SAR Team
Health Records Department
Glasgow Royal Infirmary Hospital
8 - 16 Alexandra Parade
Glasgow
G31 2ER

NHS
Greater Glasgow and Clyde

MMA Legal
STOK, 43-59 Princes Street
Stockport
SK1 1RY

Date: 27th May 2026
Your Ref: 100247
Our Ref: SAR Team /PA
Enquiries To: Patricia
Direct Line: 0141 201 3382
Email: patricia.armstrong3@nhs.scot

Dear Sir/Madam,

Re: Subject Access Request under the General Data Protection Regulation

PATIENT: MICHAEL MCLACHLAN DOB: 31/12/1962

Thank you for your request received 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
X-RAYS REPORTS

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 me.

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

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

Yours sincerely

SAR Team

PART 1 of 2

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	☐

MCLACHLAN, Michael (Mr)
BORN 31-Dec-1962 (63y) GENDER Male
CHI 3112626230

Request to GP to prescribe medication

Last updated by Luke David THOMPSON (Luke Thompson) 13 days ago (v. 1) Show History

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

Date	14-May-2026		
Hospital	Glasgow Royal Infirmary	Other	—
Specialty / Service	Urology		
Clinic	No	Please Specify	—

Dear Doctor

Your Patient Was Seen

Please Prescribe

Urgent / Routine: Routine - prescription available 48 hours following request

indication: Ureteric stent symptoms

Additions and Replacements

Product	Dose	Frequency	Current Regime Status	Comments
Hyoscine butylbromide	20mg	PRN up to 4 times per day	Addition	—

Replacements

This medication replaces which should now be stopped: —

Patient advised to collect prescription: Yes

Please Note: A Detailed Letter Will Follow.

Additional Notes / Summary

Additional Notes / Summary: —

When you click to 'Complete' a summary of the the form will be sent electronically to the registered GP practice.

Clinician Details

Name	Luke David THOMPSON
ClinicianDetailsRole	Doctor
Professional Registration Number	7831230
Contact Details	luke.thompson3@nhs.scot

MCLACHLAN, Michael (Mr)
BORN 31 Dec 1962 (63y) GENDER Male
CHI 3112626230

Glasgow Royal Infirmary

CHI: 3112626230

DNA-2022

Child 2

Total Att: 27

12 Mth Att: 3

Title: MR

MCLACHLAN **Michael**

DOB: **31/12/1962** Age: **63y** Sex: **Male**

FLAT 1-1
10 GIRVAN STREET
Glasgow
Lanarkshire
G33 2DP
07947416972

Next of kin: **SAME, Ashleigh**
Relationship: **Daughter**
07935123332

GP: **K Walker**
0141 531 6220

UROL
Bloods ☑
Bladder scan ☑ 20mls

Attendance Date: **13/05/2026** Arrival Time: **17:46**

Registration Time: **17:46** Date of Incident: **13/05/2026**

Major Incident Desc:

Reason for Attendance: **urol (gp ref)**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

Triage Category: **2** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **13/05/2026 18:38** Nurse name: **Nurse Ruby Baxter**

RR	18	bpm
Oxygen		%
Air or O2		
SpO2	95	%
HR	81	bpm
BP	151/119	mmHg
CRT		
MAP	130	mmHg
AVPU		
Temp	35.4	C
EWS Total		

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

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

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

Nursing Notes: **?RETENTION/ ABDO PAIN NEWs 1 "URO REF FROM GP. L sided abdo pain when PU. Only passed small amounts for past 24hours. Kidney stones and stents inserted earlier this month. PMH COPD, kidney stents, enlarged liver, pancreatitis "**

3112626230 31/12/1962 MCLACHLAN Michael
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To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

Date	Clinical Notes		
	Seen By	Time Seen	

13/5/16
2230

L Thompson CTC Medical
63M
PC: ⓛ flank pain
Background
ⓛ ureteric stent insitu 18/05
for ? complicated ureteric calculi
Sporadic pain + frequency
Awaiting passage
No prior Hodgkin's
OE Apyrexial HR 81 BP 151/114 RR

CT KUB
Bowel
angle
tenderness
Bladder
scan
20mls
CRP 20
eGFR >60
WCC 11.2
Hb 117
gastro

Imp: Stent symptoms
Plan: Pt if advised regarding stent symptoms
Trial Buscopan + Tramadol Warning advice given re

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By

THE CAIRNS PRACTICE

Dr Richard Parkins
Dr Kerry Walker
Dr Allan McNeill
Dr Fraser McNab
Dr Lauren Leishman
Dr Stacey Grant

SHETTLESTON HEALTH CENTRE
420 Old Shettleston Road
Glasgow G32 7JZ
Tel: 0141 531 6220
Fax: 0141 531 6298
www.thecairnspractice.co.uk

Quality Practice Award
RCGP 2012-2017
Providing quality healthcare in Shettleston

13/05/26

FAO UROLOGY
Re : Mr Michael Mclachlan, CHI 3112626230

Dear Colleagues,

This gent has stones and a stent inserted in May. He needed meropenem when he was in. Since then, he attended with pain and was dis-satisfied with his experience of being discharged.

He has come today and informed me he is now passing around 20ml of urine over 24 hours, thinks there may be some blood. He feels he is needing to go but is passing only a dribble. He is getting severe stabbing pains in L flank.

Consult note attatched.

KR,

Dr A McNeill

ℝ Encounter Report for house call

Chi Number

No data recorded.

Address and Telephone numbers

1-1 10 Girvan Street Glasgow G33 2DP
Mobile phone 07947 416 972
No data recorded.
No data recorded.

Carers details

Michael Mclachlan 31/12/1962 Male NHS: S64456335 CHI: 3112626230
No data recorded.
No data recorded.

Significant Medical History

24/03/2026 Constipation Urology - GRI
24/03/2026 Infection due to enterococcus isolated in blood cultures and treated with IV Meropenem. Urology - GRI
24/03/2026 Ureteric stone septic. Obstructing in the proximal left ureter Urology - GRI Ms Kerry Mclean
24/03/2026 Ureteroscopic insertion of ureteric stent 18/03/2026 Urology - GRI
24/03/2026 Hydroureter Urology - GRI
24/03/2026 Hydronephrosis mild. Urology - GRI
21/07/2023 Other bacterial pneumonia , A&E GRI Miss Catherine Arbuckle
08/03/2023 Chronic pancreatitis , Surgical OP, GRI Miss Catherine Arbuckle
08/03/2023 Gallstones - microcalculi within the gallbladder, Surgical OP, GRI Miss Catherine Arbuckle
30/06/2022 Pneumonia due to unspecified organism - left upper lobe with a possible hilar prominence, Medical IP, GRI Miss Catherine Arbuckle

20/12/2021 Coronavirus infection Mrs Claire Finbow
23/04/2021 Inguinal hernia - right, Surgical OP, GRI Miss Catherine Arbuckle
16/02/2021 Heroin misuse , Medical IP, GRI Miss Catherine Arbuckle
16/02/2021 Chest infection NOS , Medical IP, GRI Miss Catherine Arbuckle
16/02/2021 Drug psychosis NOS , Medical IP, GRI Miss Catherine Arbuckle
21/04/2020 Drug psychosis NOS Possible, Arran Resource Centre Mrs Claire Finbow
24/01/2020 O/E - collapse - syncope , A&E GRI Miss Catherine Arbuckle
02/05/2018 Chronic obstructive pulmonary disease Dr Richard Parkins
02/03/2018 Plain x-ray of chest - shows a calcified granuloma in the left mid zone, SHC Miss Catherine Arbuckle
18/01/2018 Drug addiction therapy - Buprenorphine 12mg, Newlands Centre Miss Catherine Arbuckle
10/10/2016 Drug psychosis NOS (in remission), Arran Centre Miss Catherine Arbuckle
05/09/2016 Drug addiction therapy - Suboxone, Newlands Centre Miss Catherine Arbuckle
24/07/2016 Drug withdrawal syndrome psychotic symptoms on withdrawal from Heroin, A&E GRI Miss Catherine Arbuckle
20/02/2016 Heroin misuse , GRI Miss Catherine Arbuckle
20/02/2016 Drug-induced hallucinosis , GRI Miss Catherine Arbuckle
26/02/2014 Endogenous depression first episode Dr Katie Gallacher
21/02/2014 Excision of submandibular gland - left, ENT OP, GGH Miss Catherine Arbuckle
20/08/2013 Internal thrombosed haemorrhoids , A&E GRI Miss Catherine Arbuckle
06/09/2012 Drug addiction therapy Suboxone treatment patient defaulted, EAST CAT Miss Catherine Arbuckle
17/10/2006 Drug addictn therap-methadone , Addiction Services, Parkhead Hospital Miss Catherine Arbuckle
28/07/2006 Drug dependence NOS acute psychotic episode Miss Catherine Arbuckle
28/07/2006 Benzodiazepine dependence , Medical IP, GRI Miss Catherine Arbuckle
28/07/2006 [X]Heroin addiction , Medical IP, GRI Miss Catherine Arbuckle
26/06/2002 Drug dependence relapse, Heroin, Cocaine, Diazepam Miss Catherine Arbuckle
09/05/2002 Deliberate self-harm Diazepam overdose Miss Catherine Arbuckle
02/04/2002 Smoke inhalation Miss Catherine Arbuckle
04/11/1997 Cubital tunnel syndrome Left medial epicondylectomy Miss Catherine Arbuckle
18/03/1997 Primary arthrodesis of joint NEC 5th PIP joint Miss Catherine Arbuckle
09/03/1997 Compartment syndrome Miss Catherine Arbuckle
02/01/1997 Primary repair of tendon Miss Catherine Arbuckle
19/10/1996 Primary repair of tendon Miss Catherine Arbuckle
17/09/1996 [X]Assault Miss Catherine Arbuckle
07/03/1996 [SO]Ulnar nerve - hand divisions Miss Catherine Arbuckle
14/02/1987 [X]Assault Miss Catherine Arbuckle
11/07/1986 [X]Assault by sharp object chest Miss Catherine Arbuckle
09/03/1986 Exploration of skin wound NEC and repair of machete wound Miss Catherine Arbuckle

Chronic Disease Register

No data recorded.
No data recorded.
No data recorded.
No data recorded.
No data recorded.
No data recorded.
No data recorded.

Current Repeat Medication

Repeat Diazepam 5mg tablets maximum 1 allowed Supply: (0.01) tablet ISSUED BY ADRS. SUPPLIED ELSEWHERE - NOT TO BE PRESCRIBED BY GP OR DISPENSED BY COMMUNITY PHARMACY
Repeat Laxido Orange oral powder sachets sugar free (Galen Ltd) maximum 6 allowed Supply: (120) sachet TWO SACHETS TO BE TAKEN TWICE DAILY Dr Kenneth Dow
Repeat Risperidone 2mg tablets Last issued: 26/02/2026 Issued: 1 maximum 6 allowed Supply: (28) tablet ONE AT NIGHT (AS PER PSYCH)
Instalments: dispense weekly Dr Lauren Leishman
Repeat Trimbow 87micrograms/dose / 5micrograms/dose / 9micrograms/dose inhaler (Chiesi Ltd) Last issued: 26/02/2026 Issued: 2 maximum 6 allowed Supply: (120) dose 2 PUFFS TWICE DAILY Dr Lauren Leishman
Repeat Creon 25000 gastro-resistant capsules (Viatris UK Healthcare Ltd) Last issued: 09/04/2026 Issued: 5 maximum 6 allowed Supply: (168) capsule 3 CAPSULES WITH MEALS AS PER HOSPITAL ADVICE Dr Kenneth Dow

Repeat Salbutamol 100micrograms/dose inhaler CFC free Last issued: 18/03/2025 maximum 6 allowed Supply: (400) dose 2 PUFFS WHEN REQUIRED Dr Fraser Mcnab
Repeat Tamsulosin 400microgram modified-release capsules Last issued: 26/02/2026 Issued: 6 maximum 6 allowed Supply: (30) capsule 1 DAILY IN THE MORNING THIS IS FOR URINARY RETENTION
Instalments: dispense weekly Dr Lauren Leishman
Repeat Creon 25000 gastro-resistant capsules (Viatris UK Healthcare Ltd) Last issued: 26/02/2026 Issued: 5 maximum 6 allowed Supply: (56) capsule 1 CAP WITH SNACKS AS PER HOSPITAL ADVICE Dr Richard Parkins
Repeat Diazepam 2mg tablets maximum 1 allowed Supply: (1) tablet ISSUED BY ARDS (NOT FOR SCRIPT FROM HERE). SUPPLIED ELSEWHERE - NOT TO BE PRESCRIBED BY GP OR DISPENSED BY COMMUNITY PHARMACY
Repeat Buvidal 128mg/0.36ml prolonged-release solution for injection pre-filled syringes (Camurus AB) maximum 1 allowed Supply: (1) pre-filled disposable injection 128MG EVERY MONTH BY DEPOT ISSUED BY ADDICTIONS, NOT FOR GP ISSUE

Acute and Repeat issues in last 3 months

09/04/2026 issue 5 Creon 25000 gastro-resistant capsules (Viatris UK Healthcare Ltd) Supply: (168) capsule 3 CAPSULES WITH MEALS AS PER HOSPITAL ADVICE Dr Kenneth Dow
26/02/2026 Paracetamol 500mg tablets Supply: (30) tablet TWO TABLETS UP TO FOUR TIMES A DAY WHEN REQUIRED. (USE FOR PAIN OR A HIGH TEMPERATURE). LEAVE AT LEAST 4 HOURS BETWEEN DOSES. Dr Kenneth Dow
26/02/2026 issue 5 Creon 25000 gastro-resistant capsules (Viatris UK Healthcare Ltd) Supply: (56) capsule 1 CAP WITH SNACKS AS PER HOSPITAL ADVICE Dr Richard Parkins
26/02/2026 issue 2 Trimbow 87micrograms/dose / 5micrograms/dose / 9micrograms/dose inhaler (Chiesi Ltd) Supply: (120) dose 2 PUFFS TWICE DAILY Dr Lauren Leishman
26/02/2026 issue 1 Risperidone 2mg tablets Supply: (28) tablet ONE AT NIGHT (AS PER PSYCH)
Instalments: dispense weekly Dr Lauren Leishman
26/02/2026 issue 6 Tamsulosin 400microgram modified-release capsules Supply: (30) capsule 1 DAILY IN THE MORNING THIS IS FOR URINARY RETENTION
Instalments: dispense weekly Dr Lauren Leishman
17/02/2026 issue 1 Trimbow 87micrograms/dose / 5micrograms/dose / 9micrograms/dose inhaler (Chiesi Ltd) Supply: (120) dose 2 PUFFS TWICE DAILY Dr Lauren Leishman

Allergies and Intolerances

No data recorded.
No data recorded.

Recalls - 3 months back to 1 month in future

No data recorded.

Referrals and Requests in last 3 months

No data recorded.

Hospital admissions in past year

No data recorded.

Consultations in past three months

13/05/2026 Other Dr Allan Mcneill
13/05/2026 15:04.00 BP 100 /60 taken Sitting Cuff: Standard recall due: O/E - blood pressure reading Dr Allan Mcneill
13/05/2026 Consultation DUTY GP

Renal stones and prev infn. Hosp admission Mar/26. Stent placed. Note back up 01/04 - but was dishcarged.

Recent ^ pain again. "agony" this morning. Freq and urge. PU small amnt. No bld. No fevers. No vomiting.

When arrived - had not brought urine sample. Managed to PU small amount. Tells me has passed < 20 ml in last 24 hours - similar to last few days. Thinks has had bit of Tr bld.

Dis-satisfied last week. States a doctor who seen him suggested need to stay in and then in morning discharged despite needing strong analgesia. Concerned issue with stent.

Daughter is a nurse.

O/E - AP. HR 69. Sats 93. BP 100/60mmHg. No resp dist. Abdo - tender lower abdo. No obvious palp bladder.

Urinalysis - leuc ++, bld +++

Imp - Known stones/stent/sepsis - c/o ^ pain and reduced U/O ??obstruction ??infn

Plan:
- Attend A&E for UROLOGY

Dr Allan Mcneill
17/04/2026 Surgery consultation Dr Fraser Mcnab - No Data Recorded
17/04/2026 Third Party Consultation Mrs Claire Finbow
01/04/2026 Document Image Docman Attachment
01/04/2026 Letter encounter from patient A&E Letter Glasgow Royal Infirmary Accident & Emergency Dr Devin Chetty Mrs Claire Finbow
25/03/2026 Surgery consultation Dr Fraser Mcnab - No Data Recorded
25/03/2026 Surgery consultation Ms Sarah Stewart
25/03/2026 Unsuccessful attempt to contact patient by telephone TC to pt: Spoke with pt who advised is not able to speak currently as "not had minute to himself". Confirmed will call back tomorrow if more suitable. Ms Sarah Stewart
25/03/2026 Telephone encounter TC to ADRS: Contacted to confirm if patient still on Buvidal inj. Pt care manager unavailable, awaiting call back from duty team.
Update: Received TC from Gwyd - care manager from ADRS NE. Confimed pt still on Buvidal - latest Rx issued for today. Advised pt given 1/52 DHC on d/c as Buvidal not noted on IDL - Gwyd confirmed although possibly not effective for pain relief. unlikely to have any serious adverse effects if taken together.
Update: Spoke with Pharmacist Amy - advised was told by Gwyd about pt and wanted to clarify story - explained. Amy advised same as Gwyd - unlikely to get any pain relief from DHC as Buvidal will block, best to try anti-inflammatories if still requiring pain relief. Advises will speak with patient to confirm this. Ms Sarah Stewart
Repeat Diazepam 5mg tablets maximum 1 allowed Supply: (0.01) tablet ISSUED BY ADRS. SUPPLIED ELSEWHERE - NOT TO BE PRESCRIBED BY GP OR DISPENSED BY COMMUNITY PHARMACY

25/03/2026 New medication commenced Laxido - 2BD (added to rpts). Co-trimox 960mg - 1BD for 7/7 from 23/03 (short course, not added to PMR).
Amendment: DHC 30mg - 1 up to QDS PRN for 1/52 given on d/c (fixed course, not added to PMR. GP to r/v if further analgesia required) - to confirm pt no longer on Buvidal injection. Ms Sarah Stewart
25/03/2026 Medication changed Diazepam 2mg + 5mg - 5mg at 7am + 12pm and 6mg at 5pm + 10pm (amended on rpts, outside medication) Ms Sarah Stewart
Repeat Laxido Orange oral powder sachets sugar free (Galen Ltd) maximum 6 allowed Supply: (120) sachet TWO SACHETS TO BE TAKEN TWICE DAILY Dr Kenneth Dow
25/03/2026 Post hospital dischrge med reconciliation with medical notes Pharm Tech: GRI Ward 70. Admission 18-24/03/26.
Pt adm under Urology. Issues: Septic ureteric stone - treated with IV meropenem + IVOST to co-trim - added to stone register + referred to stone MDT. Constipation - regular laxitive. Addictions input for Diazepam - Pt reported feeling drowsy on 6mg 8mg 8mg dosing - advised to swap to 5mg 5mg 6mg 6mg for total of 22mg per day - tolerating well. See IDL for full details.
Notes: Creon 1TDS on IDL, 3 with meals and 1 with snacks on PMR (not noted to be changed during adm, left as is), Buvidal on not IDL - to confirm with ADRS if still on. Ms Sarah Stewart
25/03/2026 Site of encounter NOS Ms Sarah Stewart

25/03/2026 Third Party Consultation Mrs Jade Deavy
25/03/2026 Document Image Docman Attachment
25/03/2026 Letter encounter from patient Clinical letter Unknown Oncology NOT CODED, NOT CODED Mrs Jade Deavy

24/03/2026 Surgery consultation Dr Fraser Mcnab - No Data Recorded

24/03/2026 Third Party Consultation Ms Lauren Eusebi
24/03/2026 Document Image Docman Attachment
24/03/2026 Letter encounter from patient Hospital Immediate Discharge Letter Glasgow Royal Infirmary Urology McKay Ms Lauren Eusebi

24/03/2026 Third Party Consultation Ms Lauren Eusebi
24/03/2026 Document Image Docman Attachment
24/03/2026 Letter encounter from patient Hospital Immediate Discharge Letter Glasgow Royal Infirmary Urology McKay Ms Lauren Eusebi

26/02/2026 Other Dr Kenneth Dow
26/02/2026 Paracetamol 500mg tablets Supply: (30) tablet TWO TABLETS UP TO FOUR TIMES A DAY WHEN REQUIRED. (USE FOR PAIN OR A HIGH TEMPERATURE). LEAVE AT LEAST 4 HOURS BETWEEN DOSES. Dr Kenneth Dow
26/02/2026 Medication requested - acute request paracetamol - issued short supply Dr Kenneth Dow

17/02/2026 Other Ms Deborah Spiers
17/02/2026 issue 1 Trimbow 87micrograms/dose / 5micrograms/dose / 9micrograms/dose inhaler (Chiesi Ltd) Supply: (120) dose 2 PUFFS TWICE DAILY Dr Lauren Leishman

Prevention

13/05/2026 15:04.00 BP 100 / 60 taken Sitting Cuff: Standard recall due: O/E - blood pressure reading Dr Allan Mcneill
04/12/2018 14:23.00 BP 116 / 70 taken Sitting Cuff: Standard recall due: O/E - blood pressure reading Dr Ellyn Russell
15/03/2018 14:56.00 BP 111 / 67 taken Sitting Cuff: Standard recall due: O/E - blood pressure reading pulse 55 Dr Katherine Grosset
24/11/2023 Ex-smoker Ex smoker vapes Sister Rachel Cuthbert
No data recorded.
24/11/2023 Weight: 52 kgs BMI: 17.1 O/E - weight Sister Rachel Cuthbert
04/06/2010 Height: 1.74 metres O/E - height Miss Catherine Arbuckle
No data recorded.

New Consultation Details

Date: Clinician:

abda pair.

Temperature Corrected cH(T) results may display incorrect results flags on printouts only, if result reports out with reference range. Please disregard result flag and refer to value.

Printed: 13/05/2026 20:45:37

Patient Sample Report

Status: **ACCEPTED**
Analyzed: 13/05/2026 20:45:25
Sample Type: **Venous**
Account Number:
Clinician:
Operator ID: EMMA TIERNEY0

Patient

ID:	3112626230
Last Name:	**MCLACHLAN**
First Name:	**MICHAEL**
Gender/Age:	Male, 63 years
Birth Date:	31/12/1962

Cartridge

Lot No.:	260227I
S/N:	00000000501449174
Exp. Date:	23/05/2026

Analyzer

Model:	GEM® *Premier 5000*
Area:	GRI
Name:	MINORS
S/N:	17010534

Results

				Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)							
cH		**41.8**	nmol/L	--	--	--	--
pCO_2		**6.4**	kPa	--	--	--	--
pO_2		**9.2**	kPa	--	--	--	--
Na^+		**139**	mmol/L	--	133	146	--
K^+		**4.1**	mmol/L	--	3.5	5.3	--
Cl^-		**106**	mmol/L	--	95	108	--
Ca^{++}		**1.26**	mmol/L	--	1.15	1.27	--
Glu	↑	**9.8**	mmol/L	--	3.5	6.0	--
Lac		**0.8**	mmol/L	--	0.6	2.2	--
CO-Oximetry							
tHb		**123**	g/L	--	--	--	--
O_2Hb	↓	**88.9**	%	--	95.0	98.0	--
COHb	↑	**5.2**	%	--	0.5	1.5	--
MetHb		**0.6**	%	--	0.5	1.5	--
HHb	↑	**5.3**	%	--	0.0	5.0	--
sO_2	↓	**94.4**	%	--	95.0	98.0	--
Derived							
BE(B)		**2.6**	mmol/L	--	--	--	--
$HCO_3^-(c)$		**28.4**	mmol/L	--	--	--	--
Hct(c)		**37**	%	--	--	--	--

↑↓ Outside Reference Range

Other Information

Operator Entered

Temp	37.0

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 16/04/2026

Consultant: Dr Devin Chetty

K Walker
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
Glasgow
G32 7JZ

Dear K Walker

Re: **McLachlan Michael** DOB: **31/12/1962** CHI: **3112626230**
FLAT 1-1
Glasgow G33 2DP

Attended on: **31/03/2026 at 19:48 hrs.** Departed on: **01/04/2026 at 02:09 hrs.**
Discharge Type: **01ap - Discharge with patient to action** Destination: **Private residence**
Previous ED Attendance in last 12 months: **2**

Presenting complaint
abdo pain

Nursing Assessment:
?Failed D/C. States was d/c H on 24/03 after the insertion of a L Ureteric stent due to a septic ureteric stone. States pain hasn't settled since d/c & has had a very poor urine output & poor po intake. Pain starts in lower abdo radiating up into L hand side of back of chest wall. Abdo is swollen in appearance. CAT 2 due to possible urine retention. No complaints of chest pain.

Investigations in ED:

1. **Urine culture**
2. **Amylase**
3. **CRP**
4. **Urea and Electrolytes**
5. **Bicarbonate**
6. **LFT**
7. **Glucose**
8. **Full Blood Count**
9. **Hep B Screen - HBsAg - current infection BBV**

10. Hep C antibody screen BBV

11. HIV antibody / antigen screen (HIV Test) BBV

12. XR Chest

Diagnosis:

Diagnosis	Side	Site
Other and Unspecified Abdominal Pain		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:
Abdominal pain since ureteric stent. Reviewed by urology but pain improved and can go home. No follow up required.

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

Yours sincerely,
Monica McKenna
Consultant

Copies to:
1. K Walker (GP)

School Address:

CHI: 3112626230

Glasgow Royal Infirmary

T5.

Total Att: 26

12 Mth Att: 2

Title: **MR**

MCLACHLAN **Michael**

Bladder Scan. Hep. IV access. ✓ Bloods ✓ VBG ✓ ECG ✓

DOB: **31/12/1962** Age: **63y** Sex: **Male**

FLAT 1-1
10 GIRVAN STREET
Glasgow
Lanarkshire
G33 2DP
07947416972

Next of kin: **SAME, Ashleigh**
Relationship: **Daughter**
07935123332

GP: **K Walker**
0141 531 6220

Attendance Date: **31/03/2026** Arrival Time: **19:48**

Registration Time: **19:48** Date of Incident: **31/03/2026**

Major Incident Desc:

Reason for Attendance: **abdo pain**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

Triage Category: **2** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **31/03/2026 20:39** Nurse name: **Nurse Chloe McMahon**

RR	**18**	bpm
Oxygen		%
Air or O2		
SpO2	**96**	%
HR	**96**	bpm
BP	**93/77**	mmHg
CRT		
MAP	**82**	mmHg
AVPU		
Temp	**36.0**	C
EWS Total		

BM	**7.1**	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: **"?Failed D/C. States was d/c H on 24/03 after the insertion of a L Ureteric stent due to a septic ureteric stone. States pain hasn't settled since d/c & has had a very poor urine output & poor po intake. Pain starts in lower abdo radiating up into L hand side of back of chest wall. Abdo is swollen in appearance. CAT 2 due to possible urine retention. No complaints of chest pain. "**

3112626230 31/12/1962 MCLACHLAN Michael
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3112626230 31/12/1962 MCLACHLAN Michael

To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

Date	**Clinical Notes**	
WCC 8.7 Hb 118. N14432	Seen By	Time Seen

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By

Glasgow Royal Infirmary
Emergency Department

NHS
Greater Glasgow and Clyde

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Initial Investigations Ordered										
FBC ☐	COAG ☐	DD ☐	INR ☐		G+S ☐		X-match units			
U+Es ☐	LFT ☐	GLU ☐	CRP ☐	TROP ☐	Para ☐	Sal ☐	Ethanol ☐	Mg ☐	VBG ☐	ABG ☐
B culture ☐		C/MSSU ☐		Urinalysis ☐		BHCG ☐		Other		
CXR ☐	AXR ☐	Other imaging:								ECG ☐
Current location:								Sent by:		

Clinical Notes Monica McKenna ED Card.

Date 4/4/26 Time 0030 Name Grade Speciality

63 ♂. Mum daughters.

PC. Abdo pain

(L) flank pain since D/C 1/52 ago
Reduced oral intake. Brings food back up when unwell. No fever.
c/o dysuria. Bowels moved 4/7 ago.
No diarr. No SOB
Not taking reg analgesia due to constipation/nausea
PMH.
Recent ureteric stent for hydronephrosis/ enterococcus on blood cultures.

Dx nephrectomy. diverticular ileal.

Sx smoke alcohol mobile (I)

o/e Comfortable
Cachectic
RS (N)

↓AIE (L) base
no added sounds

PD

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Clinical Notes

Date	Time	Name	Grade	Speciality

SBAR

mildly tender ⓓ flank.

calls OK
No focal neurology
GCS 15/15

Δ Ongoing issues with enteric start / pain control.

Hx: Urine test + blood ++ sent for MCTS
IV fluids
Analgesia - declined PR Voltarol
CXR
Admit medicine - reg advised can go straight to ward.

MMcKenzie
SHO

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Glasgow, Lanarkshire
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Clinical Notes

Date	Time	Name	Grade	Speciality

Review Urology

1/4/16
1:52pm Pt seen - Says from discharge up until a few days ago he pain was bearable, however since getting Analgesia it has improved to the point he can eat + drink.

C/O chest symptoms as well but no signs of Systemic unwell

O/E: Appears well, eating and drinking during review

WCC: 8.5
CRP: 14
eGFR: >60

A: Improved chest symptoms

Plan: Co-codamol 30/500 1-1 PO QID PRN
Has follow up - Endo from Reassurance given.
For Discharge

GF

Glasgow Royal Infirmary
Emergency Department

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HAEM	DATE or TIME		BIOCH	DATE or TIME			DATE or TIME		V/ABG	DATE or TIME	
WCC			Na			Bil			FiO_2		
Hb			K			ALT			H^+		
Plat			Cl			AST			$PaCO_2$		
Neut			Ur			GGT			PaO_2		
DD			Creat			A phos			Bic		
PT			eGFR			Alb			BE		
PTT			Glu			AdjCa			Lactate		
TT			CRP			Amyl			Ethanol		
INR			Mg			TropI HS			Para		
			Phos			BHCG			Sal		

Diagnosis and Plan

Review/Discussed with:

Handover

- ☐ Provisional Diagnosis
- ☐ Liquids/Fluids
- ☐ Analgesic/Medicines
- ☐ NEWS
- ☐ Investigations & Results
- ☐ Talk to receiving team/ward

mi • 287967 Version 1_0 • GGC0226

Patient na... 3112626230 N
Date of bi... MCLACHLAN Michael 31/12/196...
CHI No:..... FLAT 1-1 10 GIRVAN STREET Glasgow, Lanarkshire G33 2DF
...patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg) ..... Height (cm) .....

Prescription details									Administration details				
Date	Time	Name of fluid Name of additive	Volume (ml) Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments
1/4/26	0040	Hartmans	1L	IV	60		[signature]		1/4/26	07 00	KC.	WD	Cannula patent

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow (drops/min) = Volume of fluid (ml) x 20 / Duration of admin (min)

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued									Administration details - continued				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments

*Prescriber should sign this box if the fluid/additive is no longer required.

Patient

Patient

3112626230 N
MCLACHLAN
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire G33 2DF

NHS
Greater Glasgow and Clyde

Emergency Care Nursing Documentation

Initial Investigations

Initial when complete	Required?		Init		Required?		Init
Patient prepared for exam	Y	N		Pain score	Y	N	
NEWS/MEWS/ PEWS chart	Y	N		Peak flow	Y	N	
ID Band	Y	N		MSSU Results:			
12-Lead ECG	Y	N		Protein, Blood+++ leucytes++			
Blood samples	Y	N					
Blood Gas	Y	N					
Viral Swab	Y	N		B-HCG	+ve	-ve	

Communication

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

Signature:

PVC

Circle reason: RIFT

Diagnostic
Resuscitation
Intravenous Fluids
Transfusion

Insertion Date: 31/03/26 Time: 2330

Insertion Side: L R

Insertion Site: ACS

Size of PVC: Pink

Inserted by

Signature

Hand Hygiene Yes ☐

Skin Decontamination 2% chlorhexidine in 70% isopropyl alcohol Yes ☐

Sterile transparent semi-permeable dressing affixed Yes ☐

PVC Reason Explained Yes ☐

Risk Assessments and Screening Tools

	Required?		Init
SEPSIS	Y	N	
FAST +VE Y N STOPPS	Y	N	
ED Falls Risk Assessment	Y	N	
Mental Health Triage Assessment	Y	N	
Ligature low room	Y	N	

	Required?		Init
GMAWS	Y	N	
Public Protection Concern (Adult/Child)	Y	N	
Notification of Concern Completed (NOC)	Y	N	
Frailty Assessment Completed	Y	N	
4AT Assessment	Y	N	

Pause for Discharge

GGC Red Bag with Patient (nursing home resident)	Y	N
Relatives / Carer with Patient	Y	N
Name Band Removed	Y	N
Risk Assessment/Screening Tools Completed	Y	N
Discharge Information	Y	N
NEWS Chart completed within 1 hour of discharge	Y	N
Medications/Fluids prescribed as per medication prescription form	Y	N
Notes Complete	Y	N
Belongings	Y	N
Transport arranged	Y	N
Own/Taxi/Relative/SAS (Please circle)	Y	N
PVC Removed Prior to Discharge	Y	N

Signature:

Pause for Transfer

GGC Red Bag with Patient (nursing home resident)	Y	N
Relatives / Carer with Patient	Y	N
Name Band in situ	Y	N
Risk Assessment/Screening Tools Complete	Y	N
Bed Available	Y	N
SBAR complete	Y	N
NEWS Chart completed within 1 hour of transfer	Y	N
Medications/Fluids prescribed as per medication prescription form	Y	N
PVC/CVC Bundle	Y	N
Notes Complete	Y	N
Belongings	Y	N
Escort Required	Y	N

Signature:

Patient name .....

Patien

3112626230 N...
MCLACHLAN 31/12/1962
Michael
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Care Rounds Checklist

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

Signed [signature] Name [signature] Designation SN.

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

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

			Times	2300									
	1	**THINK DELIRIUM** Is the patient more confused/drowsy than normal? If yes inform registered nurse.		N.									
	2	**PAIN: ASSESS AND ADDRESS** Is the patient distressed or in pain? If yes inform registered nurse/ Review analgesia		N.									
S	3	**SKIN INSPECTION** Pressure areas checked?		N									
		R = RED D = Discloured PU - Pressure Ulcer INT = Intact M = Moisture		INT									
K	4	**KEEP MOVING** Has the patient moved or walked?		Y									
		Bed R =Right side (30°) tilt L =Left side (30°) tilt B =Back Chair W/ST = Assist to walk / stand		B.									
		ELIMINATION Does the patient need the toilet?		Y.									
I	5	I = Independent A - Assistance given IC = Incontinent (urine/ faeces)		I									
N	6	**FOOD FLUIDS AND NUTRITION** Is the patient nil by mouth?		N									
		Drink taken?		Y									
		Food, snack, or supplements taken?		N									
		Has oral hygiene been carried out as per care plan?		N									
	7	**ENVIRONMENT CHECK** Is the patient's call buzzer to hand? Is the area clutter free clean and safe? Does the patient have everything they require in safe reach?		Y									
		Is the bed in the lowest position?		Y									
	8	**INFORMATION** Is there anything else I can help you with? Inform the patient of the time of return		MD									
	9	**ESCALATION** Is there anything else I can help you with? Inform the patient of the time of return		SN									
		Care provider											
		Role											

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

Patient name .....

Patient CHI

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MCLACHLAN
Michael M
FLAT 1-1 31/12/1962
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G33 2DP

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Nursing notes

Date and Time		Name/Signature
31/01/26 2355	Pt c/o abdo pain unsure when last passed urine. Also uretic stent fitted 24/08/26 Pain in back Bladder scan nil... IV access & Bloods & VBG & ecgt obtained. Pt awaits ED R/V.	[illegible] SN.
0115.	Pt reviewed by CIC for fluids pain relief antiemetic as prescribed. Pt to be admitted to Urology	[illegible]

Patient name

Patient CHI

3112626230 M
MCLACHLAN 31/12/1962
Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire G33 2DP

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

Ongoing Care

	4 Hours	5 Hours	6 Hours	7 Hours	8 Hours	9 Hours	10 Hours	11 Hours	12 Hours
Time									
Nursing notes updated including (NEWS, MEWS,PEWS)									
Food, Fluid, Nutrition (provide details)									
IVI/IVABs									
Routine Medications prescribed and administered									
Falls risk assessment reviewed/checklist									
Skin assessed and supported (PURDRA)									
Pain assessment									
SBAR up to date and completed									
Patient/ relatives updated									
If patient not in cubicle space think about patients dignity requirements eg hearing aids, mobility aids, glasses, interpreter									
STOPPS completed									
PVC/CVC Bundle. Consider is; Dressing intact? PVC patent?									Commence CVC/PVC chart

Patient name

Patient CHI

3112626230
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Michael 31/12/1962
FLAT 1-1
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Glasgow, Lanarkshire
G33 2DP

Hospital:

Ward:

Points to consider:

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

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Greater Glasgow and Clyde

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

Pressure damage	**No RISK** ↓	**At RISK** ↓	**Grade 1 – non blanching skin** **Grade 2,3,4, suspected deep tissue injury (SDTI), ungradable pressure ulcer, Moisture Associate Skin Damage (MASD)** ↓	**Device Related Pressure Damage i.e. nasogastric, catheters, oxygen tubing** ↓
OU MUST CHECK SKIN at pressure points	Daily skin check	4 hourly positioning Complete SSKINS care plan (below)	2 hourly positioning with skin checks, Complete SSKINS care plan (below)	All devices need a SSKINS care plan (below)

1	PressureDamage	**Does the person have Pressure damage; Grade 1, 2, 3, 4, SDTI, Ungradable?**
2	Mobility	**Does the person require assistance to mobilise or change position?**
3	Continence	**Does the person have moisture issues, or, continence issues with urine and/or faeces?**
4	Nutrition	**Does the person appear malnourished and/or unable to eat or drink?**
5	Skin	**Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?**
6	Judgement	**In your clinical judgement, is this person at risk of developing pressure damage?**

Date	Location of pressure damage	Grade of ulcer	Date	Location of pressure damage	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

If NO to all questions, continue Care Rounds Prescribed as assessed for individual need and re-assess daily.
If you have answered YES to any of the questions above, please complete the SSKINS care plan below.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Check Skin	Signature
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used: Catheter ☐ Naso gastric ☐ Oxygen mask ☐ Nasal oxygen ☐ Vascular Access Device ☐ Off loading boot ☐ Other:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment: Off loading boot: ☐ Protective product:	• Reposition ____ hourly in bed. • Reposition ____ hourly in chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used: Tilting device ☐ • Knee bend in place ☐ Record reason for no knee bend:	• Does patient have Moisture Associated Skin Damage Yes ☐ • Skin care to be carried out ____ hourly. • Specify products required for increased moisture / continence management: Barrier Cream ☐ Pad / Pants ☐	• Optimise nutrition and hydration. • Refer to MUST	• Provide information in a format appropriate to patient / family/ carer needs : • Specify: Leaflet ☐ Verbal ☐ Not provided record reason:	Date discontinued: ____

Patient nam

Patient CHI



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Nursing notes cont.

Date and Time		Name/Signature

MEDICINE **PRESCRIPTION FORM**

Hospital Name: .....

MEDICINES RECONCILIATION

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

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

DOCTOR'S DECLARATION (if required by Local Protocol)

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

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

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

PATIENT DETAILS

Hospital Numb
DOB:
Date of Admis:
Consultant Na

3112626230
MCLACHLAN
Michael
31/12/196
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DF

ight:
ight:
face area:
rd:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
1/4/26	Cyclizine	10mg	PO	0040	MMcClure	ND/KC	01.00
1/4/26	Ondansetron	4mg	IV	0040	MMcClure	ND/KC	0100

TARGET OXYGEN SATURATIONS

Please CIRCLE a target saturation and prescribe oxygen on the Regular Prescription section.

94 – 98%	88– 92% (e.g. in hypercapnic respiratory failure)	Other (please specify)

On Home Oxygen? Yes / No _____ L/min

DATE: _____/_____/_____ PRESCRIBER (PRINT & SIGN): _____

	DATE →																					
	MONTH →																					
	RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N – REASSESS NEED AT LEAST EVERY 48 HRS)																					
IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N																						
ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N																						
SIGNATURE OF ASSESSOR																						
ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N																						

Parenteral Drugs : Regular Prescription

																						Patient's Own Medicine
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	A DRUG DOSE / ROUTE / DATE PRESCRIBER (PRINT & SIGN) ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY STOPPED DATE: INITIALS:	Other time																				For Use Y/N
		0700-0900																				Qty:
		1200-1400																				Date:
		1500-1800																				Assessed by:
		2200-2400																				Ordered from Pharm.
		Other time																				
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	B DRUG DOSE / ROUTE / DATE PRESCRIBER (PRINT & SIGN) ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY STOPPED DATE: INITIALS:	Other time																				For Use Y/N
		0700-0900																				Qty:
		1200-1400																				Date:
		1600-1800																				Assessed by:
		2200-2400																				Ordered from Pharm.
		Other time																				
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	C DRUG DOSE / ROUTE / DATE PRESCRIBER (PRINT & SIGN) ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY STOPPED DATE: INITIALS:	Other time																				For Use Y/N
		0700-0900																				Qty:
		1200-1400																				Date:
		1600-1800																				Assessed by:
		2200-2400																				Ordered from Pharm.
		Other time																				

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

Parenteral Drugs: Regular Prescription

3112626230
MCLACHLAN
Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP
31/12/1962 M

DATE →
MONTH →

Patient's Own Medicine

| | | |

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

H 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 ☐

J 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 ☐

K 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 ☐

L 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.

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

311262230
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Michael
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10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP
31/12/1962
M

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.

M DRUG

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

N DRUG

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

P DRUG

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

R DRUG

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

S DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

T DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

V DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

W DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

3112626230
MCLACHLAN
Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP
31/12/1962
M

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

X DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

Y DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

AA DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

BB DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

3112626230
MCLACHLAN
Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP
31/12/1962
M

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

GG DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

HH DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

JJ DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

KK DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

All Routes: As Required Prescriptions

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

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

| | | |

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, 1800.
5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.
6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.
7. The following metric unit abbreviations must be used –

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

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

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

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

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

FOR NURSES

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

Codes for Non-Administration of Drugs

(3) Patient refused	(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		

Cat. No. 40995 Ver 4, 09/2010 GGC0029

Temperature Corrected cH(T) results may display
incorrect results flags on printouts only,
if result reports out with reference range.
Please disregard result flag and refer to value.

Printed: 31/03/2026 23:42:31

Patient Sample Report

Status: **ACCEPTED**
Analyzed: 31/03/2026 23:42:16
Sample Type: **Venous**
Account Number:
Clinician:
Operator ID: LYNSEY DOLAN1

Patient

ID:	3112626230
Last Name:	**MCLACHLAN**
First Name:	**MICHAEL**
Gender/Age:	Male, 63 years
Birth Date:	31/12/1962

Cartridge

Lot No.:	260126C
S/N:	00000000501415620
Exp. Date:	16/04/2026

Analyzer

Model:	GEM® *Premier 5000*
Area:	GRI
Name:	CASU
S/N:	16090423

Results

				Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)							
cH	46.8	nmol/L	[--	--	--	--]
pCO_2	8.1	kPa	[--	--	--	--]
pO_2	2.5	kPa	[--	--	--	--]
Na^+	133	mmol/L	[--	133	146	--]
K^+	4.5	mmol/L	[--	3.5	5.3	--]
Cl^-	101	mmol/L	[--	95	108	--]
Ca^{++}	1.20	mmol/L	[--	1.15	1.27	--]
Glu	↑ 6.8	mmol/L	[--	3.5	6.0	--]
Lac	0.9	mmol/L	[--	0.6	2.2	--]
CO-Oximetry							
tHb	135	g/L	[--	--	--	--]
O_2Hb	↓ 23.5	%	[--	95.0	98.0	--]
COHb	↑ 2.7	%	[--	0.5	1.5	--]
MetHb	↓ 0.0	%	[--	0.5	1.5	--]
HHb	↑ 73.8	%	[--	0.0	5.0	--]
sO_2	↓ 24.2	%	[--	95.0	98.0	--]
Derived							
BE(B)	4.0	mmol/L	[--	--	--	--]
HCO_3^-(c)	31.6	mmol/L	[--	--	--	--]
Hct(c)	41	%	[--	--	--	--]

↑↓ Outside Reference Range.

Other Information

Operator Entered

Temp	--	37.0	°C

3112626230
MCLACHLAN M
Michael 31/12/1962

NHSGGC Adult In-Patient National Early Warning Score (NE

NHS Greater Glasgow and Clyde

3112626230
MCLACHLAN
Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DF

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

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

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed .....

Medical:.....

Date:.....

Glasgow Coma Scale

Pupil Reaction and size: s = sluggish, + = reaction, - = no reaction, c = eyes closed

Pupil Size (mm): 1 2 3 4 5 6 7 8

| Date: | | |

T5.1

Michael McLachlan.

NEWS 2 Key: 1 | 2 | 3

| | | |

NHS Greater Glasgow & Clyde
Acute Services Division

Date Printed: 25/03/2026

Private & Confidential

Dr Kerry Walker
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
G32 7JZ

Allison Walls

ggc.endouromdtggc@nhs.scot

www.nhsgg.org.uk

Dear Dr Walker,

The case described herein was discussed at the MDT meeting. Please find details below:

Name: Michael Mclachlan **CHI:** 3112626230 **CRN:**
Address: Flat 1-1, 10 Girvan Street, Glasgow, Glasgow, G33 2DP

Consultant: McKay Alastair

MDT Meeting: Endo-urology/Stone MDT

Date of MDT Review: 25/03/2026

Reason for Referral:

Outcome of MDT Review:

Reviewed on trak but not discussed at MDT:
L 5mm UU calculi, 3mm LP calculi, stented .
Outcome: L FURS urgent day case pooled list, suitable for VIC ACH

For further information please contact Allison Walls.

Please note that all clinical information is not available to the review process. Unknown clinical factors, change in the patient's condition, the clinical assessment of the clinician and the wishes of the patient may make recommendations inappropriate. However, they do represent a consensus view of the team as to the best management for this patient based on the information available.

NHS Greater Glasgow & Clyde
Acute Services Division

Date Printed: 25/03/2026

NHS
Greater Glasgow
and Clyde

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SCAN WITH ANY POA/GUARDIANSHIP PAPERWORK UNDER LEGAL NOTICES ON DISCHARGE

NHS Greater Glasgow and Clyde

3112626230
1 MCLACHLAN
2 Michael 31/12/196
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DD

Ward ED

Date completed 18103

Date revoked 22/3

Capacity Documentation For Medical Treatment

Section A - Assessment of Capacity

Capacity is assumed unless there is evidence of incapacity

☑ I believe that this person has attained the age of 16 and lacks capacity with regards to the proposed interventions because of mental disorder or inability to communicate because of physical disability. This is because they are unable to: (tick at least one of the following)

- ☐ Understand that a decision about the proposed treatment is required
- ☑ Believe, understand when presented in appropriate language, retain memory of, or weigh and balance information about the proposed treatment
- ☐ Communicate a decision, including with help of mechanical or other aids
- ☑ Understand appropriately the benefits, risks and alternatives including the consequences of not receiving the proposed treatment
- ☑ Reasonably recall the previous making of a decision about treatment

If the person lacks capacity consider whether they may be a vulnerable adult – if so refer Social Work

Section B – Welfare Attorney/Guardian

I have made reasonable enquiries to ascertain if anyone has been appointed as Welfare Guardian/Attorney or holds an intervention order for this patient and:

☐ I believe that no one has been appointed. If so the nearest relative should be consulted.

OR

☐ I believe that the undernoted has been appointed. If so then consent must be sought from them if possible.

Name: _____

Contact Details: _____

If there is a Welfare Guardian/Attorney please obtain a photocopy of the document and file in the clinical record (may be available on Clinical Portal – if not ask the Welfare Attorney/Guardian)

☐ requested Signed _____ Date _____ ☐ obtained Date _____

To revoke a statement of incapacity, score through and date the above box and the Section 47

ADULTS WITH INCAPACITY
(SCOTLAND) ACT 2000

Certificate of Incapacity under Section 47 of the Adults with Incapacity (Scotland) Act 2000

I Luke Thompson (name)

of Glasgow Royal Infirmary (address)

*am the medical practitioner primarily responsible for the medical treatment of; or

*am a person who is *a dental practitioner/an ophthalmic optician/a registered nurse and who satisfies such requirements as are prescribed by the Adults with Incapacity (Requirements for Signing Medical Treatment Certificates) (Scotland) Regulations 2007 and who is primarily responsible for treatment of the kind in question of:

Michael McLaughlin (name)

of 10 Govan Street (address) 3 0 M M 6 7 (date of birth)

for whom the *guardian/welfare attorney/person appointed by intervention order/nearest relative/carer

is

I have examined the patient named above on 0 3 0 5 2 6 (date). I am of the opinion that *he/she is incapable within the meaning of the Adults with Incapacity (Scotland) Act 2000 ("the 2000 Act") in relation to a decision about the following medical treatment:

All medical + nursing care

because of (nature of incapacity) Delirium

This incapacity is likely to continue for 3 months.

*I therefore consider it appropriate for the authority conferred by section 47(2) of the 2000 Act to subsist from:

0 3 0 5 2 6 (date of examination) until 0 2 0 8 2 6, being a period which does not exceed one year from the *date of the examination on which this certificate is based/date of revocation of the certificate issued previously by me; or

*I am of the opinion that (a) *he/she is suffering from *a severe or profound learning disability/dementia/a severe neurological disorder; and (b) *what he/she is suffering from is unlikely to improve within the meaning of the Adults with Incapacity (Conditions and Circumstances Applicable to Three Year Medical Certificates) (Scotland) Regulations 2007/ Y Y and therefore consider it appropriate for the authority conferred by section 47(2) of the 2000 Act to subsist until:

D D M M Y Y being a period which does not exceed three years from the *date of the examination on which this certificate is based/date of revocation of the certificate issued previously by me.

The authority conferred by section 47(2) of the 2000 Act shall subsist for the period specified above or until such earlier date as this certificate is revoked.

In assessing the capacity of the patient, I have observed the principles set out in section 1 of the 2000 Act.

Signed [redacted] Date 0 3 0 5 2 6

*Delete as appropriate

Section D Treatment plan

for patients receiving ongoing treatment under the terms of part 5 of the Adults with Incapacity (Scotland) Act 2000

You must tick both boxes to continue

☑ I have examined the patient named above on (date) 8/03/26 and consider that he/she needs to undergo procedures to safeguard or promote physical or mental health in relation to the treatment plan below. I have assessed his/her capacity to consent to treatment in relation to each area of intervention

☑ I have no reason to believe that any of the proposed treatments are contrary to wishes expressed by the patient, even when they had greater capacity, or to views that are consistent with their moral, cultural, family and experiential back ground

Signature _____ Print L Thompson Designation/Grade CSW

Disorder/Intervention (see note A)	Date	Capacity (C = capable I = incapable)
1. Fundamental healthcare procedures including all measures to support the following: Nutrition, hydration, hygiene, skin care and integrity, elimination, relief of pain and discomfort, mobility, communication, eyesight, hearing and simple oral hygiene.	18/03	I
2. Prevention and treatment of infection	//	I
3 Prevention of Deep Venous Thrombosis	//	I
4. AHP interventions	//	I
5. Continuing management of existing long term conditions Please specify conditions	//	I

Remember that some treatments require to be named specifically on the treatment plan. These include sedation for agitation, and any treatment which usually requires verbal consent. Covert medications must be named on the treatment plan and also require their own care plan (download from Mental Welfare Commission website). This list is not exhaustive. Section 47 does not cover discharge planning or deprivation of liberty.

Any treatment which would usually require signed consent requires a separate certificate of incapacity.

Member of staff consulting family/carers to sign:

I have discussed with the patient's representative as below

Welfare Guardian/ Power of Attorney (if one appointed):

☐ Name _____ Relationship _____ OR

Relative/ Carer/ Other individual most involved in persons care (if no Welfare Guardian/Power of Attorney):

☐ Name _____ Relationship _____

Signed _____ Print _____ Date _____

If additional items added to the treatment plan they must be discussed separately
All additional section 47 forms to be attached at section C

ADULTS WITH INCAPACITY (SCOTLAND) ACT 2000

This plan is intended to guide healthcare professionals who are caring for patients who have multiple and complex needs. It should be attached to a certificate of incapacity and retained in the patient's multidisciplinary case record.

A. Under the Act, you can only intervene if it will benefit the patient. Your intervention must be the least restrictive in relation to the patient's freedom in order to achieve the required benefit. You must take the patient's view into account and you must consult other relevant people, where reasonable and practicable.
Include all present or foreseeable disorders and/or interventions for physical and mental disorders not included in "Fundamental Healthcare Procedures" (see note B). You should consider the patient's capacity to consent to each intervention. Under the Act, the patient is incapable if he/she is incapable of acting, or making decisions, or communicating decisions, or understanding decisions, or retaining the memory of decisions.
Exclude all interventions that require express (signed) consent of the patient. Interventions of this sort need a separate certificate of incapacity. *For example, if you write "coronary heart disease and hypertension" on the plan, this authorises you to prevent disease with aspirin, or treat disease with anti-hypertensive drugs, but not operate or bypass blocked arteries.*

You may not include on this form any treatment regulated under section 48 of the Act. Please consult the regulations and separate guidance issued on these treatments. These treatments are:

Sterilisation where there is no serious malfunction or disease of the reproductive organs
Surgical implantation of hormones for the purpose of reducing sex drive
Drug treatment for the purpose of reducing sex drive, other than surgical implantation of hormones
Electro-convulsive therapy (ECT) for mental disorder
Abortion
Any medical treatment which is considered likely by the medical practitioner primarily responsible for that treatment to lead to sterilisation as an unavoidable result.

B. Fundamental healthcare procedures include all measures to promote or safeguard the following: nutrition, hydration, hygiene, skin care and integrity, elimination, relief of pain and discomfort, mobility, communication, eyesight, hearing and simple oral hygiene.

C. The Act requires you to take the views of others into account when deciding on an intervention. You should discuss this plan with professional carers and relatives of the patient. Any person with an interest in the welfare of the patient may appeal a treatment decision to the Sheriff. If the patient has a Welfare Attorney or Guardian with the authority to consent to treatment, you must consult this person where reasonable and practical. You can find out if your patient has a Welfare Attorney or Guardian by contacting the Public Guardian on 01324 678300. If this person disagrees with any element of your plan, you must refer to the Code of Practice for details of the dispute resolution process by the Mental Welfare Commission for Scotland, tel: 0131 313 8777.

D. Includes conditions diagnosed previously such as hypertension or diabetes. You may find that you need to treat a condition that is not specified in your treatment plan. If this is a short lived condition, a separate certificate in relation to it might suffice. If it is a condition that is likely to need ongoing intervention, you should consider rewriting the treatment plan.
The treatment plan is only valid for the period specified in the certificate of incapacity. The maximum period is **one year** or three years where the patient suffers from a severe or profound learning disability; dementia; a severe neurological disorder and the condition is unlikely to improve.

mi • 285848 Version 1_0 • GGC0211

SCAN WITH ANY POA/GUARDIANSHIP PAPERWORK UNDER LEGAL NOTICES ON DISCHARGE

NHS Greater Glasgow and Clyde

3112626230
M MCLACHLAN
2 Michael 31/12/196
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
P G33 2DI

Ward ED

Date completed 18/03

Date revoked 23/3

Capacity Documentation For Medical Treatment

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- ☑ Believe, understand when presented in appropriate language, retain memory of, or weigh and balance information about the proposed treatment
- ☐ Communicate a decision, including with help of mechanical or other aids
- ☑ Understand appropriately the benefits, risks and alternatives including the consequences of not receiving the proposed treatment
- ☑ Reasonably recall the previous making of a decision about treatment

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Name: _____

Contact Details: _____

If there is a Welfare Guardian/Attorney please obtain a photocopy of the document and file in the clinical record (may be available on Clinical Portal – if not ask the Welfare Attorney/Guardian)

☐ requested Signed _____ Date _____ ☐ obtained Date _____

To revoke a statement of incapacity, score through and date the above box and the Section 47

ADULTS WITH INCAPACITY
(SCOTLAND) ACT 2000

Certificate of Incapacity under Section 47 of the Adults with Incapacity (Scotland) Act 2000

I Luke Thompson (name)

of Glasgow Royal Infirmary (address)

*am the medical practitioner primarily responsible for the medical treatment of; or

*am a person who is *a dental practitioner/an ophthalmic optician/a registered nurse and who satisfies such requirements as are prescribed by the Adults with Incapacity (Requirements for Signing Medical Treatment Certificates) (Scotland) Regulations 2007 and who is primarily responsible for treatment of the kind in question of:

Michael McCallum (name)

of 10 Gurson street (address) 3 0 0 7 6 2 (date of birth)

for whom the *guardian/welfare attorney/person appointed by intervention order/nearest relative/carer

is

I have examined the patient named above on 0 8 0 3 2 4 (date). I am of the opinion that *he/she is incapable within the meaning of the Adults with Incapacity (Scotland) Act 2000 ("the 2000 Act") in relation to a decision about the following medical treatment:

Rigid cystoscopy + urethral left ureteric stent

because of (nature of incapacity) Delirium

This incapacity is likely to continue for 3 months.

*I therefore consider it appropriate for the authority conferred by section 47(2) of the 2000 Act to subsist from:

0 8 0 3 2 4 (date of examination) until 0 8 0 6 2 4, being a period which does not exceed one year from the *date of the examination on which this certificate is based/date of revocation of the certificate issued previously by me; or

*I am of the opinion that (a) *he/she is suffering from *a severe or profound learning disability/dementia/a severe neurological disorder; and (b) *what he/she is suffering from is unlikely to improve within the meaning of the Adults with Incapacity (Conditions and Circumstances Applicable to Three Year Medical Certificates) (Scotland) Regulations 2007/ Y Y and therefore consider it appropriate for the authority conferred by section 47(2) of the 2000 Act to subsist until:

0 0 M M Y Y being a period which does not exceed three years from the *date of the examination on which this certificate is based/date of revocation of the certificate issued previously by me.

The authority conferred by section 47(2) of the 2000 Act shall subsist for the period specified above or until such earlier date as this certificate is revoked.

In assessing the capacity of the patient, I have observed the principles set out in section 1 of the 2000 Act.

Signed [signature] Date 0 8 0 3 2 4

*delete as appropriate

Section D Treatment plan

for patients receiving ongoing treatment under the terms of part 5 of the Adults with Incapacity (Scotland) Act 2000

You must tick both boxes to continue

☑ I have examined the patient named above on (date) 18/03/26 and consider that he/she needs to undergo procedures to safeguard or promote physical or mental health in relation to the treatment plan below. I have assessed his/her capacity to consent to treatment in relation to each area of intervention

☑ I have no reason to believe that any of the proposed treatments are contrary to wishes expressed by the patient, even when they had greater capacity, or to views that are consistent with their moral, cultural, family and experiential back ground

Signature _____ Print LThompson Designation/Grade GP

Disorder/Intervention (see note A)	Date	Capacity (C = capable I = Incapable)
1. Fundamental healthcare procedures including all measures to support the following: Nutrition, hydration, hygiene, skin care and integrity, elimination, relief of pain and discomfort, mobility, communication, eyesight, hearing and simple oral hygiene.	18/03	I
2. Prevention and treatment of infection	〃	I
3 Prevention of Deep Venous Thrombosis	〃	I
4. AHP interventions	〃	I
5. Continuing management of existing long term conditions Please specify conditions	〃	I

Remember that some treatments require to be named specifically on the treatment plan. These include sedation for agitation, and any treatment which usually requires verbal consent. Covert medications must be named on the treatment plan and also require their own care plan (download from Mental Welfare Commission website). This list is not exhaustive. Section 47 does not cover discharge planning or deprivation of liberty.

Any treatment which would usually require signed consent requires a separate certificate of incapacity.

Member of staff consulting family/carers to sign:

I have discussed with the patient's representative as below

Welfare Guardian/ Power of Attorney (if one appointed):

☐ Name _____ Relationship _____ OR

Relative/ Carer/ Other individual most involved in persons care (if no Welfare Guardian/Power of Attorney):

☐ Name _____ Relationship _____

Signed _____ Print _____ Date _____

If additional items added to the treatment plan they must be discussed separately
All additional section 47 forms to be attached at section C

ADULTS WITH INCAPACITY (SCOTLAND) ACT 2000

This plan is intended to guide healthcare professionals who are caring for patients who have multiple and complex needs. It should be attached to a certificate of incapacity and retained in the patient's multidisciplinary case record.

A. Under the Act, you can only intervene if it will benefit the patient. Your intervention must be the least restrictive in relation to the patient's freedom in order to achieve the required benefit. You must take the patient's view into account and you must consult other relevant people, where reasonable and practicable. **Include** all present or foreseeable disorders and/or interventions for physical and mental disorders not included in "Fundamental Healthcare Procedures" (see note B). You should consider the patient's capacity to consent to each intervention. Under the Act, the patient is incapable if he/she is incapable of acting, or making decisions, or communicating decisions, or understanding decisions, or retaining the memory of decisions.

Exclude all interventions that require express (signed) consent of the patient. Interventions of this sort need a separate certificate of incapacity. *For example, if you write "coronary heart disease and hypertension" on the plan, this authorises you to prevent disease with aspirin, or treat disease with anti-hypertensive drugs, but not operate or bypass blocked arteries.*

You may not include on this form any treatment regulated under section 48 of the Act. Please consult the regulations and separate guidance issued on these treatments. These treatments are:

Sterilisation where there is no serious malfunction or disease of the reproductive organs
Surgical implantation of hormones for the purpose of reducing sex drive
Drug treatment for the purpose of reducing sex drive, other than surgical implantation of hormones
Electro-convulsive therapy (ECT) for mental disorder
Abortion
Any medical treatment which is considered likely by the medical practitioner primarily responsible for that treatment to lead to sterilisation as an unavoidable result.

B. Fundamental healthcare procedures include all measures to promote or safeguard the following: nutrition, hydration, hygiene, skin care and integrity, elimination, relief of pain and discomfort, mobility, communication, eyesight, hearing and simple oral hygiene.

C. The Act requires you to take the views of others into account when deciding on an intervention. You should discuss this plan with professional carers and relatives of the patient. Any person with an interest in the welfare of the patient may appeal a treatment decision to the Sheriff. If the patient has a Welfare Attorney or Guardian with the authority to consent to treatment, you must consult this person where reasonable and practical. You can find out if your patient has a Welfare Attorney or Guardian by contacting the Public Guardian on 01324 678300. If this person disagrees with any element of your plan, you must refer to the Code of Practice for details of the dispute resolution process by the Mental Welfare Commission for Scotland, tel: 0131 313 8777.

D. Includes conditions diagnosed previously such as hypertension or diabetes. You may find that you need to treat a condition that is not specified in your treatment plan. If this is a short lived condition, a separate certificate in relation to it might suffice. If it is a condition that is likely to need ongoing intervention, you should consider rewriting the treatment plan.
The treatment plan is only valid for the period specified in the certificate of incapacity. The maximum period is **one year** or three years where the patient suffers from a severe or profound learning disability; dementia; a severe neurological disorder and the condition is unlikely to improve.

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Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 29/08/2025

Consultant: Dr Anya Wallace

K Walker
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
Glasgow
G32 7JZ

Dear K Walker

Re: **McLachlan Michael** DOB: **31/12/1962** CHI: **3112626230**
FLAT 1-1
Glasgow G33 2DP

Attended on: **29/08/2025 at 03:40 hrs.** Departed on: **at hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **1**

Presenting complaint
?infected leg

Nursing Assessment:
?WOUND INFECTION. NEWS 3. Pt attacked by walking stick in Dec 2024. Reports wounds to both shins, ?septic at time. Attends tonight due to ongoing pain and swelling around sight. Concerned of sepsis.

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Open Wound of Other Parts of Lower Leg		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:

Michael presented with superficial lacerations on both of his shins after banging them on the coffee table 2/7 ago. There was some surrounding erythema and callor bilaterally and he was concerned regarding infection. He was systemically well. O/e there were no concerns for cellulitis. He has been discharged home with worsening advice.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Lily Lei
Doctor

Copies to:

1. K Walker (GP)

School Address:

T8

CHI: 3112626230

Glasgow Royal Infirmary

Total Att: **24**

12 Mth Att: **1**

Title: **MR**

MCLACHLAN **Michael**

DOB: **31/12/1962** Age: **62y** Sex: **Male**

FLAT 1-1
10 GIRVAN STREET
Glasgow
Lanarkshire
G33 2DP
07947416972

Next of kin: **SAME, Ashleigh**
Relationship: **Daughter**
07935123332

GP: **K Walker**
0141 531 6220

Attendance Date: **29/08/2025** Arrival Time: **03:40**

Registration Time: **03:40** Date of Incident: **29/08/2025**

Major Incident Desc:

Reason for Attendance: **?infected leg**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

Triage Category: **4** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **29/08/2025 03:49** Nurse name: **Nurse Rebecca Ross2**

Temp	**35.3**	C
HR	**65**	bpm
BP	**124/85**	mmHg
MAP	**98.00**	mmHg
RR	**18**	bpm
SpO2	**93**	%
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: **?WOUND INFECTION. NEWS 3. Pt attacked by walking stick in Dec 2024. Reports wounds to both shins, ?septic at time. Attends tonight due to ongoing pain and swelling around sight. Concerned of sepsis.**

3112626230 31/12/1962 MCLACHLAN Michael

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3112626230 31/12/1962 MCLACHLAN Michael

To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

Date	**Clinical Notes**	
	Seen By	Time Seen

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By

Glasgow Royal Infirmary
Emergency Department

NHS
Greater Glasgow and Clyde

Michael McLachlan
Patient Name
DoB
CHI Number
3112626230
or affix label

Initial Investigations Ordered

FBC ☐	COAG ☐	DD ☐	INR ☐		G+S ☐		X-match units			
U+Es ☐	LFT ☐	GLU ☐	CRP ☐	TROP ☐	Para ☐	Sal ☐	Ethanol ☐	Mg ☐	VBG ☐	ABG ☐
B culture ☐		C/MSSU ☐		Urinalysis ☐		BHCG ☐		Other		
CXR ☐	AXR ☐	Other imaging:								ECG ☐
Current location:								Sent by:		

Clinical Notes

Date 29/8/25 Time 5:42 Name L.Lei Grade ST5 Specialty

62 y/o p/w ? wound infection

HPC: Banged shins on coffee table 2/7 ago. Concerned regarding redness on wound, looking for abx. Systemically well. Erythema not spreading.

O/E NEWS: 1 (temp 35.3, SpO2 93%)



superficial laceration to both shins ō some surrounding erythema and cellulitis B/L

Lungs - inflamed laceration (no evidence of acute infection)

Plan - D/C ⓐ ō worsening advice.

Pmhx
- COPD
- depression
- drug misuse
- gallstones
- anaemia
- pancreatitis

Drug hx (clopidogrel)
- Creon
- tramadolsem
- risperidone
- trimbow
- Salbutamol

Social hx
- lives alone
- vapes
- denies alcohol or drugs

Glasgow Royal Infirmary
Emergency Department

Patient Name
DoB
CHI Number

or affix label

Clinical Notes

Date	Time	Name	Grade	Speciality

Glasgow Royal Infirmary
Emergency Department

michael
mclachlan
8112626230

Patient Name
DoB
CHI Number

or affix label

Clinical Notes

Date	Time	Name	Grade	Speciality

Glasgow Royal Infirmary
Emergency Department

Patient Name
DoB
CHI Number

or affix label

HAEM	DATE or TIME		BIOCH	DATE or TIME			DATE or TIME		V/ABG	DATE or TIME	
WCC			Na			Bil			FiO_2		
Hb			K			ALT			H^+		
Plat			Cl			AST			$PaCO_2$		
Neut			Ur			GGT			PaO_2		
DD			Creat			A phos			Bic		
PT			eGFR			Alb			BE		
PTT			Glu			AdjCa			Lactate		
TT			CRP			Amyl			Ethanol		
INR			Mg			TropI HS			Para		
			Phos			BHCG			Sal		

Diagnosis and Plan

Review/Discussed with:

Handover

- ☐ Provisional Diagnosis
- ☐ Liquids/Fluids
- ☐ Analgesic/Medicines
- ☐ NEWS
- ☐ Investigations & Results
- ☐ Talk to receiving team/ward

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Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Dermatology GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Glasgow Royal Infirmary 84 Castle Street Glasgow G4 0SF	——	**Hospital** and **hospital address** Hospital location code. G107H Email address -

Urgency of referral Routine
Date of referral 05-Jun-2024 **Date sent** 05-Jun-2024

PATIENT DETAILS

Surname	MCLACHLAN
Forename(s)	MICHAEL
Title	MR
Sex	Male
Date of birth	31-Dec-1962
CHI no.	3112626230
Area of Residence	-

Patient's address

1-1
10 GIRVAN STREET
GLASGOW
G33 2DP

Contact number(s)

Voice: 07947 416 972

101033260453S Unique Care Pathway Number: 101033260453S

REGISTERED GP DETAILS

Name	Dr Kerry Walker		
GMC code	7020285	GP code	02135
Practice name	The Cairns Practice		
Practice code	46081		

Practice address

420 OLD SHETTLESTON ROAD
SHETTLESTON
GLASGOW
G32 7JZ

Contact number(s)

Voice: 01415316220

REFERRING GP DETAILS

Name	Dr Kenneth Dow		
GMC code	7495609	GP code	09211
Practice name	The Cairns Practice (46081)		
Practice code	46081		

Practice address

Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Contact number(s)

Voice: 0141 531 6220

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: rosacea

Comment: This patient was referred to Dermatology due to Rosacea in March 2023. He reports that he missed his appointment on 14/02/24 as he was at a funeral – he is still keen to be seen. He has found doxycycline helpful but still gets flares in his symptoms. I would be grateful if he could be reappointed.
Many thanks

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history
Pre-existing conditions (High & medium priority - all)

Description	Comment	Modifier	Date of onset	Date recorded
Other bacterial pneumonia	, A&E GRI	-	21-Jul-2023	21-Jul-2023
Rosacea	[TRUNCATED]FTF ongoign rahs on face has tried rozex but not helping has googled and thinks has rosacea agree rosacea redness and pustules across both cheesk. evidence of rhinophyma also try doxyclin	-	16-Mar-2023	16-Mar-2023
Chronic pancreatitis	, Surgical OP, GRI	-	08-Mar-2023	08-Mar-2023
Gallstones	- microcalculi within the gallbladder, Surgical OP, GRI	-	08-Mar-2023	08-Mar-2023
Pharmacists	[TRUNCATED]1/Main concern on arrival was rash on face - states started after having RTA Thinks its related to airbags being deployed Looks like roscea Plan: Trail metronidazoel cream - pt advised th	-	10-Nov-2022	10-Nov-2022
MRC Breathlessness Scale: grade 3	-	-	10-Nov-2022	10-Nov-2022
Motor vehicle traffic accident NOS	[TRUNCATED]f2f had a road traffic accident 2/7, was the front seat passenger of a salon car that collided with a big van which crossed a red light. he had his seat belt on, and says the air bag was	-	05-Oct-2022	05-Oct-2022
Pneumonia due to unspecified organism	- left upper lobe with a possible hilar prominence, Medical IP, GRI	-	30-Jun-2022	30-Jun-2022
Frozen shoulder	Limited ROMof shoulder of all motion X-ray no bony injury No swelling. Analgesia not helping Agreed shoulder injection Needle phobia	-	30-Mar-2022	30-Mar-2022
Shoulder pain	[TRUNCATED]Tripped 2 weeks ago whilst walking to car. Landed on hands but painful right shoulder ever since. Had XR at the time - nil acute. Pain worsened over the last 4 days. Not sleeping. Describ	-	03-Mar-2022	03-Mar-2022
Coronavirus infection	-	-	20-Dec-2021	20-Dec-2021
Inguinal hernia	- right, Surgical OP, GRI	-	23-Apr-2021	23-Apr-2021
Heroin misuse	, Medical IP, GRI	-	16-Feb-2021	16-Feb-2021
Chest infection NOS	, Medical IP, GRI	-	16-Feb-2021	16-Feb-2021
Drug psychosis NOS	, Medical IP, GRI	-	16-Feb-2021	16-Feb-2021
Dysuria	[TRUNCATED]In for review, note recent circumcision. Was asked by Mr Fraser ? or other surgeon at time of operation whether had any trouble PU - said no. However dysuria at end of PU for around a wee	-	07-Sep-2020	07-Sep-2020
Drug psychosis NOS	Possible, Arran Resource Centre	-	21-Apr-2020	21-Apr-2020
		Continuing	14-Feb-2020	

MRC Breathlessness Scale: grade 4	cat score 28 out of 35. couldn't answer question re sleep			14-Feb-2020
Paraphimosis	[TRUNCATED]previously listed for circumcision for a paraphimosis. However he read up on the procedure online, and cancelled it as he was intimidated by the procedure. Has paraphimosis that is not ob	-	07-Feb-2020	07-Feb-2020
O/E - collapse - syncope.	, A&E GRI	-	24-Jan-2020	24-Jan-2020
Advice about investigation results	normal MSU and given symptoms on last consult --> for review for PR exam + scheduling of bloods etc. unavailable on telephone, will send letter	-	21-May-2019	21-May-2019
Urinary symptoms	[TRUNCATED]3-4 weeks of nocturia (15-20x) intermittent dysuria (states more like pressure) nil haematuria. poor @ initiate streaming. describes terminal dribbling. denies incontinence, but heavy dri	-	17-May-2019	17-May-2019
MRC Breathlessness Scale: grade 4	-	Continuing	29-Jan-2019	29-Jan-2019
MRC Breathlessness Scale: grade 3	-	Continuing	29-Jan-2019	29-Jan-2019
Paraphimosis	[TRUNCATED]Was due to get a circumcision last week for a paraphimosis. However he read up on the procedure online, and cancelled it as he was intimidated by the procedure. Pt would like to try a top	-	26-Jun-2018	26-Jun-2018
Chronic obstructive pulmonary disease	ECHO - good LV +RV function. No significant valvular disease. CXr no changes Unable to do spirometry. Still smoking plan add braltus Salbutamol Code as COPD. See PN in 4-6/52 for review.	-	02-May-2018	02-May-2018
Chronic obstructive pulmonary disease	-	-	02-May-2018	02-May-2018
Shortness of breath	[TRUNCATED]See CTPA result on portal - rigth heart strain. Spirometry in conclusive. Cough and loads of spit every morning Still smoking Never realised echo next week chest clear o2 sat 93-94 % walk	-	20-Apr-2018	20-Apr-2018
Cough	[TRUNCATED]to get an operation next Monday [circumcision], was seen at GRI - was told chest infection and had a CXR, had a course of antibiotics. CXR showed a calcified granuloma left upper/mid zone	-	15-Mar-2018	15-Mar-2018
Drug psychosis NOS	(in remission), Arran Centre	-	10-Oct-2016	10-Oct-2016
Drug withdrawal syndrome	psychotic symptoms on withdrawal from Heroin, A&E GRI	-	24-Jul-2016	24-Jul-2016
Heroin misuse	Continuing to use. Becomes psychotic when he stops. Treatment in hospital with DHC prevented this. Asking if practice can prescribe this for him. advised needs CAT referral. Patient agreed to this.	-	06-Jul-2016	06-Jul-2016
Testicular pain	bruised and swollen oe abdo soft no masses left testicle swollen and tender no evidence torsion rt ok advise analgesia try ice	-	18-Mar-2016	18-Mar-2016
[X]Assault	2/7 ago now pain daughetr on phone says in pain uncertainty what taken for pain I will phone hoim back	-	18-Mar-2016	18-Mar-2016
Heroin misuse	, GRI	-	20-Feb-2016	20-Feb-2016
Drug-induced hallucinosis	, GRI	-	20-Feb-2016	20-Feb-2016
Post-traumatic wound infection NEC	[TRUNCATED]injured r knee in blackout 2 weeks ago - then left GRI and went on hols for 2 weeks 3cm wound with surrounding cellulitis I initially suggested fluclox/TR attendance patient feels wound t	-	06-Oct-2015	06-Oct-2015
Wound observation	[TRUNCATED]walk in - injury to right knee on 20 or 21st sep and attended accident and emergency. signed himself out of hosp as thought was due to fly out on hol. went to tenerife for 2/52. self cari	Continuing	06-Oct-2015	06-Oct-2015
[V]Explanation of medication	Psych called. Olanzapine is to stop. Just for quetiepine now.	-	24-Apr-2015	24-Apr-2015
Constipation	[TRUNCATED]for last 4/7. No recent wt loss. Constant LIF pains worse on moving. No nausea/vomiting. No	-	13-Nov-2014	13-Nov-2014

	urinary symptoms. No pr blood. o/e slim, abdo soft, tender LIF, no guarding/rebound, bs active.			
Penile disorders NOS	[TRUNCATED]redness of glans of penis no urethral discharge no urinary symptoms no sores/ulcers sexually active, 1 partner for the last year, she was checked at GUM last month- fine o/e redness aroun	-	30-Apr-2014	30-Apr-2014
Discussion	not been referred anvil centre, crisis team probably best bet now 1700 given him the number	-	26-Feb-2014	26-Feb-2014
Discussion	with crisis team they will phone me back about getting him seen	-	26-Feb-2014	26-Feb-2014
Discussion	he cannot get to anvil centre today no money for bus fare will have money tomorrow would make it then message left duty cpn they will phone me back	-	26-Feb-2014	26-Feb-2014
Endogenous depression first episode	-	First ever	26-Feb-2014	26-Feb-2014
Depressed mood	[TRUNCATED]suicidal thoughts worse this week, saved up paracetamol last week but did not take. Needs seens urgently as I feel he is at risk. Keen to see someone, has good insight. Op last week went	-	26-Feb-2014	26-Feb-2014
Depressed mood	[TRUNCATED]smoking 2 bags heroin 10lb bags) twice a week. No alcohol. Suicidal thoughts but would not act. Looks down. Pinpoint pupils today. Has app at hosp this friday to have neck lump removed. H	-	19-Feb-2014	19-Feb-2014
Internal thrombosed haemorrhoids	, A&E GRI	-	20-Aug-2013	20-Aug-2013
Depressed mood	[TRUNCATED]discussed antidepressants, wants something to help with sleep. homeless and sleeping in a close several nights of the week. smoking heroin again. Attending counselling and now also attend	-	10-Jul-2013	10-Jul-2013
Discussion	never attended for bloods. scared needles. lump smaller but still present. o/e 1x1cm left sided submandibular lump. smooth. agreed will attend for bloods then review	-	10-Jun-2013	10-Jun-2013
Discussion	DWP lost last line. due tomorrow.	-	10-Jun-2013	10-Jun-2013
Lump on neck	left side. feels like a gland. No obvious source of infection. present a couple of weeks. Check bloods and review at next app in 2 weeks.	-	29-May-2013	29-May-2013
Referral to nurse	FBC, ESR, UES, LFTS,	-	29-May-2013	29-May-2013
Bereavement	[TRUNCATED]no app from CAT given they told him to see us I will call them today. Very down, not sleeping, having sucidal thoughts although would not act on them. All reactive to situation, no such t	-	09-May-2013	09-May-2013
Bereavement reaction	found 2 dead bodies feels stressed, unable to sleep at all see note KIG feels needs something to calm/get a sleep agreed to very short term hypnotic - not for repeat	-	01-May-2013	01-May-2013
Stress at home	[TRUNCATED]found friend dead in bed on Monday and the same morning then found brother in law hanging from ceiling. Feel she may revert to drug taking, has not used any drugs for 1.5 weeks. I will ca	-	01-May-2013	01-May-2013
Referral to nurse	please check UE previously mildly raised sodium	-	23-Apr-2013	23-Apr-2013
Back pain without radiation NOS	[TRUNCATED]past couple of weeks. low back. can't recall doing anything to injure back. worse on sitting/lying better if up and about. no radiation. no limb weakness/numbness. bowels ok. urinary symp	-	09-Apr-2013	09-Apr-2013
Referral to nurse	please check FBC, UE, PSA please also check urinalysis	-	09-Apr-2013	09-Apr-2013
Depressed mood	says attending drug worker next week needs sickline for 6weeks has job in 6weeks for council cutting grass is a 6month job	-	06-Feb-2013	06-Feb-2013
Dyspepsia	[TRUNCATED]recently attended gastroenterology for investigations of pancreatic abnormality but was found	First ever	23-Aug-2012	23-Aug-2012

	to be normal. He has persisting upper abdominal pain and his girlfriend who is a nurse thinks			
H/O: injury	laceration left thigh caused by hedge strimmers Not full thickness but will require to be cleaned and probably glue/suture to close	-	20-Jul-2012	20-Jul-2012
Discussion	has hard callous area on sole (L) foot advice given by sr McGougan but recommend podiatry self referral	Continuing	26-Jun-2012	26-Jun-2012
[D]Abdominal pain	[TRUNCATED]Worsening over past few weeks and associated with anorexia and weight loss. Pain felt and will abdomen and slight tenderness of sigmoid:. Claims pain is very severe at night and radiation	First ever	24-May-2012	24-May-2012
O/E - infected toe	5weeks ago toe nail removed rt gt toe sore looks infected on suboxone cannot see why cant take co-codamol can take with methadone	-	16-Mar-2012	16-Mar-2012
Referral to nurse	dressing right foot	-	16-Mar-2012	16-Mar-2012
Shoulder pain	[TRUNCATED]left-sided for 1/52 Also complaining of pain in left lateral neck and left upper arm No obvious trigger Not tried any analgesia so far O/E prominent acromioclavciular joint on right No fo	-	10-Feb-2012	10-Feb-2012
Fungal nail infection	? referred chiropody	-	25-Oct-2011	25-Oct-2011
Referral to nurse	syringe L ear	-	25-Oct-2011	25-Oct-2011
Earache symptoms	ear discomfort L ear tinnitus blocked with wax	-	25-Oct-2011	25-Oct-2011
Abnormal weight loss - symptom	[TRUNCATED]attended for review of weight loss lost 1 1/2 stone in 2 months diet unchanged weigth up 2 kg in the last week No dysphagia/abdo pain/aletered bowel habit/blood PR No cough/sputum/SOB No	-	08-Sep-2011	08-Sep-2011
Referral to nurse	Fbc, ferritin, iron studies, B12, folate, TFTs please	-	08-Sep-2011	08-Sep-2011
Abnormal weight loss - symptom	[TRUNCATED]says over last few weeks abdo pain wt loss on some benzo blocking drug was off for short time denies use illicit drugs just now sees drugs worker fortnightly box1 1 week ago normally dail	-	31-Aug-2011	31-Aug-2011
Referral to nurse	fasting glucose UE LFT	-	31-Aug-2011	31-Aug-2011
Referral to nurse	please check fasting glucose as random raised	Continuing	14-Jun-2011	14-Jun-2011
Cervicalgia - pain in neck	[TRUNCATED]on waking yesterday am Excruciating Radiates inferiorly and up to left shoulder and around chest Worse with movement Sore throat over the last week Feeling feverish No cough No sputum No	First ever	10-May-2011	10-May-2011
Chest pain	was in Barlinnie and taken to GRI - troponin negative - manages to play football weeky and no chest pain reassured	First ever	16-Dec-2010	16-Dec-2010
O/E - wax in ear	-	First ever	03-Nov-2010	03-Nov-2010
Referral to nurse	syringe ear please	First ever	03-Nov-2010	03-Nov-2010
[V]Issue of medical certificate	13/52 old hand and leg injuries, ND on subutex	-	13-Sep-2010	13-Sep-2010
Perianal itch	thought maybe worms - never seen these - discussed declined rectal exam - would like to try cream first - look out for worms	-	13-Sep-2010	13-Sep-2010
Onychogryphosis	r big toe given podiatry no	-	13-Sep-2010	13-Sep-2010
Enterobiasis - threadworm	daughter [25, granddaughter [5]	-	28-Jan-2010	28-Jan-2010
Ingrowing nail	big toe - looks clean - no inflammation, no infection, aprexcail - already referred podiatry.	-	28-Jan-2010	28-Jan-2010
Total nail avulsion	looks fungal. clipping sent. refer podiatry for removal.	-	27-Jan-2010	27-Jan-2010
Chest pain	- Troponin negative, Medical IP, GRI	-	29-Jul-2008	29-Jul-2008

Drug dependence NOS	acute psychotic episode	First ever	28-Jul-2006	28-Jul-2006
Benzodiazepine dependence	, Medical IP, GRI	First ever	28-Jul-2006	28-Jul-2006
[X]Heroin addiction	, Medical IP, GRI	First ever	28-Jul-2006	28-Jul-2006
Heroin dependence	smoking. Refer GDPS	-	03-May-2005	03-May-2005
Drug dependence	-	-	19-Aug-2003	19-Aug-2003
Drug dependence	relapse, Heroin, Cocaine, Diazepam	First ever	26-Jun-2002	26-Jun-2002
Deliberate self-harm	Diazepam overdose	First ever	09-May-2002	09-May-2002
Smoke inhalation	-	First ever	02-Apr-2002	02-Apr-2002
Cubital tunnel syndrome	Left medial epicondylectomy	First ever	04-Nov-1997	04-Nov-1997
Compartment syndrome	-	First ever	09-Mar-1997	09-Mar-1997
[X]Assault	-	First ever	17-Sep-1996	17-Sep-1996
[X]Assault	-	First ever	14-Feb-1987	14-Feb-1987
[X]Assault by sharp object	chest	First ever	11-Jul-1986	11-Jul-1986

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Chronic obstructive pulmonary disease annual review	[TRUNCATED]On timbow and SABA poor compliance with inhalers MRC grade 3/4 CAT 25- coughs often and increasingly SOB. States chest feels heavy and lots of phlegm. Pt states breathings holds him back	24-Nov-2023	24-Nov-2023
Bowel cancer screening programme	-	24-Oct-2023	24-Oct-2023
Advice to patient - subject	Type of advice given: Advice. NOTES: SR Doxycycline - not due for 1 month..	16-Oct-2023	16-Oct-2023
Rep.presc. monitoring NOS	-	08-Aug-2023	08-Aug-2023
Equivalent quantities for all medication checked	-	08-Aug-2023	08-Aug-2023
Uses monitored dosage system	-	08-Aug-2023	08-Aug-2023
Medication requested	[TRUNCATED]- acute request doxycycline - note started in March for rosacea Awaits Dermatology - referral in place Called to discuss - feels his skin is "80%" better but not back to normal Agreed con	21-Jun-2023	21-Jun-2023
Patient requests copy of medical record	1/10/22->present requested	03-Apr-2023	03-Apr-2023
Rep.presc. monitoring NOS	-	16-Mar-2023	16-Mar-2023
Equivalent quantities for all medication checked	-	16-Mar-2023	16-Mar-2023
Uses monitored dosage system	-	16-Mar-2023	16-Mar-2023
Patient reviewed	[TRUNCATED]1).right shoulder - discussed X-ray and agreed refer physiotherapy "I would be grateful for your review of this 59 year old patient who has presented with right shoulder pain On examinati	09-Dec-2022	09-Dec-2022
Rep.presc. monitoring NOS	-	07-Dec-2022	07-Dec-2022
Equivalent quantities for all medication checked	-	07-Dec-2022	07-Dec-2022
	-	07-Dec-2022	

Uses monitored dosage system			07-Dec-2022
Patient reviewed	[TRUNCATED]- Reports RTA in October as per entry 05/10/22 Was advised to attend MIU but did not go - states this was because he felt too anxious to be in waiting area Ongoing shoulder pain right sid	25-Nov-2022	25-Nov-2022
Prescription by supplementary prescriber	-	10-Nov-2022	10-Nov-2022
Medication review done by medicines management pharmacist	Due Date: 10/11/2023, Reviewing Clinician: 2,2357.	10-Nov-2022	10-Nov-2022
Medication review done by medicines management pharmacist	Due Date: 10/11/2023, Date of Review: 10/11/2022, Next Review Date: 10/11/2023, Reviewing Clinician: 2,2357.	10-Nov-2022	10-Nov-2022
Chronic obstructive pulmonary disease annual review	[TRUNCATED]Pt arrived and was disgruntled as could not get an appointment to see a doctor Poor compliance with inhaled therapy but does states breathlessness getting worse Encouraged to use inhalers	10-Nov-2022	10-Nov-2022
Admit COPD emergency	-	10-Nov-2022	10-Nov-2022
Number of COPD exacerbations in past year	1 x exacerbation which required hospital admission	10-Nov-2022	10-Nov-2022
Peripheral blood oxygen saturation on room air at rest	96 %. NOTES: HR 64.	10-Nov-2022	10-Nov-2022
Administration of first dose of SARS-CoV-2 vaccine	[TRUNCATED]Type: COVMODERNA, Stage: 1, Status: Given, Due Date: 14/10/2022, Method: Intramuscular, Source: Out of Practice, Batch No: 200020A. NOTES: C-19 Moderna (Glasgow Club Easterhouse - Public	14-Oct-2022	14-Oct-2022
Rep.presc. monitoring NOS	-	15-Sep-2022	15-Sep-2022
Equivalent quantities for all medication checked	-	15-Sep-2022	15-Sep-2022
Uses monitored dosage system	-	15-Sep-2022	15-Sep-2022
Rep.presc. monitoring NOS	-	04-Jul-2022	04-Jul-2022
Equivalent quantities for all medication checked	-	04-Jul-2022	04-Jul-2022
Uses monitored dosage system	-	04-Jul-2022	04-Jul-2022
Post hospital dischrge med reconciliation with medical notes	[TRUNCATED]GRI Ward C19 30/6/22 - 30/6/22 Michael presented with 7/7 history of productive cough and SOB - on examination there was bronchial breathing in the left lung, bloods showed WCC 9.6. CRP 6	01-Jul-2022	01-Jul-2022
Drugs not issued	Amoxycillin - Clarithromycin	01-Jul-2022	01-Jul-2022
Patient reviewed	[TRUNCATED]Very late for appt. Feels mental and physical health not good recently. Admits to taking street valium twice daily to calm himself down. Seen at ADRS yesterday - been referred for psychol	12-May-2022	12-May-2022
Injection of steroid into shoulder joint	Aseptic technique. Glenogumaral posterio approach 0.5ml 2% lidocaine bn 050502 exp 12/2023 Kenalog 40mg exp 01/2024 bn abw6474 No complications	30-Mar-2022	30-Mar-2022
Urine dipstick test	Result qualifier: Normal. NOTES: clear.	13-Jan-2022	13-Jan-2022
Immunisation course maintain protection against SARS-CoV-2	MAINT C-19 Booster Moderna (I Donnelly)	16-Dec-2021	16-Dec-2021
Administration of first dose of SARS-CoV-2 vaccine	[TRUNCATED]Type: COVMODERNA, Stage: 1, Status: Given, Due Date: 16/12/2021, Method: Intramuscular, Source: Out of Practice, Batch No: 3005688. NOTES: C-19 Booster Moderna (Glasgow Club Easterhouse	16-Dec-2021	16-Dec-2021
Pulse oximetry	93 %. NOTES: on air.	26-Nov-2021	26-Nov-2021

Chronic obstructive pulmonary disease monitoring	[TRUNCATED]Rev of trimbow inhaler Patient states he feels same is working well for him Not req to use salbutamol as much, less SOB, not coughing as much Like taking inhaler through aero chamber same	26-Nov-2021	26-Nov-2021
Chronic obstructive pulmonary disease monitoring	[TRUNCATED]Patient changed to step 3 today in COPD inhaler Feels current on Anorra not helping SOB ++ struggling at times to walk short distances Coughing ++ more so at night -, struggling to sleep	05-Nov-2021	05-Nov-2021
Advice to patient - subject	Type of advice given: Therapy, Advice printed on script: Yes. NOTES: You are not currently on the inhaler trelergy. Please await a further review from the practice nurse. .	14-Oct-2021	14-Oct-2021
Pulse oximetry	92 %.	14-Oct-2021	14-Oct-2021
Chronic obstructive pulmonary disease monitoring	[TRUNCATED]Was unable to carry out spiro to confirm COPD Patient states he stopped smoking appprox 6mths ago Reports that he hasnt been sleeping well last couple of nights and finds he can be more S	14-Oct-2021	14-Oct-2021
Blood oxygen saturation (calculated)	92.	04-Oct-2021	04-Oct-2021
BCSP faecal occult blood test normal	Result qualifier: Negative. NOTES: No action required.	10-Aug-2021	10-Aug-2021
Rep.presc. monitoring NOS	-	16-Jun-2021	16-Jun-2021
Equivalent quantities for all medication checked	-	16-Jun-2021	16-Jun-2021
Admin sec dose SARS-CoV-2 vacc	Type: COVOXFORD, Stage: 2, Status: Given, Due Date: 26/06/2021, Method: Intramuscular, Source: Out of Practice, Reason: Routine Measure, Batch No: PV46691. NOTES: C-19 AstraZeneca (By N Crawford).	26-May-2021	26-May-2021
Admin first dse SARS-CoV-2 vac	Type: COVOXFORD, Stage: 1, Status: Given, Due Date: 08/04/2021, Method: Intramuscular, Source: Out of Practice, Reason: Routine Measure, Batch No: PV46672. NOTES: C-19 AstraZeneca (By F Lundie).	08-Mar-2021	08-Mar-2021
Medication reconciliation	[TRUNCATED]IDL: Admission 16/2/21 - 18/2/21 to GRI with an acute drug induced psychosis following use of heroin. Follow up in community by care worker, Brenda Hay of NE ADRS. CXR showed patchy conso	19-Feb-2021	19-Feb-2021

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Tamsulosin 400microgram modified-release capsules	30	capsule	1 DAILY IN THE MORNING THIS I[more]	-	12-May-2022	05-Jun-2024
Trimbow 87micrograms/dose / 5micrograms/dose / 9micrograms/dose inhaler (Chiesi Ltd)	120	dose	2 PUFFS TWICE DAILY	-	26-Nov-2021	05-Jun-2024
Risperidone 2mg tablets	28	tablet	ONE AT NIGHT (AS PER PSYCH)	-	12-May-2022	05-Jun-2024
Creon 25000 gastro-resistant capsules (Viatris UK Healthcare Ltd)	56	capsule	1 CAP WITH SNACKS AS PER HOSP [more]	-	13-Mar-2023	05-Jun-2024
Creon 25000 gastro-resistant capsules (Viatris UK Healthcare Ltd)	168	capsule	3 CAPS THREE TIMES A DAY MEAL[more]	-	13-Mar-2023	14-Feb-2024
Salbutamol 100micrograms/dose inhaler CFC free	400	dose	2 PUFFS WHEN REQUIRED	-	02-May-2018	05-Jun-2024

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started

						Date last issued
Doxycycline 100mg capsules	84	capsule	ONCE DAILY FOR THREE MONTHS -[more]	-	05-Jun-2024	05-Jun-2024
NACSYS 600mg effervescent tablets (Alturix Ltd)	10	tablet	DISSOLVE ONE TABLET IN HALF A[more]	-	02-Feb-2024	02-Feb-2024
Tamsulosin 400microgram modified-release capsules	30	capsule	1 DAILY IN THE MORNING THIS I[more]	-	12-May-2022	09-May-2024
Risperidone 2mg tablets	28	tablet	ONE AT NIGHT (AS PER PSYCH)	-	12-May-2022	10-Apr-2024
Trimbow 87micrograms/dose / 5micrograms/dose / 9micrograms/dose inhaler (Chiesi Ltd)	120	dose	2 PUFFS TWICE DAILY	-	26-Nov-2021	02-Feb-2024

Blood Pressure

Date Recorded	Systolic	Diastolic
-	116	70

Body Measurements

Date Recorded	Height	Weight	BMI
-	1.74	52	17.1

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Ex smoker:	Smoking status on date of event: Ex-smoker. NOTES: vapes.	24-Nov-2023
Cigarette smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 10.	14-Feb-2020
Cigarette smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 15. NOTES: got a vapour product yesterday and plans to start this..	29-Jan-2019
Cigarette smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 15.	04-Dec-2018
Cigarette smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 15.	15-Mar-2018

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Referred By:Referring GP

Electronic Attachment Present:No

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

Clinic Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. K Walker
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Main Switchboard:	0141 211 4000
Department:	General Surgery
Contact Tel:	0141 201 6672
Enquiries to:	Kelly.Judge@ggc.scot.nhs.uk
Letter Date:	09/11/2023
Reference:	FMcG/AMcC
Dictated Date:	09/11/2023
Transcribed Date:	15/11/2023

Dear Dr. K Walker,

Michael McLachlan; D.O.B: 31 Dec 1962; CHI: 3112626230
FLAT 1-1, 10 GIRVAN STREET, Glasgow, Lanarkshire, G33 2DP

Attendance: Specialty - General Surgery; Clinic - GRDHGS8-MR D HOLROYD TELEPHONE CLINIC THURS PM
Date and Time of Appointment - 09/11/2023 15:30

Clinical Comments:
I had a telephone consultation with Mr McLachlan today. He underwent endoscopic ultrasound in February which showed evidence of chronic pancreatitis and microcalcifications within the gallbladder. This investigation was triggered by the finding of double duct sign on cross sectional imaging.

I explained these findings once again to Mr McLachlan and reassured him that we did not find anything worrying such as a cancer. I explained that we found evidence of chronic pancreatitis which is likely caused by consumption of cigarettes and alcohol over many years. The findings of microcalculi in the gallbladder are likely therefore incidental.

He continues to drink alcohol and he has replaced cigarettes with vapes. He doesn't describe any significant abdominal pains or biliary type symptoms but he does describe ongoing weight loss. I note that he has had a CT CAP in November last year which did no show any evidence of malignancy. He has been taking Creon and has been prescribed Ensures but does not take these as he does not like the taste.

In summary, regarding chronic pancreatitis, we would advise smoking and alcohol cessation along with pancreatic enzyme replacement therapy (Creon) and he also may benefit from a dietetics review. Regarding the incidental finding of microlithiasis within the gallbladder, he is asymptomatic from this

and would not be fit for cholecystectomy in any case given his diagnosis of severe COPD. I have therefore discharged him back to your care.

Kind regards.

Yours sincerely,

Dr Feidhlim McGivney

ST6 in General Surgery

Electronically Signed: Dr Feidhlim McGivney, Doctor

cc.

Clinical letter - GP: Discharge Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000
MSK Physiotherapy GRI

Dr. K Walker
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Main Switchboard:
Department:
Contact Tel:
Enquiries to:
Letter Date: 02/11/2023
Reference:
Dictated Date: 02/11/2023
Transcribed Date:

Dear Dr Walker ,

Michael McLachlan; D.O.B: 31/12/1962; CHI: 3112626230
FLAT 1-1, 10 GIRVAN STREET, Glasgow, Lanarkshire, G33 2DP

Michael attended the physiotherapy department on 21/04/2023 he was complaining of neck and shoulder pain following a whiplash type injury sustained following an RTA in Oct 2022.

He attended for his initial assessment was started on some exercises but failed to attend his review appointment on 19/06/2023 and has made no contact since.

He is now discharged.

Yours Sincerely

Linda Mercer

ESP physiotherapist (Orthopaedics)

Electronically Signed: ,

cc.

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000
Department: Acute Assessment Unit
Contact Tel: 0141 201 6655
Enquiries to: Megan Kelly
Letter Date: 31/08/2023
Reference: DR/NR
Dictated Date: 30/08/2023
Transcribed Date: 30/08/2023

Dr. K Walker
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Dear Dr Walker,

Michael McLachlan; D.O.B: 31/12/1962; CHI: 3112626230
FLAT 1-1, 10 GIRVAN STREET, Glasgow, Lanarkshire, G33 2DP

Mr McLachlan failed to attend for his follow-up chest x-ray organised for the 29th August 2023. No further follow-up has been organised by the Acute Medicine Team. Should he require further follow-up, please do not hesitate to rerefer.

Kind regards

Yours sincerely

Dr Daniel Rodgers

Consultant in Acute Medicine

Electronically Signed: Dr Daniel Rodgers, Consultant

cc.

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 04/08/2023

Consultant: Dr Emma Sur

K Walker
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
Glasgow
G32 7JZ

Dear K Walker

Re: **McLachlan Michael** DOB: **31/12/1962** CHI: **3112626230**
FLAT 1-1
Glasgow G33 2DP

Attended on: **21/07/2023 at 13:43 hrs.** Departed on: **21/07/2023 at 17:20 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **1**

Presenting complaint
chest pain

Nursing Assessment:
News 3 high viral risk. pleuritic chest pain and increased sob hx copd

Investigations in ED:

1. XR Chest	**2. Coagulation screen**	**3. Urea and Electrolytes**
4. Glucose	**5. LFT**	**6. CRP**
7. Full Blood Count	**8. Troponin I hs**	**9. Chol / Triglyceride**
10. XR Chest		

Diagnosis:

Diagnosis	Side	Site
Other Bacterial Pneumonia		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Any medication dispensed or changed is recorded in this letter in the free text below**

Clinician Notes:

3 days SOB and pleuritic chest pain. CRP 100. NEWS 0. CXR right midzone consolidation. Treated with doxycycline 5 day course. Follow up CXR requested for 6/52 post treatment.

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Sarah Saunders
Consultant

Copies to:

1. K Walker (GP)

School Address:

Ecg ✓
bloods ✓

Glasgow Royal Infirmary

CHI: 3112626230

20

ED COMPLETED

Total Att: 22
12 Mth Att: 1

Title: MR

MCLACHLAN Michael

DOB 31/12/1962 Age: 60y Sex: Male

FLAT 1-1
10 GIRVAN STREET
Glasgow
Lanarkshire
G33 2DP
07947416972

Next of kin: SHERLOCK, Martine
Relationship: Niece

GP: K Walker
0141 531 6220

Attendance Date: 21/07/2023 Arrival Time: 13:43
Registration Time: 13:43 Date of Incident: 21/07/2023
Major Incident Desc:

Reason for Attendance: chest pain

Nursing Assesement

Alerts: Not Recorded Allergies: None Known Pain Score:
Triage Category: 0 Tetanus up to date/fully immunised:
Presenting Complaint:

Observation Date: 21/07/2023 14:20 Nurse name: Nurse Lynne Nestor

Temp	36.8	C
HR	64	bpm
BP	107/71	mmHg
MAP	83.00	mmHg
RR	20	bpm
SpO2	88	%
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: "News 3 high viral risk. pleuritic chest pain and increased sob hx copd "

3112626230 31/12/1962 MCLACHLAN Michael
3112626230 31/12/1962 MCLACHLAN Michael
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3112626230 31/12/1962 MCLACHLAN Michael
3112626230 31/12/1962 MCLACHLAN Michael

Patient ID label

SATA/AAU MEDICATION DOCUMENTATION

NHS Greater Glasgow and Clyde

Once Only Prescriptions

Date	Drug	Dose	Route	Time	Prescriber (Print & Sign)	Given By	Time Given
21/7/23	Doxycycline	200mg	O	16rr		CB	1715

Discharge Medications

Date	Drug	Dose	Route	Time	Prescriber (Print & Sign)	Given By	Time Given
21/7	Cocodamol 30/500	x2	O	PRN		CB	1715
21/7	Doxycycline	100mg	O	OD	4/7	CB	1715

Glasgow Royal Infirmary
Acute Medicine Unit
(Part B - Medical Admission)

NHS
Greater Glasgow and Clyde

3112629230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Date & Time 21/1/23 16.45 Consultant Ward

Ward Review (Should be completed within 2hrs of transfer from ED)

Check List	
VTE	☐
Med - Rec	☐
Kardex	☐
CxR	☐
ECG	☐
Oxygen	☐
Patient on Bleeders list	☐

Rodgers Cons AAU

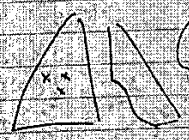
Issues (1) COPD
(2) (R) mid Pneumonia on CXR

Presents w/ ↑ SOB + Pleuritic chest pain

3/7 ↑ SOB

Vitals (R)
CRP 100
Temp 36
LCT's (R)
WCC 9.6
Hb 133
Plts 257
ECG
Sinus 56

No wheeze
(R) Some Pleuritic chest pain
on Noise on Resp Inspection
Struggling to ambulate 2° pain



(R) mid zone crepts
o wheeze
Taking Complete sentences

Plan
P. Doxy 5/7
Analgesia
Inhalers Review
CXR 6/52

Rodgers Cons.

MI - 270973-2 Part B Medical Admission V1_0 - GGC0015

NHS GG&C Adult Risk Assessment for Venous Thromboembolism (VTE)

NHS Greater Glasgow and Clyde

[excluding orthopaedics, obstetrics & ENT who have specialty-specific policies]

- **Risk Assessment must be completed for all patients within 24 hours of admission to hospital**
- **Patients must be reassessed every 48-72 hours or sooner if condition changes**
- **Reassessment must be documented in Kardex**
- **Please complete risk assessment and then sign and date Risk Assessment Result box at bottom of page.**

Pt Addressograph

Operative patients

Non-operative patients

Is the patient bed-bound or expected to have reduced mobility relative to normal state for > 2 days?

Yes ☐ No ☐

Does the patient have any risk factors for thrombosis? (tick √ all that apply)

Age >60 ☐	Use of oestrogen-containing contraceptive therapy ☐
Active cancer or cancer treatment ☐	Use of hormone replacement therapy or tamoxifen ☐
Dehydration ☐	Pregnancy or < 6 weeks post partum ☐
Known thrombophilias ☐	Critical care admission eg RDU/ITU ☐
Obesity (BMI>30) ☐	Surgical procedure with total anaesthetic/surgical time >90 min, or >60 min if surgery on lower limb or pelvis ☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or Inflammatory disease ☐	Acute surgical admission with inflammatory or intra-abdominal condition including Pelvic Inflammatory Disease ☐
	Hip fracture ☐
Personal history or first degree relative with a history of VTE ☐	All gynaecological surgery except uncomplicated gynaecological diagnostic day case procedures ☐
Varicose veins with phlebitis ☐	

- No thromboprophylaxis required.
- Continue to reassess every 48-72 hours or sooner if condition changes.
- Document all reassessments in drug kardex.
- Complete Risk Assessment Result Box.

Yes, 1 or more risk factors identified ☐ | **No risk factors identified ☐**

Indicators of high risk bleeding (tick √ all that apply)

Active bleeding ☐	Lumbar puncture, epidural/spinal anaesthesia ☐ • Expected within the next 12 hours • Within the previous 4 hours
Acquired bleeding disorders (e.g. liver failure) ☐	Other procedure with high bleeding risk – discuss with senior if unsure ☐
Concurrent use of other anticoagulants (e.g. warfarin, rivaroxaban, apixaban, edoxaban) is a contra-indication to additional pharmacological thromboprophylaxis ☐	Acute bacterial endocarditis ☐
Acute stroke (within 14 days) ☐	Surgery expected within the next 12 hours ☐
Persistent uncontrolled hypertension (BP > 230/120 mmHg) ☐	Trauma with high bleeding risk e.g. Head injury ☐
Thrombocytopenia (<75 x 10^9/l) ☐	eGFR <30ml/minute/1.73m² Dose reduction required ☐
Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands) ☐	Heparin induced Thrombocytopenia ☐
High risk of peri- or post-procedural bleeding, e.g. neurosurgery, spinal, posterior eye surgery and thyroid surgery ☐	

- Discuss with senior clinical staff before deciding to prescribe pharmacological prophylaxis
- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48-72 hours or sooner if condition changes.

No contraindications to pharmacological prophylaxis identified ☐ | **Contraindications to pharmacological prophylaxis identified ☐**

Operative patients – Enoxaparin 40mg + AES ☐*
*prior to application of AES, please check contraindications to AES

Non-operative patients – Enoxaparin 40mg ☐
Prescribe Enoxaparin at 6pm
[on day of surgery, at the later of either 4h post-op or 6pm]
Reduce Enoxaparin to 20mg if <50Kg or eGFR <30ml/minute/1.73m² ☐
If weight> 120kg, consider Enoxaparin 40mg bd (see StaffNet Guideline)
Discontinue at discharge or when returned to pre-morbid mobility

Contraindications to anti-embolism stockings (AES) Y ☐ N ☐

Peripheral neuropathy	☐
Peripheral arterial disease	☐
Cellulitis or Gross oedema	☐
Leg deformity or Fragile skin	☐
Leg / foot ulcers	☐
Allergy	☐
Unusual leg size/shape	☐

Risk assessment result – please tick √ all that apply

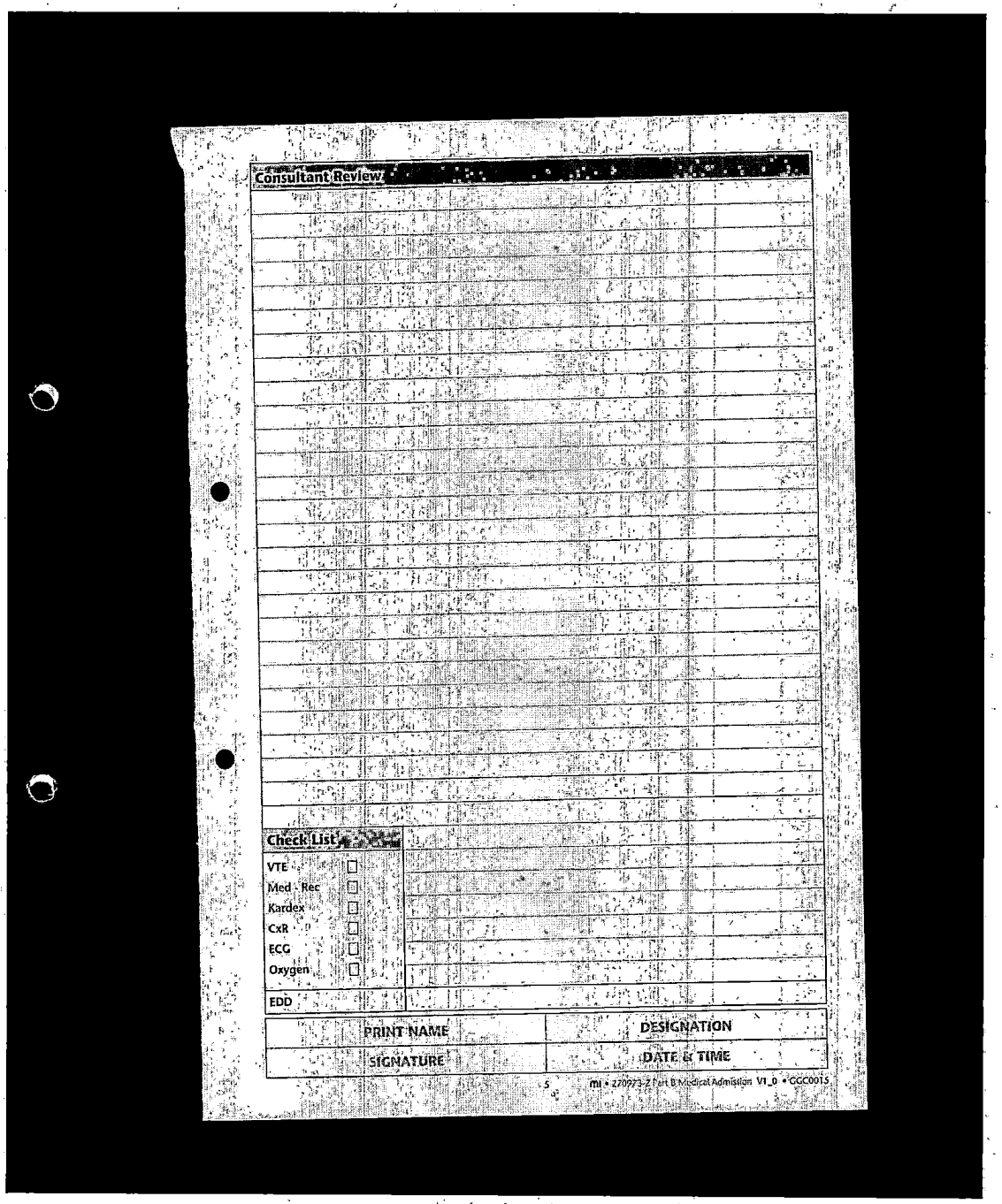
VTE risk factors: YES ☐ NO ☐ Indicators of high risk bleeding: YES ☐ NO ☐ Prescribed: LMWH ☐ AES ☐ NONE ☐

Patient informed of VTE risks and benefits of thromboprophylaxis YES ☐ NO ☐ N/A ☐ Information leaflet provided YES ☐ NO ☐

Print Assessor's Name: Signature: Date:

RAT-Medicine & Surgery – TEST OF CHANGE 09

mi • 250244 • Version 9_0 • GGC0015

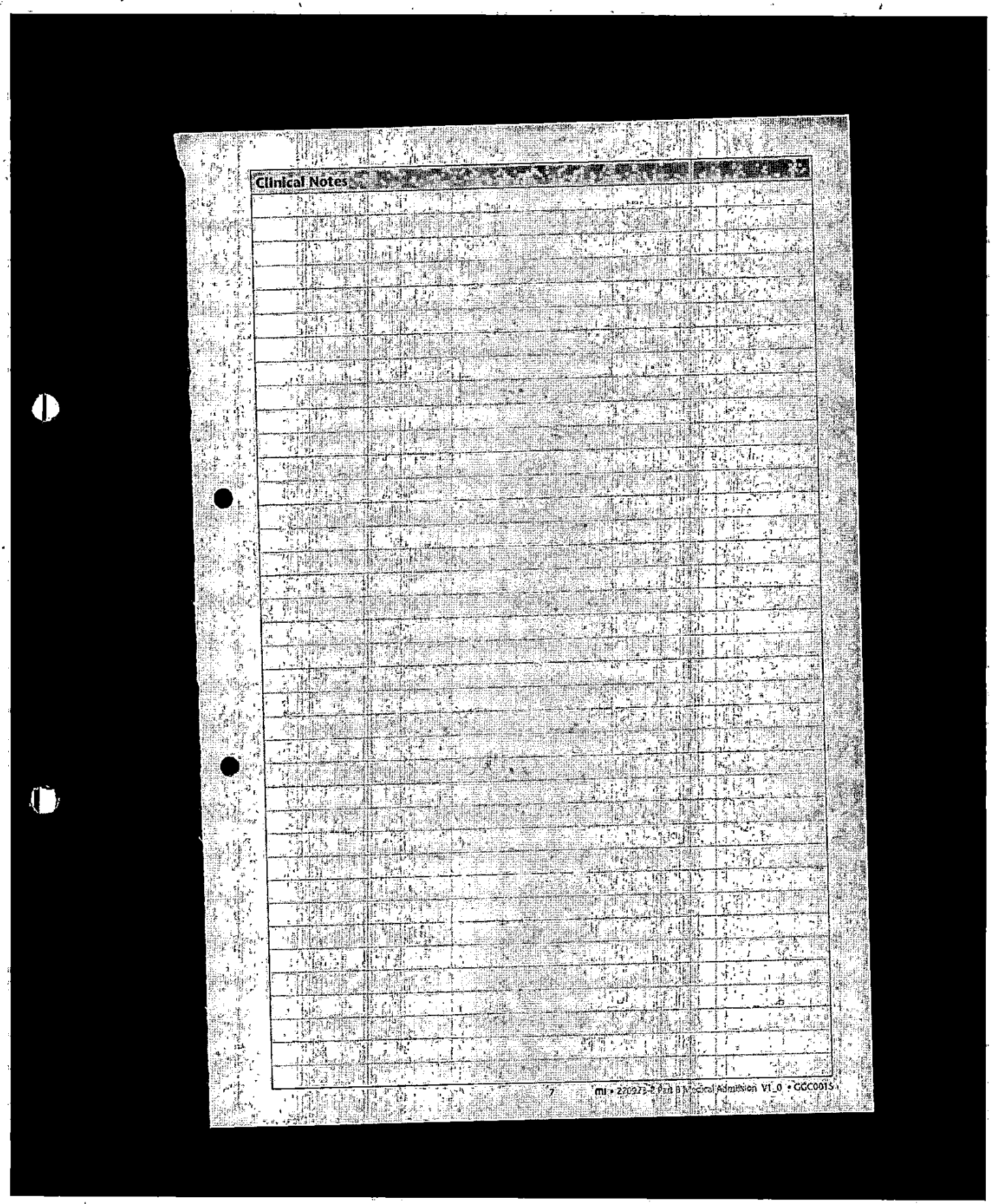


Consultant Review

Check List	
VTE	☐
Med - Rec	☐
Kardex	☐
CxR	☐
ECG	☐
Oxygen	☐
EDD	

PRINT NAME	DESIGNATION
SIGNATURE	DATE & TIME

mi • 270273-2 Part B Medical Admission V1_0 • CGC0015


Clinical Notes
7
mi • 220223_2 Part B Medical Admission V1_0 • CGC001S

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

3112826230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

1. Triage (Consider Mental Health Triage Assessment - if applicable)

Hospital: GRI	Patient Preferred Name:
Date: 21/7/23 Time: 1500	
Triage Nurse	Transport SAS/Self:

2. Presenting Complaint

Category ☐ Gap Score ☐

3. Observations

Allergies (including food allergies):

No Known allergies ☐ ✓

Resp. Rate	Sp02	Temperature	Pulse	Blood Pressure
GCS	**NEWS Score**	**PEFR**	**Blood Glucose**	**Pain Score**
/15				/10

4. Communication

I.D. band on? (Y) N

Relatives present? Y (N)

Relatives / NOK informed? Y (N)

Interpreter required? Y (N)

5. 4AT and TIME for Detection, Management, and Prevention of Delirium

Complete for patients: age 65 and over; patients of any age with an existing cognitive impairment; previous delirium; current hip fracture; or severe illness. These patients are at high risk of delirium. This should be done on admission; at each transition of care; if SQiD positive; or if any clinical concerns.

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name:
Address:

DOB:
CHI Number:

Communication with Relatives	Signatures	Time
Next of Kin: Tel:		

Nursing Notes		
Date and Time		Print Name and Signature

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name:

Address:

DOB:

CHI Number:

Nursing Notes

Date and Time		Print Name and Signature

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name:
Address:

DOB:
CHI Number:

Nursing Notes

Date and Time		Print Name and Signature

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name:

Address:

DOB:

CHI Number:

Pause for Transfer (Please tick when completed)		Tick when completed	N/A	Notes
	Relatives Informed	☐	☐	Information on discussion with relatives
	Cannula	☐	☐	
	Name Band	☐	☐	
	4AT	☐	☐	
	NEWS >7	☐	Always	
Snr Dr:	Page no:			
Prescriptions signed	Infusions	☐	☐	
	Drugs	☐	☐	
	Fluids	☐	☐	
	GMAWS	☐	☐	
GGC RED BAG - with patient		☐	☐	Please note here if any other tasks required prior to transfer
	Belongings (including patients medication)	☐	Always	
	Bed requested, accepted and ward informed/SBAR completed	☐	Always	
	Notes: medical notes, GP letter, PRF	☐	Always	
Investigations	CXR reviewed	☐		
	ECG reviewed	☐	☐	Print name
	Bloods sent	☐	☐	
	Bloods reviewed	☐	☐	
	Patient on O2: cylinder checked	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
GGC RED BAG - with patient	☐	☐	
Belongings (including patients medication)	☐	Always	
New medications explained	☐	☐	
PVC removed	☐	☐	
Relatives aware of Discharge	☐	☐	Please note here if any other tasks required prior to discharge
Social/Support Services required and contacted	☐	☐	
SAS Transport required and ref. no.	☐	☐	Print name
Other means of transport arranged by nurse	☐	☐	

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

	Date	Ward	Time
Admitted	31/12/25	A&E	15:07
Transferred			
Transferred			
Transferred			
Transferred			

SpO2 Scale 1
Target >96%

Signature:

Print Name:

Dr/ANP Initials ONLY:

Date:

SpO2 Scale 2
Target 88-92%

Signature:

Print Name:

Dr/ANP Initials ONLY:

Date:

Patient on home oxygen Y ☐ N ☐

If yes, add details of oxygen therapy

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed:

Medical:

Date:

Glasgow Coma Scale

Date																								
Time																								
Init																								
E Eye opening (4)	Spontaneous	4																						
	To speech	3																						
	To pain	2																						
	None	1																						
V Verbal response (5)	Oriented	5																						
	Confused	4																						
	Words	3																						
	Sounds	2																						
	None	1																						
M Motor response (6)	Obeys command	6																						
	Localises pain	5																						
	Withdraws from pain	4																						
	Abnormal flexion	3																						
	Extension	2																						
	None	1																						
	NT	NT																						
Assess level of pain (if possible)																								
A Alert (0)																								
V Responds to Voice (1)																								
P Responds to Pain (2)																								
U Unresponsive (3)																								
TOTAL																								

Pupil Reaction and size

s = sluggish
+ = reaction
– = no reaction
e = eye closed

Pupil Size (mm)

Pain Score – Ask the patient to rate his/her pain by using numerical scale 0 to 10 and tick the box below to assist the patient. If the patient is unable to communicate, use alternative pain scoring tools.

No Pain	Mild Pain	Moderate Pain	Severe Pain	
0	1 2 3	4 5 6	7 8 9 10	

Pain Function Score –

A	No limitations, activity unrestricted by pain or settles quickly.
B	Mild limitations, mild activity restrictions.
C	Moderate limitation, attempts but reluctant to continue because of pain. **Seek Advice**
D	Severe limitations, unable to or refuse to perform because of pain. **Urgent Review Required**

Affix Patient ID

RM • 31654 • v5 • CCC0224

NEWS 2 Key | 1 | 2 | A |

| | | |

Clinic Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. K Walker
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Main Switchboard: 0141 211 4000
Department: General Surgery
Contact Tel: 0141 201 6672
Enquiries to: Kelly.judge@ggc.scot.nhs.uk
Letter Date: 21/04/2023
Reference: DC/MAJ
Dictated Date: 21/04/2023
Transcribed Date: 26/04/2023

Dear Dr. K Walker,

Michael McLachlan; D.O.B: 31 Dec 1962; CHI: 3112626230
FLAT 1-1, 10 GIRVAN STREET, Glasgow, Lanarkshire, G33 2DP

Attendance: Specialty - General Surgery; Clinic - GRDCHGS9-D CHANG FRIDAY-AM
Date and Time of Appointment - 21/04/2023 11:10

Clinical Comments:
I carried out a telephone consultation with Mr Michael McLachlan at pancreatic clinic today.

I suspect he may have been double booked onto the clinic as he was recently seen by my colleague Mr David Holroyd on 08/03/23 with the same issue. He explains that he remains well and asymptomatic from his gallbladder point of view since he last spoke to my colleague a few weeks back. I also note in the system that he has an appointment to come back and see my colleague Mr Holroyd in 6 months time.

Please get in touch if there is anything else I can help with in the meantime.

Kind regards.

Yours sincerely,

Professor David K. Chang,

MBBS. MS. FRACS. FRCS(Glasg). PhD

Professor of Surgical Oncology, University of Glasgow

Honorary Consultant HPB Surgeon, Glasgow Royal Infirmary.

Electronically Signed: Mr David Chang, Consultant

cc. Mr David Holroyd
Consultant HPB Surgeon
Glasgow Royal Infirmary

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Dermatology GGC General Referral	—	**Consultant / receiving practitioner** and/or **specialty clinic**
Glasgow Royal Infirmary 84 Castle Street Glasgow G4 0SF	—	**Hospital** and **hospital address** Hospital location code. G107H Email address -

Urgency of referral Routine
Date of referral 16-Mar-2023 **Date sent** 16-Mar-2023

PATIENT DETAILS

Surname	MCLACHLAN
Forename(s)	MICHAEL
Title	MR
Sex	Male
Date of birth	31-Dec-1962
CHI no.	3112626230
Area of Residence	-

Patient's address

1-1
10 GIRVAN STREET
GLASGOW
G33 2DP

Contact number(s)

Voice: 07947 416 972

1010290481987

Unique Care Pathway Number: 1010290481987

REGISTERED GP DETAILS

Name	Dr Kerry Walker		
GMC code	7020285	GP code	02135
Practice name	The Cairns Practice		
Practice code	46081		

Practice address

420 OLD SHETTLESTON ROAD
SHETTLESTON
GLASGOW
G32 7JZ

Contact number(s)

Voice: 01415316220

REFERRING GP DETAILS

Name	Dr Stacey Grant		
GMC code	7460755	GP code	05282
Practice name	The Cairns Practice		
Practice code	46081		

Practice address

420 OLD SHETTLESTON ROAD
SHETTLESTON
GLASGOW
G32 7JZ

Contact number(s)

Voice: 01415316220

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: rosacea

Comment: redness and pustules across both cheesk. evidence of rhinophyma not responded to rozex.

try doxycline od for 3months
soolantra instead of rozex
wash with water or dermol

pt very keen for derm referral. feels symptoms have got much worse in short space of time. agree mod-severe rosacea with rhinophyma. would be grateful for your review.

Reason for referral

Care type requested: Out Patient
Expected outcome: Not Specified

Past medical history
Pre-existing conditions (High & medium priority - all)

Description	Comment	Modifier	Date of onset	Date recorded
Chronic pancreatitis	, Surgical OP, GRI	-	08-Mar-2023	08-Mar-2023
Gallstones	- microcalculi within the gallbladder, Surgical OP, GRI	-	08-Mar-2023	08-Mar-2023
Pneumonia due to unspecified organism	- left upper lobe with a possible hilar prominence, Medical IP, GRI	-	30-Jun-2022	30-Jun-2022
Coronavirus infection	-	-	20-Dec-2021	20-Dec-2021
Inguinal hernia	- right, Surgical OP, GRI	-	23-Apr-2021	23-Apr-2021
Heroin misuse	, Medical IP, GRI	-	16-Feb-2021	16-Feb-2021
Chest infection NOS	, Medical IP, GRI	-	16-Feb-2021	16-Feb-2021
Drug psychosis NOS	, Medical IP, GRI	-	16-Feb-2021	16-Feb-2021
Drug psychosis NOS	Possible, Arran Resource Centre	-	21-Apr-2020	21-Apr-2020
O/E - collapse - syncope	, A&E GRI	-	24-Jan-2020	24-Jan-2020
Chronic obstructive pulmonary disease	-	-	02-May-2018	02-May-2018
Drug psychosis NOS	(in remission), Arran Centre	-	10-Oct-2016	10-Oct-2016
Drug withdrawal syndrome	psychotic symptoms on withdrawal from Heroin, A&E GRI	-	24-Jul-2016	24-Jul-2016
Heroin misuse	, GRI	-	20-Feb-2016	20-Feb-2016
Drug-induced hallucinosis	, GRI	-	20-Feb-2016	20-Feb-2016
Endogenous depression first episode	-	First ever	26-Feb-2014	26-Feb-2014
Internal thrombosed haemorrhoids	, A&E GRI	-	20-Aug-2013	20-Aug-2013
Drug dependence NOS	acute psychotic episode	First ever	28-Jul-2006	28-Jul-2006
Benzodiazepine dependence	, Medical IP, GRI	First ever	28-Jul-2006	28-Jul-2006
[X]Heroin addiction	, Medical IP, GRI	First ever	28-Jul-2006	28-Jul-2006

Drug dependence	relapse, Heroin, Cocaine, Diazepam	First ever	26-Jun-2002	26-Jun-2002
Deliberate self-harm	Diazepam overdose	First ever	09-May-2002	09-May-2002
Smoke inhalation	-	First ever	02-Apr-2002	02-Apr-2002
Cubital tunnel syndrome	Left medial epicondylectomy	First ever	04-Nov-1997	04-Nov-1997
Compartment syndrome	-	First ever	09-Mar-1997	09-Mar-1997
[X]Assault	-	First ever	17-Sep-1996	17-Sep-1996
[X]Assault	-	First ever	14-Feb-1987	14-Feb-1987
[X]Assault by sharp object	chest	First ever	11-Jul-1986	11-Jul-1986

Past procedures (High and medium priority - all)

Description	Comment	Modifier	Date performed	Date recorded
Plain x-ray of chest	- shows a calcified graniloma in the left mid zone, SHC	-	02-Mar-2018	02-Mar-2018
Drug addiction therapy	- Buprenorphine 12mg, Newlands Centre	-	18-Jan-2018	18-Jan-2018
Drug addiction therapy	- Suboxone, Newlands Centre	-	05-Sep-2016	05-Sep-2016
Excision of submandibular gland	- left, ENT OP, GGH	-	21-Feb-2014	21-Feb-2014
Drug addiction therapy	Suboxone treatment patient defaulted, EAST CAT	-	06-Sep-2012	06-Sep-2012
Drug addictn therap-methadone	, Addiction Services, Parkhead Hospital	First ever	17-Oct-2006	17-Oct-2006
Primary arthrodesis of joint NEC	5th PIP joint	First ever	18-Mar-1997	18-Mar-1997
Primary repair of tendon	-	First ever	02-Jan-1997	02-Jan-1997
Primary repair of tendon	-	First ever	19-Oct-1996	19-Oct-1996
[SO]Ulnar nerve - hand	divisions	First ever	07-Mar-1996	07-Mar-1996
Exploration of skin wound NEC	and repair of machete wound	First ever	09-Mar-1986	09-Mar-1986

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Creon 25000 gastro-resistant capsules (Viatris UK Healthcare Ltd)	56	capsule	1 CAP WITH SNACKS AS PER HOSP [more]	-	13-Mar-2023	13-Mar-2023
Creon 25000 gastro-resistant capsules (Viatris UK Healthcare Ltd)	168	capsule	3 CAPS THREE TIMES A DAY MEAL[more]	-	13-Mar-2023	13-Mar-2023
Tamsulosin 400microgram modified-release capsules	30	capsule	1 DAILY IN THE MORNING THIS I[more]	-	12-May-2022	20-Feb-2023
Risperidone 2mg tablets	28	tablet	ONE AT NIGHT (AS PER PSYCH)	-	12-May-2022	20-Feb-2023
Trimbow 87micrograms/dose / 5micrograms/dose / 9micrograms/dose inhaler (Chiesi Ltd)	120	dose	2 PUFFS TWICE DAILY	-	26-Nov-2021	13-Feb-2023
Salbutamol 100micrograms/dose inhaler CFC free	400	dose	2 PUFFS WHEN REQUIRED	-	02-May-2018	10-Nov-2022

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Soolantra 10mg/g cream (Galderma (UK) Ltd)	45	gram	APPLY ONCE DAILY FOR 3 MONTHS	-	16-Mar-2023	16-Mar-2023
Doxycycline 100mg capsules	84	capsule	ONCE DAILY FOR THREE MONTHS -[more]	-	16-Mar-2023	16-Mar-2023
Dermol 500 lotion (Dermal Laboratories Ltd)	500	ml	USE THIS TO WASH WITH	-	16-Mar-2023	16-Mar-2023
Difflam 0.15% spray (Viatris UK Healthcare Ltd)	30	ml	4-8 PUFFS EVERY 1.5-3 HOURS A [more]	-	01-Feb-2023	01-Feb-2023
Co-codamol 30mg/500mg tablets	60	tablet	2 UP TO FOUR TIMES A DAY WHEN [more]	-	01-Feb-2023	01-Feb-2023
Rozex 0.75% cream (Galderma (UK) Ltd)	40	gram	APPLY SPARINGLY TWICE DAY	-	10-Nov-2022	10-Nov-2022
EasyChamber Spacer with adult mask (TriOn Pharma Ltd)	1	device	AS DIRECTED	-	10-Nov-2022	10-Nov-2022
Stexerol-D3 1,000unit tablets (Kyowa Kirin Ltd)	90	tablet	1 DAILY	-	07-Nov-2022	07-Nov-2022
Tamsulosin 400microgram modified-release capsules	30	capsule	1 DAILY IN THE MORNING THIS I [more]	-	12-May-2022	02-Dec-2022
Risperidone 2mg tablets	28	tablet	ONE AT NIGHT (AS PER PSYCH)	-	12-May-2022	03-Nov-2022

Blood Pressure

Date Recorded	Systolic	Diastolic
-	116	70

Body Measurements

Date Recorded	Height	Weight	BMI
-	1.74	58	19.1

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Cigarette smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 10.	14-Feb-2020
Cigarette smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 15. NOTES: got a vapour product yesterday and plans to start this..	29-Jan-2019
Cigarette smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 15.	04-Dec-2018
Cigarette smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 15.	15-Mar-2018
Current smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 10.	07-Oct-2015

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Referred By:Referring GP
Electronic Attachment Present:No

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

Clinic Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000
Department: General Surgery
Contact Tel: 0141 201 6672
Enquiries to: Kelly.judge@ggc.scot.nhs.uk

Letter Date: 08/03/2023
Reference: DH/MAJ
Dictated Date: 09/03/2023
Transcribed Date: 15/03/2023

Dr. K Walker
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Dear Dr. K Walker,

Michael McLachlan; D.O.B: 31 Dec 1962; CHI: 3112626230
FLAT 1-1, 10 GIRVAN STREET, Glasgow, Lanarkshire, G33 2DP

Attendance: Specialty - General Surgery; Clinic - GRDHGSI-MR D HOLROYD GS ADHOC CLINIC
Date and Time of Appointment - 08/03/2023 17:15

Clinical Comments:
I met with Michael McLachlan in HPB clinic this evening. He is a 60 year old gentleman who presented to the Acute Medical Unit last year with respiratory symptoms. His blood tests demonstrated LFT derangement and a CT on the 4th August showed CBD dilatation up to 11mm and a prominent pancreatic duct. There were no mass lesions present and a subsequent MRCP on the 14th November demonstrated similar findings to the CT scan. There was no progression evident on this and we reviewed his imaging in MDT a couple of weeks ago. He underwent an EUS on the 1st February and this showed some microcalculi within the gallbladder with mild biliary and pancreatic ductal dilatation, the latter to a maximum of 5mm. The endoscopic appearances were consistent with chronic pancreatitis and microcalculi. There were no periampullary lesions and I have reassured him regarding this today.

He is essentially asymptomatic and does not describe any abdominal pain. His appetite is fairly poor and his BMI in clinic today was 19.6. His bowels are fairly regular, although he does suffer from some constipation from time to time, but he does not have any obvious symptoms of exocrine insufficiency. His blood glucose was 5.5 today.

He is an ex-smoker and currently uses vapes. He drinks occasionally, approximately 2-3 pints of lager per week. I discussed lifestyle modification with him today. He has a background of COPD and struggles to walk any significant distance. He certainly could not manage a flight of stairs and needs to stop on a couple of occasions. Although he has microcalculi, he is asymptomatic from this

NHS
Greater Glasgow and Clyde

Patient Label
1112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

The patient attended HPB Clinic at C2 L

Hospital on 8/3/23 and I would advise a change to drug therapy from

_____ to _____

or additional therapy of Creon

as detailed below. Full letter to follow.

Additional Comments: _____

DRUG (print)	DOSE	FREQUENCY	DURATION / REVIEW DATE
Creon	75000 units	with Meals TDS	
	25000 units	with Snacks	

Yours Sincerely

Signature:

Name (print) Hamad Grade: Cons. Ext. No: 60659

White copy to - G.P. Pink copy - *File this copy in Case Records*

00545 GGC0004

MDT letter:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Dr Daniel Rodgers
Consultant in Acute Medicine
Acute Medicine Unit
Glasgow Royal Infirmary

Main Switchboard: 0141 211 4000
Department: General Surgery
Contact Tel: 0141 201 6665
Enquiries to: Karen.Burns@ggc.scot.nhs.uk
Letter Date: 10/02/2023
Reference: ED/AMcC
Dictated Date: 09/02/2023
Transcribed Date: 09/02/2023

Dear Dr Rodgers,

Michael McLachlan; D.O.B: 31/12/1962; CHI: 3112626230
FLAT 1-1, 10 GIRVAN STREET, Glasgow, Lanarkshire, G33 2DP

Many thanks for referring the above 60 year old gentleman whom we discussed today in the pancreatic MDM.

He attended the Assessment Unit with deranged liver function tests in September and had a subsequent MRCP which demonstrated a dilated bile duct for which he had an EUS on 01/02/23. It is noted at the time of EUS that his LFTs in October 2022 were normal. The CBD was 11mm with a smooth taper to the ampulla. The PD was dilated to 5mm in the head and irregularly dilated in the body and tail. There was no ampullary mass and the ampulla appeared normal on endoscopy. Several tiny microcalculi were noted. FNB was taken from the ampulla for completeness but overall the appearances were thought to represent CP and microcalcs, which does not demonstrate any concerning features.

MDM Opinion:

No concerning features on radiology or EUS.

Management Plan:

1. We will review Mr McLachlan in the outpatient clinic to discuss the option of laparoscopic cholecystectomy as it may be that he has passed small stones as a cause for his intermittently deranged LFTs. This would however be dependent upon his symptoms and wishes.
2. We will write to you again following this.

With kind regards.

Yours sincerely,

Mr Euan Dickson

Consultant Surgeon, West of Scotland Pancreatic Unit

Surgical Lead for Critical Care

Regional Lead for HPB Managed Clinical Network, GRI

Dictated, but not signed, by Mr Euan J Dickson to minimise delay. Please contact the Pancreatic Unit if clarification required.

Electronically Signed: ,

cc. Dr K Walker
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow,
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 03/02/2023

Consultant: Dr Ryan Connelly

K Walker
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
Glasgow
G32 7JZ

Dear K Walker

Re: **McLachlan Michael** DOB: **31/12/1962** CHI: **3112626230**
FLAT 1-1
Glasgow G33 2DP

Attended on: **02/02/2023 at 16:41 hrs.** Departed on: **02/02/2023 at 20:35 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **2**

Presenting complaint
chest infection

Nursing Assessment:
?URINE RETENTION. NEWS 3. Pt BIBA c/o back pain. Attended GP today who advised ED. Pt states not passed urine since 10:00am.had endoscopy 1/7 - sampling liver and bladder. Also c/o throat pain. Reduced appetite for 2/52.

Investigations in ED:
1. Full Blood Count **2. CRP** **3. Urea and Electrolytes**
4. LFT **5. XR Chest**

Diagnosis:

Diagnosis	Side	Site
General Medical Examination		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:

***NO GP ACTION* Referred ?retention but passing urine independently. mildly SOB but CXR NAD, bloods unremarkable and obs normal. Discharged home**

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Joshua Waddell
Doctor

Copies to:

1. K Walker (GP)

School Address:

CHI: 3112626230

Glasgow Royal Infirmary

(9)

Total Att: **21**

12 Mth Att: **2**

Title: **MR**

MCLACHLAN **Michael**

DOB **31/12/1962** Age: **60y** Sex: **Male**

FLAT 1-1
10 GIRVAN STREET
Glasgow
Lanarkshire
G33 2DP
07947416972

Next of kin: **SHERLOCK, Martine**
Relationship: **Niece**

GP: **K Walker**
0141 531 6220

Attendance Date: **02/02/2023** Arrival Time: **16:41**

Registration Time: **16:41** Date of Incident: **02/02/2023**

Major Incident Desc:

Reason for Attendance: **chest infection**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **02/02/2023 17:06** Nurse name: **Nurse Chloe Bilsland**

Temp	**35.3**	C
HR	**55**	bpm
BP	**106/57**	mmHg
MAP	**73.33**	mmHg
RR	**18**	bpm
SpO2	**95**	%
Oxygen		%

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

GCS	
Eyes	**4**
Motor	**6**
Verbal	**5**
Total	**15**

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

Nursing Notes: **?URINE RETENTION. NEWS 3. Pt BIBA c/o back pain. Attended GP today who advised ED. Pt states not passed urine since 10:00am.had endoscopy 1/7 - sampling liver and bladder. Also c/o throat pain. Reduced appetite for 2/52.**

3112626230 31/12/1962 MCLACHLAN Michael

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To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

Date	**Clinical Notes**	
	Seen By	Time Seen

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By

Glasgow Royal Infirmary
Emergency Department

NHS
Greater Glasgow and Clyde

3112626230
MCLACHLAN
Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP
M
31/12/1962

Initial Investigations Ordered										
FBC ☐	COAG ☐	DD ☐	INR ☐		G+S ☐		X-match units			
U+Es ☐	LFT ☐	GLU ☐	CRP ☐	TROP ☐	Para ☐	Sal ☐	Ethanol ☐	Mg ☐	VBG ☐	ABG ☐
B culture ☐		C/MSSU ☐		Urinalysis ☐		BHCG ☐		Other		
CXR ☐	AXR ☐	Other imaging:								ECG ☐
Current location:								Sent by:		

Clinical Notes

Date 02/02/23 Time 19:30 Name Rebecca Shell Grade SHO Specialty A&E

60 ♂

PC: back pain

HPC: Concerned LRTI due to back pain overlying left scapula. Nil productive cough / SOB / fevers. — similar symptom prev pneumonia / L pain present for a number of weeks

Complaining sore throat - endoscopy yesterday. GP has given diflam and co-codamol. Able to EAD. — dilated CBD & deranged LFTs

Issues with passing urine, nil dysuria / haematuria. Nil abdo pain. Seeing urology for PTH

PMHx: BPH, prev pneumonia, deranged LFTs, dilated CBD - under IX, COPD

Meds: Tamsulosin, Risperidone, Trimbow, Salbutamol

Soc:

Obs - temp 35.3, HR 55, BP 106/57, RR 18, Sats 95%

On examination:
HS 1+II +0
Chest - reduced air entry @ lung bases
Abdo SNT
Calves SNT
P.T.O

Glasgow Royal Infirmary
Emergency Department

3112626230
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Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Clinical Notes

Date	Time	Name	Grade	Speciality

ECG - Sinus brady, peaked T waves, RAD, HR 50

Impression: HRT ?

Plan: 1) bloods 2) bladder scan
3) CXR
4) likely (IV) +/- Mox

20/4/

J. Waddell - GP SHO cover

Pt handed over - Hx noted.

feels well.

bloods unremarkable

obs NAD: news 3.

O_2 89% RA (target 88-92)
RR 16
HR 63
BP 91/62
temp 35.5

bladder scan 30ml

P

Plan: D/C (IV)

J Waddell SHO cover

Glasgow Royal Infirmary
Emergency Department

3112626230
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Michael 31/12/1962
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10 GIRVAN STREET
Glasgow, Lanarkshire
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Clinical Notes

Date	Time	Name	Grade	Speciality

Glasgow Royal Infirmary
Emergency Department

3112626230 M
MCLACHLAN 31/12/1962
Michael
FLAT 1-1
10 GIRVAN STREET
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G33 2DP

HAEM	DATE or TIME		BIOCH	DATE or TIME			DATE or TIME		V/ABG	DATE or TIME	
WCC	8·8		Na	142		Bil	7		FiO_2		
Hb	146		K	4.5		ALT	17		H^+		
Plat	220		Cl	107		AST	23		$PaCO_2$		
Neut			Ur	7.3		GGT			PaO_2		
DD			Creat	82		A phos	80		Bic		
PT			eGFR	760		Alb	37		BE		
PTT			Glu			AdjCa			Lactate		
TT			CRP	5		Amyl			Ethanol		
INR			Mg			TropI HS			Para		
			Phos			BHCG			Sal		

Diagnosis and Plan

Review/Discussed with:

Handover

- ☐ Provisional Diagnosis
- ☐ Liquids/Fluids
- ☐ Analgesic/Medicines
- ☐ NEWS
- ☐ Investigations & Results
- ☐ Talk to receiving team/ward

mt • 287967 Version 1_0 • GGC0226

(9)

Emergency Department Nursing Documentation

Presenting Complaint -

Date: 02/02/23 Time: 1844

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET ibel
Glasgow, Lanarkshire
G33 2DP

NHS Greater Glasgow and Clyde

Assessment Complete by: Name NURSE (Please Print) KAYLEIGH | SOPHIE

Patient Prep / Investigations (Please tick/circle when completed)		Communication (Please Circle Tick)	
Prepare patient for examination / Clothing bag labelled + stored	☐	NEWS Chart complete / NEWS SCORE - (Record pain, blood sugar and Neuro Obs on NEWS Chart)	☑
GGC RED BAG - with patient	☐		
12 Lead ECG	☐	ID Band	☐
Weight:	☐	Peak Flow	☐
Blood Samples Obtained: Yes ☐ No ☐		Xrays / CT Scan Performed:	☐
IV Access: Yes ☐ No ☐		Relatives / NOK informed (Carers)	☐
Blood Gas: VBG ☐ ABG ☐		Child Protection Concern (considered in line with policy)	Y/N
		Adult Support and Protection	Y/N

Urinalysis

Leucocytes	☐	Nitrites	☐	Protein	☐	Blood	☐
Ketones	☐	Glucose	☐	PH		S.G.	
MSSU / CSU	☐	Toxiclogy	☐				
HCG	☐	+VE	☐	-VE	☐	Strip No -	

Screening Tools (Please tick/circle when completed)			
SEPSIS RISK? / SIRS Criteria 2 or more	Y/N	**SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)**	YES
Mental Health Triage Assessment	Y/N	If NOT WHY? - (details)	NO
GMAWS	Y/N	Date - 02/02/23 Time - 1845 Signature -	

4AT	
AMT	Correct
Age	
Date of Birth	
Place	
Current year	

No mistakes	= 0
1 mistake	= 1
> 1 mistake	= 2

Attention (months of year backwards)	
> = 7 correct	0
< 7 correct	1
Untestable	2

Alertness	
Normal	0
Mild sleepiness	0
Clearly abnormal	4

Mental status according to family/carer		
Acute change or fluctuating	4	YES
Acute change or fluctuating	0	NO

4AT score /12

STEP 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?

All over 75s and care home residents over 65. For younger patients use clinical judgement and consult local guidelines.

		YES	NO
F	**F**unctional impairment (new or worsening) eg difficulty with self care		
R	**R**esident in a care home?		
A	**A**ltered mental state such as acute confusion or dementia use the 4AT		
I	**I**mmobility/instability. New decline in mobility, difficulty mobilising without help or fall leading up to admission		
L	**L**ikely to require support for discharge? (either new or increase in existing support)		

Are any of the above criteria met? If YES to any of the above move to step 2

STEP 2 Would this person be better managed by another specialty team at present?

Indicator for care by another acute specialty regardless of age.

	YES	NO
Clear need for other specialty input eg exacerbation of known long term condition such as COPD		
Need for HDU/ITU (including non-invasive ventilation)		
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit		
Head injury with loss of consciousness		
Acute abdominal pain/surgical presentation		
Upper GI Bleed		
Chest pain with suspected acute coronary syndrome		
Trauma with suspected fracture		

Are any of the above criteria met?

If **YES** to any criteria in step 2:

- Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.

If **NO** to the list in step 2:

- Prioritise transfer of care to specialist geriatric assessment service in line with local guidance.

Screening Tools / ACTIVE CARE

(Please tick/circle when completed)

1) Pressure Damage Does the person have redness and/or existing damage? If YES - continue with a minimum of 2 hourly Active Care + Complete PUDRA		Y/N	**Date**	**Location of Redness/Ulcers**	**Grade of Ulcer**
			Independent		
2) Mobility	Does the person require assistance?	Y/N			
3) Continence		Y/N	**5) Skin**	Is skin compromised by other source, eg neurological deficit, medication, substance, diabetes, co-morbid?	Y/N
4) Nutrition		Y/N	**6) Judgment**	In your clinical judgment is this person at risk for developing pressure damage? IF YES - DETAILS	Y/N

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.

3112626230
MCLACHLAN
Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
M
31/12/1962
Label
G33 2DP

At risk of falls?
(clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc) *At risk complete risk assessment*

YES	(NO)

Pause for Transfer / Discharge (Please tick when completed)		Tick when completed	N/A	Notes
Relatives Informed of Admission / Discharge		☐	☐	Information on discussion with relatives
Relatives/carer with patient on transfer to ward		☐	Always	
GGC RED BAG - with patient		☐	Always	
Name Band		☐	Always	
Nursing Screening Tools completed		☐	Always	
Bed requested, SBAR COMPLETE		☐	☐	
NEWS chart		☐	Always	
Prescriptions / Charts signed	Infusions	☐	☐	
Cannula		☐	☐	
Notes: medical notes, GP letter, PRF		☐	☐	
Patients requiring analgesia: sufficient		☐	☐	
Belongings (including patients medication)		☐	Always	Please note here if any other tasks required prior to transfer
SAS Transport required and ref. no.		☐	☐	
Print Name Sign -				

Nursing Notes

Date and Time 02/02/23		Print Name and Signature
1846.	ABS charted. Patient into cubicle for assessment. Bloods obtained by doctor. Patient attended x-ray.	
19.40	NEWS score 6 medic aware + sats 88% low BP commenced on 2L O^2 NC. CEPHID obtained	
19.50	Medic request O^2 to be taken off too see how SATS go, aware of 88% on air	

Nursing Notes		
Date and Time		Print Name and Signature
2.2.23 2020	Bladderscan showed 112mls in bladder. Patient comfortable	FD

2/2/2023 Linked Number: CR009524574

Patient Inform	3112626230	Date:	02/02/2023
MICH/	MCLACHLAN	Incident Number:	CR009524574
Age/Gender:	Michael M	Incident Type:	EMG
Address:	31/12/1962 FLAT 1-1 10 GIRVAN STREET Glasgow, Lanarkshire	Incident Location:	WING 8 SHETTLESTON HEALTH CENTRE 420 OLD SHETTLESTON ROAD SHETTLESTON GLASGOW, G32 7JZ
DOB:			
CHI:	G33 2DP		
Ethnicity:			

Scottish Ambulance Service

Presenting Complaint

? CHEST INFECTION

Additional Comments

-s- Dr call to 60 yom c/o sore throat/back and hypoxia. -b- pt has previously had pneumonia, precautionary visit to a/e. pt had oral endoscopy 1st february - sampling liver and bladder, c/o of pain in throat and back. Pt organised visit with dr to help with throat pain. Dr stated low sats, on air 90% but pt has copd. Pt has taken 4 co-codamol today. Pt also has had difficulty passing urine. -a- o/a pt sat up and fully alert. o/e Hypertensive at 97/67. Sats 90% on air. Some crackles at bases. Pain score of 5-6/10. All other obs unremarkable. Hurts to swallow and struggling to eat/drink. No interventions provided. Uneventful journey to hospital. -r- further assessment and pain relief if deemed required.

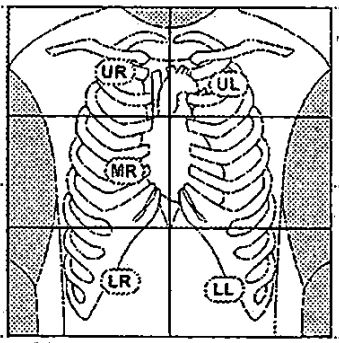
PATIENT ASSESSMENT

ACVPU Alert <C> No

A Clear

B Breathing Adequately: Yes — Respiratory Rate: 16 — SPO2: 90

Oxygen Given: No

Normal Breath Sounds. Normal Air Entry	UR		UL	Normal Breath Sounds. Normal Air Entry
Normal Breath Sounds, Normal Air Entry	MR		ML	
Creps/Crackles, Normal Air Entry	LR		LL	Creps/Crackles, Normal Air Entry

C

Pulse Rate	BP	Cap Refill	ECG Rhythm
	97/67	>2 Secs	

Rhythm	Arm	Central/Peripheral	ECG
Reg	Right	Peripheral	

D

GCS	Eyes	Voice	Motor	PEARL
15	Spontaneously (4)	Orientated (5)	Obeys Commands (6)	Yes

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
16:04			100/67	90		15	Alert					4	4		P121031S
16:02		16	97/67	90	>2 Secs	15	Alert		36.8	4.8		4	4		P121031S

HISTORY

AMPLE

Allergies	None
Medication	RESPIRADONE? Tamsulosin
Past Medical History	COPD

Last Eaten	>4 Hours Ago
Events Prior	PT EXPERIENCING PAIN AFTER ORAL ENDOSCOPY

3112626230
MCLACHLAN, Michael M 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Social History

Lives alone	Yes	Patient Occupation	Does Not Work
Patient Mobility	Fully Mobile		
Patient Communication	No Help Required		
Patient Clinical Risk Factors	Smoker, VAPES		

SOCRATES

Site	THROAT AND BACK	Onset	YESTERDAY AFTER HAVING ORAL ENDOSCOPY, 02/02/2023, 10:00
Severity	5 OR 6/10		

MEDICAL

CLOSE RECORD

Treatment On Scene	Non-Emergency

Conveyance

Transport To Hospital	Normal driving	Pre-Alert	No

INCIDENT LOG

Time Call Received	15:32	Allocated	15:43	Mobile	15:43
First Resource On Scene		Crew On Scene	15:53	Crew Left Scene	16:20
Crew At Hosp	16:34	Receiving Hospital	GLASGOW ROYAL INFIRMARY	Clear Time	

Crew ID	Crew Grade	Driver
E9885343	Student Technician Level 4	YES
E0019836	Paramedic	NO
P121031S	Student Technician Level 4	NO

(a) MICHAEL MCLACHLAN

NEWS 2 Key | 1 | 2 | 3

| | | |

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

3112626230 M
MCLACHLAN 31/12/1962
Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire G33 2DP

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1	Sp02 Scale 2	Patient on home oxygen Y☐ N☐
Target >96%	Target 88-92%	
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name: J. Waddell	
Dr/ANP Initials ONLY:	Dr/ANP Initials ONLY: JW	
Date:	Date: 2/2/23	

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed.....

Medical: .....

Date: .....

Pupil Reaction and size: s = sluggish, f = fixed, n = no reaction, c = eyes closed

Pupil Size (mm): 1 2 3 4 5 6 7 8

Glasgow Coma Scale

| Date: | | |

NHS Endoscopy Care Plan

NHS Greater Glasgow and Clyde

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Date: 1/2/23 **Consultant / Endoscopist:** C.S. McKAY

Patient liked to be known as: .....

Procedure

Gastroscopy	☐	E.R.C.P	☐	EBUS	☐
Colonoscopy	☐	E.U.S	☑	Enteroscopy	☐
Sigmoidoscopy	☐	Bronchoscopy	☐	Thoracoscopy	☐

Discharge Arrangements

Name of Escort /contact [redacted] GERALDINE	**Escort Required** Yes ☑ No ☐	**Overnight supervision arranged** Yes ☑ No ☐
Relationship Lindsay (FRIEND) [redacted] / PARTNER	**Escort to be contacted** Yes ☑ No ☐	**Overnight stay in ward** Yes ☐ No ☑
Contact tel no 07478110300 [redacted] 07874945863.		

Have you received Patient Information and understood it: Yes ☑ No ☐

Medical History and Pre Procedure check

Condition	Yes	No	Details
Diabetes		✓	Type 1 ☐ Type 2 ☐
Angina/ Ischaemic heart Disease		✓	
Hypertension		✓	
Myocardial Infarction		✓	Date:
Artificial valves		✓	
Pacemaker		✓	
CABG		✓	
Coronary artery stent		✓	
Stroke/TIA		✓	
Asthma		✓	
COPD	✓		
Epilepsy		✓	
Liver disease		✓	
Arthritis		✓	
Orthopaedic implants		✓	Specify:
Glaucoma		✓	
Anaemia		✓	
Recent surgery		✓	
Previous endoscopy	✓		3 years ago
CJD/VCJD risk		✓	
Other			

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
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G33 2DP

Presenting complaint	Yes	No	Detail other illness or complaint
Reflux			
Dysphagia			
Barretts			
Oesphageal/Gastric Varices			
Gastric ulcer			
Altered bowel habit			
PR bleeding			
Crohns disease			
Ulcerative colitis			
Surveillance colonoscopy			
Screening programme			
Other:			

Mobility Assessment

Independent Yes ☑ No ☐ If No, complete all questions

Aids and/ or assistance required Yes ☐ No ☐

Walking stick ☐ Zimmer ☐ Wheelchair ☐ Other ☐ Specify .....

Sight impairment Yes ☐ No ☑ if yes specify .....

Communication Needs (answer only applicable question)

Hearing impairment Yes ☐ No ☑

Hearing aid Yes ☐ No ☑ right ear ☐ left ear ☐ both ears ☐

Sign Interpreter required Yes ☐ No ☑

Lip reads Yes ☐ No ☑

Interpreter Required Yes ☐ No ☑ Language .....

Interpreter present Yes ☐ No ☑

Relative / friend present Yes ☐ No ☑

The use of relatives and friends as interpreters is discouraged unless it is the patient's choice to use them.

Learning Disability Yes ☐ No ☐ Carer present Yes ☐ No ☐

Dementia Yes ☐ No ☐ Incapacity form completed Yes ☐ No ☐

Current Medication (list below and tick those taken today)

Tamsulosin					
Risperidone					
Trimbow } inhaled					
Salbutamol } inhaled					
Buvidal					

ANTICOAGULANT THERAPY Yes ☐ No ☑ If yes current medication .....

When was this medication last taken Specify .....

INR Result .....

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
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Admission Observations

BP ....101/66.....Pulse .....57.....Oxygen Saturation .....92% (A.)

BM (if applicable) .....Respirations (if applicable) .....

Fasted since .....Food — 00.00 Fluid — 00.00

Bowel Prep	Klean Prep	Moviprep	Picolax	Enema / home	Enema / dept	Other
No of sachets						
Result- Good / Poor						

Patient Requests

Throat Spray ☑ IV Sedation ☑ No Sedation ☐ Not Applicable ☐

IV Cannulation

R Hand	L Hand	R Arm	L Arm	Other	Time	Inserted by (please print)
						CD

Dentures removed (if applicable) Yes ☑ No ☐ TOP

Crowns Yes ☐ No ☐ upper ☐ lower ☐ front ☐ back ☐ R side ☐ L side ☐

Bridgework Yes ☐ No ☐ upper ☐ lower ☐ front ☐ back ☐ R side ☐ L side ☐

Identiband details checked Yes ☑ No ☐

Consent form signed Yes ☐ No ☐

Consent form countersigned Yes ☐ No ☐

Underwear removed (if applicable) Yes ☐ No ☐

Jewellery removed Yes ☐ No ☐

ALLERGIES Yes ☐ if yes detail below No ☑

Details .....

Name of Admission Nurse (Print) .....PRE ADMISSION A. GEORGE / J. McAuley / K. MACDONALD.....

Signature of Admission Nurse .....DG / JM / .....

Patient's Declaration

I have read and understood the warnings regarding the after effects of sedation.

Patient's signature .....M. McLachlan.....

3112626230
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FLAT 1-1
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Intra Procedure

Endoscopist (print) ...PROF CJ MCKAY.....

Endoscopy Room Nurses (print) ...DUNCAN BAKER APOLLINIO

Surgical Pause carried out Yes ☑ No ☐

Medication Administered Pre, Intra and Post Procedure

Drug	Yes	No	Time	Dose	Route	Given/Sign/Dr/Nurse
Xylocaine spray	✓		10.10	x10spray	ORAL	BAKER
Midazolam	✓		10.15	3.5 mg	IV	
Midazolam				mg		
Midazolam				mg		
Pethidine				mg		
Pethidine				mg		
Pethidine				mg		
Fentanyl	✓		10.15.	75 mcg	IV.	
Fentanyl				mcg		
Fentanyl				mcg		
Buscopan				mg		
Buscopan				mg		
Buscopan				mg		
Antibiotics						
				mg		
				mg		
				mg		
Reversal Agents						
				mg		
				mg		
Local anaesthetic						
				mg		
				mg		
Other						
Botox				mg		

Prescribed by.....

Endoscopist Signature.....

Start Time ...10:16..... Finish Time ...10:25.....

Patient position Left Lateral ☑ Supine ☐ Prone ☐ All ☐

Oxygen therapy Yes ☑ No ☐ nasal sponge ☐ cannula ☐ mask ☐ rate ...2L...

31.12626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Observations during procedure

Time	10·05·	10·25.				
Pulse	51·	55				
SpO2	96	100				
BP						
Resps						

Procedure (please tick all relevant)

Gastroscopy		Biopsy		Varices		Adrenaline	
Colonoscopy		Hot Biopsy		Gastric Ulcer		Spot Dye	
Sigmoidoscopy		Snare Polypectomy		Duodenal Ulcer		Indigo Carmine	
E.R.C.P.		Balloon dilatation		Oesophagus		Gelofusine	
E.U.S		Injection	✓	Duodenum		Normal Saline	
Bronchoscopy		Laser		Biliary		Haemospray	
E.B.U.S		Heater Probe		Pancreatic			
Thoracoscopy		Endo clip		Haemorrhoids			
Enteroscopy		Insertion of Stent		Rectum			
		EMR		Sigmoid			
		PEG		Descending			
		Needle Aspiration		Splenic flexure			
		Brushings		Transverse			
		Washings		Hepatic flexure			
		Banding		Ascending			
		Insert of NJ tube		Caecum			
		Gastric Pacing Wire		Terminal Ileum			

Other ..... EUS .....

Sedation score	Tick	Comfort Score	Tick
Asleep		None, resting comfortably	
Drowsy	✓	One or two episodes of mild discomfort, well tolerated	
Awake		More than two episodes of discomfort, adequately tolerated.	✓
		Significant discomfort experienced several times	
		Extreme discomfort frequently during procedure	

Comments Constant Reassurance Throughout

Specimens Yes ☑ No ☐

Pathology ☐ No of pots ..... H pylori test ☐ bacteriology ☐ cytology ☑ mytology ☐

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Diathermy Yes ☐ No ☑ Type mono ☐ Argon ☐

Site of diathermy pad leg ☐ back ☐ R side ☐ L side ☐ Upper ☐ Lower ☐

Other .....

Condition of skin post diathermy normal ☐ other ☐ comment below

.....

Recovery Room Instructions (if applicable)

Oxygen 4 litres per minute if SpO2 drops below 95% ☑

Oxygen 4 litres per minute until fully awake ☐

Oxygen ..... per minute via ..... until ..... ☐

Normal Diet ☑ Fluids only ☐ Soft Diet ☐ Nil orally till further medical instructions ☐

To be seen by endoscopist before discharge ☐

Further Instructions ..... NBM - 10:40 .....

..... NO REPORT .....

Endoscopy Room Nurse Signature .....

Recovery care

Post endoscopy observations

Time	1030	11AM								
Blood pressure	154/94	109/60								
Pulse	96	48								
O2 Saturation	96%	95%								
Respiratory Rate	RED	16								
Sedation score	0	0								
Pain score	2	0								
Oxygen	A	A								
IV Cannula	✓	✓								
BM	N/A	—								
Nurse initials	FJ	NC								

Pain score 0 = no pain, 1 = minimal, 2 = mild, 3 = moderate, 4 = severe

Sedation score A - Asleep 0 - Alert 1 - Responds to verbal command

2 - Responds to painful stimuli 3 - Unresponsive

31;12626230
MCLACHLAN
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Nurses notes

3112626230
MCLACHLAN M
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Discharge Criteria	Yes	No
Stable vital signs	☑	☐
Alert and Orientated	☑	☐
Pain score is 2 or below	☑	☐
Diet and fluids taken	☑	☐
IV Cannula removed – WC	☑	☐
Received written instructions regarding sedation	☑	☐
Received verbal and written aftercare instructions	☑	☐
Patient Advice Leaflet given (if applicable)	☐	☑

Received Endoscopy Report/ Patient letter Yes ☐ No ☑

If no

Verbal report by endoscopist ☑ CNS

Follow up appointment indicated on report Yes ☑ No ☐

Follow up appointment (if given in department) .....time .....

Comments.....

.....

.....

I confirm patient is satisfactory for discharge

Print Name Sarah Watt Signature SWatt

Discharged at 1210 to care of Partner

Irregular discharge Reason .....

.....

Patients' Signature ..... Nurses Signature .....

Name of Procedure

Endoscopic Ultrasonography +/- Gastroscopy +/- Dilatation and/or Stent Insertion.

Inspection and ultrasound of the upper gastrointestinal tract with a flexible endoscope (with or without biopsy, needle aspiration, photography). Biopsy samples and images taken will be retained.

Statement of Patient

You have the right to change your mind at any time, including after you have signed this form.

I have read and understood the information in this booklet including the benefits and any risks.

I agree/disagree to any information/images/surplus tissue or other biological material not essential for my diagnosis or future treatment may be used for medical education, audit, and research with ethical approval, to improve the quality of patient care.

Agree ☑ **Disagree** ☐ **(Please tick box)**

I agree to the procedure described in this booklet and on the form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will however, have appropriate experience.

Where a trainee performs this examination, this will be undertaken under supervision by a fully qualified practitioner.

I agree to have sedation ☑

Have you ever been notified that you are at an increased risk of CJD/VCJD for public health purposes **Yes** ☐ **No** ☑

Signed M. McLachlan Date 1/2/23

Name (print in capitals) Maeve MacLachlan

Please sign here if you refuse to consent to the emergency administration of blood or blood products.

Signed _____ Date _____

_____

Staff Only

Confirmation of consent (to be completed by a healthcare professional when the patient is admitted for the procedure).

I have confirmed that the patient understands what the procedure involves including any risks.

I have confirmed that the patient has no further questions and wishes the procedure to go ahead.

Signed _____ Date 01/02/23

Consent Form

It is important that you feel you have all the information that you require about Endoscopic Ultrasonography. Once you are happy that you have enough information about this test you should sign this form to indicate that you consent to undergo the procedure.

If you would like to ask further questions please do not sign the form now. Bring it with you and you can sign it after you have spoken to a member of the healthcare staff.

EUS HPB report

Performed	01-Feb-2023 10:26	Received	01-Feb-2023 10:32
Reported	01-Feb-2023 10:32	Order Number	UNI265263-3112626230
Status	Final	Source System	MasterLab

UGI G1 Final

NHS Greater Glasgow and Clyde
EUS HPB REPORT

Name: **Michael MCLACHLAN (M)**
Date of birth: **31/12/1962**
NHS No: **3112626230**
Case Note No: **3112626230**

Address: **Flat 1-1**
10 Girvan Street
Glasgow
Lanarkshire
G33 2DP

GP: **WALKER, KERRY**
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Procedure date: **1st February 2023 (10:26)**
Priority: **Urgent**
Status: **Outpatient/NHS**
Hospital: **GRI**
Ward: **Ward - Not specified**
Referring Cons: **Mr E J Dickson (General Su**

Indications
CT imaging revealed dilated pancreatic duct and dilated bile ducts.

Report
The complete biliary and pancreatic systems were visualised. There were no peri-operative complications.

Diagnoses
BILIARY. Extrahepatic: dilated duct.

Advice/Comments
Dilated CBD/PD on CT from November. Most recent LFTs in Oct 22 are normal. On EUS the CBD is 11mm but does taper to ampulla. PD similarly dilated in head to max of 5mm and irregularly dilated in body/tail. There is no ampullary mass and papilla is normal endoscopically. There are dilated pancreatic side branches in body and tail with heterogeneous pancreatic parenchyma. Several tiny microcalculi in Hartmann's pouch. FNB from ampulla for completenss but I can see no evidence of periampullary pathology. Likely CP and microcalculi. Discuss imaging/cytology in MDT but low index of suspicion aftern EUS.

Follow up
Return to the GI surgeon and review will be in the surgical clinic.

Consultant/Endo
Prof Coli

Inst
SC

Premed
Fentanyl (I'
Midazolam
Xylocaine (Spra

Prof Colin J McKay
Consultant Upper GI Surgeon

Produced by Unisoft's GI Reporting Tool Compiled on 01/02/202:

3112626230
MCLACHLAN
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31/12/1962

BladderScan®

14:46 25/01/2023

13 mL

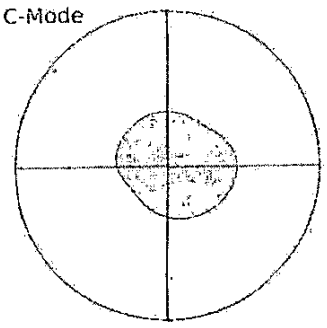
3112626230
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Michael
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Glasgow, Lanarkshire
G33 2DP
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31/12/1962

Procedure Code

Operator ID

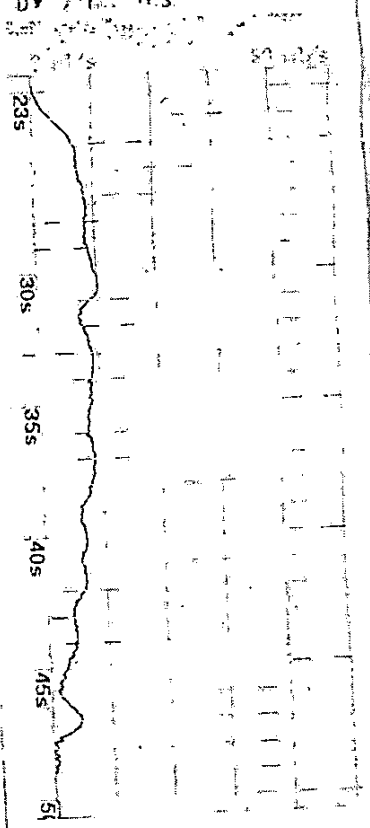
Signature

C-Mode



Console ID: C15179E1
Probe and Transducer ID: P1529848

Glasgow
3112626230
MCLACHLAN
Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP
M
31/12/1962



Results

Date: 25-Jan-2023 13:32
Voiding Time: 26 s
Flow Time: 26 s
Time To Max Flow: 8 s
Max Flow Rate: 19.2 ml/s
Avg Flow Rate: 6.5 ml/s
Voided Volume: 169 ml

Patient Information

ID:

Name:

3112626230
M
MCLACHLAN
31/12/1962
Michael

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

International Prostate Symptom Score (I-PSS)

Patient Name: Date: 25/1/23	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	YOUR SCORE
1. Incomplete Emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	(5)	
2. Frequency Over the past month, how often have you had to urinate again less than two hours after you have finished urinating?	0	1	2	3	4	(5)	
3. Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	(4)	5	
4. Urgency Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	(4)	5	
5. Weak Stream Over the last month, how often have you had a weak urinary stream?	0	1	2	(3)	4	5	
6. Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	(4)	5	

	None	Once	Twice	3 times	4 times	5 or more	YOUR SCORE
7. Nocturia Over the past month how many times did you most typically get up each night to urinate from the time you went to bed until the time you got up in the morning?	0	1	2	(3)	(4)	5	
Total I-PSS Score							29

Quality of Life due to Urinary Symptoms	Delighted	Pleased	Mostly satisfied	Mixed	Mostly unhappy	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

The I-PSS is based on the answers to seven questions concerning urinary symptoms. Each question is assigned points from 0 to 5 indicating increasing severity of the particular symptom. The total score can therefore range from 0 to 35 (asymptomatic to very symptomatic).

Although there are presently no standard recommendations into grading patients with mild, moderate or severe symptoms, patients can be tentatively classified as follows: 0 - 7 = mildly symptomatic; 8 - 19 = moderately symptomatic; 20 - 35 = severely symptomatic.

The International Consensus Committee (ICC) recommends the use of only a single question to assess the patient's quality of life. The answers to this question range from "delighted" to "terrible" or 0 to 6. Although this single question may or may not capture the global impact of BPH symptoms on quality of life, it may serve as a valuable starting point for doctor-patient conversation.

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

3112626230
MCLACHLAN M
Michael 31/12/1962
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Glasgow, Lanarkshire
G33 2DP

Date & Time		Signature, Print Name & Designation
25/1/23	Nurse led flow clinic, patient attended	
1430	nurse led flow clinic today. This	DMCormick
	was completed sucessfully —	DMCormick.
		Staff Nurse.

Letter to Patient:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000
Department: Acute Assessment Unit
Contact Tel: 0141 201 6655
Enquiries to: Nadine Robertson
Letter Date: 09/01/2023
Reference: DR/NR
Dictated Date: 28/12/2022
Transcribed Date: 30/12/2022

Michael McLachlan
FLAT 1-1
10 GIRVAN STREET
Glasgow
Lanarkshire
G33 2DP

Dear Mr McLachlan ,

I am writing to you with the result of your MRI scan. This has shown that the drainage system from the gallbladder and the liver is bigger than we would expect and there may be evidence of some retained stones from the gallbladder which is causing this.

I have referred you on to the surgical team who deal with this and they will be in touch in due course with a further appointment

Kind regards

Yours sincerely

Dr Daniel Rodgers

Consultant in Acute Medicine

Electronically Signed: Dr Daniel Rodgers, Consultant

cc.

Referral letter:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Hepatobiliary Pancreatic Team
Glasgow Royal Infirmary

Main Switchboard: 0141 211 4000
Department: Acute Assessment Unit
Contact Tel: 0141 201 6655
Enquiries to: Nadine Robertson
Letter Date: 09/01/2023
Reference: DR/NR
Dictated Date: 28/12/2022
Transcribed Date: 30/12/2022

Dear Doctor,

Michael McLachlan; D.O.B: 31/12/1962; CHI: 3112626230
FLAT 1-1, 10 GIRVAN STREET, Glasgow, Lanarkshire, G33 2DP

I would be grateful if you could see this gentleman in clinic at your next available appointment. He attended the Assessment Unit with deranged LFTs in September and had a subsequent MRCP which has shown a dilated CBD and is advised for direct visualisation.

I would be grateful if you could see him as soon as possible.
Kind regards

Yours sincerely

Dr Daniel Rodgers

Consultant in Acute Medicine

Electronically Signed: Dr Daniel Rodgers, Consultant

cc.

Referral letter:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Mr Dickson
Consultant Hepatobiliary Surgeon
GRI

Main Switchboard:	0141 211 4000
Department:	Respiratory
Contact Tel:	0141 211 8403
Enquiries to:	Jennifer.glasgow@ggc.scot.nhs.uk
Letter Date:	06/12/2022
Reference:	MMC/AG/3112626230
Dictated Date:	28/11/2022
Transcribed Date:	29/11/2022

Dear Mr Dickson,

Michael McLachlan; D.O.B: 31/12/1962; CHI: 3112626230
FLAT 1-1, 10 GIRVAN STREET, Glasgow, Lanarkshire, G33 2DP

I would be grateful if this man could be reviewed and followed up by the Pancreatic Service. He is a 59 year old man who was admitted with pneumonia in June 2022, and was referred through to the Respiratory Service for follow-up. At the time of his original admission, it was noted on CT scan that he had a dilated pancreatic duct, and the acute physicians organised an MRCP, which has eventually been done. This confirms a dilated CBD and pancreatic duct. It has also recommended direct visualisation to assess for an ampullary lesion.

He has been discharged from the Chest Clinic.

Yours sincerely

Dr Mark Cotton

Consultant Respiratory Physician

Electronically Signed: Dr Mark Cotton, Consultant

cc. Dr Alan Cameron
Consultant in Acute Medicine
GRI
Dr Bruce
Shettleston Health Centre
420 Old Shettleston Road
Glasgow

G32 7JZ

Clinic Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. SJ Bruce
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Main Switchboard: 0141 211 4000
Department: Respiratory Department
Contact Tel: 0141 211 8403
Enquiries to: Jennifer.glasgow@ggc.scot.nhs.uk
Letter Date: 28/11/2022
Reference: MMC/AG/3112626230
Dictated Date: 28/11/2022
Transcribed Date: 29/11/2022

Dear Dr. SJ Bruce,

Michael McLachlan; D.O.B: 31 Dec 1962; CHI: 3112626230
FLAT 1-1, 10 GIRVAN STREET, Glasgow, Lanarkshire, G33 2DP

Attendance: Specialty - Respiratory Medicine; Clinic - GRMCRE2-RESP DR M COTTON TB CLINIC MONDAY PM
Date and Time of Appointment - 28/11/2022 14:15

Follow Up: Discharged

Clinical Comments:

I reviewed this 59 year old man face to face in clinic today. He was referred from the General Medical Team, having presented with pneumonia and weight loss in June. His pneumonia was slow to clear, but has substantially resolved on interval CT scanning. His weight has gone up a little; he was 57.4 kg in clinic today. He continues to vape and no longer uses cigarettes. He feels his appetite has improved.
He does have severe COPD. Pulmonary function tests show an FEV_1 of 1.7L, (53% predicted), with an FEV_1 / FVC of 34%, which would be compatible with stage 2 COPD. He does have significant gas trapping, with an FRC of 189% predicted and an RV /.TLC of 132% predicted. Gas transfer is impaired at 65% predicted with a transfer co-efficient of 57% predicted. Unfortunately, he was unwilling to remain for reversibility testing. Currently he would not meet pulmonary function criteria for volume reduction therapy. I do not think he requires routine follow-up in the Chest Clinic and I have discharged him.

Yours sincerely

Dr Mark Cotton

Consultant Respiratory Physician

Electronically Signed: Dr Mark Cotton, Consultant

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Respiratory Department
0141 451 5358
ruth.scoular@ggc.scot.nhs.uk

Dr. SJ Bruce
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Main Switchboard:	
Department:	Respiratory Department
Contact Tel:	0141 451 5358
Enquiries to:	ruth.scoular@ggc.scot.nhs.uk
Letter Date:	31/10/2022
Reference:	BCK/RS
Dictated Date:	01/11/2022
Transcribed Date:	01/11/2022

Dear Dr. SJ Bruce,

Michael McLachlan; D.O.B: 31 Dec 1962; CHI: 3112626230
FLAT 1-1, 10 GIRVAN STREET, Glasgow, Lanarkshire, G33 2DP

Attendance: Specialty - Respiratory Medicine; Clinic - GRMCRE2-RESP DR M COTTON TB CLINIC MONDAY PM
Date and Time of Appointment - 31/10/2022 14:15

Follow Up: Dr Cotton's clinic 28th November 2022

Clinical Comments:

Problems:

1. Weight loss
2. Ex smoker
3. Breathlessness
4. Substance misuse

I reviewed this man in clinic on 31st October 2022. I apologise there has not been a clinic letter sent for his previous attendance. I will ask the doctor involved to sign off their letter as soon as possible. He is being investigated for weight loss and breathlessness. He has a CT scan booked for 9th November 2022. Spirometry has been requested but no date booked yet. I note his blood tests have shown he is vitamin D insufficient. Aspergillus serology was normal but total IgE was slightly elevated at 246. Blood borne virus screen was normal and HBA1C was also satisfactory.

He said he has been okay. He complained of some pain in the left side of his back and he has a soft tissue swelling medial to his left shoulder blade. He said his breathing has been bad for a number of years, he is short of breath within the house. He has support from his family. His weight has improved since he was in the ward and he feels he is eating better.

We will await his CT scan which will be performed next week. I will also see if his spirometry could be expedited. I would be grateful if you could start him on vitamin D supplements. We will review him with the results of his CT scan.

Kind regards

Yours sincerely

Dr B Choo-Kang

Consultant in Respiratory Medicine

Electronically Signed: Dr Brian Choo-Kang, Consultant

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. SJ Bruce
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Main Switchboard: 0141 211 4000
Department: Respiratory Department
Contact Tel: 0141 451 5358
Enquiries to: ruth.scoular@ggc.scot.nhs.uk
Letter Date: 03/10/2022
Reference: BCK/RS
Dictated Date: 01/11/2022
Transcribed Date: 01/11/2022

Dear Dr. SJ Bruce,

Michael McLachlan; D.O.B: 31 Dec 1962; CHI: 3112626230
FLAT 1-1, 10 GIRVAN STREET, Glasgow, Lanarkshire, G33 2DP

Attendance: Specialty - Respiratory Medicine; Clinic - GRMCRE2-RESP DR M COTTON TB CLINIC MONDAY PM
Date and Time of Appointment - 03/10/2022 13:30

Follow Up: Dr Cotton's clinic 28th November 2022.

Clinical Comments:
Today, I reviewed Mr McLachlan in Dr Cotton's TB Clinic on his behalf. Thank you for your recent referral regarding Mr McLachlan after his recent admission to hospital with shortness of breath when he was treated for a lower respiratory tract infection with antibiotics. On this admission, he subsequently had a CT scan which showed some ?infective changes. Today, we have repeated Mr McLachlan's chest x-ray which has shown resolution of these changes.

Mr McLachlan today described a massively reduced exercise tolerance in the last 3-4 months, only being able to walk 20-30 metres before absolutely having to stop for a breath. Six months ago, he would have been able to walk 30 metres at a slow pace without having to stop for a breath. He describes sputum production which is always very sticky, normally clear in colour but has assured me he has had no haemoptysis. He also has had no fevers, sweats or any night-time sweats which have woken him from sleep. His main concern today was a recent weight loss. He tells me that, on admission to the hospital, he realised he had lost nearly 2 stones in weight. His weight today in the clinic was 53 kg. His only previous weight available on portal was from February 2021 and he weighed 62 kg at that time.

He is an ex-smoker of 15 cigarettes per day and has smoked for over 40 years. He now vapes and has been vaping for the last 6 months.

He has had no bony or joint pain in recent months and noted no skin changes, no other symptoms of note. He tells me he was previously vaccinated against TB at school and has no contacts who have had TB and he has had no previous TB himself.

For employment, Mr McLachlan was a council worker and previously worked in the demolition services where he believes he has had some asbestos exposure in the past.

On examination in the clinic today, his chest was clear, however, he did have an intermittent productive cough. On examination, I note that Mr McLachlan has a small soft tissue swelling sited on his posterior chest wall over the left scapula. The swelling was mobile and soft and ?fluid filled.

have discussed Mr McLachlan with Dr Cotton today in the clinic and he has advised that, in the first case, we should update the patient's spirometry and request and urgent repeat CT thorax.

We would like to see Mr McLachlan back in the clinic in approximately one months time. I have advised him that all appointments for the above will be sent by post to his home address which he is happy with. He had no questions for me at this time.

Yours sincerely

Dr Kathleen McGee

IMT1 in Respiratory Medicine

Electronically Signed: Dr Kathleen McGee, Doctor

cc.

NHS GREATER GLASGOW & CLYDE

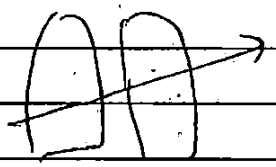
CLINICAL NOTES - MEDICAL ☑
NURSING ☐

Please tick ✔ appropriate directorate

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Date & Time	IMTI Dr K Meeran, Dr Cotton clinic	Signature, Print Name & Designation
3/10/22 13:30	SOB → recent admission to hospital with pneumonia, had abx.	PMH/ COPD drug induced psychosis ?acne rosacea.
	can only walk 20-30 m before feeling breathless, 3-4 m before need have to stop.	
		PFTs 2018
	sputum production: very sticky thick normally clear, sometimes green haemoptysis 2-3 weeks.	- unable to comply
		Abx/
	ß no fevers/sweats no night time sweats.	Trimbow. 87/5/9.
		Tamsulosin
	recent weight loss: 1.5 stone over a period of 2 months. normally around 9 stone. → (weight in kg)	Risperidone.
		IX/ CT CAP.
ex-smoker: 15/day, 40 years.	now vaping.	Hom. Lit
- lower back pain	recent development.	SHA: ex-coal miner demolition services ?asbestos exposure
	vaccinated against TB.	
	no contacts of TB., no prev TB.	

Prev. weight: 2021. 62.4kg
weight 2022 63 kg.

Date & Time		Signature, Print Name & Designation
	 intermittent cough	
	soft tissue swelling over (L) scapula mobile, soft. ?fluid filled	
	(P) Spirometry. Ø weight. repeat CT Thorax: urgent. (USOC). Ø reappoint 1/12 month. Await blood results.	~~KMS~~.

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000
Department: Urology
Contact Tel: 0141 201 3537
Enquiries to: Pauline.Milligan@ggc.scot.nhs.uk
Letter Date: 06/10/2022
Reference: MO/AJ
Dictated Date: 16/09/2022
Transcribed Date: 06/10/2022

Dr. SJ Bruce
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Dear Doctor Bruce ,

Michael McLachlan; D.O.B: 31/12/1962; CHI: 3112626230
FLAT 1-1, 10 GIRVAN STREET, Glasgow, Lanarkshire, G33 2DP

I had a telephone consultation with Mr McLachlan this morning, unfortunately he is still problematic with nocturia. As you are aware I had asked him to change his drinking habits which he did and reverted back again. He drinks very little fluids during the day and is up every 20 minutes to an hour overnight to void. Again.

I have discussed his drinking habits and I will bring him back to the clinic for further flows and scans to be carried out.

Yours sincerely

Nurse Margaret O'Connor

Urology Nurse Specialist

Electronically Signed: Nurse Margaret O'Connor, Nurse Practitioner

cc.

Referral letter: Referral

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Dr Mark Cotton
Consultant Respiratory Physician
Walton Building
Glasgow Royal Infirmary
GLASGOW
G4 0SF

Main Switchboard: 0141 211 4000
Department: GRI Ward 46 General Medicine
Contact Tel: 0141 201 6655
Enquiries to: Allan.Cameron@nhs.scot
Letter Date: 29/08/2022
Reference: AC
Dictated Date: 29/08/2022
Transcribed Date: 29/08/2022

Dear Dr Cotton,

Michael McLachlan; D.O.B: 31/12/1962; CHI: 3112626230
FLAT 1-1, 10 GIRVAN STREET, Glasgow, Lanarkshire, G33 2DP

I would be grateful for your opinion on this 59 year old man. He presented to medical receiving at the end of June with a one-week history of cough, breathlessness, subjective fevers and recent weight loss. His past history is of COPD, substance misuse and drug-induced psychosis. He is an ex-smoker who currently vapes.

Clinically he appeared very thin and was hypoxic on room air with oxygen saturations of 89%. He was not clubbed and had no palpable lymphadenopathy or organomegaly. There was some bronchial breathing in the left mid zone on auscultation.

His bloods showed an acute phase picture, with CRP 61, a normocytic anaemia, mild thrombocytosis, and moderate hypoalbuminaemia. His chest x-ray showed left mid-zone consolidation.

By the time I saw him in ward 46 he felt well and was keen to go home with oral antibiotics. I thought he was well enough to do so, but was sufficiently worried about the overall picture that I arranged an urgent outpatient CT CAP.

The report is now available to me and shows a 4 cm area of consolidation within the left lower lobe posteriorly, with further nodularity extending cranially into an area of rounded atelectasis lung posteriorly within the left lung which contains cystic air-spaces. This is posterior to the longstanding calcified granuloma (? previous TB).

The reporting Radiologist felt that the appearances and rate of change on imaging made post-primary TB the most likely diagnosis, although malignancy could not be excluded.

I thought in view of the CT report you would be the best person to contact.

Thanks in advance,

Yours sincerely

Dr A D Cameron

Consultant Physician

Electronically Signed: Dr Allan Cameron, Consultant

cc.

Final Discharge Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. SJ Bruce
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Main Switchboard: 0141 211 4000
Department: GRI C19 Ward 46 Medical
Contact Tel: 0141 201 6655
Enquiries to: Shona.Forsyth3@ggc.scot.nhs.uk
Letter Date: 12/07/2022
Reference: AC
Dictated Date: 11/07/2022
Transcribed Date: 11/07/2022

Dear Dr. SJ Bruce,

Michael McLachlan; D.O.B: 31/12/1962; CHI: 3112626230
FLAT 1-1, 10 GIRVAN STREET, Glasgow, Lanarkshire, G33 2DP

Admission: Specialty - General Medicine; Ward - GRI C19 Ward 46 Medical
Consultant - Dr Allan Cameron; Date of Admission - 30/06/2022
Date of Discharge - 30/06/2022; Discharged to - Private Residence - living with relatives or friends

Diagnosis:
Pneumonia, Unspecified (ICD10: J18.9)

Follow Up: Urgent CT thorax

Clinical Comments:
Immediate Discharge Comments:
Thank you for continuing the care of Michael McLachlan, who was admitted to GRI on 30/6/22. He presented with a 1 week history of productive cough and increased SOB. He has a background of depression, COPD and drug misuse.

On examination there was bronchial breathing in the left lung. Bloods showed WCC 9.6, CRP 61. He also had deranged LFTs and a liver screen was sent. CXR showed LUL pneumonia with a possible hilar prominence. He felt better and was discharged with oral amoxicillin and clarithromycin to treat CAP. He was discharged with worsening advice and an urgent OP CT CAP. Ward 46 GRI

Final Discharge Comments:
His liver screen was negative for hepatitic viruses, and biochemistry was as expected given the diagnosis of pneumonia, with a moderate increase in IgG and a mild IgA rise. Although his chest x-ray may simply represent a primary pneumonia, I was concerned by his history of weight loss and low albumin that the infection may be secondary to an obstructing lesion and have therefore requested a CT of his chest, which is still pending at the time of writing.

Yours sincerely
Dr Allan Cameron

Consultant Physician

Electronically Signed: Dr Allan Cameron, Consultant

cc.

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No
Consent for Sharing Withheld: No

STIRLING BRUCEThe Cairns Practice,Shettleston Health Centre,420 Old Shettleston Road, Glasgow, G32 7JZ

Main Switchboard:
Date of Completion: 30-Jun-2022

Dear STIRLING BRUCE,

Name	CHI	DoB	Address
Michael McLachlan	**3112626230**	**31-Dec-1962**	**FLAT 1-1, 10 GIRVAN STREET, Glasgow, Lanarkshire, G33 2DP**

Admitted	Type	Discharged	Destination
30-Jun-2022 01:42	IP	30-Jun-2022	Private Residence - no additional detail added

Specialty	Consultant	Ward	Telephone
General Medicine	Cameron	GRI C19 Ward 46 Medical	

Primary Diagnosis
There is no data to display.

Secondary Diagnosis
There is no data to display.

Significant Operations / Procedures:
There is no data to display.

Last Discharge Review: Elizabeth Malloch (Elizabeth Malloch - FY1 Doctor August 2021) on 30 Jun 2022 13:18

Discharge Medication:

Active Drug Name	Route	Dose	Disp	Reason	Further Details	ECS	Since Admission
Amoxicillin 500mg capsules	oral	1 capsule three times daily , Fixed Period 5 Day(s) from 30 Jun 2022	Yes				Added
Clarithromycin 500mg tablets	oral	1 tablet twice daily , Fixed Period 5 Day(s) from 30 Jun 2022	Yes				Added
Generic Trimbow 87micrograms/dose / 5micrograms/dose / 9micrograms/dose inhaler	inhalation	2 doses twice daily					Added
Risperidone 2mg tablets 28 tablet	oral	ONE AT NIGHT (AS PER PSYCH)				Y	
Salbutamol 100micrograms/ dose inhaler CFC free 200 dose	inhalation	2 PUFFS WHEN REQUIRED,				Y	
Tamsulosin 400microgram modified-release capsules	oral	1 capsule once daily in the morning					Added

"Added" means this medicine was added to the Clinical Portal record after admission. It does not necessarily mean this medicine was started by the hospital.

Dispensing Comments
.dispensed s bennett 30/6/2022

Withheld Medication:

Date	Withheld Drug Name	Route	Dose	Note	Withheld Reason
There is no data to display.					

Stopped Medication:

Date	Stopped Drug Name	Route	Dose	Note	Stopped Reason
2022-06-30	Amoxicillin 500mg capsules	oral	1 capsule three times daily , Fixed Period 5 Day(s) from 17 Feb 2021		Medication was removed from, made inactive or made

Date	Stopped Drug Name	Route	Dose	Note	Stopped Reason
					unprescribable in the drug database.
2022-06-30	Anoro Ellipta 55micrograms/dose / 22micrograms/dose dry p... 60 dose	inhalation	1 actuation once daily		Stopped before admission
2022-06-30	Buprenorphine 8mg oral lyophilisates sugar free (Espranor (Martindale Pharmaceuticals Ltd))	sublingual	1 tablet once daily Issues by addictions - not GP. Collects at community pharmacy		Stopped before admission
2022-06-30	Trazodone 100mg capsules 84 capsule	oral	3 AT NIGHT AS PER PSYCHIATRY.		Stopped before admission

Reason for Admission and Presenting Complaints	Admission Category
No data available	No data available

Clinical Comments:	Dear Dr Thank you for continuing the care of Michael McLachlan who was admitted to GRI on 30/6/22. He presented with a 1 week history of productive cough and increased SOB. He has a BG of depression, COPD and drug misuse. On examination there was bronchial breathing in the left lung. Bloods showed WCC 9.6, CRP 61. He also had deranged LFTs and a liver screen was sent. CXR showed LUL pneumonia with a possible hilar prominence. He felt better and was discharged with oral amoxicillin and clarithromycin to treat CAP. He was discharged with worsening advice and an urgent OP CT CAP. Many thanks Ward 46 GRI
Discharge Comments:	
Follow Up:	Yes Urgent OP CTCAP

Results Awaited:	Yes liver screen
Pharmacist Comments:	
Final Discharge Letter to Follow:	Yes

Yours sincerely,

Elizabeth MALLOCH

Prescription Review
Medications reviewed by pharmacist: Nigel Fan (Clinical Pharmacist)
Checked by: Jacqueline CAMPBELL3 (pharmacy technician)
Discharged by: Elizabeth MALLOCH (FY1 Doctor August 2021)

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000
Department: Urology
Contact Tel: 0141 201 3537
Enquiries to: Pauline.Milligan@ggc.scot.nhs.uk

Letter Date: 21/06/2022
Reference: MO/AJ
Dictated Date: 15/05/2022
Transcribed Date: 06/06/2022

Dr. SJ Bruce
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Dear Doctor McLachlan ,

Michael McLachlan; D.O.B: 31/12/1962; CHI: 3112626230
FLAT 1-1, 10 GIRVAN STREET, Glasgow, Lanarkshire, G33 2DP

I had a telephone consultation with Mr McLachlan, since starting on tolterodine he has no day time lower urinary tract symptoms, now he is complaining of nocturia. He has stopped all his fizzy juice and started drinking diluting juice but this is two glasses per day again I will review him back at my clinic.

Yours sincerely

Nurse Margaret O'Connor

Urology Nurse Specialist

Electronically Signed: Nurse Margaret O'Connor, Nurse Practitioner

cc.

Clinical letter - GP: Discharge letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000
Shettleston health Centre,
Physiotherapy Department
0141 232 1562
Barry Forsyth

Dr. SJ Bruce
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Main Switchboard:
Department:
Contact Tel:
Enquiries to:
Letter Date: 29/03/2022
Reference:
Dictated Date: 29/03/2022
Transcribed Date:

Dear Dr Bruce,

Michael McLachlan; D.O.B: 31/12/1962; CHI: 3112626230
FLAT 1-1, 10 GIRVAN STREET, Glasgow, Lanarkshire, G33 2DP

This patient did not keep their first appointment with us on 29-3-22 and did not notify us that they would not be attending.

No further appointment will be offered and they will be removed from our waiting list, unless they contact us within 24 hours.

Yours sincerely

Barry Forsyth

Band Six Physiotherapist

Electronically Signed: ,

cc.

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Main Switchboard: 0141 211 4000
Department: Urology
Contact Tel: 0141 201 3537
Enquiries to: Pauline.Milligan@ggc.scot.nhs.uk
Letter Date: 18/01/2022
Reference: MO/AJ
Dictated Date: 07/01/2022
Transcribed Date: 18/01/2022

Dr. SJ Bruce
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Dear Doctor Bruce ,

Michael McLachlan; D.O.B: 31/12/1962; CHI: 3112626230
FLAT 1-1, 10 GIRVAN STREET, Glasgow, Lanarkshire, G33 2DP

I had a telephone consultation with Mr McLachlan with regards to his lower urinary tract symptoms. He is still complaining of nocturia although his day time symptoms have settled. Over the phone we discussed his fluid intake and over a course of a day has one cup of tea and one bottle of fizzy juice. We discussed his fluid intake again and asked him to change his habits I would be grateful if you could prescribe a anticholinergic of your choice to reduce symptoms.

I will re-visit this with him at his next appointment.

Yours sincerely

Nurse Margaret O'Connor

Urology Nurse Specialist

Electronically Signed: Nurse Margaret O'Connor, Nurse Practitioner

cc.

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 06/01/2022

Consultant: Dr Stephen Boyce

SJ Bruce
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
Glasgow
G32 7JZ

Dear SJ Bruce

Re: **McLachlan Michael** DOB: **31/12/1962** CHI: **3112626230**
FLAT 1-1
Glasgow G33 2DP

Attended on: **05/01/2022 at 23:57 hrs.** Departed on: **06/01/2022 at 05:41 hrs.**
Discharge Type: **01b - Discharge with follow up by primary care team** Destination: **Private residence**
Previous ED Attendance in last 12 months: **1**

Presenting complaint
S.O.B.

Nursing Assessment:
Worsening SOD/DIB 2/7. non-productive cough. COVID +VE 20/12/21. Worse on exertion. Carer reports ?cyanosed @ home. PMHx COPD, asthma. NEWS 1

Investigations in ED:
1. XR Chest
2. Full Blood Count
3. Urea and Electrolytes
4. Troponin I hs
5. LFT
6. CRP

Diagnosis:

Diagnosis	Side	Site
Dyspnoea		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:

59M with PMHx of COPD presented with 2/7 dyspnoea after COVID +ve 20/12/21. Dry cough, no sputum, no wheeze. One episode chest pain, central tightness at rest around 10pm lasting 1hr. Pain eased when used inhaler. Not related to inspiration, not worse on exertion. Long standing back pain, no red flag symptoms. Eating and drinking ok, otherwise well. SPO2 95% on RA, RR normal, chest clear. HR 55, ECG unremarkable - asymptomatic. CXR and bloods unremarkable, trop <4. Discharged with worsening advice and spare salbutamol inhaler as pt not sure if he has one - technique checked. Patient advised re symptoms to be aware of re low HR; please could GP consider monitoring this.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Sarah Train
Doctor

Copies to:

1. SJ Bruce (GP)

School Address:

CHI: 3112626230

Glasgow Royal Infirmary

15

Total Att: 18

12 Mth Att: 1

Title: MR

MCLACHLAN **Michael**

DOB **31/12/1962** Age: **59y** Sex: **Male**

FLAT 1-1
10 GIRVAN STREET
Glasgow
Lanarkshire
G33 2DP
07947416972

Next of kin: **SHERLOCK, Martine**
Relationship: **Niece**

GP: **SJ Bruce**
0141 531 6220

Attendance Date: **05/01/2022** Arrival Time: **23:57**

Registration Time: **23:57** Date of Incident: **05/01/2022**

Major Incident Desc:

Reason for Attendance: **S.O.B.**

Nursing Assessment

Alerts: **Yes** Allergies: **None Known** Pain Score:

Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **06/01/2022 00:01** Nurse name: **Nurse Chelsea Adam**

Temp	36.4	C
HR	57	bpm
BP	112/65	mmHg
MAP	80.67	mmHg
RR	19	bpm
SpO2	95	%
Oxygen		%

BM	7.2	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

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

Nursing Notes: **Worsening SOD/DIB 2/7. non-productive cough. COVID +VE 20/12/21. Worse on exertion. Carer reports ?cyanosed @ home. PMHx COPD, asthma. NEWS 1**

3112626230 31/12/1962 MCLACHLAN Michael
3112626230 31/12/1962 MCLACHLAN Michael
3112626230 31/12/1962 MCLACHLAN Michael
3112626230 31/12/1962 MCLACHLAN Michael
3112626230 31/12/1962 MCLACHLAN Michael

To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

Date	**Clinical Notes**	
	Seen By	Time Seen

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By
6/1/22	Salbutamol	100mcg	to take	home 0430		

Glasgow Royal Infirmary
Emergency Department

NHS
Greater Glasgow and Clyde

3112626230
MCLACHLAN
Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP
M
31/12/1962

Initial Investigations Ordered

FBC ☐	COAG ☐	DD ☐	INR ☐		G+S ☐		X-match units			
U+Es ☐	LFT ☐	GLU ☐	CRP ☐	TROP ☐	Para ☐	Sal ☐	Ethanol ☐	Mg ☐	VBG ☐	ABG ☐
B culture ☐		C/MSSU ☐		Urinalysis ☐		BHCG ☐		Other		
CXR ☐	AXR ☐	Other imaging:								ECG ☐
Current location:								Sent by:		

Clinical Notes

Date 6/1/22 Time 0220 Name TRAIN Grade FY2 Specialty EM

59♂ PC: SOB
999 call

B/G: Drug induced psychosis
COPD - PFTs 2018 - not completed.
Previous benzo + heroin use
LUTS: Nocturia, frequency, urgency
Covid +ve 20/12

HPC: 2/7 of feeling more SOB - noticed most when talking to friends + carer - they have commented on him looking SOB/grey - this has made him anxious.
- States SOB mobilising within house - has assistance with cooking/shopping but this is also due to other disabilities (hand injury)
- Cough but dry - denies haemoptysis/sputum.
- 1 episode of chest pain today ~10pm - at rest, central, tight feeling. Felt relief with inhaler. Not related to inspiration. No radiation. Lasted ~1hr, almost gone now. Nil similar recently - had 2 months ago. Felt a little lightheaded + sweaty. No LOC.
- Long standing back pain, some shooting pains bilat down back of thighs - no neuro symptoms/incontinence/saddle anaesthesia.
- E+D ok; no abdo pain/no change in urinary symptoms.

SHx
Lives alone - cares OD for ADLs. Ex-smoker. Minimal alcohol. Denies other substance use.

DHx
Tramadol
Tamsulosin
Salbutamol
Risperidone
NKDA

Glasgow Royal Infirmary
Emergency Department

3112626230 M
MCLACHLAN 31/12/1962
Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire G33 2DP

Clinical Notes

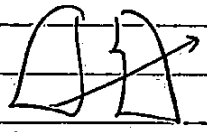
Date 6/1/22 Time 02.20 Name TRAIN Grade FY2 Speciality EM

O/E/

A - own

B - Talking full sentences. Mobilised to toilet + no SOB

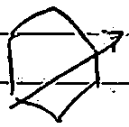
SpO_2 95% RA. RR 19.



Chest clear. No wheeze/crepts

C - Warm.
Good vol radial pulse rate - 51 - no clear cause
HS 1+11+0 → quiet.
BP 112/65
Nil oedema

D - Alert. BM 7.2

E - 
SNT
BS +ve

Calves SNT
No tenderness in midline of back.
Tone/power/sensation (N) in lower limbs bilaterally.
Gait (N).

Glasgow Royal Infirmary
Emergency Department

3112626230
MCLACHLAN
Michael M
FLAT 1-1 31/12/1962
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Clinical Notes

Date 6/1/22 Time 02 20 Name TRAIN Grade FY2 Speciality EM.

ECG - rate 51; sinus bradycardia
QTc 383 RBBB - not new.

CXR - Awaited
Bloods - Awaited
VBG - see overleaf

Imp Likely covid related SOB with ?anxiety element (not wheezy) ?ACS
Plan - Bloods inc trop
- CXR → no focal consolidation; no sig. change from previous.
- Not requiring O2 / nebuliser / pred just now
- Monitor HR + BP - unclear cause of tachy
- Aim (H) if above ok

FY2 TRAIN 0430

TRAIN FY2

Trop <4
CRP 13 Hb 127 WCC 5.6
bloods otherwise NAD
CXR - nil focal
SpO2 95%, RA (N), mobilising without dyspnoea, asymptomatic
HR 55. BP 120/60
Discussed with consultant Dr Wallace: for (H) with worsening advice + specific advice re HR - and for GP to F/U.
Discussed w/ pt - has inhalers at home - spare salbutamol provided + technique reviewed. Advice given re mobilising within limits. Worsening advice given.

TRAIN FY2

Glasgow Royal Infirmary
Emergency Department

3112626230
MCLACHLAN
Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP
M
31/12/1962

HAEM	DATE or TIME		BIOCH	DATE or TIME			DATE or TIME		V/ABG	DATE or TIME	
WCC			Na			Bil			FiO_2	VBG on AR	
Hb			K			ALT			H^+	35.9	
Plat			Cl			AST			$PaCO_2$	5.6	
Neut			Ur			GGT			PaO_2	8.8	
DD			Creat			A phos			Bic	29.2	
PT			eGFR			Alb			BE	4.7	
PTT			Glu			AdjCa			Lactate	0.7	
TT			CRP			Amyl			Ethanol		
INR			Mg			TropI HS			Para		
			Phos			BHCG			Sal		

Diagnosis and Plan

Review/Discussed with:

Handover

- ☐ Provisional Diagnosis
- ☐ Liquids/Fluids
- ☐ Analgesic/Medicines
- ☐ NEWS
- ☐ Investigations & Results
- ☐ Talk to receiving team/ward

mi • 287967 Version 1_0 • GGC0226

Patient Information					
MIC [redacted] AN			Date:	05/01/2022	
Age/Gen: 3112626230			Incident Number:	CR008230663	
Address: MCLACHLAN Michael FLAT 1-1 10 GIRVAN STREET Glasgow, Lanarkshire	M	SGOW,G33	Incident Type:	EMG	
DOB:	31/12/1962		Incident Location:	1/1 10 GIRVAN STREET RIDDRIE GLASGOW, G33 2DP	
CHI:					
Ethnicity		G33 2DP			

Scottish Ambulance Service

Presenting Complaint

SOB ON EXERTION NON PRODUCTIVE COUGH

Additional Comments

999 call for 59 yom who was covid pos 20 dec pt has been having increasing sob and non productive cough for last 2 days slightest exertion sob and sometimes struggles to speak in sentences without sob carer sait yesterday and today breathing worse cough worse and earlier pts colour was pale and blue round lips o/e pt obs normal pt slight chest tightness sore when taking deep breath

PATIENT ASSESSMENT

ACVPU	Alert		<C>	No	
A	Clear				
B	Breathing Adequately: Yes	Respiratory Rate: 20	SPO2: 95	Oxygen Given: No	
C	Pulse Rate: 58	BP: 126/73	Cap Refill: <=2 Secs	ECG Rhythm: Sinus Rhythm	
	Rhythm: Reg	Arm: Right	Central/Peripheral: Central	ECG: 3 Lead	
D	GCS: 15	Eyes: Spontaneously (4)	Voice: Orientated (5)	Motor: Obeys Commands (6)	PEARL: Yes

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
23:43	60	20	121/73	97		15	Alert								E0024619
23:35	58	20	126/73	95	<=2 Secs	15	Alert		37.1	7.2					E0024619

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
23:35	20 (0)	95 (1)		0	126 (0)	58 (0)	Alert (0)	37.1 (0)	1

HISTORY

AMPLE

Allergies	None
Medication	SEE ECS
Past Medical History	COPD, Asthma
Last Eaten	>4 Hours Ago

CLOSE RECORD

Treatment On Scene	Non Emergency

Conveyance

Transport To Hospital	Normal driving	Pre Alert	No

INCIDENT LOG

1/5/2022

Incident Number: CR00220663

Time Call Received	19:56	Allocated	23:20	Mobile	23:21
First Resource On Scene		Crew On Scene	23:26	Crew Left Scene	23:48
Crew At Hosp		Receiving Hospital	GLASGOW ROYAL INFIRMARY	Clear Time	

Crew ID	Crew Grade	Driver
E9888232	Ambulance Technician	YES
E0024619	Paramedic	NO

Printed: 06/01/2022 03:04:51

Patient Sample Report

Status: **ACCEPTED**
Analyzed: 06/01/2022 03:04:39
Sample Type: **Venous**
Account Number:
Clinician:
Operator ID: JADE DUNBAR0

Patient

ID:	3112626230
Last Name:	**MCLACHLAN**
First Name:	**MICHAEL**
Gender/Age:	Male, 59 years
Birth Date:	31/12/1962

Cartridge

Lot No.:	210914D
S/N:	000000000500223300
Exp. Date:	02/02/2022

Analyzer

Model:	GEM® *Premier 5000*
Area:	GRI
Name:	MINORS
S/N:	20054609

Results			Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)						
cH	35.9	nmol/L	--	--	--	--
pCO_2	5.6	kPa	--	--	--	--
pO_2	8.8	kPa	--	--	--	--
Na^+	139	mmol/L	--	133	146	--
K^+	4.2	mmol/L	--	3.5	5.3	--
Cl^-	107	mmol/L	--	95	108	--
Ca^{++}	1.20	mmol/L	--	1.15	1.27	--
Glu	5.8	mmol/L	--	3.5	6.0	--
Lac	0.7	mmol/L	--	0.6	2.2	--
CO-Oximetry						
tHb	129	g/L	--	--	--	--
O_2Hb	↓ 92.0	%	--	95.0	98.0	--
COHb	↑ 2.9	%	--	0.5	1.5	--
MetHb	0.5	%	--	0.5	1.5	--
HHb	4.6	%	--	0.0	5.0	--
sO_2	95.2	%	--	95.0	98.0	--
Derived						
BE(B)	4.7	mmol/L	--	--	--	--
$HCO_3^-(c)$	29.2	mmol/L	--	--	--	--
Hct(c)	39	%	--	--	--	--

↑↓ Outside Reference Range

Other Information

Operator Entered

Temp	37.0	°C

3112626230 M
MCLACHLAN 31/12/1962
Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

(15) Michael McLachlan.

NEWS 2 Key	1	2	3

| | | |

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

5/1/22

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

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

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed.....

Medical: .....

Date: .....

Pupil Reaction and size
S = sluggish
+ = reaction
- = no reaction
C = eyes closed
Pupil Size (mm) 1 2 3 4 5 6 7 8

Affix Patient ID

Glasgow Coma Scale

| | | |

(15) SSB. CoVID +VE.

Emergency Department Nursing Documentation

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

NHS Greater Glasgow and Clyde

Presenting Complaint -

Date: 6/1/22 Time: 01:25

Assessment Complete by: Name NURSE (Please Print) Tracey

Patient Prep / Investigations (Please tick/circle when completed)		Communication (Please Circle Tick)	
Prepare patient for examination / Clothing bag labelled + stored	☑	NEWS Chart complete / NEWS SCORE - (Record pain, blood sugar and Neuro Obs on NEWS Chart)	☑
GGC RED BAG - with patient	☐		
12 Lead ECG	☐	ID Band	☐
Weight:	☐	Peak Flow	☐
Blood Samples Obtained: Yes ☐ No ☐		Xrays / CT Scan Performed:	☐
IV Access: Yes ☐ No ☐		Relatives / NOK informed (Carers)	☐
Blood Gas: VBG ☐ ABG ☐		Child Protection Concern (considered in line with policy)	Y/N
		Adult Support and Protection	Y/N

Urinalysis

Leucocytes ☐	Nitrites ☐	Protein ☐	Blood ☐
Ketones ☐	Glucose ☐	PH	S.G.
MSSU / CSU ☐	Toxiclogy ☐		
HCG ☐	+VE ☐	-VE ☐	Strip No -

Screening Tools (Please tick/circle when completed)			
SEPSIS RISK? / SIRS Criteria 2 or more	Y/N	**SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)**	YES
Mental Health Triage Assessment	Y/N	If NOT WHY? - (details)	NO
GMAWS	Y/N	Date - Time - Signature -	

4AT

AMT	Correct
Age	
Date of Birth	
Place	
Current year	

No mistakes	= 0
1 mistake	= 1
> 1 mistake	= 2

Attention (months of year backwards)	
> = 7 correct	0
< 7 correct	1
Untestable	2

Alertness	
Normal	0
Mild sleepiness	0
Clearly abnormal	4

Mental status according to family/carer		
Acute change or fluctuating	4	YES
Acute change or fluctuating	0	NO

4AT score /12

STEP 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?

All over 75s and care home residents over 65. For younger patients use clinical judgement and consult local guidelines.

		YES	NO
F	**F**unctional impairment (new or worsening) eg difficulty with self care		
R	**R**esident in a care home?		
A	**A**ltered mental state such as acute confusion or dementia use the 4AT		
I	**I**mmobility/instability. New decline in mobility, difficulty mobilising without help or fall leading up to admission		
L	**L**ikely to require support for discharge? (either new or increase in existing support)		

Are any of the above criteria met? If YES to any of the above move to step 2

STEP 2 Would this person be better managed by another specialty team at present?

Indicator for care by another acute specialty regardless of age.

	YES	NO
Clear need for other specialty input eg exacerbation of known long term condition such as COPD		
Need for HDU/ITU (including non-invasive ventilation)		
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit		
Head injury with loss of consciousness		
Acute abdominal pain/surgical presentation		
Upper GI Bleed		
Chest pain with suspected acute coronary syndrome		
Trauma with suspected fracture		

Are any of the above criteria met?

If **YES** to any criteria in step 2:

- Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.

If **NO** to the list in step 2:

- Prioritise transfer of care to specialist geriatric assessment service in line with local guidance.

Screening Tools / ACTIVE CARE

(Please tick/circle when completed)

		Y/N	Date	Location of Redness/Ulcers	Grade of Ulcer
1) Pressure Damage Does the person have redness and/or existing damage? If YES - continue with a minimum of 2 hourly Active Care + Complete PUDRA					
2) Mobility	Does the person require assistance?	Y/N			
3) Continence		Y/N	**5) Skin**	Is skin compromised by other source, eg neurological deficit, medication, substance, diabetes, co-morbid?	Y/N
4) Nutrition		Y/N	**6) Judgment**	In your clinical judgment is this person at risk for developing pressure damage? IF YES - DETAILS	Y/N

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

abel

At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc) *At risk complete risk assessment*	
YES	NO

Pause for Transfer / Discharge (Please tick when completed)		Tick when completed	N/A	Notes
Relatives Informed of Admission / Discharge		☐	☐	Information on discussion with relatives
Relatives/carer with patient on transfer to ward		☐	Always	
GGC RED BAG - with patient		☐	Always	
Name Band		☐	Always	
Nursing Screening Tools completed		☐	Always	
Bed requested, SBAR COMPLETE		☐	☐	
NEWS chart		☐	Always	
Prescriptions / Charts signed	Infusions	☐	☐	
Cannula		☐	☐	
Notes: medical notes, GP letter, PRF		☐	☐	
Patients requiring analgesia: sufficient		☐	☐	
Belongings (including patients medication)		☐	Always	Please note here if any other tasks required prior to transfer
SAS Transport required and ref. no.		☐	☐	
Print Name Sign -				

Nursing Notes		
Date and Time		Print Name and Signature
	COVID tve 20.12.21	
6.1.22.	Worsening SOB. 2/7	
01.20	non productive cough.	
	Cared reports ? cyanosed	STAFF NURSE
	@ home	TM Manus
	PMH :- Asthma COPD	

Nursing Notes		
Date and Time		Print Name and Signature

Case No 6566279 **Case Active** 05/01/2022 19:45 **Case Type** Ambulance

Patient Michael Mclachlan **Sex** M **D.O.B** 31/12/1962 **Age** 59 years

Current Address
1/1 10 Girvan Street
Glasgow

G33 2DP

Home Address (if currently not at home)

Current Phone: 07947 416972 **Home Phone:** **CHI:** 3112626230

Case Origin **Callers Name** Lynsey **Callers Tel:**

Own Doctor

Surgery The Cairns Practice

NHS24 Received By Lynne Smith (Call Taker Si) () **NHS24 Triage Start** 19:46

NHS24 Triage By Lynne Smith (Call Taker Si) () **NHS24 Triage End** 19:56

NHS24 Reported Condition **NHS24 Outcome** EMGI

SAS Ref: 8230663 Possible Coronavirus : DRY COUGH, 3 DAYS ,WORSENING

NHS24 Recorded Allergies **NHS24 Recorded Medications** **NHS24 Recorded Medical History**

NHS24 Clinical Summary

Clinical summary created by: Lynne Smith (Call Taker Si) () [05/01/2022 19:57:58]
Reason for call: SAS Ref: 8230663 Possible Coronavirus : DRY COUGH, 3 DAYS ,WORSENING
05:01:2022 19:46:03 SMITHL2.. HAS COPD - RECENT COVID - SOB WHEN TALKING - SLEEPING MORE THAN NORMAL - TAKES PANIC ATTACKS - FEVER - PT GREY IN COLOUR - USED IINHALERS, NOT HELPING.. SHOOTING PAINS DOWN LEG.. NEW SOB - NEW CONTINUOUS COUGH - CONSTRICTING BAND IN CHEST - BEHAVIOUR DIFFERENT - BREATHING FASTER.. ARRANGED THROUGH SAS - REF NUM 8230663..
05:01:2022 19:54:37 MCPHEEA.. TIGHTNESS IN CHEST. CENTRAL CHEST PAIN GREY IN COLOUR. SOB. HOT AND CLAMMY. BLUE LIPS ADVISED 999..
Outcome: 999 contacted - For information only

NHS24 Disposition

999 - Ambulance (ASAP)

NHS24 NUrse Comments

Reported Condition **Received By** **Received**

TAS Assessment **Assessed By** **TAS Assess Start** **TAS Assess End**

Consultation **Consult By** **Consult Start** **Consult End**

Examination Details **Clinical Codes**

Diagnosis

Treatment

Prescriptions

Follow-up(s)

Clinic Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. SJ Bruce
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Main Switchboard:	
Department:	Urology
Contact Tel:	0141 201 3537
Enquiries to:	Pauline.Milligan@ggc.scot.nhs.uk
Letter Date:	12/11/2021
Reference:	MO/AJ
Dictated Date:	12/11/2021
Transcribed Date:	25/11/2021

Dear Dr. SJ Bruce,

Michael McLachlan; D.O.B: 31 Dec 1962; CHI: 3112626230
FLAT 1-1, 10 GIRVAN STREET, Glasgow, Lanarkshire, G33 2DP

Attendance: Specialty - Urology; Clinic - GRMOUR9-NURSE M O'CONNOR URO FRI AM
Date and Time of Appointment - 12/11/2021 09:30

Clinical Comments:
I had a telephone consultation booked today with Mr McLachlan so that we could discuss his lower urinary tract symptoms. Unfortunately I tried several times by telephone and unable to contact him. He will be given a further appointment.

Yours sincerely

Nurse Margaret O'Connor

Urology Nurse Specialist

Electronically Signed: Nurse Margaret O'Connor, Nurse Practitioner

cc.

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Dr. SJ Bruce
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Main Switchboard:	0141 211 4000
Department:	Urology Unit
Contact Tel:	0141 201 3537
Enquiries to:	Pauline.milligan@ggc.scot.nhs.net
Letter Date:	04/11/2021
Reference:	MO/CM
Dictated Date:	13/10/2021
Transcribed Date:	02/11/2021

Dear Doctor ,

Michael McLachlan; D.O.B: 31/12/1962; CHI: 3112626230
FLAT 1-1, 10 GIRVAN STREET, Glasgow, Lanarkshire, G33 2DP

Mr McLachlan, a 58 year old gentleman who attended my clinic with nocturia, frequency and urgency ongoing for 1 year, attended for flows.

IPSS symptoms score was carried out on the day where he had a score of 28 out of a possible 35. Unfortunately, he voided a very small amount in the clinic area of 146ml. Our machine does not calibrate an accurate reading at this, although it took him 33s to empty and 10ml were left in the bladder.

PSA had been checked on the day and returned at 0.3.

I would be grateful if you could try this gentleman on Tamsulosin, and I will review him back in my clinic in due course.

Kind Regards,

Margaret O'Connor

Urology Nurse Specialist

Electronically Signed: Nurse Margaret O'Connor, Nurse Practitioner

cc.

Int[illegible] ptom Score (I-PSS)

3112626230
MCLACHLAN M
Patien Michael 31/12/1962
Date: FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	YOUR SCORE
1. In Over t[illegible] u had a sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5	
2. Frequency Over the past month, how often have you had to urinate again less than two hours after you have finished urinating?	0	1	2	3	4	5	
3. Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. Urgency Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream Over the last month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	

	None	Once	Twice	3 times	4 times	5 or more	YOUR SCORE
7. Nocturia Over the past month how many times did you most typically get up each night to urinate from the time you went to bed until the time you got up in the morning?	0	1	2	3	4	5	
Total I-PSS Score							28

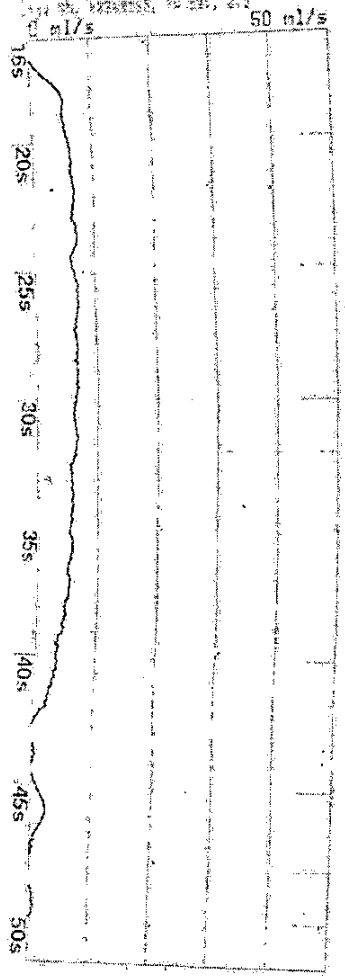
Quality of Life due to Urinary Symptoms	Delighted	Pleased	Mostly satisfied	Mixed	Mostly unhappy	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

The I-PSS is based on the answers to seven questions concerning urinary symptoms. Each question is assigned points from 0 to 5 indicating increasing severity of the particular symptom. The total score can therefore range from 0 to 35 (asymptomatic to very symptomatic).

Although there are presently no standard recommendations into grading patients with mild, moderate or severe symptoms, patients can be tentatively classified as follows: 0 - 7 = mildly symptomatic; 8 - 19 = moderately symptomatic; 20 - 35 = severely symptomatic.

The International Consensus Committee (ICC) recommends the use of only a single question to assess the patient's quality of life. The answers to this question range from "delighted" to "terrible" or 0 to 6. Although this single question may or may not capture the global impact of BPH symptoms on quality of life, it may serve as a valuable starting point for doctor-patient conversation.

DANTEC DYNAMICS



Results

Date:	08-Oct-2021 14:57
Voiding Time:	33 s
Flow Time:	28 s
Time To Max Flow:	7 s
Max Flow Rate:	7.1 ml/s
Avg Flow Rate:	5.2 ml/s
Voided Volume:	146 ml

Patient Information

ID: _____

Name: _____

BladderScan®

15:37 10/08/2021

10 mL

Patient Name

Date

Patie

Patie

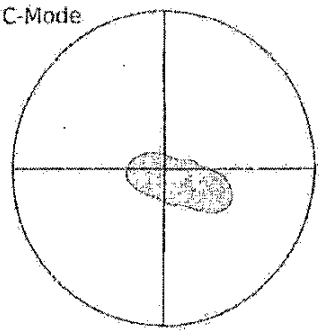
Proc

Ope

Signature

311262230
MCLACHLAN
Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP
M
31/12/1962

C-Mode



Console ID: C1517957
Probe and Transducer ID: P1525048

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Dr. SJ Bruce
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Main Switchboard: 0141 211 4000
Department: Urology
Contact Tel: 0141 201 3537
Enquiries to: Pauline.Milligan@ggc.scot.nhs.uk
Letter Date: 26/08/2021
Reference: MO/JPM
Dictated Date: 16/08/2021
Transcribed Date: 26/08/2021

Dear Dr Bruce,

Michael McLachlan; D.O.B: 31/12/1962; CHI: 3112626230
FLAT 1-1, 10 GIRVAN STREET, Glasgow, Lanarkshire, G33 2DP

Thank you for referring Mr McLachlan, a 38 year old man to the prostate assessment clinic with nocturia, frequency and urgency. This has been ongoing for approximately one year. His main complaint is up five times overnight. IPPS symptom score was 8 out of a possible 35.

On talking to Mr McLachlan, over a course of 24 hours, sometimes this can run into 48 hours, he can drink one bottle of Lucozade Sport, no other fluids are encountered. I have given him some fluid advice, we tried to encourage him to drink within the clinic area so we could do flow and scan but unfortunately he became quite agitated. He refused for us to take bloods in the form of PSA and declined a DRE. He has agreed to come back to the clinic with a full bladder where we can carry out formal flows and scans at a later stage.

Kind regards,

Margaret O'Connor

Urology Nurse Specialist

Electronically Signed: Nurse Margaret O'Connor, Nurse Practitioner

cc.

Prostate Assessment Clinic – Report sh[illegible]

Dr. S.J Bruce
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Date of Assessment: 16/08/2021

Referred by GP/Consultant:

58years

IPSS Questionnaire

QUESTION	Over the past month, how often have you	SCORE
1	Had a sensation of not emptying your bladder completely after urinating?	0
2	Had to urinate again less than 2 hours after you finished urinating?	0
3	Found you stopped and started again when urinating?	0
4	Found it difficult to postpone urination?	0
5	Had a weak urinary stream?	0
6	Had to push or strain to begin urinating?	0
7	Typically had to get up to urinate during the night?	3
	Total	5

5/35

Quality of Life:

If you were to spend the rest of your life with your urinary conditions as it is now, how would you feel?

Referral Symptoms Nocturia Frequency, Urgency
1+/year history

General Physical Condition

Past History

		Yes	No
1	Urological Procedures Circ.		✓
2	Previous Catheterisation		✓
3	Neurological Condition		✓
4	Diabetes		✓
5	Allergies		✓
6	Medication Risperidone		
7	Smoker Ex Smoker & VAPE COPD.		
8	Alcohol	✓	
9	Social Circumstances lives alone		
10	Other		

DRE Refused

MICHAEL, MCGACHAN Declined

Results

Uroflow

Voiding Time	Peak Flow	Mean Flow	Total Voided Volume	Residual Volume as per Bladderscan
s	ml	ml	ml	ml

MSSU DIPTEST

Bloods

	Performed	Results
U+E	16/08/2021	Refused
PSA		

Treatment Recommendation

Priority	Treatment	
	Clinic Review	
	Cystoscopy GA	
	Cystoscopy LA	
	Urodynamics	
	Medical Therapy	
	Other	

Comments

1 bottle lucozade sport

Return flow's Scan

Sign:

Clinic Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. SJ Bruce
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Main Switchboard: 0141 211 4000
Department: General Surgery
Contact Tel: 0141 201 6670
Enquiries to: Helen.Gaughan@ggc.scot.nhs.uk
Letter Date: 23/04/2021
Reference: KK/EB
Dictated Date: 23/04/2021
Transcribed Date: 11/05/2021

Dear Dr. SJ Bruce,

Michael McLachlan; D.O.B: 31 Dec 1962; CHI: 3112626230
FLAT 1-1, 10 GIRVAN STREET, Glasgow, Lanarkshire, G33 2DP

Attendance: Specialty - General Surgery; Clinic - GRMDGS9-MR DUXBURY FRI AM
Date and Time of Appointment - 23/04/2021 09:50

Clinical Comments:
Thank you referring this pleasant 58 year old gentleman with right inguinal hernia. I saw him face to face in Mr Duxbury's clinic this morning. He tells me he has got a couple of months history of lump in his right groin, it is not particularly causing any symptoms whatsoever. The main symptoms which he is bothered about is going the toilet to pass urine again overnight and this is most of his concern.

His past medical history includes previous Heroin, smoker (stopped 3 months ago), COPD an active smoker (10 per day).

On examination his abdomen is soft and non tender. He is not obese and he has got a plum size direct right inguinal hernia which is reducible and non tender.

We discussed in length whether we should proceed with inguinal hernia operation at present or not and as this is not bothering him at present and the main problem is urological we have agreed I will refer him to Urology for their opinion and then we will see him back in clinic in about 6 months time to discuss the hernia operation. He is happy with that. Many thanks.

Yours sincerely

Mr Khurram Khan

ST7 in General & Upper GI Surgery

Electronically Signed: Dr Khurram Khan, Doctor

cc.

McLachlan Michael CHI: 3112626230

Referral letter:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Receiving Consultant
Urology Department
Glasgow Royal Infirmary

Main Switchboard: 0141 211 4000
Department: General Surgery
Contact Tel: 0141 201 6670
Enquiries to: Helen.Gaughan@ggc.scot.nhs.uk
Letter Date: 08/06/2021
Reference: KK/EB
Dictated Date: 23/04/2021
Transcribed Date: 11/05/2021

Dear Colleague,

Michael McLachlan; D.O.B: 31/12/1962; CHI: 3112626230
FLAT 1-1, 10 GIRVAN STREET, Glasgow, Lanarkshire, G33 2DP

I would be much obliged for your opinion about this pleasant 58 year old gentleman. He was referred to us with right inguinal hernia which indeed he does have but this is not his main symptom. His main symptom is nocturia and frequency and has urgency especially at night. I will be much obliged for your opinion. I have attached a detailed letter to GP. Many thanks.

Yours sincerely

Mr Khurram Khan

ST7 in General & Upper GI Surgery

Electronically Signed: Dr Khurram Khan, Doctor

cc. **please attach copy of clinic letter dated 23.04.2021**

Clinic appt any cons: with flow & scan.
Please send IPSS questionnaire with appointment letter.

10/6/21

Dr SJ Bruce
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow G32 7JZ

Referral letter:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Receiving Consultant
Urology Department
Glasgow Royal Infirmary

Main Switchboard:	0141 211 4000
Department:	General Surgery
Contact Tel:	0141 201 6670
Enquiries to:	Helen.Gaughan@ggc.scot.nhs.uk
Letter Date:	08/06/2021
Reference:	KK/EB
Dictated Date:	23/04/2021
Transcribed Date:	11/05/2021

Dear Colleague,

Michael McLachlan; D.O.B: 31/12/1962; CHI: 3112626230
FLAT 1-1, 10 GIRVAN STREET, Glasgow, Lanarkshire, G33 2DP

I would be much obliged for your opinion about this pleasant 58 year old gentleman. He was referred to us with right inguinal hernia which indeed he does have but this is not his main symptom. His main symptom is nocturia and frequency and has urgency especially at night. I will be much obliged for your opinion. I have attached a detailed letter to GP. Many thanks.

Yours sincerely

Mr Khurram Khan

ST7 in General & Upper GI Surgery

Electronically Signed: Dr Khurram Khan, Doctor

cc. **please attach copy of clinic letter dated 23.04.2021**

Dr SJ Bruce
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow G32 7JZ

Clinic Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. SJ Bruce
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Main Switchboard:	0141 211 4000
Department:	General Surgery
Contact Tel:	0141 201 6670
Enquiries to:	Helen.Gaughan@ggc.scot.nhs.uk
Letter Date:	23/04/2021
Reference:	KK/EB
Dictated Date:	23/04/2021
Transcribed Date:	11/05/2021

Dear Dr. SJ Bruce,

Michael McLachlan; D.O.B: 31 Dec 1962; CHI: 3112626230
FLAT 1-1, 10 GIRVAN STREET, Glasgow, Lanarkshire, G33 2DP

Attendance: Specialty - General Surgery; Clinic - GRMDGS9-MR DUXBURY FRI AM
Date and Time of Appointment - 23/04/2021 09:50

Clinical Comments:
Thank you referring this pleasant 58 year old gentleman with right inguinal hernia. I saw him face to face in Mr Duxbury's clinic this morning. He tells me he has got a couple of months history of lump in his right groin, it is not particularly causing any symptoms whatsoever. The main symptoms which he is bothered about is going the toilet to pass urine again overnight and this is most of his concern.

His past medical history includes previous Heroin, smoker (stopped 3 months ago), COPD an active smoker (10 per day).

On examination his abdomen is soft and non tender. He is not obese and he has got a plum size direct right inguinal hernia which is reducible and non tender.

We discussed in length whether we should proceed with inguinal hernia operation at present or not and as this is not bothering him at present and the main problem is urological we have agreed I will refer him to Urology for their opinion and then we will see him back in clinic in about 6 months time to discuss the hernia operation. He is happy with that. Many thanks.

Yours sincerely

Mr Khurram Khan

ST7 in General & Upper GI Surgery

Electronically Signed: Dr Khurram Khan, Doctor

cc.

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

General Surgery GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Glasgow Royal Infirmary 84 Castle Street Glasgow G4 0SF	——	**Hospital** and **hospital address** Hospital location code. G107H Email address -

Urgency of referral Routine
Date of referral 16-Mar-2021 **Date sent** 16-Mar-2021

PATIENT DETAILS

Surname	MCLACHLAN
Forename(s)	MICHAEL
Title	MR
Sex	Male
Date of birth	31-Dec-1962
CHI no.	3112626230
Area of Residence	-

Patient's address

1-1
10 GIRVAN STREET
GLASGOW
G33 2DP

Contact number(s)

Voice: 07947 416 972

101022860556H Unique Care Pathway Number: 101022860556H

REGISTERED GP DETAILS

Name	Dr Kerry Walker		
GMC code	7020285	GP code	02135
Practice name	The Cairns Practice		
Practice code	46081		

Practice address

420 OLD SHETTLESTON ROAD
SHETTLESTON
GLASGOW
G32 7JZ

Contact number(s)

Voice: 01415316220

REFERRING GP DETAILS

Name	Dr. Allan McNeill		
GMC code	6162987	GP code	09211
Practice name	The Cairns Practice (46081)		
Practice code	46081		

Practice address

Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Contact number(s)

Voice: 0141 531 6220

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: R Ing Hernia

Comment: C-19 (phone -> F2F)

Hx drug misuse (longstanding). Open to ARDS. Note recent admission for 2/7 with acute psycotic episode following use of heroin.

Calling today - noted lump "down below". Sounds to be a groin lump. Feels more prominent when sitting or when coughing. Can be bit sore when coughing. Only noticed this in last few days. No vomiting. Bowels - N.

Denies any prev Hx of hernia.

O/E - R sided inguinal hernia. Non tender. Reducable. More prominent standing and coughing. No testicular lumps/swellings noted. (Chap declined)

Plan:
- Discussed - ref general surgeons
- Advised re : red flags - seek review/A&E

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history
Pre-existing conditions (High & medium priority - all)

Description	Comment	Modifier	Date of onset	Date recorded
Heroin misuse	, Medical IP, GRI	-	16-Feb-2021	16-Feb-2021
Chest infection NOS	, Medical IP, GRI	-	16-Feb-2021	16-Feb-2021
Drug psychosis NOS	, Medical IP, GRI	-	16-Feb-2021	16-Feb-2021
Drug psychosis NOS	Possible, Arran Resource Centre	-	21-Apr-2020	21-Apr-2020
O/E - collapse - syncope	, A&E GRI	-	24-Jan-2020	24-Jan-2020
Chronic obstructive pulmonary disease	-	-	02-May-2018	02-May-2018
Drug psychosis NOS	(in remission), Arran Centre	-	10-Oct-2016	10-Oct-2016
Drug withdrawal syndrome	psychotic symptoms on withdrawal from Heroin, A&E GRI	-	24-Jul-2016	24-Jul-2016
Heroin misuse	, GRI	-	20-Feb-2016	20-Feb-2016
Drug-induced hallucinosis	, GRI	-	20-Feb-2016	20-Feb-2016
Endogenous depression first episode	-	First ever	26-Feb-2014	26-Feb-2014
Internal thrombosed haemorrhoids	, A&E GRI	-	20-Aug-2013	20-Aug-2013
Drug dependence NOS	acute psychotic episode	First ever	28-Jul-2006	28-Jul-2006
Benzodiazepine dependence	, Medical IP, GRI	First ever	28-Jul-2006	28-Jul-2006
[X]Heroin addiction	, Medical IP, GRI	First ever	28-Jul-2006	28-Jul-2006
Drug dependence	relapse, Heroin, Cocaine, Diazepam	First ever	26-Jun-2002	26-Jun-2002
Deliberate self-harm	Diazepam overdose	First ever	09-May-2002	09-May-2002

Smoke inhalation	-	First ever	02-Apr-2002	02-Apr-2002
Cubital tunnel syndrome	Left medial epicondylectomy	First ever	04-Nov-1997	04-Nov-1997
Compartment syndrome	-	First ever	09-Mar-1997	09-Mar-1997
[X]Assault	-	First ever	17-Sep-1996	17-Sep-1996
[X]Assault	-	First ever	14-Feb-1987	14-Feb-1987
[X]Assault by sharp object	chest	First ever	11-Jul-1986	11-Jul-1986

Past procedures (High and medium priority - all)

Description	Comment	Modifier	Date performed	Date recorded
Plain x-ray of chest	- shows a calcified granuloma in the left mid zone, SHC	-	02-Mar-2018	02-Mar-2018
Drug addiction therapy	- Buprenorphine 12mg, Newlands Centre	-	18-Jan-2018	18-Jan-2018
Drug addiction therapy	- Suboxone, Newlands Centre	-	05-Sep-2016	05-Sep-2016
Excision of submandibular gland	- left, ENT OP, GGH	-	21-Feb-2014	21-Feb-2014
Drug addiction therapy	Suboxone treatment patient defaulted, EAST CAT	-	06-Sep-2012	06-Sep-2012
Drug addictn therap-methadone	, Addiction Services, Parkhead Hospital	First ever	17-Oct-2006	17-Oct-2006
Primary arthrodesis of joint NEC	5th PIP joint	First ever	18-Mar-1997	18-Mar-1997
Primary repair of tendon	-	First ever	02-Jan-1997	02-Jan-1997
Primary repair of tendon	-	First ever	19-Oct-1996	19-Oct-1996
[SO]Ulnar nerve - hand	divisions	First ever	07-Mar-1996	07-Mar-1996
Exploration of skin wound NEC	and repair of machete wound	First ever	09-Mar-1986	09-Mar-1986

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Anoro Ellipta 55micrograms/dose / 22micrograms/dose dry powder inhaler (GlaxoSmithKline UK Ltd)	60	dose	1 DAILY	-	14-Feb-2020	26-Jan-2021
Risperidone 2mg tablets	28	tablet	ONE AT NIGHT (AS PER PSYCH)	-	17-May-2016	15-Mar-2021
Salbutamol 100micrograms/dose inhaler CFC free	200	dose	2 PUFFS WHEN REQUIRED	-	02-May-2018	26-Jan-2021

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Risperidone 2mg tablets	28	tablet	ONE AT NIGHT (AS PER PSYCH)	-	17-May-2016	20-Nov-2020
Anoro Ellipta 55micrograms/dose / 22micrograms/dose dry powder inhaler (GlaxoSmithKline UK Ltd)	60	dose	1 DAILY	-	14-Feb-2020	12-Nov-2020

Blood Pressure

Date Recorded	Systolic	Diastolic
-	116	70

Body Measurements

Date Recorded	Height	Weight	BMI
-	1.74	62	20.4

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Cigarette smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 10.	14-Feb-2020
Cigarette smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 15. NOTES: got a vapour product yesterday and plans to start this..	29-Jan-2019
Cigarette smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 15.	04-Dec-2018
Cigarette smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 15.	15-Mar-2018
Current smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 10.	07-Oct-2015

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Referred By:Referring GP

Electronic Attachment Present:No

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

Letter to Patient: Patient Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Michael McLachlan
FLAT 1-1
10 GIRVAN STREET
Glasgow
Lanarkshire
G33 2DP

Main Switchboard: 0141 211 4000
Department: Urology Department
Contact Tel: 0141 201 33538
Enquiries to: Ruth.Dickson@ggc.scot.nhs.uk
Letter Date: 02/03/2021
Reference: MF/JD
Dictated Date: 26/02/2021
Transcribed Date: 26/02/2021

Dear Mr McLachlan,

I have been performing virtual case sheet review on patients with outstanding Urology follow up appointments.

We undertook a circumcision in August 2020 and your GP referred you the following month with some difficulties passing urine.

It was very unfortunate that we were not able to see you but many appointments have been cancelled or postponed due to the pandemic.

It's an experience that many of these problems that occur following circumcision resolve themselves.

If it has in your case I am happy and we need do nothing further but if you are still having any issues then please contact my secretary on the above number and I will arrange to get you up to see me in the near future.

Yours Sincerely

Mr Michael Fraser

Consultant Urological Surgeon

Electronically Signed: Mr Michael Fraser, Consultant

cc. Dr Bruce
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No
Consent for Sharing Withheld: No

STIRLING BRUCEThe Cairns Practice,Shettleston Health Centre,420 Old Shettleston Road, Glasgow, G32 7JZ

Main Switchboard:
Date of Completion: 18-Feb-2021

Dear STIRLING BRUCE,

Name	CHI	DoB	Address
Michael McLachlan	**3112626230**	**31-Dec-1962**	**FLAT 1-1, 10 GIRVAN STREET, Glasgow, Lanarkshire, G33 2DP**

Admitted	Type	Discharged	Destination
16-Feb-2021 23:11	IP	18-Feb-2021	Private Residence - living alone

Specialty	Consultant	Ward	Telephone
General Medicine	Jamdar	GRI Ward 11 General Medicine	

Primary Diagnosis
There is no data to display.

Secondary Diagnosis
There is no data to display.

Significant Operations / Procedures:
There is no data to display.

Last Discharge Review: Kieran Macleod (Kieran Macleod - FY1) on 18 Feb 2021 14:09

Discharge Medication:

Active Drug Name	Route	Dose	Disp	Reason	Further Details	ECS	Since Admission
Amoxicillin 500mg capsules	oral	1 capsule three times daily , Fixed Period 5 Day(s) from 17 Feb 2021	Yes				Added
Anoro Ellipta 55micrograms/ dose / 22micrograms/dose dry p... 60 dose	inhalation	1 actuation once daily	No	Patient's own supply		Y	
Buprenorphine 8mg oral lyophilisates sugar free (Espranor (Martindale Pharmaceuticals Ltd))	sublingual	1 tablet once daily , Issues by addictions - not GP. Collects at community pharmacy	No	Community Pharmacist to Supply			Added
Risperidone 2mg tablets 28 tablet	oral	ONE AT NIGHT (AS PER PSYCH)	No	Patient's own drugs at home		Y	
Salbutamol 100micrograms/ dose inhaler CFC free 200 dose	inhalation	2 PUFFS WHEN REQUIRED,	No	Patient's own supply		Y	
Trazodone 100mg capsules 84 capsule	oral	3 AT NIGHT AS PER PSYCHIATRY,	No	Patient's own drugs at home		Y	

"Added" means this medicine was added to the Clinical Portal record after admission. It does not necessarily mean this medicine was started by the hospital.

Dispensing Comments
Dispensed by J Campbell 18/02/21

Withheld Medication:

Date	Withheld Drug Name	Route	Dose	Note	Withheld Reason
There is no data to display.					

Stopped Medication:

Date	Stopped Drug Name	Route	Dose	Note	Stopped Reason
2021-02-18	Buprenorphine 8mg sublingual tablets sugar free 1 tablet	sublingual	ON 12MG/DAY. ISSUED BY ADDICTIONS. NOT FOR GP ISSUE.,		Added in error - is on espranor

Reason for Admission and Presenting Complaints	Admission Category
No data available	No data available

Clinical Comments:	Dear Doctor, Mr Michael McLachlan was admitted to Glasgow Royal Infirmary on 16/2/21 with an acute drug-induced psychosis following use of heroin. He also reported chest pain on admission and has been treated for a lower respiratory tract infection. Background: - previous drug-induced psychosis - previous benzodiazepine dependency Following a period of observation and investigation, Mr McLachlan was deemed medically fit for discharge. He will be followed up in the community by his care worker, Brenda Hay, of NE ADRS. Investigations: - CTB - nil acute - CXR - patchy consolidation at right costophrenic angle Medication: - started on a course of amoxicillin for LRTI - course to be completed at home Yours sincerely, Kieran Macleod, FY1 Acute medicine, Ward 11 Glasgow Royal Infirmary
Discharge Comments:	
Follow Up:	Yes NE ADRS
Results Awaited:	No
Pharmacist Comments:	

Final Discharge Letter to Follow:	Yes

Yours sincerely,

Kieran MACLEOD

Prescription Review
Medications reviewed by pharmacist: Jack Doherty (Pharmacist)
Checked by: Nicholas CASSIDY (Senior Pharmacy Technician)
Discharged by: Kieran MACLEOD (FY1)

SCAN WITH ANY POA/GUARDIANSHIP PAPERWORK UNDER LEGAL NOTICES ON DISCHARGE

NHS Greater Glasgow and Clyde

Sticker or Name, DOB, CHI and address	Ward SASA Date completed 16/04/21 Date revoked
MICHAEL Mc LACHLAN 3112626230	

Capacity Documentation For Medical Treatment

Section A - Assessment of Capacity

Capacity is assumed unless there is evidence of incapacity

☑ I believe that this person has attained the age of 16 and lacks capacity with regards to the proposed interventions because of mental disorder or inability to communicate because of physical disability. This is because they are unable to: (tick at least one of the following)

- ☑ Understand that a decision about the proposed treatment is required
- ☑ Believe, understand when presented in appropriate language, retain memory of, or weigh and balance information about the proposed treatment
- ☑ Communicate a decision, including with help of mechanical or other aids
- ☑ Understand appropriately the benefits, risks and alternatives including the consequences of not receiving the proposed treatment
- ☐ Reasonably recall the previous making of a decision about treatment

If the person lacks capacity consider whether they may be a vulnerable adult – if so refer Social Work

Section B – Welfare Attorney/Guardian

I have made reasonable enquiries to ascertain if anyone has been appointed as Welfare Guardian/Attorney or holds an intervention order for this patient and:

☑ I believe that no one has been appointed. If so the nearest relative should be consulted.

OR

☐ I believe that the undernoted has been appointed. If so then consent must be sought from them if possible.

Name: _____

Contact Details: _____

If there is a Welfare Guardian/Attorney please obtain a photocopy of the document and file in the clinical record (may be available on Clinical Portal – if not ask the Welfare Attorney/Guardian)

☐ requested Signed _____ Date _____ ☐ obtained Date _____

To revoke a statement of incapacity, score through and date the above box and the Section 47

ADULTS WITH INCAPACITY
(SCOTLAND) ACT 2000

Certificate of Incapacity under Section 47 of the Adults with Incapacity (Scotland) Act 2000

I AMY GILBROOK (name)

of GLASGOW ROYAL INFIRMARY (address)

*am the medical practitioner primarily responsible for the medical treatment of; or

*am a person who is *a dental practitioner/an ophthalmic optician/a registered nurse and who satisfies such requirements as are prescribed by the Adults with Incapacity (Requirements for Signing Medical Treatment Certificates) (Scotland) Regulations 2007 and who is primarily responsible for treatment of the kind in question of:

MICHAEL MCLACHLAN (name)

of 1-1 GIRVAN STREET, GLASGOW (address) 13 11 11 12 76 72 (date of birth)

for whom the *guardian/welfare attorney/person appointed by intervention order/nearest relative/carer

is

I have examined the patient named above on 11 06 12 12 72 11 (date). I am of the opinion that *he/she is incapable within the meaning of the Adults with Incapacity (Scotland) Act 2000 ("the 2000 Act") in relation to a decision about the following medical treatment:

SEE SECTION D

because of (nature of incapacity) DEMENTIA / PSYCHOSIS

This incapacity is likely to continue for 1 months.

*I therefore consider it appropriate for the authority conferred by section 47(2) of the 2000 Act to subsist from:

11 06 12 12 11 (date of examination) until 18 06 13 13 12 11, being a period which does not exceed one year from the *date of the examination on which this certificate is based/date of revocation of the certificate issued previously by me; or

*I am of the opinion that (a) *he/she is suffering from *a severe or profound learning disability/dementia/a severe neurological disorder; and (b) *what he/she is suffering from is unlikely to improve within the meaning of the Adults with Incapacity (Conditions and Circumstances Applicable to Three Year Medical Certificates) (Scotland) Regulations 2007/ Y Y and therefore consider it appropriate for the authority conferred by section 47(2) of the 2000 Act to subsist until:

D D M M Y Y being a period which does not exceed three years from the *date of the examination on which this certificate is based/date of revocation of the certificate issued previously by me.

The authority conferred by section 47(2) of the 2000 Act shall subsist for the period specified above or until such earlier date as this certificate is revoked.

In assessing the capacity of the patient, I have observed the principles set out in section 1 of the 2000 Act.

Signed [signature] Date 15 01 12 12

*delete as appropriate

Section D Treatment plan

for patients receiving ongoing treatment under the terms of part 5 of the Adults with Incapacity (Scotland) Act 2000

You must tick both boxes to continue

☑ I have examined the patient named above on (date) 16 / 02 / 21 and consider that he/she needs to undergo procedures to safeguard or promote physical or mental health in relation to the treatment plan below. I have assessed his/her capacity to consent to treatment in relation to each area of intervention

☑ I have no reason to believe that any of the proposed treatments are contrary to wishes expressed by the patient, even when they had greater capacity, or to views that are consistent with their moral, cultural, family and experiential back ground

Signature _____ Print A Gilchrist Designation/Grade SHO

Disorder/Intervention (see note A)	Date	Capacity (C = capable I = incapable)
1. Fundamental healthcare procedures including all measures to support the following: Nutrition, hydration, hygiene, skin care and integrity, elimination, relief of pain and discomfort, mobility, communication, eyesight, hearing and simple oral hygiene.	16/02	I
2. Prevention and treatment of infection		
3 Prevention of Deep Venous Thrombosis		
4. AHP interventions		
5. Continuing management of existing long term conditions Please specify conditions Possible COPD		
6. Possible Delirium / Psychosis		
7. Possible PE		
8. Possible encephalitis		

Remember that some treatments require to be named specifically on the treatment plan. These include sedation for agitation, and any treatment which usually requires verbal consent. Covert medications must be named on the treatment plan and also require their own care plan (download from Mental Welfare Commission website). This list is not exhaustive. Section 47 does not cover discharge planning or deprivation of liberty.

Any treatment which would usually require signed consent requires a separate certificate of incapacity.

Member of staff consulting family/carers to sign:

I have discussed with the patient's representative as below

Welfare Guardian/ Power of Attorney (if one appointed):

☐ Name _____ Relationship _____ OR

Relative/ Carer/ Other individual most involved in persons care (if no Welfare Guardian/Power of Attorney):

☐ Name _____ Relationship _____

Signed _____ Print _____ Date _____

If additional items added to the treatment plan they must be discussed separately
All additional section 47 forms to be attached at section C

ADULTS WITH INCAPACITY (SCOTLAND) ACT 2000

This plan is intended to guide healthcare professionals who are caring for patients who have multiple and complex needs. It should be attached to a certificate of incapacity and retained in the patient's multidisciplinary case record.

A. Under the Act, you can only intervene if it will benefit the patient. Your intervention must be the least restrictive in relation to the patient's freedom in order to achieve the required benefit. You must take the patient's view into account and you must consult other relevant people, where reasonable and practicable.
Include all present or foreseeable disorders and/or interventions for physical and mental disorders not included in "Fundamental Healthcare Procedures" (see note B). You should consider the patient's capacity to consent to each intervention. Under the Act, the patient is incapable if he/she is incapable of acting, or making decisions, or communicating decisions, or understanding decisions, or retaining the memory of decisions.
Exclude all interventions that require express (signed) consent of the patient. Interventions of this sort need a separate certificate of incapacity. *For example, if you write "coronary heart disease and hypertension" on the plan, this authorises you to prevent disease with aspirin, or treat disease with anti-hypertensive drugs, but not operate or bypass blocked arteries.*

You may not include on this form any treatment regulated under section 48 of the Act. Please consult the regulations and separate guidance issued on these treatments. These treatments are:

Sterilisation where there is no serious malfunction or disease of the reproductive organs
Surgical implantation of hormones for the purpose of reducing sex drive
Drug treatment for the purpose of reducing sex drive, other than surgical implantation of hormones
Electro-convulsive therapy (ECT) for mental disorder
Abortion
Any medical treatment which is considered likely by the medical practitioner primarily responsible for that treatment to lead to sterilisation as an unavoidable result.

B. Fundamental healthcare procedures include all measures to promote or safeguard the following: nutrition, hydration, hygiene, skin care and integrity, elimination, relief of pain and discomfort, mobility, communication, eyesight, hearing and simple oral hygiene.

C. The Act requires you to take the views of others into account when deciding on an intervention.
You should discuss this plan with professional carers and relatives of the patient. Any person with an interest in the welfare of the patient may appeal a treatment decision to the Sheriff. If the patient has a Welfare Attorney or Guardian with the authority to consent to treatment, you must consult this person where reasonable and practical. You can find out if your patient has a Welfare Attorney or Guardian by contacting the Public Guardian on 01324 678300. If this person disagrees with any element of your plan, you must refer to the Code of Practice for details of the dispute resolution process by the Mental Welfare Commission for Scotland, tel: 0131 313 8777.

D. Includes conditions diagnosed previously such as hypertension or diabetes. You may find that you need to treat a condition that is not specified in your treatment plan. If this is a short lived condition, a separate certificate in relation to it might suffice. If it is a condition that is likely to need ongoing intervention, you should consider rewriting the treatment plan.
The treatment plan is only valid for the period specified in the certificate of incapacity. The maximum period is **one year** or three years where the patient suffers from a severe or profound learning disability; dementia; a severe neurological disorder and the condition is unlikely to improve.

mi • 285848 Version 1_0 • GGC0211

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000
Department: ORTHOPAEDICS
Contact Tel: 0141 201 3105/3114
Enquiries to:

Dr. SE Hand
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Letter Date: 07/12/2020
Reference: GS/EH
Dictated Date: 25/11/2020
Transcribed Date: 26/11/2020

Dear Dr Hand,

Michael McLachlan; D.O.B: 31/12/1962; CHI: 3112626230
FLAT 1-1, 10 GIRVAN STREET, Glasgow, Lanarkshire, G33 2DP

Diagnosis: Right thumb metacarpal base bone bruise from 11.10.20.

Outcome: Discharged.

This patient attended hand clinic for review. He received an MRI scan that confirmed the bone bruise within the base of the thumb metacarpal and degenerative disease across the wrist joint to lesser degree. He tells me that he still has symptoms from the base of the thumb and I explained that with arthritic joint pain; injury recovery will take longer. There is no fracture line visible on radiographs only diagnosed on MRI and it is stable and will heal without any intervention.

I suggest that he needs to mobilise gradually and no further appointment is required.

Yours sincerely

Mr Grzegorz Sianos MD BDS EDHS

Consultant Orthopaedic Hand Surgeon

Glasgow Royal Infirmary

www.nhsggc.org.uk/orthopaedics

Electronically Signed: Mr Grzegorz Sianos, Consultant

cc.

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000
Department: Orthopaedics
Contact Tel:
Enquiries to:

Dr. SE Hand
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Letter Date: 03/12/2020
Reference: AC/SM
Dictated Date: 11/11/2020
Transcribed Date: 11/11/2020

Dear Dr Hand ,

Michael McLachlan; D.O.B: 31/12/1962; CHI: 3112626230
FLAT 1-1, 10 GIRVAN STREET, Glasgow, Lanarkshire, G33 2DP

Michael was due to be seen in the fracture clinic today at Glasgow Royal Infirmary but failed to attend. We will send a further appointment for 2 weeks time.

Yours sincerely,

Andrew Clark

Orthopaedic Registrar

Electronically Signed: Dr Andrew Clark2, Doctor

cc.

NHS
Greater Glasgow and Clyde

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

Typed: 29/10/2020
Reference: LMC/PMK/IMC

Mr Michael McLachlan
Flat 1-1
10 Girvan Street
Glasgow
G33 2DP

Dear Mr McLachlan

Patient Details: Mr Michael McLachlan, 31/12/1962, CHI: 3112626230
Date at A&E: 12/10/2020
Diagnosis: Scaphoid. Suspected fracture
Management Plan: MRI / CT or other imaging and review

Your attendance at Accident and Emergency has been reviewed. You had an injury to your wrist which does not require further treatment other than rest in a splint.

The splint should be kept on for a period of 3-4 weeks. Following that period of resting you can remove the splint to exercise the hand, wrist, elbow, and shoulders as pain allows. You may use your wrist as normal afterwards.

We would expect your pain levels to be reducing at around three weeks after injury.

Should you have any concerns or problems, please contact the Fracture Clinic Help Line on **0141 201 6416** for advice. For urgent problems or concerns out with working hours please contact or attend the local A&E department.

Yours sincerely

The Orthopaedic Department
Glasgow Royal Infirmary

www.nhsggc.org.uk/orthopaedics

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

NHS
Greater Glasgow and Clyde

Virtual Clinic Tel : 0141 211 5034
Virtual Clinic Fax: 0141 211 4060

Clinic Date: 13/10/2020
Typed: 03/11/2020

VIRTUAL TRIAGE ASSESSMENT

Re: Mr Michael McLachlan 31/12/1962; CHI: 3112626230; CRN:3112626230; Flat 1-1 10 Girvan Street Glasgow Lanarkshire G33 2DP

Patient Assessment I

Bodily site:	Scaphoid
Laterality:	Right
Injury Type:	Suspected fracture
Management plan:	MRI / CT or other imaging and review

Patient Assessment II

Patient contacted:	Uncontactable - Letter sent, Other - Enter details unable to leave a voice mail
Site:	GRI
Outcome:	# Clinic - Tuesday (Wrist / Hand)
Consultant:	Cameron Elias Jones

Patient Assessment III

Patient Called Helpline:	No
Outcome of Helpline:	
Nurses notes:	: 03/11/2020 13:50 Maria Boothroyd MRI report has gone to requestinf Consultant he wishes him to be reviewed in the hand clinic, SN McKirdy contacted a member of the hand team for advice, we will contact the patient to come in. 28/10/2020 15:47 Pamela McKirdy spoke with patient and advised of consultant review of the MRI scan, this showed no scaphoid # but he has sustained an injury to 1st MC base which also has degenerative changes evident, to use the wrist splint for 4/52 then remove and discard and commence gentle mobilisation of hand/thumb, to take regular painkillers as required. Patient discharged and Hand Splint letter to be sent out.

	13/10/2020 09:40 Linda Paterson right thumb injury. ASB tenderness no fracture seen continue with wrist splint, remove for hand washing and application of ice, mobilise other fingers and take pain relief as required; ref from A and E for MRI scan, unable to leave a voice mail he will be contacted by us with his result phone 07947416972

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 12/10/2020

Consultant: Dr Patrick O'Mailley

SE Hand
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
Glasgow
G32 7JZ

Dear SE Hand

Re: **McLachlan Michael** DOB: **31/12/1962** CHI: **3112626230**
FLAT 1-1
Glasgow G33 2DP

Attended on: **12/10/2020 at 16:37 hrs.** Departed on: **12/10/2020 at 19:06 hrs.**
Discharge Type: **01c - Discharge with referral** Destination: **Private residence**
Previous ED Attendance in last 12 months: **2**

Presenting complaint
right thumb injury

Nursing Assessment:

Investigations in ED:
1. XR Wrist Rt **2. XR Scaphoid Rt** **3. XR Thumb Rt**
4. MRI Scaphoid Right

Diagnosis:

Diagnosis	Side	Site
Sprain and Strain of Wrist	**Right**	**Wrist**

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

***No GP action required* Reports altercation and punched someone 2 days ago. On examination there was bruising and swelling of the thumb with bony tenderness of the thumb, ASB and distal radius. Wrist and thumb ROM was decreased. XR showed no obvious fracture. Imp: Treated as clinical scaphoid. Placed in a splint and referred to orthopaedics. Discharged with worsening advice.**

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Elaine Urquhart
Physiotherapist

Copies to:

1. SE Hand (GP)

School Address:

Glasgow Royal Infirmary

CHI: 3112626230

Total Att: **16**

12 Mth Att: **2**

Title: **MR**

MCLACHLAN **Michael**

DOB **31/12/1962** Age: **57y** Sex: **Male**

FLAT 1-1
10 GIRVAN STREET
Glasgow
Lanarkshire
G33 2DP
07947416972

Next of kin: **SHERLOCK, Martine**
Relationship: **Niece**

GP: **SE Hand**
0141 531 6220

Attendance Date: **12/10/2020** Arrival Time: **16:37**

Registration Time: **16:37** Date of Incident: **12/10/2020**

Major Incident Desc:

Reason for Attendance: **right thumb injury**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

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

Presenting Complaint:

Observation Date: **12/10/2020 16:45** Nurse name: **Nurse Christopher Bond**

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:

3112626230 31/12/1962 MCLACHLAN Michael
3112626230 31/12/1962 MCLACHLAN Michael
3112626230 31/12/1962 MCLACHLAN Michael
3112626230 31/12/1962 MCLACHLAN Michael
3112626230 31/12/1962 MCLACHLAN Michael

Michael McLachlan CHI 3112626230 (2)

To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

Date	Clinical Notes
12/10/20	Seen By E Urquhart PT Time Seen 17:00

P.C 57 ur old RHD (M) C (R) thumb injury

H.P.C Altercation 2/7 ago + Reports 'punched someone' → (R) thumb pain + ↓ROM since

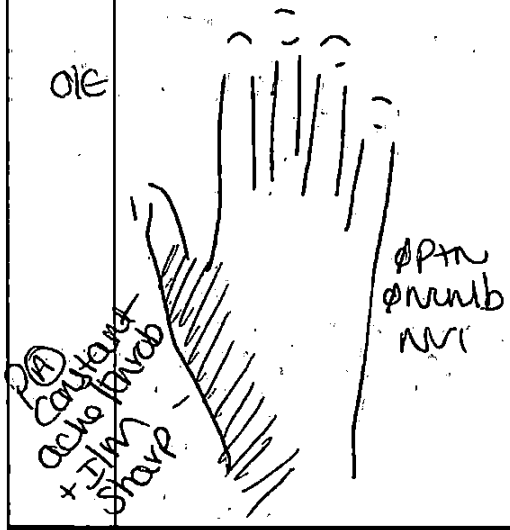
P.M.H COPD

D.H Respiridone inhalers

S.H Lives alone unemployed nil active hobbies

NKDA

O/E



Obs: mild bruising thenar eminence

Palp: RT TTO thumb, ASB ++, Scaphoid tubercle + distal radius

E Urquhart PT

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

(3)
Michael McLachlan
CHI 3112626230

Date & Time	Cont.	Signature, Print Name & Designation
21/10/20	Wrist ½ ROM TTO = limited by pain	
	thumb Ext/Abd ✓	
	opposition → TIP MF then TT pain	
	telescoping +ve ++	
	thumb Collateral -ve (R) = (L)	
	XR No obvious # Seen thumb/Scaphoid/Radius	
	IMP: Treat as Clinical Scaphoid	
Rx	Placed in Splint ± thumb Ext ⁿ	
	RICE + analgesia advice	
A/	MRI Requested by Dr Morgan	
	for Scaphoid	
pl	D/c'd + Rck VFC	E Urquhart Pt

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Urology GGC General Referral		**Consultant / receiving practitioner** and/or **specialty clinic**
Glasgow Royal Infirmary 84 Castle Street Glasgow G4 0SF		**Hospital** and **hospital address** Hospital location code. G107H Email address -

Urgency of referral Routine
Date of referral 07-Sep-2020 **Date sent** 07-Sep-2020

PATIENT DETAILS

Surname	MCLACHLAN
Forename(s)	MICHAEL
Title	MR
Sex	Male
Date of birth	31-Dec-1962
CHI no.	3112626230
Area of Residence	-

Patient's address

1-1
10 GIRVAN STREET
GLASGOW
G33 2DP

Contact number(s)

Voice: 07947 416 972

1010216241509 | Unique Care Pathway Number: 1010216241509

REGISTERED GP DETAILS

Name	Dr Kerry Walker		
GMC code	7020285	GP code	02135
Practice name	The Cairns Practice		
Practice code	46081		

Practice address

420 OLD SHETTLESTON ROAD
SHETTLESTON
GLASGOW
G32 7JZ

Contact number(s)

Voice: 01415316220

REFERRING GP DETAILS

Name	Dr. Fraser McNab		
GMC code	7131989	GP code	00043
Practice name	The Cairns Practice (46081)		
Practice code	46081		

Practice address

Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Contact number(s)

Voice: 0141 531 6220

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: Difficulty PU ?granulation around urethra following recent circumcision

Comment: Dear urology

This man has had a recent circumcision. Was asked by urology surgeon at time of operation apparently whether had any trouble PU - said no. However tells me today that since procedure has been having pain PU especially at end of flow.

OE: some granulation tissue at ?base of urethra seen, urethral meatus does appear very narrow, otherwise glans looks ok. Urinalysis leucocytes +.

Imp: ??UTI ?all related to narrow urethra - suspect more likely. Will write to urology ? any Rx options given difficulty PU and narrow urethra.

Many thanks for your advice

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history
Pre-existing conditions (High & medium priority - all)

Description	Comment	Modifier	Date of onset	Date recorded
Drug psychosis NOS	Possible, Arran Resource Centre	-	21-Apr-2020	21-Apr-2020
O/E - collapse - syncope	, A&E GRI	-	24-Jan-2020	24-Jan-2020
Chronic obstructive pulmonary disease	-	-	02-May-2018	02-May-2018
Drug psychosis NOS	(in remission), Arran Centre	-	10-Oct-2016	10-Oct-2016
Drug withdrawal syndrome	psychotic symptoms on withdrawal from Heroin, A&E GRI	-	24-Jul-2016	24-Jul-2016
Heroin misuse	, GRI	-	20-Feb-2016	20-Feb-2016
Drug-induced hallucinosis	, GRI	-	20-Feb-2016	20-Feb-2016
Endogenous depression first episode	-	First ever	26-Feb-2014	26-Feb-2014
Internal thrombosed haemorrhoids	, A&E GRI	-	20-Aug-2013	20-Aug-2013
Drug dependence NOS	acute psychotic episode	First ever	28-Jul-2006	28-Jul-2006
Benzodiazepine dependence	, Medical IP, GRI	First ever	28-Jul-2006	28-Jul-2006
[X]Heroin addiction	, Medical IP, GRI	First ever	28-Jul-2006	28-Jul-2006
Drug dependence	relapse, Heroin, Cocaine, Diazepam	First ever	26-Jun-2002	26-Jun-2002
Deliberate self-harm	Diazepam overdose	First ever	09-May-2002	09-May-2002
Smoke inhalation	-	First ever	02-Apr-2002	02-Apr-2002
Cubital tunnel syndrome	Left medial epicondylectomy	First ever	04-Nov-1997	04-Nov-1997
Compartment syndrome	-	First ever	09-Mar-1997	09-Mar-1997
[X]Assault	-	First ever	17-Sep-1996	17-Sep-1996

[X]Assault	-	First ever	14-Feb-1987	14-Feb-1987
[X]Assault by sharp object	chest	First ever	11-Jul-1986	11-Jul-1986

Past procedures (High and medium priority - all)

Description	Comment	Modifier	Date performed	Date recorded
Plain x-ray of chest	- shows a calcified graniloma in the left mid zone, SHC	-	02-Mar-2018	02-Mar-2018
Drug addiction therapy	- Buprenorphine 12mg, Newlands Centre	-	18-Jan-2018	18-Jan-2018
Drug addiction therapy	- Suboxone, Newlands Centre	-	05-Sep-2016	05-Sep-2016
Excision of submandibular gland	- left, ENT OP, GGH	-	21-Feb-2014	21-Feb-2014
Drug addiction therapy	Suboxone treatment patient defaulted, EAST CAT	-	06-Sep-2012	06-Sep-2012
Drug addictn therap-methadone	, Addiction Services, Parkhead Hospital	First ever	17-Oct-2006	17-Oct-2006
Primary arthrodesis of joint NEC	5th PIP joint	First ever	18-Mar-1997	18-Mar-1997
Primary repair of tendon	-	First ever	02-Jan-1997	02-Jan-1997
Primary repair of tendon	-	First ever	19-Oct-1996	19-Oct-1996
[SO]Ulnar nerve - hand	divisions	First ever	07-Mar-1996	07-Mar-1996
Exploration of skin wound NEC	and repair of machete wound	First ever	09-Mar-1986	09-Mar-1986

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Risperidone 2mg tablets	28	tablet	ONE AT NIGHT (AS PER PSYCH)	-	17-May-2016	07-Sep-2020
Anoro Ellipta 55micrograms/dose / 22micrograms/dose dry powder inhaler (GlaxoSmithKline UK Ltd)	60	dose	1 DAILY	-	14-Feb-2020	07-Sep-2020
Trazodone 100mg capsules	84	capsule	3 AT NIGHT AS PER PSYCHIATRY	-	02-May-2018	23-Mar-2020
Salbutamol 100micrograms/dose inhaler CFC free	200	dose	2 PUFFS WHEN REQUIRED	-	02-May-2018	29-Jul-2020

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Nitrofurantoin 100mg modified-release capsules	14	capsule	ONE TWICE A DAY	-	07-Sep-2020	07-Sep-2020
Daktacort ointment (Janssen-Cilag Ltd)	30	gram	APPLY THREE TIMES A DAY	-	07-Sep-2020	07-Sep-2020
Flucloxacillin 500mg capsules	20	capsule	ONE CAP FOUR TIMES DAILY FOR 5 DAYS	-	17-Aug-2020	17-Aug-2020
Diazepam 2mg tablets	58	tablet	TAKE 2 TABLETS THREE TIMES A [more]	-	08-May-2020	08-May-2020
Risperidone 2mg tablets	28	tablet	ONE AT NIGHT (AS PER PSYCH)	-	17-May-2016	28-Apr-2020
Diazepam 2mg tablets	58	tablet		-	28-Apr-2020	28-Apr-2020

			TAKE 2 TABLETS THREE TIMES A [more]			
Omeprazole 20mg gastro-resistant capsules	28	capsule	ONE DAILY	-	15-Apr-2020	15-Apr-2020
Risperidone 2mg tablets	28	tablet	ONE AT NIGHT (AS PER PSYCH)	-	17-May-2016	08-Apr-2020
Diazepam 2mg tablets	42	tablet	2 TABLETS (4MG) UP TO THREE T [more]	-	14-Apr-2020	14-Apr-2020
Risperidone 2mg tablets	56	tablet	ONE TABLET TWICE A DAY	-	17-May-2016	08-Apr-2020

Blood Pressure

Date Recorded	Systolic	Diastolic
-	116	70

Body Measurements

Date Recorded	Height	Weight	BMI
-	1.74	62	20.4

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Cigarette smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 10.	14-Feb-2020
Cigarette smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 15. NOTES: got a vapour product yesterday and plans to start this..	29-Jan-2019
Cigarette smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 15.	04-Dec-2018
Cigarette smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 15.	15-Mar-2018
Current smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 10.	07-Oct-2015

Clinical warnings

Additional Support Needs
No known ASN requirements

Additional relevant information
Administrative information
OK to send correspondence to home address?:Yes
Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Referred By:Referring GP
Electronic Attachment Present:No

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

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 14/04/2020

Consultant: Dr Samantha Perry

SE Hand
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
Glasgow
G32 7JZ

Dear SE Hand

Re: **McLachlan Michael** DOB: **31/12/1962** CHI: **3112626230**
FLAT 1-1
Glasgow G33 2DP

Attended on: **14/04/2020 at 15:51 hrs.** Departed on: **14/04/2020 at 18:49 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **1**

Presenting complaint
chest pain non covid

Nursing Assessment:
News 1 left sided chest pain. starting an hour ago, ongoing in triage. no covid symptoms hx copd cpe , covid low risk

Investigations in ED:

1. XR Chest	**2. Urea and Electrolytes**	**3. Bicarbonate**
4. LFT	**5. Glucose**	**6. Lipid profile (inc. HDL)**
7. Full Blood Count	**8. Troponin I hs**	**9. Gamma GT**
10. CRP		

Diagnosis:

Diagnosis	Side	Site
Chest Pain, Unspecified		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

***GP ACTION REQUIRED* Patient presented with short history of left sided chest/ RUQ pain. No associated symptoms or pleuritic in nature. Clinical examination NAD. ECG - sinus bradycardia (HR 55) otherwise nil acute. CXR - nil acute. Bloods - cholesterol 7.6 otherwise unremarkable, troponin negative. Discharged home with safetynetting advice, offered PPI but patient declined (eager to get home) - said would get medication from chemist. Note to GP - to kindly follow patient up in view of ? reflux and if ongoing issues to offer PPI. In addition consider management of hypercholesterolaemia.**

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Rachael Boardley
Doctor

Copies to:

1. SE Hand (GP)

School Address:

Glasgow Royal Infirmary

CHI: 3112626230

Total Att: **15**

12 Mth Att: **1**

Title: **MR**

MCLACHLAN **Michael**

DOB: **31/12/1962** Age: **57y** Sex: **Male**

FLAT 1-1
10 GIRVAN STREET
Glasgow
Lanarkshire
G33 2DP
07947416972

Next of kin: **SHERLOCK, Martine**
Relationship: **Niece**

GP: **SE Hand**
0141 531 6220

Attendance Date: **14/04/2020** Arrival Time: **15:51**

Registration Time: **15:51** Date of Incident: **14/04/2020**

Major Incident Desc:

Reason for Attendance: **chest pain non covid**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

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

Presenting Complaint:

Observation Date: **14/04/2020 16:11** Nurse name: **Nurse Lynne Nestor**

Temp	**35.6**	C
HR	**55**	bpm
BP	**132/74**	mmHg
MAP	**93.33**	mmHg
RR	**18**	bpm
SpO2	**100**	%
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: **"News 1 left sided chest pain. starting an hour ago, ongoing in triage. no covid symptoms hx copd cpe , covid low risk "**

3112626230 31/12/1962 MCLACHLAN Michael
3112626230 31/12/1962 MCLACHLAN Michael
3112626230 31/12/1962 MCLACHLAN Michael
3112626230 31/12/1962 MCLACHLAN Michael
3112626230 31/12/1962 MCLACHLAN Michael

To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

Date	**Clinical Notes**	
	Seen By	Time Seen

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By

Glasgow Royal Infirmary
Emergency Department

NHS
Greater Glasgow and Clyde

3112626230
MCLACHLAN, Michael
M
31/12/1962

Initial Investigations Ordered										
FBC ☐	COAG ☐	DD ☐	INR ☐		G+S ☐		X-match units			
U+Es ☐	LFT ☐	GLU ☐	CRP ☐	TROP ☐	Para ☐	Sal ☐	Ethanol ☐	Mg ☐	VBG ☐	ABG ☐
B culture ☐		C/MSSU ☐		Urinalysis ☐		BHCG ☐		Other		
CXR ☐	AXR ☐	Other imaging:								ECG ☐
Current location:								Sent by:		

Clinical Notes

31/12/20 1600 RESUS Locum SHO Specialty

57 PC - chest pain

PMH.
COPD
Prev drug dependence - under CAT team - on meds for withdrawal.
ECHO 2018 - no significant valve disease, good LV function

DH.
Anoro ellipta, trazodone, risperidone, salbutamol.

HPC.
Around 13°° today - gradual onset (L) sided, non-radiating, chest pain. Sharp in nature.
No exacerbating / relieving sx. Initially 3/10 → 5/10.
Not pleuritic in nature.

No assoc SOB / palpitations / dizziness.
Denies abdo pain / urinary or bowel sx.
No ↑T. Has long term smokers cough - non-productive + no change.

Glasgow Royal Infirmary
Emergency Department

3112626230
MCLACHLAN M
Michael 31/12/1962

Clinical Notes

Date	Time	Name	Grade	Speciality

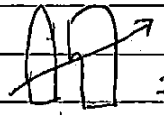
In Spain at beginning of March otherwise no long haul travel No recent surgeries / immobility. No haemoptysis. No calf pain.

Normally SOB climbing stairs. No ↑ change recently. No PND / orthopnoea sx.

Current smoker - 10/day for 40 yrs.
Drinks ~2 pints · 3-4 nights per week.
Last used drugs ~3 weeks ago.

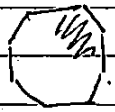
O/E Looks well.

FH - mother died from MI in 70s, ? father also had cardiac hx.

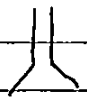


No added sounds
Equal AE

HS I+II+O.



Mild LUQ / epigastric tenderness.
Soft BS ✓



Calves SNT
No pedal oedema.

CXR - nil acute.
ECG - sinus brady, nil acute.

Glasgow Royal Infirmary
Emergency Department

3112626230
MCLACHLAN Michael M 31/12/1962

Clinical Notes

Date	Time	Name	Grade	Speciality

(P) D/w SpR J. Pope.
↳ if bloods (N) for home

1825 R BOATENGCLEY SHO.

- staff nurse received call from reception - family members in waiting room received call from patient saying he was hearing voices.
- went to see patient to ensure all okay, reports has a lot of mental health issues and didn't want to talk about things.
- wanted to leave, feeling unsettled - after speaking to patient willing to wait for remaining blood.

Call received from A&E doctor who was contacted with by a daughter for extra background info.
Daughter - 07935123332
↳ attended Avon unit with psychotic episode, wanted to admit patient by due to positive coronavirus discharged with crisis team follow up with them to call @ 7pm.

D/w senior - agreed should not change plan.
→ if bloods (N) home with plan from mental health team.

1850 Discharged home - offered PPI but declined. Safetynetting advice given.

SHO R BOATENG

Glasgow Royal Infirmary
Emergency Department

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

HAEM	DATE or TIME		BIOCH	DATE or TIME			DATE or TIME		V/ABG	DATE or TIME	
WCC	9.0		Na	141		Bil	11		FiO_2		
Hb	147		K	4.5		ALT	16		H^+		
Plat	230		Cl	103		AST	20		$PaCO_2$		
Neut	7.52		Ur	3.3		GGT	29		PaO_2		
DD			Creat	66		A phos	105		Bic	26	
PT			eGFR	>60		Alb	44		BE		
PTT			Glu	6.2		AdjCa			Lactate		
TT			CRP	1		Amyl			Ethanol		
INR			Mg			TropI HS	<4		Para		
CHOL	7.6		Phos			BHCG			Sal		

Diagnosis and Plan

Review/Discussed with:	Handover
	☐ Provisional Diagnosis
	☐ Liquids/Fluids
	☐ Analgesic/Medicines
	☐ NEWS
	☐ Investigations & Results
	☐ Talk to receiving team/ward

mi • 287967 Version 1_0 • GGC0226

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 31/01/2020

Consultant: Dr Richard Stevenson

K Walker
1539 Shettleston Road
Glasgow
Glasgow
G32 9AS

Dear K Walker

Re: **McLachlan Michael** DOB: **31/12/1962** CHI: **3112626230**
FLAT 1-1
Glasgow G33 2DP

Attended on: **24/01/2020 at 16:45 hrs.** Departed on: **24/01/2020 at 19:25 hrs.**
Discharge Type: **01b - Discharge with follow up by primary care team** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
dizzy turns

Nursing Assessment:
pt state scollapse last night found iun pub toilet by friend states wasnt intoxicated pt states today chest pain heavyiness in chest low risk cpe hx copd

Investigations in ED:

1. Urea and Electrolytes	**2. Bicarbonate**	**3. LFT**
4. Glucose	**5. Lipid profile (inc. HDL)**	**6. Full Blood Count**
7. Troponin I hs	**8. XR Chest**	

Diagnosis:

Diagnosis	Side	Site
Syncope and Collapse		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Collapse while at toilet in pub after alcohol yesterday, presents as concerned re. cause. Systemically well, nil concerning on investigations. Likely syncopal episode, pt keen for home- discharged with worsening advice.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Rona Young
Doctor

Copies to:

1. K Walker (GP)

School Address:

CHI: 3112626230

Glasgow Royal Infirmary

(8)

ECG ✓
Bloods ✓

Total Att: **14**
12 Mth Att: **0**

Title: **MR**

MCLACHLAN **Michael**

DOB: **31/12/1962** Age: **57y** Sex: **Male**

FLAT 1-1
10 GIRVAN STREET
Glasgow
Lanarkshire
G33 2DP
07947416972

Next of kin: **SHERLOCK, Martine**
Relationship: **Niece**

GP: **K Walker**
0141 531 6235

Attendance Date: **24/01/2020** Arrival Time: **16:45**
Registration Time: **16:45** Date of Incident: **24/01/2020**
Major Incident Desc:

Reason for Attendance: **dizzy turns**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:
Triage Category: ~~3~~ 3
Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **24/01/2020 16:49** Nurse name: **Nurse Geraldine Sparkes**

Temp	**36**	C
HR	**88**	bpm
BP	**149/87**	mmHg
MAP	**107.67**	mmHg
RR	**19**	bpm
SpO2	**99**	%
Oxygen		%

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **pt state scollapse last night found iun pub toilet by friend states wasnt intoxicated "pt states today chest pain heavyiness in chest " "low risk cpe " "hx copd "**

3112626230 31/12/1962 MCLACHLAN Michael
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To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

Date	**Clinical Notes**
	Seen By / Time Seen

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By

Glasgow Royal Infirmary
Emergency Department

NHS
Greater Glasgow and Clyde

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Initial Investigations Ordered

FBC ☐	COAG ☐	DD ☐	INR ☐		G+S ☐		X-match units			
U+Es ☐	LFT ☐	GLU ☐	CRP ☐	TROP ☐	Para ☐	Sal ☐	Ethanol ☐	Mg ☐	VBG ☐	ABG ☐
B culture ☐		C/MSSU ☐		Urinalysis ☐		BHCG ☐		Other		
CXR ☐	AXR ☐	Other imaging:								ECG ☐
Current location:								Sent by:		

Clinical Notes

Date 24/1/20 Time 1755 Name R.Young Grade ST3 Speciality Em

57 → self presents - collapse

At pub last night, had ~½ pint - not unusual for him.
Ate toilet - felt lightheaded → collapsed.
Woke up lying on toilet floor - had hit forehead on toilet.
Fatigued but well on arrival. NO incont / headache / tongue biting.
Well today, no further collapse.
NO headache / vomiting / visual disturbance
Occ. episodes feeling lightheaded recently - no prev. collapse.

Hx COPD - c/o ↑ cough ++, dirty sputum, chest heaviness / tightness after coughing - had this at toilet last night.

PMH - Bipolar disorder
COPD
NKDA
Current smoker
Lives alone

Meds - Salbutamol
Trazodone
Risperidone
Budesonide inh.
Buprenorphine

O/E - Alert + appears well at rest. Able to mobilise independently from W/A
- WNP HS I+II+O, calves SNT, NO ankle oedema
HR 88, BP 144/87

CONT.

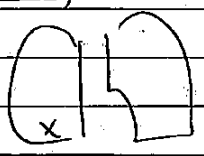
Glasgow Royal Infirmary
Emergency Department

3112626230
MCLACHLAN M
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10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Clinical Notes

Date	Time	Name	Grade	Specialty

cont →



SpO_2 99% RR 14

R. basal crepS

-GCS 15, PERRL, FROM - no nystagmus
Haemaphema NAD forehead - not boggy
Normal tone/power/sens. all 4 limbs. CN intact

→ ECG - SINR, nil acute changes
Bloods inc. Trop - NAD
↳ <4

Imp - Collapse → ?micturition syncope
- HI - no indication for CT at present

Plan - CXR in light ↑ chest symptoms → Nil focal changes

→ Pt keen for home - nil concern on Ix for syncope / need for CT
- D/C home with HI advice + strong worsening advice
- Treat with 5/7 course abx/steroids for exac. COPD

Young

Glasgow Royal Infirmary
Emergency Department

3112626230
MCLACHLAN
Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP
M
31/12/1962

Clinical Notes

Date	Time	Name	Grade	Speciality

Glasgow Royal Infirmary
Emergency Department

Patient Name
DoB
CHI Number

or affix label

HAEM	DATE or TIME		BIOCH	DATE or TIME			DATE or TIME		V/ABG	DATE or TIME	
WCC			Na			Bil			FiO_2		
Hb			K			ALT			H^+		
Plat			Cl			AST			$PaCO_2$		
Neut			Ur			GGT			PaO_2		
DD			Creat			A phos			Bic		
PT			eGFR			Alb			BE		
PTT			Glu			AdjCa			Lactate		
TT			CRP			Amyl			Ethanol		
INR			Mg			TropI HS			Para		
			Phos			BHCG			Sal		

Diagnosis and Plan

Review/Discussed with:

Handover

- ☐ Provisional Diagnosis
- ☐ Liquids/Fluids
- ☐ Analgesic/Medicines
- ☐ NEWS
- ☐ Investigations & Results
- ☐ Talk to receiving team/ward

mi • 287967 Version 1_0 • GGC0226

Emergency Department Nursing Documentation

Presenting Complaint - collapse

Date: 24/1/20 Time: 1900

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

NHS Greater Glasgow and Clyde

Assessment Complete by: Name NURSE (Please Print) Jen O'

Patient Prep / Investigations (Please tick/circle when completed)		Communication (Please Circle Tick)	
Prepare patient for examination / Clothing bag labelled + stored	☐	NEWS Chart complete / NEWS SCORE - (Record pain, blood sugar and Neuro Obs on NEWS Chart)	☐
GGC RED BAG - with patient	☐		
12 Lead ECG	☐	ID Band	☐
Weight:	☐	Peak Flow	☐
Blood Samples Obtained: Yes ☐ No ☐		Xrays / CT Scan Performed:	☐
IV Access: Yes ☐ No ☐		Relatives / NOK informed (Carers)	☐
Blood Gas: VBG ☐ ABG ☐		Child Protection Concern (considered in line with policy)	Y/N
		Adult Support and Protection	Y/N

Urinalysis

Leucocytes	☐	Nitrites	☐	Protein	☐	Blood	☐
Ketones	☐	Glucose	☐	PH		S.G.	
MSSU / CSU	☐	Toxiclogy	☐				
HCG	☐	+VE	☐	-VE	☐	Strip No -	

Screening Tools
(Please tick/circle when completed)

SEPSIS RISK? / SIRS Criteria 2 or more	Y/N	**SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)**	YES
Mental Health Triage Assessment	Y/N	If NOT WHY? - (details) NA	NO
GMAWS	Y/N	Date - 24/1/20 Time - 1900 Signature -	

4AT

AMT	Correct
Age	
Date of Birth	
Place	
Current year	

No mistakes = 0
1 mistake = 1
> 1 mistake = 2

Attention (months of year backwards)	
> = 7 correct	0
< 7 correct	1
Untestable	2

Alertness	
Normal	0
Mild sleepiness	0
Clearly abnormal	4

Mental status according to family/carer		
Acute change or fluctuating	4	YES
Acute change or fluctuating	0	NO

4AT score /12

STEP 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?

All over 75s and care home residents over 65. For younger patients use clinical judgement and consult local guidelines.

		YES	NO
F	Functional impairment (new or worsening) eg difficulty with self care		
R	Resident in a care home?		
A	Altered mental state such as acute confusion or dementia use the 4AT		
I	Immobility/instability. New decline in mobility, difficulty mobilising without help or fall leading up to admission		
L	Likely to require support for discharge? (either new or increase in existing support)		

Are any of the above criteria met? If YES to any of the above move to step 2

STEP 2 Would this person be better managed by another specialty team at present?

Indicator for care by another acute specialty regardless of age.

	YES	NO
Clear need for other specialty input eg exacerbation of known long term condition such as COPD		
Need for HDU/ITU (including non-invasive ventilation)		
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit		
Head injury with loss of consciousness		
Acute abdominal pain/surgical presentation		
Upper GI Bleed		
Chest pain with suspected acute coronary syndrome		
Trauma with suspected fracture		

Are any of the above criteria met?

If **YES** to any criteria in step 2:

- Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.

If **NO** to the list in step 2:

- Prioritise transfer of care to specialist geriatric assessment service in line with local guidance.

Screening Tools / ACTIVE CARE

(Please tick/circle when completed)

1) Pressure Damage Does the person have redness and/or existing damage? If YES - continue with a minimum of 2 hourly Active Care + Complete PUDRA		Y/N	Date	Location of Redness/Ulcers	Grade of Ulcer	
2) Mobility	Does the person require assistance?	Y/N				
3) Continence		Y/N	**5) Skin**	Is skin compromised by other source, eg neurological deficit, medication, substance, diabetes, co-morbid?		Y/N
4) Nutrition		Y/N	**6) Judgment**	In your clinical judgment is this person at risk for developing pressure damage? IF YES - DETAILS		Y/N

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.

3112626230
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At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc) *At risk complete risk assessment*		
YES	(NO)	

Pause for Transfer / Discharge (Please tick when completed)		Tick when completed	N/A	Notes
Relatives Informed of Admission / Discharge		☐	☐	Information on discussion with relatives
Relatives/carer with patient on transfer to ward		☐	Always	
GGC RED BAG - with patient		☐	Always	
Name Band		☐	Always	
Nursing Screening Tools completed		☐	Always	
Bed requested, SBAR COMPLETE		☐	☐	
NEWS chart		☐	Always	
Prescriptions / Charts signed	Infusions	☐	☐	
	Cannula	☐	☐	
Notes: medical notes, GP letter, PRF		☐	☐	
Patients requiring analgesia: sufficient		☐	☐	
Belongings (including patients medication)		☐	Always	Please note here if any other tasks required prior to transfer
SAS Transport required and ref. no.		☐	☐	
Print Name Sign -				

Nursing Notes

Date and Time			Print Name and Signature
24/1/20	Patient in ward collapse.		
1757	NEWS 0. ECG done in triage.		FD's ready
1950	Patient mobilised to toilet with zimmer frame.		
	Bowels moved.		PCairns (S/N)

Nursing Notes		
Date and Time		Print Name and Signature

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name	3112626230 MCLACHLAN M
Address	Michael 31/12/1962 FLAT 1-1 10 GIRVAN STREET Glasgow, Lanarkshire
CHI No.	G33 2DP
DoB	

	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

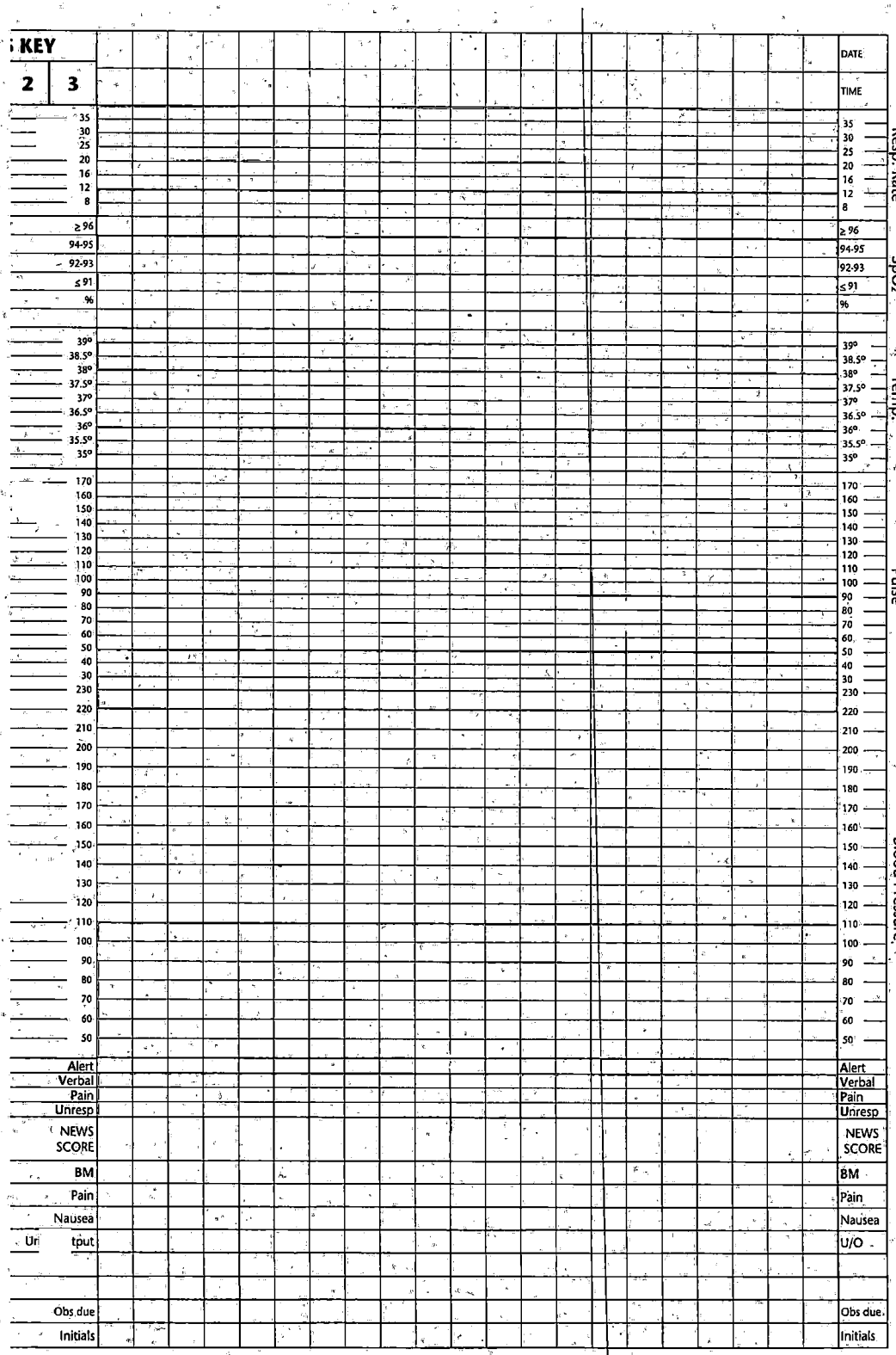
NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.

& Michael McLachlan

| | | |


KEY
2
3
DATE
TIME
35
30
25
20
16
12
8
Resp. Rate
≥ 96
94-95
92-93
≤ 91
96
SpO2
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Temp.
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Pulse
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
Urine output
U/O
Obs due
Initials

Glasgow Coma Scale

Pupil size (mm)



3112626230
MCLACHLAN M
Michael 31/12/1962

Neurological Observations

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

Pain Score

Ask the patient to rate his/her pain by choosing a number between 0 and 10. Use the diagram below to assist the patient. If patient's pain is chronic, use generic tool. If patient is unable to communicate, use observational tool.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Severe Pain			

Nausea and Vomiting
0 = None
1 = Mild (*Not distressing – no retching/vomiting*)
2 = Moderate (*Troublesome – occasional retching/vomiting*)
3 = Severe (*Distressing – frequent retching/vomiting*)

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

MEDICINE **PRESCRIPTION FORM** Hospital Name: GRI

MEDICINES RECONCILIATION

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

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

DOCTOR'S DECLARATION (if required by Local Protocol)

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

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

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

PATIENT DETAILS

Hosp
DOE
Date
Con

3112626230
MCLACHLAN
Michael
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

M
31/12/196

Height:
Weight:
Surface area:
Ward:

ONCE ONLY AND PREMEDICATION DRUGS

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

	DATE → 26																							
	MONTH → 5																							
	RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)																							
IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N																								
ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N																								
SIGNATURE OF ASSESSOR																								
ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N																								

Parenteral Drugs : Regular Prescription

																									Patient's Own Medicine
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☑	A DRUG CLEXANE DOSE 40mg ROUTE SC DATE 26/5/15 STOPPED DATE: PRESCRIBER (PRINT & SIGN) INITIALS: ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	Other time																							For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.
		0700-0900																							
		1200-1400																							
		1600-1800																							
		2200-2400																							
		Other time																							
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	B DRUG DOSE ROUTE DATE STOPPED DATE: PRESCRIBER (PRINT & SIGN) INITIALS: ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	Other time																							For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.
		0700-0900																							
		1200-1400																							
		1600-1800																							
		2200-2400																							
		Other time																							
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	C DRUG DOSE ROUTE DATE STOPPED DATE: PRESCRIBER (PRINT & SIGN) INITIALS: ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	Other time																							For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.
		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

D DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

E DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

F DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

G DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

Oral and Other Drugs: Regular Prescription

DATE → 26
MONTH → 5

Patient's Own Medicine

H — DRUG: RISPERIDONE

BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐

DOSE: 2mg | ROUTE: ORAL | DATE: 26/5/18. | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN): MUTHUS

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.

J — DRUG: TRAZODONE

BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐

DOSE: 300mg | ROUTE: ORAL | DATE: 26/5/18. | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN): MUTHUS.

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.

K — DRUG: BYDUREON (10 micrograms)

BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐

DOSE: 1 CAPSULE | ROUTE: INJ | DATE: 26/5/18. | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN): MUTHUS.

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.

L — DRUG:

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN):

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

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

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

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 ☐ | **M** | DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

NEW DOSE ☐ | PRESCRIBER (PRINT & SIGN) | INITIALS:

NEW MEDICATION ☐ | 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 ☐ | **N** | DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

NEW DOSE ☐ | PRESCRIBER (PRINT & SIGN) | INITIALS:

NEW MEDICATION ☐ | 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 ☐ | **P** | DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

NEW DOSE ☐ | PRESCRIBER (PRINT & SIGN) | INITIALS:

NEW MEDICATION ☐ | 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 ☐ | **R** | DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

NEW DOSE ☐ | PRESCRIBER (PRINT & SIGN) | INITIALS:

NEW MEDICATION ☐ | 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.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

S DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

T DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

V DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

W DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

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BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

X DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

Y DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

AA DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

BB DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

---

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DD 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

---

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

EE 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

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BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

FF 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

DATE →
MONTH →

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

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

---

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

GG DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

HH DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

JJ DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

KK DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

All Routes: As Required Prescriptions

| | | |

| | | |

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, 1800.
5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.
6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.
7. The following metric unit abbreviations must be used –

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

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

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

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

Please note - intrathecal must be written in full.

FOR NURSES

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

Codes for Non-Administration of Drugs

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

Cat. No. 40995 Ver 4, 09/2010 GGC0029

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Dr. K Walker
1539 Shettleston Road
Glasgow
G32 9AS

Main Switchboard:	0141 211 4000
Department:	Acute Assessment Unit
Contact Tel:	0141 211 5719
Enquiries to:	Jean Cairney
Letter Date:	22/05/2018
Reference:	DC/JC
Dictated Date:	12/05/2018
Transcribed Date:	16/05/2018

Dear Dr Walker,

Michael McLachlan; D.O.B: 31/12/1962; CHI: 3112626230
Flat 1-1, 31 Aberfeldy Street , Dennistoun, Glasgow, G31 3NS

Further to the EDL regarding this man's attendance on the 15th March 2018, he had his echocardiogram performed. This shows good left and right ventricular systolic function and no evidence of significant valvular disease. I have therefore arranged no further follow up.

Yours sincerely,

Dr David Colville

Consultant Physician

Electronically Signed: Dr David Colville, Consultant

cc.

CHI Number: 3112626230 Patient Name: McLachlan, Michael

Acute Services Division

Surgery and Anaesthetics Directorate

Department: Pre Op Assessment Unit

Specialty: Urology

NHS Greater Glasgow and Clyde

Hospital Name	Glasgow Royal Infirmary

Patient Details		GP Details	
Name	McLachlan, Michael	Name	WALKER, CHRISTINE
Address	FLAT 1-1 31 ABERFELDY ST Glasgow Lanarkshire G31 3NS	Address	Baillieston Health Centre 20 Muirside Road Baillieston Glasgow
Correspondance Address	,	Telephone	
Correspondance Postcode		CRN Number	30141837L, 3112626230, ZRV10290713
Telephone		Consent	Yes
Patient Contact Number	07947416972	Sensitivity	Sensitive
CHI Number	3112626230	Consultant Name	MR ERONINI
Sex	Male	Requires Transport	No
Date of Birth	31/12/1962	Religion	Roman Catholic

Next of Kin / Person to Notify	Next of Kin	Person to Notify
Name	CHEVONNE MCLACHLAN	
Address	15 TORPHIN WALK, CRAIGEND, GLASGOW	
Landline		
Mobile	07494790834	
Relationship	DAUGHTER	

Assessment Details					
Assessor	AMANDA CRICHTON	Grade	S/N	Date	26/02/2018
Ward	GRI SDAU,				

CHI Number: 3112626230 Patient Name: McLachlan, Michael

Surgery / Procedure Attending For
CIRCUMCISION. --- Pathway update 05/04/18 TCI 04/05/18 - QEUH ECHO 24/04/18 Spirometry - 06/04/18 - report states - Pt unable to comply Cancelled previously due to LRTI Mr Eronini e mailed & out for Anaesthetic review

Availability	
Are you available at short notice?	Yes
Period of unavailability	
Reasons for unavailability	
Details	

Anaesthetic History	
1. Previous GA	
Have you had a General Anaesthetic before?	Yes
Were there any problems?	No
2. Previous LA	
Have you had a Local Anaesthetic before?	Yes
Were there any problems?	No
3. Dentition Risk	
Do you have any loose teeth, caps or dentures?	Yes
Details	2 UPPER FRONT VENEERS
4. Reduced neck movement	
Do you have any neck or jaw stiffness?	No
5. Other Risk	
Has anybody in your family had a serious reaction to an anaesthetic?	No
6. Heartburn	

CHI Number: 3112626230 Patient Name: McLachlan, Michael

Do you suffer from heartburn or indigestion?	No

7. Sickle Cell Disease (risk factor)	
Do you have sickle cell disease?	No
Are there risk factors for sickle cell disease?	No

Surgical History	
8. Affects suitability for DSU or SDA	
Have you ever had surgery?	Yes
Details of relevant surgical history	EXCISION OF LARGE SUBMANDIBULAR GLAND 2013, EXPLORATION OF SKIN WOUND 1986, SURGERY TO ULNAR NERVE 1996, PRIMARY REPAIR TO TENDONS 1996 & 1997, PRIMARY ARTHRODESIS 5TH JOINT LEFT HAND 1997
Will this affect the suitability for DSU?	No
Have you ever had a serious surgical or anaesthetic complication?	No

Cardiovascular	
9. Hypertension	
Do you have high blood pressure?	No

10. Arrhythmias					
Symptoms	Irregular heartbeat	No	Palpitations	No	Atrial Fibrillation No
How often does it occur?					
Are they associated with exercise?					
Does it cause you to faint?					

11. Angina	
Do you suffer from Angina?	No

12. Heart Attack	
Have you had a heart attack?	No

CHI Number: 3112626230 Patient Name: McLachlan, Michael

13. Heart Murmur	
Do you have a heart murmur?	No

14. Blackouts	
Do you suffer from blackouts?	No

15. Heart Failure	
Have you been diagnosed with heart failure?	No

Respiratory	
16. Asthma / Bronchitis / COPD / Emphysema	
Do you have asthma, bronchitis, COPD or emphysema?	No

17. URTI (Upper Respiratory Tract Infection)	
Have you recently had a cold?	Yes
17a. Are you still unwell?	Yes
Does the patient have pyrexia?	Yes
Temperature (degrees celcius)	37

Neurological	
18. Stroke	
Have you had a stroke or TIA?	No

19. Epilepsy	
Do you have epilepsy?	No

20. Neurological Disease	
Do you have any neurological or muscular disease?	No

21. Physical Disability	
Do you have a physical disability?	No

Haemotological	
22. Bleeding Disorder	
Do you suffer from prolonged bleeding or excessive bruising?	No

CHI Number: 3112626230 Patient Name: McLachlan, Michael

23. Previous DVT	
Have you had a DVT?	No

24. Anaemia	
Do you suffer from anaemia?	No

Miscellaneous	
25. Kidney Disease	
Do you have renal failure?	Yes
25a. Document cause of kidney disease	PREVIOUS KIDNEY STONES
25b. Are you receiving dialysis?	No
25c. Does the patient have co-existing cardiac disease or poor exercise tolerance	No

26. Liver Disease	
Do you have liver disease or suffer from jaundice?	No

27. Diabetes	
Do you have diabetes?	No

28. Arthritis	
Do you have arthritis?	No

29. CJD	
Has the patient ever been notified that they are at increased risk of CJD or vCJD for public health purposes?	No

30. Other	
Do you have any serious physical / psychiatric illness or learning difficult not already mentioned?	No

CHI Number: 3112626230 Patient Name: McLachlan, Michael

Exercise Tolerance	
31. What best describes your level of fitness?	Climbs stairs without stopping

Social History		
32 How many units of alcohol each week?	6.00	units/week

33. Smoker	
Do you smoke?	Yes
How many each day?	13.00

34. Drug Abuse	
Do you currently or have you ever used intravenous or recreational drugs?	Yes
Details	PREVIOUS HEROIN ADDICTION. SMOKED, LAST USED 11/2017. SUPPORTED BY CAT TEAM AND ARRAN CENTRE.
34a. Do you take methadone?	

35. Pregnant	
LMP	
Are you pregnant?	No
Could you be pregnant?	No
Details	

36. Language	
Can the patient speak English?	Yes

Drug History
37. Drugs
List all drugs (including herbal remedies and complimentary medicines)
Risperidone 2mg bd Trazodone 100mgs nocte buprenorphine 8mgs od Buprenorphoner 2mgs od

Does the patient take any of the following?	
Anticoagulants	No
Clopidogrel	No
Aspirin	No
OCP	No
Digoxin	No
Amiodarone	No
Lithium	No

CHI Number: 3112626230 Patient Name: McLachlan, Michael

Diuretics	No
MAOIs	No

38. Herbal Remedies	
Are you taking any herbal remedies or complimentary medicine?	No

39. Steroids	
Have you taken regular oral steroids in the last year?	No

40. Allergies	
Does patient have any allergies?	No

Implants	
41. Pacemaker	
Do you have a pacemaker?	No

42. Prosthesis	
Do you have any implants?	No

43. Coronary stents	
Have you had coronary artery stents inserted?	No

Examination			
44. Age (years)	55		
Weight (kg)	61.3		
Height (m)	1.71	BMI	21

45. Risk of sleep apnoea	
Do you suffer from daytime sleepiness, restless sleep or witnessed breath holding during sleep?	No
How likely are you to fall asleep or doze in the following situations?	
a) Sitting and reading	

CHI Number: 3112626230 Patient Name: McLachlan, Michael

b) Watching TV	
c) Sitting inactive in a public place	
d) As a passenger in a car for an hour without a break	
e) Lying down to rest in the afternoon when circumstances permit	
f) Sitting and talking to someone	
g) Sitting quietly after lunch without alcohol	
h) In a car while stopped for a few minutes in traffic	
Status based on sleep apnoea score	Score

46. Blood Pressure			
Systolic/Diastolic BP	114	/	76

47. Pulse		
Pulse Rate	63	/ min
Rhythm	Regular	

48. Oxygen Saturation			
	89	%	

49. Urine Analysis	
Result	
Details	n/a

50. VTE Risk			
Is patient at risk of VTE?	Yes	Do they require prophylaxis?	Yes

Day Surgery Criteria	
51. Day Surgery Criteria	
Is the procedure suitable for day surgery?	No

52. Admission Criteria	
Appropriate admission based on nursing assessment	SDA

AHP USE ONLY: Is OT/Physio assessment required:	An OT/Physio assesssment is not required

CHI Number: 3112626230 Patient Name: McLachlan, Michael

53. MRSA Screening	
Does the Patient require a Clinical Risk Assessment? (for patients > 23 hours)	No
Has the patient ever had a previous positive MRSA result?	
Has the patient been admitted from a care home/institutional setting or another hospital?	
Does the patient have a wound/ulcer or invasive device which was present prior to admission?	

Has patient is to be admitted to any of the following?							
Orthopaedics		Vascular		Renal		Critical Care	

MRSA Lab Test Results							
Nose		Perineum		Throat		Other		Patient refused	
Other details:							

Investigations Required

Investigation	Required	Ordered	Investigation Date	Med Staff Informed	Action Required	Re-Test Required
Ferritin	No	No		No	No	
Folate	No	No		No	No	
B12	No	No		No	No	
HbA1c	No	No		No	No	
Glucose	No	No		No	No	
Group & Save	No	No		No	No	
Cross Matching	No	No		No	No	
Coagulation Screen	No	No		No	No	
Thrombophilia Screen	No	No		No	No	
Sickle Dex Test	No	No		No	No	
Hb Electrophoresis	No	No		No	No	
TFT	No	No		No	No	
Lithium level	No	No		No	No	
Digoxin level	No	No		No	No	
Amylase	No	No		No	No	
CRP	No	No		No	No	
Calcium/Bone	No	No		No	No	
PFT	No	No		No	No	
C-Spine X-Ray	No	No		No	No	
MRSA Screen	No	No		No	No	
Pregnancy Test	No	No		No	No	
Temperature	No	No		No	No	
FBC	Yes	No	15/03/2018	No	No	
U&Es	Yes	No	15/03/2018	No	No	
LFTs	Yes	No	15/03/2018	No	No	
ECG	Yes	No	15/03/2018	No	No	
ECHO	Yes	No	24/04/2018	No	No	
PEFR	Yes	Yes		No	No	
Chest X-Ray	Yes	No	15/03/2018	No	No	

CHI Number: 3112626230 Patient Name: McLachlan, Michael

Pre-op Assessment Summary	
Assessor	AMANDA CRICHTON
Grade	S/N
Summary	

CHI Number: 3112626230 Patient Name: McLachlan, Michael

PATIENT VERY MUCH SOUNDS LIKE HE HAS A CHEST INFECTION, STATES HAS HAD PRODUCTIVE COUGH FOR 3 WEEKS, PUTTING IT DOWN TO A SMOKERS COUGH. STATES GREEN IN MORNING, SPO2 89%, PEAK FLOW AVERAGE 150.

DEFERRED AND REFERRED TO GP, WITH INSTRUCTIONS TO BE REFERRED BACK TO MR ERONINI'S SECRETARY TO BE RE ASSESSED ONCE RESOLVED.

****

From: Crichton, Amanda
Sent: 26 February 2018 09:49
To: Umez-Eronini, Nkem
Cc: Paulley, Janice
Subject: POA, PT DEFERRED, CHI 3112626230

3112626230 MCLACHLAN, Michael

Dear Mr Eronini,
your patient as above, attended POA today, unfortunately I very much suspect he had a chest infection. I have referred him back to his GP with letter instruction to refer back to your secretary once resolved to be re assessed. Hope this meets with your satisfaction:

Kind Regards
Amanda

S/N A Crichton
GRI, Pre Op Assessment Service
Ext, 25899

****

From: Umez-Eronini, Nkem
Sent: 26 February 2018 10:16
To: Crichton, Amanda
Cc: Paulley, Janice; Dickson, Ruth
Subject: RE: POA, PT DEFERRED, CHI 3112626230

Thanks
He was listed from a&e by CT.
Might try and see him in the clinic as LA might be option if he really needs it.
Suspend from W/L
See OPD
Nkem

Pathway update 05/04/18 (SN M McLaughlin)
TCI 04/05/18 - QEUH
ECHO 24/04/18
Spirometry - 06/04/18

Cancelled 26/02/18 due to LRTI
Prescribed oral antibiotics

Attended A&E with bloody spit - 15/03/18
Chest x ray, ECG, Bloods & CT Angiogram obtained
Not repeated today

CHI Number: 3112626230 Patient Name: McLachlan, Michael ,

Spirometry -06/04/18
ECHO 24/04/18

For Anaesthetic review when all reported

13/04/18
Mr Eronini informed e mail
Out for anaesthetic review per Spirometry report - states - Pt unable to comply

Referrals and Type of admission - Recommended Admission pathway		
Referral by Nurse to:	Anaesthetist	Yes
	Surgeon	No
	Haematologist	No
	Cardiologist	No
	GP	No
	Cardiac Technician Pace Reset	No
	Cardiac Technician Pace Check	No
Nurse to arrange the attendance of:	Carer	No
	Interpreter	No
Nurse to:	Inform ward staff regarding the risk of alcohol withdrawl	No
Referral by Anaesthetist to:	Surgeon	No
	Haematologist	No
	Cardiologist	No
	Cardiac Technician	No
	GP	No
Type of admission to be decided by:	Anaesthetist	
Type of Admission:		
Admission Deferred:	Yes	

Advise to take usual anti-reflux medication	No
Dispensed Ranitidine as per PGD directive	No
Refer to smoking cessation clinic	No
Advise not to take "intravenous or recreational drug(s)" during the 24 hours before surgery (related to 33. Drug Abuse)	No
Anticoagulant advice	No
Clopidogrel advice	No
Aspirin advice	No
OCP advice	No

CHI Number: 3112626230 Patient Name: McLachlan, Michael

Provide Herbal Medicine Advice	No
Arrange for dialysis the day before surgery	No
Ensure facilities for dispensing methadone are available, if the patient is taking methadone.	No
Print PEFR Advice Sheet	No
Print ECG Advice Sheet	No

Anaesthetist Assessment	
Anaesthetist	
Grade	
Summary	

CHI Number: 3112626230 Patient Name: McLachlan, Michael

Acute Services Division

Surgery and Anaesthetics Directorate

Department: Pre Op Assessment Unit

Specialty: Urology

NHS Greater Glasgow and Clyde

Hospital Name	Glasgow Royal Infirmary

Patient Details		GP Details	
Name	McLachlan, Michael	Name	WALKER, CHRISTINE
Address	FLAT 1-1 31 ABERFELDY ST Glasgow Lanarkshire G31 3NS	Address	Baillieston Health Centre 20 Muirside Road Baillieston Glasgow
Correspondance Address		Telephone	
Correspondance Postcode		CRN Number	30141837L, 3112626230, ZRV10290713
Telephone		Consent	Yes
Patient Contact Number	07947416972	Sensitivity	Sensitive
CHI Number	3112626230	Consultant Name	MR ERONINI
Sex	Male	Requires Transport	No
Date of Birth	31/12/1962	Religion	Roman Catholic

Next of Kin / Person to Notify	Next of Kin	Person to Notify
Name	CHEVONNE MCLACHLAN	
Address	15 TORPHIN WALK, CRAIGEND, GLASGOW	
Landline		
Mobile	07494790834	
Relationship	DAUGHTER	

Assessment Details					
Assessor	AMANDA CRICHTON	Grade	S/N	Date	26/02/2018

CHI Number: 3112626230 Patient Name: McLachlan, Michael

Surgery / Procedure Attending For
CIRCUMCISION. --- Pathway update 05/04/18 TCI 04/05/18 - QEUH ECHO 24/04/18 Spirometry - 06/04/18 - report states - Pt unable to comply Cancelled previously due to LRTI Mr Eronini e mailed & out for Anaesthetic review

Short Notice Availability	Yes/No	Details
Available at short notice?	Yes	

Anaesthetic	Yes/No	Details/Problems
Previous GA	Yes	
Previous LA	Yes	
Detention Risk	Yes	2 UPPER FRONT VENEERS
Neck/Jaw Stiffness	No	
Other Risk	No	
Heartburn	No	
Sickle Cell Disease	No	Risk factors for sickle cell disease: No
Sleep Apnoea Score		

Surgical History	Yes/No	Details/Problems
Affects suitability for DSU	No	
Relevent details of surgical history		EXCISION OF LARGE SUBMANDIBULAR GLAND 2013, EXPLORATION OF SKIN WOUND 1986, SURGERY TO ULNAR NERVE 1996, PRIMARY REPAIR TO TENDONS 1996 & 1997, PRIMARY ARTHRODESIS 5TH JOINT LEFT HAND 1997
Any serious surgical or anaesthetic complication	No	

Cardiovascular	Yes/No	Details/Problems
Hypertension	No	
Arrhythmias		
Angina	No	
Heart Attack	No	

CHI Number: 3112626230 Patient Name: McLachlan, Michael

Murmur	No
Blackouts	No
Heart Failure	No

Respiratory	Yes/No	Details/Problems
Asthma/Bronchitis/COPD/Emphysema	No	
URTI	Yes	Patient still unwell; Patient has pyrexia;Temperature: 37ºC

Neurological	Yes/No	Details/Problems
Stroke	No	
Epilepsy	No	
Neurological Disease	No	
Physical Disability	No	

Haematological	Yes/No	Details/Problems
Bleeding Disorder	No	
Previous DVT	No	
Anaemia	No	

Miscellaneous	Yes/No	Details/Problems
Kidney disease	Yes	Caused by: PREVIOUS KIDNEY STONES;
Liver disease/jaundice	No	
Diabetes	No	
Arthritis	No	
CJD Risk	No	

Any serious illness not already mentioned?	No

Exercise Tolerance	Yes/No		Yes/No		Yes/No
Climbs stairs without stopping	Yes	Climbs stairs with stopping	No	Cannot climb stairs	No

Social	Yes/No				
Alcohol (units/week)	6	Duration: 20 years			
Smoker	Yes	13 cigs/day			
Ex Smoker					
IV drug abuser	Yes	PREVIOUS HEROIN ADDICTION. SMOKED, LAST USED 11/2017. SUPPORTED BY CAT TEAM AND ARRAN CENTRE.	Methadone Req:		
Pregnant	No	LMP	Could Be Pregnant:	No	

Drug History

List of all drugs (including herbal remedies and complimentary medicine)

CHI Number: 3112626230 Patient Name: McLachlan, Michael

Risperidone 2mg bd
Trazodone 100mgs nocte
buprenorphine 8mgs od
Buprenorphoner 2mgs od

Patient takes the following drugs	
Taking herbal remedies or complimentary medicine	No
Oral Steroids in past year	No
Does patient have any allergies?	No

Prosthesis/Implants	Yes/No
Pacemaker	No
Implanting/follow up hospital	
Date of implant	
Reason for implant	
Other reason for implant	
Type of pacemaker/impantable defibrillator	
Device manufacturer	
Model No.	
Serial No.	
Further details	

Examination							
Weight (kg)	61.3	Height (m)	1.71	BMI	21	Temp	37
Pulse (bpm)	63	Regular	Regular	BP	114/76		
SaO2 (%)	89						

Investigations	The below investigations are required.
26/02/2018	
FBC	
U&Es	
LFTs	
ECG	

CHI Number: 3112626230 Patient Name: McLachlan, Michael

ECHO

PEFR

Chest X-Ray

VTE Risk

Is patient at risk of VTE?	Yes	Do they require prophylaxis?	Yes

MRSA Screening

Does the Patient require a Clinical Risk Assessment?(for patients > 23 hours)							No
Has the patient ever had a previous positive MRSA result?							
Has the patient been admitted from a care home/institutional setting or another hospital?							
Does the patient have a wound/ulcer or invasive device which was present prior to admission?							
Has patient is to be admitted to any of the following:							
Orthopaedics	No	Vascular	No	Renal	No	Critical Care	No
MRSA Lab Test Results							
Nose	No	Perineum	No	Throat	No	Other	No	Patient refused	No
Other details:							

Admission Criteria

Appropriate admission based on nursing assessment	SDA

AHP USE ONLY: Is OT/Physio assessment required: An OT/Physio assesssment is not required

Pre-operative Assessment Summary

Assessor: AMANDA CRICHTON Grade: S/N

PATIENT VERY MUCH SOUNDS LIKE HE HAS A CHEST INFECTION, STATES HAS HAD PRODUCTIVE COUGH FOR 3 WEEKS, PUTTING IT DOWN TO A SMOKERS COUGH. STATES GREEN IN MORNING, SPO2 89%, PEAK FLOW AVERAGE 150.

DEFERRED AND REFERRED TO GP, WITH INSTRUCTIONS TO BE REFERRED BACK TO MR ERONINI'S SECRETARY TO BE RE ASSESSED ONCE RESOLVED.

****

From: Crichton, Amanda
Sent: 26 February 2018 09:49
To: Umez-Eronini, Nkem
Cc: Paulley, Janice
Subject: POA, PT DEFERRED, CHI 3112626230

3112626230 MCLACHLAN, Michael

Dear Mr Eronini,
your patient as above, attended POA today, unfortunately I very much suspect he had a chest infection. I have

referred him back to his GP with letter instruction to refer back to your secretary once resolved to be re assessed.
Hope this meets with your satisfaction.

Kind Regards
Amanda

S/N A Crichton
GRI, Pre Op Assessment Service
Ext, 25899

****

From: Umez-Eronini, Nkem
Sent: 26 February 2018 10:16
To: Crichton, Amanda
Cc: Paulley, Janice; Dickson, Ruth
Subject: RE: POA, PT DEFERRED, CHI 3112626230

Thanks
He was listed from a&e by CT.
Might try and see him in the clinic as LA might be option if he really needs it.
Suspend from W/L
See OPD
Nkem

Pathway update 05/04/18 (SN M McLaughlin)
TCI 04/05/18 - QEUH
ECHO 24/04/18
Spirometry - 06/04/18

Cancelled 26/02/18 due to LRTI
Prescribed oral antibiotics

Attended A&E with bloody spit - 15/03/18
Chest x ray, ECG, Bloods & CT Angiogram obtained
Not repeated today

Spirometry -06/04/18
ECHO 24/04/18

For Anaesthetic review when all reported

13/04/18
Mr Eronini informed e mail
Out for anaesthetic review per Spirometry report - states - Pt unable to comply

Recommended Admission Pathway	
Referral by nurse to:	Anaesthetist;
Nurse to arrange the attendance of:	
Nurse to:	
Referral by Anaesthetist to:	
Type of admission to be decided by:	Anaesthetist

CHI Number: 3112626230 Patient Name: McLachlan, Michael

Type of Admission:

Admission Deferred: Yes

Anaesthetic Assessment	**Anaesthetist:**	**Grade:**

GREATER GLASGOW AND CLYDE
FY1 PRE-ASSESSMENT CLERK-IN

Patient Label 3112626230 MCLACHLAN, M Michael 31/12/1962 FLAT 1-1 31 ABERFELDY ST Glasgow, Lanarkshire G31 3NS	Date: 5/4/16 Time: Consultant Mr. Eroini
Planned Operation: ~~TURNA~~ Circumcision	
Past Medical History: Drug misuse ↳ prev. Heroin addiction Depression	Current Medication: Trazodone 300mg OD Risperidone 2mg BD Buprenorphine 12mg OD ~~Buprenorphine~~ Allergies nkda
Clinical Examination:	
CVS: H/S I+II+0	Resp:
Abdo:  SNT BS+	Other: N:1
Comments: N:1	
Doctor: H. Sutton	Designation: FY1
GMC No. 7527482	

NHS GG&C Adult Risk Assessment for Venous Thromboembolism (VTE)

[excluding orthopaedics, obstetrics and gynaecology & ENT who have specialty-specific policies]

NHS Greater Glasgow and Clyde

- **Risk Assessment must be completed for all patients within 24 hours of admission to hospital**
- **Patients must be reassessed every 48-72 hours or sooner if condition changes**
- **Reassessment must be documented in Kardex**
- **Please complete risk assessment and then sign and date Risk Assessment Result box at bottom of page.**



3112626230
MCLACHLAN M,
Michael 31/12/1962
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

Surgical patients start here

Non-operative [mainly medical] patients start here

Is the patient bed-bound or expected to have reduced mobility relative to normal state for ≥ 2 days?

Yes ☐ No ☐

Does the patient have any risk factors for thrombosis? (tick all that apply)

Age >60	☐	Use of oestrogen-containing contraceptive therapy	☐
Active cancer or cancer treatment	☐	Use of hormone replacement therapy	☐
Dehydration	☐	Pregnancy or < 6 weeks post partum [seek specialist advice]	☐
Known thrombophilias	☐	Critical care admission eg HDU/ITU	☐
Obesity (BMI>30)	☐	Total anaesthetic + surgical time >90 minutes	☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or inflammatory disease	☐	Surgery involving pelvis or lower limb with a total anaesthetic + surgical time >60 minutes	☑
Personal history or first degree relative with a history of VTE	☐	Acute surgical admission with inflammatory or intra-abdominal condition	☐
Varicose veins with phlebitis	☐	Hip fracture	☐

- No thromboprophylaxis required.
- Continue to reassess every 48-72 hours or sooner if condition changes.
- Document all reassessments in drug kardex.
- **Risk assessment now complete**
- **Complete Risk Assessment Result Box**

Yes, 1 or more risk factors identified ☑

No risk factors identified ☐

Does the patient have any contraindications to pharmacological prophylaxis? (tick all that apply)

Active bleeding	☐	Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands)	☐
Acquired bleeding disorders (e.g. acute liver failure)	☐	Neurosurgery, spinal or posterior eye surgery	☐
Concurrent use of anticoagulants such as warfarin with INR>2)	☐	Lumbar puncture, epidural/spinal anaesthesia expected within the next 12 hours	☐
Acute stroke	☐	Other procedure with high bleeding risk – discuss with senior if unsure	☐
Uncontrolled hypertension (230/120 mmHg or higher)	☐	Lumbar puncture, epidural/spinal analgesia within the previous 4 hours	☐
Thrombocytopenia (<75 x 10^9/l)	☐	Thyroid surgery	☐

- **Discuss with senior clinical staff before prescribing pharmacological prophylaxis**
- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48-72 hours or sooner if condition changes

No contraindications to pharmacological prophylaxis identified ☑

Contraindications to pharmacological prophylaxis identified ☐

Surgical patients – Enoxaparin 40mg + AES ☑
*prior to application of AES, please check contraindications to AES

Medical patients – Enoxaparin 40mg ☐
Prescribe Enoxaparin at 6pm
[on day of surgery, at the later of either 4h post-op or 6pm]
Reduce Enoxaparin to 20mg if <50Kg or eGFR <30ml/minute/1.73m² ☐
Discontinue at discharge or when returned to pre-morbid mobility

Contraindications to anti-embolism stockings (AES) Y ☐ N ☐

Peripheral neuropathy	☐
Peripheral vascular disease	☐
Cellulitis or Gross oedema	☐
Leg deformity or Fragile skin	☐
Leg / foot ulcers	☐
Allergy	☐
Unusual leg size/shape	☐

Risk assessment result – please tick all that apply

VTE risk factors: YES ☑ NO ☐ Contraindications to pharmacological prophylaxis: YES ☐ NO ☑ Prescribed: LMWH ☑ AES ☐ NONE ☐

Patient informed of VTE risks and benefits of thromboprophylaxis YES ☐ NO ☐ N/A ☐ Information leaflet provided YES ☐ NO ☑

Print Assessor's Name: H. Sutton Signature: [signature] Date: 5/4/18

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details;
Tel: 0141 211 5457
Fax: Patient Attended
Email: GRI Assessment Unit

Date Completed: 20/03/2018

Consultant: Dr Allan Cameron

K Walker
1539 Shettleston Road
Glasgow
Glasgow
G32 9AS

Dear K Walker

Re: **McLachlan Michael** DOB: **31/12/1962** CHI: **3112626230**
FLAT 1-1
Glasgow G31 3NS

Attended on: **16/03/2018 at 08:58 hrs.** Departed on: **16/03/2018 at 13:50 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **2**

Presenting complaint
CP

Nursing Assessment:
return for CTPA

Investigations in ED:
1. Transthoracic ECHO

Diagnosis:

Diagnosis	Side	Site
Heart failure, unspecified		
Pleurisy / Pleuritic chest pain		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Dear doctor, This 55 year old presented with chest pain and haemoptysis. Described a 3 day history of coughing up blood mixed with sputum and right sided pleuritic chest pain, worse on coughing. PMHx: drug dependence (heroin and benzodiazepines), bipolar, deliberate self-harm. Troponin negative, d-dimer 213, CRP 9, WBC 9.6, otherwise unremarkable. CXR: calcified granuloma in left mid zone as previous, no new areas of consolidation. ECG: sinus rhythm, no ischaemic changes. Given history the patient underwent a CTPA to exclude PE despite negative d-dimer. CTPA showed: no evidence of PE; right basal dependent change but no focal collapse or consolidation; Mediastinal lymphadenopathy of uncertain clinical significance; right heart dysfunction; Pancreatic and CBD dilation but note normal LFTs. Plan: discharged home with out patient Echo. GP to follow up regarding: consideration of diuretics/heart failure pathway. Kind regards,

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Miriam Portela-McKean
Doctor

Copies to:

1. K Walker (GP)

School Address:

Glasgow Royal Infirmary

CHI: 3112626230

Total Att: 12

12 Mth Att: 1

Title: MR

MCLACHLAN **Michael**

DOB: **31/12/1962** Age: **55y** Sex: **Male**

FLAT 1-1
31 ABERFELDY ST
Glasgow
Lanarkshire
G31 3NS

Next of kin: **SHERLOCK, Martine**
Relationship: **Niece**

GP: **K Walker**
0141 531 6235

Attendance Date: **15/03/2018** Arrival Time: **16:02**

Registration Time: **16:02** Date of Incident: **15/03/2018**

Major Incident Desc:

Reason for Attendance: **? pte recent lrti po abx now c/o haemoptysis pcp**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **15/03/2018 16:06** Nurse name: **Nurse Nicola Seggie**

Temp	**36.4**	C
HR	**66**	bpm
BP	**117/74**	mmHg
MAP	**88.33**	mmHg
RR	**18**	bpm
SpO2	**97**	%
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: **gap 20 news 0 presents with a 3/7 hx of haemoptasis and chest pain. worse on inspiration. ?PE pmh: ? copd**

Prevention

15/03/2018 14:56.00 BP 111 / 67 taken Sitting Cuff: Standard recall due: O/E - blood pressure reading pulse 55 Dr Katherine Grosset
08/06/2011 09:46.00 BP 116 / 76 taken Standing Cuff: Standard recall due: O/E - BP reading Dr Lynne Cooke
08/06/2011 09:45.00 BP 118 / 72 taken Sitting Cuff: Standard recall due: O/E - BP reading Dr Lynne Cooke
15/03/2018 Smoker Cigarettes: 15 Cigarette smoker Dr Katherine Grosset
15/03/2018 Weight: 59 kgs BMI: 19.4 O/E - weight Dr Katherine Grosset
04/06/2010 Height: 1.74 metres O/E - height Miss Catherine Arbuckle

New Consultation Details

Date: **Clinician:**

3112626230
MCLACHLAN M
Michael 31/12/1962

Rec Phys

GEI

Dear Dr.

See note above – this man has been coughing up "quite a lot blood" for 3 days and has (R) sided chest pain on breathing. He is a smoker – he has not had haemoptysis or blood clots in the past but in view of his presentation thank you for asking him to exclude PE.

K Grosset

Glasgow Royal Infirmary
Acute Medicine Unit

(Part B - Medical Admission)

NHS
Greater Glasgow and Clyde

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

Date & Time 15/3/18 17:40 Consultant Ward AAU

Ward Review (Should be completed within 2hrs of transfer from ED) FY2 D. MATHIE

Check List

- VTE ☐
- Med - Rec ☐
- Kardex ☐
- CxR ☐
- ECG ☐
- Oxygen ☐
- Patient on Bleeders list ☐

55♂ Chest pain + haemoptysis

Background: Drug dependence (heroin, benzodiazepine)
Deliberate self harm
bipolar, depression

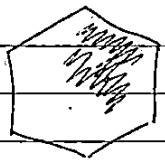
Social: smoker 10-15/day on subutex
alcohol at weekend no other illicit drug use

HPC: 3 day history coughing up blood + R side pleuritic chest pain
- "quite a lot" of blood, definitely coughing
- sore head as well
- mixed with sputum. Initially just sputum - given amoxicillin
- tight central chest pain on right side. Worse when coughing.
- ? has COPD.

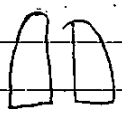
No fevers or sweats. Feeling a bit dizzy. No WL. No LOC.

Obs: T36.4 HR66 BP117/74 RR18 sats 97%

D/E: A - Maintained E -



tender + to examine guarding

B - 
hair entry
no wheeze or crops

C - HS I+II+0
regular

D - alert, orientated

Ward Review

Bloods 15/3/18 U&E Ⓝ
Trop 3
LFT Ⓝ
Glucose 5.5
FBC Hb 141 Plt 214 WCC 9.6
D-dimer 213
Coag Ⓝ
CRP 9
Bone profile: adj Ca 2.37 phos 1.07

CxR 02/03/18 calcified granuloma in left mid zone (as previous)
15/03/18 no new areas of consolidation

ECG Rate 54, sinus rhythm, high take off V_2-V_6
no ischaemic changes

Impression D-dimer negative, CxR clear
?cause chest pain + haemoptysis
Need to rule out PE

Plan ① CTPA tomorrow at 0930 slot
② treatment dose dalteparin tonight
Above plan discussed with Dr May

CT-PA: - No PE
- Ⓡ basal dependent changes
- Coronary arteries have atheromatous plaque
- Significant reflux into IVC hepatic veins & Ⓡ V dilated ↳ Ⓡ heart dysfunction
- Pan. & CBD duct dilatation @ 5mm & 9mm respectively
↳ Ⓝ LFTs
↳ Seen by GS 8/8/12: CT & EUS Ⓝ, D/C'd

Plan - D/W Dr A Cameron
↳ For D/C
↳ GP F/U & consider HF pathway & diuretic
↳ OP ECHO ordered

NHS GG&C Adult Risk Assessment for Venous Thromboembolism (VTE)

[excluding orthopaedics, obstetrics & ENT who have specialty-specific policies]

NHS Greater Glasgow and Clyde

- **Risk Assessment must be completed for all patients within 24 hours of admission to hospital**
- **Patients must be reassessed every 48-72 hours or sooner if condition changes**
- **Reassessment must be documented in Kardex**
- **Please complete risk assessment and then sign and date Risk Assessment Result box at bottom of page.**



3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
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Glasgow, Lanarkshire
G31 3NS

Operative patients

Non-operative patients

Is the patient bed-bound or expected to have reduced mobility relative to normal state for ≥ 2 days?

Yes ☐ No ☐

Does the patient have any risk factors for thrombosis? (tick √ all that apply)

Age >60	☐	Use of oestrogen-containing contraceptive therapy	☐
Active cancer or cancer treatment	☐	Use of hormone replacement therapy or tamoxifen	☐
Dehydration	☐	Pregnancy or < 6 weeks post partum	☐
Known thrombophilias	☐	Critical care admission eg HDU/ITU	☐
Obesity (BMI>30)	☐	Surgical procedure with total anaesthetic/surgical time >90 min, or >60 min if surgery on lower limb or pelvis	☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or Inflammatory disease	☐	Acute surgical admission with inflammatory or intra-abdominal condition including Pelvic Inflammatory Disease	☐
Personal history or first degree relative with a history of VTE	☐	Hip fracture	☐
Varicose veins with phlebitis	☐	All gynaecological surgery except uncomplicated gynaecological diagnostic day case procedures	☐

- No thromboprophylaxis required.
- Continue to reassess every 48-72 hours or sooner if condition changes.
- Document all reassessments in drug kardex.
- **Complete Risk Assessment Result Box.**

Yes, 1 or more risk factors identified ☐

No risk factors identified ☐

Indicators of high risk bleeding (tick √ all that apply)

Active bleeding	☐	Lumbar puncture, epidural/spinal anaesthesia • Expected within the next 12 hours • Within the previous 4 hours	☐
Acquired bleeding disorders (e.g. liver failure)	☐	Other procedure with high bleeding risk – discuss with senior if unsure	☐
Concurrent use of other anticoagulants (e.g. warfarin, rivaroxaban, apixaban, edoxaban) is a contra-indication to additional phamacological thromboprophylaxis	☐		
Acute stroke (within 14 days)	☐	Acute bacterial endocarditis	☐
Persistent uncontrolled hypertension (BP > 230/120 mmHg)	☐	Surgery expected within the next 12 hours	☐
Thrombocytopenia (<75 x 10⁹/l)	☐	Trauma with high bleeding risk e.g. Head Injury	☐
Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands)	☐	eGFR <30ml/minute/1.73m²: Dose reduction required	☐
High risk of peri- or post-procedural bleeding, e.g. neurosurgery , spinal, posterior eye surgery and thyroid surgery	☐	Heparin induced Thrombocytopenia	☐

- **Discuss with senior clinical staff before deciding to prescribe pharmacological prophylaxis**
- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48-72 hours or sooner if condition changes.

No contraindications to pharmacological prophylaxis identified ☐

Contraindications to pharmacological prophylaxis identified ☐

Operative patients – Enoxaparin 40mg + AES ☐*
*prior to application of AES, please check contraindications to AES

Non-operative patients – Enoxaparin 40mg ☐
Prescribe Enoxaparin at 6pm
[on day of surgery, at the later of either 4h post-op or 6pm]
Reduce Enoxaparin to 20mg if <50Kg or eGFR <30ml/minute/1.73m² ☐
If weight> 120kg, consider Enoxaparin 40mg bd (see StaffNet Guideline).
Discontinue at discharge or when returned to pre-morbid mobility

Contraindications to anti-embolism stockings (AES) Y ☐ N ☐

Peripheral neuropathy	☐
Peripheral arterial disease	☐
Cellulitis or Gross oedema	☐
Leg deformity or Fragile skin	☐
Leg / foot ulcers	☐
Allergy	☐
Unusual leg size/shape	☐

Risk assessment result – please tick √ all that apply.

VTE risk factors: YES ☐ NO ☐ Indicators of high risk bleeding: YES ☐ NO ☐ Prescribed: LMWH ☐ AES ☐ NONE ☐

Patient informed of VTE risks and benefits of thromboprophylaxis YES ☐ NO ☐ N/A ☐ Information leaflet provided YES ☐ NO ☐

Print Assessor's Name: _____ Signature: _____ Date: _____

RAT Medicine & Surgery – TEST OF CHANGE 09

mi • 250744 Version 9_0 • GGC0015

Medicine Reconciliation Form

Source of information: ECS ☑

Patient ☐ Relative/carer ☐ GP surg ☐ GP computer printout/letter ☐ Patient's own drugs ☐ Other (specify) _____

Admission Medicines (including OTC, herbal, homeopathic)				Plan for medicines (unless indicated to stop or hold medication should be continued on drug kardex)				
Name	Dose	Freq	Route	Amend	withhold	Stop	continue	Reason for alteration
RISPERIDONE	2mg	BD	PO				✓	
TRAZODONE	300mg	ON	PO				✓	
Allergies/adverse events	NKA							

List obtained by D. MATHIE Designation F1 R2

Recently altered/discontinued medicines prior to admission and reasons why _____

Compliance aid? Y ☐ N ☐ Type _____ If, Y Community Pharmacy _____ Phone _____

Senior Medical staff review: Sign _____ Title _____ Date and Time _____

Reviewed by pharmacist _____ Date and Time _____

Comments

Consultant Review

3112626230
MCLACHLAN M
Michael 31/12/1962

Check List	
VTE	☐
Med - Rec	☐
Kardex	☐
CxR	☐
ECG	☐
Oxygen	☐
EDD	

PRINT NAME	DESIGNATION
SIGNATURE	DATE & TIME

Clinical Notes

3112626230
MCLACHLAN M
Michael 31/12/1962

Clinical Notes

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name:
3112626230 M
MCLACHLAN 31/12/1962
Michael
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire G31 3NS

1. Triage (Consider Mental Health Triage Assessment - if applicable)

Hospital	Patient Preferred Name:
Date: / Time:	
Triage Nurse	Transport SAS/Self:

2. Presenting Complaint

Category ☐ Gap Score ☐

3. Observations

Allergies (including food allergies):

No Known allergies ☐

Resp. Rate	Sp02	Temperature	Pulse	Blood Pressure
GCS	**NEWS Score**	**PEFR**	**Blood Glucose**	**Pain Score**
/15				/10

4. Communication

I.D. band on?	Y / N
Relatives present?	Y / N
Relatives / NOK informed?	Y / N
Interpreter required?	Y / N

5. 4AT and TIME for Detection, Management, and Prevention of Delirium

Complete for patients: age 65 and over; patients of any age with an existing cognitive impairment; previous delirium; current hip fracture; or severe illness. These patients are at high risk of delirium. This should be done on admission; at each transition of care; if SQiD positive; or if any clinical concerns.

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name: 3112626230
Addr: MCLACHLAN Michael FLAT 1-1 31 ABERFELDY ST Glasgow, Lanarkshire G31 3NS
DOB: 31/12/1962
CHI N: M

Named Nurse/Team Leader: _____

Assessment Completed by: Name (PLEASE PRINT) CKENNEDY

6. Patient Preparation

Prepare patient for examination	☑	IV Cannula (if required)		Y/N
Clothing bag labelled and stored	☑	Blood samples taken If Yes, list requests		Y/N
12 Lead ECG	☐	Cardiac Monitoring		Y/N
X rays performed	☐	Height:	Weight:	

Urinalysis

Leucocytes	Nitrites	Protein	pH
Blood	S.G.	Ketones	Glucose
MSSU/CSU Sent ☐			
HCG specimen if indicated	+ve ☐	-ve ☐	Strip Lot no:

7. Peripheral Vascular Catheter (PVC) Bundle

Reason for PVC Insertion: 16/3/18

☐ IV Fluids

☐ IV Drugs

☐ Suspected haemorrhage

☑ Diagnostic tests

Insertion Date: 16/3/18

Insertion Time: 09:20

Hand hygiene performed immediately before PVC insertion.	☑
Skin antiseptic containing 70% isopropyl alcohol used to cleanse the skin and left to dry.	☑
Aseptic technique maintained throughout insertion procedure.	☑
Sterile, transparent, semi permeable dressing used to cover catheter site.	☑

Size/Colour: pink Insertion site: (L) ACF

Signature: NStewart

8. Adult Urethral Urinary Catheter Insertion (Use maintenance care plan as appropriate)

Clinical Indication for Insertion:

Insertion Date: __/__/__

Insertion Time: __:__

Signature: _____

Hand hygiene performed immediately before insertion.	☐
Aseptic technique maintained throughout insertion procedure and connection to closed drainage.	☐
Urethral meatus cleansed with saline and lubricant used.	☐

Guage: _____ _____ mls in balloon

9. General Safety Precautions to be Undertaken by All Patients

Falls Risk - if yes to any - FULL RISK ASSESSMENT

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

Date: _____

Time: :

1. Document mobility status in clinical record and complete a moving and handling assessment if appropriate	
2. Check walking aid (if required) is in reach and in use.	
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	
5. If glasses are worn, check they are available and in use	
6. If hearing aid/s are worn, check they are working and in use.	

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CHI N G31 3NS

10. Screening Tool (Requires escalation/specialist referral/separate Risk Assessments)

Child Protection concern	Y / N / (NA)	Learning Disabilities.	Y / N / (NA)
Adult Support and Protection	Y / N / (NA)	Patient has appointed Welfare Guardian/Power of Attorney	Y / N / (NA)
>65 years: 4AT/TIME BUNDLE COMPLETE?	Y / N / (NA)	Patient has Adult with Incapacity Section 47 certificate in place	Y / N / (NA)
Mental Health Triage	Y / N / (NA)	Infection Risk	Y / N / (NA)
Has swallow test been carried out?	Y / N / (NA)	STOPPS completed? Y / N / NA Date _____ Time _____ Sign _____	
Sepsis Risk: Systemic inflammatory response syndrome (SIRS) Criteria 2 or more → commence Sepsis Bundle	Y / N / (NA)	Anticipatory Care Planning? (If applicable, complete GAEL chart)	Y / N / (NA)
FRAILTY SCREENING	Y / N / (NA)	SUBSTANCE MISUSE FAST SCORE / GMAWS	Y / N / (NA)

11. Pressure Area Assessment

1 Pressure Damage — Does the person have redness and/or existing damage? Yes / (No)
If YES, prescribe a minimum of 2 HOURLY Active Care to avoid further damage occuring and complete the pressure ulcer intervention plan (PUDRA Chart).

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

2 Mobility	Does the person require assistance to mobilise?	Yes / (No)
3 Continence	Does the person have continence issues with urine and/or faeces	Yes / (No)
4 Nutrition	Does the person appear malnourished and/or unable to eat or drink	Yes / (No)
5 Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?	Yes / (No)
6 Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:	Yes / (No)

12. Record of Intentional Rounding – ask whenever patient is visited but no longer than every 2 hours

1. Think delirium: Is the patient more confused?
2. Comfort: Are you comfortable?
3. Pain: Do you have any pain?
4. Drink/Mouth Care: Would you like a drink?
5. Food: Are you hungry?
6. Continence: Do you need to go to the toilet?
7. Possessions: buzzer, tissues, glasses within reach, water available and relatives at bedside?
8. Is there anything else I can do for you?

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.
15/3/18	1620	CL												
16/3/18	0920	NS												

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.

Acute Assessment Unit

Nursing Documentation

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FLAT 1-1 31/12/1962
DOB: 31 ABERFELDY ST Glasgow, Lanarkshire
CHI N G31 3NS

Communication with Relatives		Signatures	Time
Next of Kin:	Tel:		

Nursing Notes

Date and Time		Print Name and Signature
15/03/18 1630	Pt referred for chest pain in zone (4). ECG and bloods obtained with no IV Access. Pt awaiting medic r/v.	SJN ET
1850	Pt given tx dose of dalteparin to return for CTPA at 09:00. - Pt has needle phobia	SJN ET
16/3/2018 0920	Pt returned to AAU for CTPA. appointment changed to 1120. IV cannula inserted. Observations taken as charted. Pt settled awaiting scan. Cup of tea given ———	NStewart-SJN
1310	Pt accepted cup of tea + sandwich. Awaiting results of CTPA ———	NStewart
1350	Pt discharged (H), no follow-up. PVC removed.	

Acute Assessment Unit

Nursing Documentation

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G31 3NS
CHI

Nursing Notes

Date and Time		Print Name and Signature

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name: _____

Address: _____

_____

DOB: _____

CHI Number: _____

Nursing Notes

Date and Time		Print Name and Signature

Acute Assessment Unit

Nursing Documentation

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Name: MCLACHLAN Michael
Address: FLAT 1-1 31 ABERFELDY ST Glasgow, Lanarkshire G31 3NS
DOB: 31/12/1962
CHI Numbe 3112626230 M

Nursing Notes

Date and Time		Print Name and Signature

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name:_____

Address: _____

_____

DOB:_____

CHI Number:_____

Pause for Transfer (Please tick when completed)		Tick when completed	N/A	Notes
	Relatives Informed	☐	☐	Information on discussion with relatives
	Cannula	☐	☐	
	Name Band	☐	☐	
	4AT	☐	☐	
Snr Dr.:_____ Page no.:_____	NEWS >7	☐	Always	
Prescriptions signed	Infusions	☐	☐	
	Drugs	☐	☐	
	Fluids	☐	☐	
	GMAWS	☐	☐	
	Belongings (including patients medication)	☐	Always	Please note here if any other tasks required prior to transfer
	Bed requested, accepted and ward informed/SBAR completed	☐	Always	
	Notes: medical notes; GP letter, PRF	☐	Always	
Investigations	CXR reviewed	☐		
	ECG reviewed	☐	☐	Print name
	Bloods sent	☐	☐	
	Bloods reviewed	☐	☐	
	Patient on 02: cylinder checked	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
Belongings (including patients medication)	☐	Always	
New medications explained	☐	☐	
PVC removed	☐	☐	
Relatives aware of Discharge	☐	☐	Please note here if any other tasks required prior to discharge
Social/Support Services required and contacted	☐	☐	
SAS Transport required and ref. no.	☐	☐	Print name
Other means of transport arranged by nurse	☐	☐	

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name	
Address	3112626230 MCLACHLAN M Michael 31/12/1962 FLAT 1-1 31 ABERFELDY ST Glasgow, Lanarkshire G31 3NS
CHI No.	
DoB	

	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

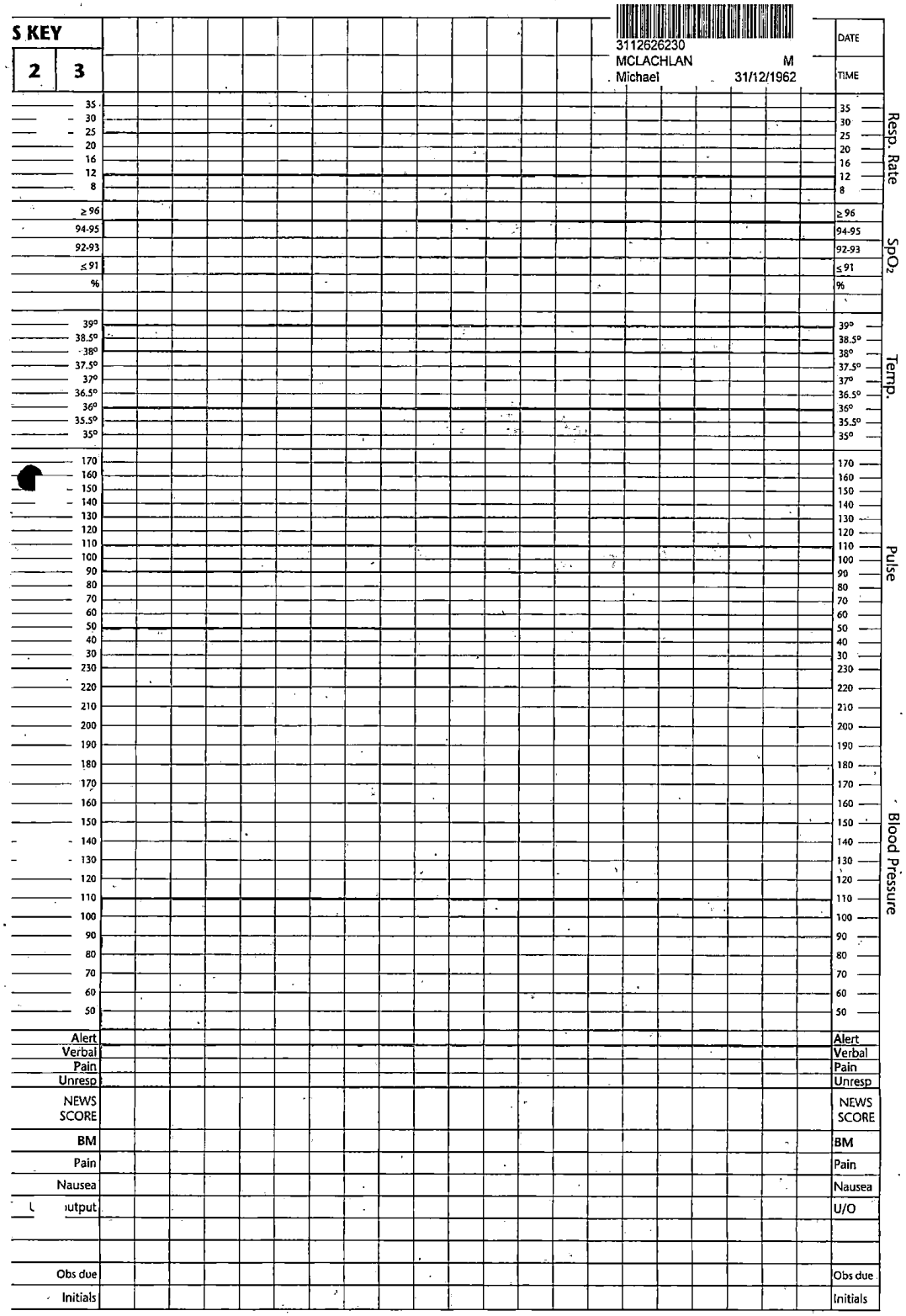
NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.

MICHEAL MCLACHLAN

	DATE:	15/03	16/3		DATE	NEW
	TIME:	1605	0900	1300	TIME	0 1
Resp. Rate Mark: •	35 30 25 20 16 12 8	•	•	•	35 30 25 20 16 12 8	
SpO_2 (Enter Value)	≥96 94-95 92-93 ≤91	97	97	96	≥96 94-95 92-93 ≤91	
Any Sup'l O_2 % Room air	%	(A)	(A)	A	%	
Temp. Mark: X	39° 38.5° 38° 37.5° 37° 36.5° 36° 35.5° 35°	X	X	X	39° 38.5° 38° 37.5° 37° 36.5° 36° 35.5° 35°	
Pulse Mark: •	170 160 150 140 130 120 110 100 90 80 70 60 50 40 30	•	•	•	170 160 150 140 130 120 110 100 90 80 70 60 50 40 30	
Blood Pressure Mark: ^ v	230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50	112	107	73	230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50	
NEWS SCORE using Systolic BP		1				
Conscious Level Mark: •	Alert Verbal Pain Unresp	(A)	•	•	Alert Verbal Pain Unresp	
Total NEWS (with all obs)		0	1	2	NEWS SCORE	
BM					BM	
Pain					Pain	
Nausea					Nausea	
Urine output					U/O	
Obs due		4°			Obs due	
Initials		TT	NS	SS	Initials	


S KEY
2
3
3112626230
MCLACHLAN
Michael
M
31/12/1962
DATE
TIME
Resp. Rate
SpO2
Temp.
Pulse
Blood Pressure
35
30
25
20
16
12
8
≥ 96
94-95
92-93
≤ 91
%
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Glasgow Coma Scale

Pupil size (mm): 1 2 3 4 5 6 7 8

3112626230
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Glasgow, Lanarkshire
G31 3NS

Neurological Observations

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

Pain Score

Ask the patient to rate his/her pain by choosing a number between 0 and 10. Use the diagram below to assist the patient. If patient's pain is chronic, use generic tool. If patient is unable to communicate, use observational tool.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Severe Pain			

Nausea and Vomiting	
0	= None
1	= Mild (*Not distressing – no retching/vomiting*)
2	= Moderate (*Troublesome – occasional retching/vomiting*)
3	= Severe (*Distressing – frequent retching/vomiting*)

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

MEDICINE

PRESCRIPTION FORM

Hospital Name: .....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐

Date _____ Name (Print) _____

Discharge Prescription Prepared & Reconciled YES ☐

Date _____ Name (Print) _____

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

DOCTOR'S DECLARATION (if required by Local Protocol)

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

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____

Address _____

Compliance Aid Details _____

Patient consent to share discharge information Y/N

Print & Sign _____

PATIENT DETAILS

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

Height:

Weight:

Surface area:

Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
15/3	DALTEPARIN	12500 UNITS	S/C	18.30	[signature]	1850	CK

DATE →

MONTH →

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

IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N

ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N

SIGNATURE OF ASSESSOR

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

Parenteral Drugs : Regular Prescription

Patient's Own Medicine

A

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

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

B

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

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

C

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

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

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

3112626230
MCLACHLAN
Michael
M
31/12/1962

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

| | | |

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

H 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 ☐

J 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 ☐

K 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 ☐

L 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.

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

3112626230
MCLACHLAN M
Michael 31/12/1962

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

M DRUG

DOSE | ROUTE | DATE

STOPPED DATE:
INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

N DRUG

DOSE | ROUTE | DATE

STOPPED DATE:
INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

P DRUG

DOSE | ROUTE | DATE

STOPPED DATE:
INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

R DRUG

DOSE | ROUTE | DATE

STOPPED DATE:
INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

S 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 ☐

T 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 ☐

V 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 ☐

W 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.

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

3112626230
MCLACHLAN
Michael
M
31/12/1962

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:

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 ☐

Y 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 ☐

AA 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 ☐

BB 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.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

Patient's Own Medicine

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

CC DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DD DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

EE DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

FF DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

3112626230
MCLACHLAN Michael M 31/12/1962

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: | 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 ☐

HH 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 ☐

JJ 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 ☐

KK 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.

All Routes: As Required Prescriptions

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

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

| | | |

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, 1800.

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

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

7. The following metric unit abbreviations must be used –

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

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

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

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

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

FOR NURSES

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

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

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

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

Codes for Non-Administration of Drugs

(3) Patient refused	(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		

Cat. No. 40995 Ver 4, 09/2010 GGC0029

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1,
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

Date & Time		Signature, Print Name & Designation
13/3	Nursing episode for LA C-c. Pat unlist	

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 13/12/2017

Consultant: Dr Phil Anderson

CA Walker
Mcglone Practice
Baillieston Health Centre
20 Muirside Road baillieston
Glasgow
Glasgow
G69 7AD

Dear CA Walker

Re: **McLachlan Michael** DOB: **31/12/1962** CHI: **3112626230**
FLAT 1-1
Glasgow G31 3NS

Attended on: **13/12/2017 at 15:25 hrs.** Departed on: **13/12/2017 at 18:33 hrs.**
Discharge Type: **01c - Discharge with referral** Destination: **Private residence**
Previous ED Attendance in last 12 months: **1**

Presenting complaint
unspecified male issue? wants male nurse?

Nursing Assessment:
?paraphimosis. for 1/7. news of 1. looks uncomfortable. pt worried about tight foreskin. can not advance foreskin over penis, has swollen. states is in pain as result.

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Phimosis and paraphimosis, redundant prepuce		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Mr McLachlan presented with a 1 day history of paraphimosis. He has a long standing phimosis and had forcefully retracted back his foreskin to clean underneath. Following this he was unable to replace it. He has always been unable to retract his foreskin easily and this causes issues with sexual intercourse. Today in ED he required a penile block in order to reduce quite a notably difficult paraphimosis. I have discussed circumcision with Mr McLachlan and he would like to go ahead with this, and infact had been meaning to get himself referred for it for some time. He has a past medical history of depression only. Kind regards, Dr R McLennan Urology SHO GRI on call 13/12/17

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Rachel McLennan
Doctor

Copies to:

1. CA Walker (GP)

School Address:

13

Glasgow Royal Infirmary

CHI: 3112626230

Total Att: **11**

12 Mth Att: **1**

Title: **MR**

MCLACHLAN **Michael**

DOB: **31/12/1962** Age: **54y** Sex: **Male**

FLAT 1-1
31 ABERFELDY ST
Glasgow
Lanarkshire
G31 3NS

Next of kin: **SHERLOCK, Martine**
Relationship: **Niece**

GP: **CA Walker**
0141 531 8050

Attendance Date: **13/12/2017** Arrival Time: **15:25**

Registration Time: **15:25** Date of Incident: **13/12/2017**

Major Incident Desc:

Reason for Attendance: **unspecified male issue? wants male nurse?**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **13/12/2017 15:36** Nurse name: **Nurse Emma Livingston**

Temp	**35.9**	C
HR	**67**	bpm
BP	**122/80**	mmHg
MAP	**94.00**	mmHg
RR	**17**	bpm
SpO2	**97**	%
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: **"?paraphimosis. for 1/7. news of 1. looks uncomfortable. pt worried about tight foreskin. can not advance foreskin over penis, has swollen. states is in pain as result. "**

3112626230 31/12/1962 MCLACHLAN Michael
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To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

Date	Clinical Notes
13/12/17	Seen By MCPHERSON Time Seen 1635h 54 o→ SP Paraphimosis Unable to replace foreskin since cleaning last night foreskin o/e extremely tight ^ + fibrosed prepuce. Have tried compression, ice + dextrose 20% swabs unsuccesfully. Refered urology @ 1735h LN.
13-12-17 1830	ATSP. Rutherman CTI. Paraphimosis 24°. Always had phimosis & difficulty ± sex. has told retracted foreskin previously a couple of times but had been able to get back in the past V. tender. O/E paraphimosis, Tight band. Tried to reduce. Too tender Penile block with 7ml 0.5% lignocaine Able to reduce - still challenging. Pt to discussion, nil else. Plan/ (H) List for circumcision pt happy. Thio CTI.

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By
13/12/17	ORAMORPH	5mg	PO	17-10	LN	CL

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name	3112626230
Address	1 MCLACHLAN M 2 Michael 31/12/1962 FLAT 1-1 31 ABERFELDY ST Glasgow, Lanarkshire G31 3NS
CHI No.	
DoB	

	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.

13 Michael McLachlan.

DATE: 13/12/17

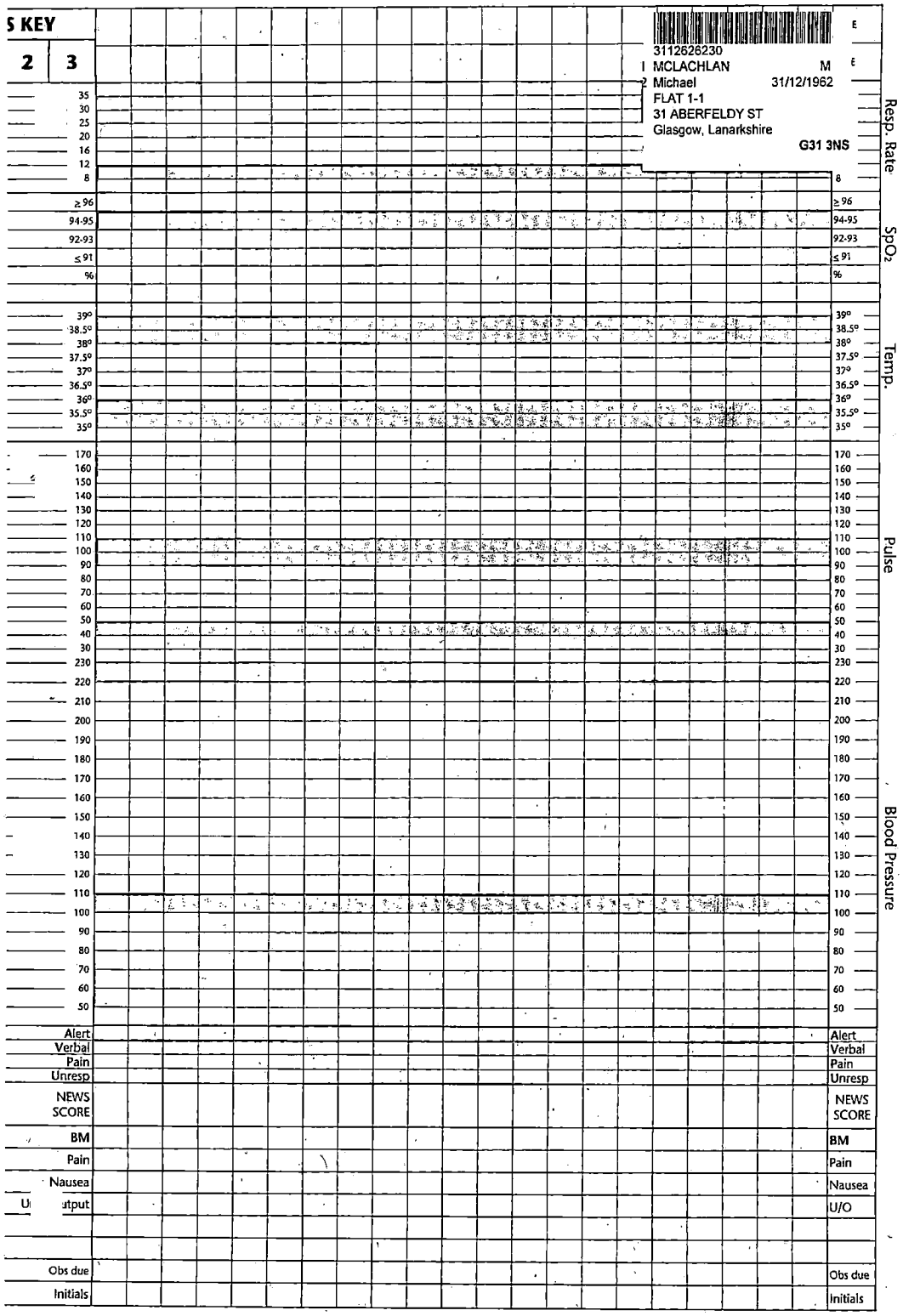
TIME: 15:35

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

NEW

0 1

Resp. Rate Mark: •	35 30 25 20 16 12 8	8
SpO_2 (Enter Value)	≥96 94-95 92-93 ≤91	97 ≥96 94-95 92-93 ≤91
Any Sup'l O_2	%	%
Room air		A
Temp. Mark: X	39° 38.5° 38° 37.5° 37° 36.5° 36° 35.5° 35°	39° 38.5° 38° 37.5° 37° 36.5° 36° 35.5° 35°
Pulse Mark: •	170 160 150 140 130 120 110 100 90 80 70 60 50 40 30	170 160 150 140 130 120 110 100 90 80 70 60 50 40 30
Blood Pressure Mark: ^ v	230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50	230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50
NEWS SCORE using Systolic BP		^ v
Conscious Level Mark: •	Alert Verbal Pain Unresp	✓ Alert Verbal Pain Unresp
Total NEWS (with all obs)		1 NEWS SCORE
BM		BM
Pain		Pain
Nausea		Nausea
Urine output		U/O
Obs due		Obs due
Initials		Initials


S KEY
2
3
3112626230
1 MCLACHLAN M
2 Michael 31/12/1962
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS
Resp. Rate
SpO2
Temp.
Pulse
Blood Pressure
35
30
25
20
16
12
8
≥ 96
94-95
92-93
≤ 91
%
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Glasgow Coma Scale

Pupil size (mm)

1 2 3 4 5 6 7 8

3112626230
MCLACHLAN M
Michael 31/12/196
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

Neurological Observations

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

Pain Score

Ask the patient to rate his/her pain by choosing a number between 0 and 10. Use the diagram below to assist the patient. If patient's pain is chronic, use generic tool. If patient is unable to communicate, use observational tool.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Severe Pain			

Nausea and Vomiting	
0	= None
1	= Mild (*Not distressing – no retching/vomiting*)
2	= Moderate (*Troublesome – occasional retching/vomiting*)
3	= Severe (*Distressing – frequent retching/vomiting*)

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

Emergency Department Nursing Documentation

3112626230
MCLACHLAN Mel
Michael 31/12/196
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

Presenting Complaint - ? paraphimosis

Date - 13/12/17 **Time –** 17:00

Assessment Complete by: Name NURSE (Please Print)

Chelsea + Edyta

Patient Prep / Investigations
(Please tick/circle when completed)

Prepare patient for examination / Clothing bag labelled + Stored	☑
12 Lead ECG	☐
Weight :	☐
Blood Samples Obtained : YES ☐ NO☐	
IV Access : YES ☐ NO☐	
Blood Gas : VBG☐ ABG☐	

Urinalysis

Leucocytes ☐	Nitrates ☐	Protein ☐	Blood ☐
Ketones ☐	Glucose ☐	PH	S.G
MSSU / CSU ☐	Toxicology ☐		
HCG ☐	+VE ☐	-VE ☐	Strip No -

Communication
(Please Circle / Tick)

NEWS Chart complete / NEWS SCORE – (Record pain, blood sugar and Neuro Obs on NEWS Chart)	☑
ID Band	☑
Peak Flow	☐
Xrays / CT Scan Performed:	☐
Relatives / NOK informed	☑
Child Protection Concern (considered in line with policy)	Y/N
Adult Support and Protection	Y/N

Screening Tools
(Please tick/ circle when completed)

SEPSIS RISK? / SIRS Criteria 2 or more	Y/N
Mental Health Triage Assessment	Y/N
GMAWS	Y/N
AMT 4 (> 65 YEARS)	Y/N
At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc) *If at risk complete risk assessment*	Y/N

	Frailty Screen (Would this person benefit from Comprehensive Geriatric Assessment (CGA)? *(Age 75 or over/age 65+ from Nursing/Residential care or admitted from community hospital?)*	
1	Functional impairment in context of significant multiple conditions)new or pre-existing)	Y/N

SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)	YES
IF NOT WHY? – (details) N/A	NO
Time – 17:00	
Date – 13/12/17	
Signature - CA	

2	Resident in a care home	Y/N
3	Acute confusion (Think Delirium) is there a diagnosis of dementia or a history of chronic confusion	Y/N
4	Immobility or Falls in the last 3/12 months	Y/N

Screening Tools / ACTIVE CARE
(Please tick/circle when completed)

1) Pressure Damage Does the person have redness and/or existing damage? If YES – continue with a minimum of 2 hourly Active Care + Complete PUDRA		Y/N	**Date**	**Location of Redness/Ulcers**	**Grade of Ulcer**
2) Mobility	Does the person require assistance?	Y/N			
3) Continence		Y/N	**5) Skin**	Is skin compromised by other source, eg neurological deficit, medication, substance, diabetes, co-morbid?	Y/N
4) Nutrition		Y/N	**6) Judgment**	In your clinical judgment is this person at risk for developing pressure damage? IF YES - DETAILS	Y/N

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Pause for Transfer / Discharge (Please tick when completed)		Tick when completed	N/A	Notes
Relatives informed of Admission / Discharge		☐	☐	Information on discussion with relatives
Name band		☐	Always	
Nursing Screening Tools completed		☐	Always	
Bed requested, SBAR COMPLETE		☐	☐	
NEWS chart		☐	Always	
Prescriptions / Charts signed	Infusions	☐	☐	
	Cannula	☐	☐	
Notes: medical notes, GP letter, PRF		☐	☐	
Patients requiring analgesia: sufficient		☐	☐	
Belongings (including patient's medications)		☐	Always	Please note here if any other tasks required prior to transfer
SAS Transport REQ / REF No		☐	☐	
Print Name Sign –				

Nursing Notes

Date & Time		Print Name & Signature
17-20	Pt settled in dept. Reviewed by Dr for admission	
13/12/17	to urology for further assesment. Given 5mg	C.Adam
	Oramorph for pain.	CA

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 15/12/2016

Consultant: Dr Colin Bell

CA Walker
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
Glasgow
G32 7JZ

Dear CA Walker

Re: **McLachlan Michael** DOB: **31/12/1962** CHI: **3112626230**
FLAT 1-1
Glasgow G31 3NS

Attended on: **15/12/2016 at 12:42 hrs.** Departed on: **at hrs.**
Discharge Type: **01b - Discharge with follow up by primary care team** Destination: **Private residence**
Previous ED Attendance in last 12 months: **3**

Presenting complaint
chest pain

Nursing Assessment:
c/o pleuritic sounding chest pain, with productive cough- states has had pain in chest for 2/7. denies pmh

Investigations in ED:

1. Bone Profile
2. CRP
3. Glucose
4. LFT
5. Troponin I hs
6. Urea and Electrolytes
7. Coagulation screen
8. D - Dimer
9. Full Blood Count
10. XR Chest

Diagnosis:

Diagnosis	Side	Site
Musculoskeletal chest pain (non - traumatic)		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:
Well localised L sided anterior chest pain, normal bloods and CXR. Advice and reassure with simple analgesia.

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

Yours sincerely,
Phil Anderson
Consultant (non admitting)

Copies to:
1. CA Walker (GP)

School Address:

CHI: 3112626230

Glasgow Royal Infirmary

(12)

Total Att: **10**

12 Mth Att: **3**

Title: **MR**

MCLACHLAN **Michael**

DOB: **31/12/1962** Age: **53y** Sex: **Male**

FLAT 1-1
31 ABERFELDY ST
Glasgow
Lanarkshire
G31 3NS

Next of kin: **SHERLOCK, Martine**
Relationship: **Niece**

GP: **CA Walker**
0141 531 6240

TR16013578
Michael McLachlan
7.5

Attendance Date: **15/12/2016** Arrival Time: **12:42**

Registration Time: **12:42** Date of Incident: **15/12/2016**

Major Incident Desc:

Reason for Attendance: **chest pain** Bloods ☑

IV ACCESS ☒

ECG ☑

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **15/12/2016 12:56** Nurse name: **Nurse Cheryl McKain**

Temp	**36.6**	C
HR	**75**	bpm
BP	**111/82**	mmHg
MAP	**91.67**	mmHg
RR	**16**	bpm
SpO2	**95**	%
Oxygen		%

BM	**7.5**	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	**4**
Motor	**6**
Verbal	**5**
Total	**15**

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

Nursing Notes: **c/o pleuritic sounding chest pain, with productive cough- states has had pain in chest for 2/7. denies pmh**

3112626230 31/12/1962 MCLACHLAN Michael

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To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

Date	**Clinical Notes**
	Seen By / Time Seen

Once Only Prescriptions (including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By

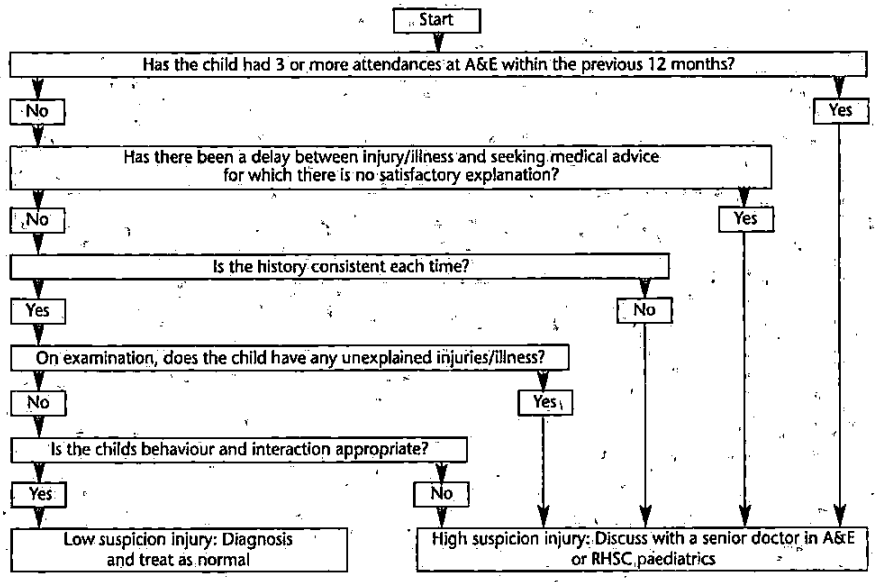
Glasgow Royal Infirmary
Unitary Patient Record
(Part A - Acute Assessment)

NHS
Greater Glasgow and Clyde

3112626230
MCLACHLAN
Michael
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS
M
31/12/1962

Injury/Illness Flow Chart for all Patients 16 and under

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



All Clinical Staff Consider

H.I.Form ☐

Audit Form ☐

Police Consent ☐

Clinical Notes

15/12/16 Admission

53 ♂ Self Tenant, Cares Pw

HPC: Hx of Heavy smoking & persistent cough over the last few months
Now - productive
No Hx of recent trauma
nil
2/7 Hx of ↑ Pain to R chest localised & sharp on movement & certain positions
No SOB / wheeze No fever / chills
No Ankle swelling

PMH: nil Drug: nil SH: Smoker 5/7 Hx: Methadone - IHD
Binge Ethanol

Please complete where appropriate:

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

80607

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

Clinical Notes

Date | Time | Name | Grade | Specialty

O/E Well, Undistressed T36-6C

Cvs Pulse 76 bpm reg BP 110/80 Hs Normal

Rs Clear, Good Air entry,

Abdo Soft, Non-tender, ↓ bowel sounds

Chest: Middle Third: → Lat. Chest wall area 5th/6th Rib fx

Bloods — (N) except D-Dimer Not clinically significant
Not Suggestive PE

CXR - Cardiac Normal → (L) upper zone: ↓ in Opacity Pneumonia
↓ lung fields Air Pleural
ECG — Sinus rhythm Axis

Musculoskeletal Rib Pain

Impression

Advice

Analgesia

Medication

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

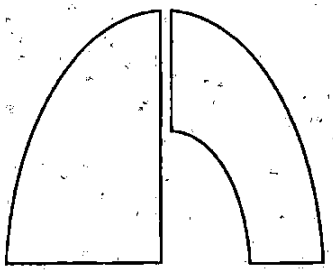
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Greater Glasgow and Clyde

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Clinical Notes

Date	Time	Name	Grade	Signature

X-Ray results



ECG findings

Other investigations

Biochem/Haematology results

Indicate which lab tests have been requested

Haem	Date and time	
WCC	9·7	
Hb	136	
Plat	194	
MCV		
Neut		
DDim	312	and time
PT	12	
PTT	30	
TT	11	

Bioch	Date and time	
Na^+	143	
K^+	4·6	
Cl^-	106	
Ur	4·5	
Creat	71	
Glu	6·0	
CRP	14	
Bil	Date and time	
AST	20	
ALT	10	
GGT		
ALP	85	
Prot		
Alb	35	
Glob		
Ca^{++}	2·41	
Amyl	Date and time	
TSH		
FT4		
Tropl	Date and time	
Chol		
Trig		
Para	Date and time	
Sal		
S osm		
ABG	Date and time	
H^+		
$PaCO_2$		
PaO_2		
Bic		
BE		
FiO_2		
Lactate		

Fluids Prescribed in A&E

Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time

Drugs Prescribed in A&E

Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time

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.

Emergency Department Nursing Documentation

NHS Greater Glasgow and Clyde

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

Label

Presenting Complaint: chest pain

Date and Time: 15/12/16 1256

Named Nurse(s): DARIN & AMANDA

Patient preparation (Please tick when completed)	Initials:	Communication (Please tick when completed)	Initials:
Prepare patient for examination and provide blankets if required	☑	Communication Aids (spectacles / hearing aid)	☐
		Relatives present, who?	☐
Clothing bagged, labelled and stored under trolley	☑	Relatives / NOK informed	☐
Name-band (if required)	☐	Interpreter required	☐
		Telephone interpretation required	☐

Observations and Investigations (Please tick when completed)		Initials:	
Vital Signs recorded on NEWS chart and NEWS score recorded. Record Pain, blood sugar and neuro obs on NEWS chart if appropriate.	☑	IV cannula (if required)	☐
Peak Flow 1. 2. 3.	☐	Blood samples taken	☑
12 Lead ECG	☑	Urinalysis and Specimen if indicated *Results:*	☐
Cardiac Monitoring	☐		
X-rays performed	☐	HCG specimen if indicated +ve ☐ -ve ☐ Strip Lot no:	☐
Other: please add	☐	Weight:	☐

Screening Tools (Please circle or tick as appropriate)		Initials:	
SEPSIS risk? SIRS Criteria 2 or more and suspicion of infection	Y/N	**Preliminary Pressure Ulcer Risk Assessment** The patient can reposition themselves whilst in the department?	Y/N
Sepsis 6 protocol initialise and departmental documentation started	Y/N		
AMT 4 (if >65 years) SCORE	/4	There is **no** reported skin damaged other than presenting trauma?	Y/N
At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc). *If at risk complete risk assessment*	Y/N	The person is fully continent? *If NO to any of the above initiate Waterlow risk assessment (within 4 hrs)*	Y/N
Mental Health Triage Assessment	Y/N	**Waterlow Score** *If >10 commence Active Care*	☐
Child Protection considered (in line with policy)	Y/N	**Active Care** (clinical judgement) (include all trolley patients at risk of pressure ulcers and all trolley patients in department for >4hrs) *Record on Active Care Chart*	☐
FAST	Y/N		
GMAWS	Y/N	Pressure damage identified on arrival in ED is documented in clinical notes	☐
Has Swallow test been carried out?	Y/N	Grade 3 or 4 Pressure Ulcers are reported on DATIX	☐

Pause for Transfer (Please tick when completed)		Tick when completed	N/A	Notes
	Relatives informed	☐	☐	Information on discussion with relatives
	Cannula	☐	☐	
	Name band	☐	☐	
	AMT4	☐	☐	
	NEWS chart NEWS >7 - Name and Page number of senior doctor caring for patient	☐	Always	
Prescriptions signed	Infusions	☐	☐	
	Drugs	☐	☐	
	Allergies are recorded (e.g. on Kardex)	☐	☐	
	Fluids	☐	☐	
	Two hour plan in place e.g. Fluids, Antibiotics and emergency drugs written up on Kardex	☐	☐	
	GMAWS	☐	☐	
	Belongings (including patient's medications)	☐	Always	Please note here if any other tasks required prior to transfer
	Bed requested, accepted and ward informed	☐	Always	
	Notes: medical notes, GP letter, PRF	☐	Always	
Investigations	CXR reviewed	☐		
	ECG reviewed	☐	☐	Print name
	Bloods sent	☐	☐	
	Bloods reviewed	☐	☐	
	Patient on O_2: cylinder checked	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	

mi • 262617 Version 1_0 • GGC0107

Patient Addressograph Label

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
Belongings (including patient's medications)	☐	Always	
New medications explained	☐	☐	
Cannula removed	☐	☐	
Relatives aware of discharge	☐	☐	Please note here if any other tasks required prior to discharge
Social/ Support Services required and contacted	☐	☐	
SAS transport required and ref no	☐	☐	Print name
Other means of transport arranged by nurse	☐	☐	

Nursing Notes and Care Plan

Date and Time		Print Name and Signature

Patient Addressograph Label

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

Nursing Notes and Care Plan

Date and Time		Print Name and Signature

Emergency Department - Active Care

I have evaluated and deemed that the frequency of care delivery over the next work shift, **based on the patient's most critical need** should be every:

(Please circle) **½ hour** **1hour** **2 hours**

Signed ..... Name .....

USE FOLLOWING CODE:

O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

Patient Addressograph Label

			Time							
	1.	**PAIN: Assess and address** If in pain inform registered nurse **Y/ N or N/A**								
S	2.	**SKIN INSPECTION** Pressure areas checked: **Y / N / I** (independent)								
		Redness (R) / Discolouration (D) / Pressure Ulcer **(PU)** / Intact **(INT)**								
K	3.	**KEEP MOVING:** Have you moved or walked **Y / N / I** (independent)								
		Bed Right side (30° tilt) – **R** Left Side (30° tilt) – **L** Back– **B**								
		Chair Assist to walk, stand or tilt **(W /ST/ T)**								
I	4.	**ELIMINATION:** Do you need the toilet? **I** = Independent **A** = Assistance given **IC** = patient incontinent of urine/faeces								
N	5.	**FOOD, FLUIDS AND NUTRITION:** Is the patient nil by mouth? **Y / N** (consider mouth care)								
		Encourage the patient to drink? **(if appropriate) Y / N / N/A**								
		Food, snack or supplement taken? **(if appropriate) Y / N / N/A**								
	6.	**ENVIRONMENT:** Is the patient able to call for assistance? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? **Y / N**								
	7.	**INFORMATION: Ask:** Is there anything else I can help you with? Inform patient of the time of return. **Y / N**								
	8.	**ESCALATION:** Escalate any issues to the Registered Nurse? **Y / N/A**								
		Nurse Initials								

USE FOLLOWING CODE	Specialist Pressure Redistributing equipment	Variations			
V = Variant	☐ Repose Mattress	Time	No.	Variation	Signed
I = Independent	☐ Moving and handling aids				
NT = No thanks	☐ Other:				

Waterlow Pressure Area Risk Assessment

Build/Weight		Skin Type/Visual Risk Areas		Sex/Age		Special Risks - Tissue Malnutrition	
Average (BMI 20-24.9)	0	Healthy	0	Male	1	Multiple organ failure/ Terminal cachexia	8
Above Average (BMI 25-29.9)	1	Tissue Paper (thin/fragile)	1	Female	2		
Obese (BMI > 30)	2	Dry (appears flaky)	1	14-49	1	Single organ failure	5
Below Average (BMI < 20)	3	Oedematous (puffy)	1	50-64	2	Peripheral Vascular Disease	5
Continence		Clammy /pyrexia	1	65-74	3	Anaemia = Hb < 8	2
Complete/Catheterised	0	Discoloured (brusing/mottled)	2	75-80	4	Smoking	1
Incontinent urine	1			81+	5	**Neurological Deficit**	
Incontinent faeces	2	Broken (established ulcer)	3	**Nutritional Element**		Diabetes/MS/CVA Motor or sensory paraplegia (Max 6)	4-6
Doubly Incontinent (urine and faeces)	3	**Mobility**		Unplanned weight loss in past 3-6 months < 5% Score 0 5-10% Score 1 >10% Score 2			
		Fully mobile	0				
Special Risks – Surgery/Trauma		Restless/Fidgety	1			**Special Risks - Medication**	
On table > 6 hours	8	Apathetic (sedated/depressed/ reluctant to move)	2			Cytotoxic, anti-inflammatory, long term/high dose steroids (Max 4)	4
Orthopaedic / below waist/Spinal (up to 48 hrs post-op)	5			BMI > 20 Score 0 BMI 18.5-20 Score 1 BMI < 18.5 Score 2			
On table > 2 hours (up to 48 hrs post op)	5	Bed bound (unconscious/unable to change position/traction)	4			Risk Score 10+ = 'At risk' 15+ = 'High Risk' 20+ = 'Very High Risk'	
		Chair Bound	5	Patient acutely ill or no nutritional intake > 5 days	2		

Patient's Initial **Waterlow Score =** If Score ≥10 Complete the Adapted Waterlow Pressure Area Risk Assessment Chart

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

3112626230
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Michael 31/12/1962
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31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS
DOB

	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

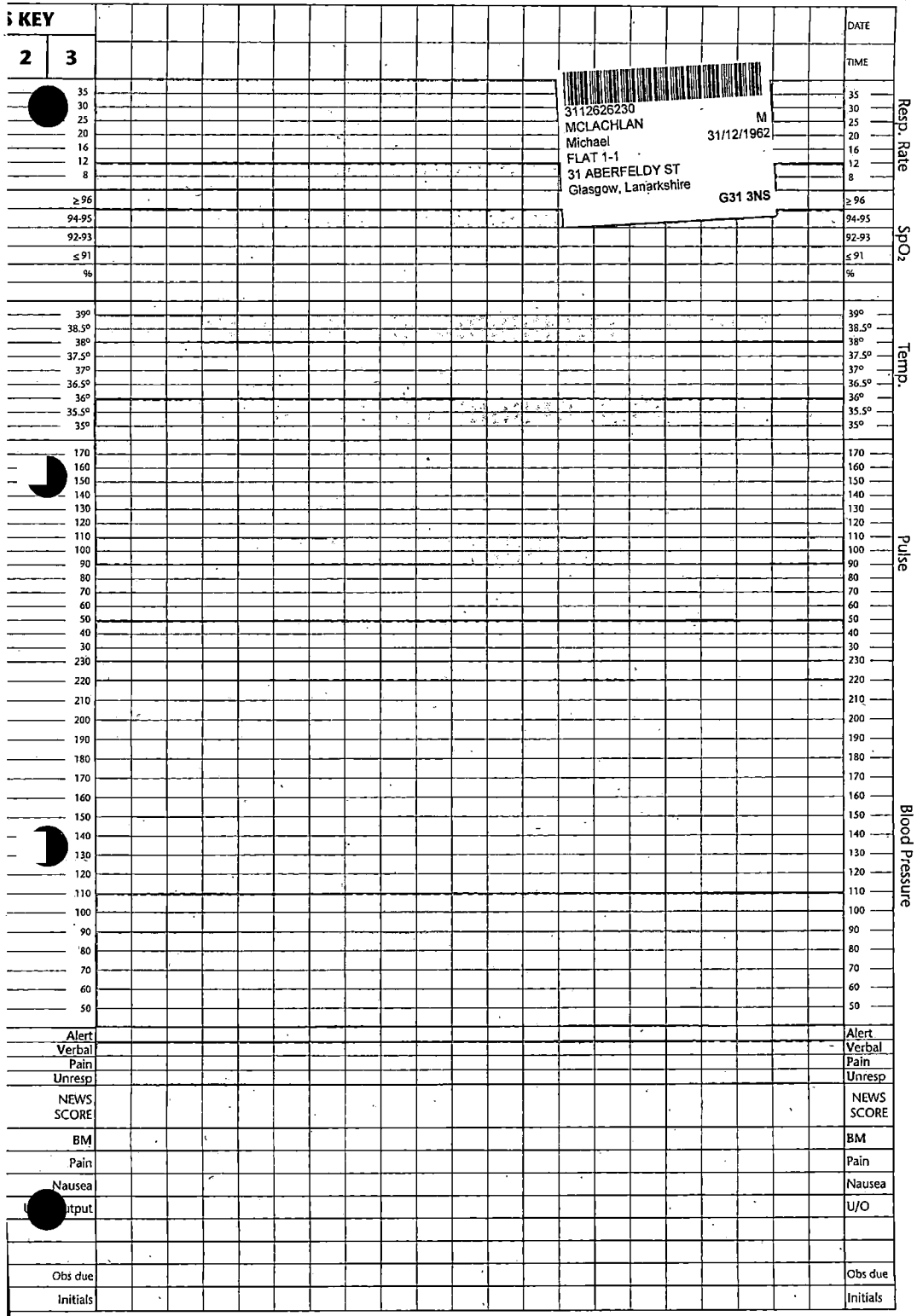
NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.

(12) Michael McLachlan

		DATE	TIME	DATE	NEW 0	NEW 1
		15/12	1250			
Resp. Rate Mark: •	35			35		
	30			30		
	25			25		
	20			20		
	16	o		16		
	12			12		
	8			8		
SpO_2 (Enter Value)	≥ 96			≥ 96		
	94-95	95		94-95		
	92-93			92-93		
	≤ 91			≤ 91		
Any Sup'l O_2	%			%		
Room air		A				
Temp. Mark: ×	39°			39°		
	38.5°			38.5°		
	38°			38°		
	37.5°			37.5°		
	37°			37°		
	36.5°	×		36.5°		
	36°			36°		
	35.5°			35.5°		
	35°			35°		
Pulse Mark: •	170			170		
	160			160		
	150			150		
	140			140		
	130			130		
	120			120		
	110			110		
	100			100		
	90			90		
	80			80		
	70	o		70		
	60			60		
	50			50		
	40			40		
	30			30		
	230			230		
Blood Pressure Mark: ◇	220			220		
	210			210		
	200			200		
	190			190		
	180			180		
	170			170		
	160			160		
	150			150		
	140			140		
	130			130		
	120			120		
NEWS SCORE using Systolic BP	110	^		110		
	100			100		
	90	V		90		
	80			80		
	70			70		
	60			60		
	50			50		
Conscious Level Mark: •	Alert	●		Alert		
	Verbal			Verbal		
	Pain			Pain		
	Unresp			Unresp		
Total NEWS (with all obs)		1		NEWS SCORE		
BM				BM		
Pain				Pain		
Nausea				Nausea		
Urine output				U/O		
Obs due				Obs due		
Initials		TRI		Initials		


KEY
2
3
DATE
TIME
3112626230
MCLACHLAN
Michael
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G31 3NS
M
31/12/1962
Resp. Rate
SpO2
Temp.
Pulse
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Neurological Observations

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

Glasgow Coma Scale

Pupil size (mm)

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8

Pain Score

Ask the patient to rate his/her pain by choosing a number between 0 and 10. Use the diagram below to assist the patient. If patient's pain is chronic, use generic tool. If patient is unable to communicate, use observational tool.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Severe Pain			

Nausea and Vomiting	
0	= None
1	= Mild (*Not distressing – no retching/vomiting*)
2	= Moderate (*Troublesome – occasional retching/vomiting*)
3	= Severe (*Distressing – frequent retching/vomiting*)

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

Acute Services Division

Rehabilitation and Assessment

Department of Acute Adult Dietetic Service

Specialty: Dietetics

NHS Greater Glasgow and Clyde

Dietetic Record Card eForm - Version 1.0 RC 0.4

Hospital Name:	Glasgow Royal Infirmary

Patient Details		**GP Details**	
Name:	McLachlan, Michael	**Name:**	WALKER, CHRISTINE
Address:	FLAT 1-1 31 ABERFELDY ST Glasgow Lanarkshire	**Address:**	Baillieston Health Centre 20 Muirside Road Baillieston Glasgow
Postcode:	G31 3NS	**Telephone:**	
Correspondence Address 1:		**Fax:**	
Correspondence Address 2:			
Correspondence Postcode:			
Telephone:			
Patient Contact Number:	07884 204431	**Consent:**	Yes
CHI Number:	3112626230	**Sensitivity:**	Sensitive
CRN:	30141837L, 3112626230, ZRV10290713	**Consultant:**	
D.O.B:	31/12/1962	**Form Date:**	09/08/2016
Sex:	Male		
Email:			
Ethnic Origin:	Not Known		

Location			
Episode Type	Outpatient		
Location	Medical	**Dietetic Team**	
Patient Consent to Treatment		Verbal	

Referring Details			
Referring Specialty	General Medicine	**Referrer's Name**	
Referring Consultant	Dr H Wilson	**Designation**	
Referrer's Contact Number			
Date of Admission		**Date Referral Received**	22/02/2016
Days from admission to referral		**First Consultation Date**	09/08/2016
Days from referral to consultation	169		
Referral Reason	Nutritional Assessment		
Other			

Communication Consideration		
Consideration	**Checked**	**Comments**
Receptive Aphasia (difficulty in processing spoken &/ or written information)		
Expressive Aphasia (difficulty speaking &/ or written information)		
Dysarthria (Pt can understand but pts speech incoherent due to muscle weakness)		
Deaf		
Blind		
English not first language		
Cognitive impairment		

Other (Please record details)	

Relevant Medications

Date	Drug	Dose	Frequency	Comments
09/08/2016				

Summary of Relevant Medical Intervention

Entry Date	09/08/2016	**Event Date**	09/08/2016
Relevant Information	Patient attended outpatient medical clinic at GRI, following admission to ward 20/21 in Feb 16. Reason for admission drug induced psychosis. Reason for dietetic referral was reported significant weight loss in 2 months prior to admission and during. Patient discharged prior to assessment, invite to clinic followed. PMH- Heroin user, bipolar, depression, suicidal ideation.		

Social History

Lives With	Alone	**Shopping**	
Cooking Abilities / facilities	Oven, microwave - dislikes cooking	**Occupation**	
Social Services / Home Care Info			
Social Services / Home Care Freq Per Week		**Social Services / Home Care Freq Per Day**	
Main Carer Name		**Main Carer Relationship**	
Carer Contact Details			
Smoking Habit (cig p/day)		**Activity Level**	
Alcohol		**Recreational Drugs**	Denies drug use since discharge feb 16.
Other			

Patient Story Date	Time	Detail
09/08/2016	09:40	Patient reports main barriers to change include money, lack of interest in meal preparation, current routine.

Objective Information & Interpretation

Date	Name	Comments
09/08/2016	Laura Tibbles	

Anthropometry

Patients Age	53 years 7 months

Usual weight (kg)	Reported	Time Period weeks	Time Period Months	Time Period Years

Comments on weight History	

Entered	Signature	MUST Score	MUST Classification	Height (m)	Weight (kg)	BMI(kg/m2)	BMI Classification	% Weight loss (from usual)	% Weight loss (from first)
09/08/2016	Laura Tibbles			1.66	59.1	21.45	Average		0

MAC cm		**MAC % of normal**	**MAC Comments**
TSF cm		**TSF % of normal**	**TSF Comments**
MAMC cm		**MAMC % of normal**	**MAMC Comments**
Waist cm		**Risk**	**Waist Comments**
HG kg		**HG % of normal**	**HG Comments**
Height Date Taken	22/02/2016	**Weight Date Taken**	09/08/2016

Entered	Signature	MUST Score	MUST Classification	Height (m)	Weight (kg)	BMI(kg/m2)	BMI Classification	% Weight loss (from usual)	% Weight loss (from first)
09/08/2016	Laura Tibbles			1.66	59.1	21.45			0

MAC cm		**MAC % of normal**	**MAC Comments**
TSF cm		**TSF % of normal**	**TSF Comments**
MAMC cm		**MAMC % of normal**	**MAMC Comments**
Waist cm		**Risk**	**Waist Comments**

HG kg		HG % of normal		HG Comments	
Height Date Taken	22/02/2016	Weight Date Taken	22/02/2016		

Interpretation (Anthropometry)

Date	Name	Comments
09/08/2016	Laura Tibbles	Noted from dietetic referral dated 22/2/16 patient reported weight loss of 8.6kg in 2/12 - clinically significant. In 6/12 weight stable at BMI 21.4 59.1kg.

Nutritional Requirements

Patient's Age	53 years 7 months	
Weight (kg)	59.1	
Ascities (kg) Adjustment		
Oedema (kg) Adjustment		
Weight Used for Calculation (kg)	59.1	
Basic Fluid Requirement (ml/d)		2068
Additional Losses (ml) (aspirate/ostomy/diarrhoea/drain)		
l Fluid Requirements (ml)		2068

Energy Requirements

Schofield	
Children (kcal/day)	0.00
Kcal	
Protein Requirements	

Requirements Summary

Energy	Schofield	
	Children (kcal/day)	0.00
	Kcal	
Protein		
Carbs (g)		
Fluid	2068	
Other		

rpretation (Nutritional Requirements)

Date	Name	Comments
09/08/2016	Laura Tibbles	

Dietary Assessment

Dietary History

Assessment Date	Dietitian Name	Student / DA Name	Source of diet history
09/08/2016	Laura Tibbles		

Food Frequency Checklist

Food Group	Food Item	Frequency

Oral / Enteral Intake or Parenteral Details

Breakfast	
Mid Morning	
Lunch	
Mid Afternoon	
Dinner	

Supper

Enteral		**Is Enteral**	No
Parenteral		**Is Parenteral**	No
Oral Supplements		**Is Oral Supplements**	No

Total Nutrient Intake

From Diet/Oral Hx (excluding supplements)

Energy (kcal)		**Protein (g)**	
% of Requirement Schofield		**% of Requirement**	
% of Requirement Children			
% of Requirement Kcal/kg			
Carb (g)			
Fluid			
Comments			

Nutritional Supplements / Enteral Feed

Energy (kcal)		**Protein (g)**	
% of Requirement Schofield		**% of Requirement**	
% of Requirement Children			
% of Requirement Kcal/kg			
Carb (g)			
Fluid			
Comments			

Combined Oral And Supplements

Energy (kcal)		**Protein (g)**	
% of Requirement Schofield		**% of Requirement**	
% of Requirement Children			
% of Requirement Kcal/kg			
Carb (g)			
Fluid			

Interpretation (Dietary Assessment)

Date	Name	Comments
09/08/2016	Laura Tibbles	Usual routine includes waking up mid-morning, nil oral intake for 2 hours, patient feels 'he needs to get his appetite by walking around for a while'. Current routine is eating small amounts throughout the day, dislikes eating large portions. Currently main influences on food choices are money - will buy food/drink when has money. Main barriers to changing current eating habits also include lack of interest in cooking meals - therefore patient is influenced by cheap convenient options when making choices at the supermarket. Diet Hx was vague, usual intake as follows: 13.00 - Sausage sandwich with butter, COT 18.00 - Ready meal - steak pie and chips, pasta, shepherds pie, COT 21.30 - Sandwich with cold meat, COT Upon further investigation, patient reports having small snacks throughout the day - unable to identify any specific food/drink he has. It appeared early on in consultation that patient had minimal interest in obtaining any advice re recent reported weight loss. Patient reports nil drug intake since admission earlier this year and denies weight loss in recent months. Attempted to explain energy/protein balance and consequences of being in deficit (weight loss). Patient reports has nil concerns with weight, eating pattern has remained static since prior to hospital admission earlier in the year. Patient also reported that his goal would be to put on weight. From above minimal diet history, patient is likely at risk of nutritional deficit of many nutrients. Briefly discussed food fortification strategies in order to improve nutritional status by incorporating variety of food groups in currently restricted diet. Patient reports too many barriers to make changes at present. Agreed to provide resource on food fortification for home and discussed easy/cheap strategies to improve energy density of diet including FCM 3xday, small nourishing snacks to be kept in the fridge. Patient declined further intervention, happy weight stable since hospital discharge.

Integrative Summary and Nutritional Care Plan

Integrative Summary

Date	Name	Comments
09/08/2016	Laura Tibbles	Patient attended outpatient medical clinic at GRI, following admission to ward 20/21 in Feb 16 with drug induced psychosis. Reason for dietetic referral was reported significant weight loss in 2 months prior to admission and during. PMH- Heroin use, bipolar, depression, suicidal ideation. Patient discharged prior to assessment, invite to clinic for follow-up. Noted weight static 59.1kg BMI 21.4 since discharge 6/12. Difficult consultation; patient unaware of reason for referral, reports nil drug use since hospital admission and nil concerns with current dietary intake and nil reported recent weight loss. It appeared very early on in brief consultation patient is in pre-contemplative stage of change. Reports social circumstances prevent from changing current eating habits, and declined further dietetic intervention after today. When asked, patient is keen to increase body weight - therefore brief advice provided to widen variety of food consumed on daily basis to improve nutritional status and food fortification resource provided for home. Patient also declined signposting to services in the area re. current perceived barriers to change. In light of weight stability since hospital admission and patients reluctance to accept dietary advice I have signposted to GP in 2-3months if patient felt further support is required, referral to CRD service to be initiated if indicated.

Stage Of Care

Date	Stage of Change
09/08/2016	Pre Contemplation

Duty Of Care

Type	Open/Ongoing Duty Of Care	Date	Dietetic Clinical Need	Name	Review	Rationale for Clinical Need & Review
Initial	close DOC	09/08/2016		Laura Tibbles		
Goal / Aim	Patient goal - weight gain in next 3-6 months.					
Subgoals	1. Provided patient with food fortification advice with goal of weight gain for patient 2. Dietitian to post food fortification resource to be utilised at home					
Monitoring Plan	Patient declined further dietetic intervention. Signposted patient to GP in 2-3 months if patient feels weight in decline, currently since admission earlier in the year weight has been stable since discharge. No further appointment to be made for patient at present.					

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 24/07/2016

Consultant: Dr Donogh Maguire

CA Walker
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
Glasgow
G32 7JZ

Dear CA Walker

Re: **McLachlan Michael** DOB: **31/12/1962** CHI: **3112626230**
FLAT 1-1
Glasgow G31 3NS

Attended on: **24/07/2016 at 00:50 hrs.** Departed on: **24/07/2016 at 06:06 hrs.**
Discharge Type: **01b - Discharge with follow up by primary care team** Destination: **Private residence**
Previous ED Attendance in last 12 months: **5**

Presenting complaint
unwell adult

Nursing Assessment:
BIBA. Hx of drug induced psychosis. Hx of heroin addiction, last took heroin at 2100hrs. Feels like something bad will happen and is hearing voices that are telling him to harm himself. Denies feeling suicidal.

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Unspecified disorder of psychological development		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Attended c/o experiencing psychotic symptoms on withdrawl from heroin. He was not currently experiencing these symptoms as recently took heroin, was concerned that whenever he stops heroin he hears persecutory voices telling him to hurt himself and accusing him of "kiddy fiddling". This is already known to psychiatry. He told me that if he goes home, either the voices will kill him or he will. He was reviewed by CPN who reviewed him and deemed him not currently psychotic and was not at risk of DSH or suicidal intent. Patient discharged by CPN with f/u.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Samson Kendall
Doctor

Copies to:

1. CA Walker (GP)

School Address:

CHI: 3112626230

Glasgow Royal Infirmary

15

Total Att: 9

12 Mth Att: 5

Title: MR

MCLACHLAN **Michael**

DOB: **31/12/1962** Age: **53y** Sex: **Male**

FLAT 1-1
31 ABERFELDY ST
Glasgow
Lanarkshire
G31 3NS

Next of kin: **SHERLOCK, Martine**
Relationship: **Niece**

GP: **CA Walker**
0141 531 6240

Attendance Date: **24/07/2016** Arrival Time: **00:50**

Registration Time: **00:50** Date of Incident: **23/07/2016**

Major Incident Desc:

Reason for Attendance: **unwell adult**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **24/07/2016 01:13** Nurse name: **Nurse Fiona Jack**

Temp	**36.1**	C
HR	**67**	bpm
BP	**143/73**	mmHg
MAP	**96.33**	mmHg
RR	**17**	bpm
SpO2	**99**	%
Oxygen		%

BM	**5.7**	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	**4**
Motor	**6**
Verbal	**5**
Total	**15**

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

Nursing Notes: **BIBA. Hx of drug induced psychosis. Hx of heroin addiction, last took heroin at 2100hrs. Feels like something bad will happen and is hearing voices that are telling him to harm himself. Denies feeling suicidal.**

3112626230 31/12/1962 MCLACHLAN Michael
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To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

Date	**Clinical Notes**	
	Seen By	Time Seen

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By

Emergency Department Nursing Documentation

Drug induced psychosis / Mental Health.

Presenting Complaint:

Date and Time: 24/7/16 0330

NHS Greater Glasgow and Clyde

3112626230
MCLACHLAN
Michael
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

M
31/12/1962

Label

Named Nurse(s):

Patient preparation (Please tick when completed)	Initials:	
Prepare patient for examination and provide blankets if required	☐	
Clothing bagged, labelled and stored under trolley	☐	
Name-band (if required)	☐	

Communication (Please tick when completed)	Initials:	
Communication Aids (spectacles / hearing aid)	☐	
Relatives present, who?	NIL	☐
Relatives / NOK informed		☐
Interpreter required		☐
Telephone interpretation required		☐

Observations and Investigations (Please tick when completed)		Initials:	
Vital Signs recorded on NEWS chart and NEWS score recorded. Record Pain, blood sugar and neuro obs on NEWS chart if appropriate.	☐	IV cannula (if required)	☐
Peak Flow . 1. 2. 3.	☐	Blood samples taken	☐
12 Lead ECG	☐	Urinalysis and Specimen if indicated *Results:*	☐
Cardiac Monitoring	☐		
X-rays performed	☐	HCG specimen if indicated +ve ☐ -ve ☐ Strip Lot no:	☐
Other: please add	☐	Weight:	☐

Screening Tools (Please circle or tick as appropriate)		Initials:	
SEPSIS risk? SIRS Criteria 2 or more and suspicion of infection Sepsis 6 protocol initialise and departmental documentation started	Y / N Y / N	**Preliminary Pressure Ulcer Risk Assessment** The patient can reposition themselves whilst in the department?	Y / N
AMT 4 (if >65 years) SCORE	/4	There is **no** reported skin damaged other than presenting trauma?	Y / N
At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc). *If at risk complete risk assessment*	Y / N	The person is fully continent? *If NO to any of the above initiate Waterlow risk assessment (within 4 hrs)*	Y / N
Mental Health Triage Assessment	Y / N	**Waterlow Score** *If >10 commence Active Care*	☐
Child Protection considered (in line with policy)	Y / N	**Active Care** (clinical judgement) (include all trolley patients at risk of pressure ulcers and all trolley patients in department for >4hrs) *Record on Active Care Chart*	☐
FAST	Y / N		
GMAWS	Y / N	Pressure damage identified on arrival in ED is documented in clinical notes	☐
Has Swallow test been carried out?	Y / N	Grade 3 or 4 Pressure Ulcers are reported on DATIX	☐

Pause for Transfer (Please tick when completed)		Tick when completed	N/A	Notes
	Relatives informed	☐	☐	Information on discussion with relatives
	Cannula	☐	☐	
	Name-band	☐	☐	
	AMT4	☐	☐	
	NEWS chart NEWS >7 - Name and Page number of senior doctor caring for patient	☐	Always	
Prescriptions signed	Infusions	☐	☐	
	Drugs	☐	☐	
	Allergies are recorded (e.g. on Kardex)	☐	☐	
	Fluids	☐	☐	
	Two hour plan in place e.g. Fluids, Antibiotics and emergency drugs written up on Kardex	☐	☐	
	GMAWS	☐	☐	
	Belongings (including patient's medications)	☐	Always	Please note here if any other tasks required prior to transfer
	Bed requested, accepted and ward informed	☐	Always	
	Notes: medical notes, GP letter, PRF	☐	Always	
Investigations	CXR reviewed	☐		
	ECG reviewed	☐	☐	Print name
	Bloods sent	☐	☐	
	Bloods reviewed	☐	☐	
	Patient on O_2: cylinder checked	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	

Patient Addressograph Label

3112626230
MCLACHLAN
Michael
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

M
31/12/1962

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
Belongings (including patient's medications)	☐	Always	
New medications explained	☐	☐	
Cannula removed	☐	☐	
Relatives aware of discharge	☐	☐	Please note here if any other tasks required prior to discharge
Social/ Support Services required and contacted	☐	☐	
SAS transport required and ref no	☐	☐	Print name
Other means of transport arranged by nurse	☐	☐	

Nursing Notes and Care Plan

Date and Time		Print Name and Signature
24/7/16 0330	BIBA — Hx drug induced psychosis + Heroin Addiction pt last took heroin @ 2130. Now ~~feels~~ secret hearing voices — telling him to harm himself. Denies feeling suicidal —	SKa SN
0440	Awaiting for CPN's patient unsettled at times but settles when reassured	(Baird SN)

Patient Addressograph Label

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

Nursing Notes and Care Plan

Date and Time		Print Name and Signature

Emergency Department - Active Care

3112626230
MCLACHLAN M
Patie Michael 31/12/1962
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every:

(Please circle) ½ hour 1hour 2 hours

Signed ..... Name .....

USE FOLLOWING CODE:

O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

			Time							
	1.	PAIN: Assess and address If in pain inform registered nurse Y/ N or N/A								
S	2.	SKIN INSPECTION Pressure areas checked: Y / N / I (independent).								
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)								
K	3.	KEEP MOVING: Have you moved or walked Y / N / I (independent)								
		Bed Right side (30° tilt) – R Left Side (30° tilt) – L Back– B								
		Chair Assist to walk, stand or tilt (W,/ST/ T)								
I	4.	ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine/faeces								
N	5.	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)								
		Encourage the patient to drink? (if appropriate) Y / N / N/A								
		Food, snack or supplement taken? (if appropriate) Y / N / N/A								
	6.	ENVIRONMENT: Is the patient able to call for assistance? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? Y / N								
	7.	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return. Y / N								
	8.	ESCALATION: Escalate any issues to the Registered Nurse? Y / N/A								
		Nurse Initials								

USE FOLLOWING CODE	Specialist Pressure Redistributing equipment
V = Variant I = Independent NT = No thanks	☐ Repose Mattress ☐ Moving and handling aids ☐ Other:

Variations

Time	No.	Variation	Signed

Waterlow Pressure Area Risk Assessment

Build/Weight		Skin Type/Visual Risk Areas		Sex/Age		Special Risks - Tissue Malnutrition	
Average (BMI 20-24.9)	0	Healthy	0	Male	1	Multiple organ failure/ Terminal cachexia	8
Above Average (BMI 25-29.9)	1	Tissue Paper (thin/fragile)	1	Female	2		
Obese (BMI > 30)	2	Dry (appears flaky)	1	14-49	1	Single organ failure	5
Below Average (BMI < 20)	3	Oedematous (puffy)	1	50-64	2	Peripheral Vascular Disease	5
Continence		Clammy /pyrexia	1	65-74	3	Anaemia = Hb < 8	2
Complete/Catheterised	0	Discoloured (brusing/mottled)	2	75-80	4	Smoking	1
Incontinent urine	1			81+	5	**Neurological Deficit**	
Incontinent faeces	2	Broken (established ulcer)	3	**Nutritional Element**		Diabetes/MS/CVA Motor or sensory paraplegia (Max 6)	4-6
Doubly Incontinent (urine and faeces)	3	**Mobility**		Unplanned weight loss in past 3-6 months < 5% Score 0 5-10% Score 1 > 10% Score 2			
		Fully mobile	0				
Special Risks - Surgery/Trauma		Restless/Fidgety	1			**Special Risks - Medication**	
On table > 6 hours	8	Apathetic (sedated/depressed/ reluctant to move)	2			Cytotoxic, anti-inflammatory, long term/high dose steroids (Max 4)	4
Orthopaedic / below waist/Spinal (up to 48 hrs post-op)	5			BMI > 20 Score 0 BMI 18.5-20 Score 1 BMI < 18.5 Score 2			
On table > 2 hours (up to 48 hrs post op)	5	Bed bound (unconscious/unable to change position/traction)	4			Risk Score 10+ = 'At risk' 15+ = 'High Risk' 20+ = 'Very High Risk'	
		Chair Bound	5	Patient acutely ill or no nutritional intake > 5 days	2		

Patient's Initial Waterlow Score

If Score ≥10 Complete the Adapted Waterlow Pressure Area Risk Assessment Chart

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name
Addre 3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
CHI N G31 3NS
DoB

	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

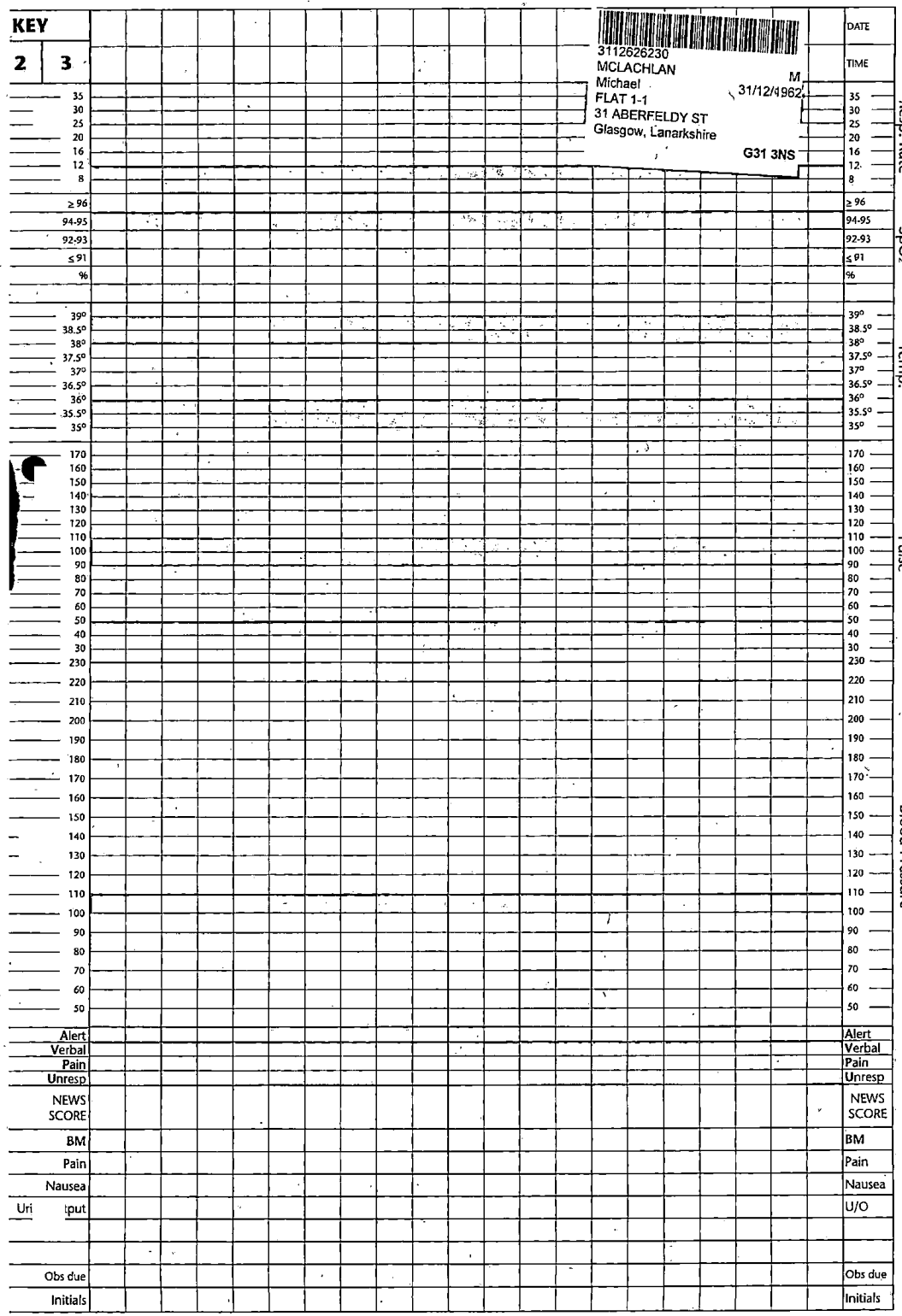
NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.

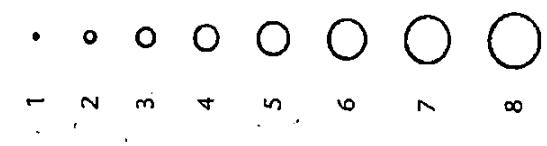
MICHAEL MCLACHLAN

| | | |


KEY
2
3
3112626230
MCLACHLAN
Michael
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS
M
31/12/1962
DATE
TIME
Resp. Rate
SpO2
Temp.
Pulse
Blood Pressure
35
30
25
20
16
12
8
≥ 96
94-95
92-93
≤ 91
%
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
Uri tput
U/O
Obs due
Initials

Glasgow Coma Scale

Pupil size (mm)



3112626230
MCLACHLAN
Michael M
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
31/12/1962
G31 3NS

Neurological Observations

Date:					24/7/10																						
Time:					6/15																						
COMA SCALE	E Eyes open	Spontaneously	4		0																						Eyes closed by swelling = C
		To speech	3																								
		To pain	2																								
		None	1																								
	V Best Verbal response	Orientated	5																								Endotracheal tube or tracheostomy = T
		Confused	4		0																						
		Inappropriate words	3																								
		Incomprehensible sounds	2																								
		None	1																								
	M Best motor response	Obeys	6		0																						Usually record the best arm response
		Localises	5																								
		Flexion - withdrawal	4																								
		Flexion - abnormal	3																								
		Extension to pain	2																								
		None	1																								
	TOTAL SCORE				/14																						
PUPILS	R	Size																									+ reacts – no reaction c. eyes closed
		Reaction																									
	L	Size																									
		Reaction																									
LIMB MOVEMENT	ARMS	Normal power																									Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness																									
		Severe weakness																									
		Spastic flexion																									
		Extension																									
		No response																									
	LEGS	Normal power																									
		Mild weakness																									
		Severe weakness																									
		Spastic flexion																									
		Extension																									
		No response																									

Pain Score

Ask the patient to rate his/her pain by choosing a number between 0 and 10. Use the diagram below to assist the patient. If patient's pain is chronic, use generic tool. If patient is unable to communicate, use observational tool.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Severe Pain			

Nausea and Vomiting
0 = None
1 = Mild (*Not distressing – no retching/vomiting*)
2 = Moderate (*Troublesome – occasional retching/vomiting*)
3 = Severe (*Distressing – frequent retching/vomiting*)

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

3112626230
MCLACHLAN
Michael
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

M
31/12/1962

NHS
eater Glasgow
and Clyde

Emergency Department
Mental Health Triage and Risk Assessr

Emergency Department Triage
This side to be completed by triage nurse

Patient Name Michael McLachlan

DoB 31/12/62 CHI

Triage Observations
Document physiological measurements

GCS	BM	HR	BP	RR	SaO_2	Temp
15/15	143/74	67	143/74	16	99	36·1

Accompanied by...
Name, relationship, particular concerns

Alone

Or describe the patient's physical appearance/clothing if attending alone as they may leave before assessment

Is the patient a young person in foster care or in a residential care placement? Yes/No

Is the patient a carer for a child or for a dependent adult? Yes/No

Is there a child protection concern or concern for an adult at risk? Yes/No

Outline of Presentation
Tick all those categories which apply and provide a brief summary

Overdose – will require medical assessment	
Self-Injury - will require wound management	
Other Mental Health Presentation	✓

Initial Presentation, Appearance and Behaviour
Respond yes or no to each question, in any order which seems appropriate

Is the patient violent, aggressive or threatening?	Yes		(No)
Is the patient obviously distressed, markedly anxious or highly aroused?		(Yes)	No
Is the patient quiet and withdrawn?		Yes	(No)
Do you think the patient is behaving inappropriately to their situation?		(Yes)	No
Do you think the patient presents an immediate risk to you, to others, or to themselves?	(Yes)		No
Do you think the patient is likely to abscond prior to assessment?	Yes		(No)
Do you think the patient's presentation suggests either delusions or hallucinations?*	(Yes)		No
Do you think the patient's presentation suggests they feel their actions are being controlled?	(Yes)		No
Are you aware of a history of mental health problems or psychiatric illness?		(Yes)	No
Are you aware of a history of violence or self harm?		(Yes)	No
Is the patient currently expressing suicidal thoughts	Yes		(No)

*Delusions; false but firmly held views and ideas. Hallucinations; false external stimuli (e.g. visual or vocal) the patient thinks are real

Triage Risk Assessment
Indicate an initial category of risk by circling one and selecting one of more risks

(High)/Moderate/Low Risk

of self-harm/violence/absconding in department

Triage Category	3	high risk – supervised *and* in the department moderate risk – supervised *or* in the department low risk – can be asked to wait if necessary

Any responses in the ~~first column~~ **High Risk**

Other patients can be categorized as **Moderate Risk**

If *all responses* are in the third column **Low Risk**

Immediate Management
Print toxbase information, and in paracetamol overdose, document 4 hour time for sample

Patient location, supervised by...	Mgmt		
Blood sample time?		Toxbase Information Printed?	

Print Name [illegible]

Signature [illegible]

Date 21/7/16 Time 01[15]

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Emergency Department Mental Health Assessment

This side to be completed by medical staff

Outline of current presentation and precipitating factors

Heroin - withdrawl persecutory delusions + and tactile/ auditory hallucinations. Last took heroin yesterday morning. Whenever it wears off he starts to hear voices "behind his walls" accusing him of "kiddy fiddling" and of "scamming people". Also telling him to harm himself / kill himself. No specific method of suicide. Also feels himself being pinched (tactile hallucination). He states he doesn't know why the want to hurt him. States if he goes home he will either be killed by them or will kill himself. However note he is not currently experiencing these symptoms

Previous mental health problems, self harm, addictions, medication etc

BG → Previous Heroin withdrawl psychosis known to ψ, Previous suicidal attempt by setting house on fire

Other relevant information; relationships, finances, employment, housing, physical health, childcare etc

PMHx - Heroin misuse, DSH,

DHx - Risperidone, Olanzapine

Appearance	Behaviour	Speech
unkempt	Hyperactive ← wide-eyed	fast,
Mood	**Thought**	**Insight**
Stressed	No detriment	Some insight. understand might be psychosis

Risk Assessment

Based on clinical assessment, indicate a category of risk of a further episode of self-harm in the short term (48 hrs) considering any protective as well as precipitating factors

High / Moderate / Low

Risk Factors (yes/no/unknown)			
male gender	y	n	u
age >18 and <65	y	n	u
depression	y	n	u
alcohol or drug use	y	n	u
separated, widowed, divorced	y	n	u
suicide plan/concealment	y	n	u
evidence of psychosis	y	n	u
ongoing suicial intent	y	n	u
lack of social support	y	n	u
chronic physical illness/pain	y	n	u
family history of suicide	y	n	u
family concerned about risk	y	n	u
disengaged/poor compliance	y	n	u
unemployed or retired	y	n	u
access to lethal means of harm	y	n	u
previous violent methods	y	n	u
history of self harm/overdose	y	n	u
previous psychiatric treatment	y	n	u
current psychiatric treatment	y	n	u
current use of benzodiazepines	y	n	u

Summary and Plan for Further Assessment

Referral to liaison psychiatry, duty doctor, CPN service, CMHT, GP, addiction services, SW, etc

Summary Concerns regarding Heroin withdrawl psychosis

Service Referred to	Time of Referral
CPN	03[45]

Discharge

Indicate the follow-up plan, advice given, and identities of others informed of the decision

Follow up and advice	Carer informed

Name and Designation of Consultant or Middle-Grade Involved in Reviewing Patient	

If young people in foster or residential care are assessed, their social work team should be informed, (via standby SW if out-of-hours), *and* correspondence given to carers present.

Print Name KENDRA Mrs Docwra

Signature [signature]

Date & Time 24/7/16

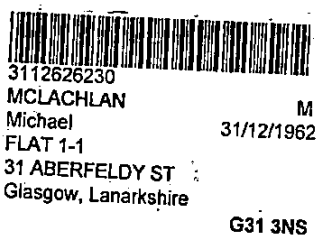
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version 2.0 -- February 2013

24/7/16 Michael McLachlan D.o.b. 31/12/62

May Include: Sleep, Appetite, Relevant substance abuse, Relevant personal history

05/20 Dressed in casual attire. Tidy, well kempt. Relaxed posture. Maintaining eye contact. Admits primary problem is his addiction to heroin and in particular impact of withdrawals claiming that when he starts withdrawing → he can experience auditory hallucinations. Informed he had some heroin last night as worried about impact of withdrawals. Exhibits insight and aware of link between withdrawal and voices. He informs he wants help. Also wants to reduce heroin and possibly come off heroin. Has hopes / plan to start on Subutex soon. Oriented to time, place + person. Appeared cognitively intact (not tested). No evidence of psychotic symptoms or insight impairment. Main focus was his worry about potential withdrawals in future but has had heroin last night.
Admits heroin primary issue and smokes it every day. Affects addiction team.
Mood described as usually OK but he is worried this may change if he has to withdraw from heroin.
Denies current suicidal ideation or intent. Denies intent to harm others. Relates he has protective factors of his family.
Informs he attempts to self care. Informs activity levels low. Claims money problems due to heroin addiction.
Denies current paranoia.
Main issue is worried about possible heroin withdrawals. At present not withdrawing and plans on discussing detox with addiction team. Advised he will continue to take drugs which were by addiction team

No current evidence of acute mental illness.
Exhibits capacity + insight.
Main concern is his possible heroin withdrawal and his worry about potential psychotic symptoms, should this happen. (Not currently withdrawing) will update his addiction team and ask team to request contact and advise him to contact our team. Advised he can call NHS 24 or OOH if needing input prior to Monday. No ongoing self harm / suicidal intent.


3112626230
MCLACHLAN
Michael
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Glasgow, Lanarkshire
G31 3NS
M
31/12/1962

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Michael
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M
31/12/1962

Scottish Ambulance Service Patient Report Form

Incident Number	CR003088939 on 23/07/2016 at 23:10		
Callsign		Incident Type	EMG
Crew1	E9888216 - Driver	Crew3	
Crew2	E0022128 - Attendant	Crew4	

INCIDENT LOG

Incident Location	FLAT 2/2 2/2 22 MOSSVALE PATH CRAIGEND GLASGOW	Incident Postcode	G33 5PS
Call Received	23:10 - 23/07/2016	Patient at Hospital	-
Call Passed	23:52 - 23/07/2016	Patient Handover	-
Crew Mobile	23:52 - 23/07/2016	Crew Clear	-
Crew at Scene	00:03 - 24/07/2016	Clear Reason	
Crew Left Scene	00:35 - 24/07/2016		
Receiving Hospital	GLASGOW ROYAL INFIRMARY		

DIAGNOSIS

Chief Complaint Code	25
Despatch Code	25B03 : Threatening Suicide - Weapons
Diagnostic Code	25B06 : 25B06 - Psych/Abnorm Behaviour/Suicidal - Unknown Status

PATIENT DETAILS

Surname	MCLAUGHLIN		
Forename	MICHAEL		
Middle Initials		Sex	Male
DoB	31/12/1962	Age	53 years 6 months 24 days
Patient Address	1/1 31 ABERFELDY ST	Patient Postcode	
Patient Telephone		Ethnicity	

PATIENT CONSENT

Mental Capacity Assessed	Deemed To Have Capacity
Level of Consent	Advice Given To Patient, Risks Of Condition Explained, Treatment Benefits Explained

PRIMARY SURVEY

AVPU Assessment	Alert
Catastrophic Haemorrhage	No
Airway Assessment	Clear
Breathing Rate	Normal
Respiratory Rate	18
Pulse	Slow
Most Peripheral Palpable Pulse Found	Radial
Skin Colour	Normal
Skin Texture	Dry
Capillary Refill Rate	< 2 Secs
CSI Assessment	No Evidence Of C-Spine Injury

VITAL SIGNS

Time	Pulse	Rthm	AVPU	RR	SYS	DIA	PEF	BG	Temp	SpO2	PS	CRT	ECG	Sepsis	GCS	RTS	NEWS	ETCO2	Lactate
00:07	55	Reg	Alert	18	148	92			37.1	98	0	< 2 Secs	Normal sinus rhythm		15	7.8			
00:20	59	Reg	Alert	18	144	76				98	0	< 2 Secs	Normal sinus rhythm		15	7.8			
00:30	72	Reg	Alert	18	142	79				99	0	< 2 Secs	Normal sinus rhythm		15	7.8			

AMPLE

Allergy Type	None
Previous Medication	RESPIRADONE
Previous Medical History	BIPOLAR DISORDER DEPRESSION HEROIN USER (SMOKER)
Last Eaten Before Incident	More Than 5 Hours
Events Prior To Incident	PT FEELS HE HAS BECOME PARANOID AFTER SMOKING HEROIN. PT STATES HE THIS IS OUT OF THE NORM AFTER HEROIN USE .

EYES AND PUPILS

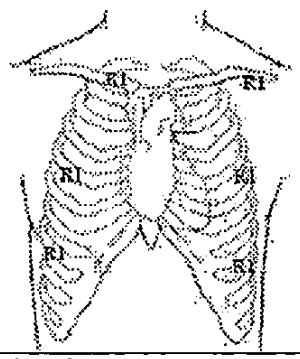
Left Eye		Right Eye	
Left Pupil Size	Normal	Right Pupil Size	Normal
Left Pupil Reaction	Normal	Right Pupil Reaction	Normal
Unequal Reaction To Light			

RESPIRATORY SYSTEM

Respiratory Assessment	Normal
Bilateral air entry, Bilateral Movement	
Other Respiratory Sounds	ALL CLEAR

Respiratory Sites

3112626230
MCLACHLAN M
Michael 31/12/1962
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31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS



EMERGENCY SERVICES

In Attendance	Paramedic, Police, Technician

PATIENT HANDOVER

Patient Mobility On Arrival	Seated	On Scene Removal	Walking
Patient Transportation	Lying	Care Delivery At Hospital	Chair
Time Of Patient Handover			

SEPSIS

Pulse	RR	SYS	Temp	GCS	BG	Pneumonia	UTI	Other infection	Abdo Pain	Diarrhoea	Abdo distension	Meningitis	Cellulitis	Septic arthritis	Wound infection	Infected indwelling device	No signs of infection
55	18	148	37.1	15		NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO
59	18	144		15		NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO
72	18	142		15		NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO

GCS

Time	Eye Opening	Verbal Response	Motor Response	Total
00:07	Spontaneous	Orientated	Obeys Commands	15
00:20	Spontaneous	Orientated	Obeys Commands	15
00:30	Spontaneous	Orientated	Obeys Commands	15

SOCIAL ASSESSMENT

Patient Age	
Situation	Patient Lives Alone
Risk Assessment	Risk Of Psychiatric Threat
Action Taken	Patient Conveyed To Hospital, Police Contacted
Additional Details Of Risk Or Concern	

SAFEGUARDING

Situation	Patient Aged Over 45, Patient Lives Alone, Possible Alcohol Or Substance Abuse
Previous History Of Mental Health Problems	History Of Alcohol Or Substance Abuse, History Of Anxiety, History Of Depression, History Of Other Mental Health Problems
Action Taken	Patient Conveyed To Hospital, Police Contacted
Details Of Risk Or Concern	

ADDITIONAL COMMENTS AND OBSERVATIONS

999 CALL FOR 53 YOM PSYCHOTIC EPISODE. O/A POLICE ON SCENE PT TOLD CREW HE IS A HEROIN ADDICT. PT TOLD CREW HE HAS TAKEN HEROIN AT 21:00 TONIGHT HAS BECAME PARANOID. HEARING VOICES TELLING HIM TO DO THINGS AGAINST HIS WILL. AND BECOMING AGGRESSIVE PT HAS HX OF MENTAL HEALTH BREAKDOWNS AND DEPRESSION AND HAS BEEN UNABLE TO TAKE HIS MEDS. O/E PT OBS AS NOTED. PT COOPERATED WITH CREW FOR ALL OBS MINUS B/M DUE TO HIS FEAR OF NEEDLES. PT STATES HE IS NOT SUICIDAL AND HAS NOT BEEN DRINKING TRANSPORTED TO GRI

REPORT MANAGEMENT

Report ID	CR003088939-24072016004414		
Software Version	1.0.440	Report Type	Interim

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 03/06/2016

Consultant: Dr Scott Taylor

CA Walker
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
Glasgow
G32 7JZ

Dear CA Walker

Re: **McLachlan Michael** DOB: **31/12/1962** CHI: **3112626230**
FLAT 1-1
Glasgow G31 3NS

Attended on: **02/06/2016 at 23:46 hrs.** Departed on: **03/06/2016 at 02:06 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **4**

Presenting complaint
od

Nursing Assessment:
Mixture of drugs throughout the day, smoken heroin, taken valium ?14 & methodone. Given Narcan 400 mcgrams as was drowsy at scene. GCS now 15 also speech sluggish. HX Psychosis & bipolar

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Acute opiate intoxication		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:
friend called SAS as patients lips had gone blue after taking heroin and valium with reduced GCS. Given narcan by SAS. Now GCS15, no slurred speech, good steady mobility and keen for discharge. No follow up required.

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

Yours sincerely,
Sarah Zacheshigriva
Doctor

Copies to:
1. CA Walker (GP)

School Address:

Glasgow Royal Infirmary

CHI: 3112626230

Total Att: 8

12 Mth Att: 4

(10)

Title: **MR**

MCLACHLAN **Michael**

DOB: **31/12/1962** Age: **53y** Sex: **Male**

FLAT 1-1
31 ABERFELDY ST
Glasgow
Lanarkshire
G31 3NS

Next of kin: **SHERLOCK, Martine**
Relationship: **Niece**

GP: **CA Walker**
0141 531 6240

Attendance Date: **02/06/2016** Arrival Time: **23:46**

Registration Time: **23:46** Date of Incident: **02/06/2016**

Major Incident Desc:

Reason for Attendance: **od**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **03/06/2016 00:05** Nurse name: **Nurse Lorraine Swanson**

Temp	**36.0**	C
HR	**67**	bpm
BP	**100/74**	mmHg
MAP	**82.67**	mmHg
RR	**18**	bpm
SpO2	**96**	%
Oxygen		%

BM	**5.6**	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	**4**
Motor	**6**
Verbal	**5**
Total	**15**

Pupils Right		Pupils Left	
Size (mm)	**3**	Size (mm)	**3**
Reaction	**Y**	Reaction	**Y**

Nursing Notes: **"Mixture of drugs throughout the day, smoken heroin, taken valium ?14 & methodone. " Given Narcan 400 mcgrams as was drowsy at scene. GCS now 15 also speech sluggish. HX Psychosis & bipolar**

3112626230 31/12/1962 MCLACHLAN Michael
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3112626230 31/12/1962 MCLACHLAN Michael

To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

Date	**Clinical Notes**	
	Seen By	Time Seen

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By

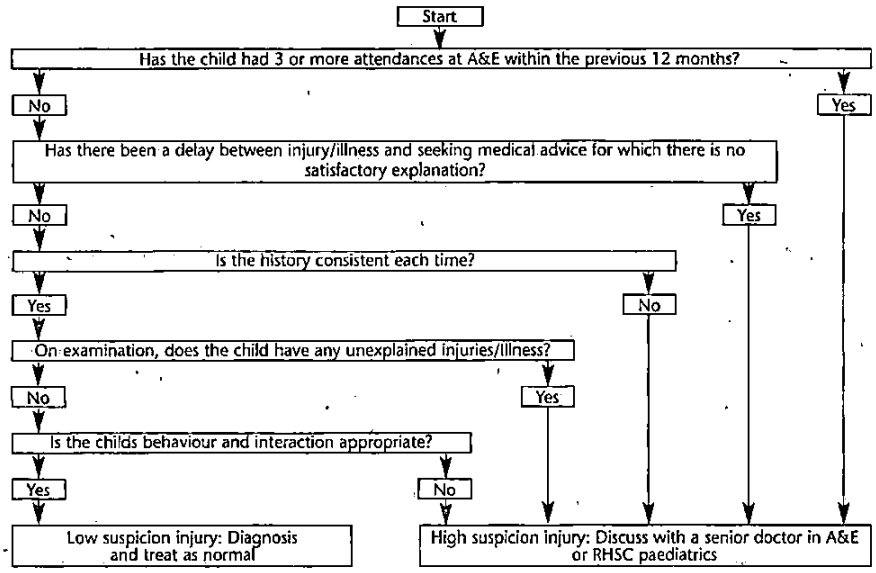
Glasgow Royal Infirmary
Unitary Patient Record
(Part A - Acute Assessment)

NHS
Greater Glasgow and Clyde

3112626230
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31/12/1962

Injury/Illness Flow Chart for all Patients 16 and under

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



All Clinical Staff Consider

H.I.Form ☐

Audit Form ☐

Police Consent ☐

Clinical Notes

3/6/16 0145 ZACHESHIGRWA GPST2 ED

53 ♂ known to CAT + CMHT.

Admits to taking heroin + valium today. Not sure how much he took. Friend called ambulance "because lips went blue."

Did not take in an attempt to harm himself.

No suicidal ideation. No current psychotic features.

Given naxon by SAS

GCS 15 + now able to walk steadily + wanting to go home.

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)

Clinical Notes

PMH - Heroin + benzodiazepine misuse ⇝ psychosis
Cocain use.
BiPolar, Depression

NKDA.

Meds - Risperidone 2mg BD.

O/E GCS 15
Pupils slightly small bilaterally
No slurred speech.
Mobilising steadily
Lips not blue/cyanotic.

HR 67
BP 100/74
RR 18 Sats 96%
BM 5.6

Imp Acute opiate intoxication - resolving

(P) discharged.
Friend will pick him up.

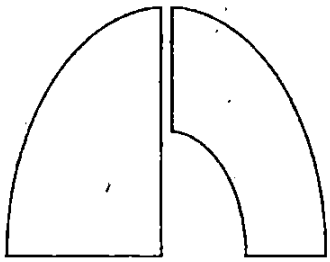
Acute Medicine Unit
Glasgow Royal Infirmary
Unitary Patient Record
(Part A - Acute Assessment)

NHS
Greater Gl
and Cl

3112626230
MCLACHLAN
Michael
M
31/12/1962

Clinical Notes

X-Ray results



ECG findings

Other investigations

Biochem/Haematology results

Indicate which lab tests have been requested.

Haem	Date and time
WCC	
Hb	
Plat	
MCV	
Neut	
DDim	Date and time
PT	
PTT	
TT	

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

Fluids Prescribed in A&E

Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time

Drugs Prescribed in A&E

Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time

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.

Scottish Ambulance Service Patient Report Form

Incident Number	CR002975774 on 02/06/2016 at 22:40		
Callsign		Incident Type	EMG
Crew1	E0018384 - Driver	Crew3	
Crew2	E9888614 - Attendant	Crew4	

INCIDENT LOG

Incident Location	FLAT 0/1 0/1 57 GADIE STREET RIDDRIE GLASGOW	Incident Postcode	G33 2DR
Call Received	22:40 - 02/06/2016	Patient at Hospital	-
Call Passed	22:41 - 02/06/2016	Patient Handover	-
Crew Mobile	22:41 - 02/06/2016	Crew Clear	
Crew at Scene	22:43 - 02/06/2016	Clear Reason	
Crew Left Scene	-		
Receiving Hospital			

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

DIAGNOSIS

Chief Complaint Code	23
Despatch Code	23D01I : Intentional Overdose and Unconscious
Diagnostic Code	23B01 : 23B01 - Overdose - No Priority Symptoms

PATIENT DETAILS

Surname	MCLACHLAN		
Forename	MICHEAL		
Middle Initials		Sex	Male
DoB	31/12/1962	Age	53 years 5 months 2 days
Patient Address	AT LOCUS	Patient Postcode	
Patient Telephone		Ethnicity	

VITAL SIGNS

Time	Pulse	Rthm	AVPU	RR	SYS	DIA	PEF	BG	Temp	SpO2	PS	CRT	ECG	Sepsis	GCS	RTS	NEWS	ETCO2	Lactate
22:51	70		Alert		116	79		6.1	3.8	96				1		2.9	3		
23:05	72		Alert		123	81									15	6.6	3		

AMPLE

Allergy Type	None
Previous Medication	RISPIRIDONE, SERIQUILL, METHADONE
Previous Medical History	PSYCHOSIS. BI POLAR.
Last Eaten Before Incident	More Than 5 Hours

EYES AND PUPILS

Left Eye		Right Eye	
Left Pupil Size	Constricted	Right Pupil Size	Constricted
Left Pupil Reaction	Normal	Right Pupil Reaction	Normal
Unequal Reaction To Light			

MEDICINES

Drug	Time	Dosage	Route	Crew No	Batch/Expiry	Pain Before	Pain After
Naloxone	23:05	400 mcg		E9888614	437066		

SEPSIS

Pulse	RR	SYS	Temp	GCS	BG	Pneumonia	UTI	Other infection	Abdo Pain	Diarrhoea	Abdo distension	Meningitis	Cellulitis	Septic arthritis	Wound infection	Infected indwelling device	No signs of infection
70		116	3.8		6.1	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO
72		123		15		NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO

GCS

Time	Eye Opening	Verbal Response	Motor Response	Total
22:51				0
23:05	Spontaneous	Orientated	Obeys Commands	15

PATIENT SUPPORT

Next of Kin	DAUGHTER	Next of Kin Telephone	
Next of Kin Address			

ADDITIONAL COMMENTS AND OBSERVATIONS

PT HAS TAKEN A MIXTURE OF DRUGS THROUGHOUT TODAY.STREET VALIUM ??? {14}.AND ALSO SMOKED HEROIN,PLUS METHODONE.NARCAN GIVEN AS PT LOC WAS DROPPING.PT MEDHX /PSYCOSIS/BI POLAR/DRUG ABUSE.

REPORT MANAGEMENT

Report ID	CR002975774-02062016232531		
Software Version	1.0.413	Report Type	Interim

Final Discharge Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. CA Walker
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Main Switchboard:
Department:
Contact Tel:
Enquiries to:
Letter Date: 18/03/2016
Reference:
Dictated Date:
Transcribed Date:

Dear Dr. CA Walker,

Michael McLachlan; D.O.B: 31/12/1962; CHI: 3112626230
FLAT 1-1, 31 ABERFELDY ST, Glasgow, Lanarkshire, G31 3NS

Admission: Specialty - General Medicine; Ward - GRI Ward 20/21 Rheumatology/General Medicine
Consultant - Dr Lucy McGeoch; Date of Admission - 20/02/2016
Date of Discharge - 03/03/2016; Discharged to - Private Residence - living with relatives or friends

Follow Up: CAT CMHT

Clinical Comments:
Dear Doctor, Diagnosis: Heroin induced psychosis PMH: Bipolar, depression Admission: This 53 year old gentleman was admitted on 20/2/16 with confusion. He was deemed medically fit after normal investigations, such as bloods and CXR. Psychiatry reviewed the patient after auditory hallucinations and persecutory delusions. He underwent a CT Head which was also normal. He was initally treated under an EDC, STDC and this was then revoked. He will be reviewed in the community by CAT and CMHT. He has been discharged from our care

Final Discharge Comments:
Nil to add

A Fletcher
GPST1.2

Electronically Signed: Dr Hilary Wilson, Consultant

cc.

McLachlan Michael CHI: 3112626230

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No Consent for Sharing Withheld: No

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000

Date of Completion: 03/03/2016

Dr. CA Walker
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Dear Dr CA Walker,

Name	CHI	DoB	Address
Michael McLachlan	3112626230	31/12/1962	FLAT 1-1 Glasgow G31 3NS

Admitted	Type	Discharged	Destination
20/02/2016 05:16	In Patient	01/03/2016	

Specialty	Consultant	Ward	Telephone
General Medicine	Dr Lucy McGeoch	GRI Ward 20/21 Rheumatology/ General Medicine	

Reason for Admission and Presenting Complaints	Admission Category
	Admission for treatment - Where the patient is expected to be treated for a diagnosed condition not otherwise specified

Diagnosis	Site	Side

Date	Procedures/Interventions/Operations

Clinical Comments:

Dear Doctor,
Diagnosis: Heroin induced psychosis
PMH: Bipolar, depression
Admission:
This 53 year old gentleman was admitted on 20/2/16 with confusion. He was deemed medically fit after normal investigations, such as bloods and CXR. Psychiatry reviewed the patient after auditory hallucinations and persecutory delusions. He underwent a CT Head which was also norma. He was initally treated under an EDC, STDC and this was then revoked. He will be reviewed in the community by CAT and CMHT. He has been discharged from our care.
Kind Regards,
Douglas Andrew
FY1 Ward 20/21 GRI

Treatments: None recorded.

Follow-up arranged: CAT CMHT

Planned Outpatient Investigations: none

Final Discharge letter to follow: y

Medication Info:

Allergies: No Allergy

Height: cm **Weight:** kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment
Quetiapine Tablet	Oral	300	mg	At Night	No duration defined	7 days supply only

Discontinued Medication:

Drug Name	Dose	UOM	Reason

Yours sincerely,
Dr Douglas Andrew
Doctor

Prescription Review

Medications Reviewed by Pharmacist: Pamela Everitt, Pharmacist
Dispensed Medications Checked by Pharmacy: Alan Fletcher, Doctor
Nurse discharging patient: Andrew Downie, Nurse

Mental Health Service

Glasgow Liaison Psychiatry Service
2nd Floor
St Mungo Building
Glasgow Royal Infirmary
84 Castle Street
Glasgow
G4 0SF

Dr Wilson
Consultant in General Medicine
Ward 20/21
Glasgow Royal Infirmary
84 Castle Street
Glasgow
G4 0SF

Date: 29th February 2016
Date Typed: 2nd March 2016

Our Ref: AB/SS/1209644

Direct Line: 0141 211 4417

Email: scott.stewart@ggc.scot.nhs.uk

Dear Dr Wilson

Re: Michael McLachlan, DOB 31.12.62 – CHI 3112626230
Flat 1/1, 31 Aberfeldy Street, Glasgow G31 3NS

Further to our service's recent involvement with Mr McLachlan including his detention under the terms of a Short Term Detention Certificate I reviewed him on ward 20/21, GRI, on 29.02.16. This was partly in relation to our obligation to review a person detained under a Short Term Detention Certificate but also to offer further advice regarding his management.

I will not go into Mr McLachlan's history in any great detail suffice to say that he was admitted in the very early hours of 20.02.16 in a distressed, agitated and overtly psychotic state. This persisted for the first few days of admission. His behaviour necessitated his detention under an Emergency Detention Certificate followed by a Short Term Detention Certificate. In summary since this time he has gradually settled such that by the point of my assessment on 29.02.16 he had been free of serious levels of agitation and psychotic symptoms for about 48 hours.

I interviewed Mr McLachlan in his side room. Mr McLachlan was cooperative with the interview, engaged eye contact normally and displayed an appropriately reactive affect throughout. His speech was normal. He was globally orientated and appeared to engage well with the interview. During the interview there was no evidence of any psychotic phenomena. Mr McLachlan can recall very little after his contact with his daughter which led to the admission. He can remember the events of the day I interviewed him but struggled to remember much from the day before. He feels that he is now largely back to normal and was keen to get home.

Impression/Suggestions

Michael McLachlan
CHI 3112626230

Mr McLachlan appears to have had a brief episode of psychosis. I note he appears to have had a similar episode of the same and that he himself felt as if this current episode was similar. I have to say from my own point of view, the time course and fluctuation during the episode to me is much more suggestive of an episode of delirium albeit that we are not clear as to what the cause of this may have been. He did tell me that he had been consuming benzodiazepines in the region of about 50mg a day for a fortnight or so before suddenly reducing this to zero a week or so prior to the admission. It is possible that his abnormal mental state was a benzodiazepine withdrawal state although admittedly this is a little unlikely. Perhaps it is the combination of these factors and his diathesis in terms of his propensity to develop psychotic symptoms which is to blame. As far as I can tell from looking at his medical records the only thing of significance was his complaint of loin pain accompanied by a brief pyrexia.

From a psychiatric point of view Mr McLachlan no longer meets the criteria for the use of the Mental Health Act and I revoked his detention as of 15.00. From our service's point of view I don't plan any review. Mr McLachlan himself is in the process of being transferred from the homeless mental health services to his area team. He expressed some concerns about this in that he wished it to go smoothly and I will therefore copy this to his consultant at that team.

Mr McLachlan is still prescribed his regular quetiapine dose and I would not suggest any change to this.

Yours sincerely

Dr Adam J Burnel
Consultant in Liaison Psychiatry

cc Dr Walker, Shettleston Health Centre, 420 Old Shettleston Road, Glasgow G32 7JZ
Consultant, Arran Centre, 121 Orr Street, Glasgow G40 2QP

.../2

Final Discharge Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. CA Walker
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Main Switchboard:
Department:
Contact Tel:
Enquiries to:
Letter Date: 20/10/2015
Reference:
Dictated Date:
Transcribed Date:

Dear Dr. CA Walker,

Michael McLachlan; D.O.B: 31/12/1962; CHI: 3112626230
FLAT 1-1, 31 ABERFELDY ST, Glasgow, Lanarkshire, G31 3NS

Admission: Specialty - General Medicine; Ward - GRI Ward 50/51 MR General Medicine
Consultant - Dr David Carty; Date of Admission - 21/09/2015
Date of Discharge - 21/09/2015; Discharged to - Private Residence - living alone

Follow Up: none

Clinical Comments:
IDL written as per case notes Dear Doctor, Diagnosis: 1. Fall secondary to confusion 2. Head injury - CT normal 3. Chest infection This 52 year old gentleman Mr. Michael McLachlan was referred to the medical unit on 21.09.15. Found by neighbours walking confused and agitated around 05.45 am. Vague history from the patient. Appeared to be very drowsy initially and stated that he has fell down from the stairs previous night. Could not recall events after that. Denies any chest pai, sob, or fever. Complained of cough in the morning since 6 months. PMH: 1. Bipolar disorder 2. Depression On admission chest and abdominal examinations were unremarkable with stable observations. Noted to have abrasion on the forehead with superficial wound on the right knee. Multiple abrasions on the hand and legs. Pinpoint pupils but reactive to the light. ECG noted as sinus rhythm. GCS-14/15. No focal neurology. CT head: Volume acquisition performed through the brain, non contrast enhanced.No significant focal intra or extra-axial abnormality has been identified. There is no evidence of acute intracranial haemorrhage. CXR:The heart is not enlarged, mediastinal contours are within normal limits. Focal air space shadowing demonstrated at the right cardiophrenic angle, may represent focal infection. Follow-up film recommended in 4-6 weeks following treatment. He was started on IV fluids and IV antibiotics. However he was keen to go home and self discharged him self against the medical advice. Tried to explain him regarding the chest infection and adverse effect. He has full capacity to make decisions and discharged him self on 21.09.15.
Final comments - nil to add
Dr H Wilson
Consultant Physician

Electronically Signed: Dr Hilary Wilson, Consultant

cc.

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 07/10/2015

Consultant: Dr Neil Dignon

CA Walker
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
Glasgow
G32 7JZ

Dear CA Walker

Re: **McLachlan Michael** DOB: **31/12/1962** CHI: **3112626230**
FLAT 1-1
Glasgow G31 3NS

Attended on: **06/10/2015 at 20:47 hrs.** Departed on: **07/10/2015 at 00:13 hrs.**
Discharge Type: **01b - Discharge with follow up by primary care team** Destination: **Private residence**
Previous ED Attendance in last 12 months: **1**

Presenting complaint
ent letter

Nursing Assessment:
has 2 week old wound to right patella, refused treatment at time, now wound ha pus, red all round wound, increase in pain, went to GP and was sent here. GP letter

Investigations in ED:
1. CRP **2. Full Blood Count** **3. LFT**
4. Urea and Electrolytes

Diagnosis:

Diagnosis	Side	Site
Open wound of knee	**Right**	
Cellulitis of other parts of limb	**Right**	**Knee**

Procedures: **None**

Immunisations: **None**

Dispensed Medication:

Dispensed Medicine	Formulation	Dose	UOM	Route	Frequency	Duration
Cocodamol 8/500 2 tabs QID PREPACKED ONLY	**Tablets (PP)**	**2**	**TABS**	**Oral**	**FOUR Times a Day**	**No duration defined**
Ibuprofen tabs 400mg TID PREPACKED ONLY	**Tablets (PP)**	**400**	**MG**	**Oral**	**THREE Times a Day**	**No duration defined**
Flucloxacillin Cap 500mg QID PREPACKED ONLY	**Capsules (PP)**	**500**	**MG**	**Oral**	**FOUR Times a Day**	**No duration defined**

Clinician Notes:

Referred by GP with two week old right knee wound. Mild cellulitis around wound. CRP 16 and WCC 9.8. Discharged with analgesia and 1 week of antibiotics. Advised to attend practice nurse at end of this week or start of next for a wound review to ensure is healing.

Followup : **Practice nurse**

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Iain Woods
Doctor

Copies to:

1. CA Walker (GP)

School Address:

CHI: 3112626230

Glasgow Royal Infirmary

13

Total Att: 6

12 Mth Att: 2

Title: MR

MCLACHLAN **Michael**

DOB: **31/12/1962** Age: **52y** Sex: **Male**

FLAT 1-1
31 ABERFELDY ST
Glasgow
Lanarkshire
G31 3NS

Next of kin: **MCLACHLAN, CHEVONNE**
Relationship: **Daughter**
07884204431

GP: **CA Walker**
0141 531 6240

Attendance Date: **07/10/2015** Arrival Time: **18:05**

Registration Time: **18:05** Date of Incident: **07/10/2015**

Major Incident Desc:

Reason for Attendance: **inf R knee, attended a+e 1/7, commenced ABX. declined by ortho. hx mental health issues, may appear vague**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **07/10/2015 18:21** Nurse name: **Nurse Andrew Docherty**

Temp	**36.1**	C
HR	**77**	bpm
BP	**99/61**	mmHg
MAP	**73.67**	mmHg
RR	**16**	bpm
SpO2	**95**	%
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: **throat. ? infection in right knee.**

3112626230 31/12/1962 MCLACHLAN Michael
3112626230 31/12/1962 MCLACHLAN Michael
3112626230 31/12/1962 MCLACHLAN Michael
3112626230 31/12/1962 MCLACHLAN Michael
3112626230 31/12/1962 MCLACHLAN Michael

To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

Date	Clinical Notes
7/10/15	Seen By F42 PRENTICE — Time Seen 1920

(S2) → KNEE LACERATION

PRESENTS 2/52 FOLLOWING KNEE INJURY

UNABLE TO RECALL EVENTS BUT SUSTAINED LACERATION TO KNEE. DECLINED SUTURE AT TIME AS NEEDLE PHOBIA.

FOR 2/52, INCREASING PAIN AT KNEE.

REFERRED FROM GP. SYSTEMICALLY WELL.

O/E: 2cm WOUND (R) KNEE - HEALING BY 2° INTENTION. SMALL AMOUNTS OF PUS IN WOUND WITH SURROUNDING ERYTHEMA. NO HEAT AT WOUND.

GOOD ROM AT KNEE.

OBS UNREMARKABLE & STABLE.

BLOODS 6/10/15 → WCC 9.8 CRP 16

R/V D WITH NURSE I MSH FOR WOUND ADVICE.

DRESSED WITH AQUACEL AND BANDAGE & ADVISED INAGINE.

I ADVISED HIM TO FINISH HIS COURSE OF ANTIBIOTICS AND TO ATTEND PRACTICE NURSE IN 1-2 DAYS FOR DRESSING CHANGE.

F42
PRENTICE

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By

℞ Encounter Report for house call

Dear Orthopaedics,
PC - Infected ® Knee.
3112626230 See Latest entry.
Yours sincerely,
Parkins GP

Chi Number

No data recorded.

Address and Telephone numbers

Flat 1-1 31 Aberfeldy Street Haghill Glasgow G31 3NS
Mobile phone 07947 416 972
No data recorded.
No data recorded.

Carers details

Michael Mclachlan 31/12/1962 Male NHS: S64456335 CHI: 3112626230
No data recorded.
No data recorded.

Significant Medical History

26/02/2014 Endogenous depression first episode Dr Katie Gallacher
21/02/2014 Excision of submandibular gland - left, ENT OP, GGH Miss Catherine Arbuckle
20/08/2013 Internal thrombosed haemorrhoids , A&E GRI Miss Catherine Arbuckle
06/09/2012 Drug addiction therapy Suboxone treatment patient defaulted, EAST CAT Miss Catherine Arbuckle
17/10/2006 Drug addictn therap-methadone , Addiction Services, Parkhead Hospital Miss Catherine Arbuckle
28/07/2006 Drug dependence NOS acute psychotic episode Miss Catherine Arbuckle
28/07/2006 Benzodiazepine dependence , Medical IP, GRI Miss Catherine Arbuckle
28/07/2006 [X]Heroin addiction , Medical IP, GRI Miss Catherine Arbuckle
26/06/2002 Drug dependence relapse, Heroin, Cocaine, Diazepam Miss Catherine Arbuckle
09/05/2002 Deliberate self-harm Diazepam overdose Miss Catherine Arbuckle
02/04/2002 Smoke inhalation Miss Catherine Arbuckle
04/11/1997 Cubital tunnel syndrome Left medial epicondylectomy Miss Catherine Arbuckle
18/03/1997 Primary arthrodesis of joint NEC 5th PIP joint Miss Catherine Arbuckle
09/03/1997 Compartment syndrome Miss Catherine Arbuckle
02/01/1997 Primary repair of tendon Miss Catherine Arbuckle
19/10/1996 Primary repair of tendon Miss Catherine Arbuckle
17/09/1996 [X]Assault Miss Catherine Arbuckle
07/03/1996 [SO]Ulnar nerve - hand divisions Miss Catherine Arbuckle
14/02/1987 [X]Assault Miss Catherine Arbuckle
11/07/1986 [X]Assault by sharp object chest Miss Catherine Arbuckle
09/03/1986 Exploration of skin wound NEC and repair of machete wound Miss Catherine Arbuckle

Chronic Disease Register

No data recorded.
No data recorded.
No data recorded.
No data recorded.
No data recorded.
No data recorded.
No data recorded.

Current Repeat Medication

No data recorded.

Acute and Repeat issues in last 3 months

06/10/2015 Flucloxacillin 500mg capsules Supply: (28) capsule ONE FOUR TIMES A DAY THIS IS FOR INFECTION Dr Andrew Little
21/08/2015 Quetiapine 100mg tablets Supply: (84) tablet TAKE 3 TABLETS AT NIGHT AS PER PSYCHIATRIST.
Notes for patient: you should be taking a total dose of 300mg (3 x 100mg tabs) Dr Paula Rogers
21/08/2015 Sertraline 50mg tablets Supply: (28) tablet 1 DAILY Dr Paula Rogers

llergies and Intolerances

No data recorded.
No data recorded.

Recalls - 3 months back to 1 month in future

No data recorded.

Referrals and Requests in last 3 months

No data recorded.

Hospital admissions in past year

No data recorded.

Consultations in past three months

07/10/2015 Surgery consultation Dr Richard Parkins
07/10/2015 Consultation Worsening right knee open wound infection. Increase pain and redness according to patient: On co-codamol, ibuprofen + flucloxacillin and not helping. ?seen ortho yesterday - no correspondence yet.
o/e temp 37
pr 88 bp 120/70 o2 sat 96
Right knee laceration over patella. Deep and discharging. Surrounding cellulliits.

plan refer ortho
Will make own way to GRI Dr Richard Parkins
07/10/2015 Smoking cessation advice for Smoking Dr Richard Parkins
07/10/2015 Smoker Cigarettes: 10 Current smoker Dr Richard Parkins
06/10/2015 Surgery consultation Sister Patricia Mcgougan

06/10/2015 Post-traumatic wound infection NEC injured r knee in blackout 2 weeks ago - then left GRI and went on hols for 2 weeks
3cm wound with surrounding cellulitis
I initially suggested fluclox/TR attendance
patient feels wound too deep and painful and requests further hospital assessment
is borderline for needing iv Rx so advised he can attend A and E - letter given
Dr Stirling Bruce
06/10/2015 Referral to nurse dress infected wound R knee Sister Patricia Mcgougan
06/10/2015 Flucloxacillin 500mg capsules Supply: (28) capsule ONE FOUR TIMES A DAY THIS IS FOR INFECTION Dr Andrew Little
06/10/2015 Wound observation walk in - injury to right knee on 20 or 21st sep and attended accident and emergency. signed himself out of hosp as thought was due to fly out on hol. went to tenerife for 2/52. self caring whilst away. had no hol insurance so didn't attend for treatment. wound appears infected. i shall ask duty gp to prescribe antibiotics and requires treatment room follow up Sister Patricia Mcgougan
21/08/2015 Third Party Consultation Mrs Gail Savage
17/08/2015 Document Image Docman Attachment
17/08/2015 Letter encounter from patient Clinical Homeless Service, Hunter Street Psychiatry Department Mrs Gail Savage

Prevention

08/06/2011 09:46.00 BP 116 / 76 taken Standing Cuff: Standard recall due: O/E - BP reading Dr Lynne Cooke
08/06/2011 09:45.00 BP 118 / 72 taken Sitting Cuff: Standard recall due: O/E - BP reading Dr Lynne Cooke
10/05/2011 10:19.00 BP 110 / 70 taken Sitting Cuff: Standard recall due: O/E - blood pressure reading Dr Catherine Curran
07/10/2015 Smoker Cigarettes: 10 Current smoker Dr Richard Parkins
No data recorded.
13/11/2014 Weight: 58 kgs BMI: 19.1 O/E - weight Dr Steve Beattie
04/06/2010 Height: 1.74 metres O/E - height Miss Catherine Arbuckle
No data recorded.

New Consultation Details

Date: Clinician:

75

Glasgow Royal Infirmary

CHI: 3112626230

Total Att: **5**

12 Mth Att: **1**

Title: **MR**

MCLACHLAN **Michael**

DOB: **31/12/1962** Age: **52y** Sex: **Male**

FLAT 1-1
31 ABERFELDY ST
Glasgow
Lanarkshire
G31 3NS

Next of kin: **MCLACHLAN, CHEVONNE**
Relationship: **Daughter**
07884204431

GP: **CA Walker**
0141 531 6240

Attendance Date: **06/10/2015** Arrival Time: **20:47**

Registration Time: **20:47** Date of Incident: **06/10/2015**

Major Incident Desc:

Reason for Attendance: **[redacted] letter**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **06/10/2015 20:56** Nurse name: **Nurse Cheryl McKain**

Temp	**35.9**	C
HR	**95**	bpm
BP	**128/82**	mmHg
MAP	**97.33**	mmHg
RR	**16**	bpm
SpO2	**99**	%
Oxygen	**21**	%

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: **has 2 week old wound to right patella, refused treatment at time, now wound ha pus, red all round wound, increase in pain, went to GP and was sent here. GP letter**

3112626230 31/12/1962 MCLACHLAN Michael
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3112626230 31/12/1962 MCLACHLAN Michael

To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

Date	Clinical Notes
6/10/15	Seen By Iain Woods — Time Seen 2330 (52)♂ Lwrist & right knee two weeks ago sustained during blackout. IRD'd from treatment at time. no painkillers Presented to GP today as Lwrist painful & discharging pus. Systemically well O/E. 1-2 cm Lwrist right knee. Healing by 2° intention. Minimal pus in Lwrist. Mild erythema around Lwrist. No heat. knee ROM normal Plan Bloods. Probably well enough for oral abx & analgesia. FBC, UEC 9.8 CRP 16. ∴ D/C with abx.

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By

ℝ Encounter Report (short)

3112626230

Address and Telephone numbers

Flat 1-1 31 Aberfeldy Street Haghill Glasgow G31 3NS
Mobile phone 07947 416 972

Carers details

Significant Medical History

26/02/2014 Endogenous depression first episode Dr Katie Gallacher
21/02/2014 Excision of submandibular gland - left, ENT OP, GGH Miss Catherine Arbuckle
20/08/2013 Internal thrombosed haemorrhoids , A&E GRI Miss Catherine Arbuckle
06/09/2012 Drug addiction therapy Suboxone treatment patient defaulted, EAST CAT Miss Catherine Arbuckle
17/10/2006 Drug addictn therap-methadone , Addiction Services, Parkhead Hospital Miss Catherine Arbuckle
28/07/2006 Drug dependence NOS acute psychotic episode Miss Catherine Arbuckle
28/07/2006 Benzodiazepine dependence , Medical IP, GRI Miss Catherine Arbuckle
28/07/2006 [X]Heroin addiction , Medical IP, GRI Miss Catherine Arbuckle
26/06/2002 Drug dependence relapse, Heroin, Cocaine, Diazepam Miss Catherine Arbuckle
09/05/2002 Deliberate self-harm Diazepam overdose Miss Catherine Arbuckle
02/04/2002 Smoke inhalation Miss Catherine Arbuckle
04/11/1997 Cubital tunnel syndrome Left medial epicondylectomy Miss Catherine Arbuckle
18/03/1997 Primary arthrodesis of joint NEC 5th PIP joint Miss Catherine Arbuckle
09/03/1997 Compartment syndrome Miss Catherine Arbuckle
02/01/1997 Primary repair of tendon Miss Catherine Arbuckle
19/10/1996 Primary repair of tendon Miss Catherine Arbuckle
17/09/1996 [X]Assault Miss Catherine Arbuckle
07/03/1996 [SO]Ulnar nerve - hand divisions Miss Catherine Arbuckle
14/02/1987 [X]Assault Miss Catherine Arbuckle
11/07/1986 [X]Assault by sharp object chest Miss Catherine Arbuckle
09/03/1986 Exploration of skin wound NEC and repair of machete wound Miss Catherine Arbuckle

Chronic Disease Register

Current Repeat Medication

Allergies and Intolerances

Referrals and Requests in last 3 months

History entries in past 3 months

06/10/2015 Referral to nurse dress infected wound R knee Sister Patricia Mcgougan
06/10/2015 Post-traumatic wound infection NEC injured r knee in blackout 2 weeks ago - then left GRI and went on hols for 2 weeks Sister Patricia Mcgougan
06/10/2015 Wound observation walk in - injury to right knee on 20 or 21st sep and attended accident and emergency. signed himself out of hosp as thought was due to fly out on hol. went to tenerife for 2/52. self caring whilst away. had no hol insurance so didn't attend for treatment. wound appears infected. i shall ask duty gp to prescribe antibiotics and requires treatment room follow up Sister Patricia Mcgougan
21/08/2015 Hospital prescription Dr Paula Rogers
17/08/2015 Letter encounter from patient Clinical Homeless Service, Hunter Street Psychiatry Department Mrs Gail Savage

Prevention

08/06/2011 09:46.00 BP 116 / 76 taken Standing Cuff: Standard recall due: O/E - BP reading Dr Lynne Cooke
08/06/2011 09:45.00 BP 118 / 72 taken Sitting Cuff: Standard recall due: O/E - BP reading Dr Lynne Cooke
10/05/2011 10:19.00 BP 110 / 70 taken Sitting Cuff: Standard recall due: O/E - blood pressure reading Dr Catherine Curran
10/05/2011 Smoker Cigarettes: 15 Cigarette smoker Dr Catherine Curran
13/11/2014 Weight: 58 kgs BMI: 19.1 O/E - weight Dr Steve Beattie
04/06/2010 Height: 1.74 metres O/E - height Miss Catherine Arbuckle

New Consultation Details

Date: **Clinician:**

Dear Dr,
Thus patient attended A+E with R knee infection 2 weeks ago - he then left department & went on holiday.
He has now returned R knee still erythematous, tender & swollen & ? suppurating. Today with fluctuswelling & tenderness over treatment room for dressing. Can he book

unlikely two days + plus two seven + is writing
further hospital opinion. If need her IV antibiotics

McLachlan Michael CHI: 3112626230

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No Consent for Sharing Withheld: No

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000
Date of Completion: 17/10/2015

Dr. CA Walker
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Dear Dr CA Walker,

Name	CHI	DoB	Address
Michael McLachlan	3112626230	31/12/1962	FLAT 1-1 Glasgow G31 3NS

Admitted	Type	Discharged	Destination
21/09/2015 12:00	In Patient	21/09/2015	

Specialty	Consultant	Ward	Telephone
General Medicine	Dr David Carty	GRI Ward 50/51 MR General Medicine	0141 211 4204/4205

Reason for Admission and Presenting Complaints	Admission Category
	Admission for treatment - Where the patient is expected to be treated for a diagnosed condition not otherwise specified

Diagnosis	Site	Side

Date	Procedures/Interventions/Operations

Clinical Comments: IDL written as per case notes
Dear Doctor,

Diagnosis:
1. Fall secondary to confusion
2. Head injury - CT normal
3. Chest infection

This 52 year old gentleman Mr. Michael McLachlan was referred to the medical unit on 21.09.15. Found by neighbours walking confused and agitated around 05.45 am. Vague history from the patient. Appeared to be very drowsy initially and stated that he has fell down from the stairs previous night. Could not recall events after that. Denies any chest pai, sob, or fever. Complained of cough in the morning since 6 months.

PMH:
1. Bipolar disorder
2. Depression

On admission chest and abdominal examinations were unremarkable with stable observations. Noted to have abrasion on the forehead with superficial wound on the right knee. Multiple abrasions on the hand and legs. Pinpoint pupils but reactive to the light. ECG noted as sinus rhythm. GCS- 14/15. No focal neurology.
CT head: Volume acquisition performed through the brain, non contrast enhanced.No significant focal intra or extra-axial abnormality has been identified. There is no evidence of acute intracranial haemorrhage.
CXR:The heart is not enlarged, mediastinal contours are within normal limits. Focal air space shadowing demonstrated at the right cardiophrenic angle, may represent focal infection. Follow-up film recommended in 4-6 weeks following treatment.
He was started on IV fluids and IV antibiotics. However he was keen to go home and self discharged him self against the medical advice. Tried to explain him regarding the chest infection and adverse effect. He has full capacity to make decisions and discharged him self on 21.09.15.

Treatments: None recorded.

Follow-up arranged: none

Planned Outpatient Investigations: none

Final Discharge letter to follow: Y

Medication Info:

Allergies: No Allergy

Height: cm **Weight:** kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment

Discontinued Medication:

Drug Name	Dose	UOM	Reason

Yours sincerely,
Dr Madusha Meemanage
Doctor

Prescription Review
Medications Reviewed by Pharmacist: ,
Dispensed Medications Checked by Pharmacy: ,
Nurse discharging patient: Madusha Meemanage, Doctor

CHI Number: 3112626230 Patient Name: McLachlan, Michael

Acute Services Division

Surgery and Anaesthetics Directorate

Department: Pre Op Assessment Unit

Specialty: Ear, Nose & Throat (ENT)

NHS Greater Glasgow and Clyde

Hospital Name	Glasgow Royal Infirmary

Patient Details		GP Details	
Name	McLachlan, Michael	Name	STODDART, DONALD
Address	2/2 5 Cambuskenneth Place C/o Cartwright Glasgow G33 5QF	Address	SHETTLESTON HEALTH CENTRE 420 OLD SHETTLESTON ROAD GLASGOW
Correspondance Address 1	,	Telephone	
Correspondance Postcode		CRN Number	30141837L, 3112626230, ZRV10290713
Telephone		Consent	Yes
Patient Contact Number	07884 204431	Sensitivity	Sensitive
CHI Number	3112626230	Consultant Name	MR HILMI
Sex	Male	Requires Transport	No
Date of Birth	31/12/1962	Religion	Roman Catholic

Next of Kin / Person to Notify	Next of Kin	Person to Notify
Name	CHEVONNE MCLACHLAN	
Address	15 TORPHIN WALK, CRAIGEND, GLASGOW	
Landline	07825 615008	
Mobile		
Relationship	DAUGHTER	

Assessment Details					
Assessor	LINDA GILLESPIE	Grade	5	Date	10/12/2013
Ward	GARTNAVAL SURGICAL ADMISSION UNIT TCI 16/12/13				

Surgery / Procedure Attending For
EXCISION OF LARGE SUBMANDIBULAR GLAND

Availability	
Are you available at short notice?	Yes
Period of unavailability	

CHI Number: 3112626230 Patient Name: McLachlan, Michael

Reasons for unavailability	
Details	

Anaesthetic History	
1. Previous GA	
Have you had a General Anaesthetic before?	Yes
Were there any problems?	No
2. Previous LA	
Have you had a Local Anaesthetic before?	Yes
Were there any problems?	No
3. Dentition Risk	
Do you have any loose teeth, caps or dentures?	Yes
Details	2 UPPER FRONT VENEERS
4. Reduced neck movement	
Do you have any neck or jaw stiffness?	No
5. Other Risk	
Has anybody in your family had a serious reaction to an anaesthetic?	No
6. Heartburn	
Do you suffer from heartburn or indigestion?	Yes
Is it relieved by medication?	Yes
Do you have a hiatus henia?	No
Do you have acid reflux?	No
How often does it occur?	weekly
7. Sickle Cell Disease (risk factor)	
Do you have sickle cell disease?	No
Are there risk factors for sickle cell disease?	No

Surgical History
8. Affects suitability for DSU or SDA

CHI Number: 3112626230 Patient Name: McLachlan, Michael

Have you ever had surgery?	Yes
Details of relevant surgical history	EXPLORATION OF SKIN WOUND 1986, SURGERY TO ULNAR NERVE 1996, PRIMARY REPAIR TO TENDONS 1996 & 1997, PRIMARY ARTHRODESIS 5TH JOINT LEFT HAND 1997
Will this affect the suitability for DSU?	No
Have you ever had a serious surgical or anaesthetic complication?	No

Cardiovascular	
9. Hypertension	
Do you have high blood pressure?	No

10. Arrhythmias						
Symptoms	Irregular heartbeat	No	Palpitations	No	Atrial Fibrillation	No
How often does it occur?						
Are they assosciated with exercise?						
Does it cause you to faint?						

11. Angina	
Do you suffer from Angina?	Yes
11a. Is your angina worsening?	No
11b. How often do you get angina?	Less Often
11c. What level of exertion causes angina?	Strenuous or rapid, prolonged exertion
11d. Have you had coronary artery stents inserted?	No

12. Heart Attack	
Have you had a heart attack?	Yes
Date of the attack(s)	?MI 2000
Date of last attack	

13. Heart Murmur	
Do you have a heart murmur?	No

14. Blackouts	
Do you suffer from blackouts?	No

CHI Number: 3112626230 Patient Name: McLachlan, Michael

15. Heart Failure	
Have you been diagnosed with heart failure?	No

Respiratory

16. Asthma/Bronchitis/COPD/Emphysema	
Do you have asthma, bronchitis, COPD, or emphysema?	No

17. URTI (Upper Respiratory Tract Infection)	
Have you recently had a cold?	No

Neurological

18. Stroke	
Have you had a stroke or TIA?	No

19. Epilepsy	
Do you have epilepsy?	No

20. Neurological Disease	
Do you have any neurological or muscular disease?	No

21. Physical Disability	
Do you have a physical disability?	No

Haemotological

22. Bleeding Disorder	
Do you suffer from prolonged bleeding or excessive bruising?	No

23. Previous DVT	
Have you had a DVT?	No

24. Anaemia	
Do you suffer from anaemia?	No

CHI Number: 3112626230 Patient Name: McLachlan, Michael

Miscellaneous	
25a. Document cause of kidney disease	PREVIOUS KIDNEY STONES
25b. Are you receiving dialysis?	No
25c. Does the patient have co-existing cardiac disease or poor exercise tolerance	No

26. Liver Disease	
Do you have liver disease or suffer from jaundice?	No

27. Diabetes	
Do you have diabetes?	No

28. Arthritis	
Do you have arthritis?	No

29. CJD	
Has the patient ever been notified that they are at increased risk of CJD or vCJD for public health purposes?	No

30. Other	
Do you have any serious physical / psychiatric illness or learning difficult not already mentioned?	No

Exercise Tolerance	
31. What best describes your level of fitness?	Climbs stairs without stopping

Social History		
32. How many units of alcohol each week?	15.00	units/week

33. Smoker	
Do you smoke?	Yes
How many each day?	20.00

CHI Number: 3112626230 Patient Name: McLachlan, Michael

34. Drug Abuse	
Do you currently or have you ever used intravenous or recreational drugs?	Yes
Details	PREVIUSLY SMOKED HERION
34a. Do you take methadone?	No

35. Pregnant	
LMP	
Are you pregnant?	No
Could you be pregnant?	No
Details	

36. Language	
Can the patient speak English?	Yes

Drug History
37. Drugs
List all drugs (including herbal remedies and complimentary medicines)
NONE

Does the patient take any of the following?	
Anticoagulants	No
Clopidogrel	No
Aspirin	No
OCP	No
Digoxin	No
Amiodarone	No
Lithium	No
Diuretics	No
MAOIs	No

38. Herbal Remedies	
Are you taking any herbal remedies or complimentary medicine?	No

39. Steroids	
Have you taken regular oral steroids in the last year?	No

CHI Number: 3112626230 Patient Name: McLachlan, Michael

40. Allergies	
Does patient have any allergies?	No

Implants	
41. Pacemaker	
Do you have a pacemaker?	No

42. Prosthesis	
Do you have any implants?	No

43. Coronary stents	
Have you had coronary artery stents inserted?	No

Examination			
44. Age (years)	50		
Weight (kg)	57		
Height (m)	1.71	BMI	19

45. Risk of sleep apnoea			
Do you suffer from daytime sleepiness, restless sleep or witnessed breath holding during sleep?	Yes		
How likely are you to fall asleep or doze in the following situations?			
a) Sitting and reading	Slight Chance		
b) Watching TV	No Chance		
c) Sitting inactive in a public place	No Chance		
d) As a passenger in a car for an hour without a break	No Chance		
e) Lying down to rest in the afternoon when circumstances permit	Slight Chance		
f) Sitting and talking to someone	No Chance		
g) Sitting quietly after lunch without alcohol	No Chance		
h) In a car while stopped for a few minutes in traffic	No Chance		
Status based on sleep apnoea score	No risk of sleep apnoea	Score	2

CHI Number: 3112626230 Patient Name: McLachlan, Michael

46. Blood Pressure			
Systolic/Diastolic BP	100	/	54

47. Pulse		
Pulse Rate	58	/ min
Rhythm		

48. Oxygen Saturation	96	%

49. Urine Analysis	
Result	
Details	

50. VTE Risk			
Is patient at risk of VTE?	Yes	Do they require prophylaxis?	Yes

Day Surgery Criteria	
51. Day Surgery Criteria	
Is the procedure suitable for day surgery?	No

52. Admission Criteria	
Appropriate admission based on nursing assessment	SDA

AHP USE ONLY: Is OT/Physio assessment required:	An OT/Physio assesssment is not required

53. MRSA Screening							
Does the Patient require a Clinical Risk Assessment? (for patients > 23 hours)							Yes
Has the patient ever had a previous positive MRSA result?							No
Has the patient been admitted from a care home/institutional setting or another hospital?							No
Does the patient have a wound/ulcer or invasive device which was present prior to admission?							No
Has patient is to be admitted to any of the following:							
Orthopaedics		Vascular		Renal		Critical Care	
MRSA Lab Test Results							
Nose		Perineum		Throat		Other	Patient refused

CHI Number: 3112626230 Patient Name: McLachlan, Michael

Other details	

Investigations Required

Investigation	Required	Ordered	Investigation Date	Med Staff Informed	Action Required	Re-Test Required
Ferritin	No	No		No	No	
Folate	No	No		No	No	
B12	No	No		No	No	
HbA1c	No	No		No	No	
Glucose	No	No		No	No	
Group & Save	No	No		No	No	
Cross Matching	No	No		No	No	
Thrombophilia Screen	No	No		No	No	
Sickle Dex Test	No	No		No	No	
Hb Electrophoresis	No	No		No	No	
TFT	No	No		No	No	
Lithium level	No	No		No	No	
Digoxin level	No	No		No	No	
Amylase	No	No		No	No	
FBC	Yes	Yes	10/12/2013	No	No	
Coagulation Screen	Yes	Yes	10/12/2013	No	No	
U&Es	Yes	Yes	10/12/2013	No	No	
LFTs	Yes	Yes	10/12/2013	No	No	
CRP	No	No		No	No	
Calcium/Bone	No	No		No	No	
ECG	Yes	Yes	10/12/2013	No	No	
ECHO	No	No		No	No	
PEFR	No	No		No	No	
PFT	No	No		No	No	
C-Spine X-Ray	No	No		No	No	
Chest X-Ray	No	No		No	No	
MRSA Screen	No	No		No	No	
Pregnancy Test	No	No		No	No	
Temperature	No	No		No	No	

Pre-op Assessment Summary

Assessor	LINDA GILLESPIE
Grade	5
Summary	

CHI Number: 3112626230 Patient Name: McLachlan, Michael

Patient is for admission under the care of Mr Hilmi of Excision of Large Submandibular Gland TCI 16/12/13 as a Same day admission

Vague Historian

?MI 2000 - Patient states that he was in Barlinnie at the time and there is no note of this on his GP referral. Given a GTN spray at this time which patient stated that he did use but once it ran out he never attended GP to have it renewed.

Angina - Patient state that he still gets chest pain every one to 2 weeks which he describes this as a sharp pain which lasts only seconds then resolves. He has never sought any further medical advice regarding this.

Previously Smoked Heroin - Nil for past year when he was prescribed Suboxone by the East CAT he took this for approximately 6 months when he stopped as he felt he did not need this any more. No current drug use.

Heartburn - Ranitidine prophylaxis given as per PGD 2013/1011

Borderline ECG - Sinus bradycardia, rSr(V1) - probable normal variant. ECG is available on clinical portal

Blood results are available on clinical portal

The above information was emailed to Dr Plenderleith on the 11/12/13 as I believe he is covering Mr Hilmi's theatre list on the 16/12/13

Referrals and Type of admission - Recommended Admission pathway		
Referral by Nurse to:	Anaesthetist	Yes
	Surgeon	No
	Haematologist	No
	Cardiologist	No
	GP	No
	Cardiac Technician Pace Reset	No
	Cardiac Technician Pace Check	No
Nurse to arrange the attendance of:	Carer	No
	Interpreter	No
Nurse to:	Inform ward staff regarding the risk of alcohol withdrawl	No
Referral by Anaesthetist to:	Surgeon	No
	Haematologist	No
	Cardiologist	No
	Cardiac Technician	No
	GP	No
Type of admission to be decided by:		
Type of Admission:	SDA	
Admission Deferred:	No	

CHI Number: 3112626230 Patient Name: McLachlan, Michael

Advise to take usual anti-reflux medication	No
Dispensed Ranitidine as per PGD directive	Yes
Refer to smoking cessation clinic	No
Advise not to take "intravenous or recreational drug(s)" during the 24 hours before surgery (related to 33. Drug Abuse)	No
Anticoagulant advice	No
Clopidogrel advice	No
Aspirin advice	No
OCP advice	No
Provide Herbal Medicine Advice	No
Arrange for dialysis the day before surgery	No
Ensure facilities for dispensing methadone are available, if the patient is taking methadone.	No
Print PEFR Advice Sheet	No
Print ECG Advice Sheet	No

Anaesthetist Assessment	
Anaesthetist	DR PLENDERLEITH
Grade	CONSULTANT
Summary	

From: Plenderleith, Louie
Sent: 11 December 2013 15:38
To: Gillespie, Linda
Subject: RE: AnaesthetistSummary[1].pdf - Adobe Reader

no that looks OK

Louie Plenderleith

CHI Number: 3112626230 Patient Name: McLachlan, Michael

Acute Services Division

Surgery and Anaesthetics Directorate

Department: Pre Op Assessment Unit

Specialty: Ear, Nose & Throat (ENT)

NHS Greater Glasgow and Clyde

Hospital Name	Glasgow Royal Infirmary

Patient Details		GP Details	
Name	McLachlan, Michael	Name	STODDART, DONALD
Address	2/2 5 Cambuskenneth Place C/o Cartwright Glasgow G33 5QF	Address	SHETTLESTON HEALTH CENTRE 420 OLD SHETTLESTON ROAD GLASGOW
Correspondance Address	,	Telephone	
Correspondance Postcode		CRN Number	30141837L, 3112626230, ZRV10290713
Telephone		Consent	Yes
Patient Contact Number	07884 204431	Sensitivity	Sensitive
CHI Number	3112626230	Consultant Name	MR HILMI
Sex	Male	Requires Transport	No
Date of Birth	31/12/1962	Religion	Roman Catholic

Next of Kin / Person to Notify	Next of Kin	Person to Notify
Name	CHEVONNE MCLACHLAN	
Address	15 TORPHIN WALK, CRAIGEND, GLASGOW	
Landline	07825 615008	
Mobile		
Relationship	DAUGHTER	

Assessment Details					
Assessor	LINDA GILLESPIE	Grade	5	Date	10/12/2013

Surgery / Procedure Attending For
EXCISION OF LARGE SUBMANDIBULAR GLAND

Short Notice Availability	Yes/No	Details
Available at short notice?	Yes	

CHI Number: 3112626230 Patient Name: McLachlan, Michael

Anaesthetic	Yes/No	Details/Problems
Previous GA	Yes	
Previous LA	Yes	
Detention Risk	Yes	2 UPPER FRONT VENEERS
Neck/Jaw Stiffness	No	
Other Risk	No	
Heartburn	Yes	Relieved by meds; Occurs: weekly
Sickle Cell Disease	No	Risk factors for sickle cell disease: No
Sleep Apnoea Score		2

Surgical History	Yes/No	Details/Problems
Affects suitability for DSU	No	
Relevent details of surgical history		EXPLORATION OF SKIN WOUND 1986, SURGERY TO ULNAR NERVE 1996, PRIMARY REPAIR TO TENDONS 1996 & 1997, PRIMARY ARTHRODESIS 5TH JOINT LEFT HAND 1997
Any serious surgical or anaesthetic complication	No	

Cardiovascular	Yes/No	Details/Problems
Hypertension	No	
Arrhythmias		
Angina	Yes	Frequency: Less Often; Caused by: Strenuous or rapid, prolonged exertion;
Heart Attack	Yes	Dates of attacks: ?MI 2000;
Murmur	No	
Blackouts	No	
Heart Failure	No	

Respiratory	Yes/No	Details/Problems
Asthma/Bronchitis/COPD/Emphysema	No	
URTI	No	

Neurological	Yes/No	Details/Problems
Stroke	No	
Epilepsy	No	
Neurological Disease	No	
Physical Disability	No	

Haematological	Yes/No	Details/Problems
Bleeding Disorder	No	
Previous DVT	No	

CHI Number: 3112626230 Patient Name: McLachlan, Michael

Anaemia	No

Miscellaneous	Yes/No	Details/Problems
Kidney disease	Yes	Caused by: PREVIOUS KIDNEY STONES;
Liver disease/jaundice	No	
Diabetes	No	
Arthritis	No	
CJD Risk	No	

Any serious illness not already mentioned?	No

Exercise Tolerance	Yes/No	Yes/No	Yes/No
Climbs stairs without stopping	Yes	Climbs stairs with stopping	No	Cannot climb stairs	No

Social	Yes/No				
Alcohol (units/week)		15			
Smoker	Yes	20 cigs/day			
Ex Smoker					
IV drug abuser	Yes	PREVIUSLY SMOKED HERION		Methadone Req:	No
Pregnant	No	LMP		Could Be Pregnant:	No

Drug History
List of all drugs (including herbal remedies and complimentary medicine)
NONE
Patient takes the following drugs

Taking herbal remedies or complimentary medicine	No
Oral Steroids in past year	No

Does patient have any allergies?	No

Prosthesis/Implants	Yes/No
Pacemaker	No
Implanting/follow up hospital	
Date of implant	
Reason for implant	
Other reason for implant	
Type of pacemaker/impantable defibrillator	

Device manufacturer	
Model No.	
Serial No.	
Further details	

Examination

Weight (kg)	57	Height (m)	1.71	BMI	19	Temp	
Pulse (bpm)	58	Regular		BP	100/54		
SaO2 (%)	96						

Investigations

The below investigations are required.

10/12/2013

FBC
Coagulation Screen
U&Es
LFTs
ECG

VTE Risk

Is patient at risk of VTE?	Yes	Do they require prophylaxis?	Yes

MRSA Screening

Does the Patient require a Clinical Risk Assessment?(for patients > 23 hours)	Yes
Has the patient ever had a previous positive MRSA result?	No
Has the patient been admitted from a care home/institutional setting or another hospital?	No
Does the patient have a wound/ulcer or invasive device which was present prior to admission?	No

Has patient is to be admitted to any of the following:

Orthopaedics	No	Vascular	No	Renal	No	Critical Care	No

MRSA Lab Test Results

Nose	No	Perineum	No	Throat	No	Other	No	Patient refused	No
Other details:									

Admission Criteria

Appropriate admission based on nursing assessment	SDA

CHI Number: 3112626230 Patient Name: McLachlan, Michael

AHP USE ONLY: Is OT/Physio assessment required:	An OT/Physio assesssment is not required

Pre-operative Assessment Summary

Assessor: LINDA GILLESPIE Grade: 5

Patient is for admission under the care of Mr Hilmi of Excision of Large Submandibular Gland TCI 16/12/13 as a Same day admission

Vague Historian

?MI 2000 - Patient states that he was in Barlinnie at the time and there is no note of this on his GP referral. Given a GTN spray at this time which patient stated that he did use but once it ran out he never attended GP to have it renewed.

Angina - Patient state that he still gets chest pain every one to 2 weeks which he describes this as a sharp pain which lasts only seconds then resolves. He has never sought any further medical advice regarding this.

Previously Smoked Heroin - Nil for past year when he was prescribed Suboxone by the East CAT he took this for approximately 6 months when he stopped as he felt he did not need this any more. No current drug use.

Heartburn - Ranitidine prophylaxis given as per PGD 2013/1011

Borderline ECG - Sinus bradycardia, rSr(V1) - probable normal variant. ECG is available on clinical portal

Blood results are available on clinical portal

The above information was emailed to Dr Plenderleith on the 11/12/13 as I believe he is covering Mr Hilmi's theatre list on the 16/12/13

Recommended Admission Pathway

Referral by nurse to:	Anaesthetist;
Nurse to arrange the attendance of:	
Nurse to:	
Referral by Anaesthetist to:	
Type of admission to be decided by:	
Type of Admission:	SDA
Admission Deferred:	No

Anaesthetic Assessment

Anaesthetist: DR PLENDERLEITH Grade: CONSULTANT

From: Plenderleith, Louie
Sent: 11 December 2013 15:38
To: Gillespie, Linda
Subject: RE: AnaesthetistSummary[1].pdf - Adobe Reader

no that looks OK

Louie Plenderleith

Acute Services Division

Diagnostics Directorate

Department of Pathology

Specialty: Ear, Nose & Throat (ENT)

NHS Greater Glasgow and Clyde

STA Form Release 1.1 RC 1.1

Hospital Name: Glasgow Royal Infirmary

Patient Details

Name:	Michael McLachlan
Address:	2/2 5 Cambuskenneth Place C/o Cartwright Glasgow
Postcode:	G33 5QF
Correspondence Address1	
Correspondence Address2	
Correspondence Postcode	
Telephone:	
CHI Number:	3112626230
CRN:	30141837L, 3112626230, ZRV10290713
D.O.B:	31/12/1962
Sex:	Male

GP Details

Name:	STODDART, DONALD
Address:	SHETTLESTON HEALTH CENTRE 420 OLD SHETTLESTON ROAD GLASGOW
Telephone:	
Consent:	Yes
Sensitivity:	Sensitive
Form Date:	10/12/2013

	Yes	No
1. Did you receive the patient leaflet "The Use of Surplus Tissue for Medical Research & Education"?		●
2. Does the patient require further information from the Bio Repository Nurses?		●
3. Do you agree that surplus tissue not essential for your diagnosis or future treatment may be used for medical, education and ethically approved medical research?		●

Withdrawl of Authorisation

Date of Withdrawl

Comments

If a patient withdraws authorisation please complete the date and any information relating to the reason for withdrawal in the comments field.

Acute Services Division

Surgery and Anaesthetics Directorate

Department of Pre Op Assessment Unit

Specialty: Ear, Nose & Throat (ENT)

NHS Greater Glasgow and Clyde

PreAdmission Form Release 1.0

Hospital Name: Glasgow Royal Infirmary

Patient Details		GP Details	
Name:	McLachlan, Michael	**Name:**	STODDART, DONALD
Address:	2/2 5 Cambuskenneth Place C/o Cartwright Glasgow	**Address:**	SHETTLESTON HEALTH CENTRE 420 OLD SHETTLESTON ROAD GLASGOW
Postcode:	G33 5QF	**Telephone:**	
Correspondence Address 1:		**Consent:**	Yes
Correspondence Address 2:		**Sensitivity:**	Sensitive
Correspondence Postcode:		**Consultant Name:**	MR HILMI
Telephone:		**Admission Date:**	16/12/2013
II Number:	3112626230	**Time:**	08:00:00
CRN:	30141837L, 3112626230, ZRV10290713	**Ward:**	GARTNAVAL SURGICAL ADMISSION UNIT
D.O.B:	31/12/1962	**Procedure/Operation:**	EXCISION OF LARGE SUBMANDIBULAR GLAND

Observations					
Temperature (celcius)		**Resps (per min)**		**Heart Rate (bpm)**	
Blood Pressure (mmHg)		**O2 Sats (%)**		**S/Mews Score**	
Changes Since POA?	*Yes*		*No*		

There are no allergies to display

Emergency Contact Numbers	
Name	
Relationship	
Phone	

Discharge	Yes	No
Estimated Date		
Transport Required		
Supervising Adult for Discharge		

ne Circumstances		Yes	No
Lives with Family Carer			
Lives Alone			
Elderly/Disabled Partner			
District Nurse	days/wks		
Home Help			
Other Services			

Medicines	Yes	No
Own Supplied		

Valuables	Yes	No
Valuables Returned		

MRSA		
Positive	**Negative**	**Unknown**

Activities of Daily Living	NOTE: NOT REQUIRED FOR DAY SURGERY
Safety and Comfort	
Breathing and circulation	
Maintaining Body Temp	
Personal Hygiene	
Elimination	
Sleep	
Mobility	
ng and drinking	
Skin Condition/Waterlow score	
Communication (including anxiety & fear) Aids worn?	
Date	Admitted By

Clinic Letter

NHS
Greater Glasgow and Clyde

Dr. DG Stoddart
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Main Switchboard: 0141 211 4000
Email Inquiries to:
Contact Tel Details: 0141 211 5539

Dictated Date: 12/11/2013
By: Mr Hilmi
Transcribed Date: 14/11/2013
By: Ann McNaughton

Dear Dr. DG Stoddart,

Patient

Name:	McLachlan Michael
CHI:	3112626230
DOB:	31 Dec 1962
Address:	2/2 5 Cambuskenneth Place Glasgow G33 5QF

Attendance

Attended:	12/11/2013 14:40
New/Return:	G R ENT
Referral Source:	General Practitioner
Consultant:	Mr Omar Hilmi
Specialty:	Ear, Nose & Throat (ENT)
Clinic:	GROHEN4-MR HILMI TUESDAY PM

Clinical Comments:

I saw Mr McLachlan in the ENT clinic today. He is getting ongoing problems with pain associated with his left submandibular gland. Having taken this on board he has decided to proceed with surgery in the form of removal of the gland itself. I have explained the risks of surgery to him today including the nature of scar, risk of bleeding, infection, ongoing pain and marginal mandibular nerve weakness in addition to hypoglossal and lingual nerve problems.
Yours sincerely

Mr Omar Hilmi
Consultant Otolaryngologist

Electronically Signed: Mr Omar Hilmi, Consultant

cc. Ann, ENT, GRI

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 20/08/2013

Consultant: Dr Ryan Connelly

DG Stoddart
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
Glasgow
G32 7JZ

Dear DG Stoddart

Re: **McLachlan Michael** DOB: **31/12/1962** CHI: **3112626230**
2/2 5 Cambuskenneth Place
Glasgow G33 5QF

Attended on: **20/08/2013 at 00:27 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
abcess?

Nursing Assessment:
patient has had a spot between his buttock cheeks and it is sore when his bowels move. it has been present for months but has got worse over the last 3 days and he has been unable to sleep due to the pain. has not taken analgesia

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Internal thrombosed haemorrhoids		

Procedures: **None**

Immunisations: **None**

Dispensed Medication:

Dispensed Medicine	Formulation	Dose	UOM	Route	Frequency	Duration
Co-amoxiclav 500/125 Tablets	**Tablets**	**0**	**TABS**	**Oral**	**No Frequency Defined**	**No duration defined**
Cocodamol 30/500 2 tabs QID PREPACKED ONLY	**Tablets (PP)**	**2**	**TABS**	**Oral**	**FOUR Times a Day**	**No duration defined**

Clinician Notes:
I would be grateful if you would consider prescribing anugesic cream or similar.

Followup : **none**
Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Jonathan Millar
Doctor

Copies to:
1. DG Stoddart (GP)

School Address:

CHI: 3112626230

Glasgow Royal Infirmary

CPR.

Total Att: 3

12 Mth Att: 0

Title: **MR**

MCLACHLAN **Michael**

DOB: **31/12/1962** Age: **50y** Sex: **Male**

2/2 5 Cambuskenneth Place
C/o Cartwright
Glasgow
G33 5QF
07884204431

Next of kin: **MCLACHLAN, CHEVONNE**
Relationship: **Daughter**
07884204431

GP: **DG Stoddart**
0141 531 6220

Attendance Date: **20/08/2013** Arrival Time: **00:27**

Registration Time: **00:27** Date of Incident: **20/08/2013**

Major Incident Desc:

Reason for Attendance: **abcess?**

Nursing Assessment

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

Triage Category: **5** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **20/08/2013 00:51** Nurse name: **Nurse Lesley Mann**

Temp	**36.7**	C
HR	**61**	bpm
BP	**142/78**	mmHg
MAP	**99.33**	mmHg
RR	**17**	bpm
SpO2	**98**	%
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: **patient has had a spot between his buttock cheeks and it is sore when his bowels move. it has been present for months but has got worse over the last 3 days and he has been unable to sleep due to the pain. has not taken analgesia**

20/8/13

0630

redyelet

nurse

SD

c/o 3-4/7

pen, itch and rash.

- fever, chills
- ↓/c.
- hx of sore throat

for 1 week

O/E Apyrexic.

- external swelling (skin change, discolouring) hip and right 3° chest.

1) Neonatal

Case Abx 5/7

Nodge

F/U ē GP.

4

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name MICHAEL MCGACHGAN
Address

CHI No. 3112626236
DoB

20/8/13

	Date	Ward
Admitted	20/8/13	ASE
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.

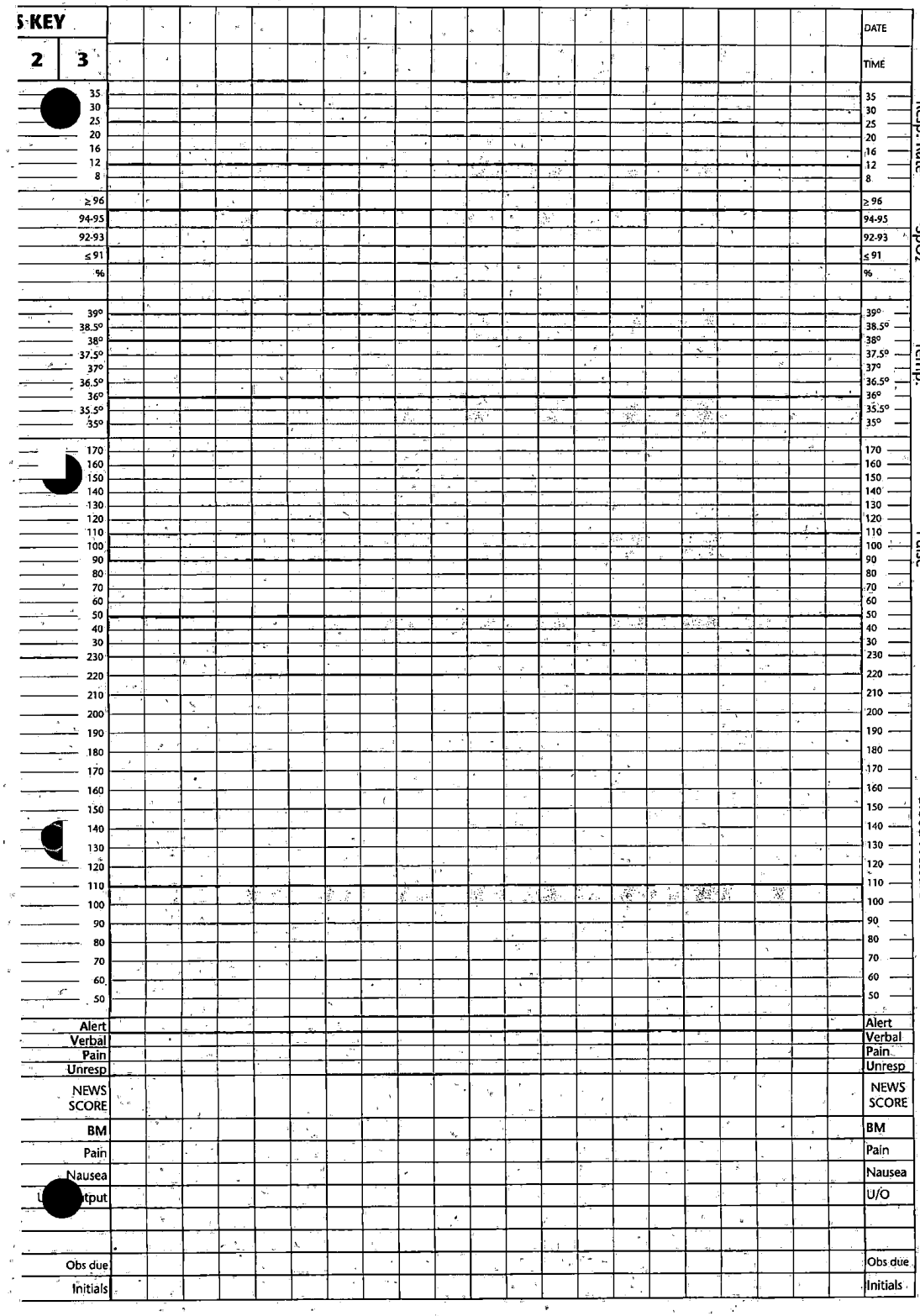
CPR MICHAEL MCLACHLAN

NEW

DATE: 20/8/13

TIME: 0051

| | | |


S KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
Blood Pressure
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Neurological Observations

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

Glasgow Coma Scale

Pupil size (mm)

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8

Pain Score

Ask the patient to rate his/her pain by choosing a number between 0 and 10. Use the diagram below to assist the patient. If patient's pain is chronic, use generic tool. If patient is unable to communicate, use observational tool.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Severe Pain			

Nausea and Vomiting	
0	= None
1	= Mild (*Not distressing – no retching/vomiting*)
2	= Moderate (*Troublesome – occasional retching/vomiting*)
3	= Severe (*Distressing – frequent retching/vomiting*)

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

CHI: 3112626230

Glasgow Royal Infirmary

CPR.

Total Att: 3

12 Mth Att: 0

Title: **MR**

MCLACHLAN **Michael**

DOB: **31/12/1962** Age: **50y** Sex: **Male**

2/2 5 Cambuskenneth Place
C/o Cartwright
Glasgow
G33 5QF
07884204431

Next of kin: **MCLACHLAN, CHEVONNE**
Relationship: **Daughter**
07884204431

GP: **DG Stoddart**
0141 531 6220

Attendance Date: **20/08/2013** Arrival Time: **00:27**

Registration Time: **00:27** Date of Incident: **20/08/2013**

Major Incident Desc:

Reason for Attendance: **abcess?**

Nursing Assessment

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

Triage Category: **5** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **20/08/2013 00:51** Nurse name: **Nurse Lesley Mann**

Temp	**36.7**	C
HR	**61**	bpm
BP	**142/78**	mmHg
MAP	**99.33**	mmHg
RR	**17**	bpm
SpO2	**98**	%
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: **patient has had a spot between his buttock cheeks and it is sore when his bowels move. it has been present for months but has got worse over the last 3 days and he has been unable to sleep due to the pain. has not taken analgesia**

20/8/13

0630

weight 53 kg

c/o 3-4/7

pen, itch and rash

- fever
- h/c
- hx of sex

for 1 week

O/E Afebrile

- external scabies (skin changes indicating rash and itch c/w scabies)

1) Neonatal

Case Hx 5/7

Delay

F/U in GP.

(4)

Clinic Letter

NHS
Greater Glasgow and Clyde

Dr. DG Stoddart
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G32 7JZ

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Main Switchboard: 0141 211 4000
Email Inquiries to:
Contact Tel Details:

Dictated Date: 06/08/2013
By: O Hilmi
Transcribed Date: 13/08/2013
By: Anne McKay1

Dear Dr. DG Stoddart,

Patient

Name:	McLachlan Michael
CHI:	3112626230
DOB:	31 Dec 1962
Address:	2/2 5 Cambuskenneth Place Glasgow G33 5QF

Attendance

Attended:	06/08/2013 14:00
New/Return:	G R ENT
Referral Source:	General Practitioner
Consultant:	Mr Omar Hilmi
Specialty:	Ear, Nose & Throat (ENT)
Clinic:	GROHEN4-MR HILMI TUESDAY PM

Clinical Comments:

I saw Mr McLachlan in the ENT Clinic today. The CT scan shows what would appear to be simply a stenosis of the submandibular duct on the left hand side causing enlargement of the gland itself. There is certainly no evidence of any worrying features and nothing to be found intra-orally. He himself reports that he is asymptomatic from this and in this situation I think we can simply keep an eye on things.

I will see him back in three months time to decide what if any further intervention is required.

Yours sincerely

O Hilmi
ENT Consultant

Electronically Signed: Mr Omar Hilmi, Consultant

cc.

North Glasgow Neck Lump Clinic
Glasgow Royal Infirmary
16 Alexandra Parade
GLASGOW
G31 2ER
Fax No: 0141 211 1211

DEPARTMENT OF OTOLARYNGOLOGY AND HEAD AND NECK SURGERY

Consultants

Mr S Robertson	0141 211 1659
Mr K MacKenzie	0141 211 0484
Mr G W McGarry	0141 211 4423
Mr O J Hilmi	0141 211 1661

Dr Stoddart, Donald
Shettleston Health Centre
420 Old Shettleston Road
Glasgow
G 32 7JZ

27/06/2013

Dear Doctor

Michael Mclachlan. Date of Birth 31/12/1962 CHI 3112626230 Post Code G33 5PF

Attended the North Glasgow Neck Lump Clinic today with a 0 week history

of a lump in the Neck

Examination of the Oral cavity showed no abnormality

Examination of the larynx and pharynx showed Not Performed

Neck Examination Revealed Left sided single mass

clinical impression:- No Abnormality

An Ultrasound Scan was organised :- Dilated Sm Duct

For CT To Define cause of submandibular duct dilatation. OPD thereafter

Outcome: Follow up opd - Mr Hilmi

Yours sincerely

Mr Omar Hilmi
Consultant Otolaryngologist

The above results represent clinical +/- Ultrasound findings only, where a biopsy has been taken the result will be given at the follow up clinic

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

ENT - Head, Neck and Throat GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Glasgow Royal Infirmary 84 Castle Street Glasgow G4 0SF	——	**Hospital** and **hospital address** Hospital location code. G107H Email address -

Urgency of referral URGENT - SUSPECTED CANCER
Date of referral 12-Jun-2013 **Date sent** 12-Jun-2013

PATIENT DETAILS

Surname	MCLACHLAN
Forename(s)	MICHAEL
Title	MR
Sex	Male
Date of birth	31-Dec-1962
CHI no.	3112626230
Area of Residence	-

Patient's address

CO HUTTON FLAT 1-1
14 MOSSFIELD WALK
CRAIGEND
GLASGOW
G33 5PF

Contact number(s)

Voice: 07884204431

101005495096C | Unique Care Pathway Number: 101005495096C

REGISTERED GP DETAILS

Name	Dr Donald Stoddart		
GMC code	2547947	GP code	02470
Practice name	Shettleston Health Centre		
Practice code	46081		

Practice address

420 OLD SHETTLESTON ROAD
SHETTLESTON
GLASGOW
G32 7JZ

Contact number(s)

Voice: 01415316220

REFERRING GP DETAILS

Name	Dr Katie Gallacher		
GMC code	6105649	GP code	-
Practice name	-		
Practice code	46081		

Practice address

Contact number(s)

-

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: lump in neck!

Comment: This man has a lump which feels like an enlarged lymph node on the left side of his neck in the anterior triangle. The lump is firm and non tender. It has now been present 3 months. There is no obvious source of infection. I would be grateful for your urgent assessment.

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Modifier	Date of onset	Date recorded
[X]Heroin addiction	, Medical IP, GRI	First ever	28-Jul-2006	28-Jul-2006
Benzodiazepine dependence	, Medical IP, GRI	First ever	28-Jul-2006	28-Jul-2006
Drug dependence NOS	acute psychotic episode	First ever	28-Jul-2006	28-Jul-2006
Drug dependence	relapse, Heroin, Cocaine, Diazepam	First ever	26-Jun-2002	26-Jun-2002
Deliberate self-harm	Diazepam overdose	First ever	09-May-2002	09-May-2002
Smoke inhalation	-	First ever	02-Apr-2002	02-Apr-2002
Cubital tunnel syndrome	Left medial epicondylectomy	First ever	04-Nov-1997	04-Nov-1997
Compartment syndrome	-	First ever	09-Mar-1997	09-Mar-1997
[X]Assault	-	First ever	17-Sep-1996	17-Sep-1996
[X]Assault	-	First ever	14-Feb-1987	14-Feb-1987
[X]Assault by sharp object	chest	First ever	11-Jul-1986	11-Jul-1986

Past procedures (High and medium priority - all)

Description	Comment	Modifier	Date performed	Date recorded
Drug addiction therapy	Suboxone treatment patient defaulted, EAST CAT	-	06-Sep-2012	06-Sep-2012
Drug addictn therap-methadone	, Addiction Services, Parkhead Hospital	First ever	17-Oct-2006	17-Oct-2006
Primary arthrodesis of joint NEC	5th PIP joint	First ever	18-Mar-1997	18-Mar-1997
Primary repair of tendon	-	First ever	02-Jan-1997	02-Jan-1997
Primary repair of tendon	-	First ever	19-Oct-1996	19-Oct-1996
[SO]Ulnar nerve - hand	divisions	First ever	07-Mar-1996	07-Mar-1996
Exploration of skin wound NEC	and repair of machete wound	First ever	09-Mar-1986	09-Mar-1986

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Hydroxyzine 25mg tablets	14	tablet	ONE AT NIGHT	-	09-May-2013	09-May-2013
Zopiclone 7.5mg tablets	5	tablet	1 TABLET AT NIGHT	-	01-May-2013	01-May-2013

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Cigarette smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 15.	10-May-2011
Cigarette smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 20.	28-Jan-2010

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:No

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

Acute Services Division

NHS Greater Glasgow and Clyde

WEST OF SCOTLAND PANCREATICO-BILIARY UNIT

GLASGOW ROYAL INFIRMARY
Alexandra Parade
Glasgow
G31 2ER

Consultants	Secretaries	Contact Details:
Mr C R Carter	Alana Hendry	0141 211 5129
Mr C J McKay	Tricia Tullan	0141 800 1977
Mr E J Dickson	Helen Falconer	0141 211 1168
		Fax: 0141 232 0701

Clinical Nurse Specialists	Contact Details:
Elspeth Cowan & Linda Dewar	0141 211 6835

Dictated: 08/08/2012
Typed: 10/08/2012
Our Ref: CJMCK/PVT

Dr Donald Stoddart
The Cairns Practice
Shettleston Health Centre
420 Old Shettleston Road
Glasgow G32 7JZ

Dear Dr Stoddart

Michael McLachlan – 31/12/1962 – CHI: 3112626230 – CRN: 30141837L
15 Torphin Walk, Glasgow, G32 6QQ

You had referred this patient to us with bile duct dilatation identified on ultrasound, carried out for abdominal pain. A CT scan was arranged which confirmed bile duct dilatation and raised suspicion of a small pancreatic head lesion.

On EUS today however, his pancreas was completely normal, the bile duct was not significantly dilated and I am happy to reassure him that there is nothing going that requires investigation from a pancreatico-biliary point of view.

Yours sincerely

Mr C J McKay
Consultant Surgeon
Lead Clinician Scottish Pancreatic & Hepatico-Biliary Cancer Network

Dictated but not signed by Mr CJ McKay

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

NHS
Greater Glasgow and Clyde

Dr DONALD STODDART
THE CAIRNS PRACTICE
SHETTLESTON HEALTH CENTRE 420 OLD SHETTLESTON ROAD GLASGOW
G32 7JZ

Date: 20 Jul 2012

Dear Dr DONALD STODDART,

Re: MICHAEL MCLACHLAN, 15 TORPHIN WALK, GLASGOW, G32 6QQ
ate of Birth: 31/12/1962 CHI number: 3112626230

Your patient attended Glasgow Royal Infirmary on the 20 Jul 2012.

The presenting complaint was:	**LEFT LEG INJURY**
Triage information:	**Not recorded**
The following investigations were carried out:	**None**
The A&E diagnosis was:	**** INJURY- NOT ASSAULT** - LACERATION - LOWER LIMB LEFT - THIGH**
The following treatment was given:	**None**
At the conclusion of treatment the patient was:	**DISCHARGED TO GP-NO REVIEW/ATTENDANCE ADVISED**
Follow-up:	**NO FOLLOW UP REQUIRED BY GP**
Additional information:	**Patient attended as requested by yourselves for scrubbing and closing of wounds. Lacerations scrubbed and closed with glue and steristrips. advised to remove steristrips in five days.**

Yours sincerely,

AGNES LANG
EMERGENCY NURSE PRACTITIONER

Accident and Emergency Department
Glasgow Royal Infirmary

30141837L

A&E No. 12000049006

Surname	MCLACHLAN	**Forename**	MICHAEL	**Title:** MR
Address:	15 TORPHIN WALK	**Postcode**	G32 6QQ	**CHI No:**3112626230
	GLASGOW	**Telephone:**	07884204431	
Date of Birth:	31.12.62	**Sex:**	M	**Age:** 49 yrs

CHI Number: 3112626230

GP Name:	STODDART DONALD		
Address:	THE CAIRNS PRACTICE SHETTLESTON HEALTH... 420 OLD SHETTLESTON ... GLASGOW	**Postcode** **Telephone:**	G32 7JZ 0141 531 6220

Next of Kin	CHEVONNE MCLACHLAN		
Relationship:	DAUGHTER		
Address:	15 TORPHIN WALK	**Postcode**	G32 6QQ
	GLASGOW	**Telephone:**	07884204431
Primary Carer:			

Date of Attendance: 20.07.12 13:28
Date of Incident:
Presenting Complaint: LEFT LEG INJURY

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

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PH- 49 yr old male council worker cut to leg with garden implement sent to A+E by G.P.

O/E- left upper leg
- superficial lacerations x 2. to lower thigh
- No bleeding or sensation loss
- A+E - 2 hrs ago.
- Tetby will be due

Allergies- none known

Plan- wounds debrided & glued + steristrips applied.
Dressing to wound.

A.L Smith.

© iSOFT Group Limited

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

General Surgery-Pancreatic/Biliary GGC General Referral		**Consultant / receiving practitioner** and/or **specialty clinic**
Glasgow Royal Infirmary 84 Castle Street Glasgow G4 0SF		**Hospital** and **hospital address** Hospital location code. G107H Email address

Urgency of referral URGENT - SUSPECTED CANCER
Date of referral 19-Jun-2012 **Date sent** 19-Jun-2012

PATIENT DETAILS

Surname	MCLACHLAN
Forename(s)	MICHAEL
Title	MR
Sex	Male
Date of birth	31-Dec-1962
CHI no.	3112626230
Area of Residence	-

Patient's address

15 TORPHIN WALK
GREENFIELD
GLASGOW
G32 6QQ

Contact number(s)

Voice: 07881578645

101003789156D

Unique Care Pathway Number: 101003789156D

REGISTERED GP DETAILS

Name	Dr Donald Stoddart		
GMC code	2547947	GP code	02470
Practice name	Shettleston Health Centre		
Practice code	46081		

Practice address

420 OLD SHETTLESTON ROAD
SHETTLESTON
GLASGOW
G32 7JZ

Contact number(s)

Voice: 01415316220

REFERRING GP DETAILS

Name	Dr M Matcha		
GMC code	6094523	GP code	87009
Practice name	-		
Practice code	46081		

Practice address

Contact number(s)

-

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: Abdo pain with US e/o distended pancreatic duct.

Comment: Dear Doctor,

I would be gratfeul for your kind review of the above mentioned gentleman who presented with h/o abdominal pain- central since the past few weeks and associated with radiation to the back, anorexia and weight loss.
Blood tests revealed normal LFT's. US abdomen revelaed distension of pancreatic duct and mild distension of CBD with recommendations for further investigations to rule out pancreatic amupullary lesion.

Thanking you
Kind Regards

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Modifier	Date of onset	Date recorded
Drug dependence NOS	acute psychotic episode	First ever	28-Jul-2006	28-Jul-2006
Benzodiazepine dependence	, Medical IP, GRI	First ever	28-Jul-2006	28-Jul-2006
[X]Heroin addiction	, Medical IP, GRI	First ever	28-Jul-2006	28-Jul-2006
Drug dependence	relapse, Heroin, Cocaine, Diazepam	First ever	26-Jun-2002	26-Jun-2002
Deliberate self-harm	Diazepam overdose	First ever	09-May-2002	09-May-2002
Smoke inhalation	-	First ever	02-Apr-2002	02-Apr-2002
Cubital tunnel syndrome	Left medial epicondylectomy	First ever	04-Nov-1997	04-Nov-1997
Compartment syndrome	-	First ever	09-Mar-1997	09-Mar-1997
[X]Assault	-	First ever	17-Sep-1996	17-Sep-1996
[X]Assault	-	First ever	14-Feb-1987	14-Feb-1987
[X]Assault by sharp object	chest	First ever	11-Jul-1986	11-Jul-1986

Past procedures (High and medium priority - all)

Description	Comment	Modifier	Date performed	Date recorded
Drug addictn therap-methadone	, Addiction Services, Parkhead Hospital	First ever	17-Oct-2006	17-Oct-2006
Primary arthrodesis of joint NEC	5th PIP joint	First ever	18-Mar-1997	18-Mar-1997
Primary repair of tendon	-	First ever	02-Jan-1997	02-Jan-1997
Primary repair of tendon	-	First ever	19-Oct-1996	19-Oct-1996
[SO]Ulnar nerve - hand	divisions	First ever	07-Mar-1996	07-Mar-1996
Exploration of skin wound NEC	and repair of machete wound	First ever	09-Mar-1986	09-Mar-1986

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
PremierPore dressing adh border 5cm x 7cm [SHERMOND]	50	dressing	AS DIRECTED	-	14-Feb-2012	17-Feb-2012

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
CO-CODAMOL (codeine & paracetamol) tabs 8mg 500mg	100	tab	TWO UP TO FOUR TIMES A DAY WH [more]	-	16-Mar-2012	16-Mar-2012
FLUCLOXACILLIN caps 500mg	20	capsule	ONE FOUR TIMES A DAY THIS IS [more]	-	16-Mar-2012	16-Mar-2012
	55	dressing	AS DIRECTED	-	21-Feb-2012	

Mepor absorbe perforat dressing a bord 7cm x 8cm [MOLNLYCKE]						21-Feb-2012
PremierPore dressing adh border 5cm x 7cm [SHERMOND]	50	dressing	AS DIRECTED	-	14-Feb-2012	14-Feb-2012
IBUPROFEN tabs 400mg	100	tablet	ONE TABLET(S) THREE TIMES DAI [more]	-	10-Feb-2012	10-Feb-2012
CO-CODAMOL (codeine & paracetamol) tabs 8mg 500mg	100	tab	TWO UP TO FOUR TIMES A DAY WH [more]	-	10-Feb-2012	10-Feb-2012

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Cigarette smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 15.	10-May-2011
Cigarette smoker:	Smoking status on date of event: Smoker, Number of cigarettes smoked per day: 20.	28-Jan-2010

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:No

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

Mr R Crawford
Mr A J Ireland
Dr S Taylor
Dr M Sheridan
Dr N Dignon
Dr T Kelliher
Dr C Fitzpatrick
Dr J Devine
Dr J Burns

Emergency Department
Glasgow Royal Infirmary
84 Castle Street
GLASGOW
G4 0SF

Tel: 0141 211 4000
Fax: 0141 211 5007

DISCHARGE SUMMARY

Date Typed: 17/05/2011
Our Ref: TK.MB

Enquiries to Emergency Department Secretary

Direct Dial: 0141 211 5166/4294
Email: Nadine.robertson@ggc.scot.nhs.uk
Michelle.blomerus@ggc.scot.nhs.uk

Dr Samantha Ross
Shettleston Health Centre
420 Old Shettleston Road
G32 7JZ

Dear Dr Ross

Michael McLachlan - 31/12/1962 - CHI: 3112626230
15 Torphin Walk, Glasgow, G32 6QQ

Admitted: 16.05.11
Discharged: 16.05.11

Mr McLachlan was admitted for observation following a head injury in which he was struck over the right eyebrow. He sustained an incised wound measuring approximately 3-4cm in length which required 3 sutures for closure. He had consumed quite a large amount of alcohol and although he had not lost consciousness he was a little confused and unsteady. He was admitted briefly to ward 46 where he rapidly improved and was fit for discharged. No review is planned and we would obliged if the sutures could be removed in five days time.

Thank you,

Yours sincerely

Dr Tadhg Kelliher
Consultant in Emergency Medicine

HOSPITAL INFORMATION MISSING



Dr SAMANTHA ROSS
SHETTLESTON HEALTH CENTRE
420 OLD SHETTLESTON ROAD GLASGOW

G32 7JZ

Date : 16 May 2011

Dear Dr SAMANTHA ROSS,

Re: MICHAEL MCLACHLAN, 15 TORPHIN WALK, GLASGOW, G32 6QQ
Date of Birth: 31/12/1962 CHI number: 3112626230

HOSPITAL INFORMATION MISSING Patient attended on the 16 May 2011.

The presenting complaint was: **HEAD INJURY**

Triage information: **PT APPROACHED PERSON CLAIMING TO BE ASSAULTED EARLIER TONIGHT. APPROX 2 INCH LAC ABOVE RIGHT EYE. ? LOC. NOW STATES CANNOT REMEMBER WHAT HAPPENED. REMEMBERS LEAVING BAR AT MIDNIGHT BUT NO RECOLLECTION OF EVENTS AFTER THIS. APPEARS INTOXICATED. PERL 2+. ADMITS ALCOHOL BUT NOT DRUGS**

The following investigations were carried out: **None**

The A&E diagnosis was: **** INJURY- NOT ASSAULT** - HEAD AND FACE TRAUMA - MINOR HEAD INJURY**

The following treatment was given:	**None**
At the conclusion of treatment the patient was:	**ADMITTED**
Follow-up:	**ADMITTED**
Additional information:	**Head injury - laceration R forehead closed with 3 sutures, appears intoxicated and unable to give hx of events. Admitted to ward 46 for observation.**

Yours sincerely,

ANNA CROW

EMERGENCY DEPT LOCUM DOCTOR

FINAL DISCHARGE LETTER

Glasgow Royal Infirmary **84 Castle Street, Glasgow G4 0SF** **0141 211 4405**

Ward 43

Consultants: Dr Paterson

Dr Samantha Ross
Shettleston Health Centre
420 Old Shettleston Road
G32 7JZ

Michael McLachlan – 30141837L
H M Prison, Barlinnie Prison
81 Lee Avenue
Glasgow
G33 2QX

CHI: 3112626230
DOB: 31/12/1962

Admitted: 29/07/2008
Discharged: 30/07/2008
Transferred:
Follow up:

Main Diagnoses:

1. Chest pain – Troponin negative

Previous/inactive Diagnoses:

Presenting complaint: chest pain

Examination: nil focal

Diagnostic tests/ procedures and relevant results:

ECG – sinus rhythm, high take off V2-V3
Troponin <0.04
ETT – no ECG changes

Progress: no further pain

Results awaited/ further action:

Medication on discharge (changes in bold):

nil

Date: 31/07/2008 **Signed:** Dr Simpson **Position:** ST1

Previous Patient Notes for Accident & Emergency (newest at the top).

Note: Specialty search returns patient notes from 13th November 2018 onwards. Patient notes older than that date, tagged Historical Notes, that don't have a specialty assigned can only be viewed within the Patient Notes section in the Clinical Documents tree.

Patient Note		**Other**
Date/Time: 21-Jul-2023 16:16	**Created By:** Staff Nurse - Ruby Baxter	**Role:** Nurse - GGC
Specialty: Accident & Emergency	**Organisation:**	Sensitive
Note: CEPHEID NEG		

Patient Note		**Other**
Date/Time: 29-Jun-2022 22:10	**Created By:** staff nurse - Jodie Cullen	**Role:**
Specialty: Accident & Emergency	**Organisation:**	Sensitive
Note: ** CEPHEID POCT -VE **		

Previous Patient Notes for General Surgery (newest at the top).

Note: Specialty search returns patient notes from 13th November 2018 onwards. Patient notes older than that date, tagged Historical Notes, that don't have a specialty assigned can only be viewed within the Patient Notes section in the Clinical Documents tree.

Patient Note		**MDT Note**
Date/Time: 09-Feb-2023 10:12	**Created By:** Venla Kantola ST6 General Surgery - 7495663	**Role:**
Specialty: General Surgery	**Organisation:**	Sensitive

Note:

HPB MDT 9/2/23

Deranged LFTs in September, dilated CBD on MRCP. EUS - no ampullary mass, normal ampulla. FNB for completeness.
Appearances felt to represent chronic pancreatitis with calcifications.
FNB - no concerning features.
LFTs now normal.

Plan:
Review in OP clinic to discuss lap chole- (possibly passed small stone as cause of intermittent LFT derangement)

Patient Note		**Remote Consultation**
Date/Time: 11-Jan-2023 13:15	**Created By:** Consultant Surgeon - Maria Coats	**Role:** Doctor - GGC
Specialty: General Surgery	**Organisation:**	Sensitive

Note:

HPB vetting
double duct on MRCP Nov 2022. previously deranged LFTs (transaminases only in July - now normal (October)
Plan: ERCP and side viewer to visualise ampulla, virtual clinic to discuss with patient first

Patient Note		**Outpatient Note**
Date/Time: 21-Dec-2022 12:10	**Created By:** Consultant - Euan Dickson	**Role:** Doctor - GGC
Specialty: General Surgery	**Organisation:**	Sensitive

Note:

VET
Ref from resp noted
Double duct
Last LFT normal
PLAN
1. EUS SOON - next 2-3/52

2. Note comorbidity may limit options
3. Then Panc MDM

Patient Note		**Outpatient Note**
Date/Time: 07-Aug-2020 09:45	**Created By:** Staff Nurse SATA - Louise Gallacher1	**Role:** Nurse - GGC
Specialty: General Surgery	**Organisation:**	Sensitive
Note: covid test carried out		

Previous Patient Notes for Acute Specialties GGC (newest at the top).

Note: Specialty search returns patient notes from 13th November 2018 onwards. Patient notes older than that date, tagged Historical Notes, that don't have a specialty assigned can only be viewed within the Patient Notes section in the Clinical Documents tree.

Patient Note		**Inpatient Note**
Date/Time: 02-Feb-2023 20:45	**Created By:** Staff Nurse - Emily McDougall	**Role:** Nurse - GGC
Specialty: Acute Specialties GGC	**Organisation:**	Sensitive
Note: CEPHEID NEGATIVE		

Patient Note		**Outpatient Note**
Date/Time: 01-Feb-2023 15:14	**Created By:** **Upper GI CNS GRI General Surgery - Sarah Watt	**Role:** Nurse - GGC
Specialty: Acute Specialties GGC	**Organisation:**	Sensitive

Note:

CNS review post EUS
Met with Michael and his partner following EUS and FNB ampulla- no evidence of peri ampullary mass, likely CP and microcalcs.
Hx revisited;
-deranged LFT's
-weight loss
-CTCAP- DCBD
-MRCP- dilated CBD and PD
- for EUS to assess ampulla region
Feels well at this time.
Experiencing some upper backpain (scapula)- recent admission with ? pneumonia
Decreased appetite over 3-4 months (was 9.5 stone, is now 7 stone post pneumonia but weight has stabilised and he states he is eating more).
Bowels normal, voiding urine (slow to start then stop start urination and dribbles).
I have advised that he seek advice and review from GP re urinary symptoms and also upper back pain ? examine chest.
They will contact GP for appointment.
Aware that his eus path and imaging will be discussed at HPB MDT likely 9.2.23 if path is available.
Aware if we do not contact him on 09.02.23 then his case will be discussed the following week 16.02.23.
CNS contact details given should he require any further information or assistance.

Patient Note		**Other**
Date/Time: 15-Dec-2021 14:55	**Created By:** Addictions Nurse, East End Addiction Service - Brenda Hay	**Role:** Nurse - GGC
Specialty: Acute Specialties GGC	**Organisation:**	Sensitive

Note:

Patient is prescribed Buvidal Injection (prolonged release Buprenorphine Depot) Not to be prescribed oral opioid replacement treatment until further notice

Previous Patient Notes for Respiratory Medicine (newest at the top).

Note: Specialty search returns patient notes from 13th November 2018 onwards. Patient notes older than that date, tagged Historical Notes, that don't have a specialty assigned can only be viewed within the Patient Notes section in the Clinical Documents tree.

Patient Note EXTENDED		**Outpatient Note**
Date/Time: 31-Oct-2022 14:38	**Created By:** Consultant in Respiratory Medicine - Brian Choo-Kang	**Role:** Doctor - GGC
Specialty: Respiratory Medicine	**Organisation:**	Sensitive

Note:

1. Weight loss
2. Ex smoker
3. Breathlessness
4. Substance misuse

CT 09/11
Recent LLL consolidation - resolved
Spiro awaited (no appt date, requested as Routine)

Vit D insufficient
Asp IgG/E ok.; total IgE 2046
BBV screen ok, HbA1c ok

No micro
Hasn't received CT appt yet

So so
Night time - pain L side of back, Shoulder blade
Breathing - bad ; for a couple years; SOB within the house.
Has a lot of support from daughters
Weight up to 8 12 (was 7 in ward)
Eating a bit better

Chest - flat swelling medial to L scapula

Plan
CT
Spiro
Vit D - ask GP to prescribe
Away Dec 23/12

Previous Patient Notes for Urology (newest at the top).

Note: Specialty search returns patient notes from 13th November 2018 onwards. Patient notes older than that date, tagged Historical Notes, that don't have a specialty assigned can only be viewed within the Patient Notes section in the Clinical Documents tree.

Patient Note		**Outpatient Note**
Date/Time: 13-May-2022 10:11	**Created By:** Urology Clinical Nurse Specialist - Margaret O'connor	**Role:** Nurse - GGC
Specialty: Urology	**Organisation:**	Sensitive
Note:		
No Day time l u t s now has nocturia has stopped drinking fizzy juice and now drinks 2 glasses of diluting juice per day fluid advice given.		

FNB OF AMPULLA OF VATER

Performed	01-Feb-2023 10:32	Received	01-Feb-2023 16:27
Reported	07-Feb-2023 15:57	Order Number	F,23.0000516.T
Status	Final	Source System	Telepath

Pathology Final

NHS GREATER GLASGOW AND CLYDE
PATHOLOGY DEPARTMENT ENQUIRIES TO: 0141-354-9487 (89487)

Date collected: 01.02.2023
Date received : 01.02.2023 Date reported: 07.02.2023

Reporting Pathologist : Fraser Duthie
Consultant Pathologist: Fraser Duthie

FNB OF AMPULLA OF VATER.

CLINICAL HISTORY

Dilated CBD and PD.

MACRO

This specimen is received in PreservCyt. A cell block has been prepared from this subsequently, containing any naturally formed clots or microbiopsies. This cell block has been processed as specimen B.

MICROSCOPY

This virtually acellular specimen contains only scanty benign biliary epithelial cells, and is not diagnostic.

Dr Fraser Duthie, Consultant

Report generated: 07/02/23
Authorised: 07/02/23 by Dr F Duthie

Submandibullar Gland

Performed	21-Feb-2014 12:00	Received	24-Feb-2014 12:21
Reported	13-Mar-2014 15:39	Order Number	D,14.0014011.Y
Status	Final	Source System	Telepath

Pathology Final

NHS GREATER GLASGOW AND CLYDE
PATHOLOGY DEPARTMENT ENQUIRIES TO: 0141-354-9487 (89487)

Date collected: 21.02.2014
Date received : 24.02.2014 Date reported: 13.03.2014

Reporting Pathologist : Douglas McLellan
Consultant Pathologist: Douglas McLellan

LEFT SUBMANDIBULAR GLAND

CLINICAL HISTORY:
Chronic stenosis. Excision of left submandibular gland. ?Normal.

MACRO:
An irregular submandibular gland 24 x 20 x 11mm. There is no obvious abnormality on section.

MICROSCOPY:
Sections show submandibular gland. There is ductal sclerosis with focal squamous metaplasia. Within duct lumina there is some proteinaceous exudate together with inflammatory cells. There is generalised parenchymal atrophy associated with a mild lympho-plasmacytic chronic inflammatory cell infiltrate. The appearances are essentially of atrophy and chronic inflammation in keeping with ductal stenosis. The possibility of IgG4 disease was considered, but is excluded on immunocytochemical staining.

Dr Douglas McLellan, Consultant

Dictated: 13/3/14
Typed: 13/03/14 JMcC

Electronically authorised by Douglas McLellan.

McLachlan, Michael ID:3112626230 31-MAR-2026 23:25:40 GREATER GLASGOW SITE-GRAE ROUTINE RECORD

31-DEC-1962 (63 yr)
Male Unknown

Room:
Loc:201

Vent. rate	63	BPM	Normal sinus rhythm
PR interval	154	ms	Normal ECG
QRS duration	90	ms	
QT/QTc	400/409	ms	
P-R-T axes	81 88	72	

Technician: ld
Test ind:lf

Location: Comments: Referred by: Lld Unconfirmed



25mm/s 10mm/mV 150Hz 9.0.10 12SL 243 CID: 1506 SID: 3140081 EID:13 EDT: ORDER:

McLachlan, Michael ID:3112626230 18-MAR-2026 01:34:19 GREATER GLASGOW SITE-GRTHRY ROUTINE RECORD

31-DEC-1962 (63 yr)
Male Unknown

Room:
Loc:229

Vent. rate	112	BPM
PR interval	130	ms
QRS duration	78	ms
QT/QTc	390/532	ms
P-R-T axes	83 93	70

Sinus tachycardia
Right atrial enlargement
Rightward axis
Pulmonary disease pattern
Prolonged QT
Abnormal ECG

Technician:
Test ind:

COMMENTS 1: COMMENTS 2:

Unconfirmed



25mm/s 10mm/mV 150Hz 9.0.10 12SL 245 CID: 1505

SID: 3140081 EID:13 EDT: ORDER:

McLachlan, Michael ID:3112626230 21-JUL-2023 14:51:14 GREATER GLASGOW SITE-GRAAU ROUTINE RECORD

31-DEC-1962 (60 yr)
Male Unknown

Room:
Loc:202

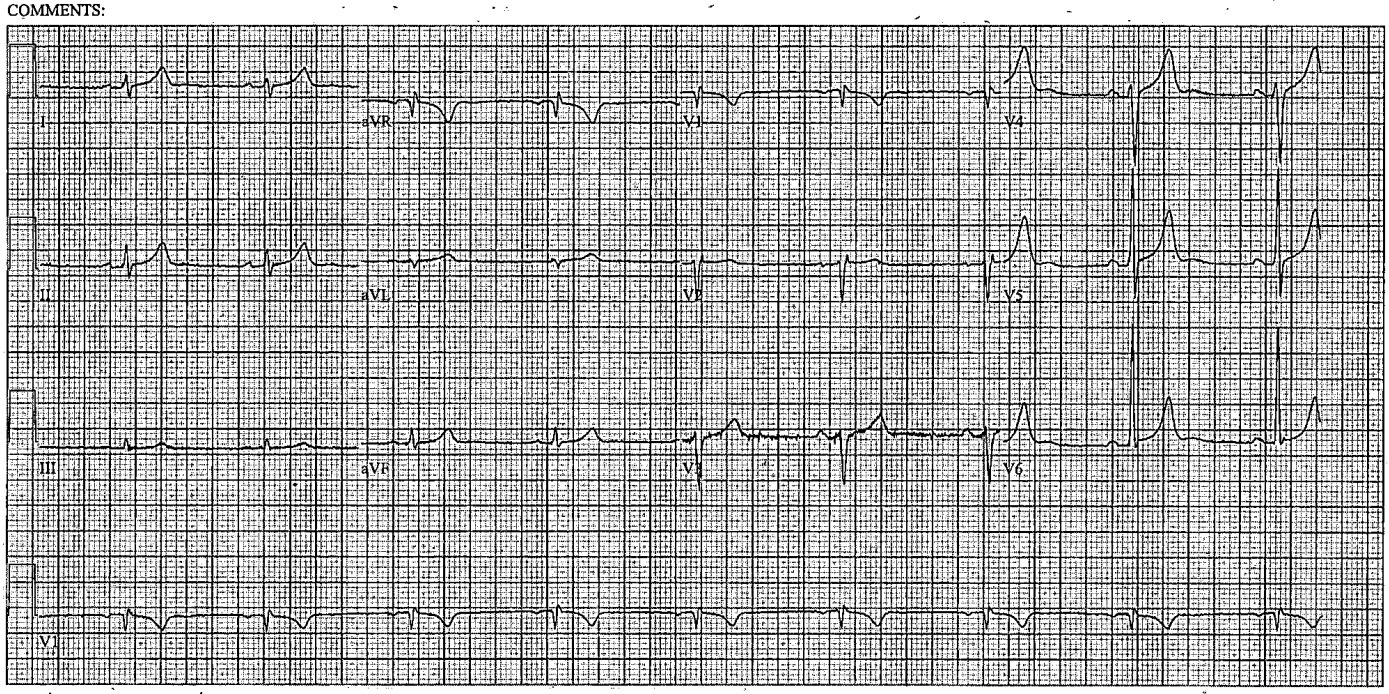
Vent. rate	54	BPM
PR interval	152	ms
QRS duration	92	ms
QT/QTc	426/403	ms
P-R-T axes	43 85	40

Sinus bradycardia
Otherwise normal ECG

Technician:
Test ind:

Unconfirmed

COMMENTS:



25mm/s 10mm/mV 150Hz 9.0.10 12SL 241 HD CID: 138

SID: 3140081 EID: EDT: ORDER:

McLachlan, Michael ID:3112626230 21-JUL-2023 14:50:46 GREATER GLASGOW SITE-GRAAU ROUTINE RECORD

31-DEC-1962 (60 yr)
Male -Unknown

Room:
Loc:202

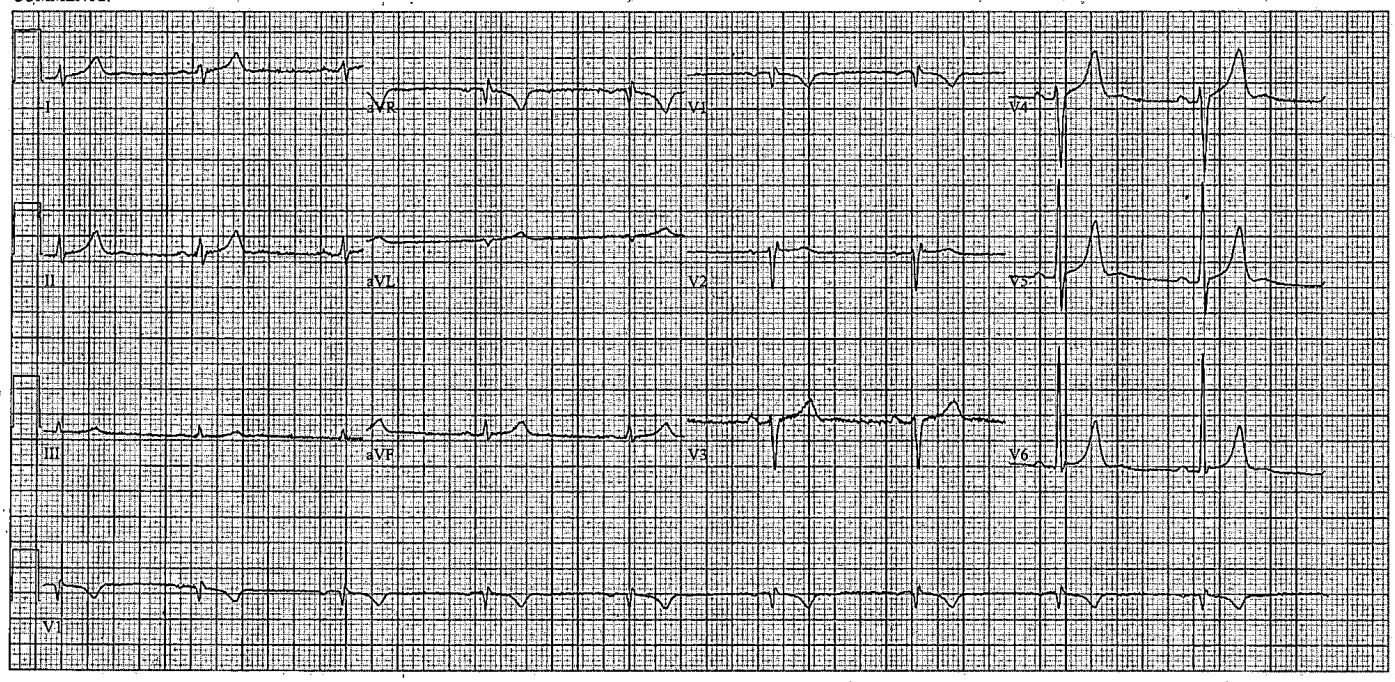
Vent. rate	54	BPM
PR interval	158	ms
QRS duration	92	ms
QT/QTc	416/394	ms
P-R-T axes	46 94	38

Sinus bradycardia
Rightward axis
Incomplete right bundle branch block
Possible Anterior infarct , age undetermined
Abnormal ECG

Technician:
Test ind:

Unconfirmed

COMMENTS:



25mm/s 10mm/mV 150Hz 9.0.10 12SL 241 HD CID: 138

SID: 3140081 EID: EDT: ORDER:

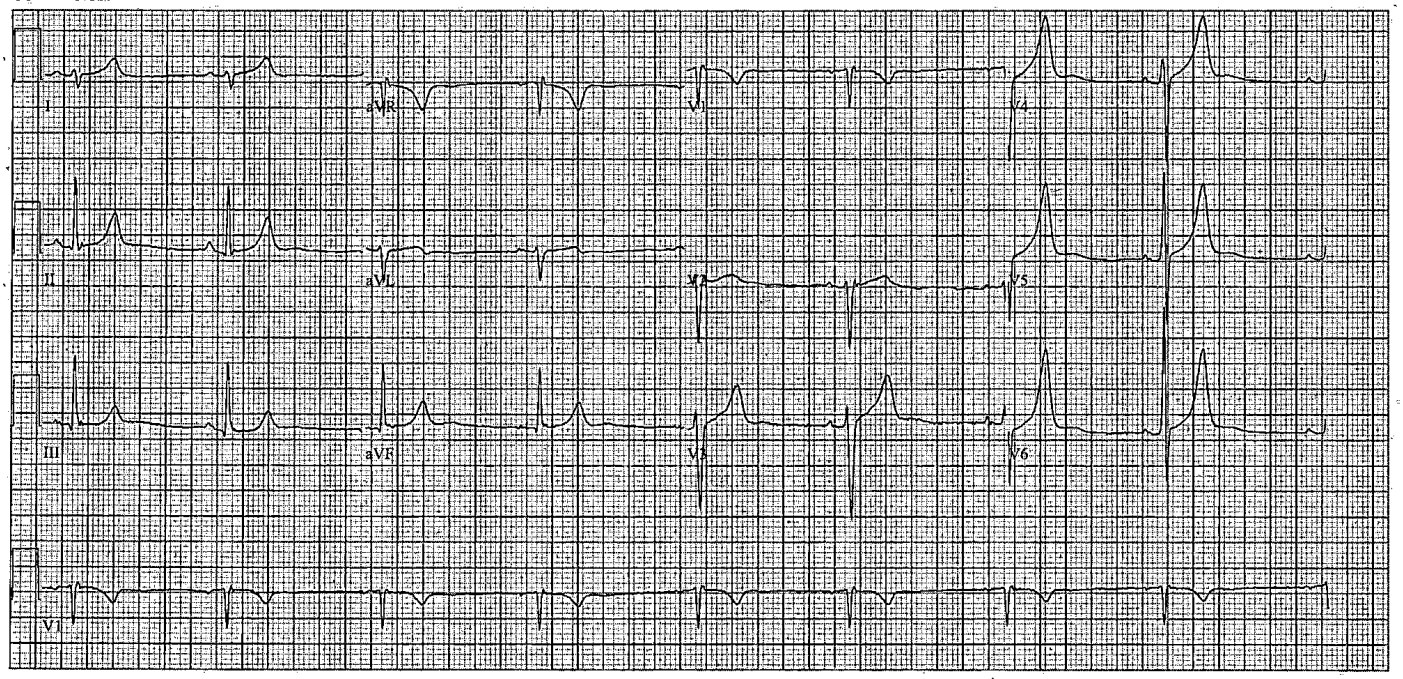
McLachlan, Michael ID:3112626230 02-FEB-2023 19:07:49 GREATER GLASGOW SITE-GRAE ROUTINE RECORD

31-DEC-1962 (60 yr)	Vent. rate	50	BPM	Sinus bradycardia
Male Unknown	PR interval	140	ms	Rightward axis
	QRS duration	104	ms	Incomplete right bundle branch block
Room:	QT/QTc	438/399	ms	Borderline ECG
Loc:201	P-R-T axes	9 94	58	

Technician:
Test ind:

Unconfirmed

COMMENTS:



25mm/s 10mm/mV 100Hz 9.0.10 12SL 241 CID: 118 SID: 3140081 EID: EDT: ORDER:

McLachlan, Michael ID:3112626230 24-JAN-2020 18:09:29 GREATER GLASGOW SITE-GRAE ROUTINE RECORD

31-DEC-1962 (57 yr)
Male Unknown

Room:
Loc:201

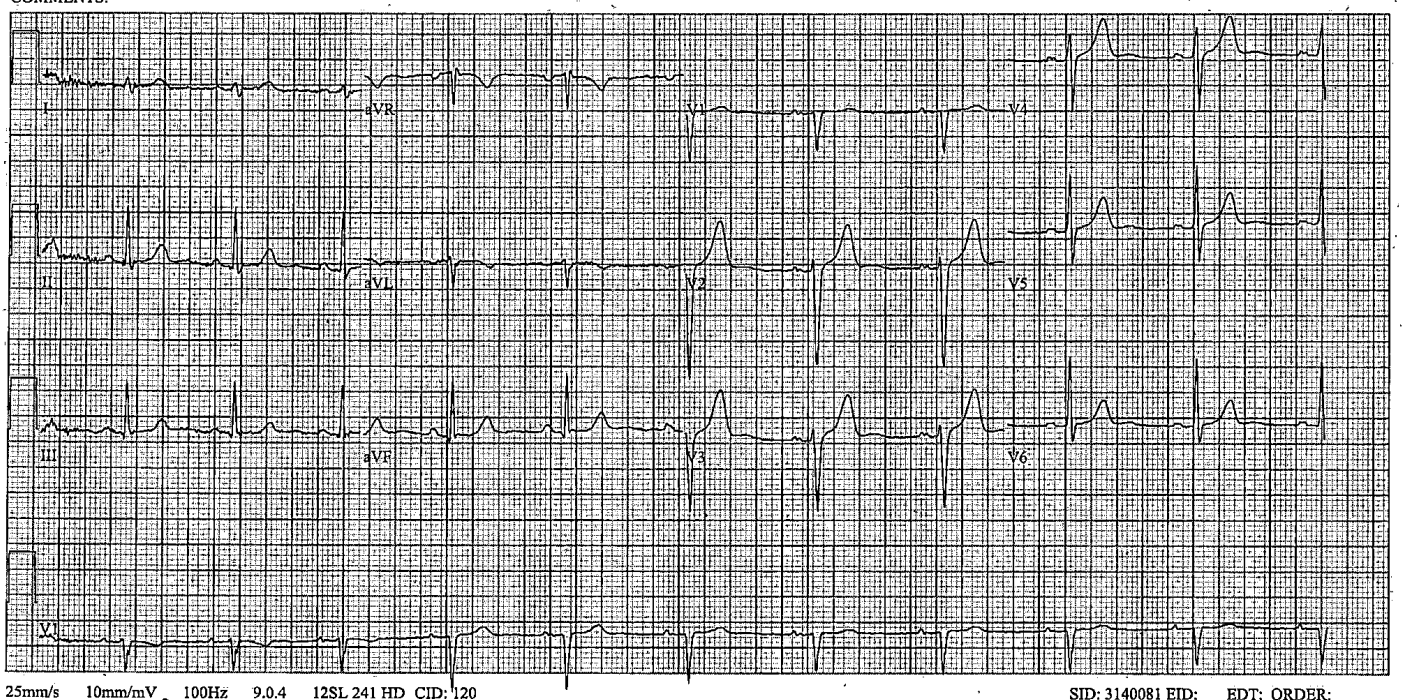
Vent. rate	65	BPM
PR interval	146	ms
QRS duration	100	ms
QT/QTc	386/401	ms
P-R-T axes	75 89	71

Normal sinus rhythm
Normal ECG

Technician:
Test ind:

Unconfirmed

COMMENTS:



25mm/s 10mm/mV 100Hz 9.0.4 12SL 241 HD CID: 120

SID: 3140081 EID: EDT: ORDER:

MCLACHLAN, Michael ID:3112626230 21-SEP-2015 09:03:02 GREATER GLASGOW SITE-GRAAU ROUTINE RECORD

52 yr		Vent. rate	91	BPM	Normal sinus rhythm
Male	Unknown	PR interval	144	ms	Normal ECG
		QRS duration	94	ms	
Room:		QT/QTc	336/413	ms	
Loc:202		P-R-T axes	45 79	45	

Technician:
Test ind:

Referred by: UNCONFIRMED ECG REPORT Sys Admin 21



25mm/s 10mm/mV 150Hz 7.1.1 12SL 237 CID: 1

SID: 3140081 EID:21021 EDT: 15:29 29-SEP-2015 ORDER:

MCLACHLAN, Michael ID:3112626230 10-DEC-2013 14:39:32 GREATER GLASGOW SITE-GRCLPO ROUTINE RECORD

31-DEC-1962 (50 yr)	Vent. rate	45	BPM	Sinus bradycardia
Male Unknown	PR interval	156	ms	rSr'(V1) - probable normal variant
	QRS duration	96	ms	
Room:	QT/QTc	424/367	ms	Borderline ECG
Loc:281	P-R-T axes	72 88	63	

Technician:GRI 216
Test ind:

Referred by:

UNCONFIRMED ECG REPORT Sys Admin 2



25mm/s 10mm/mV 150Hz 7.1.1 12SL NO SERIAL CID: 65535

SID: 3140081 EID:21002 EDT: 15:27 10-DEC-2013 ORDER:

Vital Signs™ 220 166 05 CE 0537 UK 0866

McLachlan, Michael
Male
31.12.1962 (63 Years)

Location: 201

Technician ID: ld

Test Indication: If

NJR
Sun via to pain.

Vent. rate ___ BPM
PR interval 154 ms
QRS duration 90 ms
QT/QTc-Baz 400/409 ms
P-R-T axes 81 88 72

Normal sinus rhythm
Normal ECG

Patient ID: 3112626230

Referred By: Lld

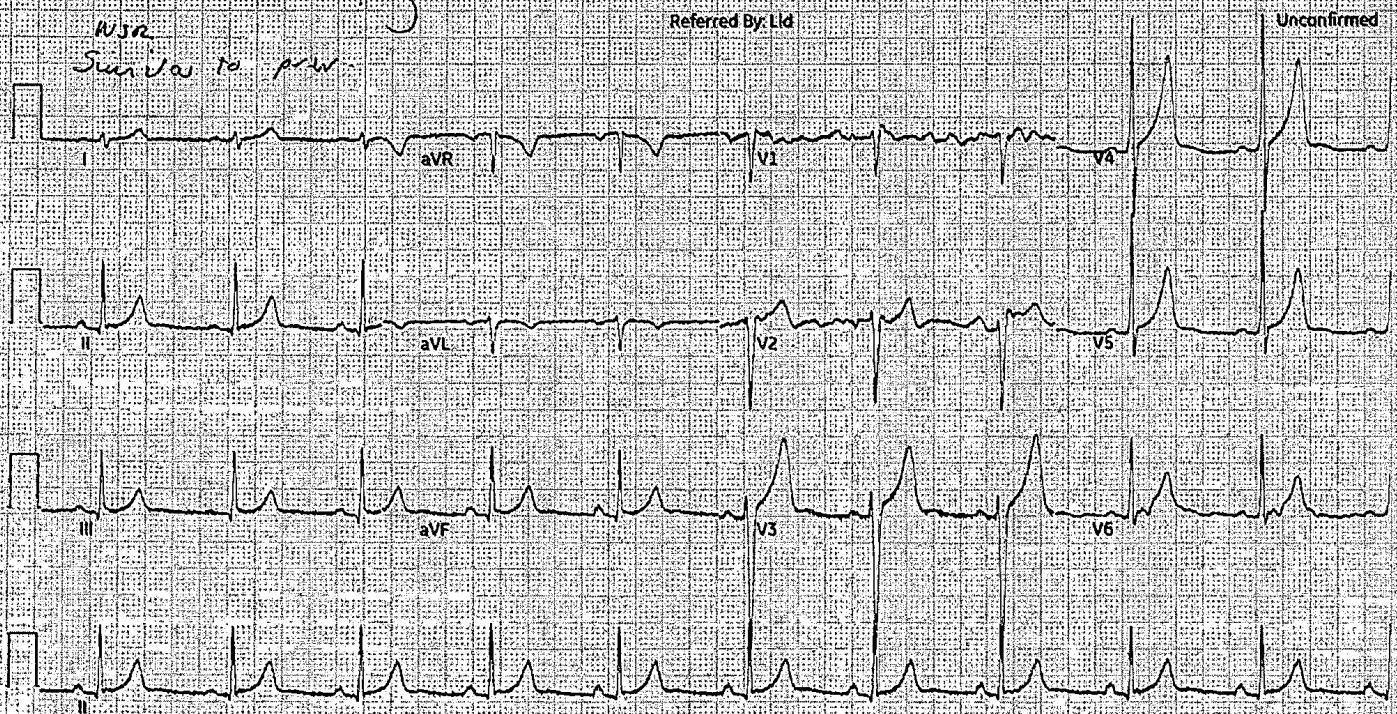
31.03.2026 11:25:40 PM

A&E

Location:
Comments:

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Unconfirmed



25mm/s 10.0mm/V 0.56-150 Hz ZPD 50 Hz MAC™ 7.1.00 SP07 12SL v23.1 4 by 2.5s + 1 rhythm ld

Vital Signs™ 226 166 05

McLachlan, Michael
Male
31/12/1962 (63 Years)

Location: 229

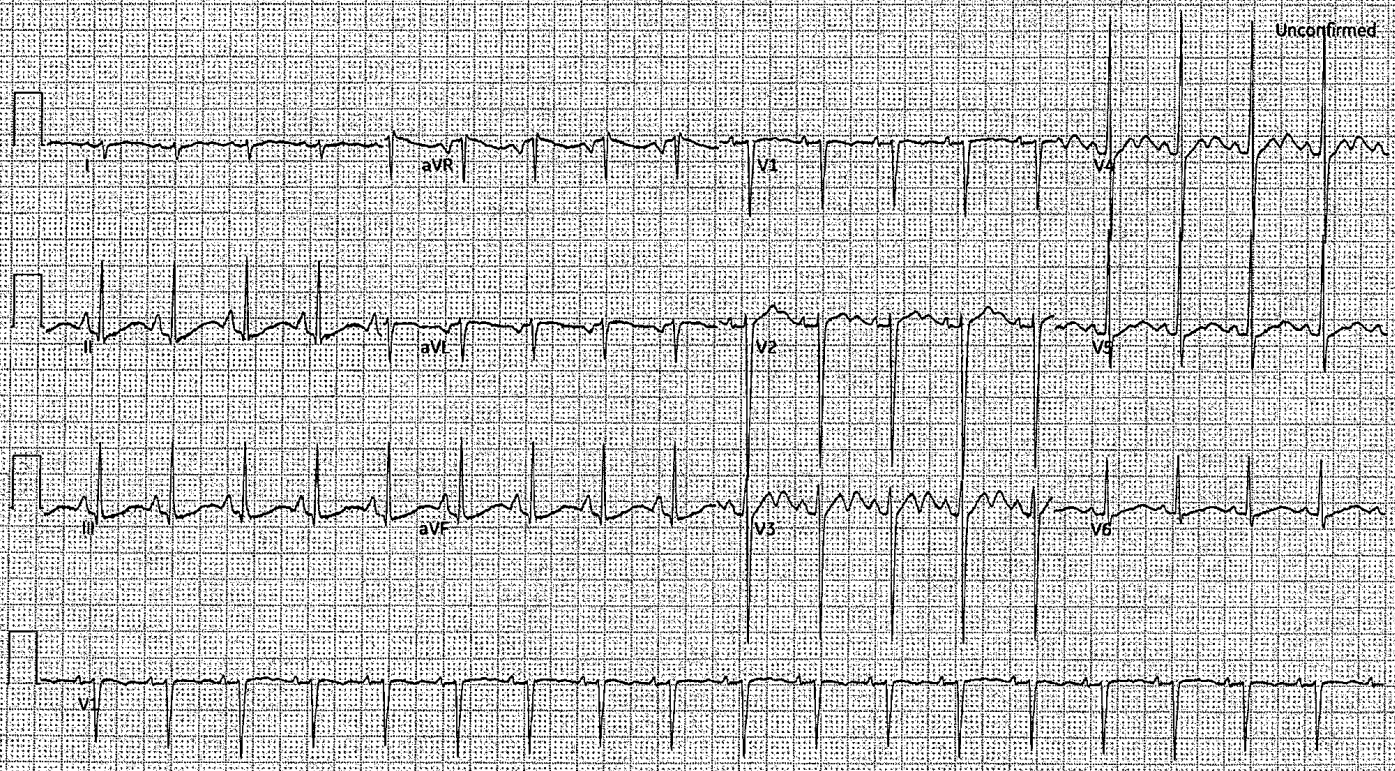
Vent. rate	11	M
PR interval	13u	ms
QRS duration	78	ms
QT/QTc-Baz	390/532	ms
P-R-T axes	83 93 70	

Patient ID: 3112626230

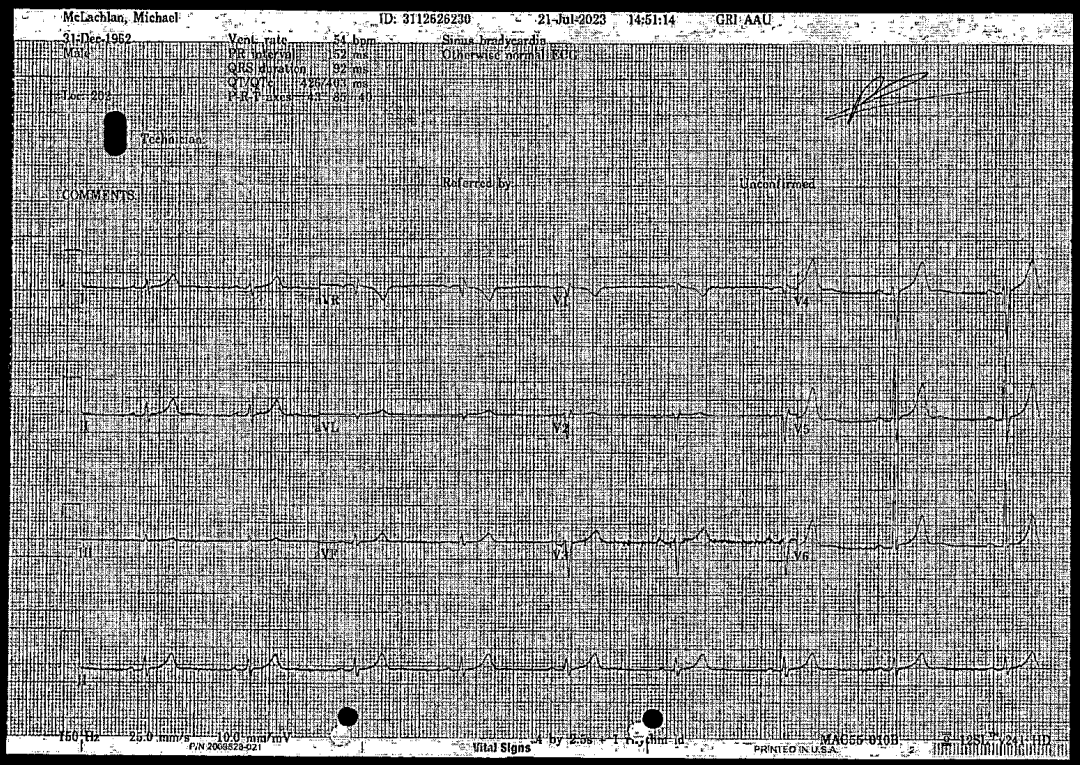
Sinus tachycardia
Right atrial enlargement
Rightward axis
Pulmonary disease pattern
Prolonged QT
Abnormal ECG

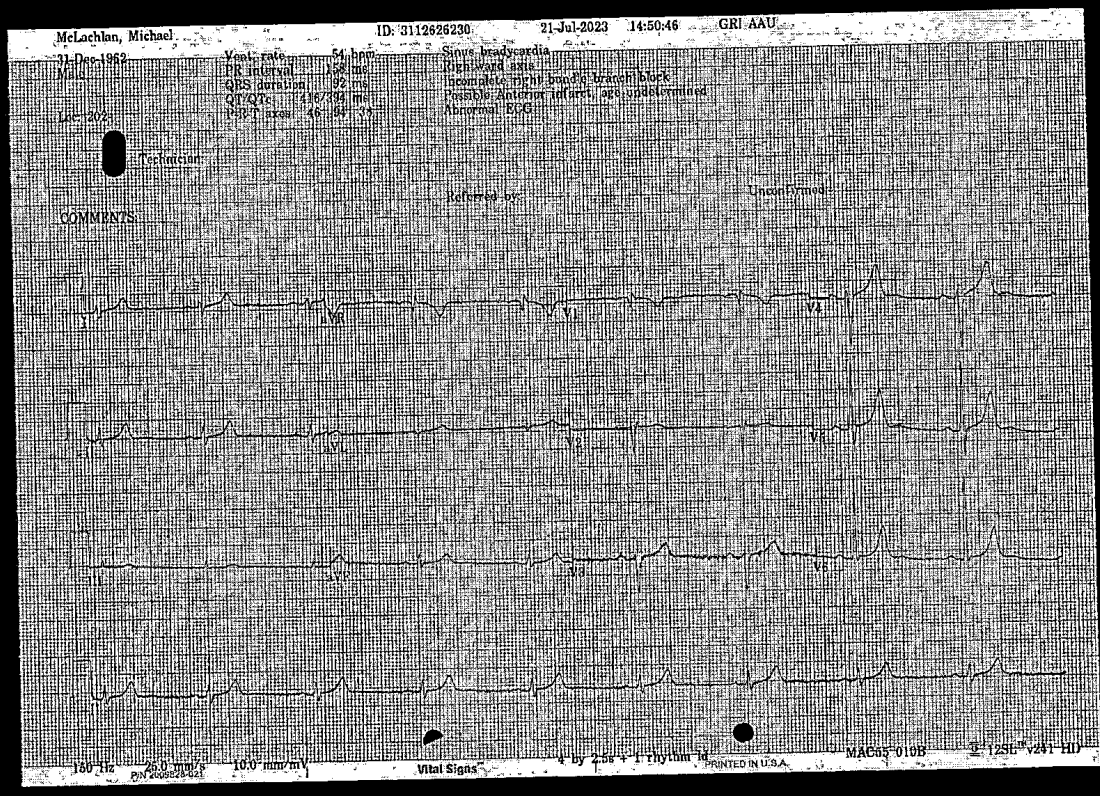
18/03/2026 01:34:19 D800
GRI QEB RECOVERY

COMMENTS 1:
COMMENTS 2:



25mm/s 10.0mm/mV 0.56-150 Hz ZPD 50 Hz MAC™ 5 1.00 SP05 12SL v24 y 2.5s + 1 rhythm Id Page 1 of 1


McLachlan, Michael
ID: 3112626230
21-Jul-2023 14:51:14
GRI AAU
31-Dec-1952
Male
Loc: 202
Vent. rate 54 bpm
PR interval 152 ms
QRS duration 92 ms
QT/QTc 426/403 ms
P-R-T axes 42 89 40
Sinus bradycardia
Otherwise normal ECG
Technician:
COMMENTS:
Referred by:
Unconfirmed
I
II
III
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6
150 Hz 25.0 mm/s 10.0 mm/mV
P/N 2008529-021
Vital Signs
4 by 2.5m + 1 rhythm
MAC55 0108
PRINTED IN U.S.A.


McLachlan, Michael
ID: 3112626230
21-Jul-2023 14:50:46
GRI AAU
31-Dec-1962
Male
Loc: 202
Technician
Vent. rate 54 bpm
PR interval 158 ms
QRS duration 92 ms
QT/QTc 416/393 ms
P-R-T axes 46 64 77
Sinus bradycardia
Borderline left axis deviation
Incomplete right bundle branch block
Possible Anterior infarct, age undetermined
Abnormal ECG
Referred by:
Unconfirmed
COMMENTS:
I
II
III
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6
150 Hz
25.0 mm/s
10.0 mm/mV
Vital Signs
4 by 2.5s + 1 rhythm II
PRINTED IN U.S.A.
MAC55 010B
12SL v241 HD

31-Dec-1962
Female

Loc: 201

Technician:

Vent. rate	50	bpm	Sinus bradycardia
PR interval	140	ms	Rightward axis
QRS duration	104	ms	Incomplete right bundle branch block
QT/QTc	438/399	ms	Borderline ECG
P-R-T axes	9	94 58	

[redacted]
3112626230 M
MCLACHLAN
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP
[redacted]

Sinus brady
RBBB
Inverted T waves

COMMENTS:

Referred by:

Unconfirmed



100 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + 1 rhythm ld MAC55 010Bspl 12SL™ v241

MCLACHLAN, MICHAEL ID: 3112626230 29-Jun-2022 20:48:40 GLASGOW ROYAL INFIRMARY ED

31-Dec-1962
Male

Vent. rate 72 b
PR interval 142 ms
QRS duration 92 ms
QT/QTc 378/413 ms
P-R-T axes 76 88 74

Normal sinus rhythm
Normal ECG

Loc: 201

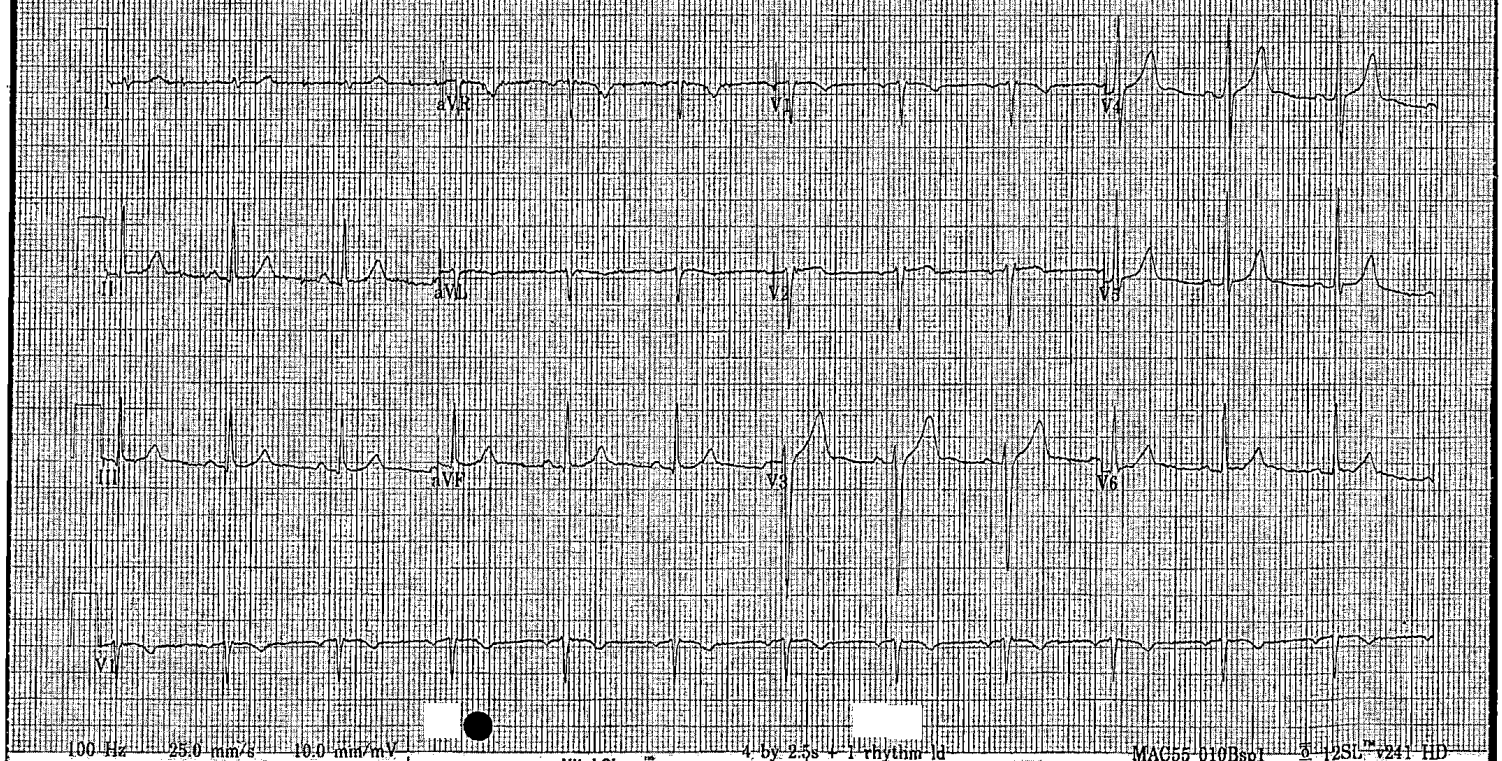
Technician:

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

COMMENTS

Referred by

Unconfirmed



100 Hz 25.0 mm/s 10.0 mm/mV
P/N 2009628-021
Vital Signs™
4 by 2.5s + 1 rhythm ld
PRINTED IN U.S.A.
MAC55 010Bsp1 12SL™ v241 HD

3112626230 6-Jan-2022 2:51:04 GLASGOW ROYAL INFIRMARY ED

31-Dec-1962
Male

Loc: 201

Technician: [redacted]

Vent. rate	51	bpm
PR interval	158	ms
QRS duration	94	ms
QT/QTc	416/383	ms
P-R-T axes	69 86 66	

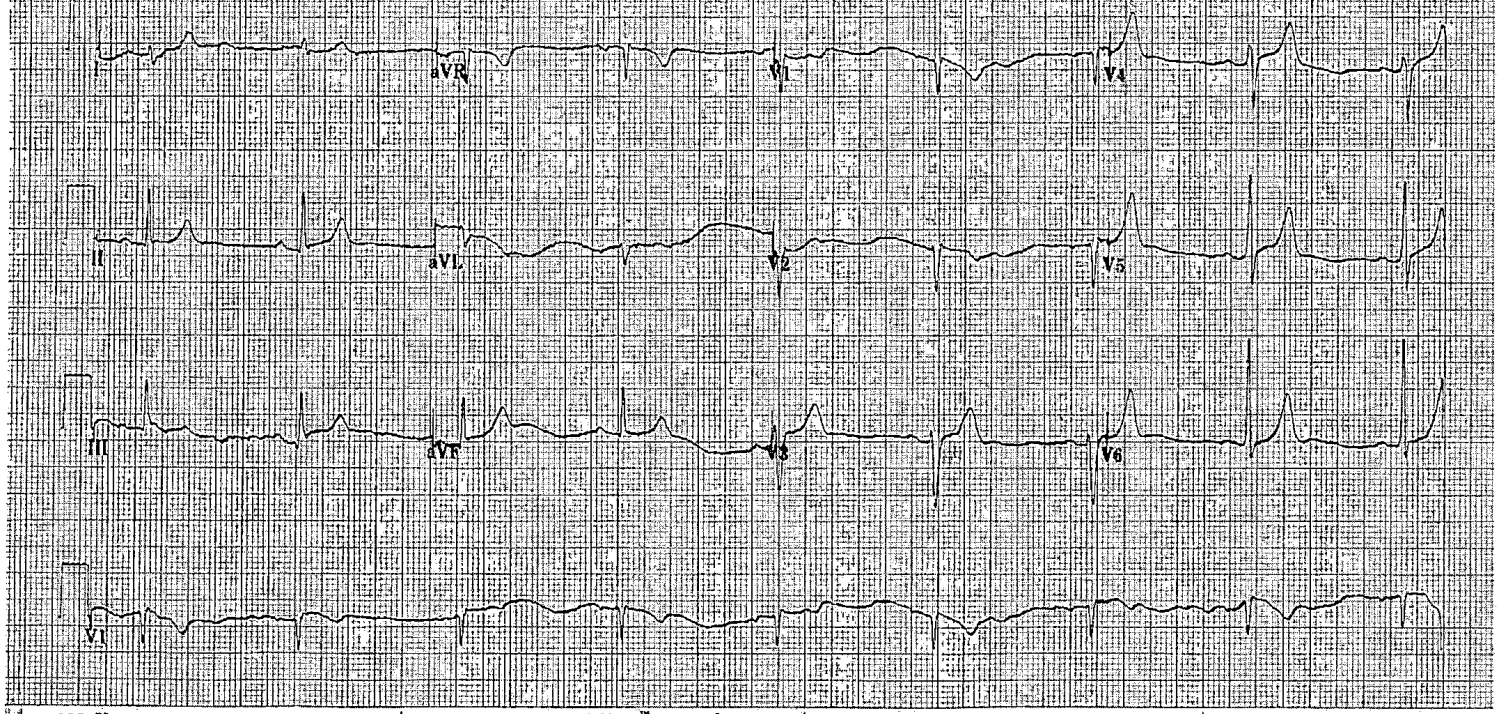
Sinus bradycardia
Incomplete right bundle branch block
Borderline ECG

[redacted]
3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

COMMENTS:

Referred by:

Unconfirmed

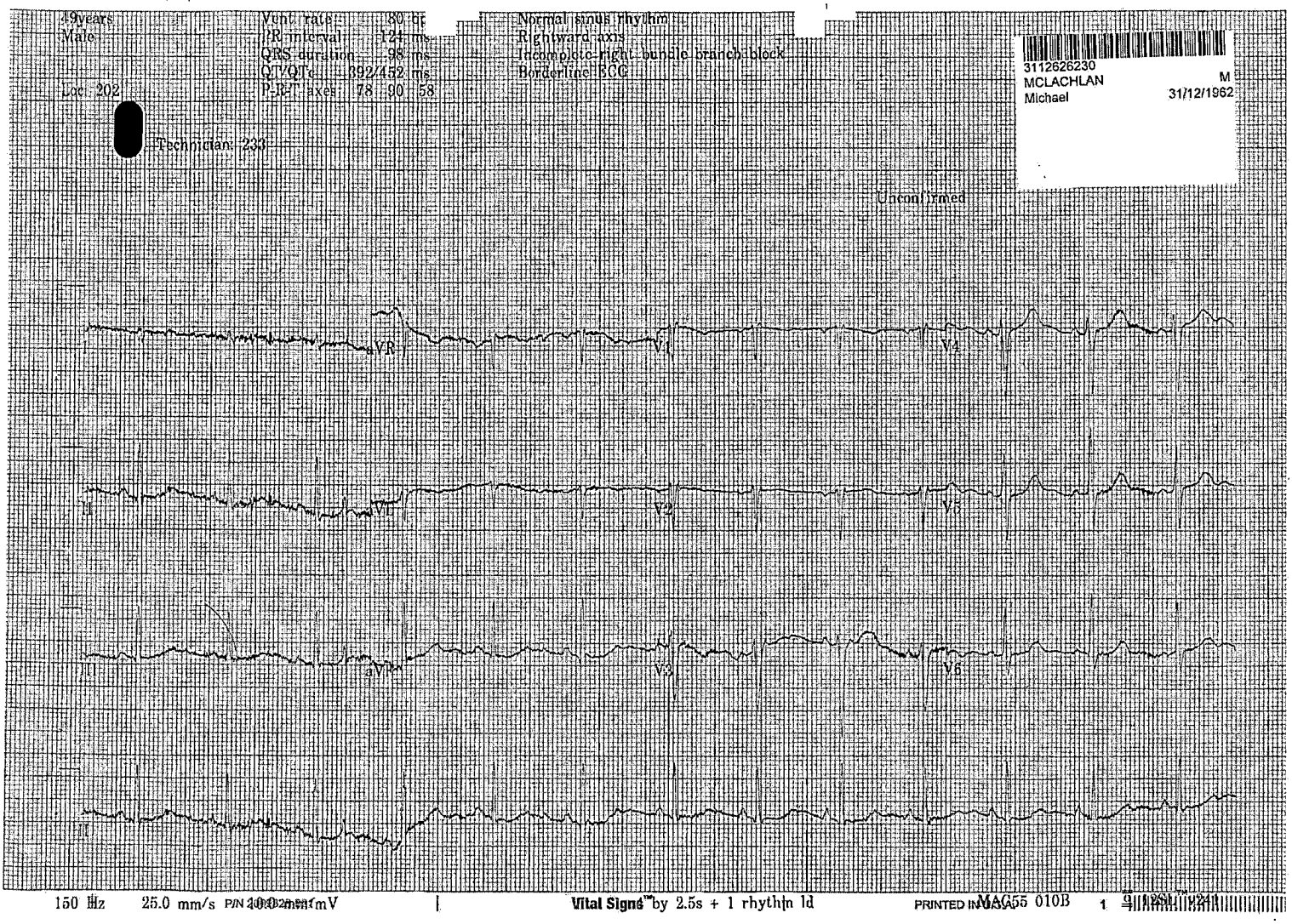


25.0 mm/s 10.0 mm/mV | 100 Hz

Vital Signs™

PRINTED IN U.S.A.

MCLAUGHLIN, MICHAEL · ID: 0031126230 16-Feb-2021 15:02:00 ACUTE ASSESSMENT UNIT,GRI



14-Apr-2020 16:21:35 GLASGOW ROYAL INFIRMARY ED

Ventr. rate	57 bpm
PR interval	144 ms
QRS duration	94 ms
QT/QTc	404/393 ms
P-R-T axes	30 59 27

Sinus bradycardia with premature atrial complexes with aberrant conduction
Anterior infarct, age undetermined
Abnormal ECG

Loc: 201

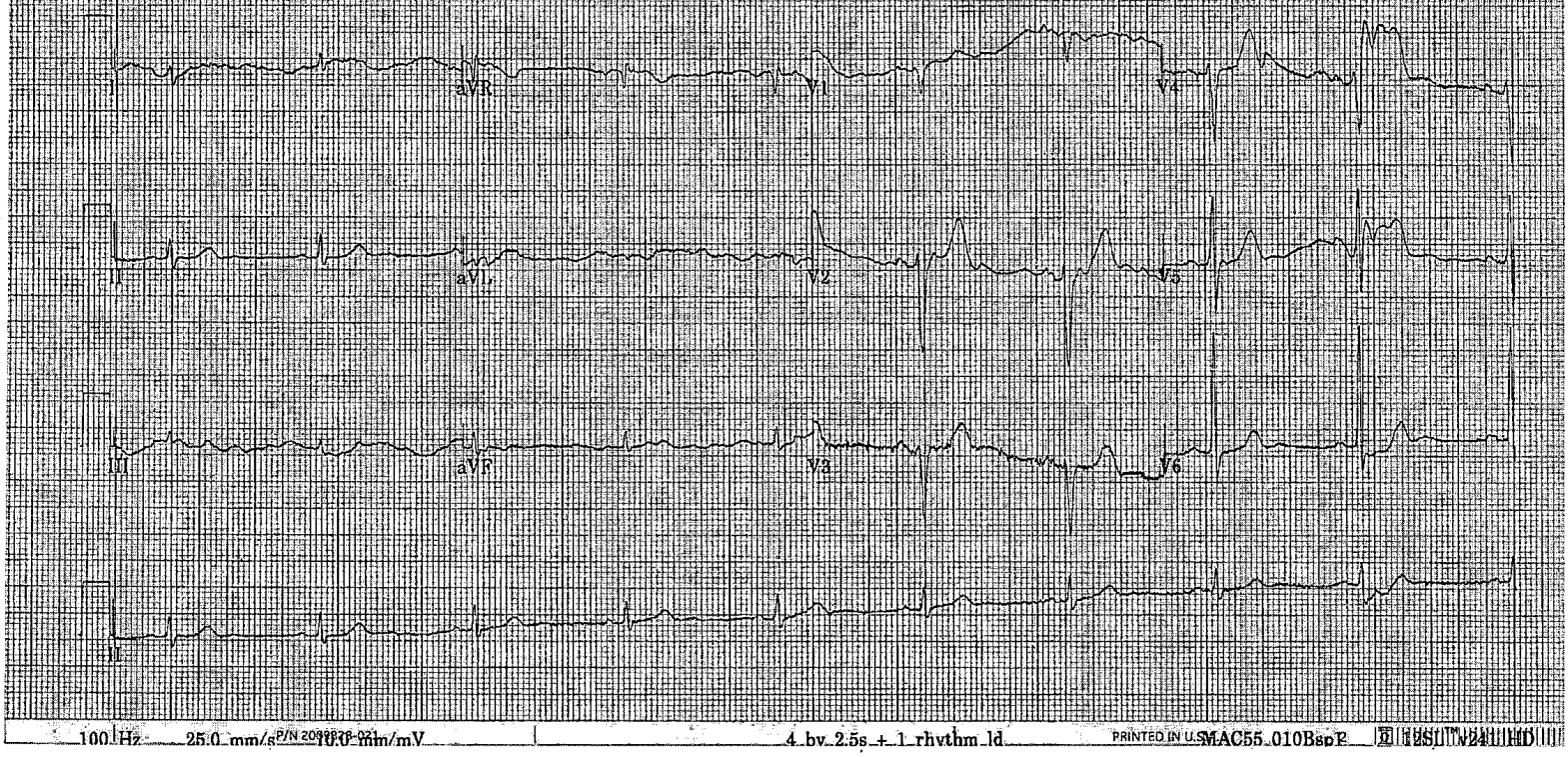
Technician:

3112626230
MCLACHLAN
Michael M
31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Referred by:

Unconfirmed

COMMENTS:



100 Hz 25.0 mm/s P/N 2089828-021 10.0 mm/mV 4 by 2.5s + 1 rhythm ld PRINTED IN U.S. MAC55 010BspP 12SL v241 HD

I 14-Apr-2020 16:21:50 GLASGOW ROYAL INFIRMARY ED

Vent. rate 56 bpm
PR interval 142 ms
QRS duration 88 ms
QT/QTc 426/411 ms
P-R-T axes 24 70 32

Sinus bradycardia
Anterior infarct, age undetermined
Abnormal ECG





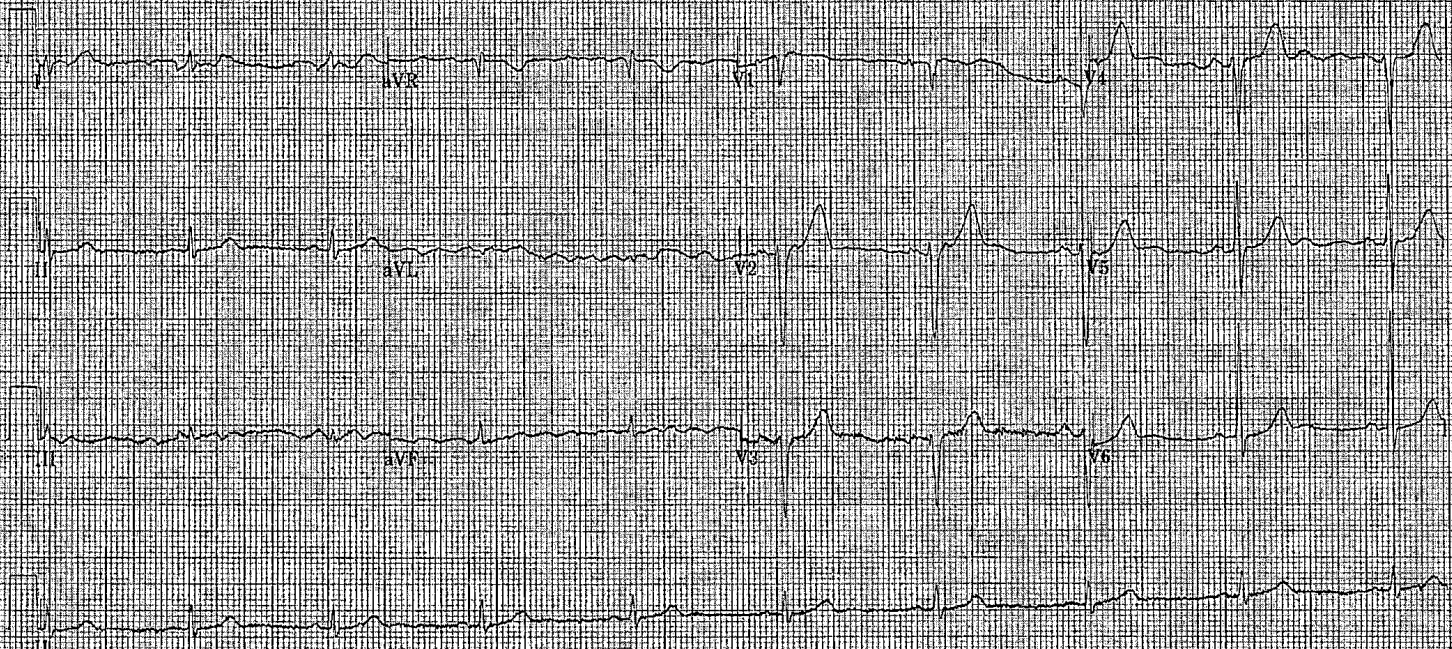
Loc: 201

Technician:

Referred by:

Unconfirmed

COMMENTS:



100 Hz 25.0 mm/s 10.0 mm/mV 4 by 25s + 1 rhythm, ld PRINTED IN U.S.A. MAC55 010Bsp1 12SL™ v241 HD

McLachlan, Michael 3112626230 24-Jan-2020 18:09:29 GLASGOW ROYAL INFIRMARY ED

31-Dec-1962
Male

Loc: 201

Technician:

Vent. rate	65	bpm
PR interval	146	ms
QRS duration	100	ms
QT/QTc	386/401	ms
P-R-T axes	75 89 71	

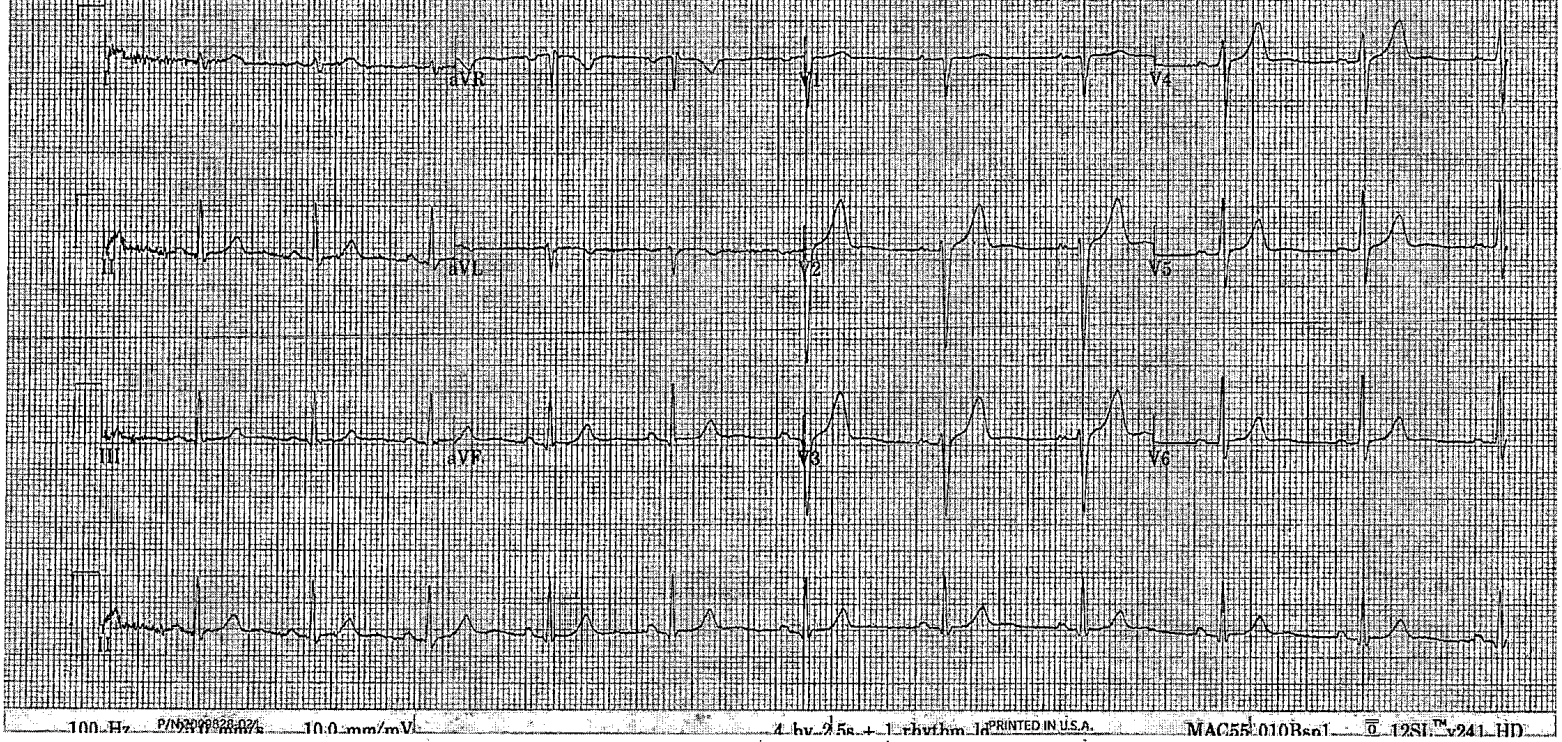
Normal sinus rhythm
Normal ECG

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Referred by:

Unconfirmed

COMMENTS:



100 Hz P/N 2009828-02A 10.0 mm/mV 4 by 2.5s + 1 rhythm Id PRINTED IN U.S.A. MAC55 010Bsp1 12SL™ v241 HD

15-Mar-2018 17:18:17 GRI AAU

Ventr. rate 54 bpm
PR interval 156 ms
QRS duration 100 ms
QT/QTc 402/381 ms
P-R-T axes 67 84 54

Sinus bradycardia
Otherwise normal ECG

Loc: 202

Technician:

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

Unconfirmed

I aVR V1 V4

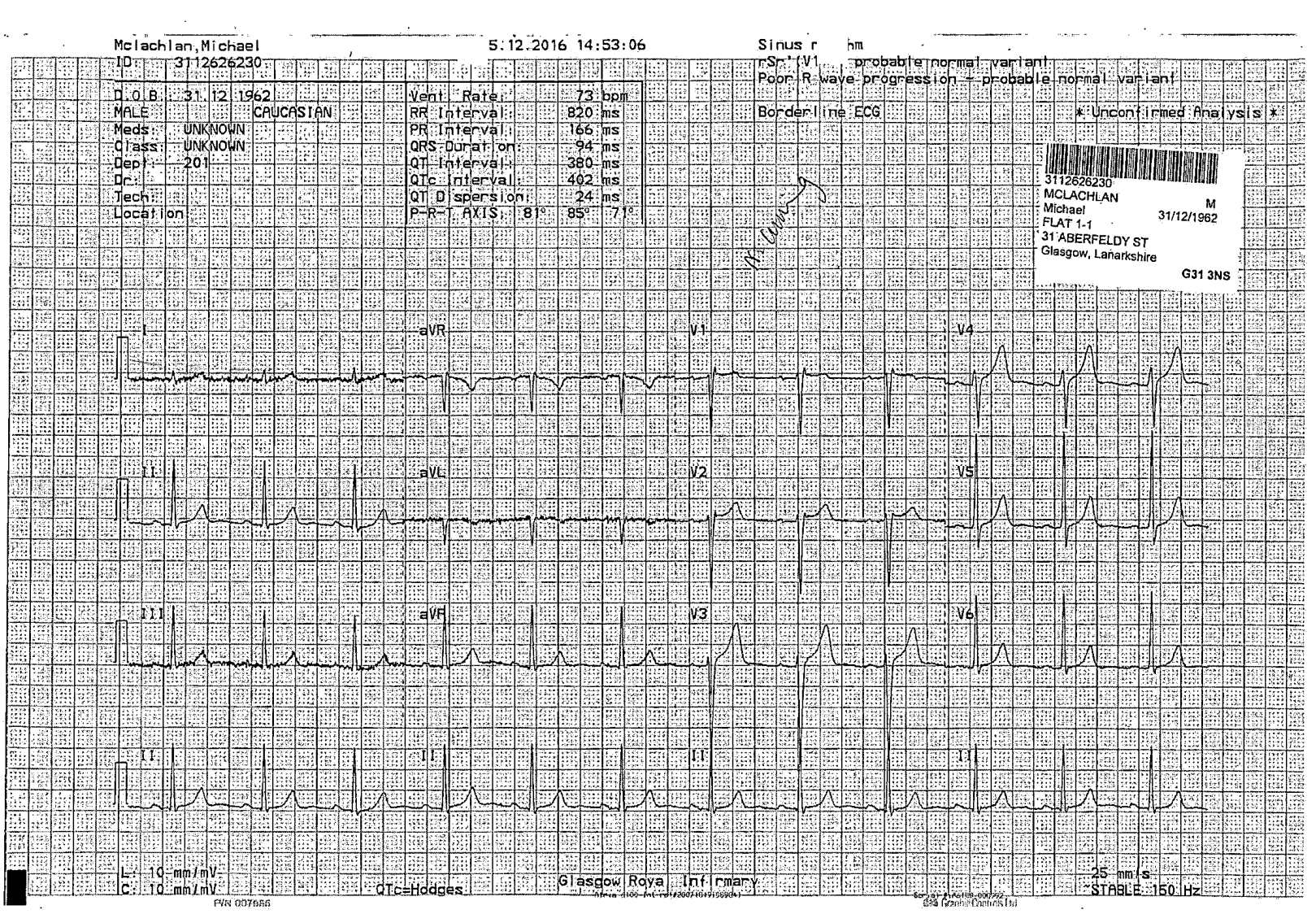
II aVL V2 V5

III aVF V3 V6

II

40 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + 1 rhythm ld MAC55 010B 12SL v241

P/N 2009810-021 PRINTED IN U.S.A.


Mclachlan,Michael
5:12.2016 14:53:06
Sinus r hm
rSr' (V1 probable normal variant
Poor R wave progression - probable normal variant
ID: 3112626230
D.O.B. 31.12.1962
MALE CAUCASIAN
Meds: UNKNOWN
Class: UNKNOWN
Dept: 201
Dr:
Tech:
Location
Vent Rate: 73 bpm
RR Interval: 820 ms
PR Interval: 166 ms
QRS Duration: 94 ms
QT Interval: 380 ms
QTc Interval: 402 ms
QT Dispersion: 24 ms
P-R-T AXIS 81° 85° 71°
Borderline ECG
* Unconfirmed Analysis *
3112626230
MCLACHLAN
Michael
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS
M
31/12/1962
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
II
II
II
II
L: 10 mm/mV
C: 10 mm/mV
QTc=Hodges
Glasgow Roya Infirmary
25 mm/s
STABLE 150 Hz
P/N 007686

Department of Respiratory Medicine
Glasgow Royal Infirmary
Pulmonary Function Report

NHS Greater Glasgow and Clyde

CHI:	3112626230				
Last Name:	McLachlan	Height:	169 cm	Physician:	Dr Cotton
First Name:	Michael	Weight:	56.9 kg	Ward:	--
Date of Birth:	31/12/1962	BMI:	20 kg/m²	Smoking status:	Smoker
Age:	59 Years	Race:	Caucasian	Smoking pk-yrs:	
Gender:	male	Pred. Module:	GLI_ECCS	Physiologist:	Giffen E
Visit date:	18/11/2022	Referral reason:			

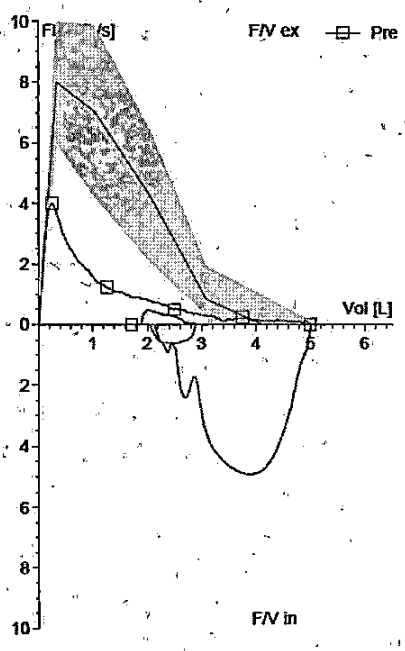
SR Range Normal +/- 1.64 to 1.64 Mild +/- 1.65 to 2.50 Moderate +/- 2.51 to 3.50 Severe +/- >3.50

Spirometry

		Pred	Best Pre	% Pred	SR	SR Graph	Best Post	% Pred	SR	% Chg
FVC	L	4.11	4.99	121	1.46					
FEV 1	L	3.21	1.71	53	-3.04					
FEV 1 % FVC	%	78	34	44	-4.71					
FEV 1 % VC MAX	%	78	34	44	-4.71					
PEF	L/s	7.99	4.01	50	-3.29					
MMEF 75/25	L/s	2.75	0.38	14	-3.48					

Bodyplethysmography

		Pred	Best	% Pred	SR	SR Graph
FRCpleth	L	3.17	5.98	189 %	3.35	
TLC	L	6.41	8.32	130 %	2.45	
VC	L	4.52	5.03	111 %	0.89	
IC	L	3.28	2.35	71 %	-1.58	
ERV	L	1.12	2.68	239 %	2.39	
RV	L	1.97	3.30	168 %	2.35	
RV % TLC	%	30	40	132 %	1.56	
FRCpl% TLC	%	56	72	128 %	2.32	



Transfer Factor

		Pred	Meas	% Pred	SR	SR Graph
Hb	g(Hb)/dL		14.60			
DLCO_SB	mmol/(min*kPa)	8.35	5.44	65	-2.38	
DLCOcSB	mmol/(min*kPa)	8.35	5.44	65	-2.38	
VA_SB	L	5.79	6.57	114	1.10	
KCO_SB	mmol/(min*kPa*L)	1.45	0.83	57	-3.04	
KCOc_SB	mmol/(min*kPa*L)	1.45	0.83	57	-3.04	

Comments

[Hb] presumed normal. One acceptable transfer factor reported and one acceptable TGV effort reported. Unable to assess reversibility - two consistent baseline efforts and patient was extremely keen to leave as a family member had taken unwell in hospital.

Reduced FEV1/FVC% indicates airflow obstruction. See comments.
Static lung volumes show hyperinflation.
Gas transfer is mildly reduced with a normal VA and reduced Kco.

E Giffen/F Wilkie

Direct Access Spirometry Report

OUTREACH SPIROMETRY SERVICE

Pre vs. Post Report

Patient Information

Name: McLachlan, Michael	**ID: 3112626230**	Birthdate: 31/12/1962
Height at test (cm): 170.0	Sex: Male	Smoking history (pk-yrs):
Weight at test (kg): 61.2	Age at test: 55	Predicted set: ECCS 1983/93, Polgar(Peds)197

Comments: Smoker-Y GP-46081 PC-G31 3NS MRC-5 SP02-97 Inhaler- N

Diagnosis:

Interpreted by:

Interpretation

Patient unable to comply with instructions to perform test to an acceptable standard. F.Wilkie

Site: KoKo327345 | Effort protocol: ATS/ERS 2005 | Test date/time: 06/04/18 14:42:18

Physician: Staff Q.C | Bronchodilator: | Pre-BD Number of efforts performed: 0

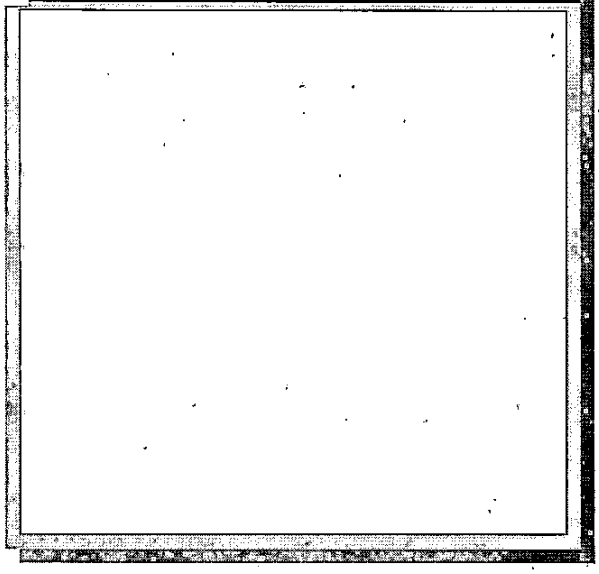
Technician: Steph Aitken | Post-BD Number of efforts performed:

Results

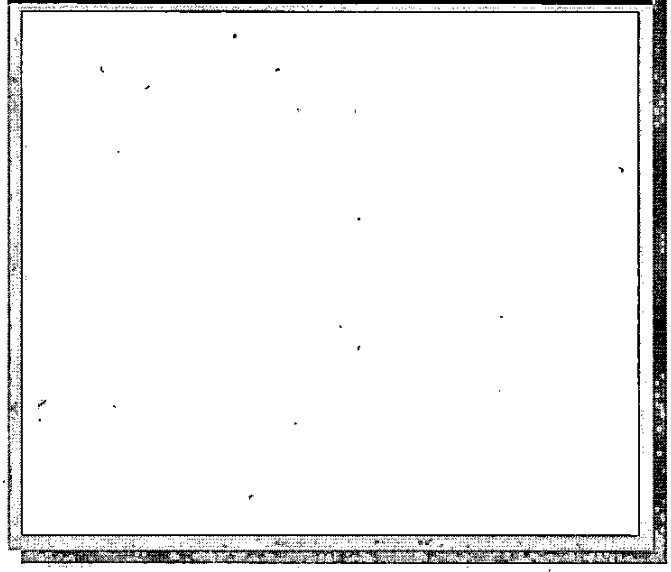
Result	Pred	Pre	%Prd	Post	%Prd	%Chg
FVC (L)	4.01	—	—	—	—	—
FEV1 (L)	3.22	—	—	—	—	—
FEV1/FVC	0.77	—		—		—
FEF25-75% (L/s)	3.64	—	—	—	—	—
PEFR (L/s)	8.24	—	—	—	—	—
Vext %	—	—	—	—	—	—

Comments: Smoker-Y GP-46081 PC-G31 3NS MRC-5 SP02-97 Inhaler- N

FVC Flow vs. Volume



FVC Volume vs. Time



XR Chest

Performed	01-Apr-2026 01:31	Received	10-Apr-2026 12:36
Reported	10-Apr-2026 12:34	Order Number	G107H43383286
Status	Final	Source System	MiSys

XR Chest Final
Michael McLachlan
Clinical History :

left flank pain and cough smoker reduced ae left base ? pneumonia

XR Chest :
Comparison made to film dated 17/03/2026.

Normal cardiomediastinal contour.
No focal consolidation or collapse.
No pneumothorax.
Normal bony thorax.

Reported by: Dr Riya Ghose (SpR) and Dr Subra Viswanathan
Verified by: Dr Subra Viswanathan

XR Abdomen

Performed	23-Mar-2026 15:04	Received	20-Apr-2026 17:27
Reported	20-Apr-2026 17:25	Order Number	G107H43349505
Status	Final	Source System	MiSys

XR Abdomen Final
Michael McLachlan
Clinical History :

63M ongoing constipation on laxatives. BNO, abdo distended. ?dilated bowel loops ? obstruction

XR Abdomen :
Left-sided ureteric stent in position as shown.
Nonspecific bowel gas pattern with no definite features of obstruction.

Reported by: Dr Stuart McEwan (SpR)
Verified by: Dr Stuart McEwan (SpR)

Ureteric stent retrograde Lt

Performed	18-Mar-2026 01:31	Received	18-Mar-2026 03:23
Reported	18-Mar-2026 03:21	Order Number	G107H43330769
Status	Final	Source System	MiSys

Ureteric stent retrograde Lt Final
Michael McLachlan
Auto reported

For autosign off in TrakCare
A radiological report will not be issued for this examination. The referrer (or a more experienced clinical colleague) will interpret and evaluate the outcome of this examination and document this outcome in the patient's case notes within an appropriate time-scale. Should the referrer wish advice or a formal report please contact the Radiology Department. Reference: Procedure 10, Evaluation of Medical Exposure, Ionising Radiation (Medical Exposure) Regulations IR(ME) R 2017

Reported by: Auto Reporting
Verified by: Auto Reporting

XR Chest

Performed	17-Mar-2026 23:33	Received	02-Apr-2026 14:19
Reported	02-Apr-2026 14:17	Order Number	G107H43330647
Status	Final	Source System	MiSys

XR Chest Final
Michael McLachlan
Clinical History :

63 M, quieter bases, slightly low sats known COPD, pyrexial ?infection. Thank you

XR Chest :
Comparison is made with the previous film of 20/10/2023 and the CT of 09/11/2022. There is some scarring superolateral to the left hilum as previously. No new focal lung pathology. Unaltered heart and mediastinal contour. No evidence of cardiac failure. No lobar collapse, pneumothorax or pleural effusion. The bony thorax is intact.

Reported by: Dr Colin Noble
Verified by: Dr Colin Noble

CT Abdomen and pelvis with contrast

Performed	17-Mar-2026 22:43	Received	18-Mar-2026 07:03
Reported	18-Mar-2026 07:01	Order Number	G405H43330611
Status	Final	Source System	MiSys

CT Abdomen and pelvis with contrast Final
Michael McLachlan
Clinical History :

63 M, 3/7 of worsening abdominal pain, nausea and vomiting.

Diffuse abdominal pain, percussion tenderness, guarding, pain on movement in bed.

WBC 30, CRP 182, pyrexial

Previous gallstones, pancreatitis and small renal calculi.

?Cause of presentation.

Thank you

CT Abdomen and pelvis with contrast :

Portal venous acquisition. Comparison is made previous CT dated 09/11/22 and MRCP dated 14/11/22.
Paucity of intra-abdominal fat limits interpretation.

Mild right sided hydronephrosis and proximal hydroureter. Previously noted 5 mm nonobstructive renal calculi at the mid pole of the left kidney has migrated and now lies within the proximal left ureter, resulting in obstruction.
Very minor urothelial enhancement of the left renal pelvis likely reflects inflammation. Possible scattered peripheral foci of hypoattenuation throughout the renal cortex may represent concurrent pyelonephritis.
Unchanged 3 mm nonobstructive renal calculi at the lower pole left kidney, unchanged from previous.
Normal right kidney.
Bladder outlines normally with multiple phleboliths within the pelvis.

Normal gallbladder with no evidence of cholecystitis.
Unchanged calibre of the CBD and pancreatic duct down to the level of the ampulla. Again, no gross obstructive ductal calculi or mass lesion identified.
Normal adrenals and spleen.
No gross abnormality to the unprepared small and large bowel.
Small right-sided inguinal hernia containing loops of small bowel. No evidence of obstruction or incarceration.

Minor nodularity/scarring at both lung bases may be inflammatory in nature. Overall, appearances have improved since prior CT in 2022.
No aggressive bony lesion.

Opinion:
5 mm left obstructive ureteric calculi with resultant mild upstream hydronephrosis and proximal hydroureter. Minor urothelial enhancement likely reflects inflammatory changes.
Possible scattered peripheral foci of hypoattenuation at left renal cortex, raises the possibility of concurrent pyelonephritis especially given raised inflammatory markers - please note this is usually a clinical diagnosis.
Discussion with urology advised.

Consultant Review:
There is a typographical error in the 4th sentence of the report. This sentence should read "Mild **left** sided hydronephrosis and proximal hydroureter". The findings are otherwise as described

above with calculus in the proximal left ureter with resultant mild hydronephrosis and hydroureter. The hypoattenuation in the left kidney suggests acute focal nephritis.

Reported by: Dr Adriel Kwek Ju Wen (SpR) and Dr Ross MacDuff
Verified by: Dr Ross MacDuff

XR Chest

Performed	21-Jul-2023 15:27	Received	09-Aug-2023 08:05
Reported	09-Aug-2023 08:03	Order Number	G107H39901145
Status	Final	Source System	MiSys

XR Chest Final
Michael McLachlan
Clinical History :
chest pain, sob ?PTE *SATA WR*

XR Chest :
PA chest radiograph: Comparison is made to chest film dated 02/02/2023.

Normal cardiomediastinal contour.
Consolidation within the right mid zone. Suggest repeat radiograph in 4 - 6 weeks post treatment to ensure resolution.
No concerning bony abnormality.

Reported by: Dr Andrew Devine (SpR)
Verified by: Dr Andrew Devine (SpR)

Review images at MDT

Performed	08-Feb-2023 08:37	Received	09-Feb-2023 13:42
Reported	09-Feb-2023 13:40	Order Number	G107H39335712
Status	Final	Source System	MiSys

Review images at MDT Final

Michael McLachlan

Clinical History : Double duct Nov 2022, previously deranged LFTs (transaminases only in July - now normal (October). EUS â€" no ampulla mass - FNB

Review images at Pancreatic MDT on 09.02.23:

=======

This is a radiology review report. This report contains information pertinent to the patient's current management and may not document all pathology or incidental non contributory minor abnormality.

It is strongly advised that this report is interpreted in conjunction with the original radiology report for this examination, which may have been performed at another hospital.

In constructing this report, additional clinical information may have been available to the review radiologist that was not available at the time of the original report.

=======

MRCP 14/11/2022 and CT CA 09/07/2022

Double duct dilatation with CBD measuring up to 11 mm and main pancreatic duct measuring up to 8 mm (previously 4 mm in 2012). No visible ampullary lesion.

EUS 01/02/2023

Dilated CBD/PD. Most recent LFTs normal. Dilated CBD, but tapers to ampulla. PD dilated maximally 5 mm in head of pancreas, but irregular in body and tail. FNA be taken but no convincing ampullary lesion. Likely background chronic pancreatitis and microcalcification. FNA be of ampulla: Non-diagnostic.

Plan

Clinic review

Consider lap chole

Reported by: Dr Abdullah Al-Adhami

Verified by: Dr Abdullah Al-Adhami

XR Chest

Performed	02-Feb-2023 18:38	Received	01-Mar-2023 18:44
Reported	01-Mar-2023 18:40	Order Number	G107H39318992
Status	Final	Source System	MiSys

XR Chest Final
Michael McLachlan
THIS REPORT WAS COMPLETED AS PART OF THE SCOTTISH NATIONAL REPORTING SERVICE (SNRRS)

Clinical Indications
cough. chest pain. reduced air entry right lung base. consolidation?

(Information via Order Comms)
–

XR Chest
Comparison made with previous. Heart and mediastinal contours are satisfactory. No new focal active pulmonary disease is seen.

–

Reported by
Dr Ross MacDuff
GMC 6026466
Consultant Radiologist
NHS GGC
Email: snrrs@gjnh.scot.nhs.uk

Reported by: External Radiologist and External Radiologist
Verified by: External Radiologist

US Bladder with flow rate

Performed	25-Jan-2023 15:05	Received	25-Jan-2023 15:07
Reported	25-Jan-2023 15:05	Order Number	G107H39288609
Status	Final	Source System	MiSys

US Bladder with flow rate Final
Michael McLachlan
Auto reported

For autosign off in TrakCare
A radiological report will not be issued for this examination. The referrer (or a more experienced clinical colleague) will interpret and evaluate the outcome of this examination and document this outcome in the patient's case notes within an appropriate time-scale. Should the referrer wish advice or a formal report please contact the Radiology Department. Reference: Procedure 10, Evaluation of Medical Exposure, Ionising Radiation (Medical Exposure) Regulations IR(ME) R 2017

Reported by: Auto Reporting
Verified by: Auto Reporting

XR Shoulder Rt

Performed	28-Nov-2022 14:55	Received	01-Dec-2022 13:08
Reported	01-Dec-2022 13:06	Order Number	G107H39100305
Status	Final	Source System	MiSys

XR Shoulder Rt Final
Michael McLachlan
Clinical History :

Road traffic accident in early October 2022. Ongoing right shoulder pain. Right shoulder non tender, no deformity on inspection. Movements limited by pain - abduction to 90 degrees, flexion to 90 degrees. External rotation to 45 degrees. X-ray to exclude bony abnormality

XR Shoulder Rt :
Comparison made to shoulder x-ray dated May of 32,022.

Two small enthesopathy seen at the superolateral aspect of the right humeral head at the insertion point for the supraspinatus tendon. These are new since previous imaging. This is possibly consistent with calcific tendonopathy. The glenohumeral joint, acromioclavicular joint and included bony thorax appear intact. No fracture demonstrated.

Artefact seen overlying the shoulder joint, most likely from patient clothing.

Reported by Laura Groves, trainee Reporting Radiographer.

Reported by: Laura Groves (Trainee Reporting Rad) and Katrina Kettlewell (Reporting Radiog)
Verified by: Katrina Kettlewell (Reporting Radiog)

MRCP

Performed	14-Nov-2022 09:49	Received	28-Nov-2022 12:04
Reported	28-Nov-2022 12:02	Order Number	G107H38786374
Status	Final	Source System	MiSys

MRCP Final
Michael McLachlan
Clinical History :
59 year old ex smoker. Deranged LFTs, weight loss. CT CAP shows dilated CBD. Further imaging suggested

MRCP :
Standard MRCP protocol. Comparison is made with the recent CT CAP dated 09/11/22.

Normal appearance of the gallbladder with no features of cholecystitis.
The CBD is distended up to 11 mm. No calculi within the gallbladder or CBD. No intra-hepatic biliary dilatation.
The pancreatic duct is dilated throughout and measures up to 8mm in the body (key image). This has increased is size from previous scan 10 years ago on 23/07/2012 with PD measuring 4 mm then, although unchanged from recent CT dated 04/08/2022.

The liver parenchyma is unremarkable.
No other significant findings within the imaged scan volume.

Summary : Dilated CBD and pancreatic duct. Direct visualisation is advised to assess for a ampullary lesion. Main duct IPMN also in the differential.

Reported by: Dr Manwella Ftouni (SpR) and Dr Abdullah Al-Adhami
Verified by: Dr Abdullah Al-Adhami

CT Thorax and abdomen with contrast

Performed	09-Nov-2022 09:42	Received	11-Nov-2022 08:19
Reported	11-Nov-2022 08:17	Order Number	G107H38904974
Status	Final	Source System	MiSys

CT Thorax and abdomen with contrast Final
Michael McLachlan
Clinical History :

USOC. 59 yo M, ex smoker. Referred to clinic due to LLL changes ?TB ?malignancy. Today in clinic notable weight loss of 11kg, new soft tissue swelling over posterior L chest wall (L scapula). ?resolving changes ?lung carcinoma

CT Thorax and abdomen with contrast :
Acquisition post intravenous contrast . Comparison is made with the CT of 04/08/2022 and the chest film of 03/10/2022. No major findings within the lower neck or the axillae. No mediastinal masses and no overtly pathological intrathoracic lymphadenopathy. There is minor coronary artery calcification. No other cardiac findings. The central pulmonary arteries are of normal calibre. The extensive consolidation within the apical segment of the left lower lobe on the previous CT has improved. There remains some fibrotic contracture with associated traction bronchiectasis. No proximal obstructive endobronchial mass. The consolidation medially within the more inferior aspect of the left lower lobe has also improved with some residual postinflammatory scarring. Diffuse centrilobular nodularity inferiorly within the left lower lobe has also improved.
Minor scarring in the right lower lobe. There is new minor inflammatory nodularity within the right middle lobe.
No evidence of diffuse interstitial lung disease. No significant pleural fluid or thickening. No focal abnormality within the oesophagus, stomach. Normal liver, gallbladder, adrenals and spleen. As before the pancreatic duct is dilated. No definite mass within the pancreas. No biliary dilation. There are small nonobstructive calculi within the left kidney. Normal right kidney. Atheromatous normal calibre aorta. No significant adenopathy within the upper abdomen. No focal abnormality within visualised large or small bowel. No major skeletal pathology. No evident soft tissue masses in relation to the left scapula or chest wall.

Summary: No clear evidence of intrathoracic malignancy. Improving inflammatory changes within the left lung.

Reported by: Dr Colin Noble
Verified by: Dr Colin Noble

XR Chest

Performed	03-Oct-2022 13:06	Received	04-Oct-2022 15:40
Reported	04-Oct-2022 15:38	Order Number	G107H38904410
Status	Final	Source System	MiSys

XR Chest Final
Michael McLachlan
Clinical History :

F/U LUL pneumonia

XR Chest :
Comparison is made with the previous film of 30/06/2022 and the CT of 04/08/2022 . Left perihilar consolidative change has significantly improved. There remains some scarring around the left hilum. No pleural effusion. No new focal lung pathology. Normal heart and mediastinal contour. The bony thorax is intact.

Reported by: Dr Colin Noble
Verified by: Dr Colin Noble

CT Thorax abdomen and pelvis

Performed	04-Aug-2022 10:37	Received	05-Aug-2022 13:30
Reported	05-Aug-2022 13:28	Order Number	G107H38593481
Status	Final	Source System	MiSys

CT Thorax abdomen and pelvis Final
Michael McLachlan
Clinical History :

URGENT OUTPATIENT STUDY PLEASE. Heavy smoker for years. Severe COPD. History of weight loss ++ over past year. LMZ pneumonia on xray, CRP only mildly elevated, not febrile. Bronchial breathing over this zone. Derragned LFTs alos. Very concerning for malignancy?

CT Thorax abdomen and pelvis :

Portal venous acquisition. Comparison is made with the previous CT PA dated 16/03/2018 and the CT abdomen/ pelvis dated 23/07/2012.

There is a 4 cm area of consolidation within the left lower lobe posteriorly (key image) with further nodularity extending cranially into an area of rounded atelectasis lung posteriorly within the left lung which contains cystic air-spaces. This is posterior to the longstanding calcified granuloma (? previous TB) and is mostly within the lower lobe superiorly but also involves the posterior aspect of the left upper lobe.
No other lung mass lesions are demonstrated.
No mediastinal, hilar or supraclavicular lymphadenopathy. Left calcified hilar nodes.
Mild coronary artery calcification.

The CBD is dilated up to 11mm (previously 6mm) with a prominent pancreatic duct again noted.
No focal liver lesions.
There are a couple of uncomplicated calculi within the inter-polar region of the left kidney, the largest measures 5mm.
The solid upper abdominal viscera and unprepared bowel are otherwise unremarkable.
Mild aortoiliac calcification.
No abdominopelvic lymphadenopathy.

No evidence of skeletal malignancy.

Opinion :
- Area of consolidation within the left lower lobe and further area of atelectasis superiorly. Given the normal chest x-ray dated 30/05/22, the rapid evolution is likely due to infection/ inflammation with post primary TB suggested. Malignancy is felt less likely but not excluded. Respiratory referral is advised. Have sputum cultures been sent?

- Dilated CBD and pancreatic duct raises the possibility of head of pancreas lesion - further investigation is required.

Tracked report.

Reported by: Dr Manwella Ftouni (SpR) and Dr Laura Thomson
Verified by: Dr Laura Thomson

XR Chest

Performed	30-Jun-2022 00:38	Received	07-Jul-2022 18:13
Reported	07-Jul-2022 18:11	Order Number	G107H38591107
Status	Final	Source System	MiSys

XR Chest Final
Michael McLachlan
Clinical History :

59M
7/7 cough + SOB + ?feverish
O/E Quite AE RLZ.
?consolidation

XR Chest :
Heart is not enlarged.
Extensive consolidation involving the left upper and mid zones and to a lesser extent the left lower zone. Appearances most likely due to infection and a repeat radiograph following appropriate antibiotic therapy is advised in approximately 8 weeks to ensure resolution.

Reported by: Dr Nadir Khan (SpR)
Verified by: Dr Nadir Khan (SpR)

XR Chest

Performed	30-May-2022 18:18	Received	04-Jun-2022 12:45
Reported	04-Jun-2022 12:41	Order Number	G107H38432204
Status	Final	Source System	MiSys

XR Chest Final
Michael McLachlan

(Information via Order Comms)

Examination Dated: 30/05/2022 18:18

Title & Technique: XR Chest

Clinical Details: Weight loss

FindingsThe lungs and pleural spaces are clear.
No focal consolidation or atelectasis.
No pneumothorax.
No pleural effusion.
Normal cardiomediastinal contour.
:

4Ways Reporting Radiologist: Desmond Owusu - GMC 7411457 on 04/06/2022 12:41

Reported by: External Radiologist
Verified by: External Radiologist

XR Chest

Performed	06-Jan-2022 03:21	Received	07-Jan-2022 16:05
Reported	07-Jan-2022 16:03	Order Number	G107H38009229
Status	Final	Source System	MiSys

XR Chest Final
Michael McLachlan
Clinical History :

59M with SOB and cough; Hx COPD. CXR for ?focal consolidation . Covid +ve 20/12. Maj15

XR Chest :
Comparison is made with the previous film of 13/10/2021. Normal heart and mediastinal contour. The small focus of scarring superolateral to the left hilum as previously. No new focal lung pathology. No evidence of cardiac decompensation. No pneumothorax or pleural effusion. The bony thorax is intact.

Reported by: Dr Colin Noble
Verified by: Dr Colin Noble

XR Chest

Performed	13-Oct-2021 19:30	Received	17-Oct-2021 10:06
Reported	17-Oct-2021 10:04	Order Number	G107H37722915
Status	Final	Source System	MiSys

XR Chest Final

Michael McLachlan

Clinical details: Ex heavy smoker. Worsening cough. still vapes. Dirty spit and speeks of blood. Reduced ae globally?LRTI ?lung pathology.

XR Chest: Comparison is made with the study of 16th February 2021.

Unchanged appearances of the calcified granuloma in the left mid zone. The lungs and pleural spaces are otherwise clear, with no focal collapse or consolidation. Normal cardiomediastinal contours.

Dr. Liam Woods - Consultant Radiologist
GMC6148344 Medica Reporting Ltd.

If you are a clinician and have a query on this report, please call Medica on 01424 377 901 or email clinical@medicagroup.co.uk

Reported by: Dr Liam Woods
Verified by: Dr Liam Woods

US Bladder with flow rate

Performed	08-Oct-2021 15:37	Received	08-Oct-2021 15:39
Reported	08-Oct-2021 15:37	Order Number	G107H37732718
Status	Final	Source System	MiSys

US Bladder with flow rate Final
Michael McLachlan
Auto reported

For autosign off in TrakCare
A radiological report will not be issued for this examination. The referrer (or a more experienced clinical colleague) will interpret and evaluate the outcome of this examination and document this outcome in the patient's case notes within an appropriate time-scale. Should the referrer wish advice or a formal report please contact the Radiology Department. Reference: Procedure 10, Evaluation of Medical Exposure, Ionising Radiation (Medical Exposure) Regulations IR(ME) R 2017

Reported by: Auto Reporting
Verified by: Auto Reporting

XR Chest

Performed	16-Feb-2021 20:50	Received	17-Feb-2021 10:27
Reported	17-Feb-2021 10:25	Order Number	G107H36972378
Status	Final	Source System	MiSys

XR Chest Final
Michael McLachlan
Clinical History :

chest pain, breathlessness and cough ?pneumonia ?pneumothorax ?covid-pneumonitis ?PE

XR Chest :

Rotated AP erect. The heart is not enlarged. Some hazy opacity at the right cardiophrenic recess is likely just due to technical factors, I am not convinced of new collapse/consolidation or effusion. Departmental PA film on good inspiration may be helpful when the patient's condition allows if you remain concerned about respiratory status.

Reported by: Dr Giles Roditi
Verified by: Dr Giles Roditi

CT Head with contrast

Performed	16-Feb-2021 20:31	Received	17-Feb-2021 09:44
Reported	17-Feb-2021 09:42	Order Number	G107H36972588
Status	Final	Source System	MiSys

CT Head with contrast Final
Michael McLachlan
Clinical History :

Acute confusion, fluctuating consciousness, raised wbc ?encephalitis

IVDU with acute agitation
) on 16-Feb-2021 at 16:16)

Plain brain and then Brain with contrast done. Contrast Brain poor quality and repeated with Fast Brain GM RA63109
on 16-Feb-2021 at 20:49)

CT Head with contrast :
Pre and post contrast enhanced CT head. Both pre and post contrast images are degraded by movement artefact.

Allowing for limitations, no acute intracranial finding demonstrated. No positive evidence of encephalitis, although this cannot be excluded on CT. No gross abnormality demonstrated of the medial temporal lobes. No large intracranial haemorrhage, space-occupying lesion or abscess. No midline shift or mass effect.

The included paranasal sinuses are grossly aerated.

Impression: Limited examination but no gross abnormality demonstrated. No positive evidence of encephalitis but this cannot be excluded on imaging.

Sticky note on PACS 22:02 p.m. on 16/02/2021.

CT Head :
Please see above.

Consultant review at 09:41: Agree with above report. Very limited study due to patient movement.

Reported by: Dr Sarah MacPherson (SpR) and Dr John Shand
Verified by: Dr John Shand

CT Head

Performed	16-Feb-2021 20:31	Received	17-Feb-2021 09:44
Reported	17-Feb-2021 09:42	Order Number	G107H36973109
Status	Final	Source System	MiSys

CT Head with contrast Final
Michael McLachlan
Clinical History :

Acute confusion, fluctuating consciousness, raised wbc ?encephalitis

IVDU with acute agitation
) on 16-Feb-2021 at 16:16)

Plain brain and then Brain with contrast done. Contrast Brain poor quality and repeated with Fast Brain GM RA63109
on 16-Feb-2021 at 20:49)

CT Head with contrast :
Pre and post contrast enhanced CT head. Both pre and post contrast images are degraded by movement artefact.

Allowing for limitations, no acute intracranial finding demonstrated. No positive evidence of encephalitis, although this cannot be excluded on CT. No gross abnormality demonstrated of the medial temporal lobes. No large intracranial haemorrhage, space-occupying lesion or abscess. No midline shift or mass effect.

The included paranasal sinuses are grossly aerated.

Impression: Limited examination but no gross abnormality demonstrated. No positive evidence of encephalitis but this cannot be excluded on imaging.

Sticky note on PACS 22:02 p.m. on 16/02/2021.

CT Head :
Please see above.

Consultant review at 09:41: Agree with above report. Very limited study due to patient movement.

Reported by: Dr Sarah MacPherson (SpR) and Dr John Shand
Verified by: Dr John Shand

MRI Scaphoid Right

Performed	28-Oct-2020 07:51	Received	28-Oct-2020 11:50
Reported	28-Oct-2020 11:48	Order Number	G107H36614624
Status	Final	Source System	MiSys

MRI Scaphoid Right Final
Michael McLachlan
Clinical History : Punch injury with right hand. Very tender over base of right thumb and anatomical snuffbox. X-rays showed no bony injury. Placed in splint with thumb extension. For MRI, scaphoid fracture?

MRI Scaphoid Right : Reviewed with radiographs of 12/10/2020.

Undisplaced intra-articular fracture of the base of 1st metacarpal. No other fracture or bone contusion. Presumed post-traumatic/ reactive effusion of the mildly degenerate 1st CMC joint, which has otherwise normal appearance and presumed degenerative subarticular oedema of the trapezium.

Mild osteoarthritis of the 1st MCP joint, radio-carpal joint and piso-triquetral joints. No significant ligamentous abnormality. Degenerate TFCC with central perforation and small presumed reactive effusion of the distal radio-ulnar joint. No other significant abnormality.

Summary:
1. Undisplaced intra-articular fracture of the first metacarpal base.
2. Mild degenerative changes of the 1st MCP, CMC, radio-carpal and piso-triquetral joints with degenerate tear of the TFCC.

Reported by: Dr Mark McCleery
Verified by: Dr Mark McCleery

XR Wrist Rt

Performed	12-Oct-2020 17:25	Received	13-Oct-2020 10:14
Reported	13-Oct-2020 10:12	Order Number	G107H36613907
Status	Final	Source System	MiSys

XR Thumb Rt Final
Michael McLachlan
Clinical History :

Punch injury 2/7 ago. BT distal radius, ASB and thumb MC with decreased ROM ?#

XR Thumb Rt :
No acute bony injury is demonstrated.

XR Scaphoid Rt :
No acute bony injury is identified.
The scaphoid appears intact.
If there is any ongoing clinical concern local scaphoid protocol should be followed.

XR Wrist Rt :
Please see right scaphoid report.

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

Report by Graham Johnstone reporting radiographer.

Reported by: Graham Johnstone
Verified by: Graham Johnstone

XR Thumb Rt

Performed	12-Oct-2020 17:25	Received	13-Oct-2020 10:14
Reported	13-Oct-2020 10:12	Order Number	G107H36613905
Status	Final	Source System	MiSys

XR Thumb Rt Final
Michael McLachlan
Clinical History :

Punch injury 2/7 ago. BT distal radius, ASB and thumb MC with decreased ROM ?#

XR Thumb Rt :
No acute bony injury is demonstrated.

XR Scaphoid Rt :
No acute bony injury is identified.
The scaphoid appears intact.
If there is any ongoing clinical concern local scaphoid protocol should be followed.

XR Wrist Rt :
Please see right scaphoid report.

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

Report by Graham Johnstone reporting radiographer.

Reported by: Graham Johnstone
Verified by: Graham Johnstone

XR Scaphoid Rt

Performed	12-Oct-2020 17:25	Received	13-Oct-2020 10:14
Reported	13-Oct-2020 10:12	Order Number	G107H36613906
Status	Final	Source System	MiSys

XR Thumb Rt Final
Michael McLachlan
Clinical History :

Punch injury 2/7 ago. BT distal radius, ASB and thumb MC with decreased ROM ?#

XR Thumb Rt :
No acute bony injury is demonstrated.

XR Scaphoid Rt :
No acute bony injury is identified.
The scaphoid appears intact.
If there is any ongoing clinical concern local scaphoid protocol should be followed.

XR Wrist Rt :
Please see right scaphoid report.

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

Report by Graham Johnstone reporting radiographer.

Reported by: Graham Johnstone
Verified by: Graham Johnstone

XR Chest

Performed	14-Apr-2020 17:36	Received	14-Apr-2020 21:45
Reported	14-Apr-2020 21:43	Order Number	G107H36175562
Status	Final	Source System	MiSys

XR Chest Final
Michael McLachlan
Clinical History :

Chest pain/ LUQ pain, BG COPD. CXR to assess for evidence of consolidation or other explanation for chest pain.

XR Chest :
COVID-19 CXR Report Proforma

Findings:

Heart not enlarged. Mediastinal contours normal. No new focal pulmonary pathology when comparison is made with previous x-ray of 24/01/2020. Scarring overlying the posterior left sixth rib is also seen on the previous exam.

Classification (please delete as appropriate):

Normal (CVCX0): COVID-19 is not excluded however, correlate with RT-PCR if clinical concern.

Reported by: Dr David Craig (SpR)
Verified by: Dr David Craig (SpR)

XR Chest

Performed	24-Jan-2020 18:35	Received	28-Jan-2020 15:15
Reported	28-Jan-2020 15:13	Order Number	G107H35952491
Status	Final	Source System	MiSys

XR Chest Final
Michael McLachlan
Clinical History :

Hx COPD, increased cough/sputum/chest heaviness, R basal creps ?consolidation

XR Chest :
Comparison is made with the previous film of 15/03/2018. Normal heart and mediastinal contour. There is a small focus of scarring projected over the anterior aspect of the left third rib as previously. No other focal lung pathology. The bony thorax is intact.

Reported by: Dr Colin Noble
Verified by: Dr Colin Noble

CT Angiogram pulmonary

Performed	16-Mar-2018 11:23	Received	16-Mar-2018 12:41
Reported	16-Mar-2018 12:39	Order Number	G107H33662398
Status	Final	Source System	MiSys

CT Angiogram pulmonary Final
Michael McLachlan
Clinical History :

55M admitted with 3 day history of chest pain and haemoptysis. Coughing up quite a lot of blood. Associated right sided pleuritic chest pain. CRP and WCC normal. CXR normal. Was treated with amoxicillin for ?LRTI 2 weeks ago but no improvement. D-dimer 213 but cinical suspicion is high and no other explanation. Need to rule out PE. Will return to ambulatory care tomorrow at 9am

CT Angiogram pulmonary :
Volume acquisition of the chest with pulmonary angiographic phase contrast. Satisfactory opacification of the pulmonary vasculature. Comparison.

Negative study for pulmonary thromboembolism.

Right basal dependent change but no focal collapse or consolidation. Prominent mediastinal nodes with an example precarinal node measuring up to 10 mm in short axis. No axillary or hilar lymphadenopathy.
Atheromatous plaque affects the coronary arteries. There is significant reflux into the IVC and hepatic veins and the right ventricle is dilated in keeping with a degree of right heart dysfunction.

The pancreatic and common bile ducts are dilated to 5 and 9mm respectively. No other subdiaphragmatic pathology.

No concerning bony lesion.

Impression:
No PE.
Mediastinal lymphadenopathy of uncertain clinical significance.
Right heart dysfunction.
Pancreatic and CBD dilation - Is there LFT derangement? I note this was seen previously but I have no record of follow up.

Reported by: Dr Lindsey Norton (ST2) and Dr John Shand
Verified by: Dr John Shand

XR Chest

Performed	15-Mar-2018 18:12	Received	24-Mar-2018 10:12
Reported	24-Mar-2018 10:10	Order Number	G107H33661859
Status	Final	Source System	MiSys

XR Chest Final
Michael McLachlan
Clinical History :

55M presented with chest pain and haemoptysis on background of recent chest infection. PMH - drug dependence. ?consolidation. D-dimer negative (213)

XR Chest :
The heart is not enlarged. Normal mediastinal contour. Calcified granuloma noted in left upper/mid zone. No evidence of active pulmonary disease.

Reported by: Dr Rhona Stevens
Verified by: Dr Rhona Stevens

XR Chest

Performed	02-Mar-2018 15:08	Received	09-Mar-2018 11:35
Reported	09-Mar-2018 11:33	Order Number	G107H33613972
Status	Final	Source System	MiSys

XR Chest Final
Michael McLachlan
Clinical History :
Heavy smoker with cough and breathlessness

XR Chest :-
Comparison is made with the previous film of 15/12/2016. There is a calcified granuloma in the left mid zone as previously. Normal heart and mediastinal contour. No other focal lung pathology. The bony thorax is intact.

Reported by: Dr Colin Noble
Verified by: Dr Colin Noble

XR Chest

Performed	15-Dec-2016 15:20	Received	15-Dec-2016 15:36
Reported	15-Dec-2016 15:34	Order Number	G107H32152779
Status	Final	Source System	MiSys

XR Chest Final
Michael McLachlan
Clinical History :
persistent cough with increasing chest pain ?focal collapse

XR Chest :
Normal cardiomediastinal contour.
No active pulmonary pathology demonstrated.
Calcified granuloma left upper/mid zone.
Bony thorax is intact.

No significant change from 20/02/2016 and 13/07/2008.

Case discussed with referring clinician.

Reported by: Dr Kenneth Mitchell (SpR)
Verified by: Dr Kenneth Mitchell (SpR)

XR Lumbar spine

Performed	01-Mar-2016 10:43	Received	01-Mar-2016 16:53
Reported	01-Mar-2016 16:53	Order Number	G107H31188600
Status	Final	Source System	MiSys

XR Lumbar spine Final

Michael McLachlan

A radiological report will not be issued for this examination. The referrer (or a more experienced clinical colleague) will interpret and evaluate the outcome of this examination and document this outcome in the patient's case notes within an appropriate time-scale. Reference: Procedure 10, Evaluation of Medical Exposure, Ionising Radiation (Medical Exposure) Regulations IR(ME) R 2000

Reported by: Auto Reporting
Verified by: Auto Reporting

CT Head

Performed	26-Feb-2016 14:17	Received	26-Feb-2016 14:45
Reported	26-Feb-2016 14:43	Order Number	G107H31174315
Status	Final	Source System	MiSys

CT Head Final
Michael McLachlan
Clinical History :

53 year old presented with opiod induced psychosis, lucid periods with marked increased agitation, hallucination and delirium. Myoclonic jerking and tonic arm posturing at times. Required sedation overnight. Seen by psychiatry who want to exclude organic cause and given fluctuations, this is ?more likely. Prescribed regular antipsychotics currently but may require sedation for scan. eGFR > 60

CT Head :
Noncontrast. Comparison 21/09/2015. There is streak artefact degrading images at the level of skull base. Allowing for this there is no gross evidence of acute territorial infarction, mass lesion, intra or extra-axial haemorrhage. Ventricles and CSF spaces within normal limits. Skull intact.

Reported by: Dr Jonathan Platt
Verified by: Dr Jonathan Platt

XR Chest

Performed	20-Feb-2016 05:03	Received	20-Feb-2016 10:59
Reported	20-Feb-2016 10:57	Order Number	G107H31156691
Status	Final	Source System	MiSys

XR Chest Final
Michael McLachlan
Clinical History :

Presents with confusion. ?LRTI causing delirium

XR Chest :
The heart is not enlarged. Calcified granuloma left upper zone. Lungs otherwise clear.

Reported by: Dr Gregory O'Neill
Verified by: Dr Gregory O'Neill

XR Chest

Performed	21-Sep-2015 10:08	Received	21-Sep-2015 12:44
Reported	21-Sep-2015 12:42	Order Number	G107H30664334
Status	Final	Source System	MiSys

XR Chest Final
Michael McLachlan
Clinical History :

Confusion, pyrexial, ?LRTI

XR Chest :
The heart is not enlarged, mediastinal contours are within normal limits. Focal air space shadowing demonstrated at the right cardiophrenic angle, may represent focal infection. Follow-up film recommended in 4-6 weeks following treatment.

Reported by: Dr Abdullah Al-Adhami
Verified by: Dr Abdullah Al-Adhami

CT Head

Performed	21-Sep-2015 10:00	Received	21-Sep-2015 10:11
Reported	21-Sep-2015 10:09	Order Number	G107H30664187
Status	Final	Source System	MiSys

CT Head Final
Michael McLachlan
Clinical History :

Confusion/agitation, fallen down stairs during night with head injury, reduced GCS, no recollection of events, ?bleed

(Information via Order Comms)

CT Head :
Volume acquisition performed through the brain, non contrast enhanced.
No significant focal intra or extra-axial abnormality has been identified. There is no evidence of acute intracranial haemorrhage.

Reported by: Dr John Shand
Verified by: Dr John Shand

CT Neck

Performed	24-Jul-2013 09:35	Received	24-Jul-2013 11:37
Reported	24-Jul-2013 11:15	Order Number	G107H28094319
Status	Final	Source System	MiSys

CT Neck Final
Michael McLachlan
Clinical History :
Dilated left submandibular duct as shown on ultrasound. CT as recommended

CT Neck :
Dual bolus helical acquisition.

The left submandibular gland is not particularly enlarged. There is dilatation of the proximal main duct to 2 mm over a length of 1 cm. No obstructing calculus identified or extrinsic enhancing mass. Findings are therefore most likely due to stricture.
No cervical adenopathy. Lower slices brain parenchyma and upper mediastinum and lung apices clear (other than left apical calcified granuloma).

Reported by: Dr Claire McArthur (SpR) and Dr Gregory O'Neill
Verified by: Dr Gregory O'Neill

US Neck

Performed	27-Jun-2013 09:17	Received	28-Jun-2013 13:23
Reported	28-Jun-2013 13:01	Order Number	G107H28090336
Status	Final	Source System	MiSys

US Neck Final
Michael McLachlan
Clinical History : Prominent submandibular gland on left?

US Neck :
The left submandibular gland has a heterogeneous appearance and there is intraglandular duct dilatation. The proximal main duct is dilated at approximately 3 mm and appears to abruptly narrow. Difficult to follow the course of it along its entire length. No calculus seen. Findings could be due to duct stricture.

Suggest referral for CT pre and post contrast.

Reported by: Dr Claire McArthur (SpR) and Dr Gregory O'Neill
Verified by: Dr Gregory O'Neill

CT Abdomen and pelvis with contrast

Performed	23-Jul-2012 09:53	Received	24-Jul-2012 15:35
Reported	24-Jul-2012 15:13	Order Number	G107H27036677
Status	Final	Source System	MiSys

CT Abdomen and pelvis with contrast Final

Michael McLachlan

Clinical History : Central abdominal pain through to back. Associated anorexia and weight loss. Normal LFT's. Ultrasound showed distended pancreatic duct and CBD. ? pancreatic ampullary lesion.

CT Abdomen and pelvis with contrast : Contrast enhanced volume acquisition scan performed.

There is no evidence of intrahepatic biliary dilatation. The CBD appears slightly prominent measuring 7-8mm in diameter. It abruptly ends in the head of the pancreas with the mildly dilated MPD, where a 1 cm diameter isodense ?small mass lesion is seen. There is a duct parallel with the CBD posteriorly which appears also slightly prominent at 6mms and may represent the cystic duct with a low insertion. The main pancreatic duct is prominent throughout its length, and is slightly bulbous in the head right distal to the presumed lesion, measuring up to 5mm diameter. The gallbladder appears normal.

There is a tiny subcapsular low density lesion in the left lobe of the liver presumably in keeping with a cyst. No other abnormality is seen in the liver, spleen, adrenals and kidneys apart from a few small calculi in both kidneys with the largest measuring just 3.5mm in the left lower pole. No associated hydronephrosis. No abnormality seen in the pelvis.
The lung bases are clear. No significant bony abnormality.

Summary: Prominent CBD and main pancreatic duct - there is a vague impression of a 1cm isodense pancreatic lesion at the distal duct. ERCP with EUS is advised. Small bilateral renal calculi.

Reported by: Dr Edit Gyomber
Verified by: Dr Edit Gyomber

US Abdomen

Performed	15-Jun-2012 14:07	Received	15-Jun-2012 16:53
Reported	15-Jun-2012 16:31	Order Number	G107H26949435
Status	Final	Source System	MiSys

US Abdomen Final
Michael McLachlan
Clinical History : Suprapubic pain.

US Abdomen : The request form has not been correctly vetted. The patient has been fasted for abdominal ultrasound.

The bladder is underfilled but no obvious mass or calculus was identified in the lumen. No right or left iliac fossae masses were identified.

The liver texture is normal. There is no focal lesion seen and no intrahepatic biliary dilatation.Normal gallbladder.

The common duct is slightly above upper limit of normal at 7.2mm. In addition to this the pancreatic duct is seen to be prominent at 5mm. In view of these appearances a distal ductal obstruction or ampullary lesion cannot be excluded on ultrasound and further investigation is advised.

Portal flow was antegrade and the spleen size normal. Both kidneys were normal. The aorta was normal.

No ascites seen.

Summary: 1.Limited imaging of suprapubic area as described.
2.Incidental finding of pancreatic duct and mild common bile duct distension. Cause for this has not been identified. Further investigation to exclude possible ampullary lesion is advised.

(GP surgery will be informed by telephone of this report).

Reported by: Elliot Craig (Sonographer)
Verified by: Elliot Craig (Sonographer)

PART 2 of 2

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	☐

Operation note:

NHS
Greater Glasgow and Clyde
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000
Department:
Contact Tel:
Enquiries to:
Letter Date: 18/03/2026
Reference:
Dictated Date: 18/03/2026
Transcribed Date:

18/03/26

Glasgow Royal Infirmary
Department:

.easK (ST7), Thompson (CT2)

Insertion of left ureteric stent

Background

CTKUB: obstructing 5mm proximal ureteric stone. WCC 30, CRP 182, eGFR 59 (>60). Febrile.

Preparation

ASA3. Short-acting spinal due to LRTI. MLD. Amoxicillin + Gentamicin given in A&E.

Procedure

Meatal stenosis. Dilated with Listers to permit insertion of 22Ch cystoscope. Urethra otherwise unremarkable. Prostate non-occlusive. Both UO's normal. No obvious urothelial lesions but full diagnostic cystoscopy not performed due to patient discomfort at end of procedure. Left UO cannulated with Sensorwire but unable to advance beyond proximal ureter. Stone not visible on fluoroscopy. Unable to get ureteric aspirate. Gentle RPG outlines upper tract. Proximal ureter kinked and unable to advance Sensorwire despite stability from ureteric catheter. Terumo wire eventually advanced to left kidney. Unable to advance ureteric catheter beyond presumed obstructing stone to exchange Terumo for Sensorwire. 6Ch x 26cm stent inserted over Terumo - both curls confirmed. Pus expelled from UO. 14Ch catheter.

Post-op

1. W70, can E&D

2. For level 2 care only if required (as per CEPOD anaesthetist)

3. Continue Amoxicillin + Gentamicin at present (await urine and blood cultures)

4. 20mg LMWH (based on body weight) + TEDS

5. TWOC in 1-2 days if well

6. I have added to stent register

7. I have referred to stone MDT

Jamie Leask (Urology ST7)

Anaesthetic Record

NHS Greater Glasgow and Clyde

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Pre-op

Procedure(s) Insertion ureteric stent

Anaesthetist(s) Bell / McCrorie

Surgeon(s)

Elective ☐ Urgent ☑ Immediate ☐

	C	SAS	ST	CT	PA
Anaesthetist(s)	☐	☐	☑	☑	☐
Surgeon(s)	☐	☐	☑	☐	

Date 18 /03 /26

Discussed with supervising consultant _____

Anaesthetic Record

SUMMARY

GA	☐	FM vent OK	☐
Spinal	☑	LMA OK	☐
Epidural	☐	Laryngoscopy gd	____
Sedation	☐		
Other LA			

ASA 1 2 (3) 4 5

Comment

Anaesthetist
Sign / Print _____

Anaesthetic Record

ASSESSMENT

FASTED.

Airway / Dentition

MP1. Caries A.
Perial upper + lower plate.
No loose teeth. No capl of crowns.
Good neck ROM.

RS

COPD Ex-smoker: 50 years 20/30/ day
PFT(2022): FEV_1 (1.7L – 53% predicted)
FEV_1 : FVC 34%.
Significant gas trapping (FRC 197% predicted)
CXR: hyperinflation
Reports being able to climb 1 flight of stairs
CVS Producing cough for 5 days

Ht 1.74m.
Wt kg
BMI

BP ___ / ___

ECG

Hb 134 Na 139 CRP: 182
WCC 30.7 K 5.1
Plts 282 U 9.0
XMatch Cr 110
Clotting Gluc

VBG
Lactate: 1.0
H^+ : 38
HCO_3 : 29

Anaesthetic Record

Allergies / Reactions

NKDA.

GI / Renal / CNS / Other

Chronic pancreatitis + gastroduodenal microcalcifications
→ deemed not fit for curative surgery by surgeons

Depression

~~Previous~~

Alcohol excess → ~~arms~~ daily
→ last drink 13/03/26.

Lives alone. 1st floor flat.
Denies SOBOE on flat.

Previous anaesthesia / Family history

Current therapy

Ropinirole
Tamsulosin 87/5/9
Tamoxifen
Creon
Salbutamol

OK with NSAIDs ☒

Risks discussed

Spinal – failure
– inferior
– bleeding
– nerve injury / paralysis

Assessor
Sign / Print / Date Rmccrorie CT2.

Anaesthetic Record

Equipment check performed ☐

Vascular access

Cannula 20 G ~~R~~ RFCF pre Thx.

A line

CVP

Airway/Ventilation

FM	✓	Pre-ox	☐
LMA		Cricoid P	☐
ETT		SV	☑
Grade		IPPV	☐

Regional Anaesthesia ☐ CSE CTZ

Spinal @ 01 50

Patient sitting ~~on~~ edge of bed. Feet on stool.
Back cleaned with 0.5% chlorhex.
Allowed to dry.
Midline. 3ml 1% lidocaine infiltrated.
L3/4 palpated.
25G Sprotte.
Clear CSF on 1st pass.
3ml 2% prilocaine injected slowly.
Block to T8 on exam.
No immediate complications.

Paracetamol (mg)	1000							
CANDANSETRON (mg)		4						
Time	01[30]	02[00]						

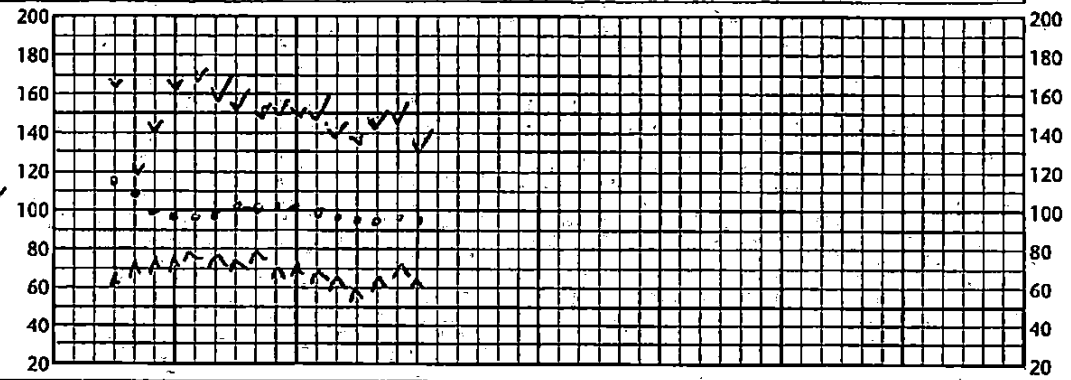
Position

L'Motomy

ECG SpO_2 ☑
NIBP

Fluid warmer ☐

Patient warmer ☐



IV Fluids	①		②						
Events									
FiO_2 N_2O ☐	Ⓐ 4L	4L	3L → →						
SpO_2	84 93	95	93	93	92				
$ETCO_2$									
ETAA									
Temp (°C)	39.6								

Eye care ☑

Pressure point care ☑

Events

Ⓐ
Ⓑ
Ⓒ
Ⓓ
Ⓔ
Ⓕ
Ⓖ
Ⓗ

IV fluids

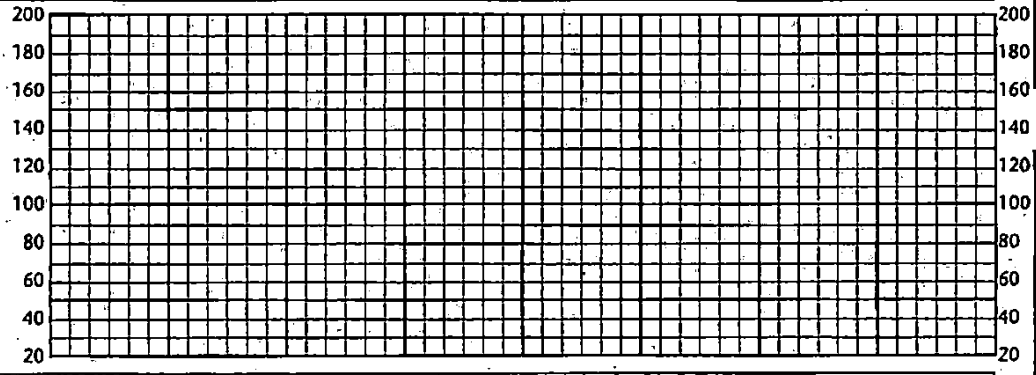
① CSL 1000 ml
② CSL 1000ml
③
④
⑤
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⑪
⑫
⑬
⑭
⑮
⑯

NHS
Greater Glasgow and Clyde

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Anaesthetic Record

Time								



IV Fluids								
Events								
FiO_2 N_2O☐								
SpO_2								
$ETCO_2$								
ETAA								

Anaesthetic Record
Anaesthetic Record
Anaesthetic Record
Anaesthetic Record

NHS Intraoperative Accountable Items Count Record

Date 18-3-26

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

WARD 70

HOSPITAL GRI

THEATRE 9

COUNTS	Scrub/Registered Practitioner Print Name	Circulating Practitioner - Signature & Print name
PRE - OP SWAB COUNT	S. Hutchison (wound)	M PERRY
PRE - OP INSTRUMENT COUNT	S. Hutchison (wound)	M PERRY
FINAL SWAB COUNT	S. Hutchison (wound)	M PERRY
FINAL INSTRUMENT COUNT	S Hutchison (wound)	M. PERRY
FINAL DISPATCH COUNT	S. Hutchison (wound)	M PERRY

SCRUB PRACTITIONER VERIFICATION

I have reviewed this count and can verify my count is correct

SCRUB PRACTITIONER 1 (Sign) - ..... S Hutchison

SCRUB PRACTITIONER 2 (Sign) - ..... N/A ☑

OPERATION : cystoscopy, retrograde + insertion of left ~~urete~~ ureteric stent

HANDOVER COUNT IN EVENT OF REPLACEMENT SCRUB PERSONEL DURING PROCEDURE (This Section N/A) ☑

Temporary Change of Scrub Practitioner (Comments if required)	Outgoing Scrub (1) Print Name	Incoming Scrub (2) Print Name	Circulating Practitioner Signature/Print Name and Time	
	Outgoing Scrub (2) Print Name	Incoming Scrub (1) Print Name	Circulating Practitioner Signature/Print Name and Time	
Permanent Change of Scrub Practitioner and/or Circulating Practitioner	Outgoing Scrub (1) Print Name	Incoming Scrub (2) Print Name	Circulating Practitioner (1) Signature/Print Name and Time	
			Circulating Practitioner (2) Signature/Print Name and Time	

TALLY OF EACH ITEM USED - ADD ANY ITEMS SPECIFIC TO YOUR SPECIALITY

Swabs (2x2)	0	Pledgelets	0	Caesarean Roll	0	ACCOUNTABLE ITEMS THAT ARE TO REMAIN IN SITU e.g. Abdo packs/Swabs, Quantity and Location
Swabs (10x10)	5	Tapes	0			
Abdominal packs	0	Sloops/Slings	0			
Sutures	3	Bulldogs	0			
Blades	0	Shods	0			
IV needles	0	Ports	0			
Syringes	4	Tibbs Cannula	0			
Discard-a-pad	0	Staple Gun Inserts	0			
Diathermy pencil	0	Spears	0			
Diathermy tips	0	Retrieval Bag (Berl)	0			
Scratch pad	0	Digital Tourniquets	0	Throat Pack IN	☐	
Reels	0	Pen & Ruler	0	Throat pack OUT	☐☐☐	
Patties	0	Bi-Polar	0	Total Number		

DISCREPANCY IN COUNT - THIS SECTION N/A ☑

DETAIL IN WHICH COUNT DISCREPANCY OCCURRED:-

Detail of the discrepancy:-

ACTION TAKEN AND OUTCOME (e.g. search undertaken, wound explored, plain x-ray taken)

Scrub Practitioner Signature if count still incorrect

.....

Datix is Completed ☐

Datix Incident Number.....

SURGEONS SIGNATURE IF COUNT INCORRECT FOLLOWING ALL POSSIBLE ACTIONS .....

PLEASE INSERT TRACEABILITY LABELS ON BACK OF BLUE COPY- TO REMAIN IN THEATRE.

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Theatre: 4

Date: 18/3/26

Patient Safety Checklists
North Sector Theatre Suite

Greater Glasgow and Clyde

Anaesthetic Pause (Sign in)
Before any form of sedation or anaesthesia

Patient, Anaesthetist, Assistant/ODP to participate in the anaesthetic pause and cease their tasks:

Silence for pause.

Ask the patient their name and DoB. Check this matches name band and CHI is correct? (Y) N

Does the patient have any Allergies? Y (N)
Or metalwork? Y/N

Ask the patient what operation they are having?
Is there a signed consent form for the expected procedure? (Y) N

Laterality – has the patient been marked? (Y) N/ NA
If lateral block planned attach **STOP BEFORE YOU BLOCK** sticker. Y/(N)
If neuraxial block, check last dose LMWH.>12h Y/(N)

Pregnancy: confirm that the pregnancy status question has been asked. Y/ N/(NA)
(n/a in males, females >55, previous hysterectomy/BSO, post menopausal, surgery for ERPOC)

Anaesthetic equipment available and checked ready to use? (Y) N/ NA

Name/Signed A Clarke A Coulson

Surgical Pause - Pre Skin Incision
Before start of surgical intervention

All the theatre team to participate in the surgical pause and cease their tasks:

Silent theatre for pause.

Scrub Team to Confirm:
Patient Name, DoB, CHI on Name Band and Consent Form? (Y) N
Operation and Laterality on Consent Form (and check mark if laterality)? (Y) N

Anaesthetic Team to Confirm:
Patient Allergies? Y (N)
Antibiotics given in correct dose? (Y) N/ NA
A.S.A. 2
Warming required ? Y/(N)
Any concerns ? Y/(N)

Anaesthetic Assistant to Confirm:
Position of any metalwork/ pacemaker? Y (N)

Surgeon to Confirm:
Does imaging need to be displayed? Y/(N)
Any concerns? Y/(N)
Intra-op DVT prophylaxis? Y/(N)
If yes circle TEDS/Flowtrons/LMWH Y/(N)

Circulating Team to Transfer Information above to the Theatre Whiteboard? (YES)

Emergency cases: CEPOD category agreed? (Y) N
ELLSA data completed ? Y/ N/(NA)

Name/Signed A Clarke

Sign Out
Towards the end of procedure

All the theatre team to participate in the surgical sign out and cease their tasks:

Silent theatre for sign out.

Lead surgeon at table (start of skin closure) (Y) N

Has the correct procedure been recorded? (Y) N
Is the swab, needle and instrument count correct? (Y) N

Is there a specimen? Y (N)
Confirm - labelled and recorded correctly? Y/(N)

Are there any packs or drains in the patient? Y (N)
What are the post-op instructions for these?

What is the estimated blood loss (EBL)? Min ml

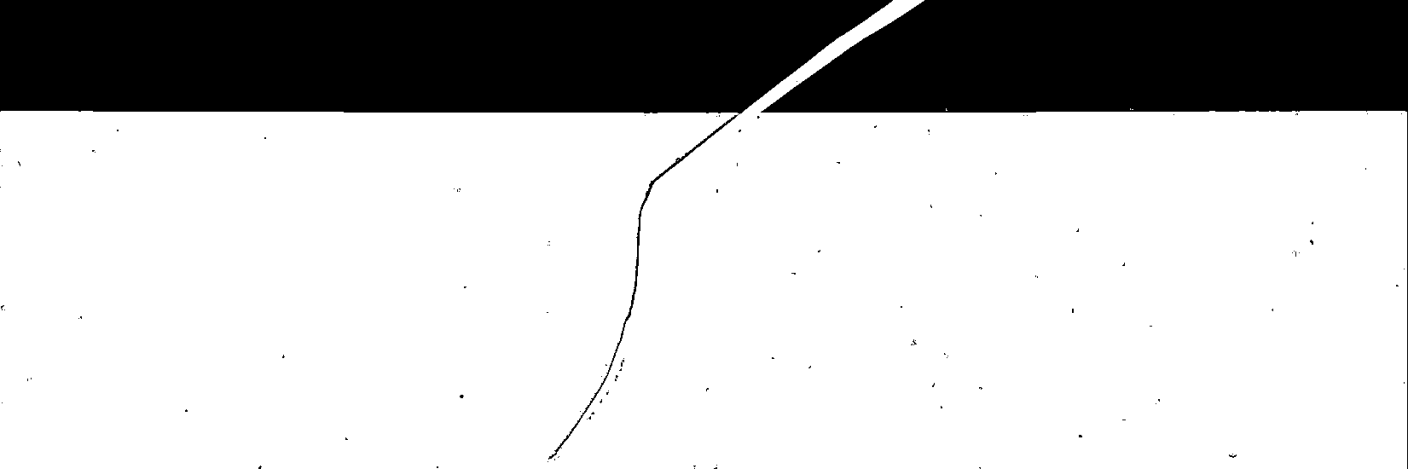
Are more antibiotics required? (Y) N
Has post-op VTE prophylaxis been prescribed? (Y) NA

Can the patient eat and drink immediately post-op? (Y) N
Any concerns for the recovery and management of this patient? Y/(N)

Is the post-op destination still appropriate? (Y) N

Name/Signed A Clarke

Review Date: June 2024



Acute Services Division

NHS Greater Glasgow and Clyde

3112626230
MCLACHLAN
Michael 31/12/196
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DI

Perioperative Care Plan

Hospital: GRI	Consultant:
Ward: AAC	Date: 18/3/26

Theatre Staff - The following information can be found within the My Admission Record (MAR)

Checked by:	Reception Practitioner	Anaesthetic Practitioner
• Relevant Medical History - see MAR	Yes ☐ No ☐	Yes ☐ No ☐

THEATRE STAFF – For Baseline Observations refer to NEWS 2 chart.

Height: ..... **Weight:** .....

WARD Other information

Document any other relevant information e.g. needle phobia, preferred name, interpreter arranged.
Please provide e.g. theatre buddy, 'Getting to know me' document if available.

WARD Safety Checklist

Up-to-date Blood Results available on Clinical Portal	Yes ☑ No ☐	Comments if required:
Blood Cross Matched confirmed by labs	Yes ☐ No ☑ N/A ☐	
Blood Grouped and Saved confirmed by labs 1st sample ☐ 2nd Sample ☐	Yes ☐ No ☑ N/A ☐	
Antibodies +ve ☐ -ve ☐		

Date of Last Menstrual Period (LMP) N/A ☑	Date __/__/__	Comments
Is there any chance you are pregnant? N/A ☑	Yes ☐ No ☐	Comments
Pregnancy test carried out with the patient's consent	Yes ☐ Refused ☐	Comments
Pregnancy test result N/A ☑	Positive ☐ Negative ☐	
Tampon removed N/A ☑	Yes ☐	Comments
MRSA Positive ☐ Negative ☐ Results pending ☐ N/A ☑		Comments
CPE Positive ☐ Negative ☐ Results pending ☐ N/A ☑		
Other Positive ☐ Negative ☐ Results pending ☐ N/A ☑		
PUDRA Yes ☐ N/A ☑ Patient Refused ☐		Comments
PVC care plan in place Yes ☑ No ☐ N/A ☐		Comments

Topical Local Anaesthetic applied Specify site and time applied	Yes ☐ No ☐ N/A ☐ Site 1: Time: Site 2: Time:	

3112626230
MCLACHLAN
Michael 31/12/196
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DI

SAFETY Checklist – Ward Check completed immediately prior to the patient being given a Pre-Med

Preoperative checks	Ward Check	Reception Check N/A ☐	Anaesthetic Practitioner
IDENTITY BAND CORRECT (Name, DoB, CHI number, gender, Ward)	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☐ No ☐
Case Notes / Scanner Folder (circle)	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☐ No ☐
ECG	Yes ☐ No ☑ N/A ☐	Yes ☑ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
MAR document	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☐ No ☐
NEWS chart	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☐ No ☐
Falls risk assessment	Yes ☐ No ☑ N/A ☐	Yes ☐ No ☑ N/A ☐	Yes ☐ No ☐ N/A ☐
Prescription Chart	Yes ☑ No ☑	Yes ☐ No ☑	Yes ☐ No ☐
Alert Sticker – specify:	Yes ☐ No ☑	Yes ☐ No ☐	Yes ☐ No ☐
Biometry	Yes ☐ No ☑	Yes ☐ No ☐	Yes ☐ No ☐
CONSENT FORM checks AWI ☑			
Correct patient information	Yes ☐ No ☐	Yes ☑ No ☐	Yes ☐ No ☐
Procedure and laterality matches Theatre list	Yes ☐ No ☐	Yes ☑ No ☐	Yes ☐ No ☐
Patient confirms proposed procedure	Yes ☐ No ☐	Yes ☑ No ☐	Yes ☐ No ☐
Correct site marked	Yes ☐ No ☐ N/A ☐	Yes ☑ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
Signed by Surgeon and Patient	Yes ☐ No ☐	Yes ☑ No ☐	Yes ☐ No ☐
Dated			
ADULTS WITH INCAPACITY (AWI) N/A ☐ Check;			
2 page Certificate of Incapacity for Single Procedure;	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☐ No ☐
Procedure and laterality matches Theatre list	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☐ No ☐
Dated and Signed by operating surgeon	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☐ No ☐
Correct site marked	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☐ No ☐
4 page Capacity Documentation for Medical treatment present	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☐ No ☐
Certificate of Incapacity under section 47 completed and;	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☐ No ☐
Dated and signed by medical practitioner	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☐ No ☐
ALLERGIES/Sensitivities and Reactions (Please also include food allergies)	Yes ☐ No ☑	Yes ☐ No ☑	Yes ☐ No ☐
If 'Yes' specify:			
Fasted from – specify time (24 hr clock) N/A ☐	Food:	Food: MON	Food:
	Fluid:	Fluid: UNSURE	Fluid:
Blood Glucose Score – if relevant	Time: Score: N/A ☑	Time: Score: N/A ☑	Time: Score: N/A ☐
INTERNAL PROSTHESIS in situ e.g. metalwork, pacemaker, implant etc If 'Yes' state location and type	Yes ☐ No ☑	Yes ☐ No ☑	Yes ☐ No ☐
EXTERNAL PROSTHESIS N/A ☑ e.g. hairpiece, false eye etc. If 'Yes' state type where stored	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☑ N/A ☐	Yes ☐ No ☐ N/A ☐

Nam 3112626230
Addr MCLACHLAN
..... 2 Michael
FLAT 1-1
Dol 10 GIRVAN STREET
CH Glasgow, Lanarkshire
31/12/196
G33 2DJ

Pre-operative checks	Ward Check	Reception Check N/A ☐	Anaesthetic Assistant
Dentures removed N/A ☑	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☐
If 'Yes' state where stored			
Loose teeth, caps and crowns and veneers	Yes ☐ No ☐	Yes ☑ No ☐	Yes ☐ No ☐
State site and type		UPPER FRONT FALSE	
Hearing aid(s) N/A ☑	R ☐ L ☐	R ☐ L ☐	R ☐ L ☐
	Insitu ☐ Removed ☐	Insitu ☐ Removed ☐	Insitu ☐ Removed ☐
If removed state where stored			
Spectacles/Contact lenses removed N/A ☐	Yes ☐ No ☑	Yes ☐ No ☑	Yes ☐ No ☐
If 'Yes' state where stored			
Make-up/ Nail polish removed N/A ☐	Yes ☐ No ☑	Yes ☐ No ☑	Yes ☐ No ☐
False nails in situ – Anaesthetist informed N/A ☐	Yes ☐ No ☑	Yes ☐ No ☑	Yes ☐ No ☐
Jewellery/Body piercing removed N/A ☐	Yes ☐ No ☑	Yes ☑ No ☐	Yes ☐ No ☐
If 'yes' state where stored		RING TAPED	
If unable to remove, please tape and state location			
Have you ever been notified that you are at increased risk of CJD or vCJD for public health purposes?	Yes ☐ No ☑	If yes, contact Infection Control Team and Theatres.	
	Not Known ☑	Infection Control Team Informed on ___/___/___	
Please complete additional CJD question form for High Risk Ophthalmology Procedures	Yes ☐ N/A ☑	Comments if required:	
Inhalers/ sprays with patient N/A ☐	Yes ☑ No ☒	Type: TAKES PUK COPD	
Anti-embolic Prophylaxis prescribed N/A ☐	Yes ☐ No ☑	Type: NO TEDS	
Paper pants in situ – If 'No' specify reason:	Yes ☐ No ☑	State reason: NO UNDERWEAR	
Voided urine/ Catheter in situ/ Urostomy (circle)	Yes ☑ No ☐	Comment if required: PU	
Pre-Medication given N/A ☐	Yes ☐ No ☑	Yes ☐ No ☐	Yes ☐ No ☐
Trolley/ Bed checked for head down tilt and O_2/ Accessories	Bed ☐ Trolley ☑		Bed ☐ Trolley ☐
	Operating chair ☐		Operating chair ☐
	Yes ☐ No ☐		Yes ☐ No ☐
PLEASE PRINT NAME AND SIGN ONCE CHECKLIST IS COMPLETE	Print: S Locke	Print: J DAVIS	Print:
	Sign: S Locke	Sign: J Davis	Sign:
	Time: 01.10	Time: 01.15.	Time::

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Surgical Brief

Surgical Brief carried out:	Yes ☑ No ☐	If 'No' specify reason:

Anaesthetics

Baseline Observations	Pulse:	BP:	Temp:	SpO_2:	Resps:

Stop Before You Block

This section NOT applicable ☐

Stop Before You Block carried out:	Yes ☑ No ☐

Anaesthetic Type – Please tick all that apply

General Anaesthetic ☐	Epidural ☐ Spinal ☑ Combined ☐	Regional Blocks ☐	Throat spray ☐ Time: _____
Local Anaesthetic ☐	Site: Drug:		mls
Sedation ☐	Drug:		mls

Skin Prepping used for Patient Monitoring / Blocks

This section NOT applicable ☑

ARTERIAL CATHETER	Yes ☐ N/A ☐	Chlorhexidine 2%/70% alcohol ☐ Chlor-a-prep solution ☐	Yes ☐ Yes ☐	Other ☐ Specify prep:
CVP CATHETER	Yes ☐ N/A ☐	Chlorhexidine 2%/70% alcohol ☐ Chlor-a-prep solution ☐	Yes ☐ Yes ☐	Other ☐ Specify prep:
SPINAL / EPIDURAL / COMBINED	Yes ☑ N/A ☐	Specify prep: Chloraprep Spray		
REGIONAL BLOCK	Yes ☐ N/A ☐	Specify prep:		

Blood Glucose Monitoring

This section NOT applicable ☑

Time								
BM Score								

Prevention of Eye Injury

This section NOT applicable ☑

Eyes protected from injury during procedure	Yes ☐	Specify:

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Anaesthetics continued

Maintenance of Normothermia

This section NOT applicable ☑

Actions taken to maintain the patient's temperature	Yes ☐ No ☐		
		Warm air blanket device – specify:	Yes ☐ No ☐ N/A ☐
		Warm Fluids	Yes ☐ No ☐ N/A ☐
		Warming Mat	Yes ☐ No ☐ N/A ☐
		Thermal Hat	Yes ☐ No ☐ N/A ☐
		IV fluid warmer	Yes ☐ No ☐ N/A ☐
Temperature documented by Anaesthetist		Other – specify:	Yes ☐ No ☐ N/A ☐

Record of Anaesthetic Pump Infusion Device Numbers

This section NOT applicable ☐

Anaesthetic Practitioner Comments

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Theatre

Safe Positioning

This section NOT applicable ☐

Moving aids used to move patient	Yes ☐ No ☐	Pat Slide ☑	Sliding sheet ☑	Roll board ☐
		Hover Mattress ☐	Other:	

Pressure Area Care (THIS MUST BE COMPLETED)

Pre-operative skin inspection scores (please circle)	Excoriation Level: mild / moderate / severe	Pressure Ulcer Grade: No concerns identified ☐ 1 2 3 4 Ungradable Suspected Deep tissue

No areas of concern identified ☐ Patient refused ☐

Area of concern identified (include area of body)	Actions taken

Position	Positioning Devices		Pressure redistribution	Arm Position
Position 1 **Time:**	Head ring ☐	Lateral supports ☐	Gel pads ☐	**R Arm Position** / **L Arm Position**
Supine ☑ Prone ☐	Pillows ☑	Hydraulic leg supports ☑	Heel gel pads ☐	At side ☐ / At side ☑
Left Lateral ☐ Right lateral ☐	Straps ☐	Limb traction ☐	Full gel mattress ☐	On boards ☐ / On boards ☐
Lloyd Davis ☐ Jack-knife ☐	Wedge ☐	Side supports ☐	Gel wedge ☐	Across chest ☑ / Across chest ☐
Tren-delenburg ☐ Reverse Tren-delenburg ☐	Sandbag ☐	Bolster ☐	Pillows ☐	Hand table ☐ / Hand table ☐
Lower limb traction ☐ Deckchair ☐	Oxford pillow ☐	Other ☐		Hand traction ☐ / Hand traction ☐
Other ☐ Lithotomy ☑	Bean bag ☐			**Secured with:** / **Secured with:**
	Head Pad ☐			J-board ☐ / J-board ☐
				Straps ☐ / Straps ☐
				Pressure care: / **Pressure care:**
				Gel/ Foam pads ☐ / Gel/ Foam pads ☐
Position 2 **Time:**	Head ring ☐	Lateral supports ☐	Gel pads ☐	**R Arm Position** / **L Arm Position**
Supine ☐ Prone ☐	Pillows ☐	Hydraulic leg supports ☐	Heel gel pads ☐	At side ☐ / At side ☐
Left Lateral ☐ Right lateral ☐	Straps ☐	Limb traction ☐	Full gel mattress ☐	On boards ☐ / On boards ☐
Lloyd Davis ☐ Jack-knife ☐	Wedge ☐	Side supports ☐	Gel wedge ☐	Across chest ☐ / Across chest ☐
Tren-delenburg ☐ Reverse Tren-delenburg ☐	Sandbag ☐	Bolster ☐	Pillows ☐	Hand table ☐ / Hand table ☐
Lower limb traction ☐ Deckchair ☐	Oxford pillow ☐	Other ☐		Hand traction ☐ / Hand traction ☐
Other ☐ Lithotomy ☐	Bean bag ☐			**Secured with:** / **Secured with:**
	Head Pad ☐			J-board ☐ / J-board ☐
				Straps ☑ / Straps ☐
				Pressure care: / **Pressure care:**
				Gel/ Foam pads ☐ / Gel/ Foam pads ☐
Position 3 **Time:**	Head ring ☐	Lateral supports ☐	Gel pads ☐	**R Arm Position** / **L Arm Position**
Supine ☐ Prone ☐	Pillows ☐	Hydraulic leg supports ☐	Heel gel pads ☐	At side ☐ / At side ☐
Left Lateral ☐ Right lateral ☐	Straps ☐	Limb traction ☐	Full gel mattress ☐	On boards ☐ / On boards ☐
Lloyd Davis ☐ Jack-knife ☐	Wedge ☐	Side supports ☐	Gel wedge ☐	Across chest ☐ / Across chest ☐
Tren-delenburg ☐ Reverse Tren-delenburg ☐	Sandbag ☐	Bolster ☐	Pillows ☐	Hand table ☐ / Hand table ☐
Lower limb traction ☐ Deckchair ☐	Oxford pillow ☐	Other ☐		Hand traction ☐ / Hand traction ☐
Other ☐ Lithotomy ☐	Bean bag ☐			**Secured with:** / **Secured with:**
	Head Pad ☐			J-board ☐ / J-board ☐
				Straps ☐ / Straps ☐
				Pressure care: / **Pressure care:**
				Gel/ Foam pads ☐ / Gel/ Foam pads ☐

Pressure Area care Chart

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Insert KEY to identify pressure re-distribution:-
E – Elevation **U**- unable to access
R - Reposition

Prevention of Compartment Syndrome
Legs in Lloyd Davis or Lithotomy Position:

This Section NOT Applicable ☐
Patient legs must be rested for 5 minutes every 3 hours. If this does not happen please document reason in comments section.

Time Legs Positioned	Position	Time legs lowered and duration	Time legs lowered and duration	Time legs lowered and duration	Time legs lowered and duration
02 04	Lithotomy				

TIME (Hourly)	HEAD/FACE N/A ☐	ARMS N/A ☐ Left	ARMS Right	HEELS N/A ☐ Left	HEELS Right	LEGS N/A ☐ Left	LEGS Right	O2 SENSOR	OPERATING TABLE RE-POSITION N/A ☐	30° TILT With PILLOW N/A ☐	SIGNATURE

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Theatre continued

Electrosurgery

This section NOT applicable ☑

Monopolar: Yes ☐ N/A ☐		Bipolar: Yes ☐ N/A ☐
Site(s) of Monopolar Return Electrode:		
Skin site(s) assessed and meets safety criteria as per policy	Yes ☐ No ☐	If 'No' state reason:
Skin site(s) clipped	Yes ☐ N/A ☐	State site:
Return Electrode site(s) checked after patient repositioned and is satisfactory	Yes ☐ No ☐ N/A ☐	If 'No' state reason and action:

Tourniquets

This section NOT applicable ☐

Tourniquet equipment applied	Yes ☐ No ☐ N/A ☐	
Padding under tourniquet	Yes ☐ No ☐ N/A ☐	
Cover over tourniquet	Yes ☐ No ☐ N/A ☐	
Post op skin check(s) is satisfactory	Yes ☐ No ☐	If 'No' state reason and action:

Site and side	Time inflated	Pressure	Time deflated	Time re-inflated	Pressure	Time de-flated

Digit Tourniquet

This section NOT applicable ☑

Site and side applied	Time applied	Time removed

Prescribed DVT Prophylaxis

Contraindicated ☐ This section NOT applicable ☑

Intermittent Pneumatic Compression Devices: _____ mmHg	Yes ☐ No ☐ N/A ☐	Left ☐ Right ☐ Bilateral ☐
Foot Pump Devices: _____ mmHg	Yes ☐ No ☐ N/A ☐	Left ☐ Right ☐ Bilateral ☐
TED Stockings	Yes ☐ No ☐ N/A ☐	Left ☐ Right ☐ Bilateral ☐
Other – Specify:	Yes ☐ No ☐ N/A ☐	Left ☐ Right ☐ Bilateral ☐

Fluids for Irrigation

This section NOT applicable ☐

Na Cl 0·9%

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Theatre continued

Skin Preparation

This section NOT applicable ☐

Site – specify: N/A ☐	Clipped	Preparation solution used	
Groin	Yes ☐ No ☐ N/A ☑	Aqueous iodine based solution ☐ Alcohol iodine based solution ☐ Aqueous iodine and sodium chloride 50/50 ☐ Batch no: _____ Expiry Date _____	Chlorhexidine gluconate solution: ___% ☐ Chlorhexidine acetate solution: _____% ☐ Other – Specify: Saline 0.9% ☑ Batch no: _____ Expiry Date: _____
Site – specify: N/A ☐	Clipped	Preparation solution used	
	Yes ☐ No ☐ N/A ☐	Aqueous iodine based solution ☐ Alcohol iodine based solution ☐ Aqueous iodine and sodium chloride 50/50 ☐ Batch no: _____ Expiry Date: _____	Chlorhexidine gluconate solution: ___% ☐ Chlorhexidine acetate solution: _____% ☐ Other – Specify: _____% ☐ Batch no: _____ Expiry Date: _____
Site – specify: N/A ☐	Clipped	Preparation solution used	
	Yes ☐ No ☐ N/A ☐	Aqueous iodine based solution ☐ Alcohol iodine based solution ☐ Aqueous iodine and sodium chloride 50/50 ☐ Batch no: _____ Expiry Date: _____	Chlorhexidine gluconate solution: ___% ☐ Chlorhexidine acetate solution: _____% ☐ Other – Specify: _____% ☐ Batch no: _____ Expiry Date: _____
Site – specify: N/A ☐	Clipped	Preparation solution used	
	Yes ☐ No ☐ N/A ☐	Aqueous iodine based solution ☐ Alcohol iodine based solution ☐ Aqueous iodine and sodium chloride 50/50 ☐ Batch no: _____ Expiry Date: _____	Chlorhexidine gluconate solution: ___% ☐ Chlorhexidine acetate solution: _____% ☐ Other – Specify: _____% ☐ Batch no: _____ Expiry Date: _____

Local Anaesthetic Infiltration to Wound

This section NOT applicable ☑

Site	Drug	Quantity

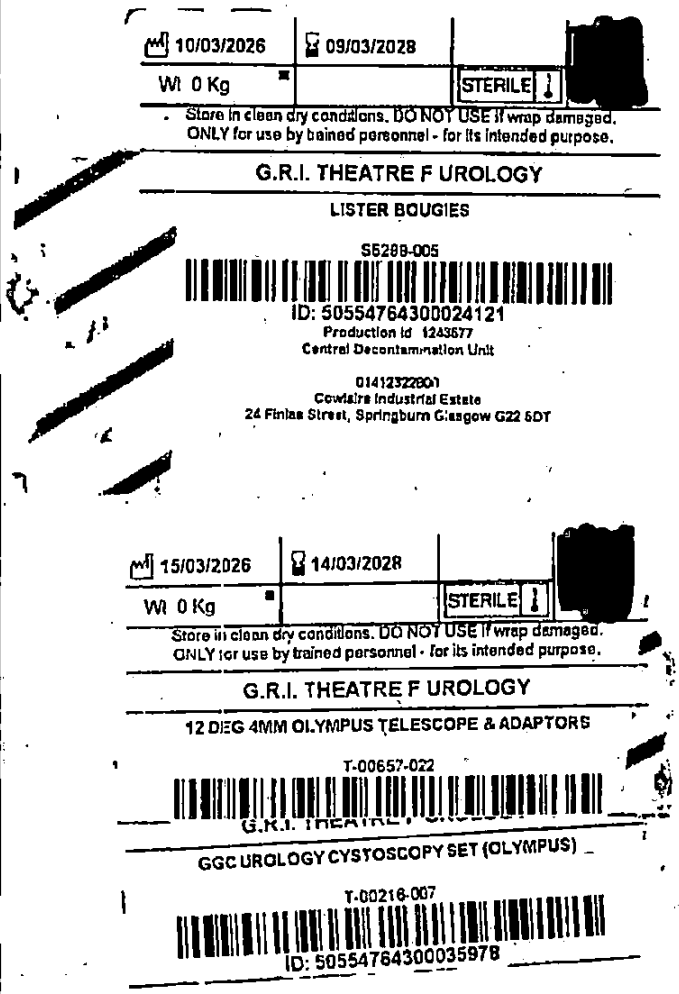
Drains

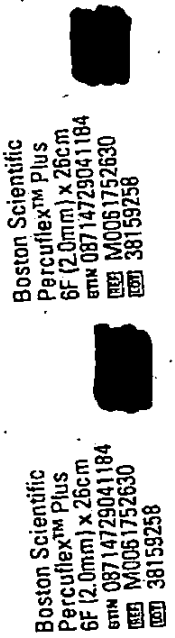
This section NOT applicable ☑

Drain	Site	Type	Size	Secured with	Dressing
1					
2					
3					
4					

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Traceability Stickers





Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Traceability Stickers

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Blood Tag Dispatch

This section NOT applicable ☑

Blood Tags checked and dispatched appropriately: Yes ☐ No ☐

Wound Closure and Dressings (including Packing)

This section NOT applicable ☑

Wound Closure used: Yes ☐ No ☐ N/A ☐ | Wound Dressings: Yes ☐ No ☐ N/A ☐

	Site	Skin Closure	Dressings	Packing and number of pieces
1		Type: Absorbable ☐ Non Absorbable ☐ Other.....		
2		Type: Absorbable ☐ Non Absorbable ☐ Other.....		
3		Type: Absorbable ☐ Non Absorbable ☐ Other:.....		
4		Type: Absorbable ☐ Non Absorbable ☐ Other.....		

Electrosurgery

Electrosurgery return electrode site post-op skin check(s) is satisfactory	Yes ☐ No ☐	If 'No' state reason and action:

Operation / Procedure Performed

Pressure Area Care (MUST BE COMPLETED)

Post-operative skin inspection scores (please circle)	Excoriation Level: mild / moderate / severe	Pressure Ulcer Grade: No concerns identified ☐ 1 2 3 4 Ungradeable Suspected deep tissue

No areas of concern identified ☐ Patient refused ☐

Actions taken if required:

Notes / Comments

Note / Comment	Time	PRINT and Sign

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Immediate Post-Operative Recovery

Surgical handover Instructions e.g. ' hand high elevation'

Verbal Handover from Theatre to Recovery

Verbal Handover given by: To:

Handover should include the following

Patient		**Other**
Patient's name		RSI
Theatre		Awake Fibre Optic Intubation
Procedure		
Allergies		

Recovery — This section NOT applicable ☐

Safe Positioning — This section NOT applicable ☐

Moving aids used to move patient: Yes ☐ No ☐	Pat Slide ☐ Sliding Sheet ☐ Roll Board ☐
If 'Yes' please specify (right)	Hover Mattress ☐ Other ☐ Specify:

Pressure Area Care (MUST BE COMPLETED) — Patient refused ☐

See post operative skin inspection score from theatre on previous page

Skin inspection required a minimum 2 hourly

Time	Patient Position	No Concerns Identified	Excoriation Level N/A ☐	Pressure Ulcer Grade N/A ☐

Area of concern identified (include area of body)	Actions taken (continue in events section on page 16)

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

03[05] - Fentanyl 25mcg (IV)
03[10] - Fentanyl 25mcg (IV)
03[15] - Fentanyl 25mcg (IV)

Post-operative Observations

Time	03[00]	03[15]	03[30]
210			
200			
190			
180			
170			
160			
150			
140			
130	128	128	123
120	^	^	^
110			
100	°	→	
90			
80			
70	V	V	V
60	70	74	64
50			
40			
30			
Airway type	1	1	1
O_2 Therapy	1L	1L	1L
SpO_2	92	92	92
Resp. Rate	16	16	16
CVP	ST	ST	ST
Temp.	37.9°C		
Pain Score	1-3	1-3	1-3
P.O.N.V.	0	0	0
Sedation Score	0	0	0
BM Score	—	—	—
IV staining	—	—	—
Hourly Urine Vol.	400ml		
Total Urine Vol.			
Wound Score	—	—	—
Circulation +ve/-ve			
Sensation +ve/-ve			
Movement +ve/-ve			
Pedal Pulse – R / L			
Drain 1			
Staff initials			

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Time							
210							
200							
190							
180							
170							
160							
150							
140							
130							
120							
110							
100							
90							
80							
70							
60							
50							
40							
30							
Airway type							
O_2 Therapy							
SpO_2							
Resp. Rate							
CVP							
Temp.							
Pain Score							
P.O.N.V.							
Sedation Score							
BM Score							
PV Staining							
Hourly Urine Vol. / Total Urine Vol.	/	/	/	/	/	/	/
Wound Score							
Circulation +ve/-ve							
Sensation +ve/-ve							
Movement +ve/-ve							
Pedal Pulse – R / L							
Drain 1							
Staff initials							

Key to Scoring / Abbreviations

Airway Type	
1	Own
2	Guedel
3	Naso-pharyngeal
4	L.M.A.
5	E.T.T.
6	Tracheostomy

Post Operative Nausea and Vomiting Assessment	
0	None
1	Mild – *Not distressed; No retching/vomiting*
2	Moderate – *Troublesome; Occasional retching/vomiting*
3	Severe – *Distressing; Frequent retching/vomiting*

Sedation Score	
0	Awake
S	Normal Sleep
1	Drowsy, easy to rouse – *Eyes open to speech or light shaking*
2	Sedated, difficult to rouse – *Eyes open only to vigorous shaking*
3	Unconscious, unrousable

Wound Score	
0	Dry and Intact
1	Slight Staining
2	Moderate Staining
3	Saturation / Pad required

Pain Score											
0	1	2	3	4	5	6	7	8	9	10	
No Pain	Mild Pain			Moderate Pain			Severe Pain				

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Events

Event	Action	Outcome

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Events

Event	Action	Outcome

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Discharge

NEWS 2 Score:	Time:	Local Discharge Criteria met: Yes ☐ No ☐

Discharge Comments

Verbal Handover from Recovery to Ward

Verbal Handover given by: To:

Handover should include the following

Patient	Anaesthetic	Theatre	Recovery	Other
Patient's name	Anaesthetic type	Drains	Skin Inspection results	
Theatre	CVP/Arterial Line	Wounds/Dressings	Surgical Instructions	
Procedure	Local anaesthetic Infiltration	Urinary catheter	NEWS 2 Score	
Allergies		Intra-operative events		
	IV Fluids			
	PVC			
	PVC Documentation			

Blood Tag Dispatch

This section NOT applicable ☐

Blood Tags checked and dispatched appropriately: Yes ☐ No ☐

18/03/26

Plain spinal, no sedation. ~~Obs~~ Remains slightly tachy, but rest of vitals satisfactory. O2 sats 92% on 1L - sats to be 88-92%. IV fluids continue. 75 mcg Fentanyl given for pain. No c/o NTV. Free drainage urinary catheter insitu. CSM intact. ——— Hannah

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Use this page to document further patient information if required.

Patient Agreement to Investigation or Treatment
Consent Form

NHS
Greater Glasgow and Clyde

Patient details (or pre-printed label)

Hospital / clinic / GP practice

Patient's surname / family name

3112626230
Patient's fi MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
Date of bir 31 ABERFELDY ST Gender Male ☑ Female ☐
Glasgow, Lanarkshire
G31 3NS

CHI numbe

Special requirements (e.g. other language / communication method)

Statement for practitioner
(to be filled in by practitioner with appropriate knowledge of proposed procedure)

Describe proposed operation, investigation or other treatment.
Where appropriate specify site or side (write in full).

Ureteroscopy
removal of fragments.

Specific risks / complications
Please detail any specific risk/complications related to the procedure that were discussed.

likely infection
scar
bleeding - Risks leaflet given.

I have explained the procedure named on this form to the patient in terms which, in my judgement, are suited to their understanding. In particular, I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure (please specify major procedures above). I have explained who will be doing the procedure if not myself.

Signature of practitioner M McLachlan

Name / Designation (print) Consultant

Date 19/3/18

Statement to be completed by patient / parent*
(*parental responsibility for a minor without capacity)

You should read this form and the notes below carefully. If there is anything you do not understand ask the Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

I understand

- The procedure, important risks and appropriate alternatives which have been explained to me by the practitioner named on this form.
- Who will be performing my procedure on the day
- That any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to the medical treatment proposed, to safeguard or promote physical or mental health.
- That examination for the purpose of teaching will not be undertaken without my consent.

I have been told about additional procedures which may become necessary during treatment. I have listed below **any procedures which I do NOT wish to be carried out without further discussion.**

I agree

- to the administration of an anaesthetic or to sedation if required,
- to the procedure named on this form,
- to the emergency administration of blood or blood products.

Additionally you have to agree or disagree to the following	**Agree**	**Disagree**
to photographic images and video recordings being held in records, and made available for teaching, audit and ethically-approved research purposes, to improve the quality of patient care.	☐	☐
that surplus tissue or other biological material not essential for my diagnosis or future treatment may be used for medical education and ethically approved medical research.	☐	☐

Patient / parent agreement to treatment

Signature V M McLachlan	Date
Name (print)	

Patient refusal for blood products

Please sign here if you refuse to consent to the emergency administration of blood or blood products, **even if this results in death.**

Signature	Date
Signature of practitioner	Date

(9)

Glasgow Royal Infirmary

CHI: 3112626230

Total Att: 4

12 Mth Att: 0

Title: MR

MCLACHLAN **Michael**

DOB: **31/12/1962** Age: **52y** Sex: **Male**

FLAT 1-1
31 ABERFELDY ST
Glasgow
Lanarkshire
G31 3NS
07881578645

Next of kin: **MCLACHLAN, CHEVONNE**
Relationship: **Daughter**
07884204431

GP: **CA Walker**
0141 531 6240

Attendance Date: **21/09/2015** Arrival Time: **08:39**

Registration Time: **08:39** Date of Incident: **21/09/2015**

Major Incident Desc:

Reason for Attendance: **UNWELL**

Nursing Assessment

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

Triage Category: **2** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **21/09/2015 08:44** Nurse name: **Nurse Lindsay Dolan**

Temp	37.8	C
HR	101	bpm
BP	109/90	mmHg
MAP	96.33	mmHg
RR	16	bpm
SpO2	95	%
Oxygen		%

BM	8.6	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	4
Motor	6
Verbal	4
Total	14

Pupils-Right		Pupils-Left	
Size (mm)	1	Size (mm)	1
Reaction	Y	Reaction	Y

Nursing Notes: **biba - pt found wandering streets this am. pt appears confused laceration to head. gcs 14 temp 37.8. pt remebers watching tennis yesterday and states takes diazepam.**

3112626230 31/12/1962 MCLACHLAN Michael
3112626230 31/12/1962 MCLACHLAN Michael
3112626230 31/12/1962 MCLACHLAN Michael
3112626230 31/12/1962 MCLACHLAN Michael
3112626230 31/12/1962 MCLACHLAN Michael

To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

Date	**Clinical Notes**
	Seen By: Time Seen:

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By
21/9/15	PARACETAMOL	1g	PO			

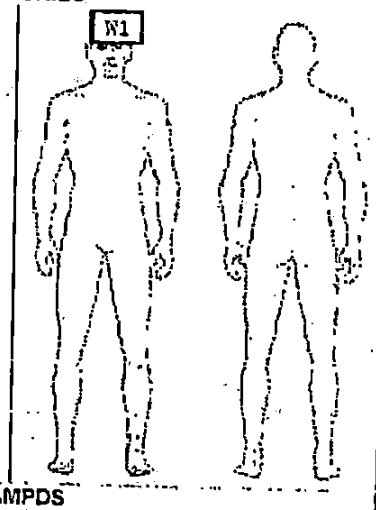
Time	08: : 09/2015
PATIEN	S
Incident number	J01
Name	MICHAEL MCLACHLAN
Address	1/1, 31 ABERFELDY STREET, DENNISTON
Age	50 years
Date of birth	31/12/1962
Gender	Male
Incident location	O/S 35 ABERFELDY STREET DENNISTOUN GLASGOW
Incident post code	G31 3NR
Incident type	EMG
Call received	21/09/2015, 07:46
Call passed	21/09/2015, 07:45
Crew mobile	21/09/2015, 07:46
Crew at scene	21/09/2015, 07:54

PRIMARY SURVEY

RESPONSE	
AVPU	Alert
AIRWAY	
Airway assessment	Clear
BREATHING	
Breathing rate	Normal
Respiratory rate	18
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	No evidence of C-spine injury
PATIENT CONSENT	
Patient consent	Treatment benefits explained, Risks of condition explained, Risk of refusal explained, Capacity to understand risks and treatment

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

INJURIES



Dispatch code	25D01V
Final code	23B01
AMPDS	
	Psy/Abnormal behave/Suicidal Not Alert - Violent
	Overdose without priority symptoms
GCS	
Final GCS eye ope	Spontaneous
Final GCS verbal	
Final GCS motor	

Time hr : min	08:04	08:10
Pulse bpm	116	122
Pulse rhythm	Reg	Reg
Resp. rpm	16	16
BP mm Hg	134 / 104	117 / 81
Refill (secs)	<2 secs	<2 secs
Flow %	-	-
Blood sugar mmol / l	6.6	-
Pain / carer concern	-	-
Pain score	0/10	0/10
Temp °C	39.3	38.6
Sats %	95	95
NEWS Total	14	14
RTS	7.6	7.6
ECG	Sinus tachy	Sinus tachy
Sepsis	2	2
Lactate	-	-
AVPU	Alert	Alert

SEPSIS

Sepsis: Pneumonia
Sepsis: UTI
Sepsis: Other infection
Sepsis: Abdo pain
Sepsis: Diarrhoea
Sepsis: Abdo distension
Sepsis: Meningitis
Sepsis: Cellulitis
Sepsis: Septic arthritis
Sepsis: Wound infection
Sepsis: Infected indwelling device

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EYES AND PUPIL SIZE AND REACTION

	Left	Right
Pupil size	Normal	Normal
Pupil reaction	Normal	Normal

AMPLE

Allergies	None
Other allergies	
Medication	UNKNOWN
Past history	UNKNOWN. ?PSYCHIATRIC.
Last eaten	>5 hrs
Events prior	PT FOUND BY NEIGHBOUR WANDERING ABOUT AT 05.45HRS TODAY. O/A PT VERY AGITATED, CONFUSED. OBVIOUSLY FELL DURING NIGHT. PT COVERED IN DIRT ETC. ?LENGTH OF TIME OUTSIDE.

EMERGENCY SERVICES ON SCENE

	Paramedic
Technician	

PATIENT HANDOVER

On arrival at scene	Standing
Scene removal	Walking
Transportation	Seated
Care delivery at hospital	Trolley

FINAL OBSERVATION AND COMMENTS

PT APPEARS AS THOUGH HE MAY HAVE TAKEN SOME DRUGS LAST NIGHT/RECENTLY. PUPILS CONSTRICTED. PT AGITATED AND POSSIBLY HALLUCINATING. NOT MAKING SENSE. HAS ABRASION TO FOREHEAD, FELL LAST NIGHT? PT ALSO PYREXIAL OF UNKNOWN CONFUSION.

Report ID

3112626230
MCLACHLAN
Michael M
FLAT 1-1 31/12/196
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

Patient Sample Report

Patient

ID:	3112626230
Last Name:	**MCLACHLAN**
First Name:	**MICHAEL**
Gender/Age:	Male, 52 years
Birth Date:	31.12.1962
Status:	**ACCEPTED**
Analyzed:	21.09.2015 09:11:19
Sample Type:	**Venous**
Account Number:	
Clinician:	
Operator ID:	KATHRYN MCKITTRICK0

Analyzer

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

Measured (37.0°C)		
cH	45.6	nmol/L
pCO_2	7.5	kPa
pO_2	1.7	kPa
Na^+	143	mmol/L
K^+	4.2	mmol/L
Cl^-	105	mmol/L
Ca^{++}	1.30	mmol/L
Glu	6.0	mmol/L
Lac	1.3	mmol/L
CO-Oximetry		
tHb	142	g/L
O_2Hb	10.6	%
COHb	1.2	%
MetHb	1.6	%
HHb	86.6	%
sO_2	10.9	%
Derived		
BE(B)	3.0	mmol/L
HCO_3^-(c)	30.2	mmol/L
Hct(c)	43	%
Operator Entered		
Temp	37.0	°C

O2 and Vent Settings

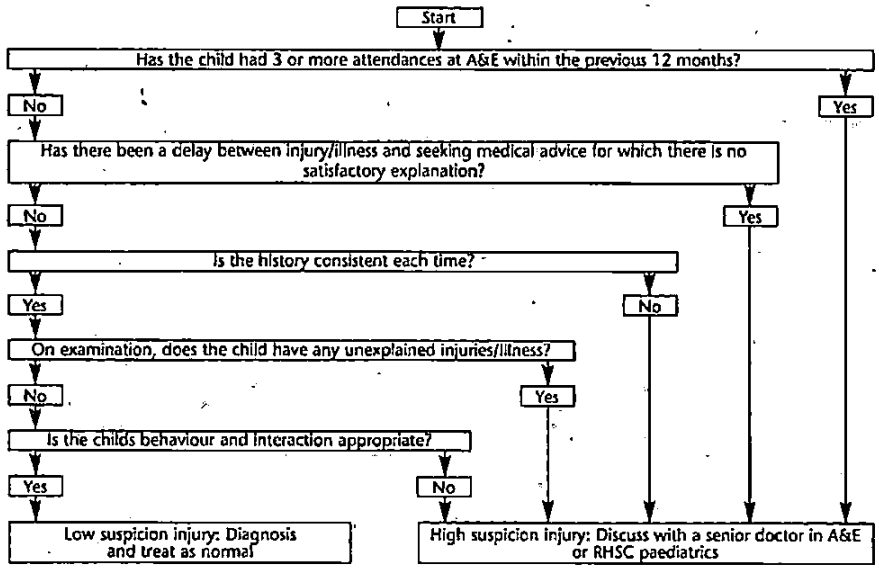
Glasgow Royal Infirmary
Unitary Patient Record
(Part A - Acute Assessment)

NHS
Greater Glasgow and Clyde

3112626230
MCLACHLAN M
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Injury/Illness Flow Chart for all Patients 16 and under

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



All Clinical Staff Consider

H.I.Form ☐

Audit Form ☐

Police Consent ☐

Clinical Notes

Date	Time	Name	Grade	Speciality
21/9/15	09:00	F. BLANN	ST4	EM

Pt 52 ♂ confused

HPC little history from patient as per PRF
found by neighbour walking in door. confused + agitated @ 05:45
states fell down stairs during night
unclear what he has been doing ? LOC
? taking drugs / alcohol
denies pain at present
AMT 3/4

PTD

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)

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Michael
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31/12/1962

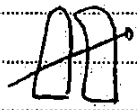
Clinical Notes

Date	Time	Name	Grade	Speciality

PMH, Bipolar — Ox, NKDA — Sw lives alone. unemployed
Venlafaxine
Sertraline
Quetiapine

OE unkempt tt — borderline pyrexial 37.8
clothes dirty + wet — HR 101 BP 109/90

Abrasion to forehead — RR 16 Sat 95%
Incised wound to (R) knee, multiple abrasions to hands + legs



bilateral afe
chest clear

HS I + II + 0
Murmur
ECG - SR rate 91 nil acute

Abdomen soft, non distended
non tender BS active

GCS 14 | 15 (V4 M6 E4)

pinpoint pupils size 1 but reactive

no gross focal neurology

mumbling + fidgeting
black staining to lips + teeth

VBG- Hb 45.6

Imp, confusion — ? infection — Lac 1.3
borderline pyrexial — ? drug ingestion — Alc 6.0
head injury — ? bleed

Plan, IV access + bloods sent inc. cultures
IV fluid
urinalysis + CXR
CT head.

F Burton ST4

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

NHS
Greater Glasgow and Clyde

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Clinical Notes

Date	Time	Name	Grade	Specialty

CT head - NAD - no bleed

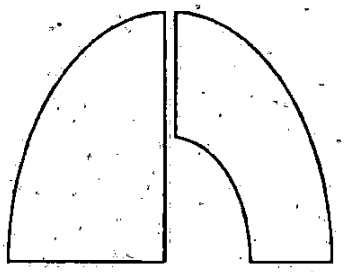
CXR - patchy (R) L2, nil grossly abnormal

Bloods - WCC ↑ 15·1 Temp ↑
CRP 13
Ethanol < 10
otherwise all within normal ranges.

Plan admit medicine
new confusion ? cause
treat as sepsis unknown origin
SIRS3 ↳ IV antibiotics.

F BLUNSTY

X-Ray results



ECG findings

Other investigations

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Biochem/Haematology results

Indicate which lab tests have been requested

Haem	Date and time
WCC	15·1
Hb	139
Plat	195
MCV	94·4
Neut	13·3
DDim	Date and time
PT	
PTT	
TT	

Bioch	Date and time
Na+	143
K+	4·3
Cl-	107
Ur	6·9
Creat	85
Glu	6·2
CRP	13
Bil	Date and time
AST	48
ALT	43
GGT	
ALP	104
Prot	
Alb	41
Glob	
Ca++	2·39
Amyl	Date and time
TSH	
FT4	
Ethanol	<10
Tropl	Date and time
Chol	
Trig	
CK	270
Para	Date and time
Sal	
S osm	
ABG	Date and time
H+	
P_aCO_2	
P_aO_2	
Bic	
BE	
FiO_2	
Lactate	

Fluids Prescribed in A&E

Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time

Drugs Prescribed in A&E

Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time

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.

Glasgow Royal Infirmary
Acute Medicine Unit

(Part B - Medical Admission)

NHS
Greater Glasgow and Clyde

3112626230
MCLACHLAN M
Michael 31/12/1962
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31 ABERFELDY ST
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Date & Time 21/9/15 1347 Consultant Dr Carty Ward 50/51

Ward Review (Should be completed within 2hrs of transfer from ED)

Check List

- VTE ☐
- Med - Rec ☐
- Kardex ☐
- CxR ☐
- ECG ☐
- Oxygen ☐
- Patient on Bleeders list ☐

Fy2 S.Ghouri ward clerk in

PC - Fall

Ido PC - 52 ♂ pt very drowsy initially → on asking why he was brought to hospital said he fell down the stairs last night. Doesn't recall events after that until he was in hospital

From A+E notes → was found by neighbour walking in close, confused + agitated at 5:45 says drinks 3 times/wk - vodka 4 pints drinks drinking last night says night have slipped. clothes all soaking wet.
ϕ chest pain, SOB, fever
c/o cough in the morning since 6 months
Had CT Head → NAD

PMH - Bipolar disorder
Depression (at present as per pt)
ϕ DM, HTN, previous stroke

SH - Lives alone
Unemployed
ex smoker
1x drug user (Heroin, until 2009)

Allergies NKDA

Medications — Sertraline
Quetiapine

Ward Review

O/E more awake now, AMT 4/4 GCS 15/15

Obs - Stable BP 112/58 mmHg

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M
31/12/1962

Chest clear HS I+II+0 regular

Abdo - SNT
BS+

CNS -

	P	T	R	S	Plantars
RUL	5/5	N	(not done)	N	↓
RLL	5/5				↓
LUL	5/5				
LLL	5/5				

(R) knee → wound closed c steristrips
bruise extending 5cm below knee
tender (R) calf - not red / hot / swollen

wounds also on top of head, (L) elbow,
also non blanching rash noted on torso + front of chest + abdo + back new? drug reaction?

Arterial Nurse Catheline, pt admitted to taking street diazepam last night.

ECG - SR ↑HR 91/min CXR - patchy consolidation (R) base

CT Head → NAD, no bleed Given 1g bd dose of IV Flucloxacillin, Benpen, Gent
Ethanol <10, CK (N)

CRP-13	Na-143	ALT-43	(R) likely community acquired Pneumonia
WCC-15.1	K-4.3	ALP-104	Switch to oral abx ?
Hb-139	Ur-6.9	Alb-41	-1/7 on weird wound
Plts-195	Cr-85	Ca-2.39	add dalteparin to bloods
MCV-94.4	AST-48		

Impression Fall 2° Sedative Diazepam

NHS GG&C Adult Risk Assessment for Venous Thromboembolism (VTE)

[excluding orthopaedics, obstetrics and gynaecology & ENT who have specialty-specific policies]

- Risk Assessment must be completed for all patients within 24 hours of admission to hospital
- Patients must be reassessed every 48-72 hours or sooner if condition changes
- Reassessment must be documented in Kardex
- Please complete risk assessment and then sign and date Risk Assessment Result box at bottom of page.

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Surgical patients start here

Non-operative [mainly medical] patients start here

Is the patient bed-bound or expected to have reduced mobility relative to normal state for ≥ 2 days?

Yes ☐ No ☐

Does the patient have any risk factors for thrombosis? (tick √ all that apply)

Age >60	☐	Use of oestrogen-containing contraceptive therapy	☐
Active cancer or cancer treatment	☐	Use of hormone replacement therapy	☐
Dehydration	☐	Pregnancy or < 6 weeks post partum [seek specialist advice]	☐
Known thrombophilias	☐	Critical care admission eg HDU/ITU	☐
Obesity (BMI>30)	☐	Total anaesthetic + surgical time >90 minutes	☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or Inflammatory disease	☐	Surgery involving pelvis or lower limb with a total anaesthetic + surgical time >60 minutes	☐
Personal history or first degree relative with a history of VTE	☐	Acute surgical admission with inflammatory or intra-abdominal condition	☐
Varicose veins with phlebitis	☐	Hip fracture	☐

- No thromboprophylaxis required.
- Continue to reassess every 48-72 hours or sooner if condition changes.
- Document all reassessments in drug kardex.
- **Risk assessment now complete**
- **Complete Risk Assessment Result Box**

Yes, 1 or more risk factors identified ☐

No risk factors identified ☐

Does the patient have any contraindications to pharmacological prophylaxis? (tick √ all that apply)

Active bleeding	☐	Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands)	☐
Acquired bleeding disorders (e.g. acute liver failure)	☐	Neurosurgery, spinal or posterior eye surgery	☐
Concurrent use of anticoagulants (such as warfarin with INR>2)	☐	Lumbar puncture, epidural/spinal anaesthesia expected within the next 12 hours	☐
Acute stroke	☐	Other procedure with high bleeding risk – discuss with senior if unsure	☐
Uncontrolled hypertension (230/120 mmHg or higher)	☐	Lumbar puncture, epidural/spinal analgesia within the previous 4 hours	☐
Thrombocytopenia (<75 x 10⁹/l)	☐	Thyroid surgery	☐

- **Discuss with senior clinical staff before prescribing pharmacological prophylaxis**
- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48-72 hours or sooner if condition changes.

No contraindications to pharmacological prophylaxis identified ☐

Contraindications to pharmacological prophylaxis identified ☐

Surgical patients – Enoxaparin 40mg + AES ☐*
*prior to application of AES, please check contraindications to AES
Medical patients – Enoxaparin 40mg ☐
Prescribe Enoxaparin at 6pm
[on day of surgery, at the later of either 4h post-op or 6pm]
Reduce Enoxaparin to 20mg if <50Kg or eGFR <30ml/minute/1.73m² ☐
Discontinue at discharge or when returned to pre-morbid mobility

Contraindications to anti-embolism stockings (AES) Y ☐ N ☐
Peripheral neuropathy ☐
Peripheral vascular disease ☐
Cellulitis or Gross oedema ☐
Leg deformity or Fragile skin ☐
Leg / foot ulcers ☐
Allergy ☐
Unusual leg size/shape ☐

Risk assessment result – please tick √ all that apply

VTE risk factors: YES ☐ NO ☐ Contraindications to pharmacological prophylaxis: YES ☐ NO ☐ Prescribed: LMWH ☐ AES ☐ NONE ☐
Patient informed of VTE risks and benefits of thromboprophylaxis YES ☐ NO ☐ N/A ☐ Information leaflet provided YES ☐ NO ☐

Print Assessor's Name: _____ Signature: _____ Date: _____

Medicine Reconciliation Form

Source of information: ECS ☐

Patient ☐ Relative/ carer ☐ GP surg ☐ GP computer printout/letter ☐ Patient's own drugs ☐ Other (specify) _____

Admission Medicines (including OTC, herbal, homeopathic)				Plan for medicines (unless indicated to stop or hold medication should be continued on drug kardex)				
Name	Dose	Freq	Route	Amend	withold	Stop	continue	Reason for alteration
Allergies/adverse events								

List obtained by _____ Designation _____

Recently altered/discontinued medicines prior to admission and reasons why _____

_____

Compliance aid? Y ☐ N ☐ Type _____ If, Y Community Pharmacy _____ Phone _____

Senior Medical staff review: Sign _____ Title _____ Date and Time _____

Reviewed by pharmacist _____ Date and Time _____

Comments

Consultant Review

Check List	
VTE ☐	
Med - Rec ☐	
Kardex ☐	
CxR ☐	
ECG ☐	
Oxygen ☐	
EDD	

PRINT NAME	DESIGNATION
SIGNATURE	DATE & TIME

Clinical Notes

Nursing Notes 21/9/15 @ 1250

52 year old man admitted via A&E following fall in close; found by neighbour confused?

News nav 0. BM's stable. Eating + drinking. Patient vague but AMT 4/4. Wound to (L) knee, steri strips applied + dressing to protect. FYI has removed but requires full medical clerk in.

Nok unaware + patient unable to provide correct phone number.

21/9/15 Fy2 Admin

1925 Pt wishing to discharge against medical advice. Despite explaining to him that he is still unsteady on his feet moreover has a chest infection for which he needs treatment. Asked him to at least stay until consultant reviews him. But pt adamant to leave. Says will see his GP & CPN. He has full capacity to make decisions. Discharge against medical advice form signed by pt

Aylward Fy2 #2207

3112626230
MCLACHLAN M
Michael 31/12/1962
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G31 3NS

Clinical Notes

Nursing notes 21/9/15 @ 1530

Discharged against medical advice;
Signed form, PVC removed. See FY2's
previous documentation.
Patient states that he will go to ~~Oban~~ Rhaw.
his GP tomorrow.

3112626230
MCLACHLAN
Michael
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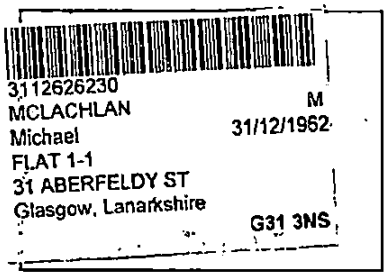
M
31/12/1962

Clinical Notes

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary

Date



Refusal of Treatment

I ....Michael McLachlan....
of ....above....

Hereby 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 ....M McLachlan....

Witness ....Syeda Ghosi....

* Delete whichever is inapplicable.

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name
Address 3112626230
MCLACHLAN
Michael M
FLAT 1-1 31/12/1962
31 ABERFELDY ST
Glasgow, Lanarkshire
CHI No G31 3NS
DoB

	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

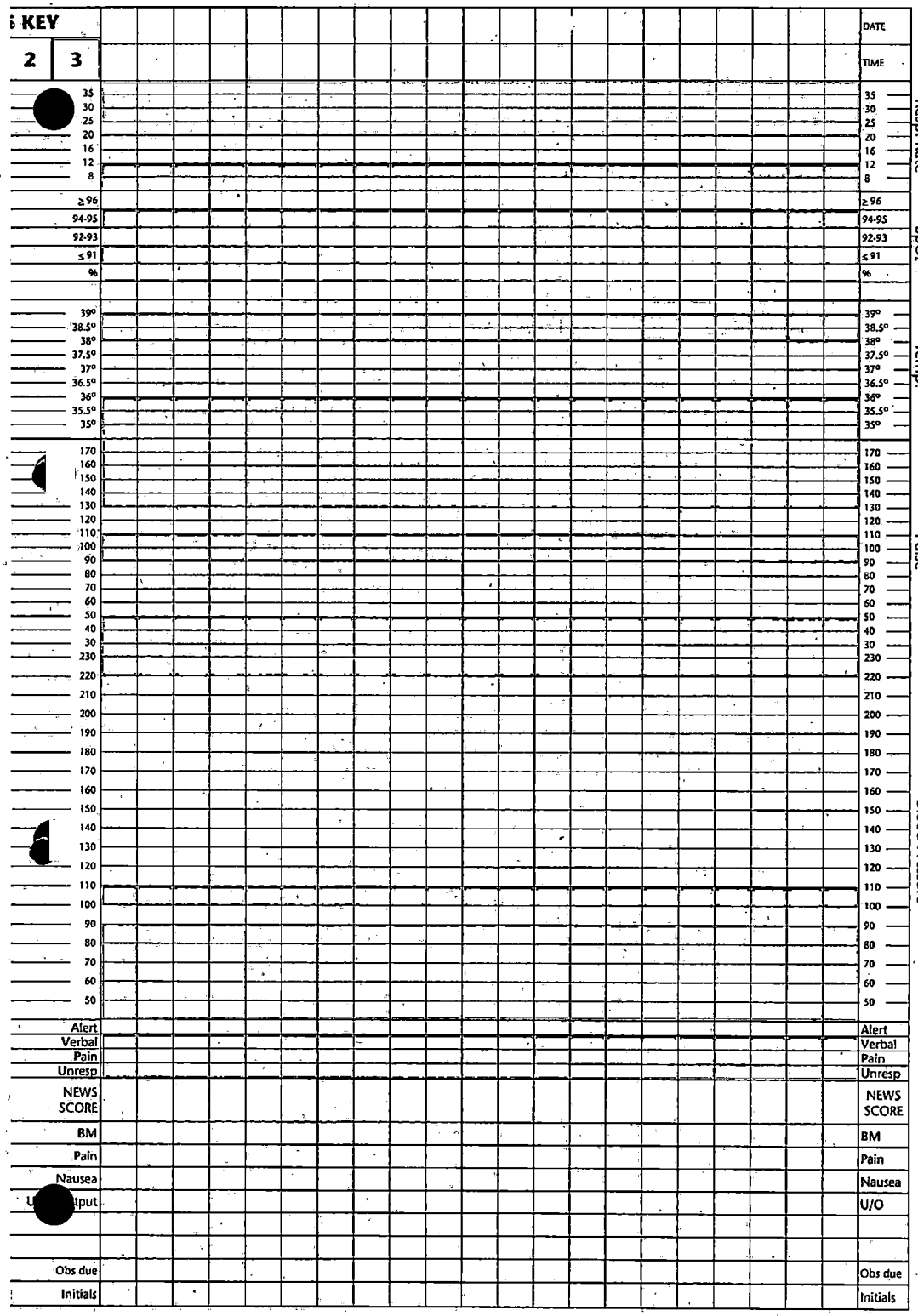
See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more **or** 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.

(9)

Michael McLachlan

| | | |


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Neurological Observations

| | | |

Acute Services Division

Nursing Admission & Assessment

NHS Greater Glasgow and Clyde

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

1. Admission

Hospital: GRI	Ward: 5
Date of admission: 21/9/15	Time:
Admitting Consultant:	Admitting Nurse:
Expected date of discharge: / /	

1. Patient Details

Preferred name: Michael	Next of Kin (NoK): Chevonne
Age: 52	Relationship: daughter
Religion: N/A	NoK Address:
Telephone: 07881578645	
GP: Dr. CA Walker Shettleston Health Centre GP address: 420 Old Shettleston Road Glasgow G32 7JZ	NoK Telephone: 07884204431
	NoK Aware of admission: ☐ Yes ☑ No
	Consent for information to be given to relatives: ☑ Yes ☐ No Nominated family contact: Telephone - Day: Telephone - Evening:
GP telephone:	

Is the patient a carer? ☐ Yes ☑ No If 'Yes' refer to Duty Social Worker if required: ☐ Referred ☐ Not required

Does the patient have an appointed Welfare Guardian / Power of Attorney? ☐ Yes ☐ No ☑ N/A

a. If 'Yes' please provide – Name: ..... Relationship: .....

Contact telephone number: .....

b. If 'Yes' does the patient have an 'Adult with Incapacity Section 47' certificate in place? ☐ Yes ☑ No ☐

If 'No' to 'b' please inform medical staff. Name of doctor informed: .....

2. Presenting Complaint / Diagnosis

Confusion

Why does the patient think they are in hospital? *Use patients own words:*

3. Allergies (including food allergies)

No known allergies: ☑

4. Observations

Cannard	Waterlow	MUST	Pulse	BP	Resp	SaO_2	Temp
✓	✓	✓	73	112/56	17	99	37.4
Urinalysis:		AMT4 Score	BM	NEWS Score	Weight Estimated / Actual	Height Estimated / Actual	BMI
		4	5.6	0	95kg	5ft 10	

5. Current Medication

Medicines reconciled on admission? ☐ Yes ☑ No

6. Relevant Past Medical History

Bipolar.

7. Risk Assessment

MUST

1. Is the patient's BMI:
   - > 20 ..... Score 0
   - 18.5-20 ..... Score 1
   - <18.5 ..... Score 2

   Score 0

2. Has the patient had unplanned weight loss in the past 3-6 months?
   - < 5% ..... Score 0
   - 5-10% ..... Score 1
   - >10% ..... Score 2

   Score 0

3. If the patient is acutely unwell and there has been or is likely to be no food intake for > 5 days:
   Score = 2

   Not applicable: Score = 0

   Score 0

MUST Score: 0

If score 1 or more, complete full Nutrition Profile

Name: .....
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8. Cognitive Impairment

For all patients ≥ 65 years, ask the following 4 AMT questions:

1. How old are you? ..... years
2. What is your date of birth? / /
3. What is this place? .....
4. What year is it? .....

If the patient does not answer all questions correctly then refer to medical staff.

AMT Score: 4 ... out of 4

Name of Doctor informed (if required)

..... Grade .....

9. MRSA Screening / CJD / Healthcare outside Scotland

Will the patient be an inpatient >23 hours? ☐ Yes ☑ No If 'Yes' complete the following section.

1. Has the patient ever had a previous positive MRSA result? ☐ Yes ☑ No ☐ Not known
2. Has the patient been admitted from a Care Home/ institutional setting or another hospital? ☐ Yes ☑ No ☐ Not known
3. Does the patient have a wound / ulcer or invasive device which was present prior to this admission? ☐ Yes ☑ No ☐ Not known

If **'Yes'** to any of the above questions **OR** if the patient is admitted to a 'high impact speciality' e.g. **Orthopaedics, Vascular, Renal Unit, Critical Care – then obtain MRSA Swabs:**

☐ **Nasal** ☐ **Perineum** ☐ **Other - Specify:** ☐ **Patient refused**

CJD: **Has the patient ever been contacted by Public Health and told that they are possibly at risk of CJD:**

☐ Yes ☑ No If 'Yes' contact Infection Control Team. Infection Control Team contacted: ☐

Healthcare outside Scotland

Has the patient been transferred from, or received health care in, a hospital outside of Scotland in the last 12 months:

☐ Yes ☑ No If 'Yes obtain rectal swab and send to microbiologty for CPE screen.

Rectal swab taken ☐ Patient refused ☐

10. Lifestyle

Smoking:

Does the patient smoke? ☑ Yes ☐ No

If 'Yes' how many per day: 15 cpd

Does the patient use nicotine replacement therapy? ☐ Yes ☑ No

Does the patient wish referral to Smoking Cessation Service?

☐ Yes ☐ No If 'Yes', date of referral: / /

Drugs: Does the patient use recreational drugs? ☑ Yes ☐ No If 'Yes' specify: diazepam street.

Alcohol (Men): How often do you have **8** or more drinks on one occasion:

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

If 'Monthly' or more then complete FAST Tool.

Alcohol (Women): How often do you have **6** or more drinks on one occasion:

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

If 'Monthly' or more then complete FAST Tool.

11. Admission Documentation Completed By

Name (Please PRINT): K. shaw	Signature:
Designation: SN	Date: 21.9.15

Acute Services Division

Nursing Admission & Assessment

2. Assessment

Hospital: GRI	Ward: 5
Date of Assessment: 21/9/15	Time: 1230

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1. Breathing and Circulation

Breathing:

- [x] No symptoms or history of respiratory problems
- [ ] Dyspnoeic at rest
- [ ] Dyspnoeic on minimal exertion
- [ ] Dyspnoeic on maximum exertion
- [ ] Productive / non-productive cough evident
- [ ] Normally receives oxygen therapy

If 'Yes' provide details:

Circulation:

- [x] No symptoms
- [ ] Known cardiac or circulatory problems

Problem identified: [ ] Yes [x] No If 'Yes' please describe

Initial KG

2. Communication

Assessment of ability to communicate:

What language does the patient speak?:

English

Interpreter: Required [ ] Not required [ ]

If required, provide details and arrangement made:

Does the patient have:

a. Speech difficulties? [ ] Yes [x] No

b. A learning disability e.g. Down's Syndrome? [ ] Yes [x] No

If 'Yes' please specify:

If 'Yes' contact Liaison Learning Disability Team.

Liaison Learning Disability Team contacted: [ ] Yes [ ] No

c. A learning difficulty e.g. dyslexia, dyspraxia? [ ] Yes [ ] No

If 'Yes' please specify:

3. Senses

Senses:

Eyesight

- [x] Normal vision
- [ ] Glasses – [ ] Distance [ ] Reading
- [ ] Prosthesis – [ ] Left [ ] Right
- [ ] Contact lenses
- [ ] Registered blind

Hearing

- [x] Normal
- [ ] Hearing impaired
- [ ] Hearing aid – [ ] Left [ ] Right

4. Mental Status

Mental Status:

- [x] Orientated
- [ ] Confused
- [ ] Distressed
- [ ] Aggressive /Abusive
- [ ] Unconcious

Problem identified: [ ] Yes [x] No If 'Yes' please describe

Initial KG

5. Hydration and Nutrition

MUST Score: 0 If score is 1 or more complete a Nutrition Profile.

Nutition Profile completed ☐ Yes ☑ No

If 'Yes' do not complete sections 5a to 5d.

- If score is 0, reassess / screen patient in 7 days.
- Complete sections 5a to 5d.

Date of reassessment: / /

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5a 1. Food likes / dislikes:

Not fussy

5a 2. Fluid likes / dislikes:

5c. Help needed with eating and drinking:

☐ Yes ☑ No

If 'Yes' provide details:

5b. Cultural or religious diet needed (e.g. vegetarian, vegan, halal, kosher etc):

☐ Yes ☑ No

If 'Yes' specify diet needed:

5d. Texture Modified Diet needed?

☐ Yes ☑ No

If 'Yes' specify texture: A☐ B☐ C☐ D☐ E☐

Thickened Fluids required? ☐ Yes ☐ No

If 'Yes' specify stage required: 1☐ 2☐ 3☐

Problem identified: ☐ Yes ☑ No If 'Yes' please describe

Initial KS

6. Elimination

Continent:
☐ Bladder
☑ Bowel

Incontinent:
☐ Bladder
☐ Bowel

NHS GGC Stool Chart commenced:
☐ Required ☐ Not required

Long-term urinary catheter in situ? ☐ Yes ☐ No If 'Yes' – Size: ..... fg Make: .....
Date catheter last changed: / /

Continence assessment commenced:
☐ Yes ☐ No ☐ Not applicable

Containment products in use? Please specify:

☐ Bowels regular
☐ Constipated
☐ Diarrhoea / loose stools

Stoma: ☐ Yes ☐ No
If 'Yes' please specify and list appliances used:

Problem identified: ☐ Yes ☑ No If 'Yes' please describe

Initial KS

7. Personal Hygiene, Oral Health and Skin Assessment

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Personal hygiene:

- [x] Self-caring and independent
- [ ] Requires assistance

Specify assistance if required:

Oral health:

Self-caring and independent	[x] Yes	[ ] No
Does the the patient have a sore mouth	[ ] Yes	[x] No
Does the patient have a non healing mouth ulcer	[ ] Yes	[x] No

If the patient has a sore mouth or non healing mouth ulcer, refer to dentist (See StaffNet for dentist referral pathway) and implement Oral Care Bundle.

Oral Hygiene Care Bundle:

- [ ] Required
- [x] Not required

Dentures:

- [ ] Not worn
- [ ] Upper set
- [ ] Lower set
- [ ] Full set
- [ ] Dentures with patient on admission

Skin assessment:

- [ ] Skin healthy with no evidence of damage
- [x] Skin broken
- [ ] Skin oedematous
- [ ] Skin discoloured
- [ ] Skin clammy

If 'Yes' to any of the above, describe skin condition:

Wound Assessment Chart completed: [x] Yes [ ] No [ ] Not applicable

Pressure ulcer evident: [ ] Yes [x] No

If 'Yes' please identify Grade and record on Pressure Ulcer record sheet – Grade: .....

Problem identified: [x] Yes [ ] No If 'Yes' please describe

Fall – Knee (L) dressed. Grazes to face

Initial KS

8. Mobility

Patient fully mobile / independent? [x] Yes [ ] No If 'No' complete Moving and Handling Assessment.

- [ ] Limited mobility
- [ ] Mobile with aid – Specify:
- [ ] Prosthesis – Specify:

Moving and Handling Plan commenced:

- [ ] Yes
- [ ] No

Problem identified: [ ] Yes [x] No If 'Yes' please describe

Initial KS

9. Maintaining a Safe Environment

Pain status:

Does the patient have pain? [ ] Yes [x] No

If 'Yes' record Pain Score on NEWS chart.

What makes their pain better? Please provide brief details:

Bed rail assessment completed: [ ] Yes [x] No

Bed rails required:

- [ ] Required
- [x] Not required

Problem identified: [ ] Yes [x] No If 'Yes' please describe

Initial KS

10 Sleep and Rest

Sleep habits:

☐ Less than 8 hours ☐ Afternoon nap
☐ Morning nap

Sleep difficulties:

☑ None ☐ Disturbed
☐ Early wakening e.g. nocturia, insomnia

Medication required: ☐ Yes ☑ No

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Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial

11 Social Circumstances

☐ Employed ☑ Unemployed ☐ Retired
☑ Lives alone
☐ Lives with Family
☐ Friend
☐ Dependants
☐ Other: ☐ Nursing Home ☐ Residential

Current Care / Support arrangements:

☐ Social Services ☐ Unpaid carer e.g. family, friends
☐ Private Carers ☑ None

If support services in place, please provide details:

Problem identified: ☐ Yes ☑ No If 'Yes' please describe

Initial

12 Privacy, Dignity and Sexuality

Does the patient have issues related to privacy, dignity and/or sexuality that are relevant to admission?

☐ Yes ☑ No

If 'Yes' please provide brief details:

13. Spiritual Care

Is there anything with regard to faith or culture that we can support the patient with during their stay in hospital (e.g. prayer, meditation)?

☐ Yes ☑ No

If 'Yes' please provide brief details:

Is there anything causing the patient a lot of anxiety at the time of admission that staff should be aware of?

☐ Yes ☑ No

If 'Yes' please provide brief details:

Ask the patient:

"Would you like the ward staff to arrange for a Hospital Chaplain to visit you while in hospital?"

☐ Yes ☐ No ☑ Not at this time

If 'Yes' please specify faith group:

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...label

14. Anticipatory Care

(This section is for patients thought to be in the last year of life, where appropriate and relevant)

Appropriate ☐ Not appropriate ☐

Is the **patient** aware of their:
Diagnosis? ☐ Yes ☐ No
Prognosis? ☐ Yes ☐ No

Is the **patient's family** aware of their:
Diagnosis? ☐ Yes ☐ No
Prognosis? ☐ Yes ☐ No

Preferred place of care:
Home: ☐ Hospital ☐ Hospice ☐

Preferred place of death:
Home: ☐ Hospital ☐ Hospice ☐

Current treatment – please identify (e.g. chemotherapy/ radiotherapy):

Other agencies involved in patient's care – please identify (e.g.) Marie Curie, MacMillan Nurses):

DNACPR order in place: ☐ Yes ☐ No
If 'Yes' are the patient's family and next of kin aware? ☐ Yes ☐ No

15. Admission Assessment Completed By

Name (Please PRINT): Kathryn Shaw.

Signature:

Designation: SN

Date: 21/9/15

Clinical Notes

Date and Time	Notes	Name, Signature and Designation

Clinical Notes continue on next page

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Clinical Notes (continued)

Date and Time	Notes	Name, Signature and Designation

MCLACHLAN, MICHAEL D: 3112626230 21-Sep-2015 9:03:02 ACUTE ASSESSMENT UNIT,GRI

Male

Loc: 202 [redacted]

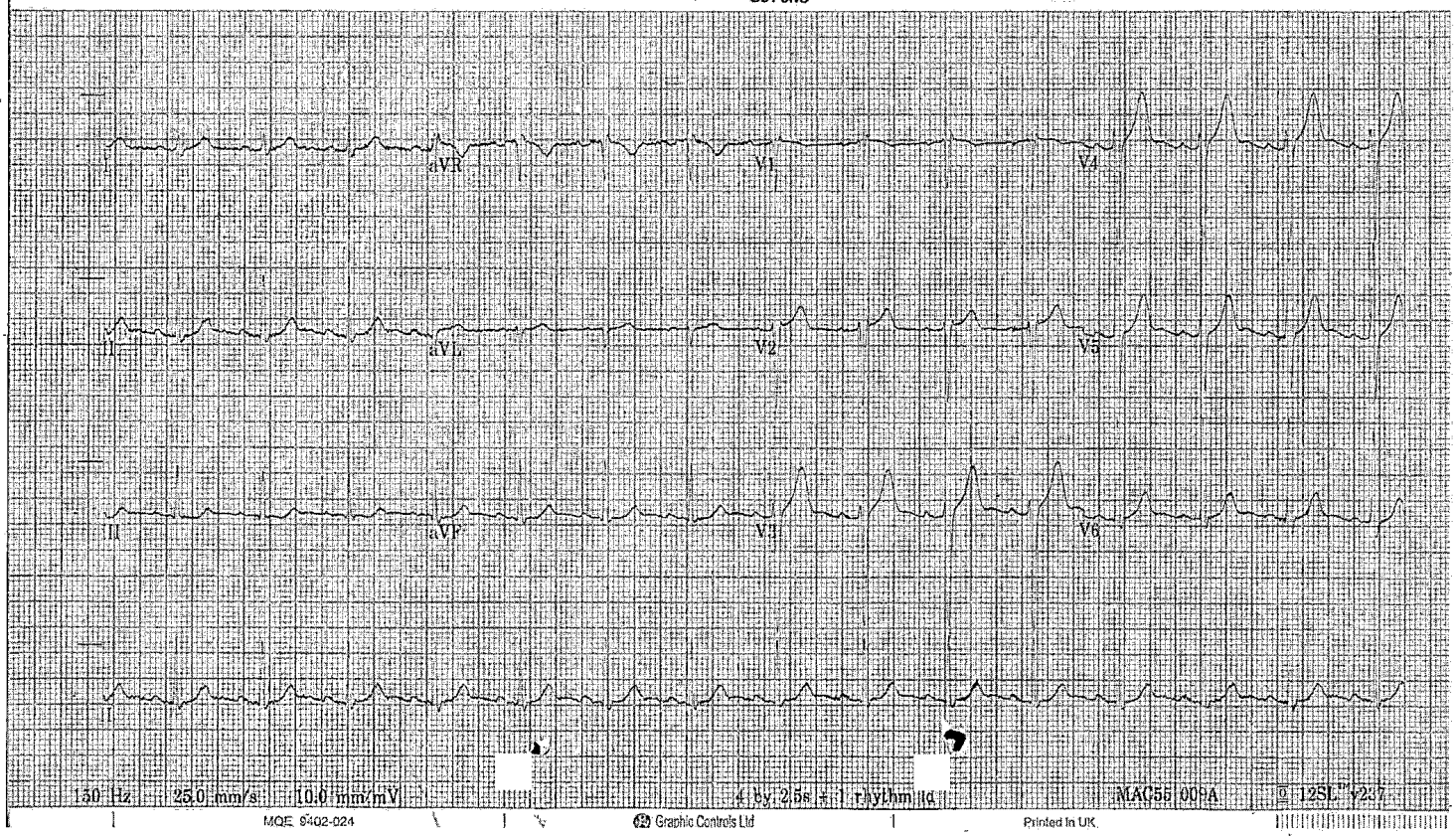
Technician:

Vent. rate	91 bpm
PR interval	144 ms
QRS duration	94 ms
QT/QTc	336/413 ms
P-R-T axes	45 79 45

Normal sinus rhythm
Normal ECG

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Unconfirmed



Acute Services Division

Hospital / Department: GRI S8

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

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G31 3NS Unit/Hospital number

Contents

1. Canard Falls Risk Assessment Scoring Form
2. Falls Assessment Care Plan
3. Glossary of terms used in risk assessment

Notes: Risk assessment should be completed within 24 hours of admission to each ward.

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

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

Referral Criteria for Hospital Falls Prevention Co-ordinator

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

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

General Safety Precautions

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

Cannard Falls Risk Assessment

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

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						Date: 21.9 Ward: 53	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		1						
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	1						
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed / chair-bound/ wheel-chair 1		1						
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		3						
				TOTAL SCORE		10						
				ACTION(S) TAKEN Enter action code(s) from Care Plan below		1-5,23						
SCORE 13+ = HIGH RISK If patient unconscious score as N/A until patient status improves.				NURSE SIGNATURE								



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

Falls Assessment Care Plan

Please tick all applicable nursing interventions

	NURSING INTERVENTIONS	Date: 21 Ward: 53	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:
Action code								
1	Falls prevention and general safety precautions discussed with patient and family.	✓						
2	Move to more observable area of ward to optimise supervision.	✓						
3	Advise patient they may experience dizziness when they mobilise initially.	✓						
4	Requires assistance with mobilisation.	✓						
5	Observe trip hazard due to invasive lines, drains and catheters.	✓						
6	Do not leave the patient unattended when using commode, toilet, in shower or the bathroom area.							
7	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.							
8	Monitor lying and standing / sitting BP and pulse.							
9	A. Patient requires footwear or podiatry referral. (Date referred: / requested :) B. Request family / carer to provide suitable footwear.							
10	Commence continence assessment, follow Local Guidelines.							
11	Refer to Occupational Therapist.							
12	Select suitable seating (refer to policy).							
13	Non slip mat on chair /floor following advice from therapists.							
14	Refer to Physiotherapist.							
15	Review Transfer techniques.							
16	Request medication review.							
17	Bed/chair monitor in use.							
18	Falls map in use for seven days for patient who has second or subsequent falls.							
19	Bed rails/bumpers to be used (refer to policy).							
20	Patient requires low bed / mattress on the floor (refer to policy.)							
21	Patient requires one to one nursing care.							
22	Refer to Hospital Falls Prevention Co-ordinator (see criteria on front cover).							
23	Other interventions.	✓						

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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 Oxycontin.

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.

Care Plan

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Commenced and Signature	1. Breathing and circulation	Date Discontinued and Signature	Date Commenced and Signature	7. Personal Hygiene, oral care and skin care	Date Discontinued and Signature
	NO concerns NEWS of 0 4			IND	
	2, 3. Communication and senses			8. Mobility	
21/9/15	NO concerns		21/9/15	IND	
	4. Cognitive status			9. Maintaining a safe environment	
	AMT 4/4 rarely quite vague			encouraged to use buzzer	
	Getting to Know Me / What matters to me			10. Sleep and Rest	
	N/A			encourage rest	
	5. Hydration and Nutrition			12. Privacy, dignity and sexuality	
	IND			no concern	
	6. Elimination			Negotiated care - Care discussed with patient / family Yes / No Patient able to participate Yes / No	
	IND · MSSU				

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Care Plan Guidance

Below are some prompt questions to help you record the individualised care that your patient requires during their inpatient stay. You should record the care that the nurse / nursing staff require to provide. The 'Negotiated Care' component provides opportunity to record any care that the patients family or carers are participating in and care that patients are being taught to support changing self care. If the patient is independent in any of the activities of living and requires no nursing intervention then you should record this in the relevant section.

When care changes a note should be made in the nursing clinical notes / progress notes to confirm why this is required.

1. Breathing and circulation	7. Personal Hygiene, oral care and skin care
Record frequency of observations, TPR BP and SAO2. Record any other care that the patient requires for their breathing or their circulation e.g. seating position, apex beat with radial pulse, pedal pulse measurement, lying and standing Blood Pressure measurement etc.	Does the patient need assistance with personal hygiene? If so what needs to be done. Do they require assistance with oral care? If so what is this. Does the patient require any specifc pressure area care outwith the Active Care documentation. If totally independent record 'self caring'.
2, 3. Communication and senses	**8. Mobility**
What assistance does the patient need with communication? If they use spectacles or a hearing aid what assistance do they needs with these? Does the patient require an interpreter?	Does the patient require assistance when mobilising? Does the patient use mobility aids? Is the patient at risk of falling? Record key information from falls risk assessment, e.g. Cannard tool, to prevent falls
4. Cognitive status	**9. Maintaining a safe environment**
What care is required to minimise risk of harm due to behavioural disturbance? Think about capacity and adults with incapacity and what you need to do with the patient to alleviate distress.	How is the patients pain being assessed? Is a specific pain assessment tool used? What does the patient require to maintain their safety?
Getting to Know Me / What matters to me	**10. Sleep and Rest**
The 'Getting to know me' Document should be used for all patients with cognitive impairment. Once completed by the patients relatives / carer record the key information to plan care in the care plan. Ask the patent what matters to them during their hospital stay and record in this area.	What would help the patient achieve a good nights rest? Does the patients sleep pattern need to be monitored? if yes record what needs to be done.
5. Hydration and Nutrition	**12. Privacy, dignity and sexuality**
Does the patient require any assistance with eating and / or drinking? Does the patient require a special diet? Do they require fluid balance monitoring?	What do you need to do to maintain the patients modesty and dignity?
6. Elimination	**Negotiated care -** Care discussed with patient / family Yes / No Patient able to participate Yes / No
Does the patient require assistance to go to the toilet? Do they use continence aids? Does their urinary output require to be monitored? Are the patients stools / bowel activity being monitored?	Discuss patient care needs with them. If the patient is learning a new self care procedure record their process and progress of learning. If the patient has a learning disability or dementia use the information obtained in the Getting to Know Me document to identify the care that the family / carer could participate in.

Fluid Balance Chart

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Michael 31/12/1962

Hospital: GRI
Ward: 51
Date: 21/9/15

Reason for Fluid Balance Chart: IVF
Is patient fluid restricted? Yes ☐ No ☑
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids? Yes ☐ No ☒ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

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ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
08:00																	
09:00																	
10:00																	
11:00																	
12:00	admitted lunch	300							300	PO							
13:00																	
14:00																	
15:00																	
16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
								*Total Intake	[redacted]						*Total Output	[redacted]	

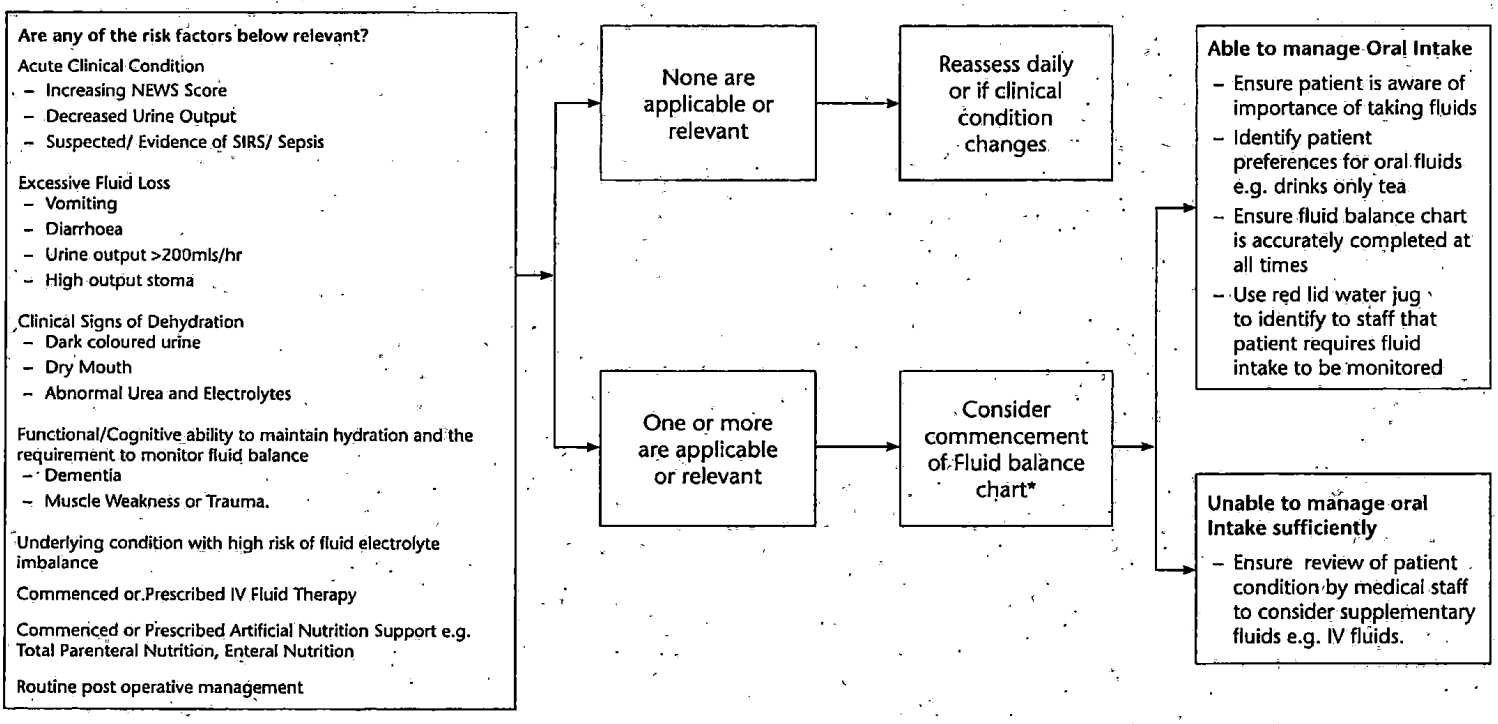
*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

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Ward 43 GRI

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Greater Glasgow and Clyde

Daily Summary of Fluid Balance

Date	Oral	I.V.	Other	Total	Urine	Gastric	Other	Total

Routine Urine Chart

Date								
Protein								
24hr Volume								
Colour								
S.G.								
Reaction								
Sugar								
Ketones								
Bilirubin								
Urobilinogen								
Blood								
Nitrite								
Leucocyte								
Sample Sent								

Stool Chart

Date	Time	Colour	Consistency	Abnormalties	F.O.B.	
					- ve	+ ve

CHI:	Modified V.I.P (Visual I n Phlebitis) Score		
	IV site appears healthy		
	One of the following is evident : slight pain or redness near site	1	Possible first signs : Observe cannula
	Two or more of the following are evident: pain,redness,swelling	2	Early stage of phlebitis - Remove & resite cannula
	All of the following are evident: pain,redness,hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: Remove & resite cannula Seek further advice
	As above including: palpable venous cord	4	
	As above including :pyrexia	5	

Insertion – Complete all sections

PVC inserted ED Theatre Ward_____	Date inserted	Insertion site	Colour of PVC	Inserted by: Name & Designation *[only if inserted in ward]*
Clinical indication IV Fluids/IV Medication ☐	Urgent access ☐	Interventional procedures ☐	Other Please state:	
Insertion Criteria (If no: please explain in comments below) Clean field used Yes ☐ No ☐ Unknown ☐	Hand hygiene Yes ☐ No ☐ Unknown ☐	Skin asepsis Yes ☐ No ☐ Unknown ☐	Dressing affixed Yes ☐ No ☐ Unknown ☐	Non touch technique (do not re- contaminate cleaned skin) Yes ☐ No ☐ Unknown ☐

Maintenance – To be completed daily

PVC 2	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	The PVC has been inserted less than 72 hours	Hand hygiene before & after all procedures	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 2 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After day 3 consider removal, if there is still a clinical reason justify rationale for PVC to remain in situ.							
Day 4 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

Date & time	PVC no.	Comments	Signature

Date removed_____ Reason for PVC removal_____ Reason PVC in greater than 72 hours_____

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

Peripheral Vascular Cannula(PVC) Insertion & Maintenance

NHS Greater Glasgow and Clyde

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis : Observe cannula
One of the following is evident : slight pain or redness near site	1	Possible first signs : Observe cannula
Two or more of the following are evident: pain,redness,swelling	2	Early stage of phlebitis - Remove & resite cannula
All of the following are evident: pain,redness,hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: Remove & resite cannula Seek further advice
As above including: palpable venous cord	4	
As above including :pyrexia	5	

Insertion – Complete all sections

PVC inserted ED Theatre Ward_____	Date inserted	Insertion site	Colour of PVC	Inserted by: Name & Designation *(only if inserted in ward)*
Clinical indication: IV Fluids/IV Medication ☐	Urgent access ☐	Interventional procedures ☐	Other Please state:	
Insertion Criteria (If no: please explain in comments below)	Clean field used Yes ☐ No ☐ Unknown ☐	Hand hygiene Yes ☐ No ☐ Unknown ☐	Skin asepsis Yes ☐ No ☐ Unknown ☐	Dressing affixed Yes ☐ No ☐ Unknown ☐
				Non touch technique (do not re- contaminate cleaned skin) Yes ☐ No ☐ Unknown ☐

Maintenance – To be completed daily

PVC 1	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	The PVC has been inserted less than 72 hours	Hand hygiene before & after all procedures	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 2 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After day 3 consider removal, if there is still a clinical reason justify rationale for PVC to remain in situ.							
Day 4 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

Date removed_____ Reason for PVC removal_____ Reason PVC in greater than 72 hours_____

Date & time	PVC no.	Comments	Signature

NHS
Greater Glasgow and Clyde

NATVNS
SCOTLAND

3112626230 3EL
MCLACHLAN No .....
Michael M
31/12/1962 .....
.....

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

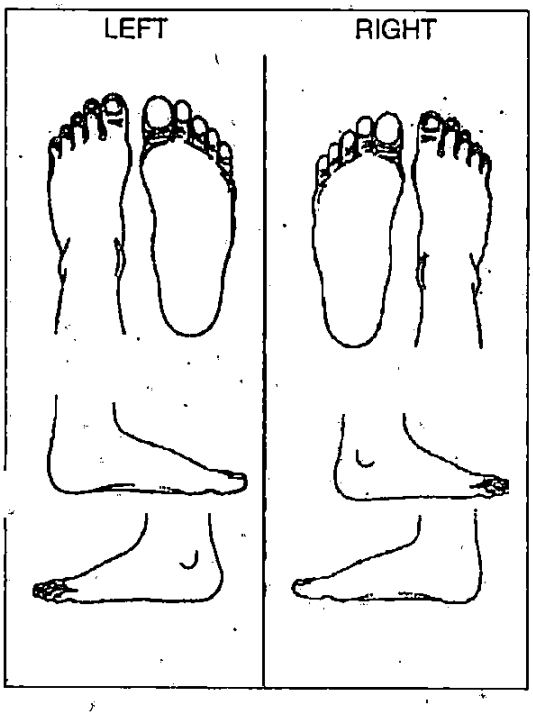
Sex		(1)								
Male	1									
Female	2									
Age										
14 -49	1									
50 -64	2	(2)								
65 - 74	3									
75 - 80	4									
81+	5									
Build/Weight for Height (BMI=weight in Kg/height in m²)										
Average - BMI 20-24.9	0	(0)								
Above average - BMI 25-29.9	1	1								
Obese - BMI > 30	2									
Below average - BMI < 20	3									
Continence										
Complete/catheterised	0	(0)								
Incontinent urine	1									
Incontinent faeces	2									
Doubly incontinent (urine & faeces)	3									
Skin Type - Visual Risks Area										
Healthy	0									
Tissue paper (thin/fragile)	1	(1)								
Dry (appears flaky)	1	(1)								
Oedematous (puffy)	1									
Clammy (moist to touch)/pyrexia	1									
Discoloured (bruising/mottled)	2									
Broken (established ulcer)	3	(3)								
Mobility										
Fully mobile	0									
Restless/fidgety	1									
Apathetic (sedated/depressed/reluctant to move)	2	(2)								
Restricted (restricted by sever pain or disease)	3									
Bedbound (unconscious/unable to change position/traction)	4									
Chairbound (unable to leave chair without assistance)	5									
Nutritional Element										
Unplanned weight loss in past 3-6 months		(0)								
<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										
Multiple organ failure/terminal cachexia	8									
Single organ failure e.g. cardiac, renal, respiratory	5									
Peripheral vascular disease	5									
Anaemia = Hb < 8	2									
Smoking	1	(1)								
Special Risks - Neurological Deficit										
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*	4-6									
Special Risks - Surgery/Trauma										
On table > 6 hours	8									
Orthopaedic/below waist/spinal (up to 48 hours post op)	5									
On table > 2 hours (up to 48 hours post op)	5									
Special Risks - Medication										
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4									
Total Score		8								
Date		21-9-15								
Initials		KS								
Time		17:00								

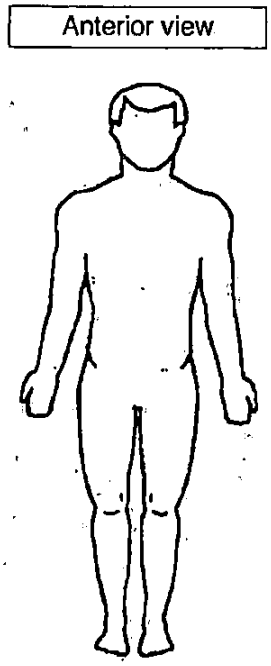
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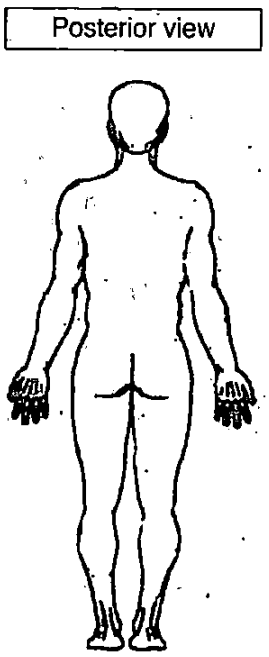
Ensure plan of care is implemented / reviewed for all identified areas of concern.

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.

GRADE 4 Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss.

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

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

FORMAL WOUND ASSESSMENT CONTINUATION

Complete on initial assessment and thereafter complete at every dressing change

Date of Assessment	21.9.15							
Number of wound	①							
Analgesia required *(Refer to local pain assessment tool)*	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Regular/ongoing analgesia	N							
Pre-dressing only	N							
Wound Dimensions (enter size)								
Length (cm/mm)	3cm							
Width (cm/mm)	0.5cm							
Depth (cm/mm)	0.5cm							
Or tract wound circumference								
Is wound tracking/undermining	N							
Photography obtained	N							
Tissue type on wound bed (enter percentages)								
Necrotic (Black)								
Sloughy (Yellow/Green)								
Granulating (Red)	100%							
Epithelialising (Pink)								
Hypergranulating (Red)								
Haematoma								
Bone/tendon visible								
Wound exudate levels/type (tick all relevant boxes)								
Low	✓							
Moderate								
High *								
Serous (Straw)								
Haemoserous (Red/Straw)								
Purulent (Green/Brown/Yellow)*								
Peri-wound skin (tick relevant boxes)								
Macerated (White)								
Oedematous *								
Erythema (Red)*								
Excoriated (Red)								
Fragile								
Dry/scaly	✓							
Healthy/intact								
Signs of Infection * 1 or more of these signs may indicate possible infection								
Heat *								
New slough/necrosis (deteriorating wound bed)*								
Increasing pain*								
Increasing exudate*								
Increasing odour*								
Friable granulation tissue*								
Treatment objectives (tick relevant box)								
Debridement								
Absorption	✓							
Hydration								
Protection	✓							
Palliative / conservative								
Reduce bacterial load	✓							
Assessors Print Initials	KJ							
Dressing Renewed (planned or unplanned dressing change)	planned							
Re-assessment date	23.9.15							

83825

WOUND TREATMENT PLAN AND EVALUATION OF

3112626230
MCLACHLAN M
: Michael 31/12/1962
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

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

Date	Wound Number	Cleansing Method, Dressing Choice & Rationale	Frequency	Evaluation & Rationale for changing dressing type	Signature
21/9/15	①	(L) knee, steristrips applied, irrigated with saline, mepilex border	as required	to promote healing, reduce bacteria, to absorb	K

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS
Apply addressograph label

Ward:

Discharge destination:

Estimated Discharge Date (1) / /

Estimated Discharge Date (2) / /

Final date of discharge : / /

Checklist	Yes	N/A	Initials	Comments
Patient informed				
Relative/carer informed				
Others informed: Care Home				
Transport arranged				
Own transport (preferred option)				
Ambulance-1 man/ 2 man am/pm				
Other: Flight, Air ambulance etc.				
Discharge medication				
Discharge prescription completed				
Compliance aids e.g. Dossette Box (involve pharmacist)				
Medication received				
Medication explained to patient and/or relative/carer				
Own medication returned to patient				
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)				
Informed of discharge				
Social work/ Other agencies/Home help				
Physiotherapist				
Occupational Therapist				
Dietician				
Speech and Language Therapist				
Clinical Nurse specialist e.g. Care Home Liaison				
Liaison/ District Nurse/Practice Nurse				
Other discharge items				
Access arrangements (e.g. keys, door entry)				
Patients clothing available for day of discharge				
Valuables e.g. cashier				
Intravenous cannula removed				
Equipment ordered (inc. walking aids) in place for discharge				
Part 2 Discharge letter - Required				
- Completed				
Out patient clinic appointment e.g. Anticoagulation clinic				
Arranged / To follow				
If unknown at time of discharge state reason				
Additional information / leaflets / factsheets				
Time of Discharge:				
Nurse's signature:	Designation:			Date: / /

Emergency Department Nursing Documentation

NHS Greater Glasgow and Clyde

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

Presenting Complaint: confused / ? H.I

Date and Time: 21/9/15 - 8.55

Named Nurse(s):

Patient preparation (Please tick when completed)	Initials:	Communication (Please tick when completed)	Initials:
Prepare patient for examination	☑	Communication Aids (spectacles / hearing aid)	☐
Provide blankets if required	☑	Relatives present?	☐
Clothing bagged, labelled and stored under trolley	☑	Relatives / NOK informed	☐
Name-band (if required)	☐	Interpreter required	☐
		Telephone interpretation required	☐

Observations and Investigations (Please tick when completed)		Initials:	
Vital Signs recorded on NEWS chart and NEWS score recorded. Record Pain, blood sugar and neuro obs on NEWS chart if appropriate.	☑	IV Cannula (if required) dated and timed	☐
Peak Flow 1. 2. 3.	☐	Blood samples taken	☐
12 Lead ECG	☐	Urinalysis and Specimen if indicated *Results:*	☐
Cardiac Monitoring	☐		
X-rays performed	☐	HCG specimen if indicated +ve ☐ -ve ☐ Strip Lot no:	☐
Other: please add	☐	Weight:	☐

Screening Tools (Please circle or tick as appropriate)		Initials:	
SEPSIS risk? SIRS Criteria 2 or more and suspicion of infection	Y / N	Preliminary Pressure Ulcer Risk Assessment The patient can reposition themselves whilst in the department?	Y / N
AMT 4 (if >65 years) SCORE	/4	There is no reported skin damaged other than presenting trauma?	Y / N
At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc). *If at risk complete risk assessment*	Y / N	The person is fully continent? *If NO to any of the above initiate Waterlow risk assessment (within 4 hrs)*	Y / N
Mental Health Triage Assessment	Y / N	Waterlow Score *If >10 commence Active Care*	☐
Child Protection considered (in line with policy)	Y / N	Active Care (clinical judgement) (include all trolley patients at risk of pressure ulcers and all trolley patients in department for >4hrs) *Record on Active Care Chart*	☐
GMAWS	Y / N	Pressure damage identified on arrival in ED is documented in clinical notes	☐
Swallow test (If CVA/stroke)	Y / N	Grade 3 or 4 Pressure Ulcers are reported on DATIX	☐

Pause for Transfer (Please tick when completed)		Tick when completed	N/A	Notes
	Relatives informed	☐	☐	Information on discussion with relatives
	Cannula dated and timed	☐	☐	
	Name band	☐	☐	
	AMT4	☐	☐	
	NEWS chart	☐	Always	
Prescriptions signed	Infusions	☐	☐	
	Drugs	☐	☐	
	Fluids	☐	☐	
	GMAWS	☐	☐	
	Belongings (including patient's medications)	☐	Always	Please note here if any other tasks required prior to transfer
	Bed requested, accepted and ward informed	☐	Always	
	Notes: medical notes, GP letter, PRF	☐	Always	
Investigations	CXR reviewed	☐	☐	
	ECG reviewed	☐	☐	Print name
	Bloods sent	☐	☐	
	Bloods reviewed	☐	☐	
	Patient on O_2: cylinder checked	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	

Patien

3112626230
MCLACHLAN M
Michael 31/12/1962
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Glasgow, Lanarkshire
G31 3NS

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
Belongings (including patient's medications)	☐	Always	
New medications explained	☐	☐	
Cannula removed	☐	☐	
Relatives aware of discharge	☐	☐	Please note here if any other tasks required prior to discharge
Social/ Support Services required and contacted	☐	☐	
SAS transport required and ref no	☐	☐	Print name
Other means of transport arranged by nurse	☐	☐	

Nursing Notes

Date and Time		Print Name and Signature
21/04/15 09:60	Seen by Dr. ECG + bloods done and send to lab. IV access established. Started on IVF. Away for CT scan.	sig C.Ainslee

Patient Addressograph Label

Nursing Notes

Date and Time		Print Name and Signature

Emergency Department - Active Care

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every:

(Please circle) ½ hour 1hour 2 hours

Signed ..... Name .....

Patient Addressograph Label

			Time							
	1.	PAIN: Assess and address If in pain inform registered nurse Y or N/A								
S	2.	SKIN INSPECTION A. Pressure areas checked:								
		B. Redness (R) / Discolouration (D) / Pressure Ulcer (PU)								
K	3.	KEEP MOVING: A. Have you moved or walked Y / N / I (independent)								
		B. Trolley Right side (30° tilt) – R Left Side (30° tilt) – L Back– B								
		C. Chair Assist to walk, stand or tilt (W /ST/ T)								
I	4.	ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine/faeces								
N	5.	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)								
		Encourage the patient to drink? (If appropriate) Y / N / N/A								
		Food, snack or supplement taken? (If appropriate) Y / N / N/A								
	6.	ENVIRONMENT: Is the patient able to call for assistance? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the trolley in lowest position?								
	7.	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return.								
	8.	ESCALATION: Escalate any issues to the Registered Nurse / Dr Y / N/A								
			Nurse Initials							

USE FOLLOWING CODE	Specialist Pressure Redistributing equipment	Variations			
V = Variant I = Independent NT = No thanks	☐ Repose Mattress ☐ Moving and handling aids ☐ Other:	Time	No.	Variation	Signed

Waterlow Pressure Area Risk Assessment

Build/Weight		Skin Type/Visual Risk Areas		Sex/Age		Special Risks - Tissue Malnutrition	
Average (BMI 20-24.9)	0	Healthy	0	Male	1	Multiple organ failure/ Terminal cachexia	8
Above Average (BMI 25-29.9)	1	Tissue Paper (thin/fragile)	1	Female	2		
Obese (BMI > 30)	2	Dry (appears flaky)	1	14-49	1	Single organ failure	5
Below Average (BMI < 20)	3	Oedematous (puffy)	1	50-64	2	Peripheral Vascular Disease	5
Continence		Clammy /pyrexia	1	65-74	3	Anaemia = Hb < 8	2
Complete/Catheterised	0	Discoloured (brusing/mottled)	2	75-80	4	Smoking	1
Incontinent urine	1			81+	5	Neurological Deficit	
Incontinent faeces	2	Broken (established ulcer)	3	Nutritional Element		Diabetes/MS/CVA Motor or sensory paraplegia (Max 6)	4-6
Doubly Incontinent (urine and faeces)	3	Mobility		Unplanned weight loss in past 3-6 months < 5% Score 0 5-10% Score 1 > 10% Score 2			
		Fully mobile	0				
Special Risks – Surgery/Trauma		Restless/Fidgety	1			Special Risks - Medication	
On table > 6 hours	8	Apathetic (sedated/depressed/ reluctant to move)	2			Cytotoxic, anti-inflammatory, long term/high dose steroids (Max'4)	4
Orthopaedic / below waist/Spinal (up to 48 hrs post-op)	5			BMI > 20 Score 0 BMI 18.5-20 Score 1 BMI < 18.5 Score 2			
On table > 2 hours (up to 48 hrs post op)	5	Bed bound (unconscious/unable to change position/traction)	4			Risk Score 10+ = 'At risk' 15+ = 'High Risk' 20+ = 'Very High Risk'	
		Chair Bound	5	Patient acutely ill or no nutritional intake > 5 days	2		

Patient's Initial Waterlow Score = If Score ≥10 Complete the Adapted Waterlow Pressure Area Risk Assessment Chart

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

MEDICINES RECONCILIATION

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

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

DOCTOR'S DECLARATION (if required by Local Protocol)

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

_____

with the following exceptions:_____

Print & Sign:_____ Date:_____

COMMUNITY PHARMACY INFORMATION

Name_____ Tel No._____
Address_____
Compliance Aid Details_____
Patient consent to share discharge information Y/N
Print & Sign_____

PATIENT DETAILS

H
D
D
C

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Michael 31/12/1962
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

Height:
Weight:
Surface area:
Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
21/9/15	FLUCLOXACILLIN	1g	IV	10:26	F. BURNS	[illegible]	10:50
21/9/15	BENZYLPENICILLIN	1.2g	IV	10:30	F. BURNS		
21/9/15	GENTAMICIN	ACCURATE	IV	10:33	F BURNS	[illegible]	11.10

DATE →
MONTH →

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

IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N

ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N

SIGNATURE OF ASSESSOR

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

Parenteral Drugs : Regular Prescription

Patient's Own Medicine

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

A DRUG

DOSE | ROUTE | DATE | 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 ☐

B 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 ☐

C 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.

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

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

D DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

E DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

F DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

G DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

H 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 ☐

J 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 ☐

K 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 ☐

L 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.

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

M DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

N DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

P DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

R DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

S DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

T DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

V DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

W DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

X DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

Y DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

AA DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

BB DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

GG DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

HH DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

JJ DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

KK DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

All Routes: As Required Prescriptions

Patient's Own Medicine

| | | |

| | | |

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, 1800.
5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.
6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.
7. The following metric unit abbreviations must be used –

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

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

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

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

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

FOR NURSES

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

Codes for Non-Administration of Drugs

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

Cat. No. 4C993 Ver 4, 09/2010

ADULT PARENTERAL GENTAMICIN (GGC): PRESCRIBING, ADMINISTRATION & MONITORING CHART

Use for patients prescribed intravenous gentamicin unless prophylactic indication or where synergistic doses (usually in endocarditis) are used. Refer to full GGC guidance for EXCLUSIONS & Cautions / Contra-indications

NHS Greater Glasgow and Clyde

Patient name: .....
3112626230
Date of birth: ..... MCLACHLAN M
Michael 31/12/1962
CHI no.: ..... FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

Age: 52 Sex: (M) / F

Weight: 70 kg (est) Height: 5'' 7 (est)

Creatinine: 85 on: 21 / 9 / 15

Initial Gentamicin Dose*: 360 mg
Predicted Frequency*: 24 hrs.
*this is not a prescription and may change. Doses must be prescribed individually below.

Source of first dose: Online calculator (preferred method) ☑ Manual calculation ☐ Weight based, creatinine not known ☐

PROMPT ADMINISTRATION
within 1 hour of recognition of sepsis reduces mortality

SIGNS OF GENTAMICIN TOXICITY
RENAL: ↓urine output/oliguria or ↑creatinine

OTO/ VESTIBULAR: NEW tinnitus, dizziness, poor balance, hearing loss, oscillating vision

Toxicities may occur irrespective of gentamicin concentration

Step 1: Calculate and prescribe the first dose of gentamicin (see overleaf for more details)
- If creatinine is known - use the online gentamicin dose calculator.
- If creatinine is not known - give 5 mg/kg gentamicin (maximum 400 mg) or, if CKD 5, give 2.5 mg/kg (maximum 180 mg) on advice of senior medical staff.
- Prescribe gentamicin 'as per chart' on the medication chart (kardex). AVOID specifying dose or administration time on the kardex.
- Prescribe individual doses in the prescription record section below, specifying the date and time the dose should be given.

Step 2: Monitor creatinine and gentamicin concentration and reassess the dosage regimen
- Check gentamicin concentration after the first dose and then at least every 2 days (see overleaf for more details).
- Monitor creatinine daily. Seek advice if renal function is unstable (e.g. a change in creatinine of >15-20%).

Step 3: Assess daily: the ongoing need for gentamicin; signs of toxicity
- Consider an alternative agent if creatinine is increasing or the patient becomes oliguric.
- If gentamicin continues for >7 days, suggest referral to audiology for assessment.
- Refer to guidelines or clinical pharmacist for further advice on prescribing, monitoring and administration.

TOXICITY Before prescribing each dose check: Renal & Oto-vestibular function	Gentamicin Prescription Record: Complete each time a dose is to be given (ensuring gentamicin is prescribed 'as per chart' on the kardex)				Administration Record: Complete each time gentamicin is administered (in addition to the kardex)			Monitoring Record: Record ALL sample dates/times accurately below. See overleaf for monitoring advice.			
	Date to be given	Time to be given 24 h clock	Gentamicin Dose (mg)	Prescriber's signature, PRINTED name and STATUS	*Infuse over 30 mins* Date given	*Infuse over 30 mins* Time started 24 h clock	Given by	Date of sample	Time of sample 24 h clock	Gent level (mg/L)	Action/ Comments (please initial action to be taken)
Cr = 85 micromol /L	21/9/15	10:50	360mg	[signature] [illegible] STR	21/9/15	11.10	[signature]				24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other :
Cr = micromol /L											24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other :
*Discuss with an infection specialist or microbiology and document in the notes if treatment continues beyond 3 to 4 days * Risks of prolonged treatment must be considered and treatment options discussed with microbiology or infection specialist											
Cr = micromol /L											24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other :
Cr = micromol /L											24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other :

Discuss with an infection specialist before continuing onto a second sheet

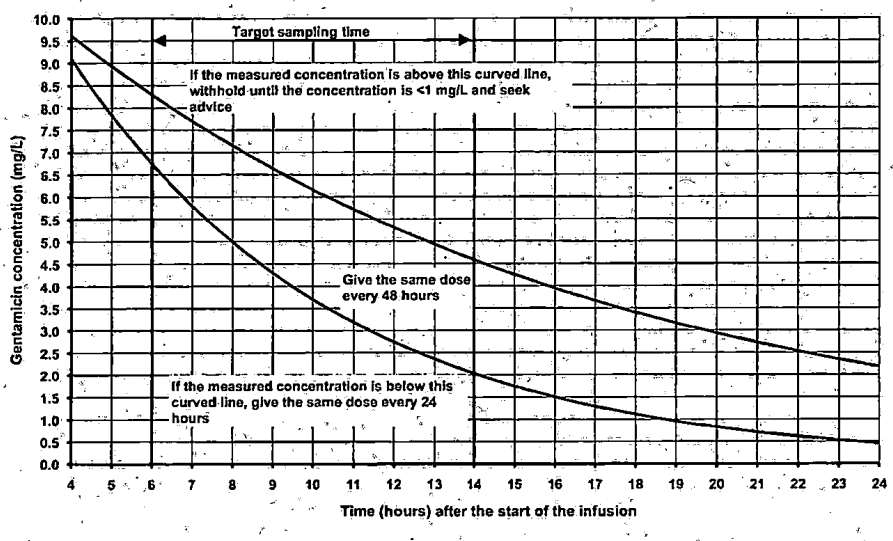
97907

Patient name: ..... CHI no.: ....

NHS Greater Glasgow and Clyde

ADULT PARENTERAL GENTAMICIN (GGC): PRESCRIBING, ADMINISTRATION & MONITORING CHART

Prescribing, monitoring, interpreting and re-prescribing advice



If the measured concentration is unexpectedly HIGH or LOW

- Were dose and sample times recorded accurately?
- Was the correct dose administered?
- Was the sample taken from the line used to administer the drug?
- Was the sample taken during drug administration?
- Has renal function declined or improved?
- Does the patient have oedema or ascites?

If in doubt, take another sample before re-prescribing and/or contact pharmacy for advice.

CEDAR ORDER CODE 97907 MIS 254539

Calculating the first dose of gentamicin

- If creatinine is known - use the online gentamicin dose calculator.
- If creatinine is not known - give 5 mg/kg gentamicin (maximum 400 mg) or, if CKD 5, give 2.5 mg/kg (maximum 180 mg) on advice of senior medical staff.
- Calculate the dosage regimen once creatinine is available.
- If the online calculator is not available, manually calculate the dose referring to the GGC Therapeutics Handbook.

Checking the patient's gentamicin concentration

- Take a blood sample 6-14 hours after the start of the first gentamicin infusion (or after 24 hours if CrCl <21 ml/min).
- Thereafter, sample at least every 2 days.
- Record the exact time of all gentamicin samples overleaf AND on the sample request form.

Interpreting gentamicin results and re-prescribing

- Record the measured concentration overleaf.
- If creatinine clearance is ≥21 ml/min and therapy is to continue, plot the gentamicin concentration on the graph opposite & reassess the dose/ dosing interval as indicated.
- If creatinine clearance is <21 ml/min and therapy is to continue, give a further dose once the measured concentration is <1 mg/L.
- Document the action taken in the medical notes and overleaf. Prescribe the next dose overleaf as appropriate.
- Contact pharmacy for further advice as necessary (e.g. if renal function is changing, the gentamicin concentration is unexpectedly high or low or the concentration is on the line between dosage intervals)
- Check microbiology sensitivities and refer to IV to Oral switch policy.

Approved by: NHSGGC Antimicrobial Utilisation Committee, August 2013
Date of Review: August 2015

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued									Administration details - continued				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional Instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments

*Prescriber should sign this box if the fluid/additive is no longer required.

Patient name. 3112626230 M
MCLACHLAN
Michael 31/12/1962
FLAT 1-1
CHI No:..... 31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg) ..... Height (cm) .....

Prescription details									Administration details				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments
21/4/15	9.50	Nacl 0.9%.	500ml	IV	Stat	/	F BUTLER ITU		21/04/15	9.25			18G13TWD Exp 06/17.

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow = (drops/min) = Volume of fluid (ml) x 20 / Duration of admin (min)

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Mental Health Services

Glasgow Liaison Psychiatry Service
2nd Floor, St Mungo Building
Royal Infirmary
84 Castle Street
GLASGOW
G4 0SF

Date rec'd. 24 February 2016
Date typed. 29 February 2016

Our ref. SR/DF/T-1209644

Direct Line. **0141 211 4417 (24417)**
Fax. **0141 232 0846 (20846)**

Dr K Walker
Shettleston Health Centre
420 Old Shettleston Road
GLASGOW
G32 7JZ

Dear Dr Walker

RE: MICHAEL McLACHLAN D.O.B. 31.12.62 (CHI:3112626230)
FLAT 1/1, 31 ABERFELDY STREET, GLASGOW G31 3NS

The above patient was assessed by Dr Catriona Ingram, CT3 in Psychiatry, and Dr Sarah Ramsay, FY1 in Liaison Psychiatry, whilst an in-patient in Glasgow Royal Infirmary.

Reason for Referral

Michael was admitted to Glasgow Royal Infirmary on 20 February 2016 following a psychotic episode symptomised by auditory hallucinations and persecutory delusions. He admitted to having been smoking Heroin in the preceding few weeks, and it was suspected that this may have been a drug-induced psychosis, as Michael is known to have had similar episodes in the past.

Nursing staff reported that Michael had been unsettled, particularly at night, with inappropriate behaviours such as attempting to get into bed with other patients. He was also experiencing auditory hallucinations at this time.

Past Psychiatric History

Michael is currently seen at Hunter Street and his CPN there is Colin Jack who he sees weekly. When I discussed this presentation with him he reported that he has seen Michael behave bizarrely in the past, with hallucinations and walking around the room on his hands and knees. He also describes Michael having long periods of low mood with marked social withdrawal from friends and family, and at other times feels that he has presented as almost hypomanic in his behaviour.

He is currently under the care of Dr Patience, Consultant Psychiatrist, who last saw him in May of 2015. As Hunter Street is primarily a service for homeless patients Michael is awaiting transfer of his community care to the Arran Centre as he is now settled with a permanent address.

Past Medical History

Michael has no significant past medical history.

Current Medications

He is on Quetiapine 300mg at night, and has been started on regular Dihydrocodeine under the advice of the Community Addictions Team as treatment for suspected Opiate withdrawal. He admitted that he has poor compliance with his Quetiapine.

Drug, Alcohol & Smoking History

Michael admits to previously smoking Heroin on a regular basis, and previous use of Diazepam and Cannabis. At present he states that he is occasionally using Heroin when he feels his mood is particularly low, though on discussion with his CPN, he has previously denied continuing Heroin use. He admits to using Heroin in the weeks prior to this admission, and also states that his previous episodes of psychosis have been associated with drug use. Urinary toxin screen was positive for Opiates but nil else.

Forensic History

Michael has several previous convictions for which he has served time in prison. The first was for attempted murder in 1979, something he states was a result of gang culture which he was involved in at that time. He was 16 at the time of conviction and served 8 years in prison. Since then he has had several convictions for which he has served time in prison related to selling Cannabis and Valium. He has been out of prison now for the last 6 years.

Personal History & Social Circumstances

Michael was born in Glasgow and is the youngest of 6 sisters and 4 brothers. He reports that he did not enjoy school and would often truant. He left school at 16 and went to prison following his involvement in gang violence.

He has had 2 significant relationships in his life, the first lasting 17 years which resulted in 3 daughters, the eldest of which is 33. He states that he is still in contact with his ex-partner and it is amicable. His second significant relationship lasted 7 years and resulted in 1 son. This broke up at the time that he went to prison for his most recent term. He reports having a good relationship with his children who he sees regularly. He mentioned that post-discharge he is considering visiting one of his daughters who lives in Belfast. We advised him that he should contact his CPN before leaving for a trip of this nature.

He was previously homeless but has been living in Aberfeldy Street for 9 months now in a private let. During this admission his daughters had expressed concern about this accommodation due to a recent break-in, and I have been informed that nursing staff are currently liaising with social work about this.

Mental State Examination

We reviewed Michael in Ward 20/21 of Glasgow Royal Infirmary. He was appropriately dressed and reactive throughout our discussion, though the content of his responses were often rather vague. He described being aware of voices that had wanted to harm him, though his recall of the exact content of these hallucinations and of the events leading to his admission was poor. He had stated that he was aware that these voices were not real. He also reported a feeling when he was first admitted that he had died. He stated that these symptoms had been worse at night and he was often unsure whether or not he was in a nightmare.

At time of review Michael was orientated to time, place, and person, and had good insight into his experiences. He reported that this episode was similar to previous episodes of psychosis, and that these past episodes have occurred in the context of drug use. There were no ongoing psychotic symptoms at the time of review. Michael reported that his mood has been low recently and that this had been his reason for his recent Heroin use, though he appeared euthymic when reviewed today. He admitted to previous thoughts of self harm, but had no ongoing thoughts of this and stated his children were a strong protective factor. He had no problems with his appetite, however, did report disturbed sleep, something which has been an issue for him for many years and has improved slightly with Quetiapine.

Impression

This was likely a drug-induced psychosis as a result of Michael's recent Heroin use, and we are happy that symptoms have now resolved and that he is fit for discharge once medically fit. This admission has been discussed with his CPN at Hunter Street, Colin Jack, who has agreed to meet with Michael at his home on Friday 26 February 2016 around lunchtime.

Yours sincerely

DR SARAH RAMSAY
FY1 IN LIAISON PSYCHIATRY

copies: Dr D Patience, Consultant Psychiatrist, Homeless Mental Health Service, 55 Hunter Street, GLASGOW G4 0UP
Colin Jack, CPN, Homeless Mental Health Service, 55 Hunter Street, GLASGOW G4 0UP

CHI: 3112626230

Glasgow Royal Infirmary

(3)

Total Att: 7

12 Mth Att: 3

Title: MR

MCLACHLAN **Michael**

DOB: 31/12/1962 ✓ Age: 53y Sex: Male

FLAT 1-1
31 ABERFELDY ST ✓
Glasgow
Lanarkshire
G31 3NS

Next of kin: **MCLACHLAN, CHEVONNE**
Relationship: **Daughter**
~~07884264431~~ 07494790834

GP: **CA Walker** 07494790834
0141 531 6240

Ashley Clayton
07935123332

Attendance Date: **20/02/2016** Arrival Time: **00:27**

Registration Time: **00:27** Date of Incident: **20/02/2016**

Major Incident Desc:

Reason for Attendance: **mental health issues**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **20/02/2016 00:58** Nurse name: **Nurse Clare Carmichael**

Temp	**36.5**	C
HR	**73**	bpm
BP	**115/77**	mmHg
MAP	**89.67**	mmHg
RR	**16**	bpm
SpO2	**99**	%
Oxygen		%

BM	**8.3**	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	**4**
Motor	**6**
Verbal	**4**
Total	**14**

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

Nursing Notes: **diagnosed with psychosis last year. daughters state patient is displaying paranoid behaviour. agitated. states feeling terrible, appears detached, confused. daughters present.**

3112626230 31/12/1962 MCLACHLAN Michael

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3112626230 31/12/1962 MCLACHLAN Michael

To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

Date	**Clinical Notes**	
	Seen By	Time Seen

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By

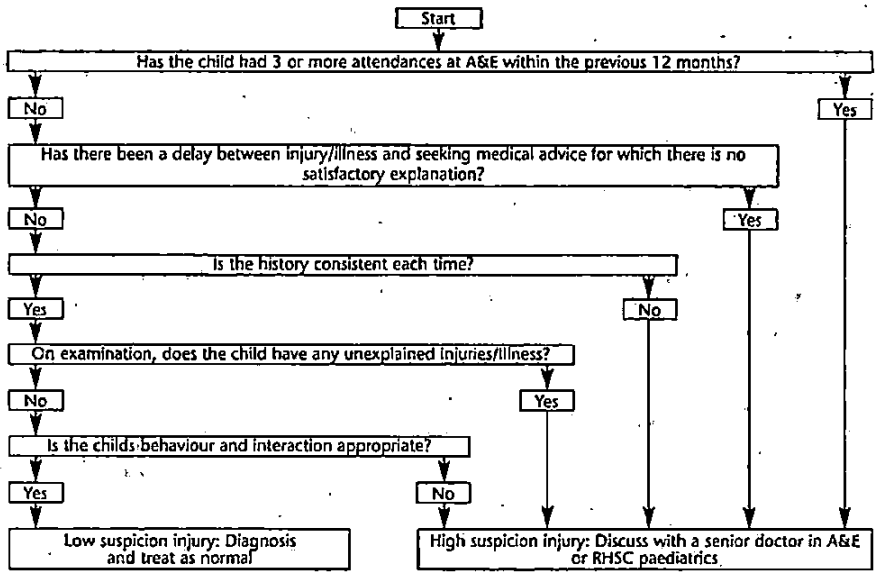
Glasgow Royal Infirmary
Unitary Patient Record
(Part A - Acute Assessment)

NHS
Greater Glasgow and Clyde

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
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Glasgow, Lanarkshire
G31 3NS

Injury/Illness Flow Chart for all Patients 16 and under

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



All Clinical Staff Consider

H.I.Form ☐

Audit Form ☐

Police Consent ☐

Clinical Notes

20/2/16 0400 K6W7 WATCH S6

(53) → PC: Confusion

HPC: Brought in by daughters
Usual not seen pt for ~2/12 prior to last few days.
Turned up at daughters house, behaving oddly
shouting out
Talking out to people when no one else there
Jumpy & suspicious when people enter room
Hx head collision, ? multiple falls & possible head injury
Noticed significant wt loss since 2/12 ago

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)

Patient Name
DoB
Unit Number

or affix label

Clinical Notes

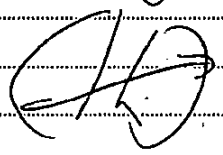
Date	Time	Name	Grade	Specialty

PMH: Bipolar disorder
Depression

OH: ~~[illegible]~~
Quetiapine

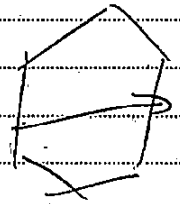
SH: Smoker
No alcohol
Smokes heroin - last used a few days ago

O/E: Alert, when left alone is having one sided conversation
& making ocular movements with arms & face



Clear RR 16
Resort Sats 99% on air

BP 1+11+0 regular HR 73 BP 115/77



Cdves SNT ↑ reflexes ↑ reflexes
CN II-XII intact Pupils size 4 PEARL
Tone, power & sensation intact in all 4 limbs

Impr: Possible psychosis but difficult to rule out organic illness

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

NHS
Greater Glasgow and Clyde

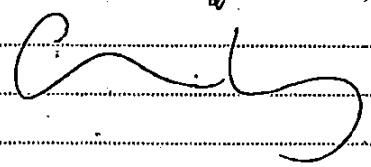
Patient Name
DoB
Unit Number

or affix label

Clinical Notes

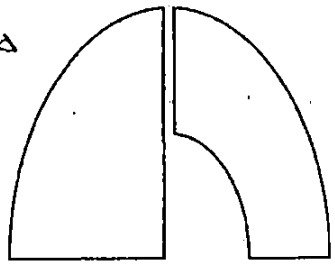
Date	Time	Name	Grade	Speciality

Plan: IV access
Bloods
CXR
Admit medics for initial work up ± ψ review



X-Ray results

Emphysematous
w/l focal



ECG findings

Other investigations

Fluids Prescribed in A&E

Drug	dose	route	freq	prescriber	signature	adminis
Drug	dose	route	freq	prescriber	signature	adminis
Drug	dose	route	freq	prescriber	signature	adminis
Drug	dose	route	freq	prescriber	signature	adminis
Drug	dose	route	freq	prescriber	signature	adminis

Drugs Prescribed in A&E

Drug	dose	route	freq	prescriber	signature	adminis
Drug	dose	route	freq	prescriber	signature	adminis
Drug	dose	route	freq	prescriber	signature	adminis
Drug	dose	route	freq	prescriber	signature	adminis
Drug	dose	route	freq	prescriber	signature	adminis

Refusal of Treatment

Hereby I declare that I am leaving

*(or taking _____ away from)

the _____ Hospital at my own de

contrary to the advice of medical staff.

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

Signature _____

Witness Date _____

* Delete whichever is inapplicable.

Bio

Indicate

Haem	D
WCC	
Hb	
Plat	
MCV	
Neut	
DDim	D
PT	
PTT	
TT	

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MCLACHLAN M
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Glasgow, Lanarkshire
G31 3NS

GLASGOW ROYAL INFIRMARY

Patient Sample Report

Patient

ID:	3112626230
Last Name:	MCLACHLAN
First Name:	MICHAEL
Gender/Age:	Male, 53 years
Birth Date:	31.12.1962
Status:	ACCEPTED
Analyzed:	20.02.2016 04:55:10
Sample Type:	Venous
Sample Number:	
Clinician:	
Operator ID:	CHRISTOPHER KELLY0

Analyzer

Model:	GEM® *Premier 4000*
Area:	GRISPARE
Name:	GRISPARE
S/N:	08061613

Measured (37.0°C)		
cH	38.9	nmol/L
pCO_2	6.0	kPa
pO_2	6.6	kPa
Na^+	143	mmol/L
K^+	3.6	mmol/L
Cl^-	107	mmol/L
Ca^{++}	1.27	mmol/L
Glu	5.2	mmol/L
Lac	1.2	mmol/L
CO-Oximetry		
tHb	148	g/L
O_2Hb	75.3	%
COHb	3.5	%
MetHb	0.6	%
HHb	20.6	%
sO_2	78.5	%
Derived		
BE(B)	3.2	mmol/L
HCO_3^-(c)	28.5	mmol/L
Hct(c)	44	%
Operator Entered		
Temp	37.0	°C
O2 and Vent Settings		
FIO_2		%

CHI: 3112626230 **Name:** Michael McLachlan **Gender:** Male **DOB:** 31/12/1962 **Age:** 53 Yrs **Phone:**

SBAR Handover

To start a new SBAR please complete below.

For Downstream wards to view a completed SBAR for a patient your ward is receiving go to 'Patient Information' (on left) and select from the list.

To view / amend an existing SBAR please select 'Patient Information' tab (on left) and select from the list.

ED/Asst Section, staff to complete for first admission to Receiving Wards

Reason for Admission	
GAP Score	
News Score	
AMT 4 for >65 years old	
Resuscitation Status DNACPR	Ensure the appropriate NHSGGC paperwork been completed for DNACPR
Resuscitation Status Patient aware	
Resuscitation Status Family aware	
More Information	
Other Treatments	
Infection Control Issue	
Fasting	
Any Other Information	
NOK Informed of transfer	
Handover completed by	
Contact Telephone No.	

Admitting to Ward Section, staff to complete when admitting to Downstream Wards

Diagnosis	CONFUSION
Relevant Medical History	PSYCHOSIS LAST YEAR DEPRESSION
Relevant Social History	LIVES ALONE
Current Treatment	RULE OUT ORGANIC CAUSE
IV Access	Yes
IV Medication	No
IV Fluids	No
Oxygen %	NIL
Diagnostic Tests	
SKIN	Intact
Patient included in Delegated Discharge	
EDD Date	
DVT Risk Assessment	
Allergies	NIL KNOWN
Mobility	Independent
Active Care	4 Hours
Nutrition	Independent

Special Diet	
STOPSS	
Behavioural Issues	AGITATED AND HALLUCINATING ON ARRIVAL TO WARD. REFUSING OBS AND REFUSING TO ANSWER ADMISSION QUESTIONS
Outstanding Investigations	
Further Information	
Completed By	
Contact No.	24204

User Christine Hutchison

Save Print

Last Update Date
20/02/2016 05:55
Last Update User
Wendy Hislop
Audit Trail

Glasgow Royal Infirmary
Acute Medicine Unit

(Part B - Medical Admission)

NHS
Greater Glasgow and Clyde

3112626230
MCLACHLAN
Michael M
FLAT 1-1 31/12/1962
31 ABERFELDY ST
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G31 3NS

Date & Time 20/2/16 0600 Consultant Ward

Ward Review (Should be completed within 2hrs of transfer from ED)

Check List	
VTE	☐
Med - Rec	☐
Kardex	☐
CxR	☐
ECG	☐
Oxygen	☐
Patient on Bleeders list	☐

ALLAN GPST 1-2

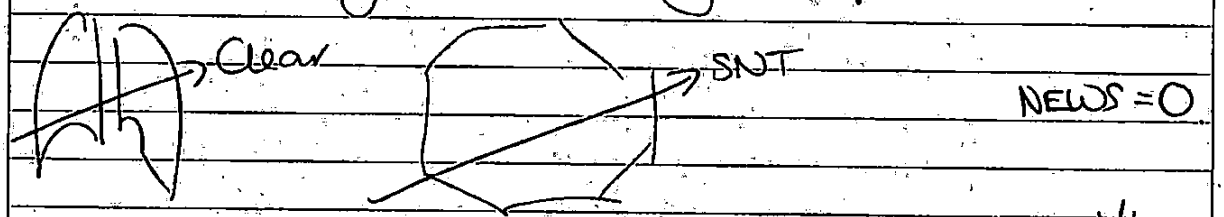
PMH - Bipolar → Quetiapine
Depression

Prev admission Sept 2015 confused - CTB (N)
→ thought due to URTI (although not significantly raised inflammatory markers

Brought in by daughters.
Last seen at Christmas.
They state he is acting strange, hallucinating and paranoid. Not normal for him.
Weight loss also.
Daughters state dad admitted to multiple falls.

No sense from Michael e no history.

o/e
Awake - babbling incoherently and extremely fast.
Knows is in GRI, DOB e address but thinks it's 2006
= AMT 3/4.
Old scarring e scabs to scalp.
Eyes shut tight e refusing to open



NEWS = 0

Normal power but unable to cooperate with full neuro.

Ward Review

Bloods

(N) inflammatory markers
(N) UEFs
(N) LFTs.

Says doesn't drink.
No drugs. → history that is IVDU.
Smoked 20pd.

At one point admitted hasn't been taking medications
? reliable info

Imp

Acute confusion ?? manic → to me this looks psychiatric
No signs of infection
likely need to rule out head injury but will need sedation — ? timing.
MSSU + tox screen.

Plan

d/w registrar regarding CTB / plan

→ doesn't require urgently today to discuss on WR & may need CT +/- LP to rule out CNS infection if no other source found.

→ speak to daughters in morning & clarify history & whether or not has stopped taking meds & clarify drug history.

RM

NHS GG&C Adult Risk Assessment for Venous Thromboembolism (VTE)

[excluding orthopaedics, obstetrics and gynaecology & ENT who have specialty-specific policies]

- Risk Assessment must be completed for all patients within 24 hours of admission to hospital
- Patients must be reassessed every 48-72 hours or sooner if condition changes
- Reassessment must be documented in Kardex
- Please complete risk assessment and then sign and date Risk Assessment Result box at bottom of page.

3112626230
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Surgical patients start here

Non-operative [mainly medical] patients start here

Is the patient bed-bound or expected to have reduced mobility relative to normal state for ≥ 2 days?

Yes ☐ No ☐

Does the patient have any risk factors for thrombosis? (tick √ all that apply)

Age >60	☐	Use of oestrogen-containing contraceptive therapy	☐
Active cancer or cancer treatment	☐	Use of hormone replacement therapy	☐
Dehydration	☐	Pregnancy or < 6 weeks post partum [seek specialist advice]	☐
Known thrombophilias	☐	Critical care admission eg HDU/ITU	☐
Obesity (BMI>30)	☐	Total anaesthetic + surgical time >90 minutes	☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or Inflammatory disease	☐	Surgery involving pelvis or lower limb with a total anaesthetic + surgical time >60 minutes	☐
Personal history or first degree relative with a history of VTE	☐	Acute surgical admission with inflammatory or intra-abdominal condition	☐
Varicose veins with phlebitis	☐	Hip fracture	☐

- No thromboprophylaxis required.
- Continue to reassess every 48-72 hours or sooner if condition changes.
- Document all reassessments in drug kardex.
- **Risk assessment now complete**
- **Complete Risk Assessment Result Box**

Yes, 1 or more risk factors identified ☐

No risk factors identified ☐

Does the patient have any contraindications to pharmacological prophylaxis? (tick √ all that apply)

Active bleeding	☐	Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands)	☐
Acquired bleeding disorders (e.g. acute liver failure)	☐	Neurosurgery, spinal or posterior eye surgery	☐
Concurrent use of anticoagulants (such as warfarin with INR>2)	☐	Lumbar puncture, epidural/spinal anaesthesia expected within the next 12 hours	☐
Acute stroke	☐	Other procedure with high bleeding risk – discuss with senior if unsure	☐
Uncontrolled hypertension (230/120 mmHg or higher)	☐	Lumbar puncture, epidural/spinal analgesia within the previous 4 hours	☐
Thrombocytopenia (<75 x 10^9/l)	☐	Thyroid surgery	☐

- **Discuss with senior clinical staff before prescribing pharmacological prophylaxis**
- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48-72 hours or sooner if condition changes

No contraindications to pharmacological prophylaxis identified ☐

Contraindications to pharmacological prophylaxis identified ☐

Surgical patients – Enoxaparin 40mg + AES ☐*
*prior to application of AES, please check contraindications to AES

Medical patients – Enoxaparin 40mg ☐
Prescribe Enoxaparin at 6pm
[on day of surgery, at the later of either 4h post-op or 6pm]
Reduce Enoxaparin to 20mg if <50Kg or eGFR <30ml/minute/1.73m² ☐
Discontinue at discharge or when returned to pre-morbid mobility

Contraindications to anti-embolism stockings (AES) Y ☐ N ☐

Peripheral neuropathy	☐
Peripheral vascular disease	☐
Cellulitis or Gross oedema	☐
Leg deformity or Fragile skin	☐
Leg / foot ulcers	☐
Allergy	☐
Unusual leg size/shape	☐

Risk assessment result – please tick √ all that apply

VTE risk factors: YES ☐ NO ☐ Contraindications to pharmacological prophylaxis: YES ☐ NO ☐ Prescribed: LMWH ☐ AES ☐ NONE ☐

Patient informed of VTE risks and benefits of thromboprophylaxis YES ☐ NO ☐ N/A ☐ Information leaflet provided YES ☐ NO ☐

Print Assessor's Name: _____ Signature: _____ Date: _____

Medicine Reconciliation Form

Source of information: ECS ☑ pt.

Patient ☑ pt. Relative/carer ☐ GP surg ☐ GP computer printout/letter ☐ Patient's own drugs ☐ Other (specify) _____

Admission Medicines (including OTC, herbal, homeopathic)				Plan for medicines (unless indicated to stop or hold medication should be continued on drug kardex)				
Name	Dose	Freq	Route	Amend	withold	Stop	continue	Reason for alteration
Quetiapine	300mg	ON	O				✓	
Allergies/adverse events	NKDA							

List obtained by _____ Designation _____

Recently altered/discontinued medicines prior to admission and reasons why _____

Compliance aid? Y ☐ N ☐ Type _____ If, Y Community Pharmacy _____ Phone _____

Senior Medical staff review: Sign _____ Title _____ Date and Time _____

Reviewed by pharmacist [signature] Date and Time 22/2/16 1220

Comments

? Poor compliance - pt vague.

Consultant Review

3112626230
MCLACHLAN M
Michael 31/12/1962
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53 ♂ . BIPOLAR
. DISCHARGED
. USUAL ISOLATION

Brought to hospital with confusion, hallucinations, falls.
Last unit taken yesterday pm > 1/52

NAD . (N) Shock.
(N) physical exam CVS (N)

Largely coherent, oriented x 4/4.
Occasional 'tangling', occasional confused speech

CMV . BIPOLAR A.D. — OFF MEDS
. ? ELEMENT OF DRUG WITHDRAWAL

Bloods (N) . RUN . TOX SCREEN (URINE)
. CT R/V
. U/MSE & PSYCHIATRY
. RESUME NORMAL MEDS & DISCHARGE
RESIDENCE
. NO INDICATION FOR CT AT PRESENT.
. DISCUSS & DOCUMENT RE DRUG COMPLIANCE & ILLICIT DRUGS.

Check List	
VTE	☐
Med - Rec	☑
Kardex	☑
CxR	☑ NAD NAD
ECG	☐ — NOT DONE
Oxygen	☐
EDD? 4/2	

PRINT NAME MURRAY	DESIGNATION CMV
SIGNATURE	DATE & TIME 25.2.16 09.30.

Clinical Notes

Nursing 20/2/16
53 year old male admitted from A&E with confusion. Refused obs on arrival. Refusing to answer questions. Meds asked to IV due to hallucinations & aggressive attitude. WATISAP SN.

Nursing Notes 20.02.16
11.40: Patient refused a wash this a.m. All medications given as prescribed. Observations carried out as charted. To be reviewed by CAT and Y. Patient remains by bedside appears more settled complying with questions and communicating back at times. No new charges at this time

C.U S.N

Plan:

20/2/16 11.00 CAT does not operate over the weekend, will need reviewed on Monday. Phoned Liason Psych on 24447; no answer. Have left a message, and will try again later. As we have contacted Psychiatry after 10 am, Mr McLachlan will not be seen today, and will be reviewed tomorrow.

Mills.

ECG x 2 performed & very uncooperative and fidgety.
- Unable to get a good ECG readings
- ? prolonged QT. (On Quetiapine)

20/2/16 1300 Liason psychiatry nurse phoned to say that as Mr McLachlan was not admitted with deliberate self harm, psychiatry review would have to wait till Monday. If we are worried about self harm in the meantime, we can contact the duty psychiatrist at Dawkwood / Metrinion now.

Mills.

Clinical Notes

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M
31/12/1962

Bloods 20/2/16

U+E (N) WCC 8.5

LFT (N) Hb 138.

glucose 5.3 platelet 199.

20.2.16 WR Murray 50/M.

T 37.0.

A little more muddled last night.
A bit kitchy but no seizures.

- DHC for opiate withdrawal
- Normal quetiapine.
- Observe closely
- Ca CRP + U R.U in AM bloods

20/2/16 Murray GPVT

ATSP - Agitation / confusion

On Arrival patient settled + sleeping.
(N) dose Quetiapine this evening
Bloods all (N).
A/W psychiatric review. / CTB / LP.

No indication for sedation at present.
Happy to re-review as required.

Amy Kilpatrick
PY1 #1190.

20/2/16 00.30 Patient unsettled, confused and hallucinating. Tried to climb out of bed, at risk of falls. Loud at times disturbing other patients. Medical Staff informed and awaiting to be reviewed. Can be aggressive as well. Vomit 150mls overnight P. Polygodo.

07.05 Remains Confused and Hallucinating, requires close monitory Vital Signs checked NEWS 0. Awaiting to be reviewed by Medical Staff Not passed urine to monitor.

Clinical Notes

2/2/16 WR Hetzler GPST 1.2
1015

Now on ward 20/21

Admitted with concerns re behaviour. hallucinating, fluctuating confusion.

Patient has history of bipolar, hasn't been taking his regular meds

Patients behaviour fluctuates, has lucid moments & then begins rambling & talking about being at a party & thinks that I am a friend of his.

Admits to smoking heroin - even 2-3 days but not every day. On ~~assessment~~ benzodiazepine

Should be taking Quetiapine 300mg at night

O.E MSE: O.
N.A evidence of bleeding
PEARL
Resp - Clear. Moving all 4 limbs freely.
AOdox x 4 (person)

Bloods - (N)
Imp - Appears psychotic at times, ?element of withdrawal

Plan
D/w On-call Psych (#19123) > will discuss with 2nd On and re-discuss with me

Dr Fletcher

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL

3112626230
MCLACHLAN M
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FLAT 1-1
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Date & Time		Signature, Print Name & Designation
21/2/16	Fletcher GPST 1.2	
1625		
	Rpw On-Call Psych	
	→ ↓ withdrawal concerns to	
	overdose - ↓ - agitation settled	
	→ consultant liaison psych for	
	assessment tomorrow	
	→ unable to specifically advise	
	re withdrawal. No access	
	to previous Psych correspondence	
	Rpw Dr McCann → for regular	
	DHC ? element of opiate	
	withdrawal.	
	Plan	
	Regular	
	Quetiapine as prescribed	
	PRN 50mg BD	
	Liaison Psych to be contacted more	
	(Nurse to observe & MSV sent)	
21/2/16	Nursing Day	
18.-20	All Care as planned.	
	Pt Hallucinating and calling out.	
	In the morning:	
	More settled thus afternoon/evening.	
	Eating and drinking quite well.	
	Routine Ketones/Protein MSU/MW	
	Urine for toxicology ✓.	

83949

Date & Time	Cont.	Signature, Print Name & Designation
21/2/16	Mobile to toilet	
	Pt's daughter states pt doesn't drink often/much but has had a history of drug misuse but he couldn't tell her if he had taken anything recently.	C Hutchison
	No new issues at time of writing	
19.00	Pt daughter has asked that only certain members of the family are told Michael is in this ward as his house was broken into a few weeks ago and they think it was tried again yesterday	
	family members daughters chevonne, michelle, Ashley Brother Gerald + sister Lil.	C Hutchison
22/2/16	Nursing Night	
05:00	Has been awake all night	
	Patient has not presented as a management problem as the need overnight has been more settled than usual.	
	Patients daughter states that patient regularly uses heroine & has previously misused methadon & Subxone.	
	Appears to be frequently hallucinating.	
	Observations as charted, Appeared	
	No Complaints offered currently	C. Lowe
	Requires 1:1 nursing to be safe on ward	C. Lowe RGN

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐ NURSING ☐

Please tick ✔ appropriate directorate

3112626230
MCLACHLAN M
Michael 31/12/196
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

Date & Time		Signature, Print Name & Designation
22/2/16	Δ Acute psychosis 2° to heroine - He admits	
1030	to taking this over the last 2/52 due to	
	stresses of home situation.	
	Her home has now been 'shut down' - he	
	has nowhere to go.	
	He is well & orientated. No acute medical	
	issues.	
	Plan & review please.	
	Social work to arrange accommodation	
	Medically fit for discharge	
22/2/16	Addictions Liaison	
1515	Thanks for referral. Note previous hx -	Dr Hilary Wilson Consultant Physician 07881815838
	Complex of organ heroin withdrawal	
	Using heroin 2/3 bags daily by	
	smoking (never injected) uses benzodiazepines	
	occasionally. Doesn't drink alcohol	
	He is closest to CAT but has a	
	CPN he says Medical Card at	
	? Bridgeton CMHT. He declined referral to CAT (happy with CPN only)	
	Plan ① DF118 increased to 60mg QID	
	② d/w re hallucinations last night	
	③ Spoke to daughter who gave me a	
	hx of acute psychosis - he was staying	
	with her for a while.	
	④ Psychiatry coming to assess tomorrow I'm told.	
	⑤ No further input planned but please re-refer if necessary.	

83949

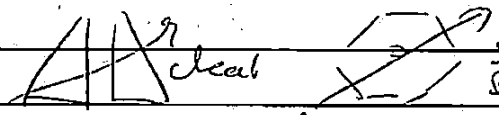
Date & Time		Signature, Print Name & Designation
22/2/16	(Nursing)	
1625	Settled morning : commenced food chart as parents do. daughter claims he has lost 1½ stones since Christmas ; scoring 2 : will refer to dietician. Mental/Monitoring for psych rev tomorrow.	
23/2/16	Nursing Night	
04:00	Not Slept at all	
	Requires 1:1 nursing overnight (again)	
	Hallucinating ++	
	Observations as charted, Appropriate	
	Fell on ward overnight	
	Requested medical c/k x2	
	DTTIX not completed as required	
	1:1 nursing continuously to Keep Safe	
	This is now the 2nd time I have recorded this.	
	States will "behave" for "tea"	
	& Dihydrocodein	
	Awaits further medical c/k	
	No issues currently	
23/02	S: Gamma FYI Nights	
04:30	ATSP for earlier hallucinations & Fall on ward.	
	On arrival, pt in bed, settled & appears to be sleeping, easily aroused.	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

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Date & Time		Signature, Print Name & Designation
	Denies any pain. Does not remember the fall.	
	On examination: No external signs of injury or bruising. Able to move head and all 4 limbs.	
		o peripheral oedema
	HS 1+11 RO quiet.	
	NEWS 0 RR 18, sats 98% on air temp 36.8 Pulse 66, BP 128/84	
	~~Nad ongoing pjs~~	
1/	No indication for sedation @ the moment as the pt is settled & sleeping To review again if needed.	
		#2294
23/2/16 1030	WR Fletcher & PST1.2	
	Note events Overnight Pt/Relative has full reconciliation of this Orientated to person, place & time at present On DTC 60mg BD & Quetiapine 300mg	

83949

Date & Time		Signature, Print Name & Designation
	NKSD	
	Plan	
	Psych RV today	
	No medical issues	
3/2/16	Fu Ramsay – Liaison.	
12.15	Seen w/ Dr Ingram CT3 in A	
	Thank you for referral.	
	No current evidence of psychotic	
	phenomenon.	
	Describes auditory hallucinations +	
	persecutory delusions prior to	
	admission when using heroin.	
	Mood appears euthymic.	
	No suicidal ideation.	
	NB. Previous Hx of violence.	
	but no specific risks at present.	
	Requires f/u by CAT/CMHT –	
	we will liaise w/ them.	
	prior to discharge. and recontact	
	mental w/ plan.	
	Imp – drug induced psychosis.	
23/2/16	(Nursing)	
1420	Resting this morning, seated	
	when his relative arrived, sleeping	
	this afternoon. Await to hear	
	back from psychiatry.	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

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Date & Time		Signature, Print Name & Designation
23/1/16	Social work regard form completed	
14:45	X please fax this to social work dept tomorrow AM X	MPaver / Montero SW
	Apparently house break-ins x2: front door not secure - (Nursing)	
16:30	psychiatry phoned to say that Michael's CPN (Colin Jack) will come to ward Friday pm to see Michael	MPaver / Montero
1630	ATSP Re Finger following fall	
	Visibly swollen	
	Normal ROM	
	Normal sensation	
	Tender on palpation more at joint	
	No obvious #	
	Cont as prev	
	PRN Paracetamol	#2005

83949

Date & Time		Signature, Print Name & Designation
24/2/16	Nursing Night	
06:00	Settled on & off	
	Continues to hallucinate ++	
	Wishes to leave. He would	
	Is a falls risk currently	
	In my opinion requires	
	Enhanced observations nurse	
	as is very disruptive in	
	room & can frequently	
	Scream and argue with	
	hallucinations.	
	Awaits further medical review	
	No Complaints offered	C. Lawrence CCNS
		C. Lawrence CCNS
24/2/16	WR Fletcher GPST1.2	
10/5		
	Well, much more settled	
	Psych R/V noted with thinks	
	Issues with house > referred to SW	
	Plan	
	Social work R/V, no medical issues	
		FLETCHER
24/2/16	pt appears settled on ward	
12.00	at time of writing. Eating and	
	drinking well. obs stable	
	as charted. Independant mobile	
	through to toilet. Refered to SW.	
	Issues with house. Psych R/V	
	await. No other issues at	
	time of writing. SN JH 24	P Leaw (student nurse)

NHS GREATER GLASGOW & CLYDE

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Date & Time		Signature, Print Name & Designation
25/2/16	Screened for OT/PT.	
	Pt referred for Physio input.	
	However note pt is (I) mobile	
	& issue's are all ↓ due	
	for review by CPN & hallucinations/	
	mental health are the issue	
	rather than mob. No PT	#3841
	issue's ———	R Conway (OT)
24/2	Fyl Andrew	
1500	1x NOK	
	D/w Family – Sister, 2x daughter + uncle	
	- Explained medically fit, nil to suggest	
	on bloods / examination or indication	
	for head / abdo scan (? history of bottling + falls	
	reported by family).	
	Will not send home until social	
	work have sorted home situation.	
	He will receive community	
	addiction + mental health team	
	follow up.	
	- They are happy with this +	
	are clearly worried about pt	
	+ home situation but happy	
	with care + situation	A Andrew
		#2005

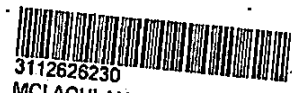
83949

Date & Time		Signature, Print Name & Designation
24/02	S. Gamma PMH Nzgts	
	ATSP re hallucination & attacking the SN	
	Pt was swinging his fist toward the nurse to hit her but stopped and missed her.	
	Security are on site..	
	Pt hallucinating, shouting and agitated.	
	Does not remember attacking the nurse.	
	Refused oral 0.5mg Haloperidol as that will poison his body.	
	D/w SHO on call, agreed to IM Haloperidol 2mg & security to stay until pt is settled.	
	Obs stable.	
	Imp / psychosis	
	P/ IM Haloperidol.	
	To c/w agitation if needed	
	Urine Tox screen.	[signature] 62224
25/2/16 0045	ATSP re Acute psychosis	
	(53) BG of Bipolar disorder.	
	2-3 episodes of acute psychosis over last few years.	
	Currently using regular heroin (smoking)	
	Prev history of Cannabis + benzo abuse.	
	Admitted c confusion on 26/2/16.	
	All bloods / CXR / MSU - ve.	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate


3112626230
MCLACHLAN
Michael
M
31/12/1962

Date & Time		Signature, Print Name & Designation
	Continued....	
	Tonight acutely psychotic.	
–	Hallucinating! Threatening behaviour.	
	Shouting about sexual abuse + accusing staff.	
	Paranoid.	
–	On DHC + quetiapine.	
	Unsure if taken anything additionally today.	
–	Daughter aware + thinks it is v. unlikely any visitors would bring anything. Has had only started using at age 47 – unclear why.	
	No family members use.	
	Imp Acute psychosis – likely drug induced.	
	Unable to rule out any acute medical cause tonight.	
	No bloods for 3–4 days.	
	D+V Med Reg – attempt IVA	
–	Use lorazepam / Haloperidol alternatively to sedate as needed.	
0045	IM lorazepam 2mg given & settled.	
	Daughter present + had been v. calming.	

83949

Date & Time		Signature, Print Name & Designation
25/2/16	Following use of im lorazepam + haloperidol.	
02[00]	Nurse unable to improve this	
	man's condition.	
	Spoke to Psych on call (Dr Gillian ?)	
-	Advised must fill out emergency	
	detention certificate + let MHTO know	
	(David Calderwood)	
-	Liaison Psych should then review	
	in the morning to see if still needed.	
-	Can use 2mg im Midazolam	
	every 15-20 mins (max 10mg)	
	until settled.	
03[00]	DNS on call MHTO - David	
	Calderwood. Unable to complete	
	assessment as already put	
	into force last night.	
25/2/16	See above entries.	
	Initially chatty & orientated	
	at start of night shift. began	
	hallucinating as soon as lights	
	dimmed. Ran at myself with	
	fist raised, shouting & swearing	
	Did seem to think I was	
	someone else though. Did not	
	hit me - became distracted.	
	Unable to settle - despite	
	sedation. Extremely agitated.	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

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Date & Time		Signature, Print Name & Designation
25/2/16	Daughter contacted and came to sit with Michael. Continued to be increasingly agitated, and required 2 security clerks to be put at. Security staff spent several hours on ward.	
	finally settled after multiple injections c IM midazolam.	
	Now under 72 hour section c TWI completed. family aware. for psych review today.	
	Datix completed - WEB: 346151	
	RFT c Temp 38° oz c PP when extremely agitated.	
	1° observations show these have now settled to normal range. Remains asleep at time of writing (07⁰⁰ hrs)	H. Macphers

83949

Date & Time		Signature, Print Name & Designation
25/2/16	WR	
10am/	Nde acute psychosis overnight requiring sedation	
	and emergency detention	
	Temp ↑	
	No signs clinically of infection · He is aware he is in GPH	
	Bowels v/v normoactive BS ✓	
	Chest clear RS ✓ RR ✓	
	Check routine bld's. If ✓ I think he should	
	be transferred to acute psychiatric unit.	
	Family informed & progress.	
	Dr Hilary Wilson Consultant Physician 07891815828	
25/2/16	- Review (liaison ψ) Pt ATD.	
	Admitted on the 19th Feb →	
	· Turned up at daughters house, confused, agitated and hallucinating.	
	· History from daughter →	
	- long history of heroin addiction, (worse over last 7/8 years)	
	- x 2-3 episodes of drug induced psychosis over the last 10 years	
	* Does not have Bipolar *	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

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M
31/12/1962

Date & Time		Signature, Print Name & Designation
25/2/16	• Mr Mclaughlan had ~~off~~ a fall ×2 [illegible] of stairs 6/8 weeks ago. Sustained head inj. → 4D from then on "not quite right" forgetting things, sleeping a little with chums. (he was clean over this period) Spent Xmas & daughters	
	Daughter saw him > 2/52 ago → Was trying to "detox" from heroin with Sheet. NFI's + Subaxon	
	*Last Friday - Turned up at daughter's. Had lost weight and obviously banged his head again (hit with full bottle).	
	⊛ Since admission - Fluctuating confusion. Mostly	

83949

Date & Time		Signature, Print Name & Designation
	might through the day and ↑ confused hallucinating at night	
	*last night ↑ agitation, confused and offensive ~ ↑ Temp.	
	↳ Placed on EOC	
	*DIE ~ Agitated, confused, disoriented in time + place	
	Seeking ++ (seen symptoms)	
	Responding to visual hallucinations	
	Imp: ~~[illegible]~~ MC 26/2/16.	
	Delirium	
	Plan ① Organic cause should be excluded	
	② Brain CT (urgent)	
	③ On STDC ✓	
	④ Start regular haloperidol.	
	⑤ Will cont to review	Consultant GROTO

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate


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Date & Time	NURSING DAY @ 1900	Signature, Print Name & Designation
25/2/12	All meds as prescribed in Kardex	
	- Written up for PRN haloperidol given x 2 with little effect.	
	- Seen by psych who recommend a CT head - await ☐	
	- See prev. notes	
	- Patient becoming very agitated · anxious at times, daughters sitting with father most of the day - transfered into side-room	
	- Eating & drinking small amounts.	
	- Obs charted - apyrexial.	
	- Disorientated · confused at times	
	- Daughter will stay o/n with her father.	J. Durkin s/n J. Durkin

83949

Date & Time		Signature, Print Name & Designation
	25/2/16 2200	
	- ongoing problems with agitation and confusion.	
	- safety of patient and staff is a major concern here.	
	- Has been restrained again and given IM haldol 5mg.	
	- Note suggestion to do a CT S> T - 2 points about this ① There does not fit well an intracerebral event so a CT is very unlikely to add anything here. ② I suspect he will need an anaesthetic for a CT>	
	- I have discussed with SHO at particular because we really should have an RMN here. - she will do her best and get back to me	
	NEIL MCKEAN ST7 11.811 NM	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

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Date & Time		Signature, Print Name & Designation
25/2/16	Increasingly agitated from start	
	of shift, culminating in leaping	
	from bed to chair to window	
	sill, and becoming suddenly	
	aggressive, punching daughter.	
	Security alert put out and	
	required to be restrained	
	under medical supervision until	
	Sedation had taken effect.	
	finally settled around 12mn.	
	DATIX completed. 1° observations	H. Macpherson
	to monitor respiratory effort.	H. Macpherson.
	NEG 346323	
26/2/16	Patient sleep peacefully.	
05[30] hrs	Good respiratory effort at	
	04[30] hrs when checked.	
	Daughters asleep in room	
	c door open for staff	
	observation. Checked just	
	after 5am and sleeping.	
	moved away to get	
	item from nearby room	
	& suddenly heard a loud	
	clatter & scream. Fell	
	getting out of the bottom	
	of bed. found by daughter	
	on floor, on all fours, but	
	immediately up onto feet	
	holding daughter. Tyl called.	H. Macpherson

83949

Date & Time		Signature, Print Name & Designation
.	Observations stable.	
26/02	S. Gamma FYI Nights	
05:20	ATSP re fall.	
	He had unwitnessed fall from bed. Daughts were sleeping on chairs, Woken up by fall noise. Pt found on the floor on his knees, elbows hands. C/o ~~Pain~~ (R) side hip ~~pain~~ pain. Able to stand up and was put back to bed.	
	On examination, pt drowsy / sleepy / uncooperative Could not examine him properly, as keeps pulling away. Able to move head and all 4 limbs. Has bruised (L) arm + elbow and right hip. (R) hip tender to touch, but able to flex / extense his legs. Does not seem to be in pain. There is also a small bruise to top of head, looks as an old bruise, not tender to touch	
	Pt sleepy. All his obs are stable for CT head today.	RR 20, sats 97% air temp 35.5 HR 67 BP 117/74
	P/ Monitor pt & assess when less drowsy not for imaging at the moment.	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

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Date & Time		Signature, Print Name & Designation
26/2/16	Patient again resettled & sleeping.	
	Unclear why he suddenly got	
	out of bed although sudden,	
	quick movement & activity	
	common behaviour when awake.	
	Obs actions remain	
	stable. S/B medics - superficial	
	injuries noted. DATIX completed	Stn
	WEB 346339	H. McPherson
	Fyl Andrew	
		Required
	① Opioid induced psychosis	Lorazepam
	- Events overnight noted ✓	Midazolam
	- For CTB today to exclude	Haloperidol
	organic causes 14:15	PRN
		on reg Haloperidol
	Obs stable	
	Bloods = WCC 8.6	
	Hb 131	
	CRP 1	
	U+E (N)	
	LFTs Added	
	Pt laid in bed asleep. Daughters report v. restless	
	night as overleaf.	
	P = Call anaesthetics over ?sedation	
	Will d/w Reg Aitken Re: this	Andrew
	option or will sedation suffice	#2005

83949

Date & Time		Signature, Print Name & Designation
26/2	Fy1 Andrews	
1100		
	D/w Anaesthetics on call #13299	
	History given - currently more settled	
	P = Observe	
	No more sedation than currently	
	Recontact if ↑ unsettled	
		DAndrews
		#2005
26/2	Nursing Daps.	
1530	- All care given as per care plan.	
	- Medication given as prescribed	
	- Obs satisfactory as charted, News 2.	
	due to BP 92\52, asymptomatic	
	- Independent to toilet	
	- Eating and drinking small amounts	
	today	
	- PT remains disorientated and confused	
	at times.	
	- Family present with PT most of	
	the day	
	- No new issues at time of writing.	STUDENT. LATHOMSON RMILLER M Miller SCN.
1645	CT Head normal-	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate



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Date & Time		Signature, Print Name & Designation
25/2/16		
1600/	Reviewed.	
	CT Head normal	
	Have communicated result to his extended	
	family – 7 relatives with him at present.	
	Reinforced that this is likely to be a drug	
	induced psychosis & will hopefully improve	
	over time.	
	DIW DI OTo. She does not feel this is typical	
	of a psychosis. She is still concerned that this	
	may be organic because there are periods of	
	normality. She wonders if an EEG would	
	be of value	
	Plan Continue to monitor & ask for neurology	
	opinion to see if he requires a LP/MRI.	
	I shall feel this is likely to be drug related given	
	his prenatal hallucinations when he took	
	heroine prior to admission.	
		Jelle
		H Nilsson
		(CON)
		07881815828

83949

Date & Time		Signature, Print Name & Designation
26/2/16 06:10	Nursing Night Report. Last evening at start of duty Micheal appeared settled and dozing while brother visiting A further two brothers visited and Micheal went out for a cigarette with them. He returned safely and brothers left within 15 minutes. Daughter and partner had arrived and were going to stay overnight. At 21:30hrs NEWS 1 T38°C Micheal complaining of lower back pain around (R) kidney When coughing Micheal experienced pain at ? base of (R) lung. Please observe. Urinalysis at ward level was N.A.D. All evening medicines tolerated and Paracetamol 1gram given for pain (sore 7) and temperature. At 23:30hrs (~~NEWS~~ RR) T37.5°C Micheal settled but when talking he appears to be rambling incoherently. When asked to slow down so staff could understand Micheal responded coherently in a jovial manner. From midnight Micheal unsettled mostly disorientated to time and	P.J. O

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL

Date & Time		Signature, Print Name & Designation
26/27.2.18	place but easily reorientated	
06.50	and redirected into bed.	
	NEWS Score (0) @ 06.46hrs.	
	Micheal remains a little	
	mixed up. Feels tired because	O/N Scotmid J Clark
	of unsettled night as mentioned	J Clark
	Micheal has been nursed 1:1	
	overnight	
27/2/18	R. Keith CTZ	
12:00	Much more settled today	
	Had a good night	
	Not trying to leave the ward	
	went down for a cigarette with family	
	Currently having lunch	
	— eating + drinking well	
	Note spiked temp 38°C overnight	
	Now afebrile, other obs ok, SpO_2 (N)	
	c/o pain (R) loin — 'feels like kidney stone'	
	No urinalysis since last on admission (negative)	
	Needs further + dip please — blood?	
	O/E — chest clear, Hs pure	
	Abdo SNT BS (+)	
	pupils pinpoint — on 60mg QDS DHC as heroin use	
	prior to admission (weaning ↓, plan?)	
	Plan — repeat bloods today	
	BC's if febrile	

83949

Date & Time		Signature, Print Name & Designation
27/2/16	cont: CXR :L ↑CRP	
	Contacted addictions liaison – not working over weekend. Continue dihydrocodeine.	
	R. Meik	
	CR	
27.2.16	Nursing days.	
1515	- ALL Care given as per Care plan	
	- Obs stable as charted, News 0	
	- PT attended to personal Care needs Independantly.	
	- medications given as prescribed.	
	- PT remain disorientated and Confused at times, family have been present throughout the day and PT has been going out of the ward accompanied for regular Cigarettes.	
	- Accurate weight obtained today.	
	- Eating and drinking well today	
	- Independent with Continence needs throughout the day.	
	- No new issues at present time	STUDENT L THOMSON K WADDELL SN K MOORE.

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☑

Please tick ✔ appropriate directorate

Michael McLachlan

MD 20-21 Grel

Date & Time		Signature, Print Name & Designation
28/2/16	Nursing notes nightshift -	
-	Family settled night.	
-	Went for cigarette with family on two occasions.	
-	Daughter also bought in fish and chips.	
-	Eating and drinking well.	
-	Independent to toilet - went for shave independantly.	
-	Bowels active	
-	For further review.	
-	Medications given as per kardex	
-	Asked medics to clarify haloperidol dose - 2.5mg.	
-	Medical staff have confirmed this dose is ok - aware.	
-	However patient found asleep therefore not disturbed to give haloperidol.	
-	observations stable as per news.	
-	Slept for long periods. No complaints at this time.	SN Duffy / Barrett
28.2.16	Nursing: -	
11:30	Nursed on 1:1 observision	
	Asleep at commencement	
	of shift. Woke a couple	
	of times complaining of	
	back pain nhs offered	
	paracetamol for pain relief	
	but refused this. Slept	
	through breakfast - last ate	
	crisps & chocolate and	
	nhs given some tea.	
	Accompanied outside to	
	have a cigarette. Writer	SN Beth Kerr
	spent some time conversing	over

83949

Date & Time		Signature, Print Name & Designation
28/2/16	with Michael. He spoke	
1130	about his family, time	
	in Barlinnie and Glenochil	
	Prisons. Orientated. No	
	sign of any external	
	stimuli	
28/2/16	R.Neilly CTR	
11:30	seems much better	
	Relaxed, reading the paper	
	Alert, orientated and appropriate	
	No further temperatures	
	Still c/o R Hip/Loin pain	
	2° Fall/trauma? Renal stone?	
	Awaiting mine dip	
	walking down to front door with family	
	↳ unlikely #	
	Bloods taken today ✓	
	Await mine dip	
	Addictions liaison 1/7 re DF118	
	R.Neilly	
	CTR	
28/2/16	Accepted prescribed DHC as	
230.	per kardex. Accepted lunch	
	reports good appetite.	
	walked along to room 7	
	and had conversation	
	with another male	
	patient whom he reports	
	to have known previously.	
	Spoke about previous heroin	
	use, then coming off	
	meth. the use of subaxone.	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL

3112626230
MCLACHLAN
Michael
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS
M
31/12/1962

Date & Time		Signature, Print Name & Designation
28/2/16	Pain in (R) side low back. Urinalysis NAD. Appreciated. Please clarify need for Haloperidol regularly - now - no confusion or agitation.	
29.2.16 1:30	F42 MUNTEANU (Resident) Patient stable over night, not agitated after asleep. The patient has not received haloperidol today because of dose clarification issues and that when the dose was clarify, the patient was asleep & settle. (P) → discuss tomorrow with psychiatry & medical reg haloperidol dose. ↓ one off haloperidol prescribe in front of [illegible]	
29/2/16	Nursing notes nightshift:	
-	settled night - slept all night	
-	Regular analgesia given for ongoing back pain	
-	Medics asked to review need for haloperidol see notes above.	
-	Observations stable as per news. Appraisal	
-	No agitation or aggressive behaviour at time of writing.	
-	No new issues to report.	[illegible]

83949

3112626230
MCLACHLAN · Michael
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS
M
31/12/1962

Date & Time		Signature, Print Name & Designation
29/2/16		
9.30am	Much better ors Weekend	
	More orientated. Reading paper	
	C/o (R) sided low back pain wc -ve urinalysis	
	Afebrile 48hrs.	
	Pain on movement. not intermittent.	
	Addiction liaison to review OHC and psychiatry	
	today to review detention order.	
	Check Routine bloods today.	Jell
		H Nurse
		(Cont)
		07881815828
29/2/16 11pm	Nursing (Daycream)	
	- Improved / Obs Stable as Charted	
	- Nthe Consultant r/v as above.	
	- Asst Addiction Nurse r/v'd.	
	- Psychiatry r/w D/t to r/w detention order.	
	- Settled @ time of writing	
	- Medications Tolerated.	SN D McElroy
	- Independent with ADL's.	OH DC
29/2/16	Yrs Ax: Nkda allergies	
	C/o oriented reasonably. Nb Hallucx.	A J Burnside
	Aware of prev abn phenomena - putting	Hon
	this down to a repeat of the prev psychotic episode	
	many years ago. Fully insightful now.	
	⇒ MSE essentially @. A possible delirium	
	prev due to BDZ c'drawl as he has	
	abruptly discontinued ↓ Xany tablets	
	a while before the presentation	

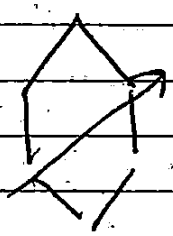
NHS GREATER GLASGOW & CLYDE

3112626230
MCLACHLAN
Michael
M
31/12/1962

CLINICAL NOTES - MEDICAL

Date & Time		Signature, Print Name & Designation
29/2/16	(Contd): I will review the STOR. Suggest continue Diazepam. I will cc correspondence to relatives CMHT for 4 days. No review planned from Liaison Y.	AJ. Burns
29/2/16. 14.40.	ACUTE ADDICTION LIAISON (802014) Brief review on ward today. Agreed Dihydrocodeine reduction with medical staff Does not wish addiction support on discharge - Re-refer if reconsiders.	KAREN MACDONALD K. MacDonald SENIOR ADDICTION NURSE
29/2/16	PYI KILPATRICK	
	ATSP re: fell Right lower back pain	
	⇒ Admitted on 20/2/16 with drug induced psychosis ⇒ Psychosis now resolved - Seen by addictions today now on ↓ dose dihydrocodeine 360mg BD (from QID).	
	Multiple falls during admission Fell 26/2 - Rt hip + Rt arm + elbow. Tonight c/o right hip / lower back pain. Worse on movement + coughing. No pain at rest Woken from sleep when turning in bed. Scoring 7/10 at worse. • radiation.	

83949

Date & Time		Signature, Print Name & Designation
	Bowels moving, ETO well Previous renal stone? Denies urinary symptoms °loin pain. °loin → groin pain. °pain on inspiration, Bloods (N) on 27/2. (Cre 22, WBC (N). Urine ~~dip~~ dip - (-) for blood.	
	A- patent B- (R) chest clear; resonant, RR 15, 98% RA.	
	C- HS I + II + 0 Agrees w/ CSNT. HR 72, BP 120/70. regular rate. °oedema.	
	 ABNT, BS +. Pain Rt lumbar area. °pain on palpation. ↑ Appt	
	Imp → MSK pain 2° to recent fall → unlikely 2° renal stone as Obs (N), (-) Blood urine dip, °urine sample	
	(P) Has Sevs NSAIDs + paracetamol Cause nausea ↳ lidocaine patch. ↳ Bloods tomorrow.	
		Amy Upatree PY1

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL

Michael McLauchlan

WD 2021 GR1

Date & Time		Signature, Print Name & Designation
1/3/16	Nursing notes nightshift	
-	Ongoing complaints of back pain.	
-	Not resolved with current analgesia	
-	Medics asked to r/v analgesia - see notes previous page.	
-	Commenced on lidocaine patch.	
-	Regular dihydrocodeine also given	
-	Appeared to have slept ok overnight	
-	Eating and drinking well.	
-	Observations satisfactory as per NEWS.	
-	Medications given as per kardex	
-	No other issues at this time.	SND Cardiothoracic
1/3/16	R.Keith CT2	
9.10		
	Remains well	
	Main issue is R sided lower back pain	
	Not affecting mobility	
	Opening bowels, passing urine	
	No bruising. MSK — 2° fall / soft tissue?	
	O/E — no bony tenderness	
	no renal angle tenderness	
	No longer continued	
	STOC revoked	
	1 Dihydrocodeine	
	(H) 48h	
	R.Keith	
	CT2	

83949

Date & Time	1/3/16	Signature, Print Name & Designation
	Patient well and uncomplaining.	
	IV's running to time. Pain relief given as per	
Kardex. Independent with A.D.L's		
	1A Joint sister.	
2/3/16	NURSE (NIGHT)	
	Settled night, appeared to have	
	slept for long periods, mobilising	
	independently. Oral medications	
	taken as prescribed: Met-ord	
	orientated prior to settling.	
	Eating and drinking.	
	Aware of possible discharge	
	tomorrow but doesn't feel	
	ready for same.	
	No new issues	SSmith SSmith
2/3/16	R.Meith CT2	
9.00	Remains settled	
	Reducing regime of Dihydrocodeine	
	Last dose given this morning	
	still feeling a bit edgy / jerky	
	No tremor / other signs of withdrawal	
	still has back pain	
	likely Msk / Soft tissue injury	
	Awaiting formal XR Report	
	Aim (H) 24h	
	Simple analgesia only	
	R.Meith	
	CT2	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL

3112626230
MCLACHLAN
Michael
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS
M
31/12/1962

Date & Time		Signature, Print Name & Designation
2/3/16 1pm	Nursing Daycream) Agreed Obs Stable as Charted. Independent with ADL's plus a.m. Nutri Medical r/w as documented Meds as Charted kardex. for Transfer to Rm 5/1. Area. SN Smc by Ward -	SN Smc
2/3/16	R.Meikle CT2	
12:00	XRay formally reported by Paul Armstrong	
	(unable to put on PACS so called with report)	
	Normal vertebral height and alignment	
	No fracture seen.	
	Renal calculi noted.	
	(urine dip –ve) R.Meikle	
	CT2	
3/3/16	Nursing-Nightshift	
	Patient had settled night	
	observations -News=1-BP-109/70	
	All medications given as per kardex	
	Taking diet and fluids	
	Mobilising independently around ward	
	Passing urine.	
	For home today-patient aware.	
	Slept for long periods	
	Uncomplaining of pain ——	BSN(Hons)/N MACDONALD

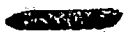
83949

Date & Time		Signature, Print Name & Designation
3/3/16	Ward Fletcher GPST 1.2	
0920		
	Well	
	· Pain-free	
	Obs stable	
	Plan	
	(1) Today	
	FIV CMHFT	
		FLETCHER
3/3/16	Nursing Diag	
	Independent with ADL	
	Meds as per Cardex	
	Obs stable as charted	
	Independent & toilet mobilising	
	for D/C today.	
	· own transport	
	med's read and explained. Medicine Rec	
	CPN FIV in place. Michael states	
	will contact CAT himself in morning	

BOWEL MOVEMENT RECORD

NHS Greater Glasgow and Clyde

Name: Michael Meladlan CHI: ..... Date Commenced: 27/2/16

Date	Time	Comments i.e. volume, blood, mucous S – small M – medium L – large	Type 1 Separate hard lumps like nuts (hard to pass) 	Type 2 Sausage shaped but lumpy 	Type 3 Like a sausage but with cracks on surface 	Type 4 Like a sausage or snake, smooth and soft 	Type 5 Soft blobs with clear-cut edges (passed easily) 	Type 6 Fluffy pieces with ragged edges, a mushy stool 	Type 7 Watery, no solid pieces (entirely liquid) 	Staff Initials
27/2	10am	L						✓		KJ Sample

Adapted from the Bristol Stool Scale developed by KW Heaton and SJ Lewis at the University of Bristol, 1997

Acute Services Division

Nursing Admission & Assessment

1. Admission

NHS Greater Glasgow and Clyde

Hospital: GRI	Ward: 51
Date of admission: 2012 / 16	Time: 0535
Admitting Consultant:	Admitting Nurse: [illegible]
Expected date of discharge: / /	

Name: [illegible] 3112626230
Addres: MCLACHLAN Michael FLAT 1-1 31 ABERFELDY ST Glasgow, Lanarkshire
M 31/12/1962
DoB:
CHI nu G31 3NS

1. Patient Details

Preferred name:	Next of Kin (NoK): Chevonne McLachlan
Age:	Relationship: Daughter
Religion:	NoK Address:
Telephone:	
GP: Dr. CA Walker	NoK Telephone: 07947908834.
GP address: Shettleston Health Centre, 420 Old Shettleston Road, Glasgow, G32 7JZ	NoK Aware of admission: ☑ Yes ☐ No
	Consent for information to be given to relatives: ☐ Yes ☐ No
	Nominated family contact:
GP telephone:	Telephone - Day:
	Telephone - Evening:

Is the patient a carer? ☐ Yes ☑ No If 'Yes' refer to Duty Social Worker if required: ☐ Referred ☐ Not required

Does the patient have an appointed Welfare Guardian / Power of Attorney? ☐ Yes ☐ No ☐ N/A

a. If 'Yes' please provide – Name: ..... Relationship: .....

Contact telephone number: .....

b. If 'Yes' does the patient have an 'Adult with Incapacity Section 47' certificate in place? ☐ Yes ☐ No ☐

If 'No' to 'b' please inform medical staff. Name of doctor informed: .....

2. Presenting Complaint / Diagnosis

? psychosis.

Why does the patient think they are in hospital? *Use patients own words:*

3. Allergies (including food allergies)

No known allergies: ☐

4. Observations

Cannard	Waterlow	MUST	Pulse	BP	Resp	SaO_2	Temp
Urinalysis:		AMT4 Score	BM	NEWS Score	Weight Estimated / Actual	Height Estimated / Actual	BMI

5. Current Medication

Medicines reconciled on admission? ☐ Yes ☐ No

6. Relevant Past Medical History

7. Risk Assessment

MUST

1. Is the patient's BMI:
   - ≥ 20 ..... Score 0
   - 18.5-20 ..... Score 1
   - <18.5 ..... Score 2

   Score ☐
2. Has the patient had unplanned weight loss in the past 3-6 months?
   - < 5% ..... Score 0
   - 5-10% ..... Score 1
   - >10% ..... Score 2

   Score ☐
3. If the patient is acutely unwell and there has been or is likely to be no food intake for > 5 days:
   Score = 2

   Not applicable: Score = 0

   Score ☐

MUST Score: ☐

If score 1 or more, complete full Nutrition Profile

Name: .....

Address: .....

.....

DoB: .....

CHI number: .....

Affix patient data label

8. Cognitive Impairment

For all patients ≥ 65 years, ask the following 4 AMT questions:

1. How old are you? ..... years
2. What is your date of birth? / /
3. What is this place? .....
4. What year is it? .....

If the patient does not answer all questions correctly then refer to medical staff.

AMT Score: ..... out of 4

Name of Doctor informed (if required)

..... Grade .....

9. MRSA Screening / CJD / Healthcare outside Scotland

Will the patient be an inpatient >23 hours? ☐ Yes ☐ No If 'Yes' complete the following section.

1. Has the patient ever had a previous positive MRSA result? ☐ Yes ☐ No ☑ Not known
2. Has the patient been admitted from a Care Home/ institutional setting or another hospital? ☐ Yes ☑ No ☐ Not known
3. Does the patient have a wound / ulcer or invasive device which was present prior to this admission? ☐ Yes ☑ No ☐ Not known

If 'Yes' to any of the above questions **OR** if the patient is admitted to a 'high impact speciality' e.g. **Orthopaedics, Vascular, Renal Unit, Critical Care – then obtain MRSA Swabs:**

☐ **Nasal** ☐ **Perineum** ☐ **Other - Specify:** ☐ **Patient refused**

CJD: Has the patient ever been contacted by Public Health and told that they are possibly at risk of CJD:

☐ Yes ☐ No If 'Yes' contact Infection Control Team. Infection Control Team contacted: ☐

Healthcare outside Scotland

Has the patient been transferred from, or received health care in, a hospital outside of Scotland in the last 12 months:

☐ Yes ☐ No If 'Yes obtain rectal swab and send to microbiologty for CPE screen.

Rectal swab taken ☐ Patient refused ☐

10. Lifestyle

Smoking:

Does the patient smoke? ☑ Yes ☐ No

If 'Yes' how many per day: 1 ocpd

Does the patient use nicotine replacement therapy? ☐ Yes ☐ No

Does the patient wish referral to Smoking Cessation Service?

☐ Yes ☐ No If 'Yes', date of referral: / /

Drugs: Does the patient use recreational drugs? ☐ Yes ☐ No If 'Yes' specify:

Alcohol (Men): How often do you have **8** or more drinks on one occasion:

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

If 'Monthly' or more then complete FAST Tool.

Alcohol (Women): How often do you have **6** or more drinks on one occasion:

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

If 'Monthly' or more then complete FAST Tool.

11. Admission Documentation Completed By

Name (Please PRINT):	Signature:
Designation:	Date:

Acute Services Division

Nursing Admission & Assessment

2. Assessment

Hospital:	Ward:
Date of Assessment: / /	Time:

Name .....
Addre 3112626230 .....
MCLACHLAN M
..... Michael 31/12/1962 .....
DoB:. FLAT 1-1 .....
31 ABERFELDY ST
CHI n Glasgow, Lanarkshire .....
G31 3NS

1. Breathing and Circulation

Breathing:

- ☑ No symptoms or history of respiratory problems
- ☐ Dyspnoeic at rest
- ☐ Dyspnoeic on minimal exertion
- ☐ Dyspnoeic on maximum exertion
- ☐ Productive / non-productive cough evident
- ☐ Normally receives oxygen therapy

If 'Yes' provide details:

Circulation:

- ☐ No symptoms
- ☐ Known cardiac or circulatory problems

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

	Initial

2. Communication

Assessment of ability to communicate:

What language does the patient speak?:

English

Interpreter: Required ☐ Not required ☑

If required, provide details and arrangement made:

.....

.....

Does the patient have:

a. Speech difficulties? ☐ Yes ☑ No

b. A learning disability e.g. Down's Syndrome?
☐ Yes ☑ No

If 'Yes' please specify:

.....

If 'Yes' contact Liaison Learning Disability Team.
Liaison Learning Disability Team contacted:
☐ Yes ☑ No

c. A learning difficulty e.g. dyslexia, dyspraxia?
☐ Yes ☑ No

If 'Yes' please specify:

.....

3. Senses

Senses:

Eyesight

- ☐ Normal vision
- ☐ Glasses – ☐ Distance ☐ Reading
- ☐ Prosthesis – ☐ Left ☐ Right
- ☐ Contact lenses
- ☐ Registered blind

Hearing

- ☐ Normal
- ☐ Hearing impaired
- ☐ Hearing aid – ☐ Left ☐ Right

4. Mental Status

Mental Status:

- ☐ Orientated
- ☑ Confused
- ☐ Distressed
- ☐ Aggressive /Abusive
- ☐ Unconcious

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

	Initial

5. Hydration and Nutrition

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

MUST Score: ..... If score is 1 or more, complete a Nutrition Profile.

Nutition Profile completed ☐ Yes ☐ No
If 'Yes' do not complete sections 5a to 5d.

- If score is 0, reassess / screen patient in 7 days.
- Complete sections 5a to 5d.

Date of reassessment: / /

5a 1. Food likes / dislikes:

5a 2. Fluid likes / dislikes:

5c. Help needed with eating and drinking:
☐ Yes ☐ No
If 'Yes' provide details:

5b. Cultural or religious diet needed (e.g. vegetarian, vegan, halal, kosher etc):
☐ Yes ☐ No
If 'Yes' specify diet needed:

5d. Texture Modified Diet needed?
☐ Yes ☐ No
If 'Yes' specify texture: A☐ B☐ C☐ D☐ E☐
Thickened Fluids required? ☐ Yes ☐ No
If 'Yes' specify stage required: 1☐ 2☐ 3☐

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

	Initial

6. Elimination

Continent:	Incontinent:	NHS GGC Stool Chart commenced:
☐ Bladder ☐ Bowel	☐ Bladder ☐ Bowel	☐ Required ☐ Not required

Long-term urinary catheter in situ? ☐ Yes ☐ No If 'Yes' – Size: .....fg Make: .....
Date catheter last changed: / /

Continence assessment commenced:	Containment products in use? Please specify:
☐ Yes ☐ No ☐ Not applicable	

☐ Bowels regular ☐ Constipated ☐ Diarrhoea / loose stools	Stoma: ☐ Yes ☐ No If 'Yes' please specify and list appliances used:

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

	Initial

7. Personal Hygiene, Oral Health and Skin Assessment

Nam
Addr 3112626230
MCLACHLAN M
Michael 31/12/1962
DoB: FLAT 1-1
31 ABERFELDY ST
CHI n Glasgow, Lanarkshire
G31 3NS

Personal hygiene:
- [x] Self-caring and independent
- [ ] Requires assistance

Specify assistance if required:

Oral health:

Self-caring and independent	[x] Yes	[ ] No
Does the the patient have a sore mouth	[ ] Yes	[x] No
Does the patient have a non healing mouth ulcer	[ ] Yes	[x] No

If the patient has a sore mouth or non healing mouth ulcer, refer to dentist (See StaffNet for dentist referral pathway) and implement Oral Care Bundle.

Oral Hygiene Care Bundle:
- [ ] Required
- [ ] Not required

Dentures:
- [ ] Not worn
- [ ] Upper set
- [ ] Lower set
- [ ] Full set
- [ ] Dentures with patient on admission

Skin assessment:
- [x] Skin healthy with no evidence of damage
- [ ] Skin broken
- [ ] Skin oedematous
- [ ] Skin discoloured
- [ ] Skin clammy

If 'Yes' to any of the above, describe skin condition:

Wound Assessment Chart completed: [ ] Yes [ ] No [ ] Not applicable

Pressure ulcer evident: [ ] Yes [ ] No

If 'Yes' please identify Grade and record on Pressure Ulcer record sheet.– Grade:.....

Problem identified: [ ] Yes [x] No If 'Yes' please describe

	Initial

8. Mobility

Patient fully mobile / independent? [x] Yes [ ] No If 'No' complete Moving and Handling Assessment.

- [ ] Limited mobility
- [ ] Mobile with aid – Specify:
- [ ] Prosthesis – Specify:

Moving and Handling Plan commenced:
- [ ] Yes
- [ ] No

Problem identified: [ ] Yes [x] No If 'Yes' please describe

	Initial

9. Maintaining a Safe Environment

Pain status:

Does the patient have pain? [ ] Yes [x] No

If 'Yes' record Pain Score on NEWS chart.

What makes their pain better? Please provide brief details:

Bed rail assessment completed: [ ] Yes [x] No

Bed rails required:
- [ ] Required
- [ ] Not required

Problem identified: [ ] Yes [x] No If 'Yes' please describe

	Initial

0. Sleep and Rest

Name: .....

Address: .....

.....

DoB: .....

CHI number: .....

Affix patient data label

Sleep habits:

☐ Less than 8 hours ☐ Afternoon nap

☐ Morning nap

Sleep difficulties:

☐ None ☐ Disturbed

☐ Early wakening e.g. nocturia, insomnia

Medication required: ☐ Yes ☐ No

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial

1. Social Circumstances

☐ Employed ☑ Unemployed ☐ Retired

☑ Lives alone

☐ Lives with Family

☐ Friend

☐ Dependants

☐ Other: ☐ Nursing Home ☐ Residential

Current Care / Support arrangements:

☐ Social Services ☐ Unpaid carer e.g. family, friends

☐ Private Carers ☐ None

If support services in place, please provide details:

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial

2. Privacy, Dignity and Sexuality

Does the patient have issues related to privacy, dignity and/or sexuality that are relevant to admission?

☐ Yes ☐ No

If 'Yes' please provide brief details:

13. Spiritual Care

Is there anything with regard to faith or culture that we can support the patient with during their stay in hospital (e.g. prayer, meditation)?

☐ Yes ☐ No

If 'Yes' please provide brief details:

Is there anything causing the patient a lot of anxiety at the time of admission that staff should be aware of?

☐ Yes ☐ No

If 'Yes' please provide brief details:

Ask the patient:

"Would you like the ward staff to arrange for a Hospital Chaplain to visit you while in hospital?"

☐ Yes ☐ No ☐ Not at this time

If 'Yes' please specify faith group:

Nam 3112626230
Addr MCLACHLAN Michael FLAT 1-1 31 ABERFELDY ST Glasgow, Lanarkshire G31 3NS
DoB: 31/12/1962 M
CHI r
Affix patient data label

14. Anticipatory Care

(This section is for patients thought to be in the last year of life, where appropriate and relevant)

Appropriate ☐ Not appropriate ☐

Is the patient aware of their:
Diagnosis? ☐ Yes ☐ No
Prognosis? ☐ Yes ☐ No

Is the patient's family aware of their:
Diagnosis? ☐ Yes ☐ No
Prognosis? ☐ Yes ☐ No

Preferred place of care:	Preferred place of death:
Home: ☐ Hospital ☐ Hospice ☐	Home: ☐ Hospital ☐ Hospice ☐
Current treatment – please identify (e.g. chemotherapy/ radiotherapy):	Other agencies involved in patient's care – please identify (e.g.) Marie Curie, MacMillan Nurses):

DNACPR order in place: ☐ Yes ☐ No
If 'Yes' are the patient's family and next of kin aware? ☐ Yes ☐ No

15. Admission Assessment Completed By

Name (Please PRINT):

Signature:

Designation:	Date:

Clinical Notes

Date and Time	Notes	Name, Signature and Designation

Clinical Notes continue on next page

Name: .....

Address: .....

.....

DoB: .....

CHI number: .....

Affix patient data label

Clinical Notes (continued)

Date and Time	Notes	Name, Signature and Designation

The Mental Health (Care and Treatment) (Scotland) Act 2003

Revocation / Termination

of Emergency Detention / Short Term Detention / Extension Certificate

REV 1

Instructions

v6.0

The following form is to be used:

to record the decision by the AMP / RMO to revoke an emergency detention, short-term detention or extension certificate, and to give notice of the termination of any of these certificates, whether as a result of revocation or any other reason

There is no statutory requirement that you use this form but you are strongly recommended to do so. This form draws attention to some procedural requirements under the Mental Health (Care and Treatment) (Scotland) Act 2003. Failure to observe procedural requirements may invalidate the notification.

Where not completing this form electronically, to ensure accuracy of information, please observe the following conventions:

Write clearly within the boxes in BLOCK CAPITALS and in BLACK or BLUE ink

For example

2	5		M	A	R	K	E	T		S	T

Shade circles like this -> ●

Not like this -> ⊗ ✓

Where a text box has a reference number to the left, you can extend your response on plain paper where there is insufficient space in the box. Extension sheet(s) should be clearly labelled with Patient's name and CHI number, and each extended response should be labelled with the appropriate text box reference number.

Patient Details

CHI Number: 3 1 1 2 6 2 6 2 3 0

Surname: M C L A C H A N

First Name(s): M I C H A E L

Other / Known As:

'Other / Known As' could include any name / alias that the patient would prefer to be known as.

Title: M R

DoB (dd / mm / yyyy): 3 1 / 1 2 / 1 9 6 2

Gender: ◉ Male ○ Female

Detention Details

The patient is detained under the authority of:

- ○ an emergency detention certificate
- ◉ a short-term detention certificate
- ○ an extension certificate

The patient is detained in:

Hospital: G L A S G O W | R O Y A L | I N F I R M A R Y

If the RMO or AMP is revoking the certificate please go to Part 1 (page 2)

If this certificate is terminating for any other reason please go to Part 3 (page 4)

Part 1: Revocation of Certificate

To be completed by AMP or RMO

AMP / RMO Details

Surname: BURNEL

First Name: ADAM

Title: DR

GMC Number: 3475889

Hospital: GLASGOW ROYAL INFIRMARY

Ward / Clinic (If appropriate): LIAISON PSYCHIATRY

Telephone No.: 01412114417

e-mail address:

Approved under section 22 of the Act by:

Health Board: NHS GREATER GLASGOW AND CLYDE

Revocation of Certificate

I, the AMP / RMO named above, am revoking the patient's detention certificate, for the reasons stated below, as I am ***no longer satisfied*** that:

◉ the patient's condition meets the criteria for detention

a) That the patient has a mental disorder;

b) that because of the mental disorder, the patient's ability to make decisions about the provision of such medical treatment is significantly impaired.

c) that if the patient were not provided with such medical treatment there would be a significant risk to the health, safety or welfare of the patient; or to the safety of any other person

○ that it continues to be necessary for the detention in hospital of the patient to be authorised by the certificate

1 MR MCLACHAN HAS NEEM SETTLING OVER THE LAST 48 HOURS. HE HAS HAD TWO OVERNIGHT PERIODS WITHOUT SIGNIFICANT AGITATION AND APPEARS TO HAVE BEEN FREE OF PSYCHOTIC SYMPTOMS FOR ABOUT 24 HOURS. AT INTERVIEW HE IS REASONABLY ORIENTATED AND SHOWS NO EVIDENCE OF ONGOING PSYCHOTIC SYMPTOMS. HE APPEARS TO BE INSIGHTFUL INTO HIS PREVIOUS ABNORMAL MENTAL STATE. HIS AFFECT AND SPEECH ARE APPROPRIATE.

Date Certificate Revoked: 29 / 02 / 2016

Time Certificate Revoked: 15:00 (24 hr)

Part 1 (cont) — To be completed by AMP or RMO

Patient's post-Detention Status

Discharge
- ○ a) The patient has been discharged from hospital, **OR**
- ◉ b) The patient has NOT been discharged from hospital.

Further care & treatment
- ◉ a) The patient will receive further psychiatric care and treatment, **OR**
- ○ b) The patient will NOT receive further psychiatric care and treatment

(where appropriate) further psychiatric care and treatment will be under the care of -

Full name and professional address of lead practitioner

Surname: TO BE ALLOCATED

First Name:

Address: ARRAN CMHT, 121 ORR STREET, GLASGOW

Postcode: G40 2QP

Notification by RMO / AMP

I confirm that I will give notice of this revocation and send a statement of the reasons for revocation to the following parties:

Revocation of an emergency detention certificate

the patient

the managers of the hospital the patient was detained in

Revocation of a short-term detention certificate or extension certificate

the patient

the patient's named person

any guardian of the patient (see notes)

any welfare attorney of the patient (see notes)

the patient's MHO

I confirm it is my responsibility to ensure that notice (in the form of a copy of this document) will be sent to the following parties within 7 days of the revocation:

The Mental Welfare Commission

The Mental Health Tribunal for Scotland

Signed
by the AMP or RMO completing this revocation

This form should now be given to the hospital managers

Notes

"Guardian" means a person appointed as a guardian under the Adults with Incapacity (Scotland) Act 2000 (asp 4) who has power by virtue of section 64(1)(a) or (b) of that Act in relation to the personal welfare of a person, where they have the power to consent

"Welfare attorney" means an individual authorised, by a welfare power of attorney granted under section 16 of the Adults with Incapacity (Scotland) Act 2000 (asp 4) and registered under section 19 of that Act, to act as such, where they have the power to consent

Part 2: Notification by Hospital Managers — To be completed by the Hospital Managers

To be completed for the revocation of an emergency detention certificate only

The following will be informed of the revocation of the emergency detention certificate as soon as is practicable:

- O patient's nearest relative
- O any person who resides with the patient (if not the nearest relative)
- O the patient's named person (if neither of the above)

Where no consent was given by an MHO to the granting of the emergency detention certificate, the local authority should also be notified as soon as practicable

Note: If the managers KNOW where the patient resides, the local authority notified should be that for the area in which the patient resides. If the managers DO NOT KNOW where the patient resides, the local authority notified should be that for the area in which the hospital is situated.

Local Authority notified

eg Glasgow City, City of Edinburgh, Highland, Scottish Borders, ect. The word "Council" may be omitted

Part 3: Termination of Detention — To be completed by the Hospital Managers

To be completed in ALL cases - where RMO/AMP has revoked certificate OR any other termination of detention

The emergency detention, short-term detention certificate or extension certificate ceased to authorise the detention of the patient on: / /

Where revoked by RMO / AMP this is date of revocation recorded on page 2

for the following reason:

- O Expiry of authority to detain
- O Revocation by patient's AMP or RMO
- O Revocation by the Mental Welfare Commission
- O Revocation by the Mental Health Tribunal
- O Transfer out of Scotland
- O Unauthorised absence
- O Death of patient
- O Termination for other reasons (give details below)

2

Completed by

Job Title

Signed

Date / /

A copy of this form should be sent to the Mental Welfare Commission and the Mental Health Tribunal for Scotland as soon as is practicable

NHS
Greater Glasgow and Clyde

MENTAL HEALTH SERVICES

FILE NOTE

Date: 25th February 2016

By: Dr Gillian Paterson, ST4 in Forensic Psychiatry

RE: Michael McLachlan DOB: 31/12/1962 CHI: 311 262 6230
Flat 1/1, 31 Aberfeldy Street, GLASGOW, Lanarkshire G31 3NS

I was contacted in my capacity as Psychiatrist On-call regarding Mr McLachlan. The duty Core Medical Trainee contacted me to request advice regarding his presentation at around 2:30 a.m. on 25th February 2016. I understand that Mr McLachlan had been admitted a few days previously to General Medicine in Glasgow Royal Infirmary with symptoms of confusion with no cause identified. The Core Medical Trainee advised me that at around 11:00 p.m. on 24th February 2016 Mr McLachlan had become more acutely confused and appeared to be experiencing hallucinations. She advised me that Mr McLachlan was on Quetiapine which he had been receiving throughout the admission and he had also been receiving Dihydrocodeine for opiate withdrawal symptoms. She advised me that he was an opiate user but there was no further clarification of his contact with Psychiatric Services. His I.V. access was very poor. I was asked to give advice about his presentation due to extreme agitation and lack of response to 6mg of Lorazepam and 7mg of Haloperidol which had been administered over the previous 3 to 4 hours. I was advised that at the time of the phone call Mr McLachlan was being stopped from leaving the hospital by members of hospital security and there were significant concerns about his mental state. We discussed detention under the Mental Health Act and I agreed that, given that Mr McLachlan was being prevented from leaving and had been treated for psychiatric symptoms as an emergency, an Emergency Detention Certificate was appropriate. I gave advice on how to fill this in and explained the importance of contacting Liaison Psychiatry later that morning. We also discussed the use of the Emergency Sedation protocol and I gave

advice regarding this. I advised on the maximum doses of Lorazepam and Haloperidol and also advised regarding the time frame for expected benefit from rapid tranquilisation medications. I advised that Benzodiazepines should be used in the first instance given that the patient is already on a second antipsychotic and of the importance of high dose antipsychotic monitoring in these situations.

Signed: ..... **Date:** **26 Feb 2016**

Dr Gillian Paterson
ST4 in Forensic Psychiatry

cc: Psychiatric Casenotes
General Medical Casenotes
Nurse in Charge, Ward 20A, Glasgow Royal Infirmary

The Mental Health (Care and Treatment) (Scotland) Act 2003

Emergency Detention Certificate

DET 1

Emergency detention certificate under **section 36** of the Act; and, record of matters within the emergency detention certificate made to the hospital managers under **section 37** of the Act **(Part 1)**.
Record of admission to hospital and notifications made under section 38 of the Act by the managers of the hospital **(Part 2)**.

The following form is to be used :

where it is necessary as a matter of urgency to detain the patient in hospital for the purpose of permitting a full assessment of the person's mental state; and where if the patient were not detained in hospital there would be a significant risk to either themselves or others.

There is no statutory requirement that you use this form but you are strongly recommended to do so. This form draws attention to some procedural requirements under the Mental Health (Care and Treatment) (Scotland) Act 2003. Failure to observe procedural requirements may invalidate the certificate.

If you are not completing this form electronically, please observe the following conventions, to ensure accuracy of information:

Write clearly within the boxes in BLOCK CAPITALS and in BLACK or BLUE ink

For example: 25 MARKET ST

Shade circles like this -> ●

Not like this -> ⊗ ✓

Where a text box has a reference number (eg CTO1_1) at the top right, you can extend your response on plain paper where there is insufficient space in the box. Extension sheet(s) should be clearly labelled with Patient's name and CHI number, and each extended response should be labelled with the appropriate text box reference number.

If unknown, please state unknown (CHI Number can be left blank)

CHI number: 3112626230

Surname: MCLACHLAN

First name(s): MICHAEL

Other / known as:

'Other / Known As' could include any name / alias that the patient would prefer to be known as.

Title: MR

DoB (dd / mm / yyyy): 31 / 12 / 1962

Gender: ⊗ Male ○ Female

Patient's home address

Line 1: FLAT 1-1

Line 2: 31 ABERFELDY STREET

Line 3: GLASGOW

Line 4:

Line 5:

Post code: G31 3NS

To be completed by the Medical Practitioner

Surname: CROCKETT

First name(s): HANNAH

Address Line 1: GLASGOW ROYAL INFIRMARY

Line 2: CASTLE STREET

Line 3:

Postcode:

As the medical practitioner named above, I declare that I have examined the patient. I am granting this emergency detention certificate because I believe the patient meets the following criteria for the reasons stated -

✓ I consider it is likely that the patient has a mental disorder.

Detail the reasons why you consider it is likely that the patient has a mental disorder

DET 1_1

The patient started at 11pm on 24/2/16 to hallucinate, became verbally and physically aggressive. He perceived to auditory and visual hallucinations. He expressed paranoid ideas of people wishing to harm him and sexually abuse him.

He has a previous history of acute psychosis (thought to be drug induced).

Note

As detailed in section 328 (2) of the Act, a person is not mentally disordered by reason only of any of the following: sexual orientation; sexual deviancy; transsexualism; transvestism; dependence on, or use of, alcohol or drugs; behaviour that causes, or is likely to cause, harassment, alarm or distress to any other person; acting as no prudent person would act.

✓ I consider it likely that because of this mental disorder, the patient's ability to make decisions about the provision of medical treatment for mental disorder is significantly impaired.

Detail the reasons why you believe this to be the case DET 1_2

He is disoriented, does not have capacity, and believe he has a mental disorder.

I am satisfied that it is necessary as a matter of urgency to detain the patient in hospital for the purpose of determining what medical treatment for mental disorder the patient requires.

Detail the reasons why you believe this to be the case DET 1_3

He is a danger to himself and those around him. He is threatening people and being physically aggressive toward them.

I am satisfied that if the patient were not detained in hospital there would be a significant risk -

✓ to the patient's health, safety or welfare; or

✓ to the safety of any other person.

Detail the reasons why you believe this to be the case DET 1_4

He is paranoid and delusional, and responding to hallucinations.

✓ I am satisfied that making arrangements with a view to the grant of a short-term detention certificate would involve undesirable delay.

Please give details of the efforts which were made with respect to the granting of a short-term detention certificate DET 1_5

Spoken with on call psychiatry registrar and sought advice. He is requiring emergency antipsychotics and benzodiazepines immediately.

CERTIFICATE (cont)

To be completed by the Medical Practitioner

Please give details of the alternatives which you considered to the granting of this certificate. Why is informal/voluntary care not appropriate ?

DET 1_6

He has been offered oral medication to help with his acute psychotic state and he has refused. mean.

☒ So far as I am able to ascertain, immediately before the medical examination was conducted, the patient was not detained in hospital under the authority of :

(a) an emergency detention certificate;
(b) a short-term detention certificate;
(c) an extension certificate;
(d) section 68 of the Act (extension of short-term detention pending determination of application); or
(e) a certificate granted under section 114(2) or 115(2) of the Act. (Compulsory treatment order: detention pending review or application for variation, & interim compulsory treatment order: detention pending further procedures).

Complete A or B as appropriate

A.

○ I have consulted with the MHO named below, and he / she consents to the granting of this emergency detention certificate.

Full name of MHO

Surname

First name(s)

Title

appointed to act as a MHO by:

Full name of local authority and building name, or town to address

Name

Building name / town

OR

B.

☒ It was not practicable to gain the consent of a mental health officer to the granting of this certificate.

(Explain why it was impracticable to consult a mental health officer and what efforts you made to do so)

DET 1_7

Patient had to be prevented from absconding to leave the hospital. Discussed with MHO on call David Calderwood at 0300 on 25/2/16.

RD1 CERTIFICATE (cont) — To be completed by the Medical Practitioner

Part 2 – Hospital Staff

Complete A or B as appropriate

A. ○ At the time of this certificate being granted this patient was an informal inpatient in the following hospital.

Hospital: GLASGOW ROYAL INFIRMARY

OR

B. ○ At the time of this certificate being signed this patient was not in hospital.

Please provide details, where relevant, of any transportation and accommodation arrangements which you have made with respect to transferring the patient to hospital.

DET 1_8

	dd	mm	yyyy	
Date examination concluded	24	02	2016	
Time examination concluded	23	00		time (24 hr clock)
Date certificate granted	24	02	2016	
Time certificate granted	23	00		time (24 hr clock)

Note:
The emergency detention certificate must be granted:
i) before the end of the day if the examination was concluded by 8.00 pm; or
ii) within 4 hours if the examination concluded between 8:00pm and the end of the day.

AND

The patient MUST be removed to hospital within 72 hours of the granting of this certificate

✓ I have completed the section at the end of this form relating to the patient's ethnicity.

Signature

The medical practitioner must now give this certificate to the managers of the hospital in which the patient is detained

Note:

If the patient is not in hospital immediately before the certificate is granted, the patient's detention in hospital under the authority of this certificate is only authorised if the certificate was given to the managers of the hospital before the patient was first admitted to hospital

If the patient is in hospital immediately before the certificate is granted, the medical practitioner shall as soon as practicable after granting the certificate, give the certificate to the managers of that hospital.

PART 3 NOTIFICATION BY HOSPITAL MANAGERS OF EMERGENCY DETENTION CERTIFICATE

To be completed by the Hospital Managers

Shade A or B as appropriate

A. ◉ The patient was an informal inpatient in the hospital detailed below when the certificate was granted. As a result the 72-hour period of detention began when the certificate was granted.

OR

B. ○ The patient was not in hospital immediately before the certificate was granted. As a result the 72-hour period of detention began when the patient was admitted to the hospital detailed below.

Full name of hospital

Name: GLASGOW ROYAL INFIRMARY

Ward / clinic: WARD 20

Time 72-hour detention period began: 23:00 time (24 hr clock)

Date 72-hour detention period began: dd 24 / mm 02 / yyyy 2016

Unless revoked, this authorisation to detain will expire on -

Expiry date: dd 27 / mm 02 / yyyy 2016

Expiry time: 23:00 time (24 hr clock)

2 NOTIFICATION BY HOSPITAL MANAGERS OF EMERGENCY DETENTION CERTIFICATE (cont)

To be completed by the Hospital Managers

Notification given

The following were informed that the emergency detention certificate was granted within 12 hours of the hospital managers receiving the emergency detention certificate

Shade as appropriate

◉ The Mental Welfare Commission by phone on 0131 ~~222 0111~~ 313 8777

Note:

i) It is the hospital managers' responsibility to ensure that arrangements have been made for contacting the Mental Welfare Commission out of hours.

ii) A copy of this emergency detention certificate (part 1 of this form) and the notifications to be made by the hospital managers (part 2 of this form) should be sent to the Mental Welfare Commission as soon as practicable after receiving the certificate, and no later than 7 days after receiving the certificate.

O The patient

O Patient's nearest relative

Full name and address of patient's nearest relative, as defined in section 254 of the Act

Phone number (if known)

O Any person who resides with the patient (if the patient's nearest relative does not reside with the patient)

Phone number (if known)

O Patient's named person (if known, and neither of the above)

Full name and address of the patient's named person

Phone number (if known)

PART 2 NOTIFICATION BY HOSPITAL MANAGERS OF EMERGENCY DETENTION CERTIFICATE (cont)

To be completed by the Hospital Managers

The following were notified in writing of the circumstances by the hospital managers within 7 days of receiving the emergency detention certificate as specified under section 38(3) of the Act. Those circumstances are:

- the reasons for granting the certificate;
- whether consent of a MHO was obtained to the granting of the certificate;
- if the certificate was granted without consent to its granting having been obtained from a MHO, the reasons why it was impracticable to consult the MHO;
- the alternatives to granting the certificate that were considered by the medical practitioner; and
- the reason for the medical practitioner determining that any such alternatives was/were inappropriate.

Shade as appropriate

O Patient's nearest relative

O Any person who resides with the patient

O Patient's named person (if known, and neither of the above)

Where it was not practicable to gain the consent of the mental health officer for the granting of this certificate, the following will be sent a copy of this certificate (part 1 of this form) within 7 days of receiving the certificate:

Complete A or B as appropriate

A. O the local authority for the area in which the patient resides

Full name of local authority (Note: you can exclude the word 'Council' if there is insufficient space)

Name

OR

B. O if the patient's address is not known, the local authority for the area in which the hospital is situated

Full name of local authority in which hospital is situated

Name

O The hospital managers have fulfilled their obligations under section 260 of the Act.

Your Details

First name and surname: MICHAEL DOWNELLY

Date (dd/mm/yyyy): 24/02/2016

Signature:

Job title: CLINICAL CO-ORDINATOR

Note:

A copy of this emergency detention certificate (part 1 of this form) and the notifications to be made by the hospital managers (part 2 of this form) should be sent to the Mental Welfare Commission as soon as practicable after receiving the certificate, and no later than 7 days after receiving the certificate.

ETHNICITY

The following information is requested to monitor the use of the Mental Health (Care & Treatment) (Scotland) Act 2003 across ethnic groups to ensure observance of equal opportunity requirements

Patient CHI Number 3 1 1 7 6 2 6 2 5 0

The patient describes his / her ethnic group as:

	O Information not provided	
White	Ø Scottish	
	O Other British	
	O Irish	
	O Other White (please specify)	
Mixed	O Please specify	
Asian, Asian Scottish, or Asian British	O Indian	
	O Pakistani	
	O Bangladeshi	
	O Chinese	
	O Other Asian (please specify)	
Black, Black Scottish, or Black British	O Caribbean	
	O African	
	O Other Black (please specify)	
Other ethnic background	O Please specify	

The Mental Health (Care and Treatment) (Scotland) Act 2003

Short Term Detention Certificate

DET 2

Instructions

v6.0

The following form is to be used:

Where the conditions for the granting of a short-term detention certificate are met.

There is no statutory requirement that you use this form but you are strongly recommended to do so. This form draws attention to some procedural requirements under the Mental Health (Care and Treatment) (Scotland) Act 2003. Failure to observe procedural requirements may invalidate the certificate.

If you are not completing this form electronically, please observe the following conventions, to ensure accuracy of information:

Write clearly within the boxes in BLOCK CAPITALS and in BLACK or BLUE ink

For example: 25 MARKET ST

Shade circles like this -> ● *Not like this ->* ⊗ ✓

Where a text box has a reference number to the left, you can extend your response on plain paper where there is insufficient space in the box. Extension sheet(s) should be clearly labelled with Patient's name and CHI number, and each extended response should be labelled with the appropriate text box reference number.

Patient Details

CHI Number: 3112626230

Surname: MCLACHLAN

First Name(s): MICHAEL

Other / Known as:

'Other / Known As' could include any name / alias that the patient would prefer to be known as.

Title: MR

Gender: ● Male ○ Female

DoB (dd / mm / yyyy): 31 / 12 / 1962

Patient's home address: 1/1 31 ABERFELDY ST
GLASGOW

Postcode: G31 3NS

Approved Medical Practitioner Details

Surname: OTO

First Name: MARIA

Title: DR

GMC Number: 3620012

Hospital: GLASGOW ROYAL INFIRMARY

Ward / Clinic (if appropriate): 21/20

Approved under section 22 of the Act by:

Health Board: NHS GREATER GLASGOW HCLYDE

PART 1: CERTIFICATE — To be completed by the Approved Medical Practitioner

Detention Criteria

As the AMP named on page 1, I declare that I have examined the patient. I am granting this short-term detention certificate because I believe the patient meets the criteria set out in section 44(4):

(a) I consider that it is likely, for the reasons stated below, that the patient has the following type(s) of mental disorder -

The patient has a mental illness	● Yes	○ No
The patient has a personality disorder	○ Yes	● No
The patient has a learning disability	○ Yes	● No

1 MR MCLAUGHLIN WAS ADMITTED ON THE 19TH OF FEBRUARY. WITH A HISTORY OF CONFUSION AND STRANGE BEHAVIOUR. SINCE ADMISSION HIS MENTAL STATE HAS FLUCTUATED FROM PERIODS OF LUCIDITY TO PERIODS OF CONFUSION, AGITATION AND OBVIOUSLY HALLUCINATING OVER THE LAST 24H. HIS CONDITION HAS DETERIORATED PRESENTING AS CONFUSED, AGITATED, RESPONDING TO VISUAL AND AUDITORY HALLUCINATIONS. MR MCLAUGHLIN HAS A HISTORY OF DRUGS MISSUSE. AND ~~THE FAMILY GAVE A HISTORY OF RECENT HEAD INJURIES.~~

(b) I consider that it is likely, for the reasons stated below, that because of this mental disorder, the patient's ability to make decisions about the provision of medical treatment for that mental disorder is significantly impaired.

2 MR MCLAUGHLIN IS DESORIENTATED IN TIME + PLACE. HE IS ACTIVELY HALLUCINATING. IT IS THERFORE IMPOSSIBLE TO HAVE A MEANINGFUL DISCUSSION REGARDING HIS TREATMENT. DUE TO HIS MENTAL DISORDER HE DOES NOT HAVE THE CAPACITY TO MAKE INFORMED DECISIONS REGARDING HIS CARE.

PART 1: CERTIFICATE — To be completed by the Approved Medical Practitioner

Detention Criteria (cont)

(c) I consider that it is likely, for the reasons stated below, that it is necessary to detain the patient in hospital for the purpose of:

- ● determining what medical treatment for mental disorder should be given to the patient
- ○ giving medical treatment to the patient.

3 MR MCLAUGHLIN AT PRESENT MUST REMAIN IN HOSPITAL IN ORDER TO COMPLETE INVESTIGATIONS TO DETERMIN THE CAUSE OF HIS MENTAL DISORDER. HIS MENTAL STATE IS SUCH THAT HE NEEDS THE LEVEL OF CARE THAT CAN ONLY BE GIVEN IN HOSPITAL BY EXPERT STAFF

(d) I consider that it is likely, for the reasons stated below, that if the patient were not detained in hospital there would be a significant risk-

- ● to the health, safety or welfare of the patient
- ● to the safety of any other person.

4 • MR MCLAUGHLIN IS VERY CONFUSED AND AGITATED AT PRESENT HE REQUIRES HELP WITH ALL ACTIVITIES OF DAILY LIVING, IS AT RISK OF FALLING AND IF HE WAS TO LEAVE HOSPITAL HE WOULD BE AT GREAT RISK
• MR MCLAUGHLIN HAS ALSO BEEN INTERMITTENTLY AGGRESSIVE REQUIRING RESTRAIN.

(e) I consider that it is likely, for the reasons stated below, that the granting of this short-term detention certificate is necessary e.g. explain why the patient cannot be treated on a voluntary basis.

5 MR MCLAUGHLAN WAS DETAINED ON AN EMERGENCY DETENTION LAST NIGHT. SINCE THEN HE HAS CONTINUED TO REQUIRE RESTRAIN. WHEN AGGRESSIVE OR ATTEMPTING TO LEAVE THE WARD.

PART 1 : CERTIFICATE (cont)

Consultation - MHO (to be completed by the MHO (see notes))

MHO details - Surname: VAN HORN

First Name: LORNA

Title: MS

Local Authority: GLASGOW CITY COUNCIL

eg Glasgow City, City of Edinburgh, Highland, Scottish Borders, etc. The word "council" may be omitted

I, the MHO named above, was consulted on the date opposite, and consent to the granting of this short-term detention certificate

Date: 25 / 02 / 2016

- ● 1) I interviewed the patient before consenting to the granting of this certificate.
- ● 2) I confirmed to the AMP the name and address of the patient's named person.
- ○ 3) I informed the patient of the availability of independent advocacy services and have taken appropriate steps to ensure that the patient has the opportunity of making use of these services.

Where any of the above has not been shaded, please state below the reasons why it was not practicable to carry out that action

***Note:** by completing this there is no longer a requirement to complete form DET3*

6 Mr McLachlan did not understand the mental health assessment process or information regarding his availability to independent Advocacy services, due to him presenting confused and disorientated to time and place.

MHO Signature

Signed by the MHO: L Van Horn

Date: 25 / 02 / 2016

Notes

Wherever practicable, the MHO should complete this sectionof the form. Where not practicable, the RMO should complete on behalf of the MHO, and include reasons why it was not practicable in box 6.

PART 1 : CERTIFICATE (cont) — To be completed by the Approved Medical Practitioner

Consultation - Named Person

Where known, the patient's named person is -

Surname: MCLAUGHLIN

First Name: SHETONNE

Title: MISS

Named Person's Address: 15 TORPHEN WALK
GREENFIELD

Postcode: G32 - 6QQ

Telephone: 07494790834 (07494790834)

Status of Named Person

- O Nominated by patient
- O Appointed by the Mental Health Tribunal for Scotland
- ● Default (primary carer or nearest relative)

Complete A or B as appropriate

A I consulted the named person prior to the granting of this certificate on: Date 25 / 02 / 2016

Summarise the views of the patient's named person about the proposed detention and the ways in which you have had regard to those views.

7 MR MCLAUGHLIN DAUGHTER ~~[illegible]~~ IS IN AGREEMENT WITH THE PROPOSED DETENTION

OR

B I did not consult the patient's named person prior to the granting of this certificate, as it was impracticable to do so, as detailed below. (Note: to include what efforts were made to consult the named person).

8

PART 1: CERTIFICATE (cont)

To be completed by the Approved Medical Practitioner

Transfer / admission of patient to hospital

If the patient was not already in hospital, please provide details, where relevant, of any transportation and accommodation arrangements which you have made with respect to transferring the patient to hospital.

9

CERTIFICATION

- Immediately before my examination of the patient, he / she was not detained in hospital under the authority of:

(a) a short-term detention certificate;
(b) an extension certificate;
(c) section 68 of this Act (extension of short-term detention pending determination of compulsory treatment order application); or
(d) a certificate granted under section 114(2) or 115(2) of this Act. (Compulsory treatment order: detention pending review or application for variation, & interim compulsory treatment order: detention pending further procedure).

By signing this certificate, I confirm that:

I have no conflict of interest as defined by the regulations.

I have completed the section at the end of this form relating to the patient's ethnicity.

Note: The certificate needs to be granted within three days of the completion of the medical examination

Date of examination 25 / 02 / 2016 AT 13:45 time (24 hr clock)

Date the certificate was granted 25 / 02 / 2016 AT 14:15 time (24 hr clock)

Signed by the AMP

PART 2: NOTIFICATION BY HOSPITAL MANAGERS

Admission Details

Shade as appropriate

O The patient's detention in hospital was authorised for a period of 28 days from their admission to hospital, and on the giving of the short-term detention certificate to the hospital managers;

OR

O The patient was already an inpatient when this short-term detention certificate was granted and their detention was authorised by the certificate being given to the hospital managers.

The patient was admitted to / was already a patient in:

Hospital

Ward / Clinic

The patient's 28-day detention in hospital began at the beginning of: ☐☐ / ☐☐ / ☐☐☐☐

Unless revoked or extended, this authorisation will cease at midnight at the end of the 28th day: ☐☐ / ☐☐ / ☐☐☐☐

Record of Notice Given

Notification in writing of the granting of the short-term detention certificate was given as soon as practicable after the hospital received the certificate to:

O The patient

O The patient's named person

O Any welfare guardian of the patient

Name and address - if applicable

O Any welfare attorney of the patient

Name and address - if applicable

Notification with a copy of the certificate was given within 7 days of it being granted to:

O The Mental Health Tribunal for Scotland

O The Mental Welfare Commission

Notification completed by date: ☐☐ / ☐☐ / ☐☐☐☐

Completion Details

O The hospital managers have fulfilled their obligations under section 260 of the Act.

Completed by:

Job Title

Signature

Date
dd / mm / yyyy ☐☐ / ☐☐ / ☐☐☐☐

PATIENT ETHNICITY

The following information is requested to monitor the use of the Mental Health (Care & Treatment) (Scotland) Act 2003 across ethnic groups to ensure observance of equal opportunity requirements

Patient CHI Number 3111262623O

The patient describes his / her ethnic group as:

	O Information not provided	
White	● Scottish	
	O Other British	
	O Irish	
	O Other White (please specify)	
Mixed	O Please specify	
Asian, Asian Scottish, or Asian British	O Indian	
	O Pakistani	
	O Bangladeshi	
	O Chinese	
	O Other Asian (please specify)	
Black, Black Scottish, or Black British	O Caribbean	
	O African	
	O Other Black (please specify)	
Other ethnic background	O Please specify	

20.02.16 12:38:59

ID: #STAT#160220123859

D.O.B.:
Loc: 50
Tech: RREIDHC

3112626230
MCLACHLAN
Michael M
FLAT 1-1 31/12/1962
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

Vent. Rate:	70	bpm
P Duration:	108	ms
QRS Duration:	130	ms
PR Interval:	122	ms
QT Interval:	434	ms
QTc Interval:	451	ms
QT Dispersion:	56	ms
P-R-T AXIS:	64° 85°	80°

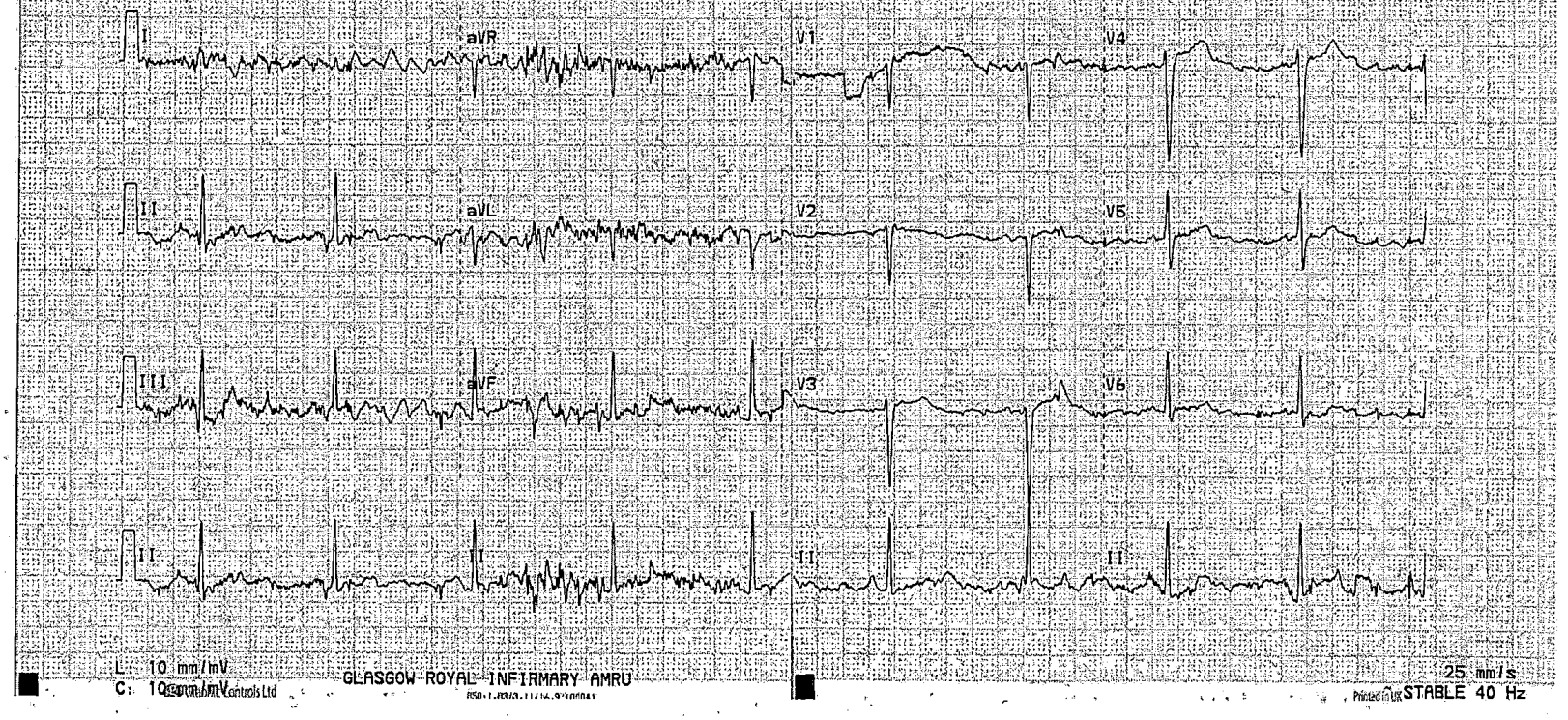
20.02.16 12:38:59

ID: #ST[redacted]160220123859

Sinus br[redacted]ardia
- aberrantly conducted supraventricular extrasystoles
- ventricular couplets
*** report made without knowing patient's sex or age ***
Possible left atrial abnormality
Conduction defect of RBBB type
Old inferior infarct
Low R(V2-V4) probably due to right ventricular hypertrophy
Lateral T wave changes are nonspecific

Abnormal ECG

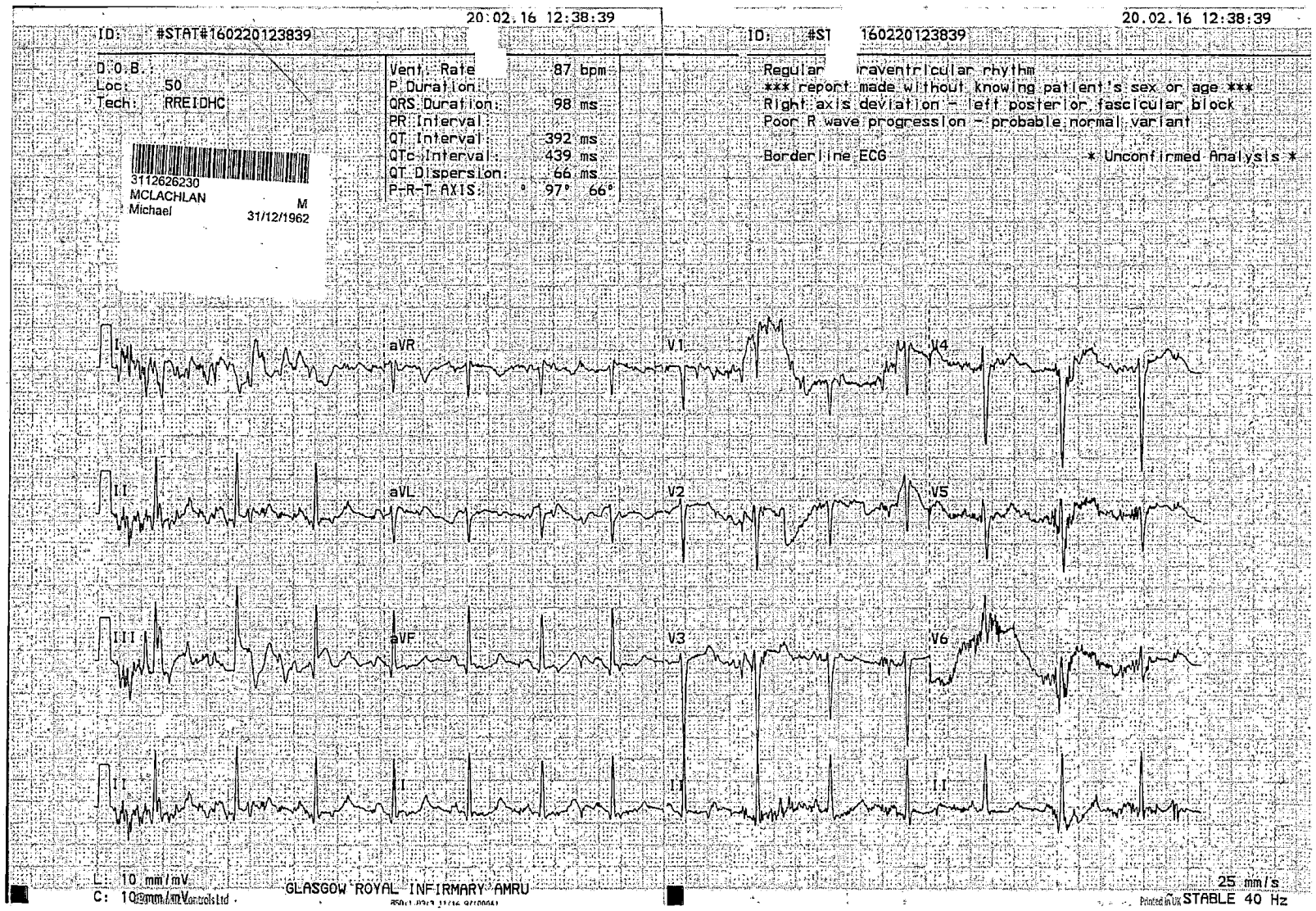
* Unconfirmed Analysis *



L: 10 mm/mV
C: 10 mm/mV

GLASGOW ROYAL INFIRMARY AMRU

25 mm/s
STABLE 40 Hz


20.02.16 12:38:39
ID: #STAT#160220123839
D.O.B.:
Loc: 50
Tech: RREIDHC
3112626230
MCLACHLAN
Michael
M
31/12/1962
Vent. Rate 87 bpm
P Duration: 98 ms
QRS Duration:
PR Interval:
QT Interval: 392 ms
QTc Interval: 439 ms
QT Dispersion: 66 ms
P-R-T AXIS: ° 97° 66°
20.02.16 12:38:39
ID: #ST 160220123839
Regular ventricular rhythm
*** report made without knowing patient's sex or age ***
Right axis deviation - left posterior fascicular block
Poor R wave progression - probable normal variant
Borderline ECG
* Unconfirmed Analysis *
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
II
I
II
L: 10 mm/mV
C: 10 mm/mV
GLASGOW ROYAL INFIRMARY AMRU
25 mm/s
STABLE 40 Hz

Acute Services Division

Hospital / Department

NHS
Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

3112626230
MCLACHLAN
Patient name: ..... Michael M
FLAT 1-1 31/12/1962
Ward: ..... 31 ABERFELDY ST
Glasgow, Lanarkshire

CHI number: ..... G31 3NS..... Unit/Hospital number .....

Contents

1. Canard Falls Risk Assessment Scoring Form
2. Falls Assessment Care Plan
3. Glossary of terms used in risk assessment

Notes: Risk assessment should be completed within 24 hours of admission to each ward.

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

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

Referral Criteria for Hospital Falls Prevention Co-ordinator

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

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

General Safety Precautions

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

Cannard Falls Risk Assessment

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

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						Date: 28/2 Ward: 31	Date: 26/2 Ward: 2021	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			?	3					
Sex	Male 1	Female 2				1	1					
Age	13-59 0	60-70 1	71-80 2	81+ 1		0	0					
Sensory deficit	Sight* 2	Hearing* 1	Balance* (2)	None 0		0	2					
Medication type **	Drugs for mental illness (1)	Blood pressure / water tablets 1	Sleeping tablets (1)	None of these 0		1	2					
Medical history	Diabetes 1	Confusion (1)	Fits 1	Incontinent 1	Inability to cooperate* (1)	1	2					
Mobility	Fully mobile (1)	Uses aids 2	Restricted* 3	Bed / chair-bound/ wheel-chair 1		1	1					
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady (3)		1	3					
				TOTAL SCORE		5	14					
				ACTION(S) TAKEN Enter action code(s) from Care Plan below		1	See beta					
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: 20/2 Ward: S1	Date: 26/2 Ward: 2012	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.							
		MM	✓					

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 Oxycontin.

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.

552 6189

* Please Fax Social work dept * OK 24/1/16

GREATER GLASGOW JOINT PLANNING AGREEMENT
GLASGOW CITY COUNCIL SOCIAL WORK REFERRAL FORM

Name: Michael McLachlan
Address: Flat 1-1
31 Abercrombie St
Postcode: G31 3NB
Telephone No:
Date of Birth: 31.12.63
Ethnic Origin:
Religion:
Marital Status:

Hospital: GRI
Hospital Unit No.: 311262230
Ward: 20
Consultant: Dr Wilson
G.P. Name: Dr Walker
G.P. Address: Shettleston H/C

Next of Kin Name: Chevonne McLachlan
Next of Kin Address: 07494790834

SPECIALITY:
(ACUTE)/CONTINUING CARE *(Delete)*
NATIONAL INSURANCE NO:
REFERRER: ~~NURSE~~/CLINICIAN/PHYSIOTHERAPIST/OCCUPATIONAL THERAPIST/OTHER
HAS PATIENT BEEN ADVISED OF REFERRAL? (YES) NO
IF NOT, WHY NOT?

DATE OF ADMISSION: 20/12/2016
PLANNED DATE OF DISCHARGE:
OR WHEN WILL PATIENT BE READY FOR DISCHARGE: Medically fit

REASON FOR REFERRAL

1. GENERAL ADVICE AND INFORMATION	
2. HOME CARE ASSESSMENT	
3. COMMUNITY CARE ASSESSMENT	
4. M.H.O. SERVICES	
5. BENEFITS ENQUIRY	
6. OTHERS—PLEASE SPECIFY	✓

ASSESSMENTS/REPORTS REQUESTED

	Date Requested
1. OCCUPATIONAL THERAPY REPORT	
2. PHYSIOTHERAPY REPORT	
3. GERIATRICIAN	
4. PSYCHO-GERIATRIC REPORT	
5. OTHER	psych

DOES PATIENT REQUIRE SERVICE PRIOR TO DISCHARGE? (YES)/NO please contact daughter
DOES PATIENT ALREADY RECEIVE HOME CARE SERVICE? YES/NO
DOES PATIENT ALREADY HAVE A SOCIAL WORKER? YES/NO

IF YES, NAME OF SOCIAL WORKER
AREA TEAM

MEDICAL HISTORY
DIAGNOSIS/PROGNOSIS:
LEVEL OF FUNCTIONING—*IF YES PLEASE SPECIFY*

COGNITIVE DEFICITS YES/(NO)
MENTAL HEALTH ISSUES YES/NO please contact
SENSORY IMPAIRMENT YES/(NO) nursing staff

MOBILITY—*PLEASE SPECIFY*

WALKS UNAIDED	YES/NO
WALKS WITH SUPPORT—1 OR 2	YES/NO
WHEELCHAIR USER	YES/NO
REQUIRES ASSISTANCE TO TRANSFER—1 OR 2	YES/NO
ARTIFICIAL LIMB	YES/NO
OTHER—PLEASE SPECIFY	YES/NO

SOCIAL CIRCUMSTANCES

LIVES ALONE	✓
LIVES WITH FAMILY	
INFIRM ELDERLY PARTNER	
HOMELESS	
OTHER	

ADDITIONAL INFORMATION
Daughter concerned re patient's Cher dad) safety at home ; Apparent break ins x2. Front door ~~has~~ apparently has scarce

REFERRED BY: Nurses
NAME: Montero
PROFESSION: S/N
SIGNATURE: Nurses
DATE: 23/12/16

ACKNOWLEDGED BY:
ACTIONED BY:
NAME:
PROFESSION:
SIGNATURE:
DATE:

W5128/0698

Record of Communication with Relatives / Carers

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

NHS Greater Glasgow and Clyde

3112626230
Name MCLACHLAN M
Addre: Michael 31/12/1962
FLAT 1-1
31 ABERFELDY ST
DoB: Glasgow, Lanarkshire
G31 3NS
Chi nu
Affix patient data label

Hospital: GRI Ward: 27

Please enter date of communication and topic (all entries must be signed and dated)

Date & Time	Full record of source; Topic of discussion; Name of relative/carer	Signed	Staff Code
23/2/16 16:30	Parents daughter has concerns re her father's safety in present home: there has been 2 attempted break-ins: front door not secure: she is asking about social work input: social worker aware		

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

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: _____

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (Please circle): 1hr 2hr 3hr (4hr) 6hr

1. Signed Name Designation S/N
2. Signed Name Designation S/N
3. Signed Name Designation S/N

Attach Addressograph label

MICHAEL MCLACHLAN

Ward: 28/2/16

NHS Greater Glasgow and Clyde

Individual patient needs: Red mat required: Y (N) Bed rails: Y (N)
'Must do's' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODE:
O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

28/2/16.

		Times	0030	0430	0810	0850	1250	1630	0100	0900	1300	1700	2200							
	1.	Pain: assess and address If in pain inform registered nurse Y / N or N/A	S	S	N	S	Y	N	N	N	N	N	Y							
S	2.	SKIN INSPECTION Pressure areas checked: Y / N / I (Independent)	I	I	I	I	I	T	1	1	1	1	1							
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)	/	/	/	/	/	/	/	/	1	1	INT							
K	3.	KEEP MOVING: Have you moved or walked Y / N / I (independent)	I	I	I	I	I	1	Y	Y	Y	Y	I							
		Bed Right side (30° tilt) – R Left Side (30° tilt) – L Back– B	B	R	B	R	B	B	L	L	X	B	R							
		Chair Assist to walk, stand or tilt (W /ST/ T)	I	I	I	I	I	/	—	•	/	/	—							
I	4.	ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces	S	S	I	S	I	1	1	1	1	1	1							
N	5.	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)	S	S	N	N	N	N	N	N	N	N	N							
		Encourage the patient to drink? Y / N / N/A	S	S	Y	NT	Y	Y	S	Y	Y	Y	Y							
		Food, snack or supplement taken? Y / N / N/A	S	S	Y	NT	Y	Y	S	Y	M	Y	Y							
	6.	ENVIRONMENT: Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S	Y	Y	Y	Y	Y	/	Y	Y	Y	Y	Y							
	7.	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return. Y/N/O/S	S	S	N	NT	NT	/	NT	NT	N	N	NT							
	8.	ESCALATION: Escalate any issues to the Registered Nurse Y / N/A	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA							
		Nurse Initials	DW	DW	DW	[illegible]	[illegible]	JC	[illegible]	[illegible]	BT	BT	[illegible]							

Attach Addressograph label

Ward:

NHS Greater Glasgow and Clyde

Specialist Pressure Redistributing equipment ordered and in place:

Dynamic Mattress:	
Cushion:	
Orthotic footwear:	
Moving & handling aids:	
Other:	

Active Care variant sheet - Care Number

1. Pain
2. A / B Skin-Inspection
3. A/B/C Keep Moving
4. Elimination
5. Food, Fluid, Nutrition
6. Environment
7. Information
8. Escalation

Date	Time	Number	Variation	Signed

CEDAR CODE 102083

MIS 258902

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 20/2/16 / 21/2/16

Attach Addressograph label

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

Ward: 20/21

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (Please circle): 1hr 2hr 3hr 4hr 6r

1. Signed [signature] Name C Hutchison Designation SN
2. Signed [signature] Name [illegible] Designation [illegible]
3. Signed ..... Name ..... Designation .....

Individual patient needs: Red mat required: Y / N Bed rails: Y / N
'Must do's' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODE:
O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

		Times	21[illegible]		22	00	02	04	06	08	10	12	15	17	20	00	02	04	06	08	12 pm	16 pm	22				
	1.	Pain: assess and address If in pain inform registered nurse Y / N or N/A	N		N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N				
S	2.	SKIN INSPECTION Pressure areas checked: Y / N / I (Independent)	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y				
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)	INT		INT	INT	INT	INT	INT	INT	INT	INT	INT	INT	INT	INT	INT	INT	INT	INT	INT	INT	INT				
K	3.	KEEP MOVING: Have you moved or walked Y / N / I (independent)	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y				
		Bed Right side (30° tilt) – R Left-Side (30° tilt) – L Back– B	B		L	B	R	B	B	B		B	B	/	/	B											
		Chair Assist to walk, stand or tilt (W /ST/ T)	T		T	T	T	T	T	T	ST		/	ST		/											
I	4.	ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces	A		A	A	A	A	A	A	A	A	A	/	1	1											
N	5.	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)	N		N	N	N	N	N	N	N	N	N	N	N	N											
		Encourage the patient to drink? Y / N / N/A	Y		S	S	S	Y	Y	Y	Y	Y	Y	Y	Y	Y											
		Food, snack or supplement taken? Y / N / N/A	Y		S	S	S	Y	Y	Y	N	Y	Y	Y	N	N											
	6.	ENVIRONMENT: Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y											
	7.	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return. Y/N/O/S	N		N	N	N	N	N	N	N	N	N	N	N	N											
	8.	ESCALATION: Escalate any issues to the Registered Nurse Y / N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A											
		Nurse Initials	T.K		TK	TK	TK	Kaw	Kaw	Kaw	JH	JH	BST	BST	BST	BST											

Attach Addressograph label Ward:

NHS Greater Glasgow and Clyde

Specialist Pressure Redistributing equipment ordered and in place:

Dynamic Mattress:	
Cushion:	
Orthotic footwear:	
Moving & handling aids:	
Other:	

Active Care variant sheet - Care Number

1. Pain
2. A / B Skin Inspection
3. A/B/C Keep Moving
4. Elimination
5. Food, Fluid, Nutrition
6. Environment
7. Information
8. Escalation

Date	Time	Number	Variation	Signed

CEDAR CODE 102083

MIS 258902

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 23/2/16

Attach Addressograph label

MCLACHLAN
Michael

Ward: 20/21

NHS Greater Glasgow and Clyde

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (Please circle): 1hr 2hr 3hr 4hr 6r

1. Signed Agnes Grant Name A. Grant Designation AHP / RN
2. Signed ..... Name ..... Designation .....
3. Signed ..... Name ..... Designation .....

Individual patient needs: Red mat required: Y / N Bed rails: Y / N
'Must do's' for me. Ask the patient if there is anything they want specifically done today:
.....

USE FOLLOWING CODE:
O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

		Times	2 BM	6 AM	10 00	12 20	15 45	17 40	22 40
	1.	Pain: assess and address If in pain inform registered nurse Y / N or N/A	N	N	N	N	N	N	N
S	2.	SKIN INSPECTION Pressure areas checked: Y / N / I (Independent)	Y	N	Y	Y	Y	I	I
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)	INT	INT	INT	INT	INT	INT	INT
K	3.	KEEP MOVING: Have you moved or walked Y / N / I (independent)	Y	Y	Y	Y	Y	Y	Y
		Bed Right side (30° tilt) – R Left Side (30° tilt) – L Back– B	B	B	CH	/	B	CH	B
		Chair Assist to walk, stand or tilt (W /ST/ T)	/	/	I	/	/	I	I
I	4.	ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces	I	I	I	I	I	I	I
N	5.	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)	N	N	N	N	N	N	N
		Encourage the patient to drink? Y / N / N/A	Y	Y	Y	Y	Y	Y	Y
		Food, snack or supplement taken? Y / N / N/A	N	N	Y	Y	Y	Y	N
	6.	ENVIRONMENT: Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S	Y	Y	Y	Y	Y	Y	Y
	7.	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return. Y/N/O/S	NT	NT	Y	NT	Y	Y	NT
	8.	ESCALATION: Escalate any issues to the Registered Nurse Y / N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		Nurse Initials	N	[illegible]	[illegible]	EH	AS	[illegible]	[illegible]

Attach Addressograph label

Ward:

NHS Greater Glasgow and Clyde

Specialist Pressure Redistributing equipment ordered and in place:

Dynamic Mattress:	
Cushion:	
Orthotic footwear:	
Moving & handling aids:	
Other:	

Active Care variant sheet - Care Number

1. Pain
2. A / B Skin Inspection
3. A/B/C Keep Moving
4. Elimination
5. Food, Fluid, Nutrition
6. Environment
7. Information
8. Escalation

Date	Time	Number	Variation	Signed.

CEDAR CODE 102083

MIS 258902

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 24/2/16

Attach Addressograph label

MICHAEL MCLACHLAN

Ward: 20/21

I have evaluated and deemed that the frequency of care delivery over the next work shift based on the patient's most critical need should be every (Please circle): 1hr 2hr 3hr 4hr 6r

1. Signed ..... Name A Greene Designation AHP/N
2. Signed ..... Name H. Macphers Designation S/N
3. Signed ..... Name ..... Designation .....

Individual patient needs: Red mat required: Y / N Bed rails: Y / N
'Must do's' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODE:
O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

		Times	06 00	06 30	10 00	14 30	19 05	22 00	02 00	06 00	12 00	18 00	23 00	04 00	06 00	10 15	13 00	17 00
	1.	Pain: assess and address If in pain inform registered nurse Y / N or N/A	N	N	N	N	N	N			N	N	N	N	N	N	N	N
S	2.	SKIN INSPECTION Pressure areas checked: Y / N / I (Independent)	I	I	I	I	I	I			N	N	I	I	I	I	I	I
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)	INT	INT	INT	INT	INT	INT			I	I			INT	INT	INT	INT
K	3.	KEEP MOVING: Have you moved or walked Y / N / I (independent)	Y	Y	Y	Y	Y	Y			Y	Y	I	I	I	I	I	I
		Bed Right side (30° tilt) – R Left Side (30° tilt) – L Back– B	B	B	B	R	B	B			B	L				–	B	B
		Chair Assist to walk, stand or tilt (W /ST/ T)	–	–	–	–	–	–			–	–			I	–	–	–
I	4.	ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces	I	I	I	I	I	I			I	I	I	I	I	I	I	I
N	5.	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)	N	N	N	N	N	N			N	N	N	N	N	N	N	N
		Encourage the patient to drink? Y / N / N/A	Y	Y	Y	Y	Y	Y			N	N	Y	S	Y	Y	Y	Y
		Food, snack or supplement taken? Y / N / N/A	N	N	Y	Y	Y	Y			N	Y	Y	S	N	N	Y	Y
	6.	ENVIRONMENT: Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S	Y	Y	Y	Y	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y
	7.	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return. Y/N/O/S	NT	NT	NT	NT	NT	NT			NT	NT	NT	S	NT	NT	N	N
	8.	ESCALATION: Escalate any issues to the Registered Nurse Y / N/A	NA	NA	NA	NA	NA	NA			NA	NA	NA	S	NA	NA	NA	NA
		Nurse Initials																

Attach Addressograph label

Ward:

NHS Greater Glasgow and Clyde

Specialist Pressure Redistributing equipment ordered and in place:

Dynamic Mattress:	
Cushion:	
Orthotic footwear:	
Moving & handling aids:	
Other:	

Active Care variant sheet - Care Number

1. Pain
2. A / B Skin Inspection
3. A/B/C Keep Moving
4. Elimination
5. Food, Fluid, Nutrition
6. Environment
7. Information
8. Escalation

Date	Time	Number	Variation	Signed

MIS 258902

CEDAR CODE 102083

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 26/2/16.

Attach Addressograph label

MICHAEL MCLACHLAN

Ward: 20/21

NHS Greater Glasgow and Clyde

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (Please circle): 1hr 2hr 3hr 4hr 6hr

1. Signed ..... Name H. Mackerson Designation SIN
2. Signed ..... Name ..... Designation .....
3. Signed ..... Name ..... Designation .....

Individual patient needs: Red mat required: Y / N Bed rails: Y / N
'Must do's' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODE:
O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

26/2/16. 27/2/16.

		Times	18 00	22	06 00	12 pm	16 pm	20 00	24
	1.	Pain: assess and address If in pain inform registered nurse Y / N or N/A	N	N	N	N	N	N	N
S	2.	SKIN INSPECTION Pressure areas checked: Y / N / I (Independent)	I	I	I	I	I	I	I
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)	—	—	—	—	—	—	—
K	3.	KEEP MOVING: Have you moved or walked Y / N / I (independent)	Y	Y	Y	Y	Y	Y	Y
		Bed Right side (30° tilt) – R Left Side (30° tilt) – L Back– B	—	—	BACK	—	—	—	B
		Chair Assist to walk, stand or tilt (W /ST/ T)	WT	—	—	—	—	—	—
I	4.	ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces	I	I	I	I	I	I	I
N	5.	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)	N	N	Y	N	N	N	N
		Encourage the patient to drink? Y / N / N/A	Y	Y	Y	Y	Y	Y	Y
		Food, snack or supplement taken? Y / N / N/A	Y		Y	Y	Y	Y	Y
	6.	ENVIRONMENT: Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S	Y	Y	Y	Y	Y	Y	Y
	7.	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return. Y/N/O/S	N	NT	NT	N	N	N	N
	8.	ESCALATION: Escalate any issues to the Registered Nurse Y / N/A	NA	NA	NA	NA	NA	NA	NA
		Nurse Initials	GM	SS	JC	BT	BT	DW	DW

Attach Addressograph label

Ward:

NHS Greater Glasgow and Clyde

Specialist Pressure Redistributing equipment ordered and in place:

Dynamic Mattress:	
Cushion:	
Orthotic footwear:	
Moving & handling aids:	
Other:	

Active Care variant sheet - Care Number

1. Pain
2. A / B Skin Inspection
3. A/B/C Keep Moving
4. Elimination
5. Food, Fluid, Nutrition
6. Environment
7. Information
8. Escalation

Date	Time	Number	Variation	Signed

CEDAR CODE 102083

MIS 258902

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 1/3/16

Attach Addressograph label

Michael McLachlan

Ward: 20-21 GRI

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (Please circle): 1hr 2hr 3hr 4hr (6r)

1. Signed ..... Name DRAPER Designation SN
2. Signed ..... Name ..... Designation ..... SN
3. Signed ..... Name mpaddon Designation SN

Individual patient needs: Red mat required: Y (N) Bed rails: Y (N)
'Must do's' for me. Ask the patient if there is anything they want specifically done today:

3/3/16

USE FOLLOWING CODE:
O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

			Times	06 00	30 06	14 30	20 30	23 30	10 00	16 00	20 00	1 30	6 am
	1.	Pain: assess and address If in pain inform registered nurse Y / N or N/A		N	N	N	N	N	N	N	N	N	N
S	2.	SKIN INSPECTION Pressure areas checked: Y / N / I (Independent)		I	I	I	I	I	I	I	I	I	I
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)		INT	I	INT	INT	-	I	I	INT	INT	INT
K	3.	KEEP MOVING: Have you moved or walked Y / N / I (independent)		I	I	I	I	I	I	I	I	I	I
		Bed Right side (30° tilt) – R Left Side (30° tilt) – L Back– B		B	B	B	B	-	I	I			
		Chair Assist to walk, stand or tilt (W /ST/ T)		I	I	I	I	-	I	I			
I	4.	ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces		I	I	I	I	I	I	I	I	I	I
N	5.	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)		N	N	N	N	N	N	N	N	N	N
		Encourage the patient to drink? Y / N / N/A		Y	Y	Y	X	Y	Y	Y	Y	S	/
		Food, snack or supplement taken? Y / N / N/A		S	Y	Y	X	Y	Y	Y	Y	S	/
	6.	ENVIRONMENT: Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S		S	Y	Y	Y	Y	Y	Y	S	S	S
	7.	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return. Y/N/O/S		S	N	NT	Y	N	Y	Y	N	N	N
	8.	ESCALATION: Escalate any issues to the Registered Nurse Y / N/A		NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
		Nurse Initials		RM	CL	LZ	RM	SS	PC	PC	PC	RC	RC

Attach Addressograph label Ward:

NHS
Greater Glasgow and Clyde

Specialist Pressure Redistributing equipment ordered and in place:

Dynamic Mattress:	
Cushion:	
Orthotic footwear:	
Moving & handling aids:	
Other:	

Active Care variant sheet - Care Number

1. Pain
2. A / B Skin Inspection
3. A/B/C Keep Moving
4. Elimination
5. Food, Fluid, Nutrition
6. Environment
7. Information
8. Escalation

Date	Time	Number	Variation	Signed

MIS 258902

CEDAR CODE 102083

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 2/3/16

Attach Addressograph label

3112626230
MCLACHLAN
Michael
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
M
31/12/1962
G31 3NS

Ward: 20/21

NHS Greater Glasgow and Clyde

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (Please circle): 1hr 2hr 3hr 4hr (6r)

1. Signed SSmith Name SSMITH Designation SN
2. Signed ..... Name ..... Designation .....
3. Signed ..... Name ..... Designation .....

Individual patient needs: Red mat required: Y / (N) Bed rails: Y / (N)
'Must do's' for me. Ask the patient if there is anything they want specifically done today:
.....

USE FOLLOWING CODE:
O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

			Times	07	09																
	1.	Pain: assess and address If in pain inform registered nurse Y / N or N/A		N																	
S	2.	SKIN INSPECTION Pressure areas checked: Y / N / I (Independent)		I																	
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)		INT																	
K	3.	KEEP MOVING: Have you moved or walked Y / N / I (independent)		I																	
		Bed Right side (30° tilt) – R Left Side (30° tilt) – L Back– B		L																	
		Chair Assist to walk, stand or tilt (W /ST/ T)		I																	
I	4.	ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces		I																	
N	5.	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)		N																	
		Encourage the patient to drink? Y / N / N/A		Y																	
		Food, snack or supplement taken? Y / N / N/A		S																	
	6.	ENVIRONMENT: Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S		S																	
	7.	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return. Y/N/O/S		S																	
	8.	ESCALATION: Escalate any issues to the Registered Nurse Y / N/A		NA																	
			Nurse Initials	RM																	

Attach Addressograph label Ward:

NHS
Greater Glasgow and Clyde

Specialist Pressure Redistributing equipment ordered and in place:

Dynamic Mattress:	
Cushion:	
Orthotic footwear:	
Moving & handling aids:	
Other:	

Active Care variant sheet - Care Number

1. Pain
2. A / B Skin Inspection
3. A/B/C Keep Moving
4. Elimination
5. Food, Fluid, Nutrition
6. Environment
7. Information
8. Escalation

Date	Time	Number	Variation	Signed

CEDAR CODE 102083

MIS 258902

3112626230
MCLACHLAN
Michael
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

M 31/12/1962

Care Plan

NHS Greater Glasgow and Clyde

Commenced and Signature	1. Breathing and circulation	Date Discontinued and Signature
25/2 Hyl	Smoker	
27/2 K/1	OOS BD	
WM	2, 3. Communication and senses	
	4. Cognitive status	
WM	Confused	
	Getting to Know Me / What matters to me	
	5. Hydration and Nutrition	
25/2 Hyl	Independant	
28/2/16.	~~Independant~~ Eating & drinking well	Salwanda
	6. Elimination	
WM	To be assessed	
27/2/16	Bowels active. Voiding urine freely.	Discontinued

Commenced and Signature	7. Personal Hygiene, oral care and skin care	Date Discontinued and Signature
WM 28/2/16	Independant with shower & soap	Discontinued
	care	
WM	8. Mobility	
	Independant	
28/2/16	mobilising Independently	Discontinued
	9. Maintaining a safe environment	
25/2 Hyl	Needs clo due to agitation	
	& confusion & risk of	
	injury.	
	10. Sleep and Rest	
25/2 Hyl	Poor sleep in general	
28/2/16	slept well.	Discontinued
	12. Privacy, dignity and sexuality	
	Negotiated care -	
	Care discussed with patient / family Yes / No	
	Patient able to participate Yes / No	

223591

Care Plan Guidance

Below are some prompt questions to help you record the individualised care that your patient requires during their inpatient stay. You should record the care that the nurse / nursing staff require to provide. The 'Negotiated Care' component provides opportunity to record any care that the patients family or carers are participating in and care that patients are being taught to support changing self care. If the patient is independent in any of the activities of living and requires no nursing intervention then you should record this in the relevant section.

When care changes a note should be made in the nursing clinical notes / progress notes to confirm why this is required.

1. Breathing and circulation	7. Personal Hygiene, oral care and skin care
Record frequency of observations, TPR BP and SAO2. Record any other care that the patient requires for their breathing or their circulation e.g. seating position, apex beat with radial pulse, pedal pulse measurement, lying and standing Blood Pressure measurement etc.	Does the patient need assistance with personal hygiene? If so what needs to be done. Do they require assistance with oral care? If so what is this. Does the patient require any specifc pressure area care outwith the Active Care documentation. If totally independent record 'self caring'.
2, 3. Communication and senses	**8. Mobility**
What assistance does the patient need with communication? If they use spectacles or a hearing aid what assistance do they needs with these? Does the patient require an interpreter?	Does the patient require assistance when mobilising? Does the patient use mobility aids? Is the patient at risk of falling? Record key information from falls risk assessment, e.g. Cannard tool, to prevent falls
4. Cognitive status	**9. Maintaining a safe environment**
What care is required to minimise risk of harm due to behavioural disturbance? Think about capacity and adults with incapacity and what you need to do with the patient to alleviate distress.	How is the patients pain being assessed? Is a specific pain assessment tool used? What does the patient require to maintain their safety?
Getting to Know Me / What matters to me	**10. Sleep and Rest**
The 'Getting to know me' Document should be used for all patients with cognitive impairment. Once completed by the patients relatives / carer record the key information to plan care in the care plan. Ask the patent what matters to them during their hospital stay and record in this area.	What would help the patient achieve a good nights rest? Does the patients sleep pattern need to be monitored? if yes record what needs to be done.
5. Hydration and Nutrition	**12. Privacy, dignity and sexuality**
Does the patient require any assistance with eating and / or drinking? Does the patient require a special diet? Do they require fluid balance monitoring?	What do you need to do to maintain the patients modesty and dignity?
6. Elimination	**Negotiated care -** Care discussed with patient / family Yes / No Patient able to participate Yes / No
Does the patient require assistance to go to the toilet? Do they use continence aids? Does their urinary output require to be monitored? Are the patients stools / bowel activity being monitored?	Discuss patient care needs with them. If the patient is learning a new self care procedure record their process and progress of learning. If the patient has a learning disability or dementia use the information obtained in the Getting to Know Me document to identify the care that the family / carer could participate in.

3112626230
MCLACHLAN
Michael
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

M
31/12/1962

NHS
Greater Glasgow and Clyde

AMU

Daily Summary of Fluid Balance

Date	Oral	I.V.	Other	Total	Urine	Gastric	Other	Total
20/2/16	800					150		

Routine Urine Chart

Date								
Protein								
24hr Volume								
Colour								
S.G.								
Reaction								
Sugar								
Ketones								
Bilirubin								
Urobilinogen								
Blood								
Nitrite								
Leucocyte								
Sample Sent								

Stool Chart

Date	Time	Colour	Consistency	Abnormalties	F.O.B.	
					- ve	+ ve

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patient's name: Micheal McLachlan	Ward: 20/21
Unit number:	Discharge destination: (1)
CHI number:	Estimated Discharge Date (1) / /
	Estimated Discharge Date (2) / /
Apply addressograph label	Final date of discharge : 3 / 3 / 16

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓		AD	
Relative/carer informed	✓		AD	
Others informed: Care Home				
Transport arranged				
Own transport (preferred option)	✓		AD	
Ambulance-1 man/ 2 man am/pm				
Other: Flight, Air ambulance etc.				
Discharge medication				
Discharge prescription completed	✓		AD	
Compliance aids e.g. Dossette Box (involve pharmacist)				
Medication received	✓		AD	
Medication explained to patient and/or relative/carer	✓		AD	
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	Liaison - w/ by medics Patient will contact CAT himself			
Other discharge items				
Access arrangements (e.g. keys, door entry)	✓		AD	
Patients clothing available for day of discharge	✓		AD	
Valuables e.g. cashier				
Intravenous cannula removed		✓	AD	
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: 1159	
Nurse's signature:	Designation: RN Date: 3/3/16

FORM NUMBER 0005752

VI MEDICAL ILLUSTRATION • DISCHARGE • 12410/14.01.08

FOOD RECORD CHART

Department of Nutrition & Dietetics

3112626230
MCLACHLAN
Michael
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

Name: _____ M 31/12/1962

Ward: _____

Date commenced: _____

- Please record ALL food and drinks taken.
- Use handy measures such as 1 cup, ½ bowl etc.
- State if patient has refused food or drinks.
- If intake is ½ or less than ½ of normal hospital meals after 3 days, consider referral to the Dietitian for further assessment.

DAY	BREAKFAST	MID-MORNING	LUNCH	MID-AFTERNOON	EVENING MEAL	SUPPER	NURSING OR DIETETIC COMMENTS
22/2/16		Commenced →	¾ chopped pork in Roll ~~spiced~~ oasis (fruit)	Water	mince pie 1 potato Bournville bar	1 CUP Tea.	
23/2/16	½ Roll & Jam Porridge ¾. Tea (100mls).	Tea (150mls)	Sausage roll.	Bottle of Oasis fruit juice. Roll & chopped pork.	Pie, Beans and mash. Rice Pudding	½ Steak pie. Juice.	
24/2/16	½ roll and Butter. Bowl of porridge, Tea.	SCOTCH pie (ALL) 30ml Oasis Juice	Gamon steak + Mash.	~~Packet~~ packet of crisps.	Sausages + gravy Custard Bar of chocolate	TEA Biscuits	OVER

Form No. 9519612

VIC759

25/02/16

DAY	BREAKFAST	MID-MORNING	LUNCH	MID-AFTERNOON	EVENING MEAL	SUPPER	NURSING OR DIETETIC COMMENTS
	—	—	Roast Parsnip 3 Spoons of mac cheese Cup of Juice	½ Bread + Ham Approx 100ml Milk 120ml Lucozade 1 Square Bar Chocolate	Packet of Crisps 3 Biscuits 2 Sips of Water	3 Forks of Mince Parsnip, Cabbage. Cup of orange Juice	
26/2/16	—	—	Soup fish chips Milk.	2 cups homemade soup. Scott Pie.	Lasange baby new potatos Apple Sponge-Custard 4 bits toblerone		
27/2/16	Rice Krispies Tea Roll + Butter	Tea	Juice 2 Corned Beef Sandwich	Juice Packet of Crisps 2 Large cups of Soup	Sausage Roll + potatoes Crumble + Custard 1 Pint Milk	Cup of Tea x2 Fish Sandwich cheese and ½ piece Grapes	
28/2/16	Crisps x1 pack	Tea Cream egg	Omlette carrots potatoe croquettes Juice	Chicken Pie + pot			

Fluid Balance Chart

N 3112626230
D MCLACHLAN M
Michael 31/12/1962
C FLAT 1-1
31 ABERFELDY ST
Al Glasgow, Lanarkshire
G31 3NS

Hospital: _____
Ward: _____
Date: 20/2/16

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs
+/- _____

Does patient require thickened fluids?
Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume	INPUT							OUTPUT	
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
08:00	[illegible]	300							300								
09:00																	
10:00																	
11:00																	
12:00	cereal	200							500								
13:00																	
14:00	Water	100							600	UTT							
15:00																	
16:00																	
17:00	Dinner	150							750								
18:00																	
19:00																	
20:00																	
21:00	Water	50							800		150						
22:00																	
23:00																	
		800							*Total Intake [redacted]							*Total Output [redacted]	

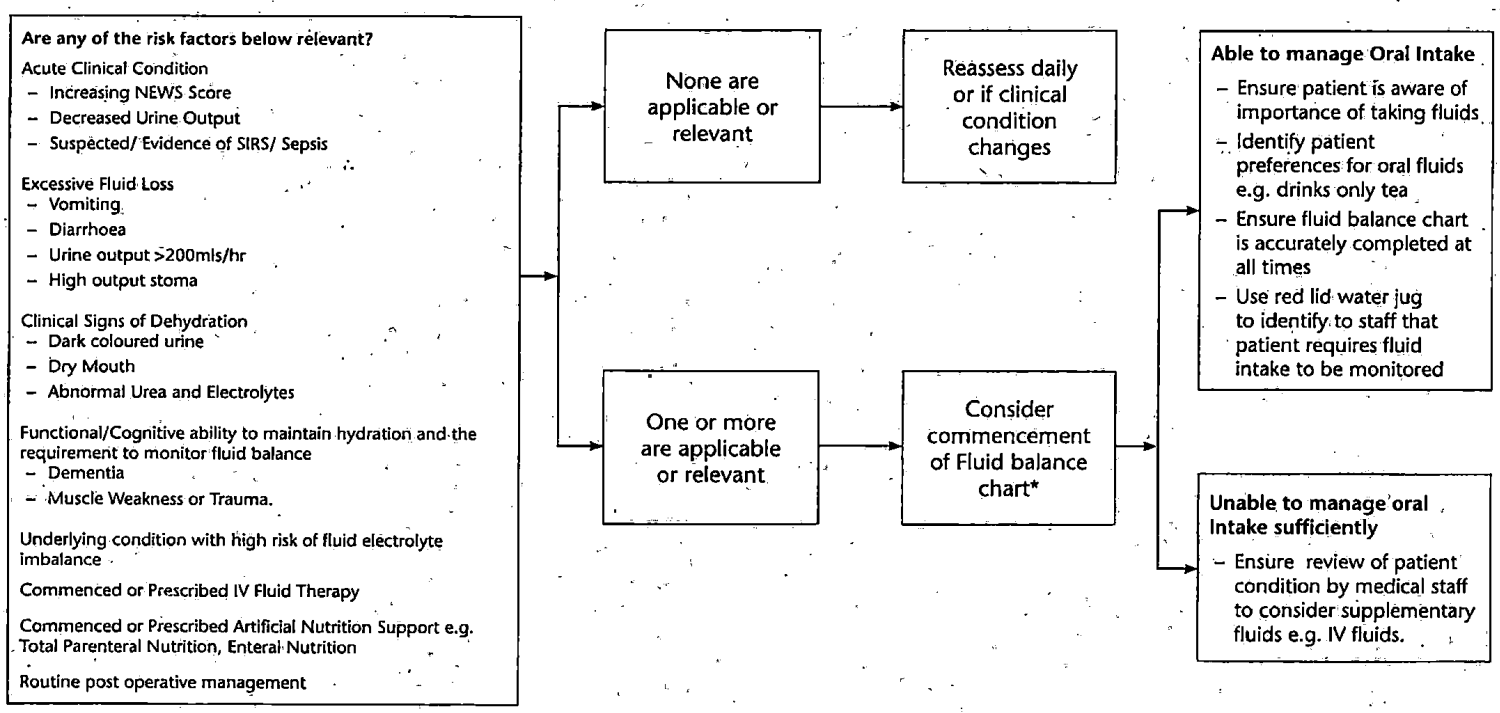
*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name	3112626230 MCLACHLAN Michael M 31/12/1962
Address	FLAT 1-1 31 ABERFELDY ST Glasgow, Lanarkshire G31 3NS
CHI No.	
DoB	

SHEET (2)

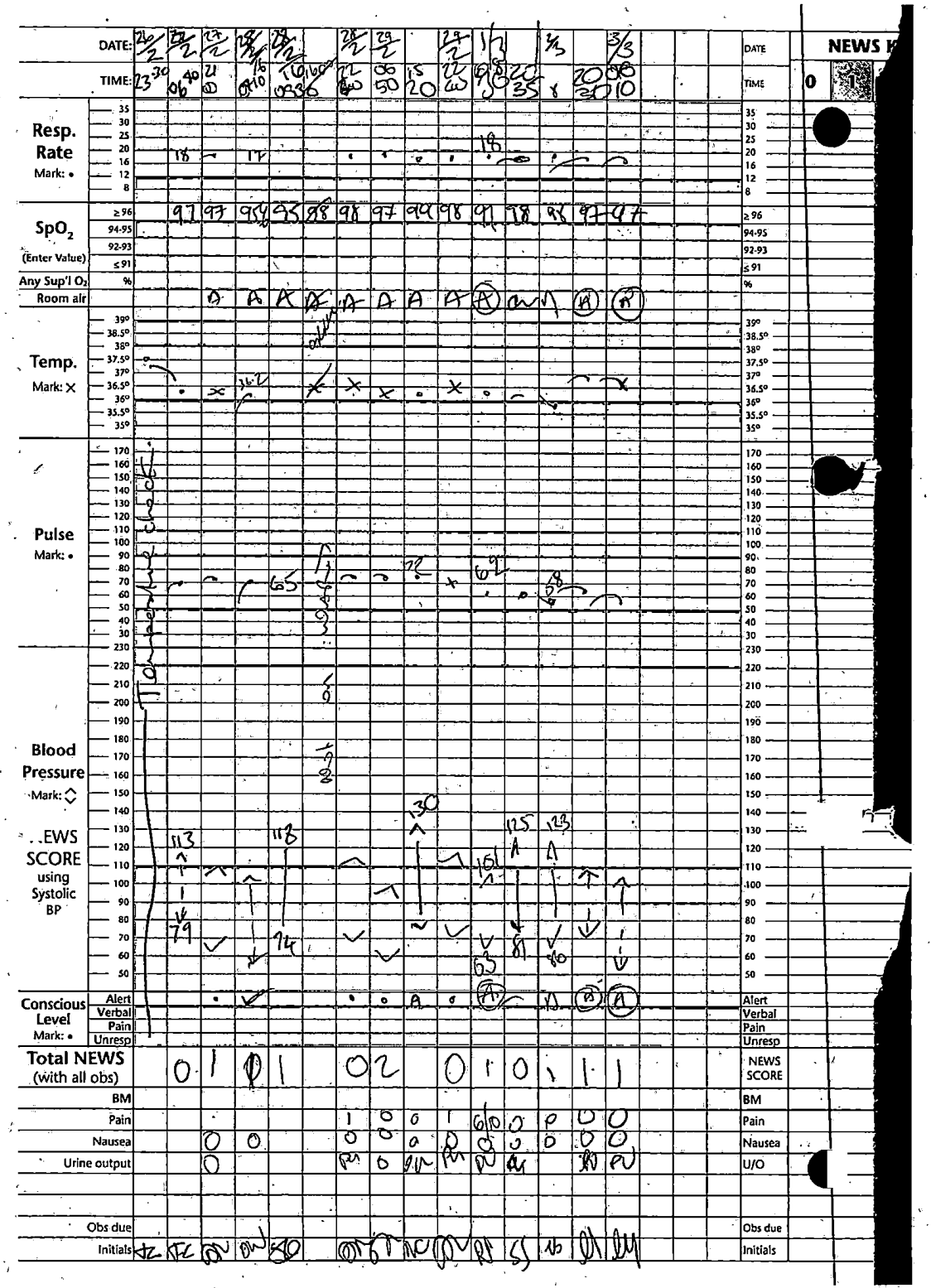
	Date	Ward
Admitted		
Transferred		
Transferred		

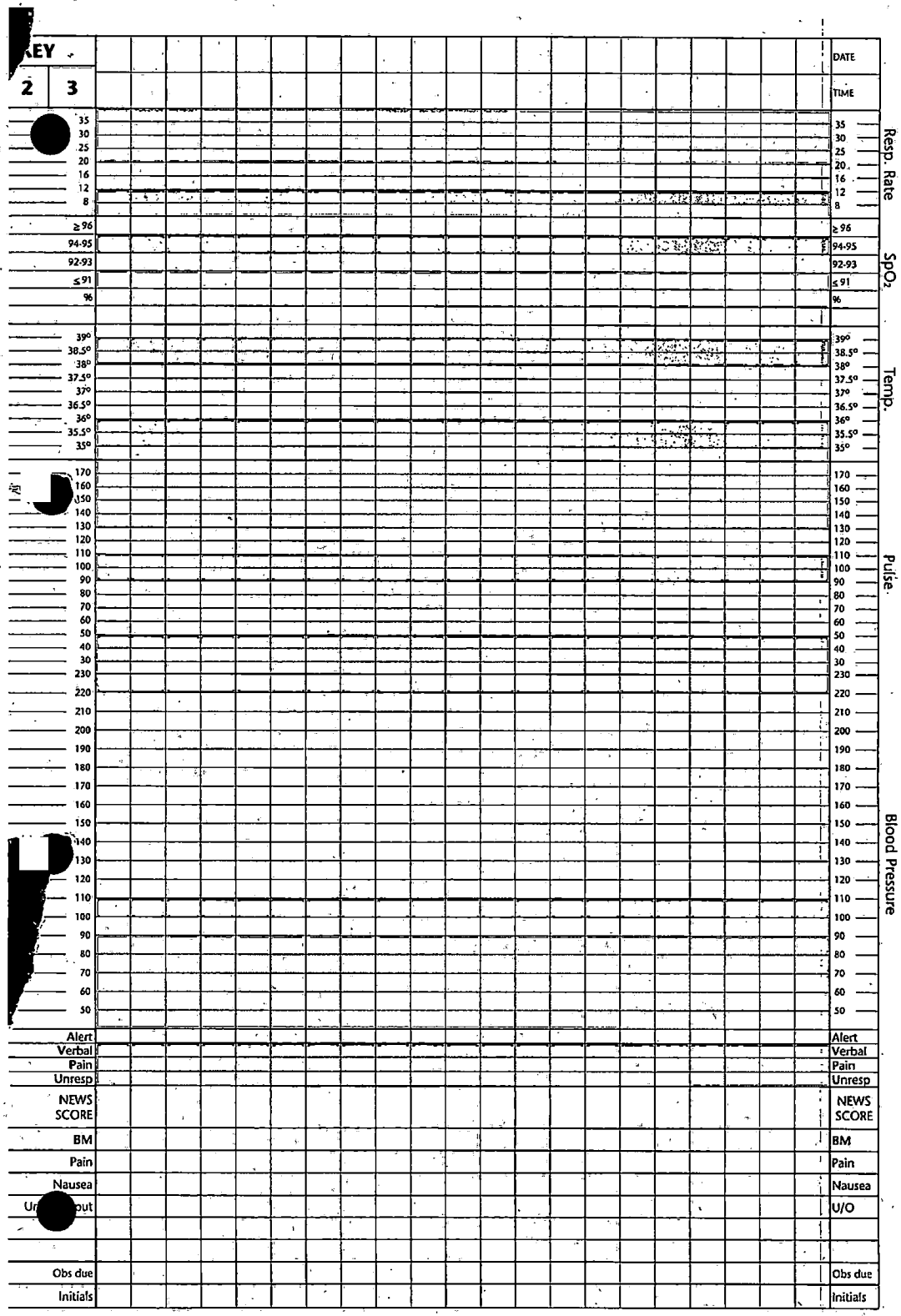
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more **or** 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


DATE
TIME
NEWS
Resp. Rate
Mark: •
SpO2
(Enter Value)
Any Sup'l O2
Room air
Temp.
Mark: ×
Pulse
Mark: •
Blood Pressure
Mark: ◇
EWS SCORE using Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
NEWS SCORE
BM
Pain
Nausea
Urine output
U/O
Obs due
Initials


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥96
94-95
92-93
≤91
96
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Neurological Observations

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

Glasgow Coma Scale

Pupil size (mm)

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8

Pain Score

Ask the patient to rate his/her pain by choosing a number between 0 and 10. Use the diagram below to assist the patient. If patient's pain is chronic, use generic tool. If patient is unable to communicate, use observational tool.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Severe Pain			

Nausea and Vomiting	
0	= None
1	= Mild (*Not distressing – no retching/vomiting*)
2	= Moderate (*Troublesome – occasional retching/vomiting*)
3	= Severe (*Distressing – frequent retching/vomiting*)

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

Dedsigned by Medical Illustration Services • 231261

3112626230
MCLACHLAN
Michael
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire
G31 3NS

M
31/12/196:

Cli· t) Moving and Handling Risk Assessment Form

Patient's name:	Named Nurse:	If Patient is totally independent, tick here and go to date box	Risk: Low / Medium / High
		✓ ✓	

BODY BUILD				Problems with comprehension, behaviour, co-operation (specify):
Obese		Tall		
Above average		Medium		
Average		Short		
Below average				Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
RISK OF FALLS				
High		Low		

Transfers (Including To/From: Bed; Wheelchair; Commode; Toilet)

HOIST/STANDAID (Specify)	ASSISTANCE	SUPERVISION	INDEPENDENT
Model:	People: 1 2 3	Additional Information:	
Sling type:	Walking aid (specify)		
Sling size:			

Toileting

HOIST/STANDAID	ASSISTANCE	SUPERVISION	INDEPENDENT
	People: 1 2 3	Additional Information:	

Move on / off bed pan

HOIST	MANEOUVRE	ASSISTANCE	SUPERVISION	N/A
	Roll patient	People 1	Additional Information:	
	Monkey pole	People 2		
	Patient bridges	People 3		

Move up / down bed

HOIST	HANDLING AIDS	ASSISTANCE	SUPERVISION	INDEPENDENT
	Sliding sheet	People 1	Additional Information:	
	Monkey pole	People 2		
	Rope ladder	People 3		

Transfer to / from trolley (or bed etc.)

HOIST	HANDLING AIDS	ASSISTANCE	SUPERVISION	INDEPENDENT
	Patslide	People 1	Additional Information:	
	Other	People 2		
	Fabric sliding aid	People 3		

Sit up over side of bed

BED REST	ASSISTANCE	SUPERVISION	INDEPENDENT
	People: 1 2 3	Additional Information (e.g. equipment to be used – swivel cushion):	

Into Bath or Shower

WHICH BATH	HANDLING AID	ASSISTANCE	SUPERVISION	INDEPENDENT
Shower	Shower chair	People 1	Additional Information:	
Variable height bath	Bathing Hoist e.g. Atanti	People 2		
Bed bath	Sling lifting Hoist	People 3		

Walking

NO WALKING	WALKING AID (specify)	ASSISTANCE	SUPERVISION	INDEPENDENT
		People 1	Distanced walked / Additional Information:	
		People 2		
		People 3		

Other Instructions

Recording Symbol:	/	X	*
Date Assessed:	20/2/16	28/2/16	
Assessor's signature:	[signature]	[signature]	
Proposed Review date:		6/2/16	

05236

Continuation Sheet

Transfers (Including To/From: Bed; Wheelchair; Commode; Toilet)

HOIST/STANDAID (Specify)	ASSISTANCE	SUPERVISION	INDEPENDENT
Model:	People: 1 2 3	Additional Information:	
Sling type:	Walking aid (specify)		
Sling size:			

Toileting

HOIST/STANDAID	ASSISTANCE	SUPERVISION	INDEPENDENT
	People: 1 2 3	Additional Information:	

Move on / off bed pan

HOIST	MANEOUVRE	ASSISTANCE	SUPERVISION	N/A
	Roll patient	People 1	Additional Information:	
	Monkey pole	People 2		
	Patient bridges	People 3		

Move up / down bed

HOIST	HANDLING AIDS	ASSISTANCE	SUPERVISION	INDEPENDENT
	Sliding sheet	People 1	Additional Information:	
	Monkey pole	People 2		
	Rope ladder	People 3		

Transfer to / from trolley (or bed etc.)

HOIST	HANDLING AIDS	ASSISTANCE	SUPERVISION	INDEPENDENT
	Patslide	People 1	Additional Information:	
	Other	People 2		
	Fabric sliding aid	People 3		

Sit up over side of bed

BED REST	ASSISTANCE	SUPERVISION	INDEPENDENT
	People: 1 2 3	Additional Information (e.g. equipment to be used – swivel cushion):	

Into Bath or Shower

WHICH BATH	HANDLING AID	ASSISTANCE	SUPERVISION	INDEPENDENT
Shower	Shower chair	People 1	Additional Information:	
Variable height bath	Bathing Hoist e.g. Alenti	People 2		
Bed bath	Sling lifting Hoist	People 3		

Walking

NO WALKING	WALKING AID (specify)	ASSISTANCE	SUPERVISION	INDEPENDENT
		People 1	Distanced walked / Additional Information:	
		People 2		
		People 3		

Other Instructions

Recording Symbol:	/	X	*
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name	
Address	3112626230 MCLACHLAN M Michael 31/12/1962 FLAT 1-1 31 ABERFELDY ST Glasgow, Lanarkshire G31 3NS
CHI No.	
DoB	

SHEET NO (1)

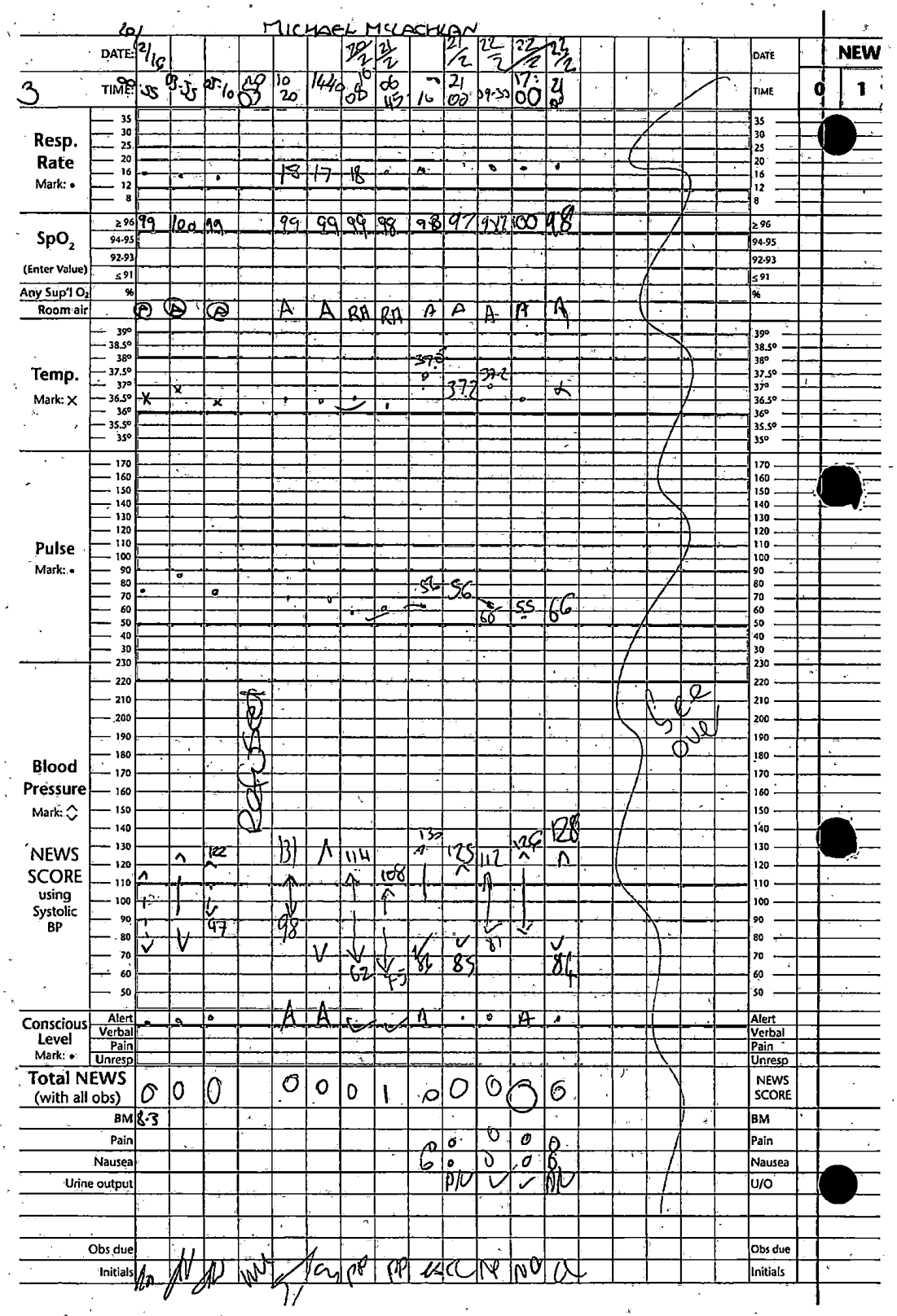
	Date	Ward
Admitted		
Transferred		
Transferred		

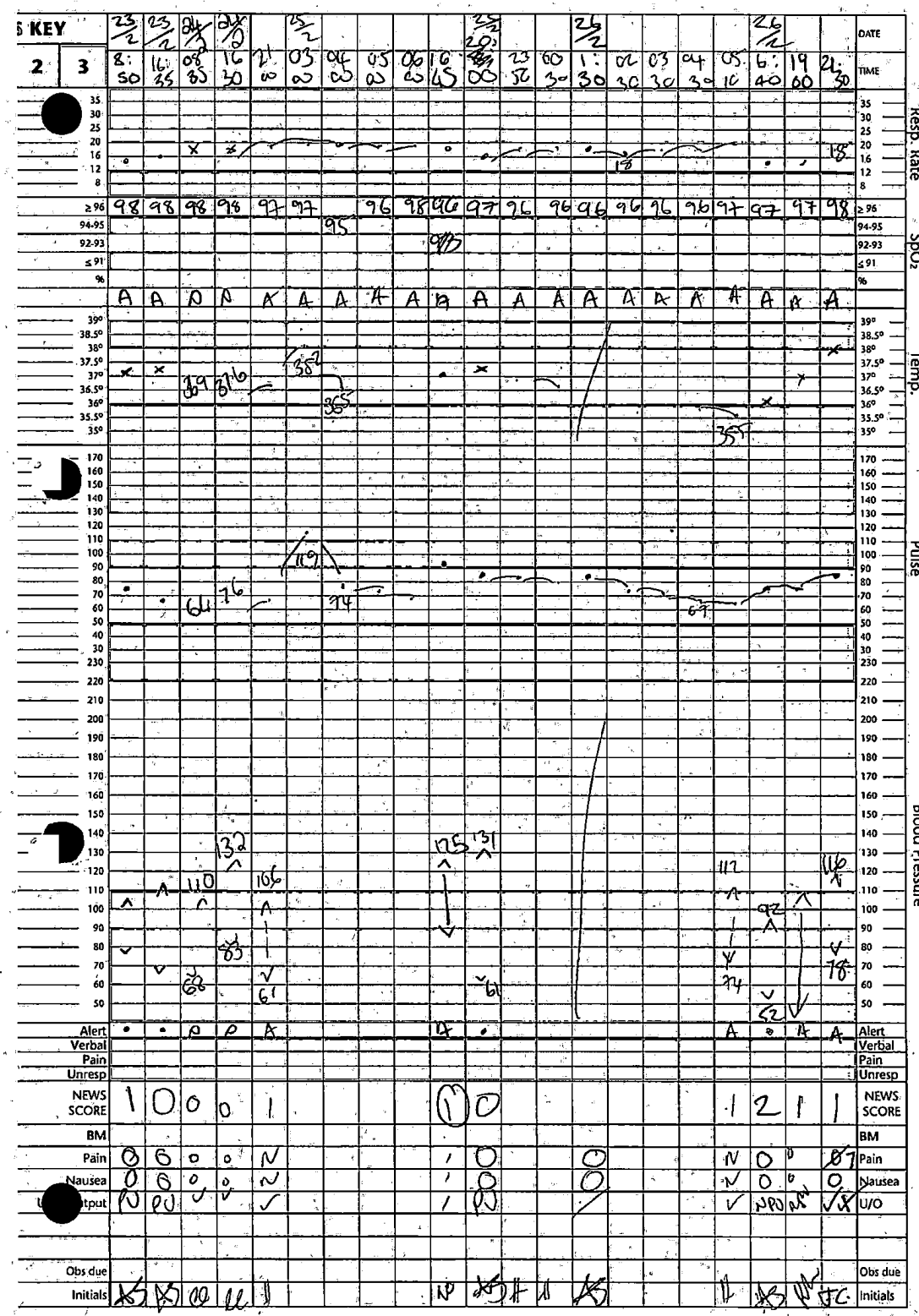
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


MICHAEL MCLACHLAN
DATE
TIME
NEW
Resp. Rate
Mark: •
SpO2
(Enter Value)
Any Sup'l O2
Room air
Temp.
Mark: ×
Pulse
Mark: •
Blood Pressure
Mark: ◇
NEWS SCORE using Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
NEWS SCORE
BM
Pain
Nausea
Urine output
U/O
Obs due
Initials


KEY
2
3
DATE
TIME
Resp. Rate
SpO2
Temp.
Pulse
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Neurological Observations

| | | |

Write or affi

3112626230

Name: MCLACHLAN Michael M

Address: FLAT 1-1, 31 ABERFELDY ST, Glasgow, Lanarkshire G31 3NS

CHI: DOB: 31/12/1967

Hospital &

Peripheral Vascular Cannula(PVC) Insertion & Maintenance

NHS Greater Glasgow and Clyde

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy		
One of the following is evident : slight pain or redness near site	1	Possible first signs : Observe cannula
Two or more of the following are evident: pain,redness,swelling	2	Early stage of phlebitis - Remove & resite cannula
All of the following are evident: pain,redness,hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis Remove & resite cannula Seek further advice
As above including: palpable venous cord	4	
As above including :pyrexia	5	

Insertion – Complete all sections

PVC inserted ED Theatre Ward 20&21	Date inserted 20/2/11	Insertion site (L)arm	Colour of PVC Pink	Inserted by: Name & Designation *[only if inserted in ward]*
Clinical indication: IV Fluids/IV Medication ☐	Urgent access ☐	Interventional procedures ☐	Other Please state:	
Insertion Criteria (If no: please explain in comments below)	Clean field used Yes ☐ No ☐ Unknown ☐	Hand hygiene Yes ☐ No ☐ Unknown ☐	Skin asepsis Yes ☐ No ☐ Unknown ☐	Dressing affixed Yes ☐ No ☐ Unknown ☐ / Non touch technique (do not re- contaminate cleaned skin) Yes ☐ No ☐ Unknown ☐

Maintenance – To be completed daily

PVC 1	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	The PVC has been inserted less than 72 hours	Hand hygiene before & after all procedures	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 2 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After day 3 consider removal, if there is still a clinical reason justify rationale for PVC to remain in situ.							
Day 4 __/__/__	Yes ☐ No ☐	V.I.P: 0	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 __/__/__	Yes ☐ No ☐	V.I.P: 0	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

Date removed_____ Reason for PVC removal_____ Reason PVC in greater than 72 hours_____

Date & time	PVC no.	Comments	Signature

MIS 269426
81117

CHI:	Modified V.I.P (Visual Inf..... Phlebitis) Score		
	IV site appears healthy	0	No phlebitis : Observe cannula
	One of the following is evident : slight pain or redness near site	1	Possible first signs : Observe cannula
	Two or more of the following are evident: pain,redness,swelling	2	Early stage of phlebitis - Remove & resite cannula
	All of the following are evident: pain,redness,hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: Remove & resite cannula Seek further advice
	As above including: palpable venous cord	4	
	As above including :pyrexia	5	

Insertion – Complete all sections

PVC inserted ED Theatre Ward 20+21		Date inserted 25.2.16	Insertion site (L) hand.	Colour of PVC GREY	Inserted by: Name & Designation *[only if inserted in ward]*
Clinical indication	IV Fluids/IV Medication ☐	Urgent access ☐	Interventional procedures ☐	Other Please state:	
Insertion Criteria (if no: please explain in comments below)	Clean field used Yes ☐ No ☐ Unknown ☐	Hand hygiene Yes ☐ No ☐ Unknown ☐	Skin asepsis Yes ☐ No ☐ Unknown ☐	Dressing affixed Yes ☐ No ☐ Unknown ☐	Non touch technique (do not re- contaminate cleaned skin) Yes ☐ No ☐ Unknown ☐

Maintenance – To be completed daily

PVC 2	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	The PVC has been inserted less than 72 hours	Hand hygiene before & after all procedures	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 2 ~~27~~ 2/16	Yes ☐ No ☑	V.I.P: 0	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Left in situ ☑ Removed ☐	KJ
Day 3 28/2/16	Yes ☐ No ☑	V.I.P: 0	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Left in situ ☑ Removed ☐	DW
After day 3 consider removal, if there is still a clinical reason justify rationale for PVC to remain in situ.							
Day 4 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

Date & time	PVC no.	Comments	Signature

Date removed Reason for PVC removal Reason PVC in greater than 72 hours

Nutrition Profile

NHS Greater Glasgow and Clyde

Name:	Date of admission: 20/2/16
Address: 3112626230 MCLACHLAN M ! Michael 31/12/1962 FLAT 1-1 31 ABERFELDY ST Glasgow, Lanarkshire G31 3NS	Time: 0550
DoB:	HOSPITAL: GRI
CHI number:	Ward: S1
Affix patient data label	

To be recorded within 24 hours of admission*

Height: 5' metres Actual ☐ Patient/ carer reported ☐ Alternative measurement ☑

Weight: 11½ kg Actual ☐ Patient/ carer reported ☐ Alternative measurement ☑

Recent unplanned weight loss: Yes ☐ No ☑ undated 22/2/16 daughter has stated weight loss 1½ stones since December

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

Is there evidence of recent weight loss?

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

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☑

Please state:

Food Allergies: Yes ☐ No ☐ If 'Yes' please state:

Eating likes and dislikes (including appetite):	Drinking likes and dislikes:	Patient NBM Yes ☐ No ☑ If 'Yes' why?:

Are there any contributing factors that may affect food intake such as **physical** (e.g. swallowing difficulties, loose teeth), **physiological** (e.g. nausea), **psychological** (e.g. dementia), **social or environmental?** Yes ☐ No ☑

Please specify all factors:

Is the patient on oral nutritional supplements? Yes ☐ No ☐

If 'Yes' please state:

Is the patient experiencing oropharyngeal swallowing problems (excluding oesophageal issues e.g. GORD, Stricture)? Yes ☐ No ☑

If 'Yes' please complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS). If oesophageal problem present please discuss with medical staff.

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☑

If 'Yes' please state:

Has this patient received written information about inpatient food (e.g. "Food in Hospitals" leaflet)?

Yes ☐ No ☐ Not applicable (received on previous admission) ☐

Profile completed by: Name (PRINT): WMcLachlan Signature: WMcLachlan Date: 20/2/16

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

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

Is your patient on the Liverpool Care Pathway (LCP)? Yes ☐ No ☐

If 'Yes' please follow LCP advice as screening for malnutrition may not be appropriate.

Malnutrition Universal Screening Tool ('MUST')

Date	20/11/24											
Initials	MM	MP										
Height (see page 1) 165 Weight	11/11/24	59.1 kgs										
Oedema or ascites present Y/N	N	N										
BMI (refer to chart on page 4)	22	22										
'MUST'												
Step 1: BMI Score (refer to chart on page 4) >20 (>30 = Obese) .....0 18.5 - 20 .....1 <18:5.....2	0	0										
Step 2: Weight Loss Score Unplanned weight loss in past 3-6 months: <5% ..... 0 5-10% ..... 1 >10% 2	0	2										
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	Comm Food chart										
Step 4: Overall Risk of Malnutrition Total:	0	2										

Step 5: Management Guidelines

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

Management Plan

FOR ALL PATIENTS

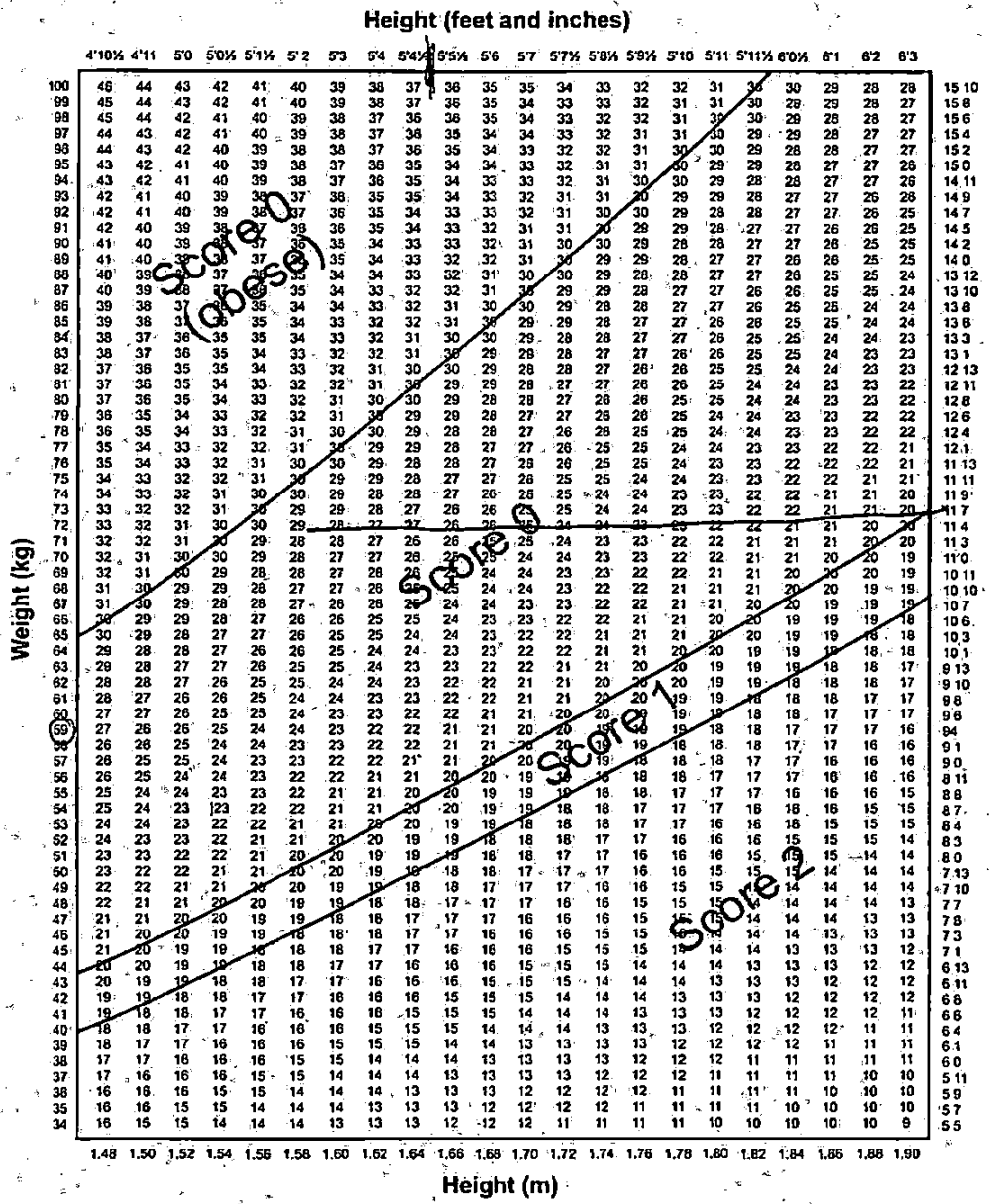
- Provide help and advice on food choices and eating and drinking when necessary.
- Treat underlying conditions and initiate appropriate treatment to relieve symptoms that affect nutritional intake e.g. nausea, vomiting, constipation, diarrhoea and/or pain.
- Refer to dietitian if any specialist advice is required.
- Use a recognised system to identify when equipment or asssistance is required at mealtimes (e.g. red mats, coloured napkins).
- REMEMBER TO CONSIDER YOUR PATIENT'S HYDRATION REQUIREMENTS.
- Ensure Discharge Plan includes most recent 'MUST' Score and any necessary follow-up requirements.

Referral Services		Referred by	Method of referral	Reason for referral
Nutritional Support Team	Date Referred / /			
Dietitian	Date Referred: 2/2/16	M Bowers	Telecare	Weight loss
Speech and Language Therapy	Date Referred: / /			
Occupational Therapy	Date Referred / /			
Dental Service	Date Referred / /			

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Action discussed with patient / carer	Review date	Name (PRINT) Signature/ Designation
		3 day food chart to be Referred to dietician Reweigh 1 week			M Bowers
1/3/16	0	Needs weight for MUST please		7/3/16	SSmith SN

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	6.2-12.4 kg	>12.4 kg
126 kg	<6.3 kg	6.3-12.6 kg	>12.6 kg

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

Medical Illustration Services • 23526
STORES ORDER CODE 41850

NHS
Greater Glasgow and Clyde

NATVNS
SCOTLAND

WRITE 3112626230
Surnan MCLACHLAN M
Michael 31/12/1952
Forena FLAT 1-1
31 ABERFELDY ST
DoB .... Glasgow, Lanarkshire
G31 3NS
Locatio

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

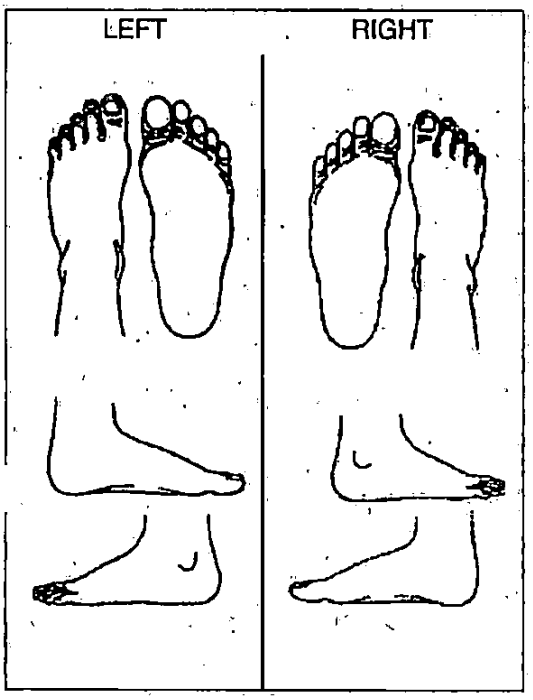
Sex										
Male	1	1	1							
Female	2									
Age										
14 -49	1									
50 -64	2	2	2							
65 - 74	3									
75 - 80	4									
81+	5									
Build/Weight for Height (BMI=weight in Kg/height in m²)										
Average - BMI 20-24.9	0	0								
Above average - BMI 25-29.9	1									
Obese - BMI > 30	2									
Below average - BMI < 20	3									
Continence										
Complete/catheterised	0	0	0							
Incontinent urine	1									
Incontinent faeces	2									
Doubly incontinent (urine & faeces)	3									
Skin Type - Visual Risks Area										
Healthy	0	0	0							
Tissue paper (thin/fragile)	1									
Dry (appears flaky)	1									
Oedematous (puffy)	1									
Clammy (moist to touch)/pyrexia	1									
Discoloured (bruising/mottled)	2									
Broken (established ulcer)	3									
Mobility										
Fully mobile	0	0	0							
Restless/fidgety	1									
Apathetic (sedated/depressed/reluctant to move)	2									
Restricted (restricted by sever pain or disease)	3									
Bedbound (unconscious/unable to change position/traction)	4									
Chairbound (unable to leave chair without assistance)	5									
Nutritional Element										
Unplanned weight loss in past 3-6 months										
<5% Score 0, 5-10% Score 1, >10% Score 2	0-2									
BMI > 20 Score 0, BMI 18.5-20 Score 1, BMI < 18.5 Score 2	0-2									
Patient acutely ill or no nutritional intake > 5 days	2									
Special Risks - Tissue Malnutrition										
Multiple organ failure/terminal cachexia	8									
Single organ failure e.g. cardiac, renal, respiratory	5									
Peripheral vascular disease	5									
Anaemia = Hb < 8	2									
Smoking	1		1							
Special Risks - Neurological Deficit										
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*	4-6									
Special Risks - Surgery/Trauma										
On table > 6 hours	8									
Orthopaedic/below waist/spinal (up to 48 hours post op)	5									
On table > 2 hours (up to 48 hours post op)	5									
Special Risks - Medication										
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4	3	4							
Total Score		3	4							
Date		20/12	29/12							
Initials		MW	DW							
Time										

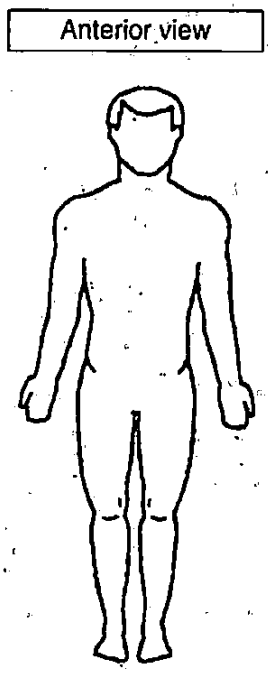
83826

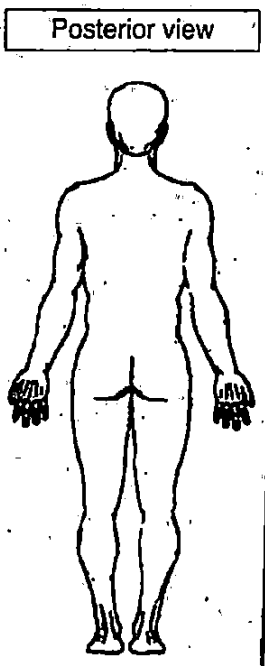
Ensure plan of care is implemented / reviewed for all identified areas of concern.

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.

GRADE 4 Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss.

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

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

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

MEDICINES RECONCILIATION

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

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

DOCTOR'S DECLARATION (if required by Local Protocol)

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

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

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

PATIENT DETAILS

Hosp 3112626230
DOB, MCLACHLAN Michael M 31/12/1962
FLAT 1-1
31 ABERFELDY ST
Glasgow, Lanarkshire G31 3NS
Date c
Consu

Height:	
Weight:	
Surface area:	
Ward:	

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
24/02	HALOPERIDOL	2mg	IM	23:20	[signature]	[signature]	23:30
25/2	LORAZEPAM	2mg	IM	0045	[signature]	[signature]	0045
25/2	Lorazepam	4mg	IM	00	[signature]	[signature]	0200
25/2	Haloperidol	5mg	IM	0210	[signature]	[signature]	0210
25/2	Haloperidol	2mg	IM	0230	[signature]	[signature]	0230
25/2	Midazolam	2mg	IM	0240	[signature]	[signature]	0245
25/2	Midazolam	2mg	IM	2345	[signature]	[signature]	2345
29.2	haloperidol	2.5mg	PO				

DATE →
MONTH →

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

IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N

ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N

SIGNATURE OF ASSESSOR

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

Parenteral Drugs : Regular Prescription

Patient's Own Medicine

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

A DRUG

DOSE | ROUTE | DATE | 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 ☐

B 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 ☐

C 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.

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

| | | |

Oral and Other Drugs: Regular Prescription

DATE / MONTH: 20/2, 21/2, 22/2, 23/2, 24/2, 25/2, 26/2, 27/2, 28/2, 29/1, 1/3, 2/3

Patient's Own Medicine

H — DRUG: QUETIAPINE
DOSE: 300mg | ROUTE: PO | DATE: 20/02 | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: 300mg
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

J — DRUG: DIHYDROCODEINE
DOSE: 30mg | ROUTE: O | DATE: 21/2 | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

K — DRUG: DIHYDROCODEINE
DOSE: 60mg | ROUTE: O | DATE: 22/2 | STOPPED DATE: 29/2 | STOPPED INITIALS: SC
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

L — DRUG: HALOPERIDOL
DOSE: 2.5mg | ROUTE: O | DATE: 25/2 | STOPPED DATE: 29/2 | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

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

DATE: 29/1/12 | MONTH: 2/3/12

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

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

M — DRUG: DIHYDROCODEINE
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐
DOSE: . | ROUTE: ORAL | DATE: 29/2
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
STOPPED — DATE: | INITIALS:

N — DRUG: DIHYDROCODEINE
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐
DOSE: 60mg | ROUTE: ORAL | DATE: 29/2
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: not on D/C
STOPPED — DATE: 1/3 | INITIALS: SC
0700-0900: X

P — DRUG: Lidocaine Patch 5%
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐
DOSE: 1 Patch | ROUTE: TOP | DATE: 29/2
PRESCRIBER (PRINT & SIGN): [illegible]
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: ON 12HRS / OFF FOR 12HRS
STOPPED — DATE: 1/3 | INITIALS: SC

R — DRUG: DIHYDROCODEINE
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐
DOSE: 60mg | ROUTE: ORAL | DATE: 1/3/12
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: not on D/C
STOPPED — DATE: | INITIALS:
0700-0900: X X [illegible] X X

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

S 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 ☐

T 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 ☐

V 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 ☐

W 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.

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

X DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

Y DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

AA DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

BB DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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 HALOPE

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) | 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) | 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) | 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) | 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.

All Routes: As Required Prescriptions

Patient's Own Medicine

LL — DRUG: PARACETAMOL — STOPPED: DATE: / INITIALS:
DOSE: 1g | ROUTE: O | INDICATION: temp / pain
PRESCRIBER (PRINT & SIGN): DA | MAX.FREQ.: QID | DATE: 23/12
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

| | | |

| | | |

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

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

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

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

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

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

FOR NURSES

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

Codes for Non-Administration of Drugs

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

Cat. No. 40995 Ver 4, 09/2010

Green trousers, Green Tshirt: grey Jacket with fur on hood.

Glasgow Royal Infirmary

CHI: 3112626230

Total Att: 17

12 Mth Att: 3

(2)

Title: **MR**

MCLACHLAN **Michael**

DOB **31/12/1962** Age: **58y** Sex: **Male**

FLAT 1-1
10 GIRVAN STREET
Glasgow
Lanarkshire
G33 2DP
07947416972

Next of kin: **SHERLOCK, Martine**
Relationship: **Niece**

GP: **SJ Bruce**
0141 531 6220

Attendance Date: **16/02/2021** Arrival Time: **13:47**

Registration Time: **13:47** Date of Incident: **16/02/2021**

Major Incident Desc:

Reason for Attendance: **Daughter will bring -low covid risk. Sudden onset L sided chest pain, was agitated and jumpy with GP. Admits to smoking heroin, prev hx drug induced psychosis (no ft)**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

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

Presenting Complaint:

Observation Date: **16/02/2021 13:56** Nurse name: **Nurse Amy Lamont**

Temp	**35.7**	C
HR	**84**	bpm
BP	**144/78**	mmHg
MAP	**100.00**	mmHg
RR	**22**	bpm
SpO2	**94**	%
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: **LOW COVID RISK, NO FT. episode of central chest pain around half an hour ago radiating down arm ?which one. daughter present, attended GP as agitated and hallucinating, shouting at people. ?psychosis episode GP has contacted CPN. cat 0 for ecg**

3112626230 31/12/1962 MCLACHLAN Michael

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Glasgow Royal Infirmary
Acute Medicine Unit

(Part B - Medical Admission)

NHS
Greater Glasgow and Clyde

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Date & Time 16/02/21 1440 Consultant Dr CAMERON Ward SAPA

Ward Review (Should be completed within 2hrs of transfer from ED) A Tilsrook (SHO)

Check List

- VTE ☐
- Med - Rec ☐
- Kardex ☐
- CxR ☐
- ECG ☐
- Oxygen ☐
- Patient on Bleeders list ☐

58 M

PC: Chest pain + ? drug-induced psychosis

HPC: reports he smoked heroin on Tuesday
Agitated last few days. Reports ↓ Paranoia.
(L) Sided chest + back pain - last few days
Last hour he says. ↓ Griffing pain
Cough. ↓ Denies haemoptysis.
Denies taking other drugs. States hasn't taken regular meds for 2/52

PMH: Prev. drug-induced psychosis - on Risperidone ? COPD - no spirometry
Prev. Benzodiazepine dependency when withdrawing from heroin

DH: see med rec

fh: } no hx
SH: }

SH/ GI: unable to get hx

CVS: unable to get Hx

GU:

Neuro:

Resp: As above

MSK:

O/E/ NEWS = ↑ 4 RR 22 Sats 94% on air Temp 35.7

Seems distressed + in pain ++ intermittently
- sometimes answers questions
- sometimes retching + tearful

Ward Review

16/02 A Swiatek cont...

Difficult to examine
Chest clear
Abdo SNT
Bs active
° Leg oedema
many all 4 limbs

ECG - SR

Imp/ ? Delirium
? Drug-induced psychosis
? Heroin withdrawal
? PE
Need to r/o ACS
? Pneumonia

(P) CXR
Close bloods
Add on D-dimer
PRN Haloperidol PO if possible
AWI
Collateral hx
D/W Addictions ward about retaining Buprenorphine dose
- Pharmacy is ND Green
410 Cumbernauld Rd
01415542165
- confirmed collects weekly on Friday
° collected on Friday last week.

A Swiatek SHO

NHS GG&C Adult Risk Assessment for Venous Thromboembolism (VTE)

[excluding orthopaedics, obstetrics & ENT who have specialty-specific policies]

NHS Greater Glasgow and Clyde

- **Risk Assessment must be completed for all patients within 24 hours of admission to hospital**
- **Patients must be reassessed every 48-72 hours or sooner if condition changes**
- **Reassessment must be documented in Kardex**
- **Please complete risk assessment and then sign and date Risk Assessment Result box at bottom of page.**

Pt Addressograph

Operative patients | **Non-operative patients**

Is the patient bed-bound or expected to have reduced mobility relative to normal state for ≥ 2 days?

Yes ☐ | No ☐

Does the patient have any risk factors for thrombosis? (tick √ all that apply)

Age >60	☐	Use of oestrogen-containing contraceptive therapy	☐
Active cancer or cancer treatment	☐	Use of hormone replacement therapy or tamoxifen	☐
Dehydration	☐	Pregnancy or < 6 weeks post partum	☐
Known thrombophilias	☐	Critical care admission eg HDU/ITU	☐
Obesity (BMI>30)	☐	Surgical procedure with total anaesthetic/surgical time >90 min, or >60 min if surgery on lower limb or pelvis	☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or Inflammatory disease	☐	Acute surgical admission with inflammatory or intra-abdominal condition including Pelvic Inflammatory Disease	☐
Personal history or first degree relative with a history of VTE	☐	Hip fracture	☐
Varicose veins with phlebitis	☐	All gynaecological surgery except uncomplicated gynaecological diagnostic day case procedures	☐

- No thromboprophylaxis required.
- Continue to reassess every 48-72 hours or sooner if condition changes.
- Document all reassessments in drug kardex.
- **Complete Risk Assessment Result Box.**

Yes, 1 or more risk factors identified ☐ | **No risk factors identified ☐**

Indicators of high risk bleeding (tick √ all that apply)

Active bleeding	☐	Lumbar puncture, epidural/spinal anaesthesia • Expected within the next 12 hours • Within the previous 4 hours	☐
Acquired bleeding disorders (e.g. liver failure)	☐	Other procedure with high bleeding risk – discuss with senior if unsure	☐
Concurrent use of other anticoagulants (e.g. warfarin, rivaroxaban, apixaban, edoxaban) is a contra-indication to additional phamacological thromboprophylaxis	☐		
Acute stroke (within 14 days)	☐	Acute bacterial endocarditis	☐
Persistent uncontrolled hypertension (BP > 230/120 mmHg)	☐	Surgery expected within the next 12 hours	☐
Thrombocytopenia (<75 x 10⁹/l)	☐	Trauma with high bleeding risk e.g. Head Injury	☐
Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands)	☐	eGFR <30ml/minute/1.73m²: Dose reduction required	☐
High risk of peri- or post-procedural bleeding, e.g. neurosurgery, spinal, posterior eye surgery and thyroid surgery	☐	Heparin induced Thrombocytopenia	☐

- **Discuss with senior clinical staff before deciding to prescribe pharmacological prophylaxis**
- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48-72 hours or sooner if condition changes.

No contraindications to pharmacological prophylaxis identified ☐ | **Contraindications to pharmacological prophylaxis identified ☐**

Operative patients – Enoxaparin 40mg + AES ☐*

*prior to application of AES, please check contraindications to AES

Non-operative patients – Enoxaparin 40mg ☐

Prescribe Enoxaparin at 6pm

[on day of surgery, at the later of either 4h post-op or 6pm]

Reduce Enoxaparin to 20mg if <50Kg or eGFR <30ml/minute/1.73m² ☐

If weight> 120kg, consider Enoxaparin 40mg bd (see StaffNet Guideline).

Discontinue at discharge or when returned to pre-morbid mobility

Contraindications to anti-embolism stockings (AES) Y ☐ N ☐

Peripheral neuropathy	☐
Peripheral arterial disease	☐
Cellulitis or Gross oedema	☐
Leg deformity or Fragile skin	☐
Leg / foot ulcers	☐
Allergy	☐
Unusual leg size/shape	☐

Risk assessment result – please tick √ all that apply

VTE risk factors: YES ☐ NO ☐ Indicators of high risk bleeding: YES ☐ NO ☐ Prescribed: LMWH ☑ AES ☐ NONE ☐

Patient informed of VTE risks and benefits of thromboprophylaxis YES ☐ NO ☐ N/A ☐ Information leaflet provided YES ☐ NO ☐

Print Assessor's Name: _____ Signature: _____ Date: _____

Medicine Reconciliation Form

Source of information: ECS ☑

Patient ☐ Relative/carer ☐ GP surg ☐ GP computer printout/letter ☐ Patient's own drugs ☐ Other (specify) _____

Admission Medicines (including OTC, herbal, homeopathic)				Plan for medicines (unless indicated to stop or hold medication should be continued on drug kardex)				
Name	Dose	Freq	Route	Amend	withhold	Stop	continue	Reason for alteration
ANORO ELLIPTA 55/22	1 PUFF	~~OD~~	INH					
SALBUTAMOL 100micrograms/dose	2 PUFFS	PRN	INH					
RISPERIDONE	2mg	ON	ORAL					
TRAZODONE	300mg	ON	ORAL					
BUPRENORPHINE	12mg	OD	S. LING					
Allergies/adverse events								

List obtained by _____ Designation _____

Recently altered/discontinued medicines prior to admission and reasons why _____

Compliance aid? Y ☐ N ☐ Type _____ If, Y Community Pharmacy _____ Phone _____

Senior Medical staff review: Sign _____ Title _____ Date and Time _____

Reviewed by pharmacist _____ Date and Time _____

Comments

Consultant Review Seen in SATA

58♂ presents with agitation, paranoia, confusion. Also reports left posterior back pain / pleurisy.

Note he has stopped taking all of his medications (including Risperidone for previous drug-induced psychosis)

Bloods unremarkable

Agitated and hallucinating on present. Some retching. Only occasional brief spells

→ 1mg Lorazepam
→ 2mg Haloperidol
→ 10mg Metoclopramide
→ CT brain
→ ? dural + CXR.

A + arrow CCWS.
16/2/21 16:21 AAU

Check List

VTE	☐
Med - Rec	☐
Kardex	☐
CxR	☐
ECG	☐
Oxygen	☐
EDD	

PRINT NAME	DESIGNATION
SIGNATURE	DATE & TIME

Clinical Notes

16/2/21 Sroxburgh locum SHO
1830

Attempted to contact daughter for collateral (07935123332) - no answer.

Pt settled at present.

SR

1900 Call from daughter (Ashley)

Pt has had previous psychotic episodes requiring sedation + VP stay.
Has been living alone + isolating due to COVID.
Doesn't drink.
Thinks people on TV are talking to him + is having visual hallucinations.
Very confused + agitated

I explained bloods ok but needs CTB + Ψ r/v. Currently settled after sedation.

Ashley has offered to come in to stay with her dad as this usually settles him
↳ I said this wasn't necessary just now but she is happy to be called overnight if needed.

SR

16/2/21 NURSING (ADMISSION) 2350
Admitted to ward 50/51 from SATA with ? drug induced psychosis. NEWS = 5.
Arrived on ward GCS - 11/15. E-3 V-3 - M-5.
Has had significant amount of IV sedation in SATA.
Medics on ward made aware as has had 30mg IV diaz, 8mg IV loraz & 8mg IV haldol.
CTB obtained. - await report.

RGRSN

Clinical Notes

17/2/21 0100 IMT 2 Brain

~~CT~~

ATSP by Nursing Staff - new to SOI/SI
- concern re quantity of sedation.

58 ♂ Admitted with agitation/paranoid confusion and back pain.

PMH: previous drug induced psychosis.
?COPD.

Assaulted staff member in SATH.
Has had: 8mg IV lorazepam since 1600
8mg IV haloperidol
30mg IV diazepam
CTB nil acute cx ~~not found~~ ?@ basal. Ddimer -ve.
Now settled.
Hourly neuro obs → GCS "/15 on arrival to SOI/SI

O/E: Pupils pinpoint equal + reactive.
Responds to voice.
Appears Mumbling, eventually said "what?".
alert Localising to pain, not obeying commands.
WCC 10.7. Sats 98% on air, maintaining own airway

P: Continue neuro obs.
Check blood glucose
Monitor, ↑ r/v when fit
AWI.

Clinical Notes

17/2/21 0930 Acute Addiction Liaison (211-0238)
Thank you for the referral.
On ~~assessment~~ review Michael is currently too confused and agitated to complete assessment. AWI in place.
Espranor 8mg confirmed. Kennyhill Pharmacy (554-2165)
Take Home - weekly. Last supervised dose 12/2/21. Rx exp 26/2/21.
May I suggest the following plan:
① Prescribe Espranor 8mg daily as per Guidelines on the management of problematic drug users in GGC hospitals p.24 App. 5
No opiates for 12hrs.
② May I ask ward staff to re-refer once condition improves.
③ If discharged prior to AAL assessment May I ask ward staff to contact:
Care Manager Brenda Hay, East ADRS (565-0200) and
Kennyhill Pharmacy (554-2165)
Many Thanks
M. SLOWEY/ngl
Addictions Nurse.

17/2/21. ur-Curie Cas/.
10"

Ⓢ prev drug-induced psychosis

-admitted agitated + hallucinating, CP.
-CT - nil acute.
-GCS 11 → 13/14.
-No fevers. No O_2 req.
-WCC 10·7 other bods Ⓝ
-D-dimer -ve
-CxR ? patchy cas^n Ⓡ cardiophrenic angle.

-Still wandering around ward.
-? responding to ~~visual~~ external hallucinations

↳ add PO abx for chest.
- B12/Fol/TFTs.
- if not settling MRI + LP for ? encephalitis.
- add Buprenorphine as per addictions.

Curie

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☑
NURSING ☐

Please tick ✔ appropriate directorate

3112626230 M
MCLACHLAN 31/12/196
Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire G33 2DP

Date & Time	Evening W/R /	Signature, Print Name & Designation
17/2/21	- N/s report nihilistic delusions today.	
1720	- Otherwise little change.	
	↳ PO Atox for chest	
	B12 / Fol / Ferr / TFTs	
	Urine toxicology	
	if settles consider MRI + LP to R/O encephalitis.	
	Will need Ψ once organic cause excluded.	
		[illegible] (CAS)
		CLERK
17/2/21	Nursing Dayshift	
18³⁰	Patient settled at present but has been agitated at times throughout the day. News score ~~8~~ error 5, for New Confusion and sats 94% and pulse of 92. Meds given as per Kardex. Patient independant with ADLs, washed independantly in toilet this morning. Patient has been confused, repeatedly asked where he is and why he is here. Patient also informed staff he "shouldn't be here" as he "should have died yesterday" because he has "no organs" inside him. Patient has spoke with daughter and is eager to get home.	A. MARQUES STN.

83949 GCC0072

Date & Time	Nursing Note	Signature, Print Name & Designation
17/2/21	Patient settled, News stable Patient	
0010	not agitated but has been eager to	KDMN
	go to new ward. Medications as	Holly Newton
	per Kardex. Independent with ADLs	
	and mobility.	
18/2/21	Patient admitted to ward 11. Transferred	
08:00	independently from chair to bed.	
	All care plans & risk assessments	
	updated. No aggitation or signs	
	of confusion at present. Had a	
	cup of tea and now appears to	
	be sleeping.	GB/LBROWN/SN
18/2/21	Nursing @ 11.10	
	- Settled day so FW. No aggitation currently	
	- obs as per Chart	
	- Medication as per kardex	
	- Small amount of diet and fluid taken	
	- Mobile around the bed dem.	
	- No new issues currently	PO Falconbridge
18/2/21	PPI K MACLEOD. (WARD 11)	
1130.		
	Admitted 16/2 - drug induced psychosis + paranoia.	
	↳ heroin.	
	+ chest pain.	
	Hx of Benzo dependance	
	Prev. drug induced psychosis.	
	(PD)	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐ NURSING ☐

Please tick ✔ appropriate directorate

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Date & Time	(FY1 K MACLEOD (CONT))	Signature, Print Name & Designation
	NEWS 0.	
	Issues • Drug-induced psychosis. - ongoing confusion.	
	(- Heroin.)	
	→ on Buprenorphine 8mg OD regularly.	
	- had-t taken prescribed meds ~ 2/52.	
	• CT on admission - Nil acute.	
		Bloods (N)
		TFTs, folate, ferritin, B_{12} (N)
	Pt saw v. settled on ward, sitting d lunch. Not agitated.	
	feels well this AM. Reports ∅ voices / and hallucinations-	
	and nil obvious.	
	Would be keen for further psych input	
	in community as states can feel when	
	an 'episode' is coming on - usual triggers.	
	NB.: to liaise to East ADRS - / named worker.	
	Brenda Hay	
	Plan • re-referred to acute addictions liaison	
	• once AAL seen. ?(H)	
18/2/21	For home today; await meds from pharmacy	MACLEOD FY1
		R BEAID

83949 GCC0072

Date & Time	Nursing Day	Signature, Print Name & Designation
8/2/21	Pt for ⒽⒹ today	
1700	See dic checklist.	
	Refused to wait for abx for dic.	

My Admission Record

NHS Greater Glasgow and Clyde

3112626230
MCLACHLAN
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Affix patient ID label

Hospital: GRI Ward: 50/51
Date of Admission: 16/2/21 Time: 2320
Information obtained from: Name:
Patient ☐ Relative ☐ Other ☐ _____
Preferred Name: MICK
Age: 58 Telephone Number:
Consultant: Dr McGregor

Communication

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

Preferred first contact

Name: Ashley
Relationship: daughter
Address:

Telephone: 07935 123 332
Is this person aware of your admission?
Yes ☐ No ☐
Can we share information with this person?
Yes ☐ No ☐

Preferred second contact

Name: Sobkan. Chevonne
Relationship: Daughter
Address:

Telephone: 07494 790 834.
Is this person aware of your admission?
Yes ☐ No ☐
Can we share information with this person?
Yes ☐ No ☐

Presenting Complaint / Diagnosis

? Drug induced psychosis

Explained to the patient? Yes ☐ No ☐ Not Applicable ☐
Do you understand the reason for your admission? Yes ☐ No ☐

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

No known allergies ☐

Relevant past medical history

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

Power of Attorney / Guardianship / Adult with Incapacity

3112626230
MCLACHLAN
Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
M
31/12/1962
G33 2DP
Affix patient ID label

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

Yes ☐ No ☑

OR

Does someone have Guardianship?

Yes ☐ No ☑

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

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

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

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

Carbapenemase-producing enterobacteriaceae (CPE)

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

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

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

MRSA Screening

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

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

Nasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

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

If **YES inform the IPCT** ☐

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M
31/12/1962
Affix patient ID label

Lifestyle

Smoking

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

Never smoked ☐

Do you use eCigarettes? Yes ☐ No ☐

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

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why:_____

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

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

Drugs

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

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

Heroin use

Alcohol

Do you drink alcohol? Yes ☐ No ☑

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

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

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

Name (Please PRINT): R McGuigan Signature: R McGuigan

Designation: SN Date: 16/2/21

My Assessment Record

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

1. Breathing and Circulation

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

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

2. Communication

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

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Affix patient ID label

3. Senses

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

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

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

Can you describe where and what the pain is like?

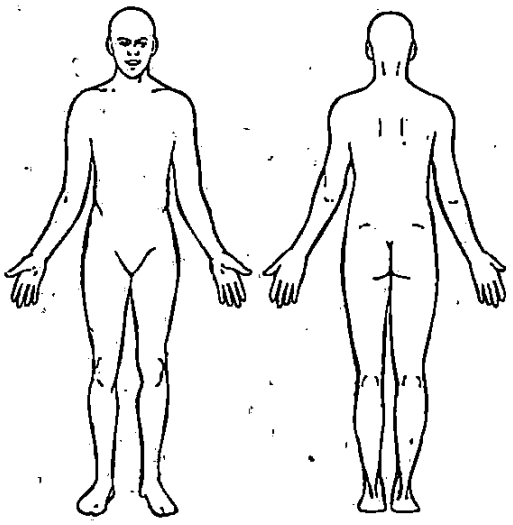
Have you had treatment / intervention for the pain?

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

Can you describe any chronic pain that you have?

What makes the pain better?

Mark current pain on body chart



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4. Cognitive Status THINK DELIRIUM

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

N.B. Think Delirium

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

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

and follow the guidance

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

No

What do you like to eat and drink?

What do you not like to eat and drink?

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

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

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Assessment of the patient's hydration and nutrition needs

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

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

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

6. Elimination

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

Assessment of the patient's elimination needs

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

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

What products do you normally use for this continence issue?

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

Date urinary catheter last changed ___/___/___

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

Bowels

When did your bowels last move?

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

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

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

What products do you normally use for this continence issue?

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

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

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

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

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

Pressure ulcer identified on admission: Yes ☐ No ☑

Pressure Ulcer Grade: _____

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

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

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



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8. Mobility

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

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

9. Maintaining a Safe Environment

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

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

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

10. Sleep and Rest

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

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11. Social Circumstances

Do you:

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

Other please specify_____ ☐

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

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

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

12. Emotional and Spiritual Care

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

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

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

Healthcare Chaplain informed Yes ☐ N/A ☑

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13. Person Centred Care

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

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

Informal Support

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

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

Name: .....

Contact Details: .....

.....

.....

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

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

Yes ☐ No ☐

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

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Required Support

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

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

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

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

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

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



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Risk Assessments/Other Documentation

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

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation

Name:

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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation

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Date and Time	Notes	Print Name, Signature and Designation

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1. Triage (Consider Mental Health Triage Assessment - if applicable)

Hospital	Patient Preferred Name:
Date: Time:	
Triage Nurse	Transport SAS/Self:

2. Presenting Complaint

Category ☐ Gap Score ☐

3. Observations

Allergies (including food allergies):

No Known allergies ☐

Resp. Rate	Sp02	Temperature	Pulse	Blood Pressure
GCS	**NEWS Score**	**PEFR**	**Blood Glucose**	**Pain Score**
/15				/10

4. Communication

I.D. band on?	Y / N
Relatives present?	Y / (N)
Relatives / NOK informed?	(Y) / N
Interpreter required?	Y / (N)

5. 4AT and TIME for Detection, Management, and Prevention of Delirium

Complete for patients: age 65 and over; patients of any age with an existing cognitive impairment; previous delirium; current hip fracture; or severe illness. These patients are at high risk of delirium. This should be done on admission; at each transition of care; if SQiD positive; or if any clinical concerns.

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NHS Greater Glasgow and Clyde

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Named Nurse/Team Leader: Sarah-joy Mags Helen Clara

Assessment Completed by: Name (PLEASE PRINT) _____

Patient Preparation

Prepare patient for examination	☑	IV Cannula (if required)	Y/N
Clothing bag labelled and stored	☑	Blood samples taken	
GGC RED BAG - with patient	☐	If Yes, list requests	Y/N
12 Lead ECG	☑	Cardiac Monitoring	Y/N
X rays performed	☐	Height:	Weight:

Urinalysis

Leucocytes	Nitrites	Protein	pH
Blood	S.G.	Ketones	Glucose
MSSU/CSU Sent ☐			
HCG specimen if indicated	+ve ☐	-ve ☐	Strip Lot no:

Peripheral Vascular Catheter (PVC) Bundle

Reason for PVC Insertion:

☐ IV Fluids

☐ IV Drugs

☐ Suspected haemorrhage

☑ Diagnostic tests

Insertion Date: 16/2/21

Insertion Time: 15:15

Hand hygiene performed immediately before PVC insertion.	☑
Skin antiseptic containing 70% isopropyl alcohol used to cleanse the skin and left to dry.	☑
Aseptic technique maintained throughout insertion procedure.	☑
Sterile, transparent, semi permeable dressing used to cover catheter site.	☑
Size/Colour: Pink Insertion site: L arm	
Signature: _____	☑

8. Adult Urethral Urinary Catheter Insertion (Use maintenance care plan as appropriate)

Clinical Indication for Insertion:

Insertion Date: __/__/__

Insertion Time: __:__

Signature: _____

Hand hygiene performed immediately before insertion.	☐
Aseptic technique maintained throughout insertion procedure and connection to closed drainage.	☐
Urethral meatus cleansed with saline and lubricant used.	
Guage: _____ _____ mls in balloon	☐

9. General Safety Precautions to be Undertaken by All Patients

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

Date: 16-2-21

Time: 17:00

1. Document mobility status in clinical record and complete a moving and handling assessment if appropriate	2nd
2. Check walking aid (if required) is in reach and in use.	NA
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	Yes
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	NA
5. If glasses are worn, check they are available and in use	NA
6. If hearing aid/s are worn, check they are working and in use.	NA

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10. Risk Assessment

If Yes to any of the 5 questions below complete the falls interventional plan. Whether Yes or No, update this assessment in acute wards, or, at the time of a fall or, upon a change in patient's clinical condition.

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

11. Screening Tool (Requires escalation/specialist referral/separate Risk Assessments)

Child Protection concern	Y / N / (NA)	Learning Disabilities	Y / N / (NA)
Adult Support and Protection	Y / N / (NA)	Patient has appointed Welfare Guardian/Power of Attorney	Y / N / (NA)
>65 years: 4AT/TIME BUNDLE COMPLETE?	Y / N / (NA)	Patient has Adult with Incapacity Section 47 certificate in place	Y / N / (NA)
Mental Health Triage	(Y) / N / NA	Infection Risk vaccine covid risk.	Y / N / NA
Has swallow test been carried out?	Y / N / (NA)	STOPPS completed? Y / N / (NA) Date_____ Time_____ Sign_____	
Sepsis Risk: Systemic inflammatory response syndrome (SIRS) Criteria 2 or more → commence Sepsis Bundle	Y / N / (NA)	Anticipatory Care Planning? (If applicable, complete GAEL chart)	Y / N / (NA)
FRAILTY SCREENING Completed on Trakcare	Y / N / (NA)	SUBSTANCE MISUSE FAST SCORE / GMAWS	(Y) / N / NA

12. Pressure Area Assessment

1 Pressure Damage	Does the person have redness and/or existing damage? Yes / (No) If YES, prescribe a minimum of 2 HOURLY Active Care to avoid further damage occuring and complete the pressure ulcer intervention plan (PUDRA Chart).

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

2 Mobility	Does the person require assistance to mobilise?	Yes / (No)
3 Continence	Does the person have continence issues with urine and/or faeces	Yes / (No)
4 Nutrition	Does the person appear malnourished and/or unable to eat or drink	Yes / (No)
5 Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?	Yes / (No)
6 Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:	Yes / (No)

13. Record of Intentional Rounding – ask whenever patient is visited but no longer than every 2 hours

1. Think delirium: Is the patient more confused?
2. Comfort: Are you comfortable?
3. Pain: Do you have any pain?
4. Drink/Mouth Care: Would you like a drink?
5. Food: Are you hungry?
6. Continence: Do you need to go to the toilet?
7. Possessions: buzzer, tissues, glasses within reach, water available and relatives at bedside?
8. Is there anything else I can do for you?

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.
16.2.21	152°	SH												

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.

16.2.21 Brought to m 2 very erratic behaviour. 152° At first not able to answer or move, not making Contact. Then when attempting to take ecg, got agitated, not making Coherent Conversation + attempting to take off trousers/shoes. Managed to walk to bed + ecg + bloods and PVC inserted. Being rlv by doctor @ present for ECG complete.

1900 Mick became very agitated after being reviewed by the doctor. Speaking, yelling incoherently @ times. Trying to leave room in his underwear. Bce rlv by Consultant Cameron + meds given as charted. Slept for abt 2 hours + is now awake + wandering around. Medical team given Cmat @ present due to agitation.

16.2.21. 2210. WHILST IN ROOM 2 AND ONE TO ONE WITH MR MCLACHLAN HE JUMPED OUT OF CHAIR AND GRABBED ME BY BOTH SHOULDERS. HE HAD A FIRM GRIP OF ME AND WOULDN'T LET ME GO. HE HAD HIS FACE VERY CLOSE TO MINE AND I FELT HE WAS GOING TO FURTHER ASSAULT ME. I THEN SHOUTED FOR HELP. AT THIS POINT HE WAS PUNCHING (Henderson Me

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Communication with Relatives		Signatures	Time
Next of Kin:	Tel:		

Nursing Notes

Date and Time		Print Name and Signature

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Address:
DOB:
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Date and Time		Print Name and Signature

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Nursing Notes

Date and Time		Print Name and Signature

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Address:

DOB:

CHI Number:

Pause for Transfer (Please tick when completed)		Tick when completed	N/A	Notes
	Relatives Informed	☐	☐	Information on discussion with relatives
	Cannula	☐	☐	
	Name Band	☐	☐	
	4AT	☐	☐	
	NEWS >7	☐	Always	
Snr Dr.: _____ Page no.: _____				
Prescriptions signed	Infusions	☐	☐	
	Drugs	☐	☐	
	Fluids	☐	☐	
	GMAWS	☐	☐	
GGC RED BAG - with patient		☐	☐	Please note here if any other tasks required prior to transfer
	Belongings (including patients medication)	☐	Always	
	Bed requested, accepted and ward informed/SBAR completed	☐	Always	
	Notes: medical notes; GP letter, PRF	☐	Always	
Investigations	CXR reviewed	☐		
	ECG reviewed	☐	☐	Print name
	Bloods sent	☐	☐	
	Bloods reviewed	☐	☐	
	Patient on 02: cylinder checked	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
GGC RED BAG - with patient	☐	☐	
Belongings (including patients medication)	☐	Always	
New medications explained	☐	☐	
PVC removed	☐	☐	
Relatives aware of Discharge	☐	☐	Please note here if any other tasks required prior to discharge
Social/Support Services required and contacted	☐	☐	
SAS Transport required and ref. no.	☐	☐	Print name
Other means of transport arranged by nurse	☐	☐	

Document Owner: Pamela Cheung, AAU Team, GRI

Management of patients with behavioural disturbance



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Tick that all areas have been considered on each shift

Nursing Interventions — Date	16/2/21		17/02/21											
Day (D) / Night (N)	D	N	D	N	D	N	D	N	D	N	D	N	D	N
Is the patient in pain, constipated or dehydrated? Use pain, bowel, fluid charts.		✓	✓											
Does the patient have delirium? Follow NHSGGC Delirium Guidelines. Any signs of infection?		✓	✓											
GMAWS if indicated by FAST assessment, referral to addictions service if necessary.		N/A	NIL											
Continually assess body language, speech, behaviour, level of distress or agitation. Don't restrict patient's mobility unless a risk to self or others. Guard your own exit, don't block patient's exit.		✓	/											
Approach and speak to patient calmly, allowing time for reply. Don't make sudden movements. Tell patient who you are and what you are going to do, every time.		✓	/											
What is the best ward environment or placement for patient? Reduce noise/activity to minimum.		✓	/											
Minimise potential weapons and falls risks: ensure only essential items in room or on your person		✓	/											
Identify level of nursing observation required to ensure patient's safety, use 2014 Guidance. If situation unmanageable or unsafe, escalate to Line Manager/coordinator.		✓	/											
Record all actions in clinical notes, particularly level of observation required and strategies used.		✓	/											
Medical Management plan: ensure medication is given as prescribed, use sedation as last resort.		✓	/											
Seek Psychiatric Liaison advice where necessary and ensure advice is acted upon.		✓	/											
Does the patient have reduced cognitive function? Use AMT4/4AT/TIME. Consider AWI. Complete 'Getting to Know Me'/'What matters to Me'. Involve family members, ask for their help in interpreting behaviours and suggesting calming or diversionary strategies. Familiar faces may comfort and help situation if patient distressed.		✓	/											
Previous violent history? If ongoing situation, complete H&S risk assessment with clinical management plan.		✓	/											
Report any significant incidents on Datix; inform manager, H&S/V&A team, Alert on Trakcare.		✓	/											
If assistance required - shout for help or use emergency call bells/panic buttons. If severe situation, phone police on **999** (not local police number).		✓	/											
Sign/Initial		RM	[illegible]											

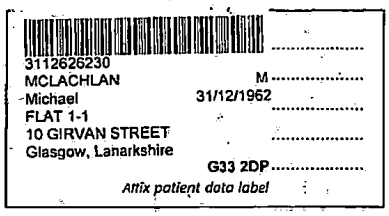
Patient Monitoring:

(please tick relevant box to right)

- ☐ Stress & Distressed behaviour
- ☐ Challenging behaviour
- ☐ Monitoring the use of bed / chair alarms
- ☐ Step down one-to-one care

NHS Greater Glasgow and Clyde

Week commencing: _____



How to complete the chart: Identify patient's behaviour. Enter each code at the time the behaviour is observed – see example and codes listed below.

Update 2 hourly day and night or when behaviour changes. Give each behaviour a separate number code.

Date	8.00am	10.00am	12 noon	2.00pm	4.00pm	6.00pm	8.00pm	10.00pm	12 m'night	2.00am	4.00am	6.00am
08.09.14	2	4	1 + 2	3	2	3 + 4	7	1 + 3	6	1 + 2	1 + 2	1 + 2
16/2/21	X	X	X	X	X	X	X	X	2 / 4+6	4 / 4	4 / 4	4 /
17/2/21	6/4 6/4 2	1, 2,	1, 2	1, 2	1, 6	1, 6				WAKE 1	1+2	1+2
18/2/21												

Codes:

1. Settled
2. Sleeping
3. Getting up from chair unassisted
4. Agitated
5. Verbally aggressive
6. Getting up from bed unassisted
7. Physically aggressive
8. Fall
9. _____
10. _____
11. _____
12. _____

Identify level of nursing observation required to ensure patient's safety, use 2014 Guidance. If situation unmanageable or unsafe, escalate to Line Manager/coordinator.

Guidelines to step down one-to-one observation

Look for patterns of settled behaviour. After discussion with the MDT re. patterns of settled behaviour, gradually withdraw one-to-one care at these times. Designate a member of staff to commence 15 minute observations. Ensure patient is in an observable area of the ward and has their call bell to hand. Ensure patient has all their personal effects to hand and all needs are met. Discuss safety precautions with the patient and their family.

NHSGGC Bedrail Risk Assessment

3112626230
MCLACHLAN
Michael
M
31/12/1962
NHS
Greater Glasgow & Clyde

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

Patient Name:

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

CHI Number:

	Use guidance on the reverse of this document when completing this Risk Assessment								
		DATE	16/12/21		18/12/21				
		TIME	2355		0130				
		WARD	5015		11				
		HOSPITAL	GRI		GRI				
	SECTION ONE – GENERAL		Y	N	Y	N	Y	N	Y	N
1	Is the patient likely to fall, roll, slip or slide from the bed?		✓			✓				
2	Has the patient requested the use of bedrails?			✓		✓				
	IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED									
	SECTION TWO – COGNITIVE AND PHYSICAL STATUS									
3	Is the patient at risk of climbing out of bed?			✓		✓				
4	Is the patient stressed, delirious or restless?		✓	✓		✓				
5	Is the patient small in stature?			✓		✓				
6	Does the patient have an unusually large or small head that might present an entrapment issue?			✓		✓				
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?			✓		✓				
	IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
	SECTION THREE – COMMUNICATION									
8	Has the patient been consulted regarding the use of bedrails?		P	✓	✓					
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition			✓	✓					
10	Has the use of bedrails been discussed with relatives/carers?			✓		✓				
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?			✓		✓				
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?			✓		✓				
	IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
	SECTION FOUR – DECISION MAKING		Y	N	Y	N	Y	N	Y	N
13	Will bedrails be used for this patient at the present time?		✓			✓				
14	Rationale for use of bedrails: (Please insert code in the box on the right)									
	A – Risk of falling from the bed									
	B – Risk of rolling from the bed		✓							
	C – Risk of slipping from the bed									
	D – Risk of sliding from the bed									
	E – Patient request									
15	Bedrail risk assessment completed by:		[illegible]		[illegible]					
16	Bedrails checked by:		[illegible]		[illegible]					
17	Date		16/12/21		18/12/21					

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

A. Alternatives to bed rails:-

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

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

Is patient:-

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

C. Safe use and application of bedrails:-

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

D. Record keeping:-

All of the following should be recorded:-

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

Bedrail risk assessments should be made as follows:-

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

Care Rounds Checklist

Date: 18/2/21

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

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

Attach Ad



3112626230
MCLACHLAN
Michael
M
31/12/1962

Ward: J0/5/ ~~→~~ 11

NHS Greater Glasgow and Clyde

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

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

		Times	0135	0800	1230
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N
S	3	**SKIN INSPECTION** Pressure areas checked:	I	I	I
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	—	—	—
K	4	**KEEP MOVING** Has the patient moved or walked?	I	I	I
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	—	—	—
		Chair Assist to walk or stand (W/ST)	—	—	—
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	I	I
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N
		Drink taken?	Y	Y	Y
		Food, snack, or supplement taken?	N	Y	Y
		Has oral hygiene been carried out as per care plan?	I	I	I
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	N	NT	NT
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	-	NA	NA
		Care provider / role	B	MC	AK

Care Rounds Checklist

Date: 17/2/21

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

1. Signed _____ Name R McGUIGAN Designation SN
2. Signed _____ Name Kirsty McSwiggan Designation SN
3. Signed _____ Name _____ Designation _____

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MCLACHLAN Michael M 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

NHS Greater Glasgow and Clyde

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

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

		Times	01:35	03:30	05:00	11:30	16:00	18:45	22:40											
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	Y	Y	Y	Y	Y	Y	Y											
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N	N											
S	3	**SKIN INSPECTION** Pressure areas checked:	Y	Y	Y	N	N	N	N											
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	INT	INT	INT	INT	I	I	I											
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y	Y	Y											
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	R	L	-	B		CH	B											
		Chair Assist to walk or stand (W/ST)	ST	SW	W	-	W	W												
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	N	I	I	N	I	I	I											
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N	N											
		Drink taken?	N	N	N	N	Y	Y	N											
		Food, snack, or supplement taken?	N	N	N	/	Y	Y	/											
		Has oral hygiene been carried out as per care plan?	N	N	Y	/	Y	I	/											
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y	Y											
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	Y	NT	NT	NT	NT	NT	NT											
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA	NA	NA											
		Care provider / role	RM	KS	RM	SW	RM	AM SW	M											

PATIENT DETAILS:
NAME: (PLACE ID
DOB: IF AVAIL
UN:

3112626230 M
MCLACHLAN 31/12/1962
Michael

CORE CARE PLAN

Date	No	Problem/Need	Patient Goal/Nursing Outcome	Action	Eval. date	Sig.
16/2	1.	Orientation. 4AT: AMT:	▪Familiarise patient with new surroundings. ▪Detect signs of new/increasing confusion. ▪Treat cause(s) of confusion.	▪Introduce yourself and other staff on admission. ▪Show patient ward layout as soon as mobile. ▪Observe for changes in mental state-consider behaviour chart. ▪Carry out relevant investigations. ▪Commence TIME bundle	23/2	R
16/2	2.	Observations	▪Record NEWS. ▪Detect abnormalities and escalate as per deteriorating patient protocol.	▪Ensure appropriate baseline observations are obtained, then repeated as indicated on NEWS chart. ▪Ensure frequency of recordings is marked on observation chart and reviewed following each NEWS score. ▪Use variance section on back page if required.	23/2	R
16/2	3.	Hydration and Nutrition.	Ensure fluid and nutrition requirements are met.	▪Complete MUST ▪If problems are detected: •Refer to dietician ☐ date: •If patient requires special diet, ensure this is ordered and available ☐ date: •Assess RAG status ☐ date: •Consider 3 day food chart ☐ date:	23/2	R

Date	No	Problem/Need	Patient Goal/Nursing Outcome	Action	Eval date	Sig
16/2	4.	Elimination.	▪Maintain normal elimination where possible and assess need for appropriate intervention where required.	▪Bristol Stool Chart ☐ ▪Urinary Catheter Care Plan ☐ ▪Maintain privacy and dignity at all times. ▪Promote hand hygiene following use of toilet.	23/2	R
16/2	5.	Mobility.	▪Optimise mobility.	▪Assess and record baseline mobility on M+H assessment. ▪If potential for improvement, refer to physio: Referred to physio: ☐ Date:	23/2	R
16/2	6.	Patient Hygiene.	☑ Independent with ADLs.	▪Provide any supplies required and inform of options for washing	23/2	R
			☐ Requires some assistance with ADLs.	▪Assess patient and offer either: ▪Assisted wash at bedside or, ▪Assisted shower / bath.		
			☐ Requires all care	▪Provide bed-bath and oral hygiene with two nurses.		
16/2	7.	Oral Hygiene	☑ Independent with ADLs.	▪Provide any supplies	R	
			☐ Requires some assistance with ADLs.	▪Assist with tooth brushing/denture cleaning/mouth care as require. Delete as appropriate.		
			☐ Requires all care	▪Ensure 2-3 hour mouth care is completed using pink sponges and appropriate cleansing agent. ▪Apply lubricant to lips.		

Written by:
30/05/20Review date:

9

Care plans	Date & Sign when complete
Communication Sheet	18/2
Generic Care Plan	18/2
Falls Risk Assessment	18/2
MUST	
Moving & Handling	18/2
Bedrail Assessment	18/2
Discharge Checklist	18/2
PUDRA (Go in bedside folder)	18/2
TIME BUNDLE (if appropriate)	

Record of Communication with Relatives / Carers

NHS Greater Glasgow and Clyde

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

Hospital:	Ward:

Name: .....
Address: .....
.....
DoB: .....
Chi number:

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G33 2DP

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

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

Date	Record of Communication	Print and Sign Name	Staff Code

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

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

Record Name of who discussed with; details of discussion; action agreed.			
Date	Record of Communication	Print and Sign Name	Staff Code

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patient's name:  3112626230 MCLACHLAN M Unit number: : Michael 31/12/1962 CHI number: FLAT 1-1 10 GIRVAN STREET Glasgow, Lanarkshire G33 2DP	Ward: \ \ Discharge destination: **Estimated Discharge Date** (1) / / **Estimated Discharge Date** (2) / / Final date of discharge : / /

Checklist	Yes	N/A	Initials	Comments
Patient informed				
Relative/carer informed				
Others informed: Care Home				
Transport arranged				
Own transport (preferred option)				
Ambulance-1 man/ 2 man am/pm				
Other: Flight, Air ambulance etc.				
Discharge medication				
Discharge prescription completed				
Compliance aids e.g. Dossette Box (involve pharmacist)				
Medication received				
Medication explained to patient and/or relative/carer				
Own medication returned to patient				
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)				
Informed of discharge				
Social work/ Other agencies/Home help				
Physiotherapist				
Occupational Therapist				
Dietician				
Speech and Language Therapist				
Clinical Nurse specialist e.g. Care Home Liaison				
Liaison/ District Nurse/Practice Nurse				
Other discharge items				
Access arrangements (e.g. keys, door entry)				
Patients clothing available for day of discharge				
Valuables e.g. cashier				
Intravenous cannula removed				
Equipment ordered (inc. walking aids) in place for discharge				
Part 2 Discharge letter - Required				
- Completed				
Out patient clinic appointment e.g. Anticoagulation clinic				
Arranged / To follow				
If unknown at time of discharge state reason				
Additional information / leaflets / factsheets				
Time of Discharge:				
Nurse's signature:	Designation:		Date: / /	

Adult Peripheral Vascular Cannu

Insertion and Maintenance Care Plan

3112626230
MCLACHLAN
: Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

M
31/12/1962

CHI: _____
Address: _____
Hospital: _____

NHS Greater Glasgow and Clyde

Insertion criteria: Please complete this section at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☑ Resuscitation/Chest Pain ☐ IV Drugs ☑ Fluids ☐ Transfusion ☐

PVC Inserted: Day 0	Date: 16/2/21 Hospital: GRI Area: ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☑ AAU Unknown ☐ _____
Insertion site:	R Hand ☐ R Arm ☐ R Foot ☐ L Hand ☐ L Arm ☑ L Foot ☐ Other: _____
Colour of cannula:	Blue ☐ Pink ☑ Green ☐ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☑ If No, state reason: Psychosis

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? (Diagnostics, Resuscitation/ Chest Pain, IV Drugs, Fluids, Transfusion)	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day 17/2/21	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☐ N/A ☑	RM
Day 1 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: ___/___/___ Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: ___/___/___

*Reason For Removal: _____

Modified Visual Infusion Phlebitis (VIP) Score

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis : Observe cannula
One of the following is evident : slight pain or redness near site	1	Possible first signs : Observe cannula
Two or more of the following are evident: pain, redness, swelling	2	Early stage of phlebitis : Remove & resite cannula
All of the following are evident: pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: Remove & resite cannula Seek further advice
As above including: palpable venous cord	4	
As above including: pyrexia	5	

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and S. aureus bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids ? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → Can I switch my patient from IV to oral antibiotics?

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature ≤ 37.9°C, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE** is available reliably (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, S. aureus bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abcess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy. Record the intended duration on the medicine kardex

YES

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

NO

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Care Plan

NHS
Greater Glasgow and Clyde

Care discussed with patient ☑ Yes ☐ No ☐ Unable		If unable, give reason:	
Care discussed with family ☐ Yes ☐ No ☑ Unable		If unable, give reason: COVID RESTRICTION	

Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
18/2/21 EB	Observations as per NEWS.				
				5. Hydration and Nutrition	
			18/2/21 EB	Normal diet & fluids	
	2, 3. Communication and senses				
18/2/21 EB	Communicating freely				
				6. Elimination	
	4. Cognitive status		18/2/21 EB	Independent.	
18/2/21 EB	Drug induced psychosis				

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Care Plan

NHS
Greater Glasgow and Clyde

Date Commenced and Signature	7. Personal Hygiene, oral care, skin care and wound care	Date Discontinued and Signature	Date Commenced and Signature	9. Maintaining a safe environment, Technical Care	Date Discontinued and Signature
18/2/21 EB	Independent - May require prompting		18/2/21 EB	Call buzzer to hand	
				10. Sleep and Rest	
			18/2/21 EB	Promote peaceful environment	
	8. Mobility				
18/2/21 EB	Independent			12. Privacy, dignity and sexuality	
			18/2/21 EB	Maintain privacy & dignity.	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

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Fluid Balance Chart

3112626230
MCLACHLAN M
Michael 31/12/1962

Hospital: GRI
Ward: 50/51
Date: 18/2/21

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____

Fluid balance from previous 24hrs
+/- _____

Does patient require thickened fluids?
Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

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

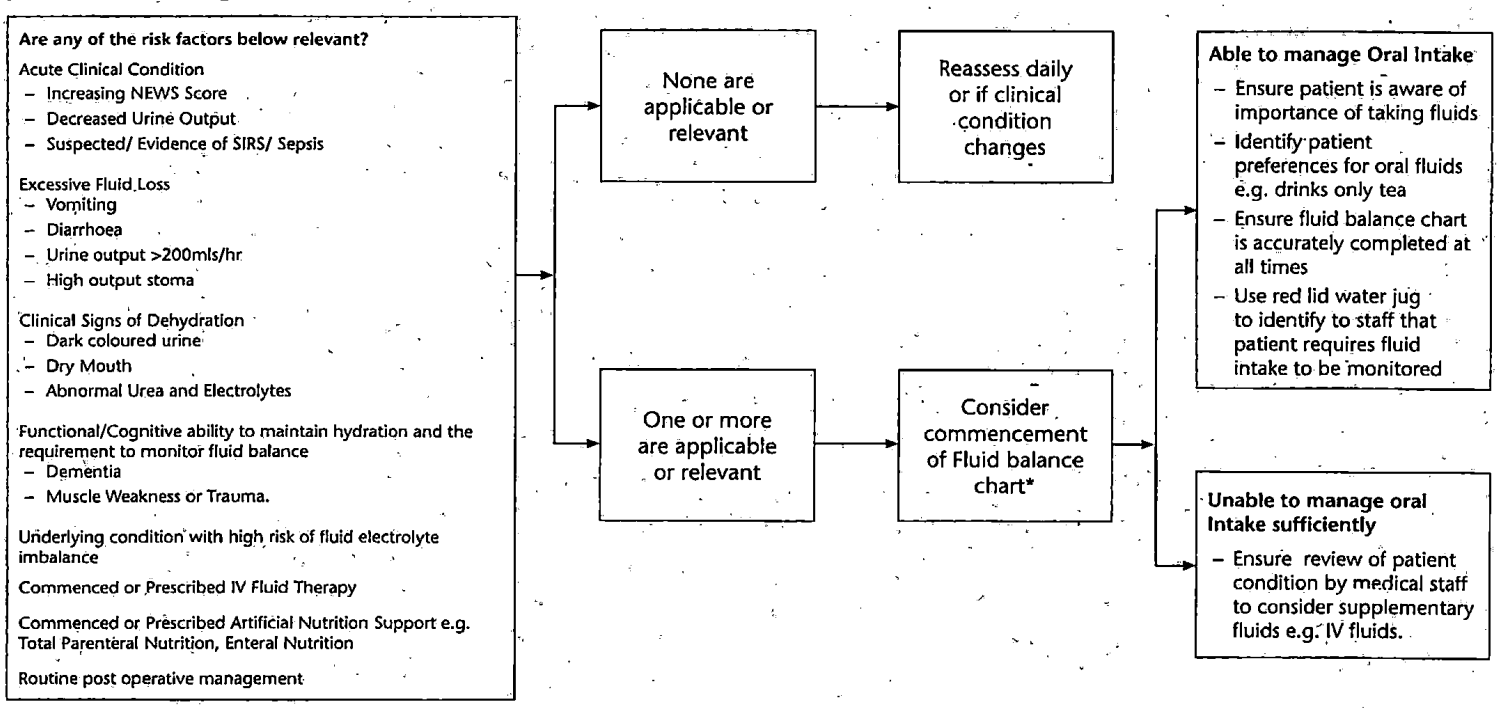
*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2

Fluid Balance Chart

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Hospital: GRI
Ward: 50/51
Date: 17/2/21

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids? Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00	ADMITTED																
01:00																	
02:00																	
03:00										UTT							
04:00																	
05:00																	
06:00																	
07:00	Brekfast	100							100								
08:00																	
09:00																	
10:00		Asleep.															
11:00	Asleep.									WUP.							
12:00	Lunch	200															
13:00		Asleep.															
14:00	Asleep									UATI							
15:00	Asleep.									WUP							
16:00																	
17:00	Dinner	300								UATI.							
18:00	Water	100								UTT							
19:00																	
20:00																	
21:00	TEA	150															
22:00																	
23:00																	
								*Total Intake							*Total Output		

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

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.

Are any of the risk factors below relevant?

Acute Clinical Condition
- Increasing NEWS Score
- Decreased Urine Output
- Suspected/ Evidence of SIRS/ Sepsis

Excessive Fluid Loss
- Vomiting
- Diarrhoea
- Urine output >200mls/hr
- High output stoma

Clinical Signs of Dehydration
- Dark coloured urine
- Dry Mouth
- Abnormal Urea and Electrolytes

Functional/Cognitive ability to maintain hydration and the requirement to monitor fluid balance
- Dementia
- Muscle Weakness or Trauma.

Underlying condition with high risk of fluid electrolyte imbalance

Commenced or Prescribed IV Fluid Therapy

Commenced or Prescribed Artificial Nutrition Support e.g. Total Parenteral Nutrition, Enteral Nutrition

Routine post operative management

None are applicable or relevant → Reassess daily or if clinical condition changes

One or more are applicable or relevant → Consider commencement of Fluid balance chart*

Able to manage Oral Intake
- Ensure patient is aware of importance of taking fluids
- Identify patient preferences for oral fluids e.g. drinks only tea
- Ensure fluid balance chart is accurately completed at all times
- Use red lid water jug to identify to staff that patient requires fluid intake to be monitored

Unable to manage oral Intake sufficiently
- Ensure review of patient condition by medical staff to consider supplementary fluids e.g. IV fluids.

Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2

3112626230
MCLACHLAN
Michael
M
31/12/1962

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date 18/2/21 Time 11:00 of initial height and weight on admission to hospital		Actual	*Patient reported	*If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height	5ft5 cm	☐	☑	
Admission Weight	62.40 Kg	☑	☐	

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

Patients reported normal weight _____ Unable to Recall ☐

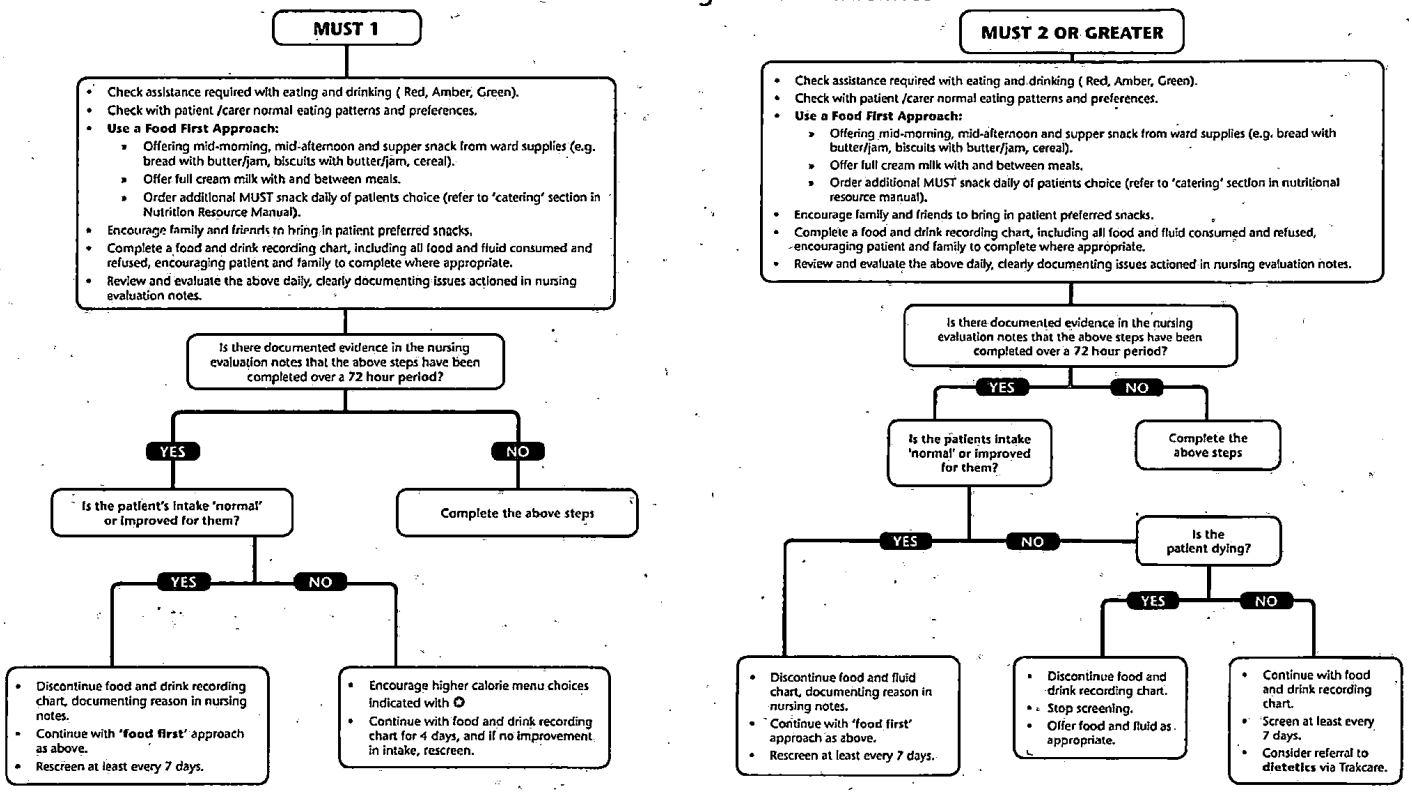
Any unplanned weight loss in the last 6 months Yes ☐ how much_____ No ☐ Don't Know ☐

Date	18/2/21							
Time	11:00							
Ward	11							
Oedema/ Ascities present Y/N	N							
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes	CH							
Weight (kgs)	62.40							
BMI	23							
Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days								
Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	0							
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	0							
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	0							
Step 4 Overall Risk of Malnutrition TOTAL	0							
Rescreen on	25/2/21							
Signature	JM							

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

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

MUST STEP 5 Management Guidelines



DISCHARGE

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

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

m1 • 285884 v3.0 • GGC0250

3112626230
MCLACHLAN M
Michael 31/12/1962

FALLS RISK ASSESSMENT

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

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS
TO BE UNDERTAKEN FOR ALL PATIENTS

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

	Ward: 50/51 Date: 16/12/21 Time: 23:45	Ward: 11 Date: 18/12/21 Time: 08:00	Ward: Date: Time:	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	✓	✓			
2. Check walking aid (if required) is in reach and in use.	N/A	✓			
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	✓	✓			
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	✓	✓			
5. If glasses are worn, check they are available and in use.	N/A	✓			
6. If hearing aid/s are worn, check they are working and in use.	N/A	✓			

RISK ASSESSMENT

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

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

Highlight risk of fall at the ward safety brief.

Patient Details

FALLS INTERVENTIO[illegible] CHECKLIST

NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

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

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

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

atient) Moving and Handling Assessment Form

3112626230

Person Name	MCLACHLAN Michael	M 31/12/1962	Named Nurse:		Person is totally independent (tick here and go to date box)	✓

1. (

Problems with comprehension, behaviour, co-operation (specify):

Weight	Height
Kg	cm
BMI	

Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):

Risk of Falls: Yes ☐ No ☐

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist ☐	Standaid ☐	Walking Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
Model		Aid Type	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist ☐	Standaid ☐	Walking Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information:	

4. Move on / off bed pan

Hoist ☐	Manoeuvre ☐	Assistance ☐	Supervision ☐	N/A ☐
See No 2 Sit to Stand Transfers for details	Roll patient ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information:	
	Monkey pole ☐			
	Independent bridging ☐			

5. Move up / down bed

Hoist ☐	Handling Aids ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details	Sliding sheets ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information:	
	Monkey pole ☐			
	Rope ladder ☐			

6. Lateral Transfer to / from trolley / bed

Hoist ☐	Handling Aids ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify) ☐			

7. Sit up over side of bed

Bed Rest ☐	Assistance ☐	Supervision ☐	Independent ☐
	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment ☐	Handling Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
Shower ☐	Shower chair ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath ☐	Shower trolley ☐			
Bed bath ☐	Bathing hoist (eg Arjo) ☐			

9. Walking

No Walking ☐	Walking Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
	see 'sit to stand transfers'	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:	16/2/21		
Assessor's signature:	R		
Proposed Review date:	23/2/21		

Continuation Sheet

1. General Information (Only complete this section if changed from over page)

Body Build		Problems with comprehension, behaviour, co-operation (specify):
Weight	Height	
Kg	cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
BMI		
Risk of Falls: Yes ☐	No ☐	

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist ☐	Standaid ☐	Walking Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
Model		Aid Type	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist ☐	Standaid ☐	Walking Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information:	

4. Move on / off bed pan

Hoist ☐	Manoeuvre ☐	Assistance ☐	Supervision ☐	N/A ☐
See No 2 Sit to Stand Transfers for details	Roll patient ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information:	
	Monkey pole ☐			
	Person bridges ☐			

5. Move up / down bed

Hoist ☐	Handling Aids ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details	Slicing sheets ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information:	
	Monkey pole ☐			
	Rope ladder ☐			

6. Lateral Transfer to / from trolley / bed

Hoist ☐	Handling Aids ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify) ☐			

7. Sit up over side of bed

Bed Rest ☐	Assistance ☐	Supervision ☐	Independent ☐
	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment ☐	Handling Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
Shower ☐	Shower chair ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath ☐	Shower trolley ☐			
Bed bath ☐	Bathing hoist (eg Aleni) ☐			

9. Walking

No Walking ☐	Walking Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
	see 'sit to stand transfers'	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	4th Assessment	5th Assessment	6th Assessment
Recording Symbol:	☐ / Forward slash	☐ X Where a forward slash exists, add a back slash to make a cross	☐ * Where a slash or cross exists add slashes to make a star
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

3112626230 MCLACHLAN Michael FLAT 1-1 10 GIRVAN STREET Glasgow, Lanarkshire M 31/12/1962 G33 2DP	Hospital: GRI Ward: 50151	Points to consider: • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes.

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

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

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

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
17/2/21	00:00	N	N	N	N	N	N	4 hrly	
18/2/21	00:00	N	N	N	N	N	N	4 hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	

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

Prevention of Pressure Ulcer Interventional Plan

NHS Greater Glasgow and Clyde

Attach Addressograph

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

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

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan: 17/08/21	Check: • Pressure areas 4 hourly. • Skin under medical devices ✓ hourly. • Specify medical devices used:	Specify: • Mattress: Soft foam • Cushion: ✓ • Detail additional pressure redistributing equipment:	• Reposition 4 hourly in bed and chair. • Overnight patient / carer has agreed to repositioning 4 hourly • Specify any manual handling equipment used:	• Skin care to be carried out 4 hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☑	Date discontinued:
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued:
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued:

3112626230
MCLACHLAN
Michael
M
31/12/1962

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NHS
Greater Glasgow and Clyde

AMU

Daily Summary of Fluid Balance

Date	Fluid Balance	Fluid Balance out	Balance	Weight

Fluid balance discontinued : date: by:

Routine Urinalysis

Date							
Bilirubin							
Urobilinogen							
Ketones							
Glucose							
Protein							
Blood							
Nitrite							
pH							
Spec. Grav.							
Leucocytes							
Colour							
Sample(Y/N)							
Comments							
Initial							

Other specimens obtained (eg CPE/MRSA/wound swabs)

Date taken						
Sample						

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

3112626230
MCLACHLAN
Michael
M
31/12/1962

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

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

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed.....

Medical: .....

Date: .....

Glasgow Coma Scale

| | | |

NEWS 2 Key | 1 | 2 | 3

Date 16-2-21 | Time 13:56

A ⇔ B Respirations Breaths/min

≥25	3
21-24	2
12-20	0
9-11	1
≤8	3

A ⇔ B SpO2 Scale 1 Oxygen saturation (%)

≥96	0
94-95	1
92-93	2
≤91	3

SpO2 Scale 2 Oxygen saturation (%) Use Scale 2 if target range is 88-92% e.g. in chronic hypercapnic respiratory failure

Only use scale 2 under direction of qualified clinician

≥97 on O2	3
95-96% on O2	2
93-94% on O2	1
≥93 on air	0
88-92	0
86-87	1
84-85	2
≤83	3

Air or oxygen?

Air (A) or O2 L/min	0
O2 L/min 2	2

C Blood Pressure mmHg (Score uses systolic BP only)

≥220	3
201-219	0
181-200	0
161-180	0
141-160	0
121-140	0
111-120	0
101-110	1
91-100	2
81-90	3
71-80	3
61-70	3
51-60	3
≤50	3

C Pulse Beats/min

≥131	3
121-130	2
111-120	1
101-110	1
91-100	1
81-90	0
71-80	0
61-70	0
51-60	0
41-50	1
31-40	3
≤30	3

D

Any changes in neuro response, do GCS. Immediate medical review. Check Blood Glucose. Think Delirium.

A Alert	0
C New Confusion	3
V Verbal	3
P Pressure	3
U Unresponsive	3

E Temperature

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

NEWS Total

Blood glucose	7.0
Pain / function score	04
Time Pt last passed urine	10.20
Fluid balance chart indicated Y/N	N
GCS indicated Y/N	N
Time NEWS due	23.00
Escalation of care Y / N	N
Initials	AB

Abbreviations for recording oxygen device

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

3112626230
MCLACHLAN
Michael
M
31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

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

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

Think ACE

- **A** Action: Working diagnosis (consider SEPSIS). Consider frequency of observations. Management plan. Set review time. Document.
- **C** Communicate: Inform nurse of plan. Inform senior medic if necessary. Document the discussion.
- **E** Escalate: Document the treatment escalation plan. Should include need for next level of care & consideration of resuscitation status.

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

MEDICINES RECONCILIATION

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

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

DOCTOR'S DECLARATION (if required by Local Protocol)

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

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

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

PATIENT DETAILS

Hosp 3112626230
DOB MCLACHLAN Michael M 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Date Glasgow, Lanarkshire
Con G33 2DP

Height:
Weight:
Surface area:
Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
16/2/21	LORAZEPAM	4mg	IV		A AMRAN	A	1600
16/2/21	HALOPERIDOL	2mg	IV		A AMRAN	A	1610
16/2/21	HALOPERIDOL	3mg	IV		A AMRAN	A	1620
16/2/21	DIAZEPAM	10mg	IV		A AMRAN	A	1625
16/2/21	DIAZEPAM	10mg	IV		A AMRAN	A	1630
16/2/21	HALOPERIDOL	3mg	IV	1915	SA		
16/2/21	LORAZEPAM	4mg	IV	1945	SA	SA	2015
16/2/21	DIAZEPAM	10mg	IV	2200			2200

TARGET OXYGEN SATURATIONS

Please CIRCLE a target saturation and prescribe oxygen on the Regular Prescription section.

94 – 98%	88 – 92% (e.g. in hypercapnic respiratory failure)	Other (please specify)

On Home Oxygen? Yes / No _____ L/min

DATE: ____/____/____ PRESCRIBER (PRINT & SIGN): _____

DATE →
MONTH →

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

IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N

ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N

SIGNATURE OF ASSESSOR

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

Parenteral Drugs : Regular Prescription

Patient's Own Medicine

A

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

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

B

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

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

C

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

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

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

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

D DRUG

DOSE | ROUTE | DATE

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.

Oral and Other Drugs: Regular Prescription

| | | |

Oral and Other Drugs: Regular Prescription

| | | |

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

S 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 ☐

T 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 ☐

V 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 ☐

W 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.

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:

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 ☐

Y 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 ☐

AA 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 ☐

BB 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.

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 →

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

GG DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

HH DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

JJ DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

KK DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

All Routes: As Required Prescriptions

Patient's Own Medicine

| | | |

| | | |

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, 1800.

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

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

7. The following metric unit abbreviations must be used –

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

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

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

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

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

FOR NURSES

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

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

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

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

Codes for Non-Administration of Drugs

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

Cat. No. 40995 Ver 4, 09/2010 GGC0029

Glasgow Royal Infirmary

10

CHI: 3112626230

Total Att: 20

12 Mth Att: 2

Title: **MR**

MCLACHLAN **Michael**

DOB **31/12/1962** Age: **59y** Sex: **Male**

FLAT 1-1
10 GIRVAN STREET
Glasgow
Lanarkshire
G33 2DP
07947416972

Next of kin: **SHERLOCK, Martine**
Relationship: **Niece**

GP: **SJ Bruce**
0141 531 6220

Attendance Date: **29/06/2022** Arrival Time: **17:01**

Registration Time: **17:01** Date of Incident: **29/06/2022**

Major Incident Desc:

Reason for Attendance: **unwell**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **29/06/2022 17:53** Nurse name: **Nurse Edyta Romaniszyn**

Temp	36.3	C
HR	78	bpm
BP	91/63	mmHg
MAP	72.33 /	mmHg
RR	19	bpm
SpO2	92	%
Oxygen		%

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

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

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

Nursing Notes: **"SOB & FEELING GENERALLY UNWELL. NEWS 3. ?chest infection. Hx of COPD, symptoms on going for 10/7, have not seen GP. states has lost a lot of weight. COVID RISK. "**

3112626230 31/12/1962 MCLACHLAN Michael

3112626230 31/12/1962 MCLACHLAN Michael
3112626230 31/12/1962 MCLACHLAN Michael
3112626230 31/12/1962 MCLACHLAN Michael
3112626230 31/12/1962 MCLACHLAN Michael

To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

Date	**Clinical Notes**
	Seen By: Time Seen:

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By

Glasgow Royal Infirmary
Emergency Department

NHS
Greater Glasgow and Clyde

3112626230
MCLACHLAN
Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DF
31/12/1962

Initial Investigations Ordered

FBC ☐	COAG ☐	DD ☐	INR ☐		G+S ☐		X-match units			
U+Es ☐	LFT ☐	GLU ☐	CRP ☐	TROP ☐	Para ☐	Sal ☐	Ethanol ☐	Mg ☐	VBG ☐	ABG ☐
B culture ☐		C/MSSU ☐		Urinalysis ☐		BHCG ☐		Other		
CXR ☐	AXR ☐	Other imaging:								ECG ☐
Current location:								Sent by:		

Clinical Notes

29/6/22 2207 N. Rylatt FY2 EM

59 PC: Unwell
Cough + Fabs

Hx
2/7 of cough - yellow sputum
+ tiny streaks to comb up.
TSOB - SOB eff 10m
(Usually can do ~ 50m)
Argue 2/7 chest tight wise
↑ Sx on time.
Usually freely feverish

VEtD ↓ appetite
PO No N&V pain.
dPU volume
BO - constipated.
No leg swelling / pain
Stable weight loss recently
Lives alone - gets help from family
Nil (E)
No EtOH
Vapes -
No drugs.

By: Alcoholic syndrome
pan self-harm
Drug misuse
Depression
COPD
Long haul
pan drug-ind. psychosis

DH/ECS
Temazepam
Trimbow
Risperidone
Salbutamol
Busulfan - last tx in 16/12/21
Oral omeprazole

Glasgow Royal Infirmary
Emergency Department

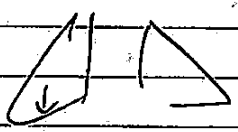
3112626230
MCLACHLAN
Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DF
31/12/1962
M

Clinical Notes

Date	Time	Name	Grade	Speciality

a/e Lads 2 ring's cachelor

OGs
fry—

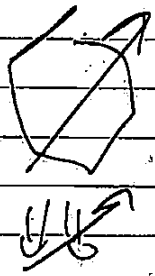


↓ATE
RLZ
¢ cohesn

RR 14 SpO2 92-/.
HR 78 BP 91/63
T 36.3

Hs lt LLTO
pt ~ 80
CRT 3s
dry mark

BP 80/53 on
bolus now 2



ECG:

SR 72, QTc 413
ant wall
ischaem

Imp. 2 CAP — CURB 65 = 1/2
x x✓ x
Low risk

62 Radiguard, but at present CAP likely

Plan
- IV amox
- Await bloods
- IVF
- CXR
- Radial cannula @ present

Glasgow Royal Infirmary
Emergency Department

3112626230
MCLACHLAN
Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DR
M
31/12/1962

Clinical Notes

Date	Time	Name	Grade	Speciality

VBG:
H+ 32 ℓ Na 127 HS 164
pO2 87 K 4.2
pCO2 5.7
HCO3- 31.3 Glu 6.7
Lac 1.3

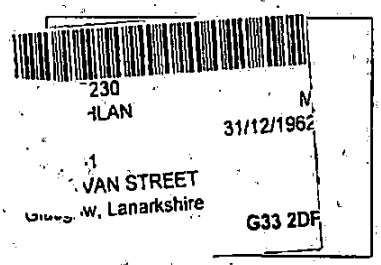
↳ ? chron retention
→ scan 88-92% from now

Bld - Na 136 → ℓ n/v lube
K 4.8 Ba 5 HS 93 (127) on
Cl 100 ASS 81 Mt 503 L 01/22
Ca 2.5 ALT 74 Unc 9.6
Cr 57 ALP 140
CRP 61 Alb 18 PT - 1.3
Bili 27 APTT - 0.9
Glu 6.5

Imp ↑CRP
↓HS
↑LFTs is ? obstruct pattern - no obst pain
? malignancy.

CXR - LLZ opacity. ? consolidation

Glasgow Royal Infirmary
Emergency Department



HAEM	DATE or TIME		BIOCH	DATE or TIME			DATE or TIME		V/ABG	DATE or TIME	
WCC			Na			Bil			FiO_2		
Hb			K			ALT			H^+		
Plat			Cl			AST			$PaCO_2$		
Neut			Ur			GGT			PaO_2		
DD			Creat			A phos			Bic		
PT			eGFR			Alb			BE		
PTT			Glu			AdjCa			Lactate		
TT			CRP			Amyl			Ethanol		
INR			Mg			Tropl HS			Para		
			Phos			BHCG			Sal		

Diagnosis and Plan

Review/Discussed with:

Handover

- ☐ Provisional Diagnosis
- ☐ Liquids/Fluids
- ☐ Analgesic/Medicines



s & Results

ing team/ward

3112626230 M
MCLACHLAN 31/12/1962 1:39:31
Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire G33 2DP

Sample Type: Venous
Account Number:
Clinician:
Operator ID: ROBYN STEWART0

Patient

ID:	3112626230
Last Name:	MCLACHLAN
First Name:	MICHAEL
Gender/Age:	Male, 59 years
Birth Date:	31/12/1962

Cartridge

Lot No.:	220411A
S/N:	00000000500317232
Exp. Date:	04/07/2022

Analyzer

Model:	GEM® *Premier 5000*
Area:	GRI
Name:	CASU
S/N:	16090423

Results			Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)						
cH	33.8	nmol/L	[--	--	--	--]
pCO_2	5.7	kPa	[--	--	--	--]
pO_2	8.7	kPa	[--	--	--	--]
Na^+	↓ 127	mmol/L	[--	133	146	--]
K^+	4.2	mmol/L	[--	3.5	5.3	--]
Cl^-	99	mmol/L	[--	95	108	--]
Ca^{++}	↓ 1.12	mmol/L	[--	1.15	1.27	--]
Glu	↑ 6.7	mmol/L	[--	3.5	6.0	--]
Lac	1.3	mmol/L	[--	0.6	2.2	--]
CO-Oximetry						
tHb	164	g/L	[--	--	--	--]
O_2Hb	↓ 89.0	%	[--	95.0	98.0	--]
COHb	↑ 4.3	%	[--	0.5	1.5	--]
MetHb	0.9	%	[--	0.5	1.5	--]
HHb	↑ 5.9	%	[--	0.0	5.0	--]
sO_2	↓ 93.8	%	[--	95.0	98.0	--]
Derived						
BE(B)	6.8	mmol/L	[--	--	--	--]
$HCO_3^-(c)$	31.3	mmol/L	[--	--	--	--]
Hct(c)	48	%	[--	--	--	--]

↑↓ Outside Reference Ran

Other Information

Operator Entered 37.0

3112626
MCLA
Mi

Ward 46
Short Stay Medicine
HEAD INJURY
Nursing Documentation

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

NHS Greater Glasgow and Clyde

Hospital: GRI	Date: 30/6/22
Time: 0150	Admitting Nurse: KHAN

PATIENT DETAILS CHECKED AND CORRECT	YES	NO	N/A
Patient Name:	✓		
Patient Address:	✓		
Date of Birth:	✓		
Next of Kin Name and Contact Details: Shvonne		✓	
Next of Kin Informed:		✓	
GP Details:	✓		
Religion:		✓	

Presenting Complaint: 7/7 cough, fever

Past Medical History:	Current Medications:
COPD	

Allergies: NKOA

Resp Rate	SpO2	Temp	Pulse	Blood Pressure
17	93 (2l/nc)	36.1	74	96/59
GCS	NEWS	Blood Glucose	ID Band	Interpreter
15	4	—	Y	NA
Height: 5'8	Weight: 9st	MUST:	BMI:	

If BMI <18 commence food chart and refer to dietician ☐

Cognitive impairment - For all patients > 65 years, complete TIME	YES	NO	N/A
			✓

Urinalysis:

If positive obtain MSSU ☐ Date obtained:

Ward 46
Short Stay Medicine
HEAD INJURY
Nursing Documentation

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Peripheral Vascular Catheter (PVC) Bundle

Reason for PVC Insertion:
- ☐ IV Fluids
- ☐ IV Drugs
- ☐ Suspected haemorrhage
- ☐ Diagnostic tests

Insertion Date: __/__/__ IN ED

Insertion Time: ____:____

Hand hygiene performed immediately before PVC insertion.	☐
Skin anticseptic containing 70% isopropyl alcohol used to cleanse the skin and left to dry.	☐
Aseptic technique maintained throughout insertion procedure.	☐
Sterile, transparent, semi pereable dressing used to cover catheter site.	☐

Size/colour: pink Insertion site: (R) hand

Red Flags (Requires escalation/specialist referral/separate Risk Assessments)

Child Protection concern	N	Learning Disabilities	N
Adult Support and Protection	N	Patient has appointed Welfare Guardian/Power of Attorney	N
Confused Patient *(if more confused than baseline, consider DELIRIUM)*	N	Patient has Adult with Incapacity Section 47 certificate in place	N
Substance Misuse	N	Infection Risk	N
Has swallow test been carried out?	N	STOPPS completed?	N
		Falls Risk? *(If at risk, complete full falls Bundle)*	N

Dietry Requirements (Specify): Normal diet & fluid

Pressure Area Assessment

1 Pressure Damage	Does the person have redness and/or existing damage? Yes / (No) If YES, prescribe a minimum of 2 HOURLY Active Care to avoid further damage occuring and complete the pressure ulcer intervention plan (PUDRA Chart).

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

2 Mobility	Does the person require assistance to mobilise?	Yes / (No)
3 Continence	Does the person have continence issues with urine and/or faeces	Yes / (No)
4 Nutrition	Does the person appear malnourished and/or unable to eat or drink	Yes / (No)
5 Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?	Yes / (No)
6 Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:	Yes / (No)

Active Care Plan Commenced ☐

Ward 46
Short Stay Medicine
HEAD INJURY
Infection Risk

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MRSA Screening / CJD / Healthcare outside Scotland

Will the patient be an inpatient >23 hours? ☐ Yes ☑ No If 'Yes' complete the following section.

1. Has the patient ever had a previous positive MRSA result? ☐ Yes ☑ No ☐ Not known
2. Has the patient been admitted from a Care Home/ institutional setting or another hospital? ☐ Yes ☑ No ☐ Not known
3. Does the patient have a wound / ulcer or invasive device which was present prior to this admission? ☐ Yes ☑ No ☐ Not known

If 'Yes' to any of the above questions **OR** if the patient is admitted to a 'high impact speciality' e.g. **Orthopaedics, Vascular, Renal Unit, Critical Care – then obtain MRSA Swabs:**

☐ **Nasal** ☐ **Perineum** ☐ **Other - Specify:** ☐ **Patient refused**

CPE

1. Has the patient been CPE positive? ☐ Yes ☑ No ☐ Not known
2. Has the patient been an inpatient in hospital outwith Scotland in the last 12 months? ☐ Yes ☑ No ☐ Not known
3. Has the patient had dialysis outwith Scotland in the last 12 months? ☐ Yes ☑ No ☐ Not known
4. Has the patient been in close conatct with a person infected with CPE? ☐ Yes ☑ No ☐ Not known

CJD

1. Have you been notified that you are at increased risk of CJD? ☐ Yes ☑ No ☐ Not known

Appropriate Care Plan Used	☐ Yes	☑ No	☐ N/A
Is patient Isolated	☐ Yes	☑ No	☐ N/A

If 'NO' - Reason:

Ward 46
Short Stay Medicine
HEAD INJURY
Nursing Documentation

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Lifestyle

Smoking:
Are you a smoker ☑ ex-smoker ☐ never smoked ☐
If ex-smoker when did they stop? .....
If smoker how many cigarettes per day..Vape.....

If smoker, or recent ex-smoker, would they like to use nicotine replacement therapy to prevent withdrawal discomfort while in hospital? ☐ Yes ☑ No
If smoker, would they like to stop now with the support from stop smoking service? ☐ Yes ☑ No
If Yes refer to Smoking Cessation Service

Drugs: Does the patient use recreational drugs? ☐ Yes ☑ No If 'Yes' specify:

Alcohol (Men): How often do you have 8 or more drinks on one occasion:
☑ Never ☐ Less than monthly
☐ Monthly ☐ Weekly ☐ Daily or almost daily
If 'Monthly' or more then complete FAST Tool.

Alcohol (Women): How often do you have 6 or more drinks on one occasion:
☐ Never ☐ Less than monthly
☐ Monthly ☐ Weekly ☐ Daily or almost daily
If 'Monthly' or more then complete FAST Tool.

Admission Documentation Completed By

Name (Please PRINT): KAYN	Signature:
Designation: S/N	Date: 30/6/22

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☑	Information on discussion with relatives
Belongings (including patients medication)	☑	Always	
New medications explained	☑	☐	
PVC removed	☑	☐	
Relatives aware of Discharge	☑	☐	Please note here if any other tasks required prior to discharge
Social/Support Services required and contacted	☐	☑	
SAS Transport required and ref. no.	☐	☑	Print name
Other means of transport arranged by nurse	☐	☑	
Follow-up organised and explained	☑	☐	F/U CTB

Date: 30/6/22	Signature:

Ward 46
Short Stay Medicine
HEAD INJURY
Nursing Documentation

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	AIM	ASSESSMENT / INTERVENTIONS
1 MONITORING OF VITAL SIGNS Standard observations (BP, P, T, R, SaO_2) - requirement & frequency CSM/Neurovascular observations Special observations eg. blood glucose, peak flow, Neurological obs Special requirements (O_2, chest physio)	To detect abnormalities and maintain optimum function.	obs as per NEWS
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.	PVC chart insitu IV fluids IV abx
3 MAINTAINING SAFETY Level of conciousness Chronic / Acute confusion Alcohol withdrawal Seizures Wandering / at risk of injury	To maintain safety at all times.	Buzzer system explained GCS 15/15
4 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.	independent
5 PRESSURE AREA CARE Waterlow score Interventions	The patients skin will remain healthy and intact.	skin intact
6 PAIN Monitor effectiveness of analgesia - involve patient & medical staff - use of Pain Chart	The patient will state that he is comfortable.	Pain free o/A
7 PERSONAL HYGIENE Self caring or Specify assistance required Mouth care Eye care	To maintain a high standard of personal hygiene. To promote independence.	independent
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 & fluid
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.	Fully Continent

Ward 46

Clinical Notes

Medical ☐ Nursing ☐

Please tick appropriate Directorate

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Date and Time		Signature/ Designation
0150 30/6/22	pt admitted yc 7/7 hx cough yc yellow sputum, ↓ appetite. Bloods obtained, CXR obtained, CRP 61, LFTs deranged. Hb 93, Plt 503. neut 7.4 Glu 6.5. ECG - NSR. Commenced on IV abx. c/A to Ward NEWS (4) SPFTS 93% on 2ltre via N/C. BP 96/59, IV Fluids insitu, IV abx to be prescribed. for rpt bloods mane, however pt states needle phobia. tea and sandwich accepted. no other issues at present	

Ward 46
Clinical Notes
Medical ☐ Nursing ☐
Please tick appropriate Directorate

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Date and Time		Signature/ Designation
30/6/22	Wk6.	
11 hrs		
Wk6.	59 ♂ presents with	
- A CURBON	Yr2 of SOB, productive	
CONS	cough.	
	↓ Oral morphine	
	Subjective fevers	
	Says he has lost	
	significant weight recently.	
	Nov bloods.	
	- Nb 18.	
	CRP 61	
	plt 505	
	Hb 93	
	LFT - mild derangement	
	not clearly obstructive	
	CXR - LUL pneumonia	
	? ↓ hilar prominence	
	OE - Thin	
	Not unwell	
	Not clubbed	
	Bronchial breathing LUZ	
		→

Ward 46

Clinical Notes

Medical ☐ Nursing ☐

Please tick appropriate Directorate

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Date and Time		Signature/ Designation
	(cont)	
	Obs - SpO_2 89% on BP 100/60 T (N)	
	Δ (1) Pneumonia	
	(2) ? Underlying malignancy	
	(3) COPD	
	Plan - Oral Ab	
	- Amox + Clar	
	- Accept SpO_2 88-92	
	- Sputum C+S	
	- Lower screen	
	- Can get (+) but needs OP urgent CT CAP	
	Nursing notes.	A
		A Unrel Cons

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

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Date & Time		Signature, Print Name & Designation
30/6	Nursing Day. All care as planned	
15.30	obs stable. medication given	
	as per hepma. Scale 2	
	for Sats. IFTS deranged.	
	Sputum cts ☐.	
	pt awaiting script.	
	abx then Home following	
	GP CTCAP. IVF last bag	
	running —	JMcf (J)
17.30	pt discharged from ward	
	abx given —	JMcf (J)

83949 GCC0072

10

Emergency Department Nursing Documentation

Presenting Complaint -

Date: 29/6/22 Time: 2050

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Label

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Assessment Complete by: Name NURSE (Please Print)

Patient Prep / Investigations (Please tick/circle when completed)		Communication (Please Circle Tick)	
Prepare patient for examination / Clothing bag labelled + stored	☑	NEWS Chart complete / NEWS SCORE - (Record pain, blood sugar and Neuro Obs on NEWS Chart)	☑
GGC RED BAG - with patient	☐		
12 Lead ECG	☐	ID Band	☐
Weight:	☐	Peak Flow	☐
Blood Samples Obtained: Yes ☐ No ☐		Xrays / CT Scan Performed:	☐
IV Access: Yes ☐ No ☐		Relatives / NOK informed (Carers)	☐
Blood Gas: VBG ☐ ABG ☐		Child Protection Concern (considered in line with policy)	Y/N
		Adult Support and Protection	Y/N

Urinalysis							
	Leucocytes ☐	Nitrites ☐	Protein ☐	Blood ☐
	Ketones ☐	Glucose ☐	PH	S.G.
	MSSU / CSU ☐	Toxiclogy ☐		
	HCG ☐	+VE ☐	-VE ☐	Strip No -

Screening Tools
(Please tick/circle when completed)

SEPSIS RISK? / SIRS Criteria 2 or more	Y/N	**SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)**	YES
Mental Health Triage Assessment	Y/N	If NOT WHY? - (details)	NO
GMAWS	Y/N	Date - Time - Signature -	

4AT

AMT	Correct
Age	
Date of Birth	
Place	
Current year	

Attention (months of year backwards)	
> = 7 correct	0
< 7 correct	1
Untestable	2

Alertness	
Normal	0
Mild sleepiness	0
Clearly abnormal	4

No mistakes	= 0
1 mistake	= 1
> 1 mistake	= 2

Mental status according to family/carer		
Acute change or fluctuating	4	YES
Acute change or fluctuating	0	NO

4AT score

/12

STEP 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?

All over 75s and care home residents over 65. For younger patients use clinical judgement and consult local guidelines.

		YES	NO
F	Functional impairment (new or worsening) eg difficulty with self care		
R	Resident in a care home?		
A	Altered mental state such as acute confusion or dementia use the 4AT		
I	Immobility/instability. New decline in mobility, difficulty mobilising without help or fall leading up to admission		
L	Likely to require support for discharge? (either new or increase in existing support)		

Are any of the above criteria met? If YES to any of the above move to step 2

STEP 2 Would this person be better managed by another specialty team at present?

Indicator for care by another acute specialty regardless of age.

	YES	NO
Clear need for other specialty input eg exacerbation of known long term condition such as COPD		
Need for HDU/ITU (including non-invasive ventilation)		
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit		
Head injury with loss of consciousness		
Acute abdominal pain/surgical presentation		
Upper GI Bleed		
Chest pain with suspected acute coronary syndrome		
Trauma with suspected fracture		

Are any of the above criteria met?

If **YES** to any criteria in step 2:

- Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.

If **NO** to the list in step 2:

- Prioritise transfer of care to specialist geriatric assessment service in line with local guidance.

Screening Tools / ACTIVE CARE

(Please tick/circle when completed)

1) Pressure Damage Does the person have redness and/or existing damage? If YES - continue with a minimum of 2 hourly Active Care + Complete PUDRA		Y/N	Date	Location of Redness/Ulcers	Grade of Ulcer	
				Ind		
2) Mobility	Does the person require assistance?	Y/N				
3) Continence	Ind	Y/N	5) Skin	Is skin compromised by other source, eg neurological deficit, medication, substance, diabetes, co-morbid?		Y/N
4) Nutrition	Ind	Y/N	6) Judgment	In your clinical judgment is this person at risk for developing pressure damage? IF YES - DETAILS		Y/N

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.
29/6/22	2058	OK												

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ph Label

At risk of falls?
(clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc) *At risk complete risk assessment*

YES	NO

Pause for Transfer / Discharge (Please tick when completed)		Tick when completed	N/A	Notes
Relatives Informed of Admission / Discharge		☐	☐	Information on discussion with relatives
Relatives/carer with patient on transfer to ward		☐	Always	
GGC RED BAG - with patient		☐	Always	
Name Band		☐	Always	
Nursing Screening Tools completed		☐	Always	
Bed requested, SBAR COMPLETE		☐	☐	
NEWS chart		☐	Always	
Prescriptions / Charts signed	Infusions	☐	☐	
	Cannula	☐	☐	
Notes: medical notes, GP letter, PRF		☐	☐	
Patients requiring analgesia: sufficient		☐	☐	
Belongings (including patients medication)		☐	Always	Please note here if any other tasks required prior to transfer
SAS Transport required and ref. no.		☐	☐	
Print Name Sign -				

Nursing Notes

Date and Time		Print Name and Signature
29/6/22 2050	SOB/ exac of COPD - ECG ✓ Bloods ✓ Nons (4) awaits VIV. CXR ✓ Obtained ✓ IV fluids ✓ Recannulated IV ✓ Ig Amx ✓.	

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FALLS RISK ASSESSMENT

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

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS
TO BE UNDERTAKEN FOR ALL PATIENTS

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

	Ward: 46 Date: 30/6/22 Time: 02.00	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	✓				
2. Check walking aid (if required) is in reach and in use.	NA				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	✓				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	✓				
5. If glasses are worn, check they are available and in use.	NA				
6. If hearing aid/s are worn, check they are working and in use.	NA				

RISK ASSESSMENT

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

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

Highlight risk of fall at the ward safety brief.

Patient Details

FALLS INTERVENTION CHECKLIST

NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

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

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

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

W 3112626230
N MCLACHLAN
D Michael
W FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

M
31/12/1962 CHI: _____
Address: _____
Hospital: _____

NHS Greater Glasgow and Clyde

Insertion criteria: Please complete this section at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☑ Resuscitation/Chest Pain ☐ IV Drugs ☑ Fluids ☑ Transfusion ☐

PVC inserted: Day 0	Date: 30/6/22 Hospital: GRI Area: ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☐ ____ Unknown ☐ _____
Insertion site:	R Hand ☑ R Arm ☐ R Foot ☐ L Hand ☐ L Arm ☐ L Foot ☐ Other: _____
Colour of cannula:	Blue ☐ Pink ☐ Green ☑ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☑ If No, state reason: Verbal explanation given

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? (Diagnostics, Resuscitation/ Chest Pain, IV Drugs, Fluids, Transfusion)	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 1 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: ___/___/___ Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: ___/___/___

*Reason For Removal: _____

Modified Visual Infusion Phlebitis (VIP) Score

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis : **Observe cannula**
One of the following is evident : slight pain or redness near site	1	Possible first signs : **Observe cannula**
Two or more of the following are evident: pain, redness, swelling	2	Early stage of phlebitis : **Remove & resite cannula**
All of the following are evident: pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: **Remove & resite cannula**
As above including: palpable venous cord	4	**Seek further advice**
As above including: pyrexia	5	

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and S. aureus bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids ? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → Can I switch my patient from IV to oral antibiotics?

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature ≤ 37.9°C, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE is available reliably** (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, S. aureus bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abcess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy. Record the intended duration on the medicine kardex

YES → This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

NO

Care Rounds Checklist

Date: 30/6/22

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

1. Signed S/N Name KARK IC Designation S/N
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Att 3112628230 MCLACHLAN Michael M 31/12/1962

War

NHS Greater Glasgow and Clyde

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

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

		Times	0800	0830	0900	1300	1500															
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N															
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N															
S	3	**SKIN INSPECTION** Pressure areas checked:	I	I	I	I	I															
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	–	–	–	–	–															
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	I	I	I	I															
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	C	B	B	B	B															
		Chair Assist to walk or stand (W/ST)		–	–	–	–															
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	I	I	I	I															
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N															
		Drink taken?	Y	N	Y	NT	Y															
		Food, snack, or supplement taken?	Y	N	Y	Y	Y															
		Has oral hygiene been carried out as per care plan?	I	I	I	I	I															
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y															
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	Y	NT	N	N															
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA															
		Care provider / role		NA	NA	IC	IC															

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

3112626230
MCLACHLAN M
Michael 31/12/1962 D
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name: R-Bryce	
Dr/ANP initials ONLY:	Dr/ANP initials ONLY:	
Date:	Date: 29/6/22	

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed.....

Medical:.....

Date:.....

Pupil Reaction and size: s = sluggish, + = reaction, o = no reaction, c = eyes closed. Pupil Size (mm): 1 2 3 4 5 6 7 8

Affix Patient ID

Glasgow Coma Scale

| | | |

Affix Patient ID

3112626230
MCLACHLAN
Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP
M
31/12/1952

NEWS 2 Key | 1 | 2 | 3

| | | |

MEDICINE **PRESCRIPTION FORM**

Hospital Name: .....

MEDICINES RECONCILIATION

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

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

DOCTOR'S DECLARATION (If required by Local Protocol)

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

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

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

PATIENT DETAILS

Hospital Number: 
3112626230
DOB: MCLACHLAN Michael FLAT 1-1 10 GIRVAN STREET Glasgow, Lanarkshire G33 2DP M 31/12/1962
Date of Admission
Consultant Name:
e area:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
24/6	Amoxicillin	1g	IV	2227		88/102	22

TARGET OXYGEN SATURATIONS

Please CIRCLE a target saturation and prescribe oxygen on the Regular Prescription section.

94 – 98%	88– 92% (e.g. in hypercapnic respiratory failure)	Other (please specify)

On Home Oxygen? Yes / No _____ L/min

DATE: _____/_____/_____ PRESCRIBER (PRINT & SIGN): _____

DATE →
MONTH →

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

IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N

ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N

SIGNATURE OF ASSESSOR

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

Parenteral Drugs : Regular Prescription

Patient's Own Medicine

| | | |

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

| | | |

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.

H

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

J

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

K

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

L

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

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

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

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

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

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

S | 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 ☐

T | 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 ☐

V | 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 ☐

W | DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

X 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 ☐

Y 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 ☐

AA 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 ☐

BB 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.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

CC DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

DD DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

EE DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

FF DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

GG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

HH

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

JJ

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

KK

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

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.

All Routes: As Required Prescriptions

| | | |

Patient's Own Medicine

| | | |

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, 1800.

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

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

7. The following metric unit abbreviations must be used –

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

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

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

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

Please note - intrathecal must be written in full.

FOR NURSES

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

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

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

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

Codes for Non-Administration of Drugs

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

Cat. No. 40995 Ver 4, 09/2010 GGC0029

Patient name: 3112626230 M
Date of birth: MCLACHLAN 31/12/1962
CHI No:..... Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DF

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg) ..... Height (cm) .....

Prescription details									Administration details				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional Instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments
29/6	2200	Hartmann's	500	IV	30				29/6	2245	N		
29/6	2235	Hartmann's	500	IV	10				30/6	01 38	[illegible]		
29/6	0010	Hartmann's	500	IV	20				30/6	03 15	[illegible]		22D20T4G 03/2024
29/6	0050	Hartmann's	500	IV	40				30/6	05 30	[illegible]		
30/6		HARTMANNS	500	IV	4?				30/6	10 30	JH		

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow (drops/min) = Volume of fluid (ml) x 20 / Duration of admin (min)

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued

Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional Instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)
		HARTMANN'S	500	IV	6°			

Administration details - continued

Date	Time	Given by	Checked by	Comments
30/6/22	12.00	JI		

*Prescriber should sign this box if the fluid/additive is no longer required.

Inpatient prescription & administration record for Michael McLachlan (3112626230)

01:00
02/07/22

Admission: 30/06/2022 => 30/06/2022

Patient Demographics

MCLACHLAN Michael (3112626230)
DOB: 31/12/1962
Flat 1-1, 10 Girvan Street,
Glasgow,
Lanarksh,
G33 2DP

Admitted: 30/06/2022 02:14
Discharged: 30/06/2022 16:55

Transfer history

Admission	2022-06-29 17:02:00	RAE GRI ED
Transfer	2022-06-30 02:14:00	R46 GRI WARD 46

Responsible Consultant history

Assigned No Consultant 30/06/22 02:14

Allergy

Admission Allergy Check performed by: Judith Fleming
Current recorded allergy (reaction): No Known Drug Allergies

AMOXICILLIN 500 mg Capsules

☐	30/06/22 22:00	500 mg THREE times daily - 7am;12pm;10pm (Oral)	Judith Fleming
☒	30/06/22 13:30	500 mg (Oral)	Judith Fleming

30/06/22 13:30 — 30/06/2022 13:35 — Jannat Latif

CLARITHROMYCIN 500 mg Tablets

☒	30/06/22 22:00	500 mg TWICE daily at 7am and 10pm (Oral)	Judith Fleming
☒	30/06/22 13:31	500 mg (Oral)	Judith Fleming

30/06/22 13:31 — 30/06/2022 13:35 — Jannat Latif

RISPERIDONE 2 mg Tablets

☒	30/06/22 22:00	2 mg ONCE daily at 10pm (Oral)	Judith Fleming

TAMSULOSIN 400 micrograms Modified Release Capsules

☒	01/07/22 07:00	400 microgram ONCE daily at 7am (Oral)	Judith Fleming

TOLTERODINE 4 mg Modified Release Capsules

☒	01/07/22 08:00	4 mg ONCE daily at 8am (Oral)	Judith Fleming

TRIMBOW 87mcg/5mcg/9mcg per metered inhal. Aerosol Inhaler

☒	30/06/22 22:00	2 Puff(s) TWICE daily at 7am and 10pm (Inhalation)	Judith Fleming

PARACETAMOL 500 mg Tablets as required

☐	30/06/22 13:13	1,000 mg FOUR times daily - 7am;12pm;5pm;10pm (Oral) FOR PAIN	Judith Fleming

SALBUTAMOL 100 micrograms (EASYHALER) Dry Powder Inhaler as required

☒	30/06/22 13:12	200 microgram (Inhalation) FOR BREATHLESSNESS	Judith Fleming

Key: Prescription details | Recorded as "Admitted On" | Prescribed as "Self Administer" | Discontinuation details | HEPMA Prescription additional notes | HEPMA Patient admission notes (admission specific) | HEPMA Patient retained notes (not specific to admission)

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Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, NHS Ayrshire & Arran and NHS Greater Glasgow & Clyde

HEPMA MAP v1.0

MICHAEL MCLACHLAN

Scottish Ambulance Service

Age/Gender:	63 Years, 2 Months, 17 Days, Male
DOB:	31/12/1962
Address:	1/1 10 GIRVAN STREET RIDDRIE GLASGOW, G33 2DP
CHI Number:	
Ethnicity:	White Scottish
Incident Date:	17/03/2026 11:43:00
ePCR Number:	7-2-170326-114317
Incident Number:	CR013055810
Incident Type:	EMG
Incident Location:	1/1 10 GIRVAN STREET RIDDRIE GLASGOW, G33 2DP

PATIENT INFO

ADDITIONAL COMMENTS

Presenting Complaint:	?kidney stones

Timestamp	Additional Comment	Crew Name
17/03/2026 12:28:00	999 call for 63yo male c.o 3 day hx of ?kidney stone pain worsening today. Vomiting for 3 days unable to keep fluids down. Not able to pass urine for 3 days. not slept, states pain worse today. Cant keep any meds down. o.A gcs15 alert to crew. Obs as staled. Pyrexia 39 but can't take paracetamol. Nil tx as double tech crew. Transfered to gri for further assessment.	

ACVPU

Options:	Alert

CATASTROPHIC HAEMORRHAGE

Catastrophic Haemorrhage:	No

AIRWAY

Assessment:	Clear

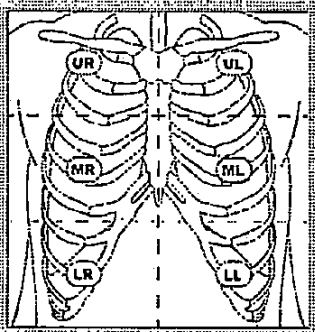
BREATHING

Breathing Adequately:	No	Initial Respiratory Rate:	16
Initial SpO2:	93	Initial SpO2 On Air:	Yes

Chest Examination

Chest Signs/Sounds:	Cough

Anterior

Normal Percussion, Normal Breath Sounds, Normal Air Entry	UR		UL	Normal Percussion, Normal Breath Sounds, Normal Air Entry
Normal Percussion, Normal Breath Sounds, Normal Air Entry	MR		ML	Normal Percussion, Normal Breath Sounds, Normal Air Entry
Normal Percussion, Normal Breath Sounds, Normal Air Entry	LR		LL	Normal Percussion, Normal Breath Sounds, Normal Air Entry

Tension Pneumothorax

Tension Pneumothorax Suspected:	No

CIRCULATION

Pulse Rate:	98	**Rhythm:**	Reg
Cap Refill:	<=2 Secs	**Central Peripheral:**	Central
Arm:	Right	**Systolic Pressure:**	146
Diastolic Pressure:	81	**ECG:**	3 Lead

Rhythm

Rhythm:	**Sinus Rhythm**

Skin

Appearance:	Normal	**Skin Texture:**	Dry
Skin Temperature:		**Warm**	

DISABILITY

Initial GCS:

Timestamp	Eyes Value	Eyes Score	Voice Value	Voice Score	Motor Value	Motor Score	Final Score
17/03/2026 12:12:00	Spontaneously	4	Orientated	5	Obeys Commands	6	15

Eyes

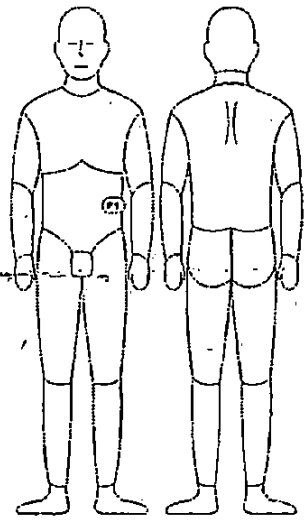
Left Pupil Size (Mm):	3	**Right Pupil Size (Mm):**	3
Pupils Equal And Reactive To Light (Pearl):		**Yes**	

Blood Glucose

Blood Sugar Value (MMOL/L):	9.9

EXAMINATION

Assessment Graphic



Pain Table

ID	Pain Scale	Body Part
P1	10	Abdomen

OBSERVATIONS

Observations Assessment

Timestamp	Pulse	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	Temp	BM	ECG	P(L | R)	PEF	Crew
[illegible]	[illegible]			4	[illegible]		[illegible]					9		J2

NEWS Score

Timestamp	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
17/03/2026 12:13:00	16 (0)	-	93 (0)	0	146 (0)	98 (1)	Alert (0)	39 (1)	2

AMPLE

Allergies:	**None**

Respiratory Disease

Type:	**COPD**

Other

Other:	**Prev kidney stones**

Last Eaten

Last Eaten:	**>4 Hours Ago**

Events Prior

Events Prior:	**3 day hx of left sided abdo pain, prev kidney stones**

SOCIAL HISTORY

General Appearance:	**Normal, Frail**

Living Arrangement

Lives Alone:	**No**

Mobility

Patient Mobility:	**Fully Mobile**

Communication

Communication Requirements:	**No Help Required**

Clinical Risks

Factors:	**None Identified**

CLOSE REPORT

CHI: 3112626230

Glasgow Royal Infirmary

10

Total Att: 25

12 Mth Att: 1

Title: MR

MCLACHLAN Michael

DOB: 31/12/1962 Age: 63y Sex: Male

FLAT 1-1
10 GIRVAN STREET
Glasgow
Lanarkshire
G33 2DP
07947416972

Next of kin: SAME, Ashleigh
Relationship: Daughter
07935123332

GP: K Walker
0141 531 6220

Attendance Date: 17/03/2026 Arrival Time: 12:32

Registration Time: 12:32 Date of Incident: 17/03/2026

Major Incident Desc:

Reason for Attendance: **Kidney stones**

Nursing Assessment

Alerts: Not Recorded Allergies: None Known Pain Score:

Triage Category: 3 Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 17/03/2026 13:29 Nurse name: Nurse Ruby Baxter

RR	18	bpm
Oxygen		%
Air or O2		
SpO2	93	%
HR	77	bpm
BP	139/70	mmHg
CRT		
MAP	93	mmHg
AVPU		
Temp	37.7	C
EWS Total		

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

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

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

Nursing Notes: **ABDO PAIN/ FLANK PAIN NEWs 2 3/7 hx vomiting, L sided abdo pain and L flank pain. States hasn't PU for 3/7. Not eating and drinking, unable to keep anything down. Pyrexia w SAS. PMH kidney stones, enlarged liver, pancreatitis, COPD**

3112626230 31/12/1962 MCLACHLAN Michael
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3112626230 31/12/1962 MCLACHLAN Michael

To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

Date	**Clinical Notes**
	Seen By: Time Seen:

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By
17/03/26	DICLOFENAC	100mg	PR	1654		EM
17/03/26	ONDANSETRON	4mg	ORAL	1654		EM

Patient name

Patient CHI

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

NHS
Greater Glasgow and Clyde

Emergency Care Nursing Documentation

Initial Investigations

Initial when complete	Required?		Init		Required?		Init
Patient prepared for exam	Y	N		Pain score	Y	N	
NEWS/MEWS/ PEWS chart	Y	N		Peak flow	Y	N	
ID Band	Y	N		MSSU Results:			
12-Lead ECG	Y	N					
Blood samples	Y	N					
Blood Gas	Y	N					
Viral Swab	Y	N		B-HCG	+ve	-ve	

Communication

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

name,relationship, location, particular concerns

Signature:

PVC	Diagnostic Resuscitation Intravenous Fluids Transfusion	Insertion	Insertion Side: L R	Size of PVC:	Inserted by
Circle reason: D R I F T		Date: Time:	Insertion Site:		Signature

Hand Hygiene Yes ☐	Skin Decontamination 2% chlorhexidine in 70% isopropyl alcohol Yes ☐	Sterile transparent semi-permeable dressing affixed Yes ☐	PVC Reason Explained Yes ☐

Risk Assessments and Screening Tools				Required?		Init		Required?		Init
			SEPSIS	Y	N		GMAWS	Y	N	
FAST +VE	Y	N	STOPPS	Y	N		Public Protection Concern (Adult/Child)	Y	N	
			ED Falls Risk Assessment	Y	N		Notification of Concern Completed (NOC)	Y	N	
			Mental Health Triage Assessment	Y	N		Frailty Assessment Completed	Y	N	
			Ligature low room	Y	N		4AT Assessment	Y	N	

Pause for Discharge

GGC Red Bag with Patient (nursing home resident)	Y	N
Relatives / Carer with Patient	Y	N
Name Band Removed	Y	N
Risk Assessment/Screening Tools Completed	Y	N
Discharge Information	Y	N
NEWS Chart completed within 1 hour of discharge	Y	N
Medications/Fluids prescribed as per medication prescription form	Y	N
Notes Complete	Y	N
Belongings	Y	N
Transport arranged	Y	N
Own/Taxi/Relative/SAS (Please circle)	Y	N
PVC Removed Prior to Discharge	Y	N

Signature:

Pause for Transfer

GGC Red Bag with Patient (nursing home resident)	Y	N
Relatives / Carer with Patient	Y	N
Name Band in situ	Y	N
Risk Assessment/Screening Tools Complete	Y	N
Bed Available	Y	N
SBAR complete	Y	N
NEWS Chart completed within 1 hour of transfer	Y	N
Medications/Fluids prescribed as per medication prescription form	Y	N
PVC/CVC Bundle	Y	N
Notes Complete	Y	N
Belongings	Y	N
Escort Required	Y	N

Signature:

Patient name

Patient C

3112626230
MCLACHLAN M
2 Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

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Care Rounds Checklist

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

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

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

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

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

Patient name .....

Patient

3112626230 M
MCLACHLAN 31/12/1962
Michael

NHS
Greater Glasgow and Clyde

Nursing notes

Date and Time		Name/Signature
17/3/26 16[14]	Abdo pain/flank pain. Vomiting (L) sided abdo pain and (L) flank pain. Not PU for 3/7. Unable to keep anything down. At CI.	
	A/w cubicle space ———	S Lisn
19[13]	Bloods obtained prior to cubicle space allocation.	
	Pt awaits medical r/v	[illegible]
	Nil complaints from pt	A Dobson
19[58]	Afe sandwich nil vomitty at present.	[illegible]
21:12	Declined drink and sandwich	Tew
00·40	Pt pyrexic declined paracetamol	S.Wilson SN Samantha Wells

Patient name .....

Patient CHI .....

or use sticker

NHS
Greater Glasgow and Clyde

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

Ongoing Care

	4 Hours	5 Hours	6 Hours	7 Hours	8 Hours	9 Hours	10 Hours	11 Hours	12 Hours
Time									
Nursing notes updated including (NEWS, MEWS,PEWS)									
Food, Fluid, Nutrition (provide details)									
IVI/IVABs									
Routine Medications prescribed and administered									
Falls risk assessment reviewed/checklist									
Skin assessed and supported (PURDRA)									
Pain assessment									
SBAR up to date and completed									
Patient/ relatives updated									
If patient not in cubicle space think about patients dignity requirements eg hearing aids, mobility aids, glasses, interpreter									
STOPPS completed									
PVC/CVC Bundle. Consider is; Dressing intact? PVC patent?									Commence CVC/PVC chart

Patient name .....

Patient CHI .....

or use sticker

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

NHS Greater Glasgow and Clyde

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

Pressure damage	No RISK ↓	At RISK ↓	Grade 1 – non blanching skin Grade 2,3,4, suspected deep tissue injury (SDTI), ungradable pressure ulcer, Moisture Associate Skin Damage (MASD) ↓	Device Related Pressure Damage i.e. nasogastric, catheters, oxygen tubing ↓
YOU MUST CHECK SKIN over pressure points	Daily skin check	4 hourly positioning Complete SSKINS care plan (below)	2 hourly positioning with skin checks, Complete SSKINS care plan (below)	All devices need a SSKINS care plan (below)

1	PressureDamage	Does the person have Pressure damage; Grade 1, 2, 3, 4, SDTI, Ungradable?
2	Mobility	Does the person require assistance to mobilise or change position?
3	Continence	Does the person have moisture issues, or, continence issues with urine and/or faeces?
4	Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5	Skin	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6	Judgement	In your clinical judgement, is this person at risk of developing pressure damage?

Date	Location of pressure damage	Grade of ulcer	Date	Location of pressure damage	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

If NO to all questions, continue Care Rounds Prescribed as assessed for individual need and re-assess daily.
If you have answered YES to any of the questions above, please complete the SSKINS care plan below.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Check Skin	Signature
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used: Catheter ☐ Naso gastric ☐ Oxygen mask ☐ Nasal oxygen ☐ Vascular Access Device ☐ Off loading boot ☐ Other:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment: Off loading boot: ☐ Protective product:	• Reposition ____ hourly in bed. • Reposition ____ hourly in chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used: Tilting device ☐ • Knee bend in place ☐ Record reason for no knee bend:	• Does patient have Moisture Associated Skin Damage Yes ☐ • Skin care to be carried out ____ hourly. • Specify products required for increased moisture / continence management: Barrier Cream ☐ Pad / Pants ☐	• Optimise nutrition and hydration. • Refer to MUST	• Provide information in a format appropriate to patient / family/ carer needs : • Specify: Leaflet ☐ Verbal ☐ Not provided record reason:	Date discontinued:

Patient name .....

Patient CHI .....

or use sticker

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Greater Glasgow and Clyde

Nursing notes cont.

Date and Time		Name/Signature

Glasgow Royal Infirmary
Emergency Department

NHS
Greater Glasgow and Clyde

3112626230
MCLACHLAN
Michael 31/12/196
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2D

Initial Investigations Ordered

FBC ☐	COAG ☐	DD ☐	INR ☐		G+S ☐		X-match	units		
U+Es ☐	LFT ☐	GLU ☐	CRP ☐	TROP ☐	Para ☐	Sal ☐	Ethanol ☐	Mg ☐	VBG ☐	ABG ☐
B culture ☐		C/MSSU ☐		Urinalysis ☐		BHCG ☐		Other		
CXR ☐	AXR ☐	Other imaging:								ECG ☐
Current location:								Sent by:		

Clinical Notes

Date	Time	Name	Grade	Speciality
17/3	2150	Breonna	FHO	Locum GP

63 F 3/7 of worsening abdominal pain. Stab sensation ↓ side (Mark) now diffuse.
Nausea + vomiting, unable to tolerate food or fluids.
↓ urine output ocp → started passing urine
Bowel symptoms, some SOB + cough; No sputum
Haematuria's

PMH: Rheumatoid Arthritis
Depression
Epilepsy
COPD
Dry mouth
Pneumonia

Meds: Risperidone
Tramadol
Tamsulosin
Creon

Allergies: Nil

Glasgow Royal Infirmary
Emergency Department

Patient Name
DoB
CHI Number

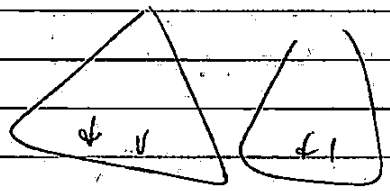
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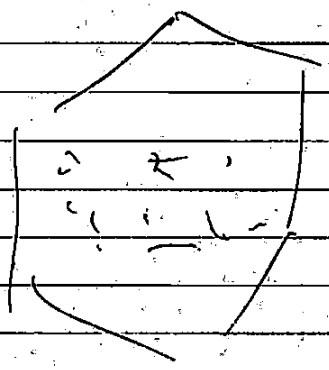
Clinical Notes

Date	Time	Name	Grade	Speciality

OIE

HS 1+140 ↓ creeps, worn
Pephers pulm regur no delay

Chest -  quiet chest

Abdo -  diffuse tenders guarding percuss tenders Bistre

calm SpT

OBS - PU7, sats 93% on, HR 77
BP 139/70, temp 37.7

temp 39 with SATS

GCS 15/15
Visibly sweaty and uncomfortable

VBG - pH 7.35, lactate 1.

Glasgow Royal Infirmary
Emergency Department

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

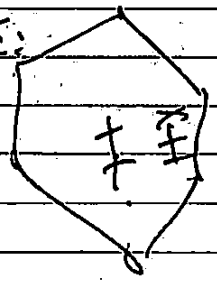
Clinical Notes

Date	Time	Name	Grade	Speciality
17/3/26	2350	LThompson	CT2	Urology

63M
3/7 Hx ⓒ loin pain
rigors vomited
Deteriorated on ward

DM
COPD
Chronic pain
ETOH
Drug misuse

OE:



Tender over
ⓒ abdomen
+ loin

Temp 38.0 in ambulance

CTAP 17/03:
5mm ⓒ in proximal ureter
3mm ⓒ non obstructive renal calculus
Likely community pyelonephritis

WCC 30 Lactate 1
CRP 182 eGFR 59

Grade 2 COPD given Resp Physio letter 2022
Pt states can manage flight of stairs
and volunteers with homeless
Previously able to have Lap chole done
to COPD

Imp: Infected obstruction 5mm ⓒ proximal
ureteric stone
Plan: DW J Nash and Urology agreement with below
1) Blood cultures sent (+)
2) IV Cefuroxime + Augmentin 3) DW anaesthetics for RV
4) VTE prophylaxis 5) Keep fasted prior to Ⓒ ureteric stent

Glasgow Royal Infirmary
Emergency Department

Patient Name
DoB
CHI Number

or affix label

HAEM	DATE or TIME		BIOCH	DATE or TIME			DATE or TIME		V/ABG	DATE or TIME	
WCC	30.7		Na	139		Bil	10		FiO_2		
Hb	134		K	5.1		ALT	21		H+		
Plat	282		Cl	103		AST	NA		$PaCO_2$		
Neut	28.6		Ur	9		GGT			PaO_2		
DD			Creat	100		A phos	103		Bic	27	
PT			eGFR	59		Alb	32		BE		
PTT			Glu	8.1		AdjCa			Lactate		
TT			CRP	182		Amyl	56		Ethanol		
INR			Mg			TropI HS			Para		
			Phos			BHCG			Sal		

Diagnosis and Plan

Sepsis
→ ? Source Abdo / chest

IV can
Bloods
CTAP → (L) obstructive renal stone.
CXR → clear - ? ? small to prevent
Cultures

Review/Discussed with:

Plan urology on call
→ Amoxil, Gentamicin
with renal, consultant
Rad. in ED. ? for theatre
tonight

Handover

- ☐ Provisional Diagnosis
- ☐ Liquids/Fluids
- ☐ Analgesic/Medicines
- ☐ NEWS
- ☐ Investigations & Results
- ☐ Talk to receiving team/ward

mi • 287967 Version 1_0 • GGC0226

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire.
G33 2DP

Date & Time		Signature, Print Name & Designation
	WR McKay	
18/3/26	Stent inserted overnight NEWS 3	
08:45	On Amox + Gent	
	Feeling bloated	
	P/ cont ABx + IVF	M Stat
	Stent out today	
18/3/26	M Stewart FY1	
	As per community addictions team	
	22mg diazepam per day	
	Divided dose	
	6mg Morning	
	8mg Lunch	
	8mg Evening	M Stat
19/3/26	WR - McKay	
	ASeptic stone - stent 1/3	
	Note rise in WCC	
	Remains stable - no temp spikes	
	Plan/ CPs IV amox + gent	
	Daily bloods	
	Resident to take on	
	morpeem if deteriorates	ES.

Date & Time		Signature, Print Name & Designation
19/3/26	M. Gowan CT1- Urology	
13:10		
	DW microbiology	
	↳ Enterococcus isolated in BCs.	
	CRP rise to 460 today	
	Advice as follows:	
	- Stop amox + gent	
	- Start meropenem	
	- Likely for 7 days abx	
	starting from today (Stop date 26/3)	
	- Consider IVOST day 4-5, but	
	can re-contact micro for advice	
	if needed.	CT1
20/3/26	WR Ward	
	WCC - 28.5	Δ Obstructing calculus
	eGFR - 56	ⓐ ureteric stent (18/3-
	CRP - 460	
	(P) → Cont IV abx.	
	→ Cont fluids. over rehand	

NHS GREATER GLASGOW & CLYDE

CLI 3112626230 MCLACHLAN Michael M 31/12/1962 EDICAL ☐
FLAT 1-1 URSING ☐
10 GIRVAN STREET
Glasgow, Lanarkshire ite directorate
G33 2DP

3112626230
Michael
Mclachlan

Date & Time		Signature, Print Name & Designation
	URE Ar Left	
21/3/22	Pt not at bedside	Bloods improved
0900hrs		WCC: 16
		CRP: 300(s)
	Plan: Contin IVT	
	Contin IV Abx	
	URE Ar Left	
22/3/22		
0900hrs	Pt not at bedside	
	Bloods improving	
	Plan: IV. Abx	
22/03	M Stewart FY1	
1630	Diazepam regime changed as per	
	patient request - Finding 8mg too	
	strong	
	Prev 6mg + 8mg + 8mg	
	Now 5mg + 5mg + 6mg + 6mg	M Stewart
	22mg Daily total	

83949 GGC0072

Date & Time		Signature, Print Name & Designation
	WR Rhodhouin	
23/3/26		
	NEWS - 0	
	Not opening bowels	
	→ Laxatives.	
	IP. → Glycerol suppositories	
	→ Abdo x-ray ? dilated bowel loops	
	→ IVOST to co-trimoxazole.	
	from IV abx.	
		N. Chua
		CO F.
23/3/26	Abdo XR - A. GREWAL FY1	
	Appearances of dilated bowel loops, similar to CTAP 17103126. Reviewed with SHO Nayanakin	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☑
NURSING ☐

Please tick ✔ appropriate directorate

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Date & Time		Signature, Print Name & Designation

Ward Round - Ward 70 Urology

NHS

Date: 24/3/26 Time: 9:00

Ward Round Lead: Mr Tolhurst News Score: 0

Diagnosis: Septic Stone Pain Score:

☐ Fluid Balance- 24hrs ..... Is Oxygen Required?

Radiology Required N/A ☐

Drug Kardex Reviewed ☑

MED RECS ☐

Delirium/4AT Score ☐

Microbiology Sensitive to trimethoprim ☑

VTE Up to Date ☑

Bloods Reviewed ☑

Treatment Escalation/DNACPR Full escalation ☐

Plan:

On oral Co-trim

No temp stent

(P) (A) today.

Signature:

Status: M. Gkrin GI

mli • 310671

83949 GCC0072

Care Rounds Checklist

Date: 181326

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

1. Signed EGBride Name EMGBRIDE Designation BN
2. Signed Aman Name Amandeep Kaur Designation STIN
3. Signed Kjumper Name Karen Jumper Designation JW

Attach Add
3112626230
MCLACHLAN Michael M 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP
Ward: 70

NHS Greater Glasgow and Clyde

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

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

		Times	04 00	06 00	08 00	10 15	12 20	14 25	16 30	18 30
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N	N	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N	N	N
S	3	**SKIN INSPECTION** Pressure areas checked:	Y	Y	Y	Y	Y	Y	Y	Y
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	R	R	R	R	R	R	R	R
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y	Y	Y	Y
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B	B	B	B	R	L	B	R
		Chair Assist to walk or stand (W/ST)			-					/
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	C	C	C	C	C	C	C	C
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N	N	N
		Drink taken?	Y	Y	Y	N	Y	Y	N	Y
		Food, snack, or supplement taken?	N	N	Y	N	N	Y	N	Y
		Has oral hygiene been carried out as per care plan?	N	N	-	N	N	-	N	Y
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	NT	NT	NT	NT	NT	NT
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA	NA	NA	NA
		Care provider / role	EMB BN	KJ	KJ	KJ	KJ	KJ	KJ	KJ

Care Rounds Checklist

Date: 19/3/26

Attach Ad

3112626230
MCLACHLAN
Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP
M
31/12/1962

Ward: 70

NHS Greater Glasgow and Clyde

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

1. Signed [signature] Name Joanne Jempson Designation JW
2. Signed [signature] Name [illegible] Designation CW
3. Signed _____ Name _____ Designation _____

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

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

		Times	06	08 05	10 20	12 25	14 30	16 35	18 40	20 00	22 25									
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	N									
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	N									
S	3	**SKIN INSPECTION** Pressure areas checked:	Y	Y	Y	Y	Y	Y	Y	Y	Y									
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	R	R	R	R	R	R	R	R	R									
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y	Y	Y	Y	Y									
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	L	B	L	L	K	B	L	R	L									
		Chair Assist to walk or stand (W/ST)	Com																	
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	C	C	NT	NT	INCONT	NT	A	—	A									
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N	N	N	N									
		Drink taken?	N	Y	Y	Y	N	Y	N	N	N									
		Food, snack, or supplement taken?	N	N	N	N	N	N	N	N	N									
		Has oral hygiene been carried out as per care plan?	N	N	N	N	N	N	N	N	N									
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y	Y	Y	Y									
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	NT	NT	NT	NT	NT	NT	NT									
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA	NA	NA	NA	NA									
-		**Care provider / role**	RN	RN	RN	RN	RN	RN	RN	RN	RN									

Care Rounds Checklist

Date: 20/3/26

Attach

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Ward: Glasgow, Lanarkshire
G33 2DP

NHS Greater Glasgow and Clyde

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

1. Signed PMutchell Name Pamela Mutchen Designation SN
2. Signed KOonnelly Name KOONNELLY Designation SN
3. Signed _____ Name _____ Designation _____

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

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

		Times	06	10	14	18	22	02	06	08 30	10 20	12 40	15 40	15 15	17	19	20 23						
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	N	O	N	N	N	N	N						
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	Y	Y	O	Y	Y	O	Y	Y	Y	Y	N						
S	3	**SKIN INSPECTION** Pressure areas checked:	Y	Y	Y	Y	N	N	O	N	N	O	N	Y	Y	Y	Y						
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	R	R	R	R	—	—	O	—	R	R	L	R									
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y	Y	O	Y	Y	O	Y	Y	Y	Y	Y						
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B	L	R	B	B	B	O	B	B	O	L	B	B	B	B						
		Chair Assist to walk or stand (W/ST)																					
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	A	A	A	A	—	—	O	—	—	O	B	—	N	N	I						
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N	O	N	N	O	N	N	N	N	N						
		Drink taken?	N	—	N	N	Y	Y	O	Y	Y	O	Y	Y	Y	Y	Y						
		Food, snack, or supplement taken?	N	—	N	N	N	N	O	N	N	O	N	N	Y	N	N						
		Has oral hygiene been carried out as per care plan?	N	—	N	N	N	N	O	N	N	O	N	N	N	N	N						
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y	O	Y	Y	O	Y	Y	Y	Y	Y						
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	M	M	M	M	NT	NT	O	NT	NT	O	NT	NT	NT	NT	M						
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA	NA	O	NA	NA	O	NA	NA	NA	NA	NA						
		Care provider / role	KM	KM	KM	KM	LJ	LJ	AA	LJ	LJ	AA	LJ	LJ	AA	AA	KM						

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name
20/3/26	0740	263	Patient declined skin inspection. Complaining of pain 8/10. Not eating	LBT LILLI CRAIL
20/3/26	1515	26	Patient in pain. Not drinking much, not eating	LBT LILLI CRAIL

Care Rounds Checklist

Date: 21/3/26

Attach Ad

3112626230
MCLACHLAN
Michael
M
31/12/1962

Ward: 70

NHS Greater Glasgow and Clyde

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

1. Signed KOonelly Name KOONNELLY Designation QN
2. Signed BMcInly Name BMcInly Designation SN
3. Signed _____ Name _____ Designation _____

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

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

			Times	03	06	09	12	15	18	21	00								
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		N	N	N	N	N	N	N	N								
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.		N	N	N	N	N	N	N	N								
S	3	**SKIN INSPECTION** Pressure areas checked:		NT	NT														
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		–	–	–	–	I	I	I	I								
K	4	**KEEP MOVING** Has the patient moved or walked?		Y	Y	Y	Y	Y	Y	Y	Y								
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		L	B	R	L	R	L	L	B								
		Chair Assist to walk or stand (W/ST)		W	W	W	W	W	W	W	W								
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		C	C	I	I	I	I	I	I								
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?		N	N	N	N	N	N	N	N								
		Drink taken?		N	N	Y	Y	Y	Y	Y	N								
		Food, snack, or supplement taken?		N	N	Y	Y	Y	–	Y	N								
		Has oral hygiene been carried out as per care plan?		N	N	I	I	I	I	I	N								
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		Y	Y	Y	Y	Y	Y	Y	Y								
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.		NT	NT	N	N	N	N	NA	N								
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.		NA	NA	NA	NA	NA	NA	NA	NA								
			Care provider / role	IB	IB	MW	CM	CM	CM	CM	IB								

Care Rounds Checklist

Date: 22/3/26

Attach Add

3112626230
MCLACHLAN, Michael M, 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Ward: 70

NHS Greater Glasgow and Clyde

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

1. Signed KDonnelly Name KDONNELLY Designation SN
2. Signed AMC Name AMACLARTY Designation SN
3. Signed [illegible] Name [illegible] Designation [illegible]

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

A1

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

		Times	00	02	04	06	08	10	12	14	16	18	20	22						
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	N	N	N	N						
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	N	N	N	N						
S	3	**SKIN INSPECTION** Pressure areas checked:	NAD	NAD	NAD	NAD	NAD	NAD	NAD	NAD	NAD	I	I	NAD						
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	INT	INT	–	–	I	I	I	I	I	I	I	I						
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y						
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B	B	B	B		R		B	R	W	R	B						
		Chair Assist to walk or stand (W/ST)	W	ST/W	C	C	W		W											
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	C	IC	I	I	I	I	I	I	I	I	I	I						
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N	N	N	N	N	N	N						
		Drink taken?	Y	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y						
		Food, snack, or supplement taken?	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y						
		Has oral hygiene been carried out as per care plan?	I	I	I	I	I	I	I	I	I	I	I	–						
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y						
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	NT	NT	NT	NT	NAD	NAD	NAD	NAD	NT	NT						
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NAD	NAD	NAD	NAD	NAD	NAD	NAD	NAD	NAD	NAD	NAD	NAD						
		Care provider / role	KD	KD	KD	KD	AMC	AMC	AMC	AMC	AMC	AMC	AMC	AMC						

Care Rounds Checklist

Date: 23/3/26

Attach /

3112626230
MCLACHLAN
Michael
M
31/12/1962
Ward: FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

NHS Greater Glasgow and Clyde

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

1. Signed [signature] Name Emma Designation C
2. Signed Pmitchell Name Pamela Mitchell Designation SN
3. Signed [signature] Name J.TEMPLETON Designation SIN

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

nil

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

		Times	M/N/02:04	06	08	10	12:00	14:10	15:00	18:00	20:00	22:10
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N	N	O	N	N	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N	N	O	Y	N	N
S	3	**SKIN INSPECTION** Pressure areas checked:	I	I	I	I	I	I	I	O	I	Y	Y
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	I	I	I					O	I	R M	R INT
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y	Y	Y	O	Y	Y	Y
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B	L	L	B		B	L	O	B	B	L
		Chair Assist to walk or stand (W/ST)	W	-	-		N	N	N	O	-	-	-
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	I	I	I	I	I	I	O	I	I	I
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N	N	O	N	N	N
		Drink taken?	Y	S	S	Y	Y	Y	N	O	N	Y	Y
		Food, snack, or supplement taken?	W	S	S	N	Y	N	N	O	Y	Y	Y
		Has oral hygiene been carried out as per care plan?	W	S	S	I	Y	Y	I	O	N	I	I
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y	Y	O	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	S	S	NT	NT	N	NT	O	N	NT	NT
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	S	S	NA	NA	NA	NA	O	NA	NA	NA
		Care provider / role	CM	CM	CM	MM	MM	LT	LT	LC	LT	LC	LC

Care Rounds Variance Sheet

Attach Ad
3112626230
MCLACHLAN
Michael
M
31/12/1962

Ward:

NHS
Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name
23/6/20	1150	26	Pain but refusing pain tablets. Not eating often	REST
23/3/20	1600	2	pain around waste	L EST

mi • 278936 v2.1 • GGC0098

Care Rounds Checklist

Date: 24/3/26

Attach A

3112626230
MCLACHLAN
Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

M
31/12/1962

Ward: 20

NHS Greater Glasgow and Clyde

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

1. Signed _____ Name J.TEMPLETON Designation S/N
2. Signed _____ Name A-MCCALLUM Designation SN
3. Signed _____ Name _____ Designation _____

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

NJ

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

		Times	10 00	10 02	10 04	10 06	08 16	10 22	12 26	14 30	16 35
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	N
S	3	**SKIN INSPECTION** Pressure areas checked:	Y	Y	Y	Y	Y	Y	Y	Y	Y
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	R,M	R,M	R,M	R,M	R,M	R,M	R,M	R,M	R,M
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y	Y	Y	Y	Y
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	L	L	L	B	R	L	B	R	L
		Chair Assist to walk or stand (W/ST)	—	—	—	—	—				
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	I	I	I	I	I	I	I	I
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N	N	N	N
		Drink taken?	Y	—	N	Y	Y	N	N	Y	Y
		Food, snack, or supplement taken?	—	—	N	—	Y	N	N	N	Y
		Has oral hygiene been carried out as per care plan?	Y	—	N	—	—	N	N	N	—
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	NT	NT	NT	NT	NT	NT	NT
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA	NA	NA	NA	NA
		Care provider / role	LC	LC	LC	LC	NS	NS	NS	NS	NS

Fluid Balance Chart

N: 3112626230
D MCLACHLAN M
C Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Afi Glasgow, Lanarkshire
G33 2DP

Hospital: GRI
Ward: 70
Date: 18/3/26

Reason for Fluid Balance Chart MONITOR
Is patient fluid restricted? Yes ☐ No ☑
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids? Yes ☐ No ☑ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: EM Designation: SN

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input: Oral Fluids Type	Oral Fluids Volume	Enteral Type	Enteral Volume	IV / Other Type	IV / Other Volume	Type	Volume	Running Total INPUT	Output: Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
00:00																	
01:00																	
02:00																	
03:00																	
04:00	COMMENCED		JUICE 500ML														
05:00										600						600	DM
06:00	SQUASH	150							150								
07:00	MILK	150							300								
08:00																	
09:00	JUICE	100							400								
10:00																	
11:00	WATER	200							600	600						1200	
12:00																	
13:00	WATER	200															
14:00																	
15:00																	
16:00						500			1100	500							
17:00																	
18:00																	
19:00																	
20:00	TEA	200							1300								
21:00										900						2100	IB
22:00																	
23:00																	
									*Total Intake							*Total Output	

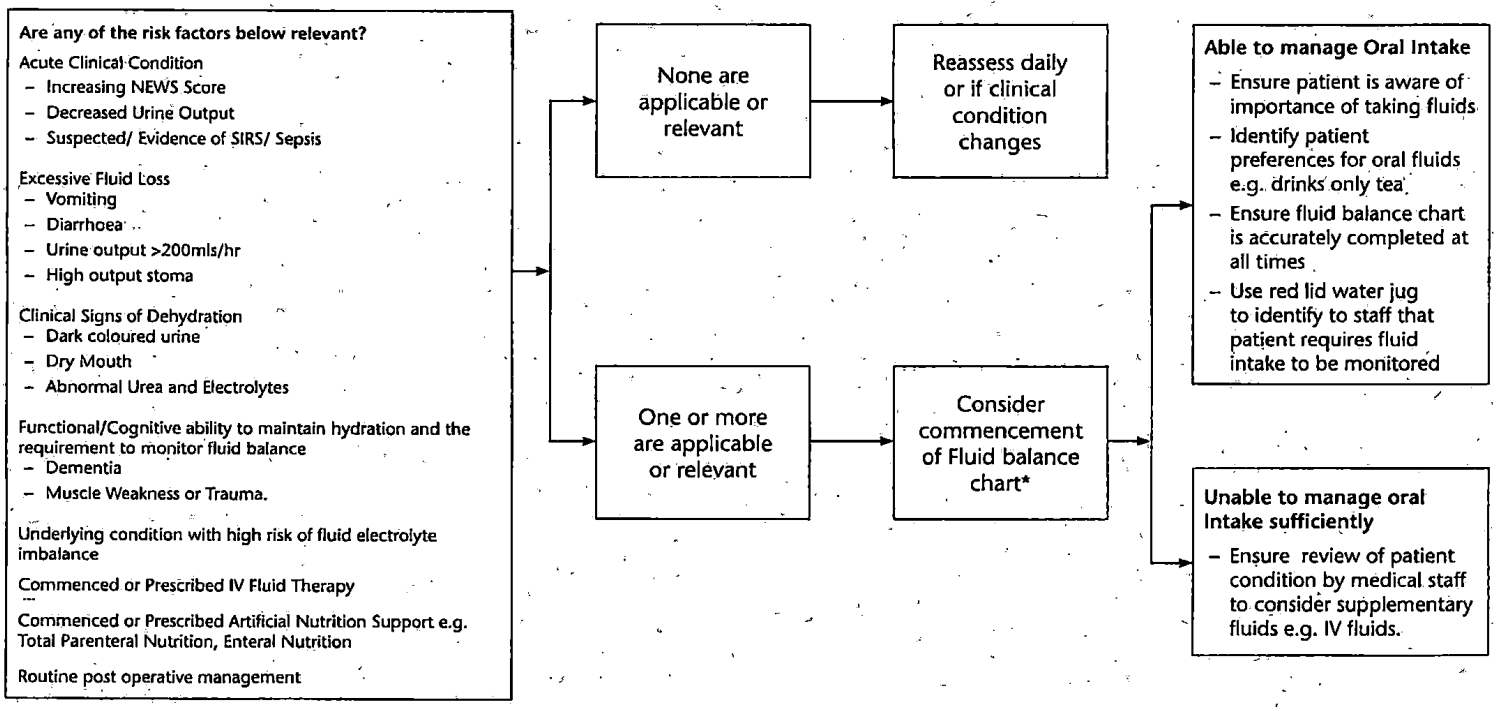
*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2

Fluid Balance Chart

N
D 3112626230 M
MCLACHLAN
CI Michael 31/12/1962
FLAT 1-1
Aff. 10 GIRVAN STREET
Glasgow, Lanarkshire G33 2DP

Hospital: GRI
Ward: 70
Date: 19/3/26

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

NHS Greater Glasgow and Clyde

Does patient require thickened fluids?
Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input								Running Total	Output						Running Total	Initials
	Oral Fluids		Enteral		IV / Other					Urine	Gastric / Vomit	Bowel	Type	Type	Type		
	Type	Volume	Type	Volume	Type	Volume	Type	Volume	INPUT							OUTPUT	
00:00																	
01:00																	
02:00										500						500	
03:00																	
04:00																	
05:00											EMPTIED OWN BAG						JB
06:00	------																
07:00	TEA	100															
08:00	B/fast	300							300	100		catheter removed				600	MM
09:00																	
10:00	H2O	200							500								
11:00																	
12:00						100			600	150						750	MM
13:00												PVS	12 mls				SB
14:00																	
15:00																	
16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00	Tea	200							800								
22:00										100		Bales				1650	MM
23:00																	
								*Total Intake							*Total Output		

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

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.

Are any of the risk factors below relevant?

Acute Clinical Condition
- Increasing NEWS Score
- Decreased Urine Output
- Suspected/ Evidence of SIRS/ Sepsis

Excessive Fluid Loss
- Vomiting
- Diarrhoea
- Urine output >200mls/hr
- High output stoma

Clinical Signs of Dehydration
- Dark coloured urine
- Dry Mouth
- Abnormal Urea and Electrolytes

Functional/Cognitive ability to maintain hydration and the requirement to monitor fluid balance
- Dementia
- Muscle Weakness or Trauma.

Underlying condition with high risk of fluid electrolyte imbalance

Commenced or Prescribed IV Fluid Therapy

Commenced or Prescribed Artificial Nutrition Support e.g. Total Parenteral Nutrition, Enteral Nutrition

Routine post operative management

None are applicable or relevant → Reassess daily or if clinical condition changes

One or more are applicable or relevant → Consider commencement of Fluid balance chart*

Able to manage Oral Intake
- Ensure patient is aware of importance of taking fluids
- Identify patient preferences for oral fluids e.g. drinks only tea
- Ensure fluid balance chart is accurately completed at all times
- Use red lid water jug to identify to staff that patient requires fluid intake to be monitored

Unable to manage oral Intake sufficiently
- Ensure review of patient condition by medical staff to consider supplementary fluids e.g. IV fluids.

Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

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Fluid Balance Chart

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Hospital: GRI

Ward: 70

Date: 22/3/26

Reason for Fluid Balance Chart _____

Is patient fluid restricted? Yes ☐ No ☐

If yes how many mls in 24 hours? _____

Fluid balance from previous 24hrs +/- _____

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

Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:

1. Type _____ circle how many daily 1 2 3

2. Type _____ circle how many daily 1 2 3

Signature: _____ Designation: _____

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00	—								—	200						200	M
07:00	tea	50															
08:00																	
09:00	TEA	100															
10:00																	
11:00	Juice	Sips															
12:00																	
13:00	Juice	100															
14:00																	
15:00	Juice	SIP								PU							
16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
								*Total Intake	[redacted]						*Total Output	[redacted]	

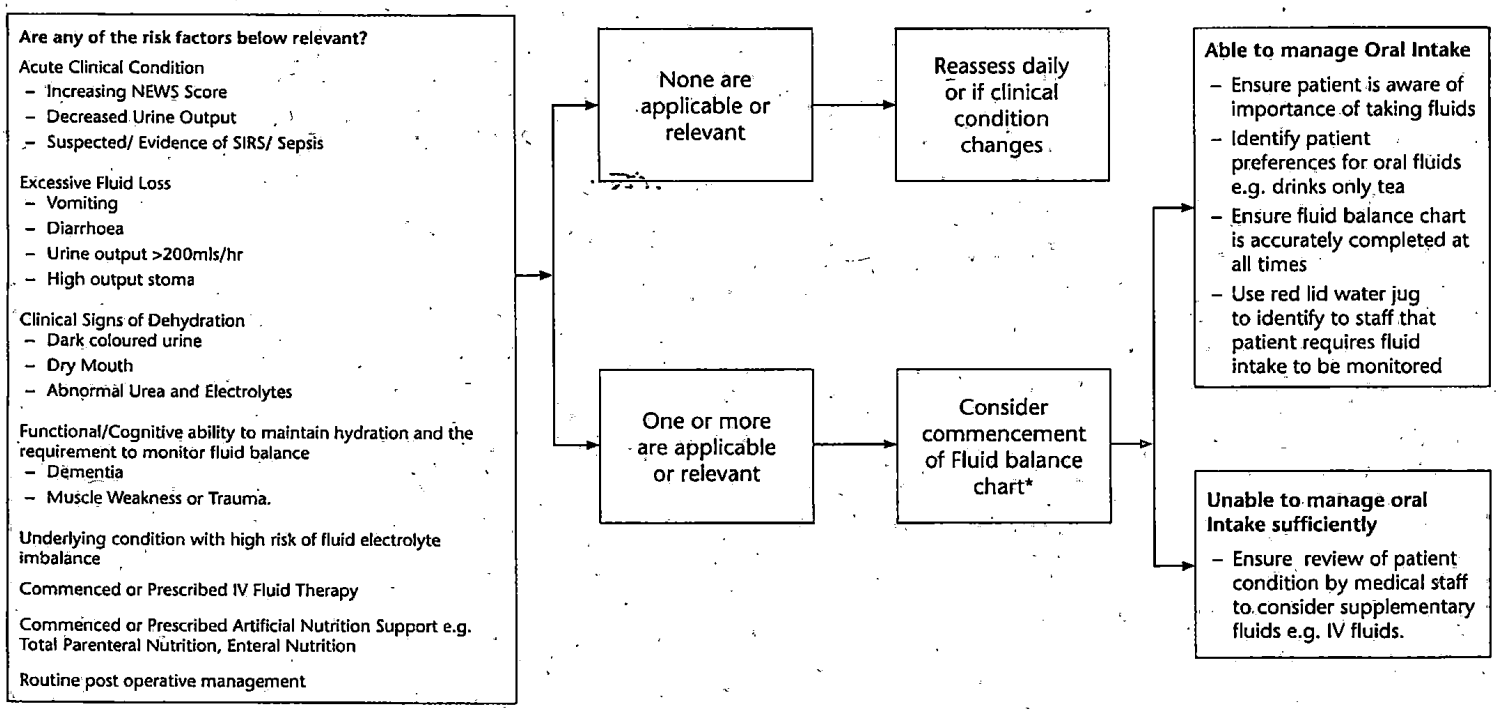
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*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

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Fluid Balance Chart

Name: ....
D: 3112826230
Cl: MCLACHLAN Michael M 31/12/1962
FLAT 1-1
Aff: 10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Hospital: GRI
Ward: 70
Date: 21/3/26

Reason for Fluid Balance Chart _____

Is patient fluid restricted? Yes ☐ No ☐

If yes how many mls in 24 hours? _____

Fluid balance from previous 24hrs
+/- _____

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

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

Signature: _____ Designation: _____

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00																	
02:00																	
03:00											Em						
04:00																	
05:00												UTT					
06:00																	
07:00										UTT							
08:00	BF	200															
09:00																	
10:00	Tea	150															
11:00																	
12:00	Juice	150								UTT							
13:00																	
14:00	Juice	150															
15:00																	
16:00																	
17:00	Tea	150								UTT							
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
								*Total Intake	[redacted]						*Total Output	[redacted]	

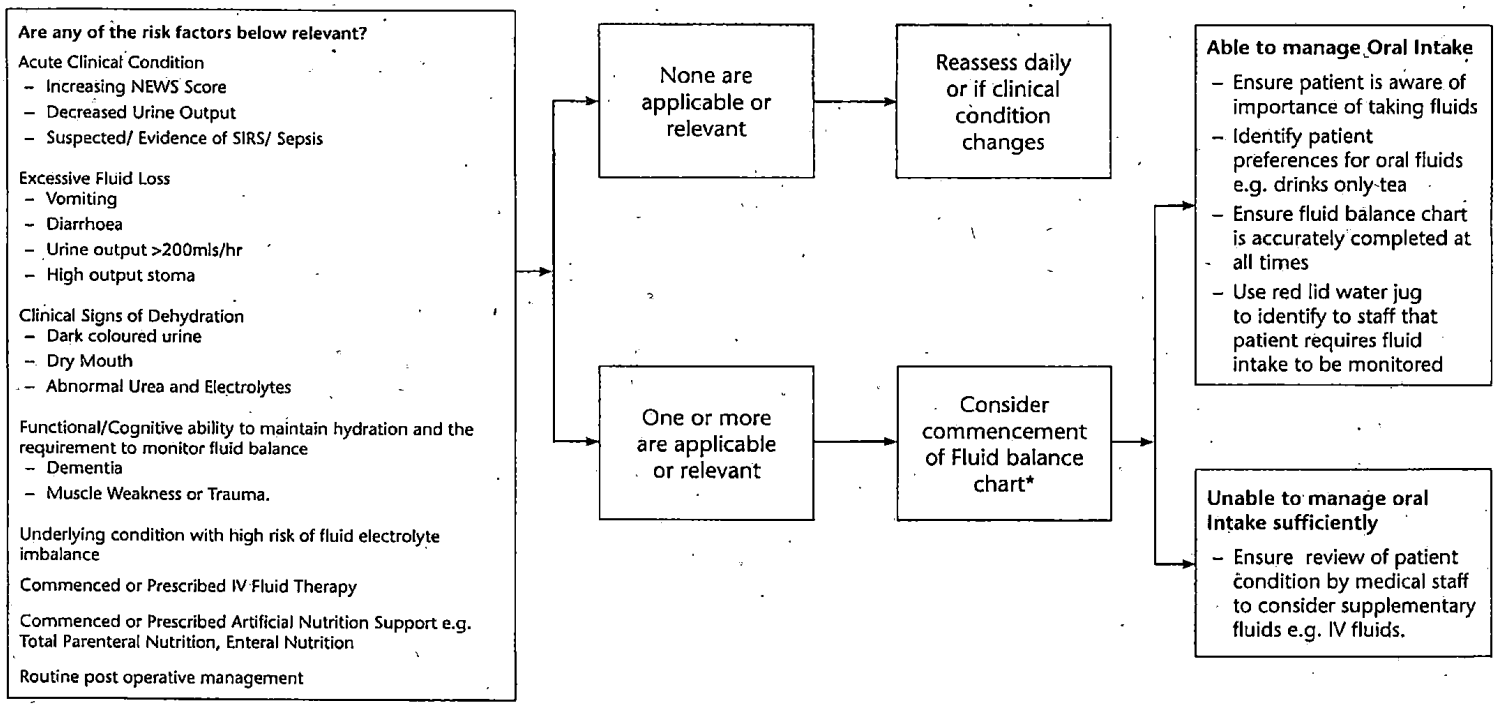
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MIS • EDU • 237971-2

Fluid Balance Chart

N 3112626230
D MCLACHLAN Michael M 31/12/1962
C FLAT 1-1 10 GIRVAN STREET Glasgow, Lanarkshire
Afi G33 2DP

Hospital: GRI
Ward: 70
Date: 22/3/26

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids? Yes ☐ No ☐ Stage _____
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2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00																	
02:00																	
03:00																	
04:00				Wf 50													
05:00									50		UT						
06:00																	
07:00																	
08:00																	
09:00																	
10:00																	
11:00																	
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17:00																	
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20:00																	
21:00																	
22:00																	
23:00																	
							*Total Intake								*Total Output		

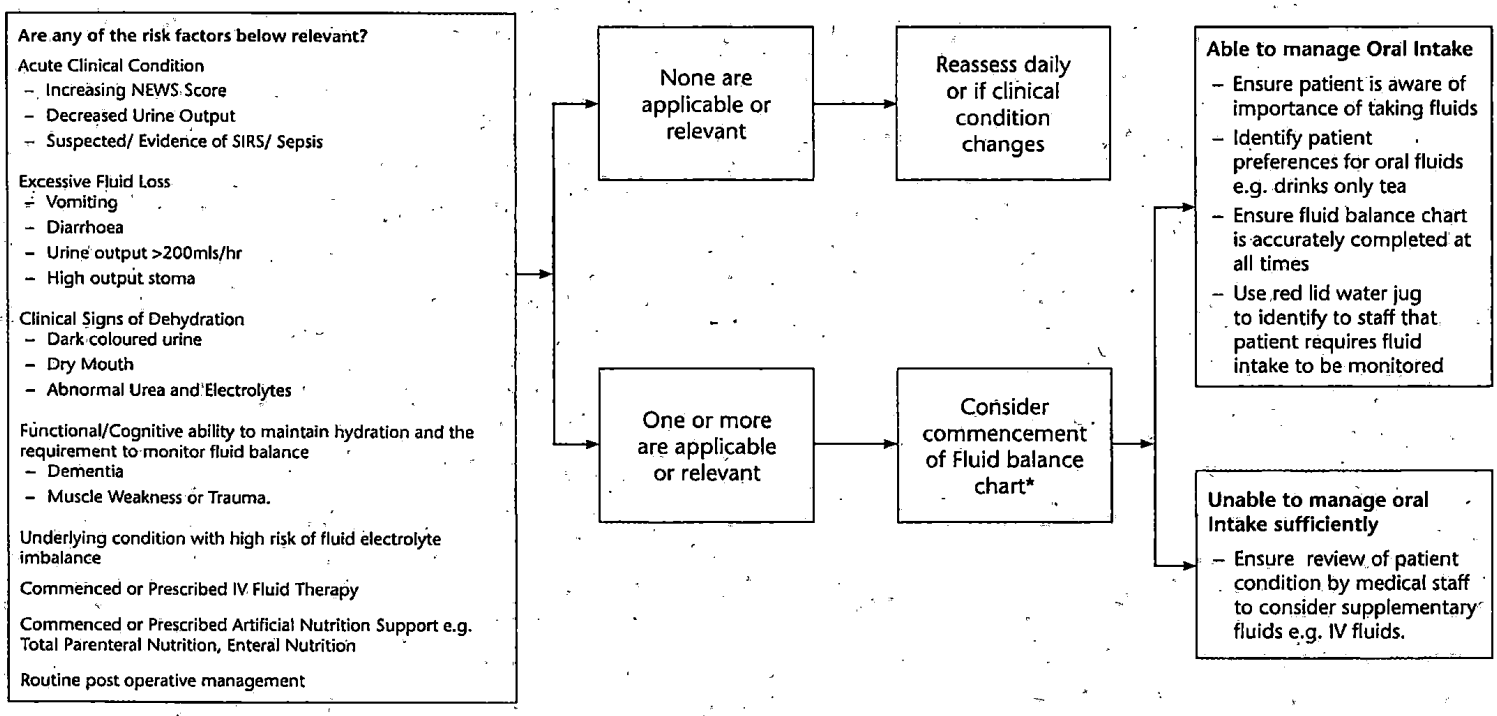
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Write on affix label

3112626230
MCLACHLAN M
Michael 31/12/1952
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Peripheral Venous Cannula (PVC) Insertion & maintenance

Please complete insertion details for each PVC inserted

Care & maintenance to be undertaken & documentation completed twice each day.

Modified Visual Infusion Phlebitis (VIP) Score		
PVC site appears healthy	0	No phlebitis: Continue care and maintenance
Either slight pain or redness near site	1	Possible first signs: Observe PVC site
Two or more: pain / redness / swelling	2	Early stage of phlebitis: **Remove and resite PVC**
All: pain / redness / hardening of surrounding area	3	Phlebitis/thrombophlebitis: **Remove and resite PVC**
As above and including: palpable venous cord	4	**Seek further advice**
As above and including: pyrexia	5	

NHS Greater Glasgow and Clyde

Insertion details:	Where inserted:	Insertion site:	Side:	Size of cannula:	Inserted by:
Date: ___/___/___ (Day 1) Time: ___:___	☐ ED ☐ Theatre ☐ ITU/HDU ☐ Ward ___ ☐ Unknown	☐ Hand ☑ Arm Other ___	☐ Left ☑ Right	☐ 26G Purple ☐ 24G Yellow ☐ 18G Green ☐ 23G Blue ☐ 16G Grey ☑ 20G Pink ☐ 14G Orange	Print: ___ Signature: ___ Designation: ___

Clinical indication:	☐ Diagnostics	☐ Resuscitation	☐ IV medications	☐ Fluids	☐ Transfusion
Insertion criteria:	Hand hygiene performed ☐ Yes ☐ No	Skin decontamination (2% chlorhexidine in 70% isopropyl alcohol) ☐ Yes ☐ No	Sterile transparent semi-permeable dressing affixed ☐ Yes ☐ No	PVC explained to patient/carer ☐ Yes ☐ No	

DRIFT PVCs are associated with an increased risk of phlebitis, thrombosis, infection and S.aureus bacteraemia.

Justify the need for your patient to have a PVC using the DRIFT mnemonic.
- ✓ **D**iagnostics - Does the patient need the PVC for a diagnostic procedure e.g. CT scan
- ✓ **R**esuscitation - Is the patient at risk of cardiac or respiratory arrest?
- ✓ **I**ntravenous (IV) - Does the patient require intravenous (IV) medication? Could these be switched to another route?
- ✓ **F**luids - Does the patient require IV fluids? Could this be switched or oral fluids?
- ✓ **T**ransfusion - Does the patient require a transfusion of blood products?

Signs of local or systemic infection

Local infection
- Erythema / inflammation
- Exudate
- Hot to touch
- Pain/tenderness

Systemic Infection
- Hypotension
- Tachycardia
- Pyrexia

Adult IVOST Guideline:

Paediatric IVOST Guideline:

Always refer to full IV route to Oral route Switch Therapy (IVOST) guidelines

IV → Oral Antibiotic Switch Therapy (IVOST) Guideline

Review need for IV antibiotics daily
Can antibiotic therapy be stopped? (eg: alternative diagnosis)?
If ongoing antibiotics required - document patient progress/IVOST plan within 72 hours

Switch to oral when:

a **CLINICAL IMPROVEMENT** in signs of infection eg: temperature ≤37.9°C, reduction in the NEWS score, improving SEPSIS
a **ORAL ROUTE** is available reliably (eating/drinking no concerns regarding absorption)
a **UNCOMPLICATED INFECTION** i.e. specialist advice not required prior to IVOST: Infection requiring specialist advice includes CNS infection, Cystic fibrosis, S. aureas bacteraemia (minimum 14 days IV), Endocarditis, Vascular graft or bone/joint infection, Undrainable deep abscess.

DO NOT use CRP in isolation to assess IVOST suitability as does not reflect severity of illness
Record the stop date on HEPMA

If IVOST criteria met → Switch to oral
Review MICROBIOLOGY results and NARROW THE SPECTRUM based on cultures
IF not responsive MICROBIOLOGY switch to oral as outlined below

3112626230
MCLACHLAN
Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

M
31/12/1962

NHS
Greater Glasgow and Clyde

PVCs should be removed as soon as no longer clinically indicated.

Maintenance – to be completed twice daily (Observe for signs and symptoms of local or systemic infection)

Date	Need for PVC reviewed today?		Any sign of PVC site infection?		Is the dressing intact?		Before / after PVC procedures; hand hygiene performed?		PVC patent?		What has been done?		Sign: Print: Designation:
	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	
Day 1 Insertion Date __/__/__	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day / Night
Day 2 19/12/26	☐ Yes ☐ No	☑ Yes ☐ No	VIP ____	VIP 0	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☑ Left in situ ☐ Redressed ☐ Removed	Day / Night
Day 3 19/12/26	☑ Yes ☐ No	☐ Yes ☐ No	VIP 2	VIP ____	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day / Night
Day 4	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day / Night
Day 5	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day / Night
Day 6	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day / Night
Day 7	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Removed	Day / Night

PVCs should be removed on day 7. Reassess ongoing needs and vessel health for most appropriate vascular access device. Date removed __/__/__

Reason for removal	☐ Site infection	☐ Infiltration	☐ Extravasation	☐ End of treatment	Other:

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Adult Urethral Urinary Catheter(UUC)

Insertion & Maintenance Care Plan

Ca BRILLANT AquaFlate REF A310114
A5-Silicone (IPN053453)
Long-Term LOT 40E25H5473
(up to 12 weeks use)
Standard, 2-way Foley 2030-07-31
SIZE: Ch. 14 O.D.: 4.7mm / 10ml
Teleflex Medical, IDA Business and Technology Park, Dublin Road, Athlone, Co. Westmeath, Ireland

NHS Greater Glasgow and Clyde

Insertion – Complete all sections

Date and time inserted	Urethral Urinary Catheter inserted	Gauge	5" mls in balloon	Inserted by (Print name & designation [if known])
18/3/26 0300	Hospital QRI ED ☐ Theatre ☑ ITU/HDU ☐ Ward ____	14		L Thomson SpR

Clinical indication for urethral urinary catheterisation	Long term urethral urinary catheter ☐ (> 28 days)	Short term urethral urinary catheter ☑ (≤ 28 days)	
Post Procedure			

Patient had urethral urinary catheter inserted in the community/out with NHS GGC Yes ☐ No ☑ Date UUC inserted (if known) ____

Insertion Criteria		Comments
Alternatives to urethral urinary catheterisation considered	Yes ☑ No ☐	
Hand hygiene is performed immediately before urethral urinary catheter insertion	Yes ☑ No ☐	
Aseptic technique performed at insertion	Yes ☑ No ☐	
Urethral Urinary catheter of smallest gauge used and balloon filled to recommended level	Yes ☑ No ☐	
Urethral meatus cleaned with sterile saline and sterile lubricant used	Yes ☐ No ☑	
Aseptic technique maintained when connecting urethral urinary catheter to closed drainage system	Yes ☑ No ☐	

DAILY MAINTENANCE: FOR ALL PATIENTS WITH A URETHRAL URINARY CATHETER:

- Staff must wear gloves and apron and perform hand hygiene before and after urinary catheter procedures.
- The drainage bag must be emptied when clinically indicated using a clean disposable container for each patient. Please refer to Insertion and maintenance of adult indwelling urethral urinary catheter SOP.

Maintenance – To be completed daily (observe for signs and symptoms of infection)

Please regard Day 1 as day of insertion or the day patient is admitted to hospital with Urethral Urinary Catheter.	Ward	Does the patient still require a urethral urinary catheter?	Is the urethral urinary catheter connected to a closed drainage system and changed in line with manufacturer's instructions?	Daily meatal hygiene has been carried out? (soap and water)	Urine drainage bag is situated below the level of the bladder and not in contact with any surface e.g. floor?	Signature and Print Name
Day 1 18/3/26	70	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	EC Rice FM.
Day 2 19/3/26	82	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	ESmart/E Smart
Day 3 __/__/__		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	

Date removed: 19/3/26 Time removed: 0905 Reason for Urethral Urinary Catheter removal: End of treatment Removed by: ____

3112626230
MCLACHLAN M
Michael 31/12/1962
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Peripheral Venous Cannula (PVC) Insertion & maintenance

Please complete insertion details for each PVC inserted

Care & maintenance to be undertaken & documentation completed twice each day.

Modified Visual Infusion Phlebitis (VIP) Score		
PVC site appears healthy	0	No phlebitis: Continue care and maintenance
Either slight pain or redness near site	1	Possible first signs: Observe PVC site
Two or more: pain / redness / swelling	2	Early stage of phlebitis: **Remove and resite PVC**
All: pain / redness / hardening of surrounding area	3	Phlebitis/thrombophlebitis: **Remove and resite PVC** **Seek further advice**
As above and including: palpable venous cord	4	
As above and including: pyrexia	5	

NHS Greater Glasgow and Clyde

Insertion details: Date: 19/03/26 (Day 1) Time: 14:45	**Where inserted:** ☐ ED ☐ Theatre ☐ ITU/HDU ☑ Ward 70 ☐ Unknown	**Insertion site:** ☐ Hand ☑ Arm Other _____	**Side:** ☑ Left ☐ Right	**Size of cannula:** ☐ 26G Purple ☐ 24G Yellow ☐ 18G Green ☐ 23G Blue ☐ 16G Grey ☑ 20G Pink ☐ 14G Orange	**Inserted by:** Print: A Vanko Signature: [signature] Designation: FY1
Clinical indication:	☑ Diagnostics	☑ Resuscitation	☐ IV medications	☑ Fluids	☑ Transfusion
Insertion criteria:	Hand hygiene performed ☑ Yes ☐ No	Skin decontamination (2% chlorhexidine in 70% isopropyl alcohol) ☑ Yes ☐ No	Sterile transparent semi-permeable dressing affixed ☑ Yes ☐ No	PVC explained to patient/carer ☑ Yes ☐ No	

DRIFT PVCs are associated with an increased risk of phlebitis, thrombosis, infection and S.aureus bacteraemia.

Justify the need for your patient to have a PVC using the DRIFT mnemonic.
- ✓ Diagnostics - Does the patient need the PVC for a diagnostic procedure e.g. CT scan
- ✓ Resuscitation - Is the patient at risk of cardiac or respiratory arrest?
- ✓ Intravenous (IV) - Does the patient require intravenous (IV) medication? Could these be switched to another route?
- ✓ Fluids - Does the patient require IV fluids? Could this be switched or oral fluids?
- ✓ Transfusion - Does the patient require a transfusion of blood products?

Signs of local or systemic infection

Local infection
- Erythema / inflammation
- Exudate
- Hot to touch
- Pain/tenderness

Systemic Infection
- Hypotension
- Tachycardia
- Pyrexia

Adult IVOST Guideline:

Paediatric IVOST Guideline:

Always refer to full IV route to Oral route Switch Therapy (IVOST) guidelines

IV → Oral Antibiotic Switch Therapy (IVOST) Guideline

Review need for IV antibiotics daily
Can antibiotic therapy be stopped? (eg: alternative diagnosis)?
If ongoing antibiotics required - document patient progress/IVOST plan within 72 hours

Switch to oral when:

a **CLINICAL IMPROVEMENT** in signs of infection eg: temperature ≤37.9°C, reduction in the NEWS score, improving SEPSIS

a **ORAL ROUTE** is available reliably (eating/drinking no concerns regarding absorption)

a **UNCOMPLICATED INFECTION** i.e. specialist advice not required prior to IVOST: Infection requiring specialist advice includes CNS infection, Cystic fibrosis, S. aureas bacteraemia (minimum 14 days IV), Endocarditis, Vascular graft or bone/joint infection, Undrainable deep abscess.

DO NOT use CRP in isolation to assess IVOST suitability as does not reflect severity of illness

Record the stop date on HEPMA

If IVOST criteria met → Switch to oral
Review MICROBIOLOGY results and NARROW THE SPECTRUM based on cultures
IF not responsive MICROBIOLOGY switch to oral as outlined below

N 3112626230
A MCLACHLAN
Michael
M
C FLAT 1-1
31/12/1962
D 10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

NHS Greater Glasgow and Clyde

PVCs should be removed as soon as no longer clinically indicated.

Maintenance – to be completed twice daily (Observe for signs and symptoms of local or systemic infection)

Date	Need for PVC reviewed today?		Any sign of PVC site infection?		Is the dressing intact?		Before / after PVC procedures; hand hygiene performed?		PVC patent?		What has been done?		Sign: Print: Designation:
	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	
Day 1 Insertion Date 19/03/26	☐ Yes ☐ No	☑ Yes ☐ No	VIP ____	VIP 0	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night KD
Day 2 20/3/26	☑ Yes ☐ No	☑ Yes ☐ No	VIP 0	VIP 0	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day pmitchell pn Night KD
Day 3 21/3/26	☑ Yes ☐ No	☐ Yes ☐ No	VIP 0	VIP 0	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☑ Yes ☐ No	☑ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day pmitchell pn Night KD
Day 4 22/3/26	☑ Yes ☐ No	☐ Yes ☐ No	VIP 0	VIP 0	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☑ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day am LSP Night
Day 5 23/3/26	☑ Yes ☐ No	☑ Yes ☐ No	VIP 0	VIP 0	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☑ Left in situ ☐ Redressed ☐ Removed	☑ Left in situ ☐ Redressed ☐ Removed	Day pmitchell pn Night SN
Day 6 24/3/26	☑ Yes ☐ No	☐ Yes ☐ No	VIP 0	VIP ____	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day SN Night
Day 7	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Removed	Day Night

PVCs should be removed on day 7. Reassess ongoing needs and vessel health for most appropriate vascular access device. Date removed 24/03/26

Reason for removal	☐ Site infection	☐ Infiltration	☐ Extravasation	☑ End of treatment	Other:

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M
31/12/1962

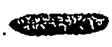
Name: ____

BOWEL MOVEMENT RECORD

NHS
Greater Glasgow and Clyde

CHI: _____

Date Commenced: 23/3/26

Date	Time	Comments i.e. volume, blood, mucous S = small M = medium L = large	Type 1 Seperate hard lumps like nuts (hard to pass) 	Type 2 Sausage shaped but lumpy 	Type 3 Like a sausage but with cracks on surface 	Type 4 Like a sausage or snake, smooth and soft 	Type 5 Soft blobs with clean cut edges (passed easily) 	Type 6 Fluffy pieces with ragged edges, a mushy stool 	Type 7 Watery, not solid pieces (entirely liquid) 	Staff Initials
23/3 -	States bowels		not moved for		over 7 days					EL
23/3	states		BO	small	smart	today				JT

Adapted from the Bristol Stool Scale developed by KW Heaton and SJ Lewis at the University of Bristol, 1997.

Food and Drink Recording Chart

Reason for recording intake: _____

NHS Greater Glasgow and Clyde

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Michael 31/12/1962
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10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

Guidance:

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

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

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

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

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

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

Date: 20-3-26	Day Number: 1
Food and Drink Intake	
Breakfast: refused	
Snack: 2 CUSTARD CREAMS	
Lunch: refused	
Snack: Rice Pudding	
Evening Meal: refused	
Supper:	
Overnight:	
Is the patients intake 'normal' or improved for them? Yes ☐ No ☐ Unsure ☐	
Continue: ☐ **Discontinue:** ☐	
Rationale: _____	
Signed: _____ **Print:** _____	

Date: 21/3/26	Day Number: 2
Food and Drink Intake	
Breakfast:	
Snack: ?	
Lunch: scrambled Egg + potatoes + Broccoli + soup (1/2)	
Snack: Rice pudding + Tea	
Evening Meal:	
Supper:	
Overnight:	
Is the patients intake 'normal' or improved for them? Yes ☐ No ☐ Unsure ☐	
Continue: ☐ **Discontinue:** ☐	
Rationale: _____	
Signed: _____ **Print:** _____	

Patient Address Label

Food and Drink Recording Chart

NHS Greater Glasgow and Clyde

Reason for recording intake: _____

Guidance:

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

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

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

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

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

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

Date: 22-3-26	Day Number:
Food and Drink Intake	
Breakfast: Refused	
Snack:	
Lunch: Beef Mash	
Snack:	
Evening Meal: REF	
Supper: ref	
Overnight:	
Is the patients intake 'normal' or improved for them? Yes ☐ No ☐ Unsure ☐	
Continue: ☐ **Discontinue:** ☐ **Rationale:** _____ **Signed:** _____ **Print:** _____	

Date: 23-3-26	Day Number:
Food and Drink Intake	
Breakfast: Refused	
Snack: bar of chocolate	
Lunch:	
Snack: grapes	
Evening Meal: NOTHING / REF	
Supper: REF	
Overnight:	
Is the patients intake 'normal' or improved for them? Yes ☐ No ☐ Unsure ☐	
Continue: ☐ **Discontinue:** ☐ **Rationale:** _____ **Signed:** _____ **Print:** _____	

3112626230 M
MCLACHLAN 31/12/1962
Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire G33 2DP

NOTES CAREPLANS DUE UPDATED

ASSESSMENT	REVIEW DATE	REVIEW DATE	REVIEW DATE	REVIEW DATE
BEDRAILS	25/3/26			
FALLS PREVENTION	25/3/26			
MOVING AND HANDLING	25/3/26			
MUST	23/3/26			
4AT	N/A			
SIGNATURE				

NHSGGC Adult In-Patient National Early Warning Score (NE)

NHS Greater Glasgow and Clyde

Affix Patient ID

3112526230
M MCLACHLAN
2 Michael M
FLAT 1-1 31/12/1962
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

	Date	Ward	Time
Admitted			
Transferred	19/3/26	7D.	0400
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☒
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name: [illegible]	
Dr/ANP initials ONLY:	Dr/ANP initials ONLY: [illegible]	
Date:	Date: 19/3	

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed .....

Medical: .....

Date: .....

Glasgow Coma Scale

Pupil Reaction and size
s = sluggish
f = reaction
- = no reaction
c = eyes closed
Pupil Size (mm) 1 2 3 4 5 6 7 8

| Date: | | |

C10

NEWS 2 Key | 1 | 2 | 3

| | | |

NHSGGC Adult In-Patient National Early Warning Score (NI)

NHS Greater Glasgow and Clyde

3112626230
MCLACHLAN
Michael
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

M
31/12/1962

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

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

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed.....

Medical:.....

Date:.....

Pupil Reaction and size

b = sluggish
+ = reaction
- = no reaction
c = eyes closed

Pupil Size (mm) 1 2 3 4 5 6 7 8

Glasgow Coma Scale

Date:
Time:

Eyes Opened by spelling = NT — Spontaneously 4; To sound 3; To pressure 2; None 1; Not testable NT

Endotracheal tube or tracheostomy = NT — Oriented 5; Confused 4; Words 3; Sounds 2; None 1; Not testable NT

Always record the best response — Obeys command 6; Localising pain 5; Normal flexion 4; Abnormal flexion 3; Extension 2; None 1; Not testable NT

TOTAL 15

Right size:
Right reaction:
Left size:
Left reaction:

Record right (R) and left (L) separately if there is a difference between the two sides — Normal power; Mild weakness; Severe weakness; Spastic flexion; Extension; No response

Record right (R) and left (L) separately if there is a difference between the two sides — Normal power; Mild weakness; Severe weakness; Spastic flexion; Extension; No response

Affix Patient ID

Pain Function Score

A	No limitations, activity unrestricted by pain or settles quickly
B	Mild limitations, mild activity restrictions
C	Moderate limitations, attempts but reluctant to continue because of pain. Seek Advice
D	Severe limitations, unable to or refuse to perform because of pain. Urgent Review Required

Pain Score

Ask the patient to rate his/her pain by using numerical scale 0 to 10. Use the chart below to assist the patient. If the patient is unable to communicate, use alternative pain scoring tools.

No Pain	Mild Pain		Moderate Pain			Severe Pain			
0	1	2	3	4	5	6	7	8	9	10

nhi • 316654 v5.2 GGC0264

NEWS 2 Key	1	2	3

Date	8/11	23/8	23/3	23/3	24/3		
Time	11.00	09'86	16 02	20	04	08	

A + B
Respirations Breaths/min

						≥25	3
						21-24	2
•	•	•	•	•		12-20	0
						9-11	1
						≤8	3

A + B
SpO2 Scale 1
Oxygen saturation (%)

97						≥96	0
						94-95	1
						92-93	2
						≤91	3

SpO2 Scale 2
Oxygen saturation (%)
Use Scale 2 if target range is 88-92% e.g. in chronic hypercapnic respiratory failure

Only use scale 2 under direction of qualified clinician

						≥97 on O2	3
						95-96% on O2	2
						93-94% on O2	1
96	95	95				≥93 on air	0
				92		88-92	0
						86-87	1
						84-85	2
						≤83	3

Air or oxygen?

A	A	A	A	A		Air (A) or O2 device	0
						O2 L/min 2	2

C
Blood Pressure mmHg
(Score uses systolic BP only)

						≥220	3
						201-219	0
						191-200	0
						161-180	0
						141-160	0
		114				121-140	0
						111-120	0
						101-110	1
						91-100	2
						81-90	3
						71-80	3
		72				61-70	3
						51-60	3
						≤50	3

C
Pulse
Beats / min

						≥131	3
						121-130	2
						111-120	2
						101-110	1
						91-100	1
						81-90	0
•						71-80	0
	69	68				61-70	0
						51-60	0
						41-50	1
						31-40	3
						≤30	3

D
Any changes in neuro response, do GCS. Immediate medical review. Check Blood Glucose. Think Delirium.

•	A	A	A	A		A Alert	0
						C New Confusion	3
						V Verbal	3
						P Pressure	3
						U Unresponsive	3

E
Temperature

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

NEWS Total	0	0	0	0	0	
Blood glucose	7.0	/	/	/	/	
Pain / function score	0A	3/A	0/A	0	0	
Time Pt last passed urine	10.20	R	M	PM	PM	
Fluid balance chart indicated Y/N	N	Y	Y	Y	Y	
GCS indicated Y/N	N	N	N	N	N	
Time NEWS due	23.00	16 00	20 00	04	08	
Escalation of care Y/N	N	N	N	N	N	
Initials	AB	JT	JT	JT	JT	

NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

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

Think ACE

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

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

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

Affix Patient ID

Affix Patient ID

Abbreviations for recording oxygen device

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

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued									Administration details - continued				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments
20/03	0830	HARTMANNS	500	IV	60				20/3	15 10			
20/03		HARTMANNS	500	IV	60				21/3	06 10	KD.		
21/03		HARTMANNS	500	IV	60				21/3	23 15	KD		
		HARTMANNS	500	IV	60				22/3	05 20			

*Prescriber should sign this box if the fluid/additive is no longer required.

Patient name: 3112626230
MCLACHLAN M
Date of birth: Michael 31/12/1962
FLAT 1-1
CHI No: 10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DP

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg) ..... Height (cm) .....

Prescription details									Administration details				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments
18/03	11-15	HARTMANNS	500	IV	6°		M Stott		18/3/26	1120	am		
18/03		HARTMANNS	500	IV	6°		M Stott		18/03/26	1610	SO		
18/03		HARTMANN'S	500	IV	6°		F. NOWAK		19/3	1130	ES		
19/03		HARTMANN'S	500	IV	6°		F. NOWAK		19/3	2125	KD.		
20/03		HARTMANN'S	500	IV	6°		F. NOWAK		20/3	04[00]	LM (STN)		

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow (drops/min) = Volume of fluid (ml) x 20 / Duration of admin (min)

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

ADULT INTRAVENOUS (IV) GENTAMICIN (GGC): PRESCRIBING, ADMINISTRATION & MONITORING CHART

NHS Greater Glasgow and Clyde

Use for patients prescribed intravenous gentamicin UNLESS prophylactic indication, synergistic dosing (usually in endocarditis) or a patient group where local unit policy applies (e.g. cystic fibrosis, renal unit, receiving renal replacement, major burns). Refer to full GGC guidance for exclusions & cautions/contra-indications.

Patient name: 3112626230 MCLACHLAN Michael
Date of birth: 31/12/196[illegible]
CHI no.: ...

Age: 63 Sex: (M) / F
Weight: 46kg Height: 175cm
Creatinine (Cr): 110 on: 17.3.26

Initial Gentamicin Dose*: 200mg
Predicted Frequency*: 48h-1
*this is not a prescription and may change. Doses must be prescribed individually below.

Source of first dose: Online calculator (preferred method) ☑ Manual calculation (see Handbook) ☐ Weight based, if creatinine not known ☐

Step 1 **Calculate and prescribe the first dose of gentamicin (see overleaf for more details), inform nurse that the dose is due**
- If creatinine is known - use the NHSGGC gentamicin dose calculator.
- If creatinine is not known - give 5mg/kg actual body weight of gentamicin (maximum 400mg) or, if CKD 5, give 2.5mg/kg (maximum 180mg) on advice of senior medical staff. Calculate the dosage regimen once creatinine is available.
- Prescribe gentamicin on HEPMA (see overleaf for details on how to do this correctly).
- Also prescribe individual doses in the prescription record section below, specifying the date and time the dose should be given.
- DO NOT prescribe doses in advance of the day they are due. For 48 hourly dosing write 'no dose required' below on the days gentamicin has not to be administered.

Step 2 **Monitor creatinine and gentamicin concentrations and reassess the dosage regimen**
- Check a gentamicin concentration after the first dose and then at least every 2 days (see overleaf for more details).
- Monitor creatinine daily and record under 'Toxicity' below. Seek advice if renal function is unstable (e.g. a change in Cr of >15-20%).

Step 3 **Assess daily - for signs of toxicity, response and the ongoing need for gentamicin**
- Consider an alternative agent if signs of renal toxicity. STOP and seek advice from an infection specialist if suspected oto/vestibular toxicity.
- **Discuss with an infection specialist before continuing gentamicin for >4 days.** For courses >5 days, refer to audiology for assessment.
- To refer to audiology: contact the local audiology department directly to confirm their referral method/requirements.

Step 4 The prescriber should issue the attached gentamicin patient information leaflet (PIL) to the patient/carer as soon as possible (unless this is considered to be inappropriate). Do not delay giving gentamicin.

PIL issued to: patient ☐ Other: .....
Reason(s) for non-issue: .....
Date of issue: ..... Signature: .....

PROMPT ADMINISTRATION
within 1 hour of recognition of sepsis reduces mortality

TOXICITY may occur irrespective of gentamicin concentration:
Signs of renal toxicity: ↓ urine output/oliguria or ↑ creatinine
Signs of oto/vestibular toxicity: NEW tinnitus, dizziness, poor balance, hearing loss, oscillating vision

TOXICITY Before prescribing each dose check: Renal & Oto-vestibular function	IV Gentamicin Prescription Record: Complete each time a dose is to be given (ensure gentamicin is also prescribed on HEPMA, see overleaf)				Administration Record: Complete each time gentamicin is administered (in addition to HEPMA)			Monitoring Record: Record ALL sample dates/times accurately below. See overleaf for monitoring advice.			
	Date to be given	Time to be given (24h clock)	Gentamicin dose (mg)	Prescriber's signature, PRINTED name and STATUS	*Infuse over 30 mins: Date given	*Infuse over 30 mins: Time started (24h clock)	Given by	Date of sample	Time of sample (24h clock)	Gent result (mg/L)	Action/ Comments (please initial action to be taken)
Cr = 110 µmol /L	17/3	2340	200mg	[illegible]	18/03/26	00:22	[illegible]				24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other :
Cr = µmol /L											24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other :
Discuss with microbiology or infectious diseases and document this in the notes if treatment continues beyond 4 days. The risks of prolonged treatment must be considered and treatment options discussed with microbiology or infectious diseases											
Cr = µmol /L											24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other :
Cr = µmol /L											24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other :
Discuss with an infection specialist before continuing onto a second sheet											

Patient name: ..... CHI no.: .....

ADULT INTRAVENOUS IV GENTAMICIN (GGC): PRESCRIBING, ADMINISTRATION & MONITORING CHART

Prescribing, monitoring, interpreting and re-prescribing advice

For PRESCRIBERS – *for further information see the 'HEPMA prescribing of Gentamicin IV and Vancomycin IV advice for adults' document on GGC Clinical Guidelines Platform.*

Follow STEP 1 to STEP 4 overleaf when prescribing and monitoring.

Further information on prescribing gentamicin

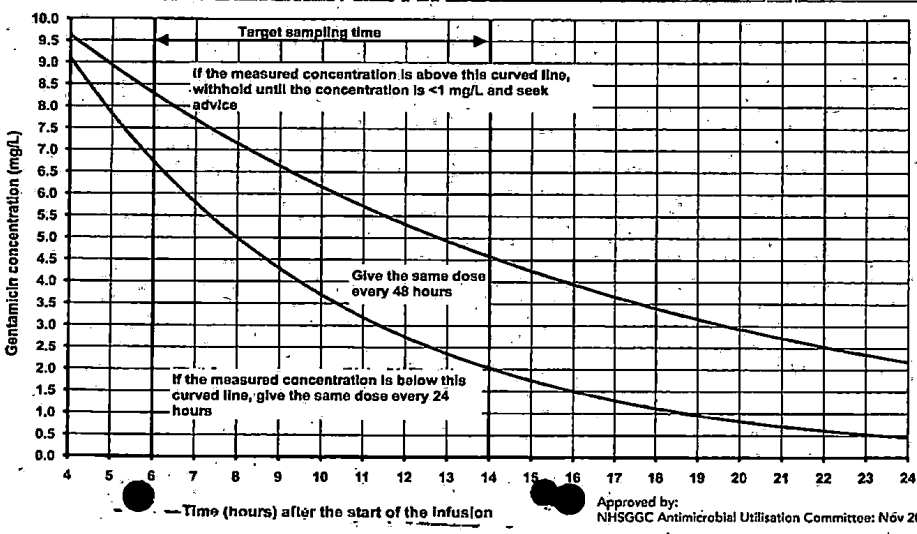
- On HEPMA – prescribe gentamicin as 'GENTAMICIN AS PER PAPER CHART Intravenous Infusion'. This should be prescribed as a PRN order. The dosage is automatically populated as "1 dose" and should be left as this. No dosage frequency should be entered on HEPMA.

Interpreting gentamicin results & re-prescribing

- Record the exact time of all gentamicin samples overleaf. Print the TrakCare sample request at the time of sample collection (to ensure that the time on TrakCare/Clinical Portal is accurate).
- **If creatinine clearance (CrCl) ≥21 ml/min:** sample 6-14h after the start of the infusion, plot the gentamicin concentration on the graph below & reassess the dose/dosing interval as indicated.
- **If CrCl <21 ml/min:** sample 24h after the start of the infusion and only give a further dose once the measured concentration is <1 mg/L.
- Document the action taken in the medical notes and overleaf. Prescribe the next dose overleaf when appropriate. Repeat gentamicin sampling at least every 2 days (daily if CrCl <21ml/min).
- Contact pharmacy for advice as necessary (e.g. changing renal function, gentamicin concentration unexpectedly high/low/on the line between dosage intervals when plotted on the graph).
- Check microbiology sensitivities & refer to the IV to Oral switch policy. To stop therapy tick the 'Stop' box, score though the chart with the word 'STOP' & discontinue the HEPMA prescription.

For NURSES – *for further information see the 'HEPMA prescribing of Gentamicin IV and Vancomycin IV advice for adults' document on GGC Clinical Guidelines Platform.*

- Before administering CHECK HEPMA to ensure that gentamicin hasn't been discontinued there. Check creatinine & gentamicin blood concentrations are being monitored (these are recorded overleaf). Discuss with the prescriber promptly if you are unsure if this monitoring is being done. Be alert for signs of toxicity (see overleaf) & alert the prescriber promptly if any are evident.
- Record the **date and exact time** the dose was given **on BOTH this chart and HEPMA (with two nurses' signatures).**



If the measured concentration is unexpectedly HIGH or LOW

- Were dose and sample times recorded accurately?
- Was the correct & full dose administered?
- Was the sample taken from the line used to administer the drug?
- Was the sample taken during drug administration?
- Has renal function declined or improved?
- Does the patient have oedema, ascites or an extreme weight?

If in doubt, take another sample before re-prescribing and/or seek advice from pharmacy

Mitochondrial DNA mutation genetic testing

The mitochondrial DNA mutation m.1555A>G predisposes to **severe hearing loss** following aminoglycoside exposure. Consider the need for genetic testing, especially in patients requiring recurrent or long-term treatment with aminoglycosides (e.g. enterococcal endocarditis, complex drug resistant infections including tuberculosis or cystic fibrosis or recurrent neutropenic sepsis) **but DO NOT delay urgent treatment in order to test.**

Results can take up to 28 days to come back. See Therapeutics Handbook for further information.

Approved by:
NHSGGC Antimicrobial Utilisation Committee: Nov 2023

Date of Review: Nov 2026

Information for patients about Intravenous Gentamicin

NHS Greater Glasgow and Clyde

Why have I been given this leaflet?

This leaflet gives you some important information on a medicine called gentamicin. This is to help you to:

- Be more involved in your treatment
- Understand why we take blood samples
- Be aware of the important potential side effects of gentamicin
- Understand the importance of letting the doctor, nurse or pharmacist know if you have any side effects
- Feel able to ask questions about your treatment

What is gentamicin and what is it used for?

Gentamicin is a powerful antibiotic that we use to treat certain types of serious bacterial infections. We have prescribed you gentamicin because it is the appropriate antibiotic for your infection.

When serious infection is suspected doctors aim to give gentamicin as soon as possible. Therefore if you are very unwell we sometimes start treatment before you or your family have had a chance to read this leaflet.

If you answer 'Yes' to any of these questions, please tell your doctor, nurse or pharmacist immediately:

- Do you have any hearing or balance problems, or have you (or your relatives) had hearing or balance problems as a side effect from previous antibiotic use?
- Do you (or your relatives) have a mitochondrial disease (mutations in the parts of your cells which help make energy)?
- Are you allergic to gentamicin or any other antibiotics?
- Are you pregnant or breast feeding?
- Do you have reduced kidney function?
- Do you have myasthenia gravis?
- Are you taking any other medicines: including 'water tablets' such as furosemide; over the counter medications; or herbal remedies?
- Have you taken gentamicin before?

How is gentamicin given?

The nurses in hospital will give you gentamicin as an injection into a vein or via a drip. We may change the dose and how often you take it during the course of treatment.

How will I be monitored?

We will measure the amount of gentamicin in your blood to make sure you are on the right dose by taking a blood test. This will also tell us how your kidneys are working. You may also need a hearing and balance test (see possible side effects).

How long will I take gentamicin?

Usually you will take gentamicin for up to 4 days. If you need gentamicin for more than 5 days, your doctor will arrange for you to have hearing and balance tests (see possible side effects).

What are the possible side effects?

Like all medicines, gentamicin may cause side effects. However, most are rare and not all patients will experience them. **It is extremely important that you tell your doctor, nurse or pharmacist if you experience any of these side effects at any time as they could be serious or long-term.**

- **Reduced kidney function:** you might not have any symptoms but may notice you are passing less urine
- **Allergic reactions:** including rash, itch, fever, shortness of breath, a tight chest or wheezing, chills or shivers, swelling or redness of the skin
- **Hearing or balance problems,** these may include:
  - Hearing impairment: you may experience a ringing in your ears (tinnitus) or hearing loss
  - Disturbances in balance: you may feel dizzy or have difficulty in keeping your balance
  - Visual disturbances: you may experience jerky or bouncing vision

If you have any questions while in hospital, please ask a member of staff. When you go home, you should contact your GP, Practice Nurse or Community Pharmacist for any further advice if required. If you are ill on a day or at a time when your GP surgery is closed, you can call NHS 24 on ☎ 111.

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

MEDICINES RECONCILIATION

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

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

DOCTOR'S DECLARATION (if required by Local Protocol)

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

_____

with the following exceptions:_____

Print & Sign:_____ Date:_____

COMMUNITY PHARMACY INFORMATION

Name_____ Tel No._____
Address_____
Compliance Aid Details_____
Patient consent to share discharge information Y/N
Print & Sign_____

PATIENT DETAILS

Hos
DOI
Date
Con

3112626230
MCLACHLAN
Michael 31/12/196
FLAT 1-1
10 GIRVAN STREET
Glasgow, Lanarkshire
G33 2DL

Height:
Weight:
Surface area:
Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
17/3	MORPHINE	5mg	IV	2140			85-15
17/3	MORPHINE	5mg	IV	2330			23-40
17/3	AMOXICILLIN	1g	IV	2340			Missed
17/3	GENTAMICIN	APR	IV	2340			00:252
18/3	Paracetamol	1g	oral	0000		PC Declined	
18/3	Paracetamol	1000mg	IV	0210		MB	0210

TARGET OXYGEN SATURATIONS

Please CIRCLE a target saturation and prescribe oxygen on the Regular Prescription section.

94 – 98%	88 – 92% (e.g. in hypercapnic respiratory failure)	Other (please specify)

On Home Oxygen? Yes / No _____ L/min

DATE: _____/_____/_____ PRESCRIBER (PRINT & SIGN): _____

	DATE → 17																									
	MONTH → 3																									
	RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)																									
IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N																										
ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N																										
SIGNATURE OF ASSESSOR																										
ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N																										

Parenteral Drugs : Regular Prescription

Patient's Own Medicine

A — BEFORE ADMISSION ☐ — NEW DOSE ☐ — NEW MEDICATION ☑

DRUG: AMOXICILLIN

DOSE: 1g | ROUTE: IV | DATE: 11/3 | 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.

B — BEFORE ADMISSION ☐ — NEW DOSE ☐ — NEW MEDICATION ☑

DRUG: GENTAMICIN

DOSE: APC | ROUTE: IV | DATE: 11/3 | 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.

C — BEFORE ADMISSION ☐ — NEW DOSE ☐ — NEW MEDICATION ☑

DRUG: Enoxaparin

DOSE: 40 mg | ROUTE: S/C | DATE: 11/3 | 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.

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

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

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

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

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

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

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

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 ☐

H DRUG: Paracetamol

DOSE: 1000 mg | ROUTE: oral | DATE: 18/3/26 | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN): [signature]

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

J DRUG:

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

PRESCRIBER (PRINT & SIGN):

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

K DRUG:

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

PRESCRIBER (PRINT & SIGN):

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

L DRUG:

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

PRESCRIBER (PRINT & SIGN):

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

M DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

N DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

P DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

R DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

S 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 ☐

T 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 ☐

V 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 ☐

W 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

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

| | | |

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 →

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

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

---

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

GG DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

HH DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

JJ DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

KK DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

All Routes: As Required Prescriptions

Patient's Own Medicine

| | | |

[redacted]

| | | |

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, 1800.
5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.
6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.
7. The following metric unit abbreviations must be used –

Milligram = mg	Gram = g
Millilitre = ml	Millimoles = mmol

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

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

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

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

Please note - intrathecal must be written in full.

FOR NURSES

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

Codes for Non-Administration of Drugs

(3) Patient refused	(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		

Cat. No. 40995 Ver 4, 09/2010 GGC0029

Inpatient prescription & administration record for Michael McLachlan (3112626230)

Admission: 18/03/2026 => 24/03/2026

00:01
27/03/26

Patient Demographics

MCLACHLAN Michael (3112626230)
DOB: 31/12/1962
Flat 1-1, 10 Girvan Street,
Glasgow,
Lanarkshi
G33 2DP

Admitted: 18/03/2026 04:20
Discharged: 24/03/2026 16:50

Transfer history

Admission	2026-03-17 12:33:00	RAE GRI ED
Transfer	2026-03-18 04:20:00	R70 GRI WARD 70

Responsible Consultant history

Assigned No Consultant	17/03/26	12:33
Alastair Mckay	18/03/26	04:20

Allergy

Admission Allergy Check performed by:
Current recorded allergy (reaction): No Known Drug Allergies

Amoxicillin 1000 mg (1g) Injection

18/03/26 07:00 1,000 mg THREE TIMES DAILY 7am:12pm:10pm (Intravenous Slow Bolus Injection) — Ferdinand Noukwe Noukwe

Indication : Abdominal Intra-Abdominal Sepsis

18/03/26	07:00	18/03/2026	06:08	Rachel Dick/ Jean Templeton	
18/03/26	12:00	18/03/2026	12:46	David Maclaren/ Stephen Mitchell	
18/03/26	22:00	18/03/2026	21:49	Travis Tempest/ Robyn Hart	
19/03/26	07:00	19/03/2026	06:49	Rachel Dick/ Travis Tempest	
19/03/26	12:00	19/03/2026	13:07	David Maclaren/ Elizabeth Smart	

Discontinued on: 19/03/2026 13:07:00 by: Marc Gurun . Reason: Inadequate Response

Co-trimoxazole 960 mg Tablets

23/03/26 22:00 960 mg TWICE DAILY 7am:10pm (Oral) — Aneesha Grewal

23/03/26	22:00	23/03/2026	22:35	Jean Templeton	
24/03/26	07:00	24/03/2026	07:48	Amy McCallum	

Creon 25,000 Capsules

18/03/26 07:00 1 Capsule THREE times daily at 7am, 12 noon, and 5pm (Oral) — Ferdinand Noukwe Noukwe

18/03/26	07:00	18/03/2026	07:55	David Maclaren	
18/03/26	12:00	18/03/2026	12:24	David Maclaren	
18/03/26	17:00	18/03/2026	16:39	David Maclaren	
19/03/26	07:00	19/03/2026	07:53	Elizabeth Smart	
19/03/26	12:00	19/03/2026	12:16	David Maclaren	
19/03/26	17:00	19/03/2026	16:36	David Maclaren	
20/03/26	07:00			Derek Hodgson	Refused by Patient
20/03/26	12:00			Derek Hodgson	Refused by Patient
20/03/26	17:00			Derek Hodgson	Refused by Patient
21/03/26	07:00			Pamela Mitchell	Refused by Patient
21/03/26	12:00			Pamela Mitchell	Refused by Patient
21/03/26	17:00			Bernadette McIntyre	Refused by Patient
22/03/26	07:00			David Maclaren	Refused by Patient
22/03/26	12:00	22/03/2026	12:19	David Maclaren	
22/03/26	17:00	22/03/2026	16:31	David Maclaren	
23/03/26	07:00			Pamela Mitchell	Refused by Patient
23/03/26	12:00			Derek Hodgson	Refused by Patient
23/03/26	17:00	23/03/2026	16:28	Pamela Mitchell	
24/03/26	07:00			Amy McCallum	Refused by Patient
24/03/26	12:00			Amy McCallum	Refused by Patient

Diazepam 5 mg Tablets

23/03/26 07:00 5 mg TWICE daily at 7am and 12 midday (Oral) — Mhairi Stewart

23/03/26	07:00	23/03/2026	07:49	Pamela Mitchell	
23/03/26	12:00	23/03/2026	12:29	Derek Hodgson	
24/03/26	07:00	24/03/2026	07:48	Amy McCallum	

Key: Prescription details; Recorded as "Admitted On"; Prescribed as "Self Administer"; Discontinuation details; HEPMA Prescription additional notes; HEPMA Patient admission notes (admission specific); HEPMA Patient retained notes (not specific to admission)

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Diazepam 5 mg Tablets *(Continued)*

24/03/26	12:00	24/03/2026	11:34	Amy McCallum	

Diazepam 2 mg Tablets

☒ 18/03/26 22:00 8 mg TWICE daily at 1pm & 10pm (Oral) — Mhairi Stewart

18/03/26	22:00	18/03/2026	21:21	Travis Tempest	
19/03/26	13:00	19/03/2026	12:16	David Maclaren	
19/03/26	22:00	19/03/2026	21:58	Kerry Donnelly	
20/03/26	13:00	20/03/2026	12:27	Derek Hodgson	
20/03/26	22:00	20/03/2026	22:18	Kerry Donnelly	
21/03/26	13:00	21/03/2026	12:15	Pamela Mitchell	
21/03/26	22:00	21/03/2026	22:35	Kerry Donnelly	
22/03/26	13:00	22/03/2026	12:19	David Maclaren	

☒ 22/03/26 22:00 8 mg TWICE daily at 1pm & 10pm (Oral) — Mhairi Stewart

22/03/26	22:00			Suzanne Gilmour	Other - see patient nursing notes

☒ 18/03/26 14:18 8 mg (Oral) — Mhairi Stewart

18/03/26	14:18	18/03/2026	14:28	David Maclaren	

☒ 19/03/26 07:00 6 mg ONCE DAILY MORNING 7am (Oral) — Mhairi Stewart

19/03/26	07:00	19/03/2026	06:47	Travis Tempest	
20/03/26	07:00	20/03/2026	08:19	Derek Hodgson	
21/03/26	07:00	21/03/2026	07:49	Pamela Mitchell	
22/03/26	07:00	22/03/2026	08:00	David Maclaren	

Discontinued on: 22/03/2026 16:27:00 by: Mhairi Stewart . Reason: Course Complete

☒ 22/03/26 17:00 6 mg TWICE daily at 5pm and 10pm (Oral) — Mhairi Stewart

22/03/26	17:00	22/03/2026	16:33	David Maclaren	
22/03/26	22:00	22/03/2026	22:33	Suzanne Gilmour	
23/03/26	17:00	23/03/2026	16:28	Pamela Mitchell	
23/03/26	22:00	23/03/2026	22:35	Jean Templeton	

Enoxaparin (Inhixa) 20 mg in 0.2mL Pre-Filled Syringe

☒ 21/03/26 17:00 20 mg ONCE daily at 5pm (Subcutaneous Bolus Injection) — Mhairi Stewart

21/03/26	17:00			Bernadette McIntyre	Refused by Patient
22/03/26	17:00	22/03/2026	16:31	David Maclaren	
23/03/26	17:00	23/03/2026	16:28	Pamela Mitchell	

☒ 20/03/26 19:20 20 mg (Subcutaneous Bolus Injection) — Mhairi Stewart

20/03/26	19:20	20/03/2026	22:17	Kerry Donnelly	

Enoxaparin (Inhixa) 40 mg in 0.4mL Pre-Filled Syringe

☒ 19/03/26 17:00 40 mg ONCE daily at 5pm (Subcutaneous Bolus Injection) — Arush Vanka

19/03/26	17:00	19/03/2026	16:36	David Maclaren	
20/03/26	17:00			Mhairi Stewart	Drug discontinued

Discontinued on: 20/03/2026 19:20:00 by: Mhairi Stewart . Reason: Course Complete

Laxido (Orange) Sachets

☒ 23/03/26 22:00 2 Sachet TWICE DAILY 7am:10pm (Oral) — Aneesha Grewal

23/03/26	22:00			Jean Templeton	Refused by Patient
24/03/26	07:00			Amy McCallum	Refused by Patient

☒ 23/03/26 08:55 2 Sachet (Oral) — Aneesha Grewal

23/03/26	08:55			Derek Hodgson	Refused by Patient

Meropenem 1000 mg (1g) Injection

☒ 19/03/26 22:00 1,000 mg THREE TIMES DAILY 7am:12pm:10pm (Intravenous Intermittent Infusion) — Marc Gurun

19/03/26	22:00	19/03/2026	22:00	Kerry Donnelly/ Suzanne Gilmour	
20/03/26	07:00	20/03/2026	06:16	Travis Tempest/ Kerry Donnelly	
20/03/26	12:00	20/03/2026	13:12	Pamela Mitchell/ Derek Hodgson	
20/03/26	22:00	20/03/2026	23:31	Travis Tempest/ Kerry Donnelly	
21/03/26	07:00	21/03/2026	06:44	Travis Tempest/ Kerry Donnelly	
21/03/26	12:00	21/03/2026	12:51	Bernadette McIntyre/ Pamela Mitchell	
21/03/26	22:00	21/03/2026	21:44	Suzanne Gilmour/ Robyn Hart	
22/03/26	07:00	22/03/2026	06:06	Suzanne Gilmour/ Kerry Donnelly	
22/03/26	12:00	22/03/2026	12:10	David Maclaren/ Caitlin Greenshields	
22/03/26	22:00	22/03/2026	21:51	Suzanne Gilmour/ Robyn Hart	
23/03/26	07:00	23/03/2026	06:19	Robyn Hart/ Suzanne Gilmour	
23/03/26	12:00			Derek Hodgson	Prescription Clarification Required

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Meropenem 1000 mg (1g) Injection *(Continued)*

Discontinued on: 23/03/2026 14:11:00 by: Aneesha Grewal . Reason: Condition Resolving/Resolved

☒ 19/03/26 13:07 1,000 mg (Intravenous Intermittent Infusion) Marc Gurun

19/03/26	13:07	19/03/2026	13:13	David Maclaren/ Elizabeth Smart

Risperidone 2 mg Tablets

☒ 18/03/26 22:00 2 mg ONCE DAILY NIGHT 10pm (Oral) Ferdinand Noukwe Noukwe

18/03/26	22:00	18/03/2026	23:01	Travis Tempest	
19/03/26	22:00			Kerry Donnelly	Refused by Patient
20/03/26	22:00			Kerry Donnelly	Refused by Patient
21/03/26	22:00			Kerry Donnelly	Refused by Patient
22/03/26	22:00			Suzanne Gilmour	Refused by Patient
23/03/26	22:00			Jean Templeton	Refused by Patient

Tamsulosin 400 micrograms Modified Release Capsules

☒ 18/03/26 07:00 400 microgram ONCE daily at 7am (Oral) Ferdinand Noukwe Noukwe

18/03/26	07:00	18/03/2026	07:55	David Maclaren
19/03/26	07:00	19/03/2026	07:52	Elizabeth Smart
20/03/26	07:00	20/03/2026	08:19	Derek Hodgson
21/03/26	07:00	21/03/2026	07:49	Pamela Mitchell
22/03/26	07:00	22/03/2026	07:55	David Maclaren
23/03/26	07:00	23/03/2026	07:49	Pamela Mitchell
24/03/26	07:00	24/03/2026	07:46	Amy McCallum

Trimbow 87mcg/5mcg/9mcg Inhaler

☒ 18/03/26 07:00 2 Puff(s) TWICE daily at 7am and 10pm (Inhalation) Ferdinand Noukwe Noukwe

18/03/26	07:00			David Maclaren	Drug unavailable
18/03/26	22:00			Travis Tempest	Self Administers
19/03/26	07:00			Elizabeth Smart	Self Administers
19/03/26	22:00			Kerry Donnelly	Self Administers
20/03/26	07:00			Derek Hodgson	Self Administers
20/03/26	22:00			Kerry Donnelly	Self Administers
21/03/26	07:00			Pamela Mitchell	Self Administers
21/03/26	22:00			Kerry Donnelly	Self Administers
22/03/26	07:00	22/03/2026	07:55	David Maclaren	
22/03/26	22:00			Suzanne Gilmour	Self Administers
23/03/26	07:00			Pamela Mitchell	Self Administers
23/03/26	22:00			Jean Templeton	Self Administers
24/03/26	07:00			Amy McCallum	Self Administers

Cyclizine 50 mg Tablets as required

☒ 19/03/26 22:15 50 mg THREE times daily - 7am;12pm;10pm (Oral) FOR NAUSEA Ferdinand Noukwe Noukwe

50.00	20/03/2026	13:11	Pamela Mitchell	
50.00	20/03/2026	22:18	Kerry Donnelly	

Dihydrocodeine 30 mg Tablets as required

☒ 21/03/26 06:34 30 mg FOUR TIMES DAILY 7am:12pm:5pm:10pm (Oral) FOR PAIN Melina Bendz

30.00	21/03/2026	06:34	Kerry Donnelly	
30.00	21/03/2026	12:16	Pamela Mitchell	
30.00	21/03/2026	20:01	Kerry Donnelly	
30.00	22/03/2026	06:27	Kerry Donnelly	
30.00	22/03/2026	17:50	David Maclaren	

Gentamicin AS PER PAPER CHART Intravenous Infusion as required

☒ 18/03/26 04:20 1 Dose (Intravenous Intermittent Infusion) SEE PAPER CHART Ferdinand Noukwe Noukwe

Discontinued on: 19/03/2026 13:07:00 by: Marc Gurun . Reason: Inadequate Response

Glycerol 4 g (Adult) Suppositories (Glycerin) as required

☒ 23/03/26 08:55 4 g (Rectal) FOR CONSTIPATION Aneesha Grewal

Laxido (Orange) Sachets as required

☒ 20/03/26 11:42 1 Sachet TWICE DAILY 7am:10pm (Oral) FOR CONSTIPATION Mhairi Stewart

1.00	20/03/2026	13:11	Pamela Mitchell
1.00	22/03/2026	22:34	Suzanne Gilmour

Discontinued on: 23/03/2026 08:55:52 by: Aneesha Grewal . Reason: Discontinued due to conflict

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Morphine sulfate 10 mg in 5mL Oral Solution as required

☒ 18/03/26 04:25 5 mg (Oral) FOR PAIN Max 6 dose/24h thn Dr r/v — Ferdinand Noukwe Noukwe

5.00	18/03/2026	07:01	Jean Templeton
5.00	18/03/2026	09:16	David Maclaren
5.00	19/03/2026	00:53	Rachel Dick
5.00	19/03/2026	22:40	Kerry Donnelly
5.00	20/03/2026	18:33	Derek Hodgson

Discontinued on: 21/03/2026 06:34:00 by: Melina Bendz . Reason: Patient Non-Compliant

Paracetamol 500 mg Tablets as required

☒ 18/03/26 04:22 1,000 mg FOUR times daily - 7am;12pm;5pm;10pm (Oral) FOR PAIN — Ferdinand Noukwe Noukwe

1,000.00	18/03/2026	20:27	Travis Tempest

☒ 18/03/26 20:28 500 mg FOUR times daily - 7am;12pm;5pm;10pm (Oral) FOR PAIN — Mhairi Stewart

500.00	22/03/2026	17:50	David Maclaren

Salbutamol 100 micrograms (Easyhaler) Dry Powder Inhaler as required

☒ 18/03/26 04:34 400 microgram (Inhalation) FOR BREATHLESSNESS — Ferdinand Noukwe Noukwe

Patient level notes

added by **Rachel Dick** on 19/03/2026 at 00:57

Title: oramorph

Oramorph signed for @00:55 but patient refused to take it, as stated it makes him feel sick and wants it IV - I have made him aware we do not give morphine IV on this ward.

added by **Travis Tempest** on 18/03/2026 at 23:12

Title: Risperidone administration

Resperidone 2mg 18/3/26 23:00 (Charted howver not administered as PT refused)

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