

Triage FELL PLAYING FOOTBALL EARLIER TONIGHT, C/O PAIN OVER BASE OF R THUMB, SWELLING EVIDENT, UNABLE TO MAKE A FIST. CAP REFILL NORMAL

Tetanus Cover:

Allergies:

P= **BP=** / **RR=** **Sat=** **BM=**

PF= **GCS=** E: M: V: Total:

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time
21/9/10	PARACETAMOL	1g QDS	O	A. Laing		

- 16 yo old male [illegible] [illegible]
playing football earlier today.
Pain & swelling in thumb.

O/E. Right hand - dominant
- Anatomical snuff box tenderness
- Swelling to thumb + thenar
eminence
- No bruising - Pulses present
- Sensation normal
- Healing wound on palmar aspect
of hand.
- ↓ ROM - unable to oppose thumb
& pinkie
- Various scars & abrasions on hand & arm

PMH - asthma
Allergies - none known
X. Ray - NBI seen scaphoid
Plan - wrist splint & thumb extension
analgesia
hand clinic ~~2 weeks~~
~~Referral [illegible]~~ cancelled A.L.

A Long.

O/15
Review of x ray -
intra-articular # base proximal phalanx.
D/w Dr [illegible]. Patient's mother then
phoned at 0.30. appointment made
at hand clinic tomorrow 3 pm.

A Long.

Department of Trauma & Orthopaedics
Glasgow Royal Infirmary
84 Castle Street
Glasgow G4 0SF

TEL: 0141 211 5838
FAX: 0141 211 4060

NHS
Greater Glasgow and Clyde

DISCHARGE SUMMARY

CONSULTANT: MISS N. JANE MADELEY

ADMITTED:	22/04/2012	WARD:	61
DISCHARGED:	24/04/2012	AGE:	19/04/1994
HOSPITAL NUMBER:	23096429V	CHI NUMBER:	1904946291
DISPOSAL HOME		NAME :	Mr Ryan McCourt
FOLLOW UP		ADDRESS:	0/1 427 Bilsland Drive Glasgow G20 9JN

DISTRIBUTION OF LETTERS : Dr James McKinlay The Barony Medical Centre 30 Auchinloch Street Glasgow G21 4AH	

	FINAL DIAGNOSIS	ICD10		OPERATION	OPCS
1.	L2 fracture		1.		

Dear Dr McKinlay

The above named 18 year old gentleman jumped 30feet from a window onto concrete having lost his keys. He landed on his feet but complained of sudden back pain. He was taken to A&E where imaging was carried out which confirmed comminuted fractures through the superior endplate of L2. There was also slight loss of height of L1 vertebral body. However the posterior elements of the spine were undamaged and we were able to confirm with the spinal injuries unit that this was a stable injury which could be treated with mobilisation as able. In order to facilitate this he was fitted with an airback brace by our Orthotic Department. This enabled him to be mobilised with analgesia. Ryan was made aware that it could take 6-8 weeks for his symptoms to markedly improve but that no further treatment is required. Never at any point did he have any abnormal neurology. He will have follow up in the fracture clinic in due course to make sure his symptoms are settling as expected.

Yours sincerely

JANET McCAUL
Specialist Registrar - Orthopaedics

ORTHOTIST HAS SEEN REFERRAL – KEEP IN NOTES FOR REFERENCE
23/04/12 1.50pm orders called post request by medical staff.

Acute Services Division

NHS Greater Glasgow and Clyde

Rehabilitation and Assessment Directorate

Orthotic Referral

Chi number:	Referrer (PRINT NAME): SHARLIE D JONES
Unit number:	Signature: Sharlie D Jones
Surname: 23096429V MCCOURT M	
DoB: RYAN 19/04/1994	Referral source: PITU/SIO
Address: 0/1 427 BILSLAND DRIVE	Contact details: ward 61
GLASGOW G20 9JN	
Postcode: CHI-1904946291	Consultant: Miss Madeley
Telephone:	Outpatient | (Inpatient)
Mobile 'phone:	Planned discharge date:
e-mail:	Date of referral: 23/04/12
Registered G.P.	
PLEASE USE PATIENT LABEL	

Special Needs

Patient's weight:

Communication difficulties (please specify):

Medical alert:

Interpreter required - NO ☑ YES ☐ Language/ Dialect:

Transport required - NO ☐ 1 man ☐ 2 man ☐ Wheelchair ☐ Accompanied ☐

Diabetic - YES ☐ NO ☑ Unknown ☐

Relevant History and Diagnosis

Asthma

Presenting Problem

L2 # stable spinal injury advice for spinal brace before mob.

Objectives of Treatment

Control pain	☐	Immobilise	☐	Control specific movement	☐
Correct deformity	☐	Protect joint	☐	Accommodate fixed deformity	☐
Relieve weight	☐	Prevent ulceration	☐	Enhance mobility	☐

Other Relevant Information

Current Medication

Assessed priority of referral:

Date referral recieved:	Referral type:

Patient Sample Report

Patient	
ID:	23096429V
Last Name:	MCCOURT
First Name:	RYAN
Gender/Age:	Male, 18 years
Birth Date:	19.04.1994
Status:	ACCEPTED
Analyzed:	22.04.2012 02:02:52
Sample Type:	
Account Number:	
Clinician:	
Operator ID:	GRAEME BOYLE0

Analyzer	
Model:	GEM® *Premier 4000*
Area:	GRICASU
Name:	CASU
S/N:	06090159

Measured (37.0°C)		
cH	↑ 46.4	nmol/L
pCO_2	↑ 6.4	kPa
pO_2	↓↓ 4.5	kPa
Na^+	143	mmol/L
K^+	3.8	mmol/L
Cl^-	107	mmol/L
Ca^{++}	1.15	mmol/L
Hct	46	%
Glu	5.2	mmol/L
Lac	1.4	mmol/L

CO-Oximetry		
tHb	15.5	g/dL
O_2Hb	↓ 62.3	%
COHb	↑ 4.8	%
MetHb	1.4	%
HHb	↑ 31.5	%
sO_2	↓ 66.4	%

Derived		
BE(B)	-1.2	mmol/L
HCO_3^-(c)	25.3	mmol/L

Operator Entered		
Temp	37.0	°C

O2 and Vent Settings		
FIO_2		%

↑↓ Outside Reference Range
↑↑ ↓↓ Outside Critical Range

E-Pacer PATIENT REPORT

Time 02:16 Date 22/04/2012

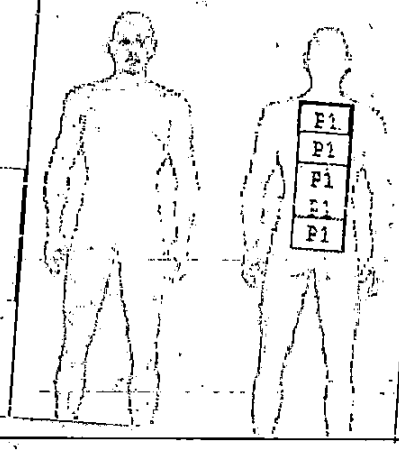
PATIENT AND INCIDENT DETAILS

Incident number	PA004142276.001
Name	RYAN MCCOURT
Age	18
Date of birth	19/04/1994
Gender	Male
Incident location	IN CLOSE 427 BILSLAND DRIVE RUCHILL GLASGOW
Incident post code	G20 9JN
Incident type	EMG
Call received	22/04/2012, 01:41
Call passed	22/04/2012, 01:42
Crew mobile	22/04/2012, 01:42
Crew at scene	22/04/2012, 01:46
Crew left scene	22/04/2012, 02:01
Patient at hospital	22/04/2012, 02:01
Receiving hospital and department	GRIN Glasgow Royal Infirmary

PRIMARY SURVEY

RESPONSE	
AVPU	Alert
AIRWAY	
Airway assessment	Clear
BREATHING	
Breathing rate	Fast
Respiratory rate	24
Oxygen given	100%
CIRCULATION	
Pulse rate	Fast
Most peripheral pulse found	Radial
Cap refill rate	<2 secs
Skin colour	Normal
Skin texture	Dry
C-SPINE INJURY	
Suspicion of CSI	Movement of fingers and toes
CSI Treatment	Collar, Head hugger, Spinal board

INJURIES



PAIN

P1. No pain relief provided
P2.
P3.
P4.

AMPDS

Dispatch code	17D01
Final code	17D02

Extreme fall - (>30ft) - Falls, Long Fall > 6ft/2m

GCS

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

VITAL SIGNS

Tim hr : min	Pul bpm	Res rpm	BP mm Hg	Cap refil (secs)	Pea flow %	Blo sug mmol / l	Tem °C	SpC %	GC Total	RTS	SEV	ECG	Pain score
01:50	110	24	118 / 83	<2 secs	-	-	-	100	15	7.550			

EYES AND PUPIL SIZE AND REACTION

	Left	Right
Pupil size	Dilated	Dilated
Pupil reaction	Normal	Normal

SUBSTANCES AFFECTING CONDITION

Alcohol

FINAL OBSERVATION AND COMMENTS

999 CALL FOR 18YRS MALE INTOXICATED JUMPED OUT OF FLAT WINDOW APPROX 30FT ONTO CONCRETE SLABBING O/A PATIENT STANDING IN CLOSE C/O BACK PAIN .MINOR LACERATIONS TO ARMS IMMOBILISED STAND BY ARRANGED GRI. PMH ASTHMA.

Report ID b65f60db-1e9a-4f9d-9f0d-67444780fb04

GLASGOW ROYAL INFIRMARY

Radiology Report

Patient Name:	MCCOURT RYAN	**Report Date:**	22-Apr-2012 12:00
Patient ID:	1904946291	**Accession No.:**	G107H26831914
Patient Birth Date:	19-Apr-1994	**Report Status:**	F
Referring Physician:	Dr NJ Madeley	**Reason For Study:**	

Report Summary]
Clinical History :
Fall from 30 feet. L2 fracture on plain film.
CT Spine lumbar]
CT Spine lumbar :
CT confirms a comminuted fracture through the superior plate of the L2 vertebral body with several small fracture fragments lying just anterior to the anterior superior corner of the to the body. The posterior cortex is intact.
There is also slight loss of height of the L1 vertebral body with an irregular cortical outline of the antero-superior corner, suspicious of a further undisplaced fracture.
There is a lucent line running through the inferior articulating processes of the posterior elements of L1 bilaterally. Although the margins do appear relatively corticated, appearances are thought most likely to represent acute avulsion type fractures.
Conclusion:
Fractures of L2 and probably L1 anterior vertebral bodies and inferior articulating process of L1.

Reported by : *Dr Ewen Robertson (SpR)*

2nd Report by :

Verified by : *Dr Subra Viswanathan*

Produced by Carestream Health PACS

Back

CRIS: 6179391 Patient Details Address GP

Hospital No 23096429V

Chi No. 1904946291

Surname MCCOURT

Forenames RYAN

DoB 19/04/1994 Male

Film Location Not traced since creation

427 BILSLAND DRIVE
GLASGOW
LANARKSHIRE
G20 9JN

Search Enquire *Result Log off

Attended	Ward	Referrer
22/04/2012 @ 0225	G107HAE	Dr Claire Fitzpatrick

Verified Report

Clinical History :
Jumped 30 feet. Back pain. Wrist tender.

Reported	Typed	Verified
By: Dr Ewen Robertson (SpR) On: 22/04/2012 At: 0906	By: Dr Ewen Robertson (SpR) On: 22/04/2012 At: 1022	By: Dr Ewen Robertson (SpR) On 22/04/2012 At: 1022

Verified Report

XR Cervical spine : Lateral, AP and open-mouth peg view performed.

An incomplete trauma series. The cervico- thoracic junction is not visible on the lateral projection of either the cervical or thoracic spine radiographs.

However, vertebral alignment is maintained with no prevertebral soft tissue swelling. No evidence of cervical spine fracture.

Code N: No note: No sticky note available. Referrer's interpretation is unknown

Reported	Typed	Verified
By: Dr Ewen Robertson (SpR) On: 22/04/2012 At: 0906	By: Dr Ewen Robertson (SpR) On: 22/04/2012 At: 1022	By: Dr Ewen Robertson (SpR) On 22/04/2012 At: 1022

Verified Report

R Thoracic spine :
No evidence of thoracic vertebral malalignment or acute fracture. No para-vertebral soft tissue swelling.

Code N: No note: No sticky note available. Referrer's interpretation is unknown

Reported	Typed	Verified
By: Dr Ewen Robertson (SpR) On: 22/04/2012 At: 0906	By: Dr Ewen Robertson (SpR) On: 22/04/2012 At: 1022	By: Dr Ewen Robertson (SpR) On 22/04/2012 At: 1022

Verified Report

XR Lumbar spine :
There is loss of height of the L1 and L2 vertebral bodies with a fracture fragment anterior to the antero-superior corner of L2 vertebral body. The posterior vertebral cortices appear intact.

If there is concerning neurology, further imaging is recommended.

Code N: No note: No sticky note available. Referrer's interpretation is unknown

Reported	Typed	Verified
By: Dr Ewen Robertson (SpR)	By: Dr Ewen Robertson (SpR)	By: Dr Ewen Robertson (SpR)

On: 22/04/2012 At: 0906	On: 22/04/2012 At: 1022	On 22/04/2012 At: 1022

Verified Report

XR Wrist Rt :

No evidence of acute fracture.

Code N: No note: No sticky note available. Referrer's interpretation is unknown

Reported	Typed	Verified
By: Dr Ewen Robertson (SpR) On: 22/04/2012 At: 0906	By: Dr Ewen Robertson (SpR) On: 22/04/2012 At: 1022	By: Dr Ewen Robertson (SpR) On 22/04/2012 At: 1022

Back Log off

Accident and Emergency Department
Glasgow Royal Infirmary

④

23096429V

A&E No. 12000027034

Wd 62.

Surname	MCCOURT	**Forename**	RYAN	**Title:** MR	
Address:	0/1 427 BILSLAND DRIVE	**Postcode**	G20 9JN	**CHI No:**	1904946291
	GLASGOW	**Telephone:**	07878048331		
Date of Birth:	19.04.94	**Sex:**	M	**Age:**	18 yrs

CHI Number: 1904946291

GP Name:	MCKINLAY JAMES		
Address:	THE BARONY MEDICAL ...	**Postcode**	G21 4AH
	30 AUCHINLOCH STREET		
	GLASGOW	**Telephone:**	0141 557 6161

Next of Kin	MARY MCCOURT		
Relationship:	PARENT		
Address:	0/1 427 BILSLAND DRIVE	**Postcode**	G20 9JN
	GLASGOW	**Telephone:**	07878048331
Primary Carer:	RELATIVES IN MWA		

Date of Attendance: 22.04.12 02:05
Date of Incident:
Presenting Complaint: STANDB/JUMPED FROM WINDOW

Triage **Tetanus Cover:**

Allergies:

P= **BP=** / **RR=** **Sat=** **BM=**

PF= **GCS=** E: M: V: Total:

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time

Glasgow Royal Infirmary
Unitary Patient Record
(Part A - Acute Assessment)

NHS
Greater Glasgow and Clyde

23096429V
MCCOURT M
RYAN 19/04/1994
0/1, 427 BILSLAND DRIVE
GLASGOW G20 9JN
CHI-1904946291

Injury/Illness Flow Chart for all Patients 16 and under

Please tick the appropriate box as you go through the Flow Chart

Start

Has the child had 3 or more attendances at A&E within the previous 12 months? — No / Yes

Has there been a delay between injury/illness and seeking medical advice for which there is no satisfactory explanation? — No / Yes

Is the history consistent each time? — Yes / No

On examination, does the child have any unexplained injuries/illness? — No / Yes

Is the childs behaviour and interaction appropriate? — Yes / No

Low suspicion injury: Diagnosis and treat as normal

High suspicion injury: Discuss with a senior doctor in A&E or RHSC paediatrics

All Clinical Staff Consider

H.I.Form ☐

Audit Form ☐

Police Consent ☐

Clinical Notes

22/4/12 O/A [illegible] / FERNS [illegible]
STANDBY (Trauma Team Called)

18yo ♂
Jumped 30 ft from Window onto concrete.
Apparently just moved in & lost keys, locked in so jumped out window.
Landed on feet on concrete.
Up & walking when SAS arrived, c/o back pain.

Usually fit & well
No meds, no allergies.

Please complete where appropriate:

AMT (if >65 years)	CURB Score (if <65 years)
	SIRS

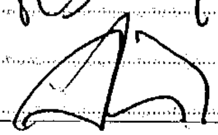
80907

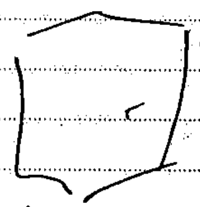
Acute Medicine Unit
Glasgow Royal Infirmary
Unitary Patient Record
(Part A - Acute Assessment)

23096429V M
MCCOURT 19/04/1994
RYAN
0/1 427 BILSLAND DRIVE
GLASGOW G20 9JN
CHI-1904946291

Clinical Notes

O/E A&O GCS 15 smells strongly of alcohol
HR 90 BP 118/70
RR 20 sats 100%.
HS I + II + nil

 clear, chest wall stable

 soft
BS

pelvis stable.
No pain hips/knees/ankles/heels
FROM hips.
Log rolled - no obvious bony tenderness
No step.
Numerous abrasions both hands & arms
tender around (R) distal radius.
NV intact.
X-ray full spine, → Wedge # L2 c ?L1.
(R) wrist → no # seen.

Acute Medicine Unit
Glasgow Royal Infirmary
Unitary Patient Record
(Part A - Acute Assessment)

NHS
Greater Glasgow and Clyde

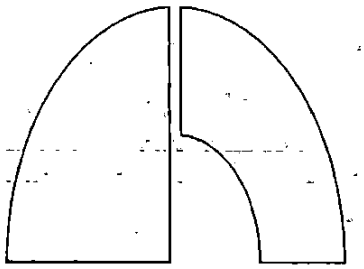
23096429V
MCCOURT M
RYAN 19/04/1994
0/1 427 BILSLAND DRIVE
GLASGOW G20 9JN
CHI-1904946291

Clinical Notes

Imp # lumbar vertebrae
Plan Admit ortho.

[signature]

X-Ray results



ECG findings

Other investigations

Biochem/Haematology results

Indicate which lab tests have been requested

Haem		
WCC		
Hb		
Plat		
MCV		
Neut		
DDim		
PT		
PTT		
TT		

Bioch		
Na^+		
K^+		
Cl^-		
Ur		
Creat		
Glu		
CRP		
Bil		
AST		
ALT		
GGT		
ALP		
Prot		
Alb		
Glob		
Ca^{++}		
Amyl		
TSH		
FT4		
Tropl		
Chol		
Trig		
Para		
Sal		
S osm		
ABG		
H^+		
P_aCO_2		
P_aO_2		
Bic		
BE		
FiO_2		
Lactate		

Fluids Prescribed in A&E

signature

signature

signature

signature

signature

Drugs Prescribed in A&E

signature

signature

signature

signature

signature

Refusal of Treatment

Hereby I declare that I am leaving

*(or taking _____ away from)

the _____ Hospital at my own desire and

contrary to the advice of medical staff.

I have had the risks of so doing explained to me, and accept full responsibility for my action.

Signature _____

Witness Date _____

* Delete whichever is inapplicable.

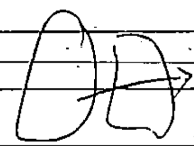
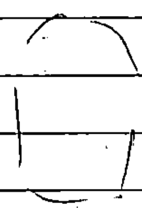
23096429V
MCCOURT M
RYAN 19/04/1994
0/1 427 BILSLAND DRIVE
GLASGOW G20 9JN
CHI-1904946291

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL

Date & Time		Signature, Print Name & Designation
22/4/12	Date: 22/4/12 Ward: 6D MRSA Screening: A: Clinical Risk Assessment (CRA) - for patients >23 hours — YES / NO 1. Has the patient ever had a previous positive MRSA result? NO ✓ 2. Has the patient been admitted from a care home/ institutional setting or another hospital? NO ✓ 3. Does the patient have a wound/ulcer or invasive device which was present prior to admission? NO ✓ If 'Yes' to any question or if the patient is within (or admitted to) a High Impact Speciality* complete section B ['Not known' = 'No'] *Orthopaedics / Vascular / Renal / Critical Care [please circle] B: MRSA Lab Test: Nose ☐ Perineum ☐ Other (s) Throat Groin, Patient refused ☐	
	Admitted to ward following fall from window Wedge # L2 ?L1 #.	[signature]
22/4/12 0530	CST clerking:	
	180 → Jumped 30ft from window. Locked in flat. Landed on feet on concrete path. Felt 'winded' initially. Walking when ambulance service arrived. C/o back pain. No other injuries reported. Intoxicated on arrival in A&E.	
PMHx	Nil of note	
DHx	Nil regular NKDA	
SHx	Lives c̄ mother, brother. Apprentice panel	

83949

Date & Time		Signature, Print Name & Designation
	Non smoker	
	~2L cider/week	
	Systemic, nil of note	
	O/E, intoxicated	
	[illegible]	
	HS I+II+0	
	Pulse regular 	= AE
	JVP ↔	°added
	°Oedema chest wall	- nad
	 SNT Pelvis stable	
	⊕ BS No tenderness on palpation of long bones. Tender over Ⓡ DRUJ	
	NROM at upper/lower limbs	
	Neuro,	

	RUL	LUL	RLL	LLL
Tone	N	→	→	→
Power	N	→	→	→ 5/5
Coord	N	→	→	→
Sensation	N	→	→	→
Proprioception	N	→	→	→
Reflexes	N	→	→	→
Plantars			↓	↓

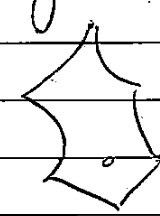
Ⓡ wrist: minimally tender over DRUJ
NV intact
Ⓝ ROM

cont.

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL

23096429V
MCCOURT M
RYAN 19/04/1994
0/1 427 BILSLAND DRIVE
GLASGOW G20 9JN
CHI-1904946291

Date & Time		Signature, Print Name & Designation
	XR - # L2	
	? L1 #	
	(P) bloods	
	Analgesia	
	In collar, nursed flat	
	~~For F/U on WC~~	
	FOC (N) AST 43	
	CK (529) bloods otherwise	LEONARD
	unremarkable.	CNST
		3681
22/4/12	WR MADELEY/[illegible].	
0900	→ Hx noted	
	(18) Intoxicated on admission	
	- Fall from 30 ft.	
	- Severe back pain this morning.	- C-spine
		- painfree.
	- O/E - log rolled - minimally tender	full ROM.
	over lumbar region.	
	- normal perianal sensation	
	Lower limbs - power 5/5 bilaterally	
	- sensation intact bilaterally.	
	XRAY - L2 #.	
	PLAN - Lie flat.	
	- CT lumbar spine.	[signature]
		SHO
		3681.

83949

Date & Time		Signature, Print Name & Designation
22/04/12	NURSING 13[45]	
	Observations stable, c.s.m	
	to all limbs intact. Remains	
	on flat bedrest, spinal protocol	
	until c/t reported. Analgesia	
	as per kardex. no complaints.	
	M. Jacobs (S/N)	
2 4/12 14[45]	SHO ORTHO KGL	
	D/w spinal Injuries: SHO	
	→ clearance.	
	→ ranitidine.	
	→ ~~(?)~~ lie flat	
	→ will d/w consultant	
	manc + contact with advice.	
NIGHT	Mews nil. Tolerating oral fluids	[signature]
	Still to void urine. No complaints	SHO
	of discomfort. ~~[illegible]~~	3681.
	Log roll continues. Skin intact	
	to pressure areas. Abrasions to	
	arms exposed air dry. Tolerates	
	analgesia.	P Moss
02[00]	Voided urine spontaneously.	P Moss SN
27/4/12	WR Madeley	
	awaiting word from spinal Injuries re: stability of fracture.	
	likely for mobilisation but await their advice.	J M[illegible] SpR[illegible]

GLASGOW ROYAL INFIRMARY

Radiology Report

Patient Name:	MCCOURT RYAN	**Report Date:**	22-Apr-2012 12:00
Patient ID:	1904946291	**Accession No.:**	G107H26831914
Patient Birth Date:	19-Apr-1994	**Report Status:**	F
Referring Physician:	Dr NJ Madeley	**Reason For Study:**	

[Report Summary]
Clinical History :
Fall from 30 feet. L2 fracture on plain film.
[CT Spine lumbar]
CT Spine lumbar :
CT confirms a comminuted fracture through the superior endplate of the L2 vertebral body with several small fracture fragments lying just anterior to the anterior superior corner of the to the body. The posterior cortex is intact.
There is also slight loss of height of the L1 vertebral body with an irregular cortical outline of the antero-superior corner, suspicious of a further undisplaced fracture.
There is a lucent line running through the inferior articulating processes of the posterior elements of L1 bilaterally. Although the margins do appear relatively corticated, appearances are thought most likely to represent acute avulsion type fractures.
Conclusion:
Fractures of L2 and probably L1 anterior vertebral bodies and inferior articulating process of L1.

Reported by : *Dr Ewen Robertson (SpR)*

2nd Report by :

Verified by : *Dr Subra Viswanathan*

Produced by Carestream Health PACS

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL

23096429V
MCCOURT M
RYAN 19/04/1994
0/1 427 BILSLAND DRIVE

GLASGOW G20 9JN
CHI-1904946291

Date & Time	62541 Mr Fraser	Signature, Print Name & Designation
13th 23/4/12	C. Kennedy SHO	
	I have spoken with the spinal injuries unit SHC at SGH this afternoon Ryan's CT has been reviewed at the MDT, consensus L2 crush # for conservative Mx, no transfer. The SHO however was not able to clarify if mobilisation/weightbearing was possible and a decision for a lumbar brace. → He will once again discuss with his consultant and call back ~16:00 pm this afternoon with further advice	
→ 23/4/12	The spinal injuries unit has got back in contact: - Ryan's mobilisation should be guided by his consultant at GRI - if pain free advise mobilisation with knee potentially. - No spinal f/u required - If further questions, Mr Fraser @ SGH would be happy to discuss consultant to consultant. He can be contacted on 62541.	
23/4/12 16:00	fitted Airback brace with TL50 support. To prevent lumbar spinal flexion and support # site. Any problems contact Orthotics	DAVID STUART ORTHOTIST

83949

Date & Time		Signature, Print Name & Designation
23/4/12	Nursing — Days:	
	Settled day	
1	Observations stable MEWS 0	
6	Oral analgesia given as prescribed	
8	Taking fluids + diet well.	
9	Using urinals. No bowel movement	
	today	
	Fitted with Lumbar Support.	[signature]
24/4/12	Settled overnight: Oral analgesia	
R	given. Remained on bedrest	[signature]
24/4/12	Nursing 1140	
	Up to sit with air back brace	
	in situ. Mobilising with elbow	
	crutches. Visited by [illegible] physio.	
	Patient states hasn't moved his bowels	
	since Friday but is passing flatus.	
	Nurse Practitioner informed + will	
	review. Possibly for discharge later	
	today. MEWS = 0. Care [illegible] planned.	[signature] [illegible] Staff

NHS
Greater Glasgow and Clyde

ORTHOPAEDIC PHYSIOTHERAPY ASSESSMENT

Unit N
Surna
First N 23096429V
Addre MCCOURT M
RYAN 19/04/1994
0/1 427 BILSLAND DRIVE
DOB GLASGOW G20 9JN
CHI: CHI-1904946291

Ward/Unit: 61
Consultant: Miss S. Madeley
Admission Date: 22/04/12
Referral Date: 23/04/12
Tel. No.: 07878048331
Age: 18

Consent ______________________

PC # L2 + ? # L1

HPC jumped 30 foot from window onto concrete due to lost keys under influence alcohol

MRI/Investigations/Results

PMH Asthma.

DH See Kardex

Contraindications/Precautions/Allergies nil known

SH lives c̄ parents Apprentice panel worker
Ⓗ, EXT steps, smokes

Management/Post op/Trauma round Instruction 23/04/12 Awaiting spinal team review & advice SDJ 23/04/12 1-50 pm spinal advice L2 # stable for spinal brace + then to mob. orthotics contacted + referral made by phone SDJ.

Objective Date Completed: 24/4/12
lying supine in bed.
AO1 c̄ trunk brace donning.

Chest issues? Y ☐ N ☑

Lie/sit: Ind ☑ Sup ☐ AO1 ☐ AO2 ☐ Unable ☐ Other: ____

Sit/stand: Ind ☑ Sup ☐ AO1 ☐ AO2 ☐ Standaid ☐ Unable ☐ Other: ____

Bed/chair: Ind ☑ Sup ☐ AO1 ☐ AO2 ☐ Standaid ☐ Hoist ☐ Other: ____

Gait: Ind ☑ Sup ☐ AO1 ☐ AO2 ☐ Unable ☐

W/S x __ ☐ E/C x 2 ☑ WZF ☐ Other: ____

Walking Aid Provided: None ☐ W/S x __ ☐ E/C x 2 ☑ WZF x __ ☐ Other: ____

Date	Signature	Print Name	Designation	Initials
23/04/12	[signature]	SHARLIE D JONES	Team Lead	SDJ
24/04/12	[signature]	B. [illegible]	SCP	[illegible]

Patients Name: Ryan M'Court CHI: 1904946291

Traffic light updated: Y ☐ N ☑ Mobility recommendation (I) z 2 x ec's

EMS completed: Y ☐ N ☑ Tinetti completed: Y ☐ N ☑ (if Y, see attached)

Stairs: Ind ☑ Sup ☐ AO1 ☐ AO2 ☐ Unable ☐ N/A ☐

Number of stairs completed 12 Handrail used? Y ☑ (L) ↑ N ☑ / 2 x ec's

Walking Aid Documentations Completed: Y ☑ N ☐ Own aids ☐ N/A ☐

Physiotherapy discharge criteria met: Y ☑ N ☐ → Continued Rehab ☐

Follow-up Required: Y ☐ N ☑ Appointment / Referral Sent:

Patient and Physiotherapist Expectations:

(I) z ec's on d/c.

Problem List

Date	Problem	
24/4/12	1. Requires brace for mob	
	2.	
	3.	
	4.	
	5.	

Patient Agreed Goals/Treatment Plan

Date	Goal	Management Plan	Timescale	
24/4/12	(I) z ec's		Today	BA
	Assist z air		1/7	BA
	hand brace			

Continuation

24/4/12	Pt mobile (I) z ec's as required	
	+ (I) on stairs as required	
	Always z mob + advice of use of	
	brace for 6/52 while mobilising	BA
24/4/12	Pt given information booklet about	
	air hand brace	
	Pt observed mobilising (I) on ward	
	mainland	BA

Date	Signature	Print Name	Designation	Initials
24/4/12	[signature]	BARRON	SCAN	BA

North Glasgow Hospitals

Profile / Careplan for 24 / 72 hour stay

NHS Greater Glasgow and Clyde

DATE OF ADMISSION 22/4/12	TIME 05	WARD	TYPE OF ADMISSION	EMERGENCY / PLANNED / TRANSFER FROM	OTHER	ADMITTING NURSE

SURNAME
FORENAME
ADDRESS

23096429V
MCCOURT M
RYAN 19/04/1994
0/1 427 BILSLAND DRIVE
GLASGOW G20 9JN
CHI-1904946291

TEL Nos.
WISHES TO BE KNOWN AS

DATE OF BIRTH
AGE 18
MENSTRUAL CYCLE
PARA
RELIGION
G.P. AND ADDRESS

Dr. J MCKINLAY
Drs McGowan, Cron, Howat, McK
The Barony Medical Centre
30 Auchinloch Street
Glasgow
0141 557 6161

ALLERGIES: NKDA.

CHEMICAL DEPENDANCY: Smoker 10pd. Alcohol

PROSTHESIS:

BASELINE RECORDS	
HEIGHT	
WEIGHT	
B.P.	
TEMP.	
PULSE	
RESPIRATION	
DENTURES	

NEXT OF KIN Mary Cairns
ADDRESS Same address
RELATIONSHIP Mother.
TEL.Nos. 07878048331

SOCIAL CIRCUMSTANCES
LIVES WITH Parent.
External stairs
TYPE OF HOUSE

SUPPORTING SERVICES —

STORAGE OF VALUABLES
RETURNED

STORAGE OF DRUGS
RETURNED

REASON FOR ADMISSION	PAST MEDICAL HISTORY	CURRENT DRUG THERAPY
# Wedge L2.	Ashma, No Inhalers,	
?L1#		

PATIENTS NAME CONSULTANT

ASSESSMENT

SAFETY AND COMFORT	BREATHING AND CIRCULATION	MAINTAINING BODY TEMPERATURE	EATING AND DRINKING	MOBILITY
Independent	Asthma.	Independant	~~Diet~~ Normal Diet.	Ind

PERSONAL HYGIENE	ELIMINATION	SLEEP	COMMUNICATION (INCLUDING FEARS & ANXIETIES)
Independant	Normal functions	normal patterns	No problems

SKIN CONDITION

PRE-OPERATIVE CARE PLAN

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

POST-OPERATIVE CARE PLAN

DATE	No.	PROBLEM	AIM	INTERVENTION	SIGNATURE	EVALUATION	DISC.
		POTENTIAL COMPLICATIONS OF SURGICAL PROCEDURE/ ANAESTHESIA	PREVENTION OR EARLY DETECTION OF SAME	A) NURSE PATIENT IN LATERAL POSITION UNTIL FULLY CONSCIOUS			
		AIRWAY OBSTRUCTION/ RESPIRATORY DEPRESSION		B) MONITOR RATE & DEPTH OF RESPIRATION			
		SHOCK DUE TO BLEEDING/ EFFECTS OF ANAESTHETIC AGENTS		A) MONITOR BLOOD PRESSURE AND PULSE FREQUENCY			
				B) OBSERVE OPERATION SITE FOR FRESH BLEEDING/STAINING			
		PAIN		A) IF REQUIRED, ADMINISTER ANALGESIA AS PRESCRIBED BY DOCTOR AND MONITOR EFFECT WITH PATIENT			
		NAUSEA/VOMITING		A) IF REQUIRED, ADMINISTER ANTIEMETIC AS PRESCRIBED BY DOCTOR AND MONITOR EFFECT WITH PATIENT			
		URINE RETENTION DUE TO BLADDER ATONY		A) CHECK PATIENT PASSES URINE			
		INABILITY TO MAINTAIN OWN PERSONAL HYGIENE DUE TO EFFECTS OF ANAESTHESIA		A) ASSIST PATIENT TO HAVE POST-OPERATIVE WASH/SHOWER			
				A) OFFER MOUTHWASH/WATER TO BRUSH TEETH			

Western Infirmary, GLASGOW

NHS
Greater Glasgow and Clyde

NAME:
UNIT NO.: 23096429V
MCCOURT M
(LABEL) RYAN 19/04/1994
0/1 427 BILSLAND DRIVE
GLASGOW G20 9JN
CHI-1904946291

WARD: 61

ON DAY OF ADMISSION, SELECT AND RECORD CARE WHICH IS MOST APPROPRIATE FOR PATIENT.

RECORD **CHANGES** OF CARE IN NURSING ACTION FLOWCHART.

USE AN ARROW e.g. ⟶ TO INDICATE **CONTINUATION** OF CARE ON THE FLOWCHART

ALL ENTRIES MUST BE RECORDED IN BLACK INK AND SIGNED.

WATERLOW SCORE (MUST BE COMPLETED ON ADMISSION FOR **EVERY** PATIENT)

Build/Weight		Skin		Sex/Age		Continence		Mobility		Appetite	
								Fully	0	Average	1
Average	0	Healthy	0	Male	1	Complete/		Restless/Fidgety	1	Poor	
Above Average	1	Tissue paper	1	Female	2	catheterised	0	Apathetic	2	Fluids only/	2
Obese	2	Dry	1	14 - 49	1	Occasional		Restricted	3	Nasogastric feed	
Below Average	3	Oedematous	1	50 - 64	2	incontinence	1	Inert/traction	4	Nil by mouth	3
		Discoloured	2	65 - 74	3	Cath./incont.		Chairbound	5	anorexic	
		Broken/spot	3	75 - 80	4	faeces	2				
				81 +	5	Doubly incont.	3				

SPECIAL RISKS			
Tissue Malnutrition	**Neurological Deficit**	**Major Surgery Trauma**	**Medication**
Terminal Cachexia 8	Diabetes, MS, CVA, 4-6	Orthopaedic Below waist/	High dose Anti-inflammatory,
Cardiac Failure 5	Motor / Sensory	Spinal 5	Steroids,
P.V.D. 5	Paraplegia	On table	Cytotoxics 4
Anaemia 2		> 2 hours 5	
Smoking 1			

SCORE
10+ AT RISK
15+ HIGH RISK
20+ VERY HIGH RISK

22/4/12

	AIM	ASSESSMENT / INTERVENTIONS
1 MONITORING OF VITAL SIGNS Standard observations (BP, P, T, R, $Sa0_2$) - requirement & frequency CSM/Neurovascular observations Special observations eg. blood glucose, peak flow, Neurological obs Special requirements (0_2, chest physio)	To detect abnormalities and maintain optimum function.	O/A.
2 IV THERAPY Peripheral / Central Line - Sites Use of Venflon Careplan Infusion Chart in use NB: 4° temp required if patient has an IV	Early detection / prevention of the problems of IV therapy.	venflon (R) Arm
3 MAINTAINING SAFETY Level of conciousness Chronic / Acute confusion Alcohol withdrawal Seizures Wandering / at risk of injury	To maintain safety at all times.	Alert.
MOBILITY / MOVING & HANDLING Assess DVT risk using SIGN guidelines Specify limitations/current ability & aids used Traction Active/Passive exercise TED Stockings on admission	To prevent / reduce the complications of reduced mobility. To move the patient safely. To promote independence.	Bedrest
5 PRESSURE AREA CARE Waterlow score Interventions	The patients skin will remain healthy and intact.	Intact (Abrasions)
6 PAIN Monitor effectiveness of analgesia - involve patient & medical staff - use of Pain Chart	The patient will state that he is comfortable.	As per kardex
7 PERSONAL HYGIENE Self caring or Specify assistance required	To maintain a high standard of personal hygiene.	maximum assistance
Mouth care Eye care	To promote independence.	
8. NUTRITIONAL STATUS Score: (Use nutrition risk assessment) Special Dietary requirements Fasting / fluid restrictions Fluid balance monitoring required	To maintain adequate nutritional intake. To promote healing.	normal diet & fluids
9 URINARY & BOWEL FUNCTION Independent or specify aids used (urinals, bedpan etc) Catheterised - size free drainage / hourly volumes Bowel - Stoma, Aperients – Chart daily	To detect any problems with output. To promote independence.	Bottles & bedpans
10 OTHER e.g. Wound Care / Dressing	The patient will have clean & dry wounds.	Nil
NB: For other wounds, use GRI Tissue Viability Careplan	To promote Healing.	

Sign: _____

Date: 23/4/12	Date: 24/4/12	Date:	Date:	Date:
BO OBS	QDS OBS + MEWS			
VENFLON (L) ARM.	~~NO~~ IV RECS			
ALERT + ORIENTATED.	ALERT + ORIENTATED CANNARD = 4 LOW FALLS RISK			
BEDREST LOG ROLL	UP WITH FOR BACK BRACE. ELBOW CRUTCHES			
INTACT ABRASIONS	WATERLOW = 2 ADVISE OWN POSITION CHANGES			
AS PER DRUG KARDEX	AS PER DRUG KARDEX			
MAXIMUM ASSISTANCE	MINIMUM ASSISTANCE			
NORMAL DIET + FLUIDS	NORMAL DIET + FLUIDS MUST = 0			
URINALS.	UP TO TOILET			
NIL	N/A			
[illegible]	[illegible]			

Date:	Date:	Date:	Date:	Date:

Notes

Nutrition Profile

NHS Greater Glasgow and Clyde

Name: 23096429V MCCOURT RYAN M 0/1 427 BILSLAND DRIVE 19/04/1994 GLASGOW G20 9JN CHI-1904946291	Date of admission: 22/4/12
Address:	Time: 0500
	HOSPITAL: GRI
DoB:	Ward: 61
CHI number:	
Affix patient data label	

To be recorded within 24 hours of admission*

Height: 5'8 m/ft Actual ☐ Patient/ carer reported ☑ Alternative measurement ☐

Weight: 9 11 kg/stones Actual ☐ Patient/ carer reported ☑ Alternative measurement ☐

Recent unplanned weight loss: Yes ☐ No ☑

If 'Yes' how much?: kg/stones. Over what period of time?: weeks/months

Is there evidence of recent weight loss?

No ☑ Loose clothing ☐ History of reduced food intake/appetite ☐ Swallowing problem ☐

Eating and drinking likes and dislikes (including appetite and/or NBM status):

NO Allergies.
Eats most things

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): [illegible] Signature: [illegible] Date: 22/4/12

NOTE: This is ADMISSION DATA - please refer to changes in Care Plan.

* Quality Improvement Scotland (2003). Food, Fluids and Nutritional Care in Hospitals Edinburgh QIS

Malnutrition Universal Screening Tool ('MUST')

Date	22/4									
Initials	LB									
Height (see page 1)		Weight	11st							
Oedema or ascites present Y/N	N									
BMI	22									

'MUST'

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

Step 5: Management Guidelines

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

Management Plan

FOR ALL PATIENTS

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

Referral Services

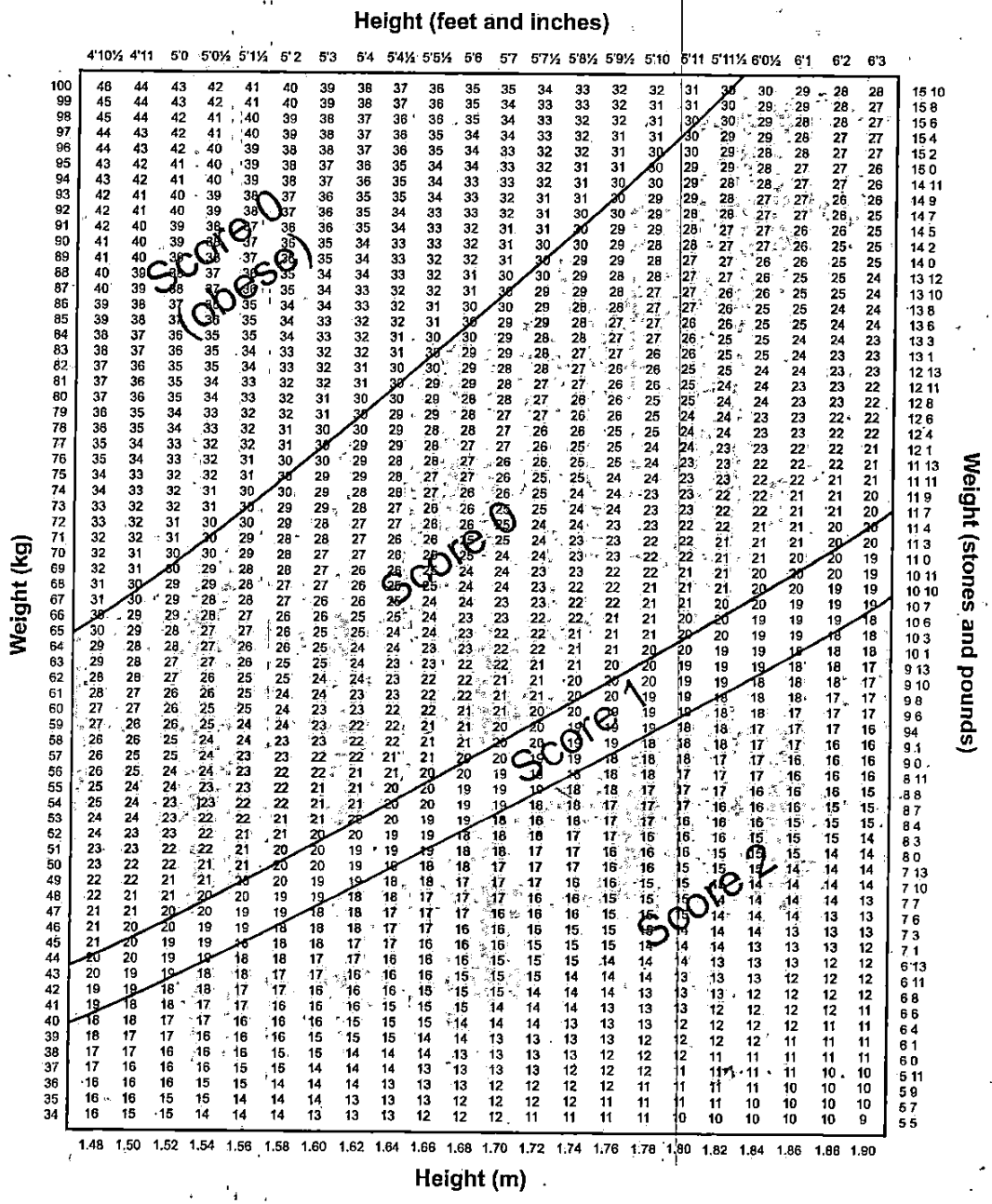
Dietitian	Date: / /	Outcome:
Speech and Language Therapy	Date: / /	Outcome:
Occupational Therapy	Date: / /	Outcome:
Dental Service	Date: / /	Outcome:

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Review date	Name (PRINT) Signature/Designation
22/4	low	Review weekly	1/52	

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

Step 1 - BMI Score



Step 2 - Weight Loss Score

Weight before weight loss (kg)	Score 0 Wt loss <5%	Score 1 Wt loss 5-10%	Score 2 Wt loss >10%
34 kg	<1.7 kg	1.7-3.4 kg	>3.4 kg
36 kg	<1.8 kg	1.8-3.6 kg	>3.6 kg
38 kg	<1.9 kg	1.9-3.8 kg	>3.8 kg
40 kg	<2 kg	2-4 kg	>4 kg
42 kg	<2.1 kg	2.1-4.2 kg	>4.2 kg
44 kg	<2.2 kg	2.2-4.4 kg	>4.4 kg
46 kg	<2.3 kg	2.3-4.6 kg	>4.6 kg
48 kg	<2.4 kg	2.4-4.8 kg	>4.8 kg
50 kg	<2.5 kg	2.5-5 kg	>5 kg
52 kg	<2.6 kg	2.6-5.2 kg	>5.2 kg
54 kg	<2.7 kg	2.7-5.4 kg	>5.4 kg
56 kg	<2.8 kg	2.8-5.6 kg	>5.6 kg
58 kg	<2.9 kg	2.9-5.8 kg	>5.8 kg
60 kg	<3 kg	3-6 kg	>6 kg
62 kg	<3.1 kg	3.1-6.2 kg	>6.2 kg
64 kg	<3.2 kg	3.2-6.4 kg	>6.4 kg
66 kg	<3.3 kg	3.3-6.6 kg	>6.6 kg
68 kg	<3.4 kg	3.4-6.8 kg	>6.8 kg
70 kg	<3.5 kg	3.5-7 kg	>7 kg
72 kg	<3.6 kg	3.6-7.2 kg	>7.2 kg
74 kg	<3.7 kg	3.7-7.4 kg	>7.4 kg
76 kg	<3.8 kg	3.8-7.6 kg	>7.6 kg
78 kg	<3.9 kg	3.9-7.8 kg	>7.8 kg
80 kg	<4 kg	4-8 kg	>8 kg
82 kg	<4.1 kg	4.1-8.2 kg	>8.2 kg
84 kg	<4.2 kg	4.2-8.4 kg	>8.4 kg
86 kg	<4.3 kg	4.3-8.6 kg	>8.6 kg
88 kg	<4.4 kg	4.4-8.8 kg	>8.8 kg
90 kg	<4.5 kg	4.5-9 kg	>9 kg
92 kg	<4.6 kg	4.6-9.2 kg	>9.2 kg
94 kg	<4.7 kg	4.7-9.4 kg	>9.4 kg
96 kg	<4.8 kg	4.8-9.6 kg	>9.6 kg
98 kg	<4.9 kg	4.9-9.8 kg	>9.8 kg
100 kg	<5 kg	5-10 kg	>10 kg
102 kg	<5.1 kg	5.1-10.2 kg	>10.2 kg
104 kg	<5.2 kg	5.2-10.4 kg	>10.4 kg
106 kg	<5.3 kg	5.3-10.6 kg	>10.6 kg
108 kg	<5.4 kg	5.4-10.8 kg	>10.8 kg
110 kg	<5.5 kg	5.5-11 kg	>11 kg
112 kg	<5.6 kg	5.6-11.2 kg	>11.2 kg
114 kg	<5.7 kg	5.7-11.4 kg	>11.4 kg
116 kg	<5.8 kg	5.8-11.6 kg	>11.6 kg
118 kg	<5.9 kg	5.9-11.8 kg	>11.8 kg
120 kg	<6 kg	6-12 kg	>12 kg
122 kg	<6.1 kg	6.1-12.2 kg	>12.2 kg
124 kg	<6.2 kg	kg	>12.4 kg
126 kg	<6.3 kg	kg	>12.6 kg

Weight before weight loss (st/lb)	Score 0 Wt loss <5%	Score 1 Wt loss 5-10%	Score 2 Wt loss >10%
5st 4lb	<4lb	4lb-7lb	>7lb
5st 7lb	<4lb	4lb-8lb	>8lb
5st 11lb	<4lb	4lb-8lb	>8lb
6st	<4lb	4lb-8lb	>8lb
6st 4lb	<4lb	4lb-9lb	>9lb
6st 7lb	<5lb	5lb-9lb	>9lb
6st 11lb	<5lb	5lb-10lb	>10lb
7st	<5lb	5lb-10lb	>10lb
7st 4lb	<5lb	5lb-10lb	>10lb
7st 7lb	<5lb	5lb-11lb	>11lb
7st 11lb	<5lb	5lb-11lb	>11lb
8st	<6lb	6lb-11lb	>11lb
8st 4lb	<6lb	6lb-12lb	>12lb
8st 7lb	<6lb	6lb-12lb	>12lb
8st 11lb	<6lb	6lb-12lb	>12lb
9st	<6lb	6lb-13lb	>13lb
9st 4lb	<7lb	7lb-13lb	>13lb
9st 7lb	<7lb	7lb-13lb	>13lb
9st 11lb	<7lb	7lb-1st	>1st
10st	<7lb	7lb-1st	>1st
10st 4lb	<7lb	7lb-1st	>1st
10st 7lb	<7lb	7lb-1st 1lb	>1st 1lb
10st 11lb	<8lb	8lb-1st 1lb	>1st 1lb
11st	<8lb	8lb-1st 1lb	>1st 1lb
11st 4lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 7lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 11lb	<8lb	8lb-1st 3lb	>1st 3lb
12st	<8lb	8lb-1st 3lb	>1st 3lb
12st 4lb	<9lb	9lb-1st 3lb	>1st 3lb
12st 7lb	<9lb	9lb-1st 4lb	>1st 4lb
12st 11lb	<9lb	9lb-1st 4lb	>1st 4lb
13st	<9lb	9lb-1st 4lb	>1st 4lb
13st 4lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 7lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 11lb	<10lb	10lb-1st 5lb	>1st 5lb
14st	<10lb	10lb-1st 6lb	>1st 6lb
14st 4lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 7lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 11lb	<10lb	10lb-1st 7lb	>1st 7lb
15st	<11lb	11lb-1st 7lb	>1st 7lb
15st 4lb	<11lb	11lb-1st 7lb	>1st 7lb
15st 7lb	<11lb	11lb-1st 8lb	>1st 8lb
15st 11lb	<11lb	11lb-1st 8lb	>1st 8lb
16st	<11lb	11lb-1st 8lb	>1st 8lb
16st 4lb	<11lb	11lb-1st 9lb	>1st 9lb
16st 7lb	<12lb	12lb-1st 9lb	>1st 9lb
16st 11lb	<12lb	12lb-1st 9lb	>1st 9lb

VI MEDICAL ILLUSTRATION • NUTRITION & DIET • 12366/01.09.08
STORES ORDER CODE 41850

NHS
Greater Glasgow and Clyde

NATVNS
SCOTLAND

WRITE	23096429V
Surna	MCCOURT
	RYAN M
Foren	0/1 427 BILSLAND DRIVE 19/04/1994
DoB	GLASGOW G20 9JN
	CHI-1904946291
Loca	

ADAPTED WATERLOW PRESSURE AREA RISK ASSESSMENT CHART

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

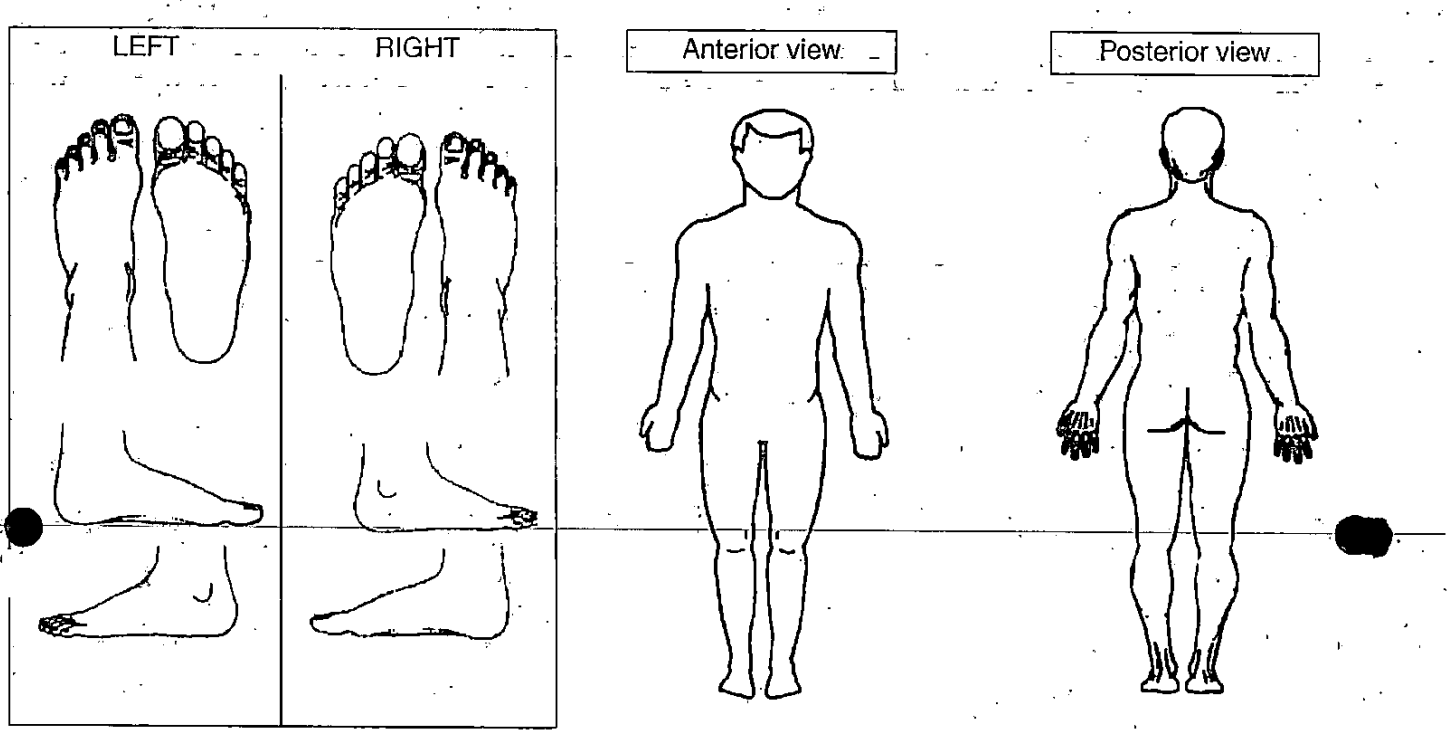
Sex									
Male	1	1	1	1					
Female	2								
Age									
14 -49	1	1	1	1					
50 -64	2								
65 - 74	3								
75 - 80	4								
81+	5								
Build/Weight for Height (BMI=weight in Kg/height in m²)									
Average - BMI 20-24.9	0	0	0	0					
Above average - BMI 25-29.9	1								
Obese - BMI > 30	2								
Below average - BMI < 20	3								
Continence									
Complete/catheterised	0	0	0	0					
Incontinent urine	1								
Incontinent faeces	2								
Doubly incontinent (urine & faeces)	3								
Skin Type - Visual Risks Area									
Healthy	0	0	0	0					
Tissue paper (thin/fragile)	1								
Dry (appears flaky)	1								
Oedematous (puffy)	1								
Clammy (moist to touch)/pyrexia	1								
Discoloured (bruising/mottled)	2								
Broken (established ulcer)	3								
Mobility									
Fully mobile	0			0					
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	4	4						
Chairbound (unable to leave chair without assistance)	5								
Nutritional Element		0	0	0					
Unplanned weight loss in past 3-6 months									
<5% Score **0**, 5-10% Score **1**, >10% Score **2**	0-2								
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		0	0	0					
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								
Special Risks - Neurological Deficit		0	0	0					
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*	4-6								
Special Risks - Surgery/Trauma		0	0	0					
On table > 6 hours	8								
Orthopaedic/below waist/spinal (up to 48 hours post op)	5								
On table > 2 hours (up to 48 hours post op)	5								
Special Risks - Medication									
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4	0	0	0					
Total Score		6	6	2					
Date		22/4	27/4	26/4					
initials		[illegible]	[illegible]	[illegible]					
Time		0500	113	1140					

83826

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.



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.

ADE 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.

Acute Services Division

Hospital / Department

NHS
Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

23096429V
MCCOURT
Patient name: ..... RYAN M
0/1 427 BILSLAND DRIVE 19/04/1994
Ward: ..... GLASGOW
CHI-1904946291 G20 9JN
CHI number: .....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 to each ward.

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

Continuing Care Wards: Risk assessment and care plan reviewed monthly.

Referral Criteria for Hospital Falls Prevention Co-ordinator

1. Cannard score of 18+.
2. Second or subsequent fall
3. Significant Injury caused by a fall. (Significant Injury defined as any fracture, significant bruising or laceration to head or body.)

The patient should be referred with any of the above criteria.

General Safety Precautions

- Ensure patient has buzzer to hand
- Check patient has the manual dexterity and cognitive ability to operate buzzer
- Place personal items within easy reach
- Keep the bed in lowest position possible (use low bed if available)
- DO NOT leave patients with cognitive impairment unattended on commodes, in toilets, baths and showers.
- Patients with poor mobility, who are known not to ask for assistance, should not be left unattended on commodes, toilets, baths and showers.
- If noted that mobility / transfers are unsafe refer to physio / OT for assessment
- If patient wears glasses, ensure they are clean
- Ensure patient's footwear is adequate
- Lock wheels on all wheelchairs, beds, commodes and trolleys when in use
- Provide adequate lighting at night
- Request medication review if appropriate
- Clean up spills immediately
- Orientate patient to the ward environment

Cannard Falls Risk Assessment

(Must be completed within 24 hours of admission to each ward)

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						Date: 22/4 Ward: 61	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			1						
Sex	Male 1	Female 2				1						
Age	13-59 0	60-70 1	71-80 2	81+ 1		0						
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		2						
Medication type **	Drugs for mental illness 1	Blood pressure / water tablets 1	Sleeping tablets 1	None of these 0		2						
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						
SCORE 13+ = HIGH RISK If patient unconscious score as N/A until patient status improves				NURSE SIGNATURE								

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

Falls Assessment Care Plan

Please tick all applicable nursing interventions

Action code	NURSING INTERVENTIONS	Date: 28/1 Ward: 61	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:
1	Falls prevention and general safety precautions discussed with patient and family.	✓						
2	Move to more observable area of ward to optimise supervision.							
3	Advise patient they may experience dizziness when they mobilise initially.							
4	Requires assistance with mobilisation.							
5	Observe trip hazard due to invasive lines, drains and catheters.							
6	Do not leave the patient unattended when using commode, toilet, in shower or the bathroom area.							
7	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.							
8	Monitor lying and standing / sitting BP and pulse.							
9	A. Patient requires footwear or podiatry referral. (Date referred: / requested :) B. Request family / carer to provide suitable footwear.							
10	Commence continence assessment, follow Local Guidelines.							
11	Refer to Occupational Therapist.							
12	Select suitable seating (refer to policy).							
13	Non slip mat on chair /floor following advice from therapists.							
14	Refer to Physiotherapist.							
15	Review Transfer techniques.							
16	Request medication review.							
17	Bed/chair monitor in use.							
18	Falls map in use for seven days for patient who has second or subsequent falls.							
19	Bed rails/bumpers to be used (refer to policy).							
20	Patient requires low bed / mattress on the floor (refer to policy.)							
21	Patient requires one to one nursing care.							
22	Refer to Hospital Falls Prevention Co-ordinator (see criteria on front cover).							
23	Other interventions.							

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

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 (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-amilofruse.

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

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.

Patient Observation Chart

NHS Greater Glasgow and Clyde

Name	
Address	23096429V MCCOURT M RYAN 19/04/1994 0/1 427 BILSLAND DRIVE
Hospital No.	GLASGOW G20 9JN CHI-1904946291
DOB	

Admitted Date _____ Ward _____

Transferred Date _____ Ward _____

Transferred Date _____ Ward _____

Patient Observation Chart Guidelines

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

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

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

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

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

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

Pain Score

Remember to check scores after pain relief.
Patient asked to report pain at rest and on movement.
0 = No pain at rest or on movement
1 = No pain at rest, slight pain on movement
2 = Intermittent pain at rest, moderate on movement
3 = Continuous pain at rest severe on movement
Review 5 mins after I/V, 1 hour after I/M, S/C or oral analgesia.
Sustained pain score of 2 or pain score of 3 requires intervention.

Sedation Score

0 = Awake, alert, orientated
1 = Mild, aroused by verbal stimulus
2 = Moderate, aroused by physical stimulus
3 = Severe, no response
S = Normal sleep, easy to rouse
Score 2 or 3 requires immediate intervention

Nausea Score

0 = No nausea
1 = Mild (No treatment wanted)
2 = Moderate (Treatment required)
3 = Severe (Clinical problem persists despite treatment)
Review 1 hour after treatment. Inform doctor if additional treatment required.

(4) RYAN McCOURT

DATE	22/1							23/4									
Time	0200	0300	0435	2000	1100	1800	2200	1400									TEMP X
BP ^ v and Pulse •																	40°C 39°C 38°C 37°C 36°C 35°C
Resp. Rate	16	18	16	17	15	15	16	16	16								
Inspiration O_2%	RA	AIR	AIR	A	A	A	A	A	A								
SpO_2%	99	96%	95%	98	96%	99%	99	99	95								
Pain Score				1	0	0	0	0	0								
Sedation Score				0	0	0	0	0	0								
Nausea Score				0	0	0	0	0	0								
Blood Glucose	5.1																

MEWS																	
	Resp. Rate				0	0	0	0	0	0							
	Pulse				0	0	0	0	0	0							
	Systolic BP				0	0	0	0	0	0							
	GCS / AVPU				0	0	0	0	0	0							
	Urine Output				0	0	0	0	0	0							
	Temp.				0	0	0	0	0	0							
	SpO_2%				0	0	0	0	0	0							
	TOTAL				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 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			

DATE																	TEMP X
Time																	
BP ^ v and Pulse •	240																
	230																
	220																40°C
	210																
	200																39°C
	190																
	180																38°C
	170																
	160																37°C
	150																
	140																36°C
	130																
	120																35°C
	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

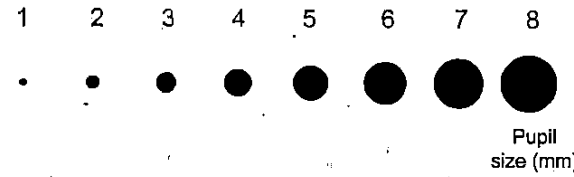
Score is 1-3	Increase frequency of patient observations, monitor trends and inform Nurse in Charge.
Score is 3 in one category	Contact Senior Nurse and increase frequency of patient observations.
Score is 4 and above or increasing by 2 or more Patient's GCS falls by 2 or more Any patient whose condition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

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

Neurological Observation Chart

DATE																				
Time				0200	0300	0400	0435													
COMA SCALE	E Eyes open	Spontaneously	4	✓	○	○	○													Eyes closed by dwelling = C
		To speech	3																	
		To pain	2																	
		None	1																	
	V Best verbal response	Orientated	5	✓	○	○	○													Endotracheal tube or tracheostomy = T
		Confused	4																	
		Inappropriate words	3																	
		Incomprehensible sounds	2																	
		None	1																	
	M Best motor response	Obeys	6	✓	○	○	○													Usually record the best arm response
		Localises	5																	
		Flexion - withdrawal	4																	
		Flexion - abnormal	3																	
		Extension to pain	2																	
		None	1																	
		TOTAL SCORE		15	15	15	15													
PUPILS	R	Size																		= reacts —no reaction c. eyes closed
		Reaction																		
	L	Size																		
		Reaction																		
LIMB MOVEMENT	ARMS	Normal power																		Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness																		
		Severe weakness																		
		Spastic flexion																		
		Extension																		
		No response																		
	LEGS	Normal power																		
		Mild weakness																		
		Severe weakness																		
		Extension																		
		No response																		

Glasgow Coma Scale



DATE																				
Time																				
COMA SCALE	E Eyes open	Spontaneously	4																	Eyes closed by dwelling = C
		To speech	3																	
		To pain	2																	
		None	1																	
	V Best verbal response	Orientated	5																	Endotracheal tube or tracheostomy = T
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		None	1																	
		TOTAL SCORE																		
PUPILS	R	Size																		= reacts —no reaction c. eyes closed
		Reaction																		
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		Reaction																		
LIMB MOVEMENT	ARMS	Normal power																		Record right (R) and left (L) separately if there is a difference between the two sides
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		Severe weakness																		
		Spastic flexion																		
		Extension																		
		No response																		
	LEGS	Normal power																		
		Mild weakness																		
		Severe weakness																		
		Extension																		
		No response																		

Medical Illustration Services, MIS 111948 - Reorder CEDAR 35497

NHS
Greater Glasgow and Clyde

NATVNS
SCOTLAND

WRITE, IMPRINT OR ATTACH LABEL
Surname McCall CHI No .....
Forenames Ryan Sex .....
DoB .....
Location GRI 61

DAILY REPOSITIONING & SKIN INSPECTION CHART

DATE 23/4/12

- Inspect skin for evidence of change
- Reassess at every positional change and document below
- Reposition the person to reduce the risk of further damage, eg using the 30 degree tilt
- Use manual handling aids to minimise risk of friction and shear
- Individuals on any form of pressure redistribution equipment still require skin inspection and regular repositioning
- Provide suitable seating including pressure redistribution cushions, if required, encourage repositioning/mobilisation where possible
- Acutely ill people are seated out for no longer than 2 hours and returned to bed for no less than 1 hour

(Reference: Best Practice Statement-Prevention & Management of Pressure Ulcers-March 2009)

TIME	REPOSITIONING (USING CODES) FROM	TO	SKIN INSPECTION COMMENTS	ACTION TAKEN	SIGNATURE
Eg: 08.00	L	U	Left Hip Non-Blanching	Reassess at next positional change	
2300	B	B	INTACT	Log roll	[illegible]
23/4 1030	B	B	INTACT	Log roll	[illegible]

de: L = LEFT, R = RIGHT, B = BACK, P = PRONE (FRONT), M = MOBILISED, U = UP TO SIT

NHS
Greater Glasgow and Clyde

NATVNS
SCOTLAND

WRITE, IMPRINT OR ATTACH LABEL

Surname ..... CHI No .....

Forenames ..... Sex .....

DoB .....

Location .....

DAILY REPOSITIONING & SKIN INSPECTION CHART

DATE _____

- Inspect skin for evidence of change
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- Reposition the person to reduce the risk of further damage, eg using the 30 degree tilt
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TIME	REPOSITIONING (USING CODES) FROM	TO	SKIN INSPECTION COMMENTS	ACTION TAKEN	SIGNATURE
Eg: 08.00	L	U	Left Hip Non-Blanching	Reassess at next positional change	

Code: L = LEFT, R = RIGHT, B = BACK, P = PRONE (FRONT), M = MOBILISED, U = UP TO BI

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patient's name:	Ward: G1
Unit number: 23096429V MCCOURT M	Discharge destination: Home
CHI number: RYAN 19/04/1994 0/1 427 BILSLAND DRIVE GLASGOW G20 9JN CHI-1904946291	Estimated Discharge Date (1) / /
	Estimated Discharge Date (2) / /
	Final date of discharge : 24/4/12

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. cashier		✓	✓	
Intravenous cannula removed		✓	✓	
Equipment ordered (inc. walking aids) in place for discharge		✓	✓	
Part 2 Discharge letter - Required	✓		✓	
- Completed	✓		✓	
Out patient clinic appointment e.g. Anticoagulation clinic				
Arranged / To follow	✓		✓	
If unknown at time of discharge state reason		✓	✓	
Additional information / leaflets / factsheets				
Time of Discharge:	17:30			
Nurse's signature:		Designation: SN		Date: 24/4/12

FORM NUMBER 0005752

Acute Services Division

Part 2 Discharge Letter / Transfer Plan

NHS Greater Glasgow and Clyde

- [x] Glasgow Royal Infirmary 0141 211 4000
- [ ] Stobhill Hospital 0141 201 3000
- [ ] Western Infirmary 0141 211 2000
- [ ] Southern General Hospital 0141 201 1100
- [ ] Victoria Infirmary 0141 201 6000
- [ ] Mansionhouse Unit 0141 201 6101
- [ ] Gartnavel General Hospital 0141 211 3000
- [ ] Blawarthill Hospital 0141 211 9000
- [ ] Drumchapel Hospital 0141 211 6000
- [ ] Lightburn Hospital 0141 211 1500
- [ ] Vale of Leven Hospital 01389 754 121
- [ ] Royal Alexandra Hospital 887 9111
- [ ] Inverclyde Royal Hospital 01475 633777
- [ ] Other:

Name: Ryan McCourt

Address: 0/1 427 Bilsland Drive Glasgow , G20 9JN

Discharge Address:

CHI number: 1904946291

Unit number: 2309629V D.O.B. 19/4/94

Telephone: ~~07875~~

Next of kin: Mary Cairn

Relationship: Mother

Address: As Above

Telephone: 07878048331

Ward: 61

Telephone: 0141/ 211 / 4327

Admission date: 22 / 4 / 12

Final discharge/transfer date: 24 / 4 / 12

Named Nurse: S/N D. McKee

Consultant: Ms Massey

G.P.: Dr J. McKinlay

Address: Drs McGowan, Crum, McKinlay, McK... The Barony Medical Centre 30 Auchinloch St, Glasgow

Telephone: 557 6161

Post Discharge Services Arranged (e.g. District Nurse, CPN, Day Hospital, Home Care)
State package requested and time of first visit.

Service:	Service:
Contact number:	Contact number:
Service details: [illegible]	Service details: [illegible]

[illegible handwriting]

Additional/Transfer Information (including equipment/adaptions)

FORM NUMBER 0481892

VI MEDICAL ILLUSTRATION • DISCHARGE • 4587/14.01.08

Patient Assessment/Comments

Mobility: MOBILISES INDEPENDENTLY WITH A/E BACK ISSUES

Personal hygiene/Dressing: ~~INDEPENDENT~~ INDEPENDENT

Continence: Catheter in situ: Yes ☐ No ☑
Type: Size:
Date of change:

Continence details:

Dietary requirements: NORMAL DIET & FLUIDS

Communication / Swallowing: NO ISSUES

Mental state: ~~ALERT & ORIENTATED~~

Skin condition/Waterlow Score: INTACT

Wound care/Stoma care: N/A

Special Instructions for Patient (e.g. Exercise , Diet, Wounds, Others)

AIR BACK TO BE WORN WHEN UP.

Others/Follow-up arrangements

24/5/12 AT 0930 , MR WHEELWRIGHT'S CLINIC

Progress discussed with patient: Yes ☑ No ☐
Progress discussed with relative/carer: Yes ☑ No ☐

This information has been fully discussed with Patient/Carer.

Date and signature of Nurse: [signature] [illegible]

Date and signature of Patient/Carer: X [illegible]

Diagnosis:

L1 AND L2 FRACTURES

CONSERVATIVE MANAGEMENT

TOP COPY TO - Patient; OTHER COPIES TO - G.P.; District Nurse; Case Notes.

Immediate Discharge and Medicine Prescription Form - Confidential

Glasgow Royal Infirmary
Glasgow G4 0SF
Telephone: 0141 211 4000

Ref. No: 234585

Name of GP
Surgery/Health Centre

to all 4 copies

Patient:
Address:
23096429V M
MCCOURT
RYAN 19/04/1994
0/1 427 BILSLAND DRIVE
GLASGOW G20 9JN
CHI-1904946291

DOB:
Weight: CHI no:

Ward: 61 Tel: 211 9200
Consultant:
Named Nurse:
Specialty: ORTHO
Admission date: / /
Mode of admission: Elective ☐ Emergency ☑ Transfer ☐
Source of Admission
Discharge date: / /

NURSE TO COMPLETE
Out Patient appointment date
Diagnosis informed (circle) Patient Relative
Circle support services set up:
District Nurse Home Help Health Visitor
Oncology referral Hospice: day care OR home care
Discharge address if not home:

WARD USE ONLY
Medication Rec. on Ward by:
Checked against kardex:
Issued by: Date:
Signature of Recipient:

All known drug sensitivities / adverse reactions:
NKDA

Reason for Admission, Diagnosis	Treatment, Investigations, Operations	Complications
Jump/fall from window 30ft →	# L1 + L2 Air Back Brace	

New Drug	New Dose	MEDICINE	Form	Dose	TIMES FOR ADMINISTRATION: am 8	md 12	pm 2	pm 6	pm 10	Other times	Course length
		Paracetamol	O	1g	✓	✓		✓	✓		
		Dihydrocodeine	O	30mg	✓			✓			
		Dihydrocodeine	O	30mg		max 4 times with routine					
		Diclofenac	O	50mg		4 to 6 hourly for pain					

Medicines Discontinued	Reason if known e.g. side effect	Other Information

PHARMACY USE ONLY
Clinical Pharmacy Check ☐ Professional Check ☐

Quantity supplied	Dispensing Details
80 x	PREPACK
56 x	PREPACK
28 x	PREPACK

Dispensed by: LE Date: 24/04/12
Checked by:

Non-childproof containers required: Yes ☐ No ☐
Medicine compliance aids required: Yes ☐ No ☐
Specify:

Medication Collected by:

Prescribers name: L McArdle Signature: L McArdle Date 24/4/12
Designation: F1 Pager number: 7-28

White copy - G.P.; Pink copy - Case Notes; Blue copy - Pharmacy; Yellow copy - Patient

You must use a ballpoint pen and fully complete this form or the prescription will not be dispensed

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

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐
Date _____ Name (Print) _____
Discharge Prescription Prepared & Reconciled YES ☑
Date 24.4.12 Name (Print) [illegible]

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

DOCTOR'S DECLARATION (if required by Local Protocol)

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

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

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

PATIENT DETAILS

Hospital No.
23096429V M
MCCOURT 19/04/1994
RYAN
0/1 427 BILSLAND DRIVE
GLASGOW G20 9JN
CHI-1904946291

Height:
Weight:
Surface area:
Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
24/4	Phosphate enema	x1	PR	1500	[illegible]	R [illegible]	

Name Ryan McCourt
CHI No 1904946291

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

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only

(Maximum number of doses as per protocol)

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

Notes for Users

FOR PRESCRIBERS:

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

DATE → 22 23

MONTH → 04

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

IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N

ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N

SIGNATURE OF ASSESSOR

ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N

Parenteral Drugs : Regular Prescription

Patient's Own Medicine

A

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☑

DRUG: CLEXANE

DOSE: 40mg | ROUTE: S/C | DATE: 22/4

PRESCRIBER (PRINT & SIGN): [signature]

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

STOPPED DATE: INITIALS:

		For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
Other time						
0700-0900						
1200-1400						
1600-1800	✓ [signature]					
2200-2400						
Other time						

B

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG:

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

STOPPED DATE: INITIALS:

		For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
Other time						
0700-0900						
1200-1400						
1600-1800						
2200-2400						
Other time						

C

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG:

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

STOPPED DATE: INITIALS:

		For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
Other time						
0700-0900						
1200-1400						
1600-1800						
2200-2400						
Other time						

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

Parenteral Drugs: Regular Prescription

		DATE → / MONTH →		Patient's Own Medicine
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	D DRUG / DOSE / ROUTE / DATE / PRESCRIBER (PRINT & SIGN) / STOPPED DATE: INITIALS: / ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	Other time 0700-0900 1200-1400 1600-1800 2200-2400 Other time		For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	E DRUG / DOSE / ROUTE / DATE / PRESCRIBER (PRINT & SIGN) / STOPPED DATE: INITIALS: / ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	Other time 0700-0900 1200-1400 1600-1800 2200-2400 Other time		For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	F DRUG / DOSE / ROUTE / DATE / PRESCRIBER (PRINT & SIGN) / STOPPED DATE: INITIALS: / ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	Other time 0700-0900 1200-1400 1600-1800 2200-2400 Other time		For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	G DRUG / DOSE / ROUTE / DATE / PRESCRIBER (PRINT & SIGN) / STOPPED DATE: INITIALS: / ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	Other time 0700-0900 1200-1400 1600-1800 2200-2400 Other time		For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.

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

Name Ryan McCourt

CHI No 190696 8291

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

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

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

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name except in circumstances where bioavailability differences between brands of the drug are so important as to warrant prescribing by brand name

Oral and Other Drugs: Regular Prescription

DATE: 22 | 22 | 26
MONTH: 4 | 4 | 4

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

H
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐
DRUG: PARACETAMOL
DOSE: 1g | ROUTE: PO | DATE: 22/4/12 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

J
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐
DRUG: DIHYDROCODEINE
DOSE: 30mg | ROUTE: PO | DATE: 22/4/12 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

K
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☑
DRUG: RANITIDINE
DOSE: 150mg | ROUTE: oral | DATE: 22/4 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time | 0700-0900 | 1200-1400 | 1600-1600 | 2200-2400 | Other time

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

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

Oral and Other Drugs: Regular Prescription

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

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

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

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

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

Name Ryan McCourt

CHI No 1906946 8291

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

Nurse/Midwife Administration by Sym[illegible] Relief Policy or other Pro[illegible] - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

Warning: Check the As Required and Regular Prescription sections to ensure that the [illegible]

FOR PRESCRIBERS:

1. Prescribe drugs [illegible]

Oral and Other Drugs: Regular Prescription

		DATE → / MONTH →	Patient's Own Medicine
BEFORE ADMISSION ☐ / NEW DOSE ☐ / NEW MEDICATION ☐	**S** DRUG / DOSE / ROUTE / DATE / PRESCRIBER (PRINT & SIGN) / ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY / STOPPED DATE: INITIALS:	Other time / 0700-0900 / 1200-1400 / 1600-1800 / 2200-2400 / Other time	For Use Y/N / Qty: / Date: / Assessed by: / Ordered from Pharm.
BEFORE ADMISSION ☐ / NEW DOSE ☐ / NEW MEDICATION ☐	**T** DRUG / DOSE / ROUTE / DATE / PRESCRIBER (PRINT & SIGN) / ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY / STOPPED DATE: INITIALS:	Other time / 0700-0900 / 1200-1400 / 1600-1800 / 2200-2400 / Other time	For Use Y/N / Qty: / Date: / Assessed by: / Ordered from Pharm.
BEFORE ADMISSION ☐ / NEW DOSE ☐ / NEW MEDICATION ☐	**V** DRUG / DOSE / ROUTE / DATE / PRESCRIBER (PRINT & SIGN) / ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY / STOPPED DATE: INITIALS:	Other time / 0700-0900 / 1200-1400 / 1600-1800 / 2200-2400 / Other time	For Use Y/N / Qty: / Date: / Assessed by: / Ordered from Pharm.
BEFORE ADMISSION ☐ / NEW DOSE ☐ / NEW MEDICATION ☐	**W** DRUG / DOSE / ROUTE / DATE / PRESCRIBER (PRINT & SIGN) / ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY / STOPPED DATE: INITIALS:	Other time / 0700-0900 / 1200-1400 / 1600-1800 / 2200-2400 / Other time	For Use Y/N / Qty: / Date: / Assessed by: / Ordered from Pharm.

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

X DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

Y DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

AA DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

BB DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

Name Ryan McCourt

CHI No 190696 8291

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

Nurse/Midwife Administration by Symptomatic Relief Policy or other Prot__ol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

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

Notes for [illegible]

FOR PRESCRIBERS:

1. Prescribe drugs generically unless [illegible] circumstances where [illegible] drug are so important as to warrant [illegible]

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

CC DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DD DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

EE DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

FF DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

Name Ryan McCourt

CHI No 190696 8291

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

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol) [redacted]

Warning: Check the As Required and Regular Prescription sections to ensure that the

All Routes: As Required Prescriptions

	Drug	Dose	Route	Indication	Prescriber (Print & Sign)	Max. Freq.	Date	Stopped (Date / Initials)	Additional Instructions / Comments / Pharmacy
LL (New Medication ☑)	DICLOFENAC	50mg	PO	pain	[signature] BUTCHER	[illegible]	22/4		
MM	MORPHINE	5mg	IV	PAIN	[signature] BUTCHER		22/4		
NN	DIHYDROCODEINE	30mg-60mg	PO	pain	[signature]	4-6°	22/4/12		ALSO ON REGULAR - MAX 120mg/day PRN
PP	ORAMORPH	5mg	PO	pain	[signature]	2°	22/4/12		

Administration record:

Drug			
LL	DATE	22/4/12	23/4
	TIME	0400	05 15
	DOSE	50mg	50
	GIVEN BY	[initials]	[initials]
MM	DATE		
	TIME		
	DOSE		
	GIVEN BY		
NN	DATE	23/4	23/4
	TIME	16 15	05
	DOSE	30	30
	GIVEN BY	[initials]	[initials]
PP	DATE		
	TIME		
	DOSE		
	GIVEN BY		

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

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

Patient's Own Medicine

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

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

Name Ryan McCourt

CHI No 190494 8291

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

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

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

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

Notes for Users

FOR PRESCRIBERS:

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

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

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

4. Time should be recorded in 24hr format e.g. 0600, 1600.

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

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

7. The following metric unit abbreviations must be used –

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

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

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

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

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

FOR NURSES

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

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

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

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

Codes for Non-Administration of Drugs

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