NHS Forth Valley

Carseview House
Castle Business Park
Stirling
FK9 4SW

Telephone: 01324 566292
Fax:

NHS Forth Valley

Private and Confidential
MMA Legal Limited
Stok
43-59 Princes Street
Stockport
SK1 1RY

Date: 29 April 2026
Your Ref: 100106
Our Ref: GDP/0021239

Enquiries to: Legal Admin Team
Extension:
Direct Line: 01324 566292

Dear Sir/Madam

Re: Gary Scrimshaw

With reference to your recent access request please find enclosed copy health records as requested.

Please note that records held by Forth Valley Royal Hospital will include records for Falkirk Community Hospital and Stirling Health & Care Village.

If we can be of any further assistance then please do not hesitate to contact us.

Yours Sincerely

Legal Admin Team
E-mail: fv.healthrecs-legal@nhs.scot

FVRH Emergency Department Forth Valley Royal Hospital

04

Date of attendance: 20/05/2024 22:04
Presenting complaint: chest pain (Sas wr)

Surname:	Scrimshaw	**Forename:**	Gary	**Title:**	Mr
Address:	40 Johnston Crescent Tillicoultry Clackmannanshire	**Postcode:**	FK13 6PZ	**CHI:**	3011795258
Telephone:	07340830479				
Date of Birth:	30/11/1979	**Sex:**	Male	**Age:**	44 Years

GP Name:	G Campbell		
Address:	25544/1 Tillicoultry Medical Practice Park Street Tillicoultry Tillicoultry FK13 6AG	**Telephone:**	01259 750531

Next of Kin

Name:	Tracey Scrimshaw		
Relationship:	Wife	**Postcode:**	FK13 6PZ
Address:	40 Johnston Crescent Tillicoultry Clackmannanshire	**Telephone:**	07423556817

Triage Information

chest pain
R sided chest pain, stabbing in nature, non raditing, clammy, sweaty - denies pain at triage, no cardiac hx
recent problem

Observations

P=	63	**BP=** 124 / 67	**RR=** 17	**Sat=** 97	**BM=**
Peak Flow=			**GCS=**		**News=** 0

Temp= 36.6

Emergency Department / Pre-Hospital Drugs | **Allergies**

Date	Drug	Dose	Route		Signature	Given by	Time

DNW

Clinical Notes

Seen by:		Time:	

Attach continuation sheets here

Attach here onto face of pocket

Guidelines Used:	

PVC INSERTION BUNDLE AND REMOVAL RECORD

GARY SCRIMSHAW

PATIENT LABEL

3007952588

PLEASE COMPLETE ALL BOXES

The patients skin is decontaminated and allowed to dry	YES / NO
Hand hygiene & gloves donned prior to insertion	YES / NO
Aseptic Non Touch Technique is used to insert PVC	YES / NO
If not possible, use either STERILE GLOVES or MINI CHLORAPREP	
Sterile dressing & sticker (date & time) applied after insertion	YES / NO

Why is PVC clinically indicated for patient?: (please tick)

IV Fluids		Blood Transfusion	
IV Drugs		Diagnostics	
Predicted clinical need			

Colour:
Insertion Site:
Ward/Department:
Inserted by:
Date & Time:
Removed: YES / NO

INVESTIGATIONS

Bloods Required:

FBC U&E GLU LFT CRP AMY CLOTTING G&S ESR PARACETAMOL

TROP D-DIMER CULTURES VBG* ABG* (*attach to notes) URINALYSIS HCG ECG

Others:

SIGN

BLOODS TAKEN? YES / NO TIME TAKEN 2240 PRINT

Preliminary Pressure Ulcer Risk Assessment (PPURA):

Mobility:	Person is fully mobile without equipment/assistance
Continence:	Person is fully continent
Nutrition:	Person appears well nourished and able to eat and drink
Skin:	Skin to pressure points satisfactory/intact

Points to Consider

* People who are overweight may not be well nourished
* Use of repose mattress or pressure relieving heel protectors.

Record your answer in the grid below Y = Yes or N = No
If the answer is NO to any assessments undertake a BRADEN and consider any other assessment

DATE	TIME	MOBILITY	CONTINENCE	NUTRITION	SKIN INSPECTED	SKIN INTACT	BRADEN COMPLETED	SIGNATURE

SKIN DESCRIPTION i.e. REDNESS, SKIN BROKEN, BLISTER / ULCER	ACTION TAKEN

4 A T

ALERTNESS (assess for drowsiness or agitation, if asleep attempt to rouse)		Tick
Normal	0	
Mild sleepiness (easily roused <10 seconds)	0	
Clearly abnormal	4	
AMT4 (age, date of birth, place, current year)		**Tick**
No mistakes	0	
1 mistake	1	
2 or more mistakes	2	
ATTENTION (ask for months of the year backwards)		**Tick**
Achieves 7 or more correctly	0	
Starts but scores less than 7/Refuses to start	1	
Untestable	2	
ACUTE CHANGE OR FLUCTUATION (significant change incl. evidence of psychotic symptoms)		**Tick**
No	0	
Yes	4	
Total score (score of 4 or more indicates likely delirium - initiate TIME bundle)		

FALLS TRIGGER TOOL [Complete only if 65 years or over]

2 or more falls in the last 6 months?	YES / NO	Tries to walk alone and is unsteady?	YES / NO
Fall since admission to department?	YES / NO	Patient/relatives anxious about falls	YES / NO
Admitted to department with fall?	YES / NO	4AT more than 4/evidence of confusion	YES / NO

COMPLETED BY .....

If you have answered yes to 2 or more questions,

- For patients being admitted please document recommendation that a full care bundle is required to be completed.
- Please add FALLS RISK IDENTIFIER to Trakcare (EPR→ Patient Alerts→ New→ Ward Signifiers→ Falls risk).

PATIENT LABEL

CLINICAL NOTES

Near Patient Testing Results

Troponin.....Initials.....

Time of Trop.....

D-dimer.....

Urine dipstick

Leucs
Nitrite
Protein
Blood
Ketones
Glucose

Blood Gases

Arterial/venous (circle)
Time taken

FiO2
pH
pCO2
PO2
BE
Lactate

Urine Pregnancy Test
HCG positive/negative (circle)

Fast

Free fluid identified:
Yes/No (circle)

AAA

Aorta clearly seen
Yes/No (circle)
Measured diameter.....

Protetanus
Immune/Not immune (circle)

Patient/Legal Guardian Permission to release info for legal purpose including Police Yes / No

Patient Signature..... Print Name..... Date.....

ING1716

[redacted]

5/20/2024 Incident Number: CR010941114

Patient Information

GARY SCRIMSHAW

Age/Gender: 44 years 5 months 21 days Old Male
Address: 96 JOHNSTON CR. TILLICOULTRY FK13 6PZ
DOB: 30/11/1979
CHI: 3011795258
Ethnicity: White Scottish

Date: 20/05/2024
Incident Number: CR010941114
Incident Type: EMG
Incident Location: NEW BREWERY KELLIEBANK ALLOA, FK10 1NU

Scottish Ambulance Service

Presenting Complaint

AS1 44YOM CHEST PAIN

Additional Comments

O/a alert and orientated gcs15. At work, hpc - since 1400 has been having intermittent chest pain at rest. Episodes lasting 10-15 mins each time, started at rest, radiates to right arm and down to fingers. Has been feeling nauseated and clammy. Also feels sob during these episodes. Worsening whilst at work tonight called ambulance then. o/e - obs as charted,Chest clear, 12 lead ecg sinus rhythm with what appears to be an rsr pattern on v1 and v2. given aspirin and gtn. Pain score was 6/10 with sas, was worse before sas arrival. After gtn pain reduced to a 1/10. unknown if family hx of heart problems as grown up through care system. Shx - lives with wife, smoker, no alcohol intake. transported to fvrh for assessment. nok - tracey - 07423556817.

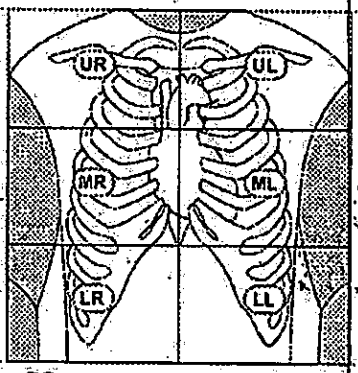
PATIENT ASSESSMENT

ACVPU Alert <C> No

A Clear

B Breathing Adequately: Yes | Respiratory Rate: 20 | SPO2: 97

Oxygen Given: No

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

C

Pulse Rate	BP	Cap Refill	ECG Rhythm
85	146/84	<=2 Secs	Sinus Rhythm

Rhythm	Arm	Central/Peripheral	ECG
Reg	Right	Peripheral	12 Lead

D

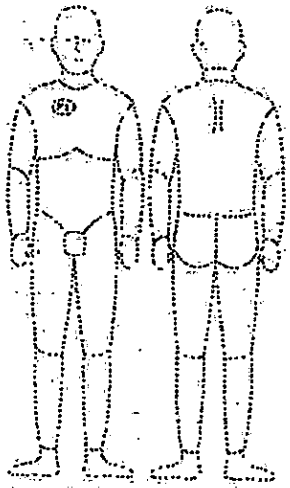
GCS	Eyes	Voice	Motor	PEARL
15	Spontaneously (4)	Orientated (5)	Obeys Commands (6)	

E

[redacted]S A RECONSTITUTED DOCUMENT PRINTED FROM EDRM

[redacted] [redacted] [redacted]

[redacted]



Pain

ID	Body Part	Pain Scale
P1	Chest	6

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
21:38	72	18	120/64	97	<=2s	15	Alert								E0000196
21:13	85	20	146/84	97	<=2 Secs	15	Alert		36.8	8	Sinus Rhythm				E9886581

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
21:13	20 (0)	97 (0)		0	146 (0)	85 (0)	Alert (0)	36.8 (0)	0

Drugs

Time	Drug	Dosage	Units	Route	Drug Expiry Date	Pain Before	Pain After	CrewID
21:30	Aspirin	300	mg	OR	06/2025			E0000196
21:32	GTN	800	mcg	SL	06/2026	6	3	E0000196

HISTORY

AMPLE

Allergies	None
Medication	SEE ECS
Past Medical History	SHERMANS DISEASE (BACK CURVATURE, BACK INJURY).
Last Eaten	>4 Hours Ago
Events Prior	CHEST PAIN INTERMITTENT SINCE 1400, WORSENING

Social History

Lives alone: No | Living With: WIFE | Patient Occupation: FACTORY WORKER.

Patients General Appearance	Normal
Living Arrangement	Dependants
Patient Mobility	Fully Mobile
Patient Communication	No Help Required
Patient Clinical Risk Factors	Smoker
Patient Enviromental Risk Factors	None Identified

[redacted]

5/2024

Incident Number: CR0105111114

Site	RIGHT SIDE	Onset	1400 ONWARDS
Character	TIGHT STABBING, Intermittent, Worsening	Radiates	Yes. RIGHT ARM TO FINGER TIPS
Associated Symptoms	CLAMMY, Nausea	Timing	LAST 3 10-15 MINS EACH EPISODE
Exacerbating Or Relieving Symptoms	GTN HELPED.	Severity	6/10

Safeguarding

Safeguarding Assessment	Adult >= 16

MEDICAL

ACS

Associated Symptoms	Breathlessness

CLOSE RECORD

Treatment On Scene	Non-Emergency

Conveyance

Transport To Hospital	Normal driving	Pre-Alert	No

INCIDENT LOG

Time Call Received	20:48	Allocated	20:49	Mobile	20:49
First Resource On Scene		Crew On Scene	21:04	Crew Left Scene	21:32
Crew At Hosp	21:51	Receiving Hospital	FORTH VALLEY ROYAL HOSPITAL	Clear Time	

Crew ID	Crew Grade	Driver
E0000196	Paramedic	YES
E9886581	Paramedic	NO

Emergency Discharge Letter (Authorised)

FVRH Emergency Department
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

G Campbell
Tillicoultry Medical Practice
Park Street
Tillicoultry
Tillicoultry
FK13 6AG

CHI Barcode: 3011795258

Date of Completion: 21-May-2024

GP Practice

GP Name:	G Campbell	**GP GMC:**	7277373
GP Practice Address:		**GP Practice Code:**	7277373/25544
		GP Clinic Code:	25544
		GP Telephone:	

Patient Demographics

Patient Name:	SCRIMSHAW, Gary	**Date Of Birth:**	30-Nov-1979
Patient Address:	40 Johnston Crescent Tillicoultry Clackmannanshire FK13 6PZ	**Gender:**	Male
		CHI No:	3011795258
Telephone No:	07340830479		

Admission Details

Patient Location:	FVRH Emergency Department	**Admission Date:**	20-May-2024
Admission Care Provider:	Dr Ainsley Heyworth	**Admission Time:**	22:04
Source Of Admission:	999 Emergency Services		

Presenting Complaint

chest pain (Sas wr)

Diagnosis

Diagnosis	Site	Laterality
ED diagnosis - Left before clinical assessment		

Procedures

No Procedure Results

Medications

Nil records exist

Discharge Details

Discharge Type:	Admitted	**Discharge Date:**	21-May-2024
Discharge Destination:	Admission to same NHS healthcare provider / hospital - Medical Ward	**Discharge Time:**	03:01
Referred To:			

Notes for GP

Person completing record

Authorised by
Name:
Designation or role:
Specialty:
Date completed: 21-May-2024

Clinically completed by
Name:
Designation or role:
Specialty:

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
G Campbell	GP	Tillicoultry Medical Practice

Immediate Discharge Letter (Authorised)

G Campbell
Tillicoultry Medical Practice
Park Street
Tillicoultry
Tillicoultry
FK13 6AG

Acute Medicine
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

CHI Barcode: 3011795258

Date of Completion: 21-May-2024

Patient Demographics

Patient Name:	SCRIMSHAW, Gary	**Date Of Birth:**	30-Nov-1979
Patient Address:	40 Johnston Crescent Tillicoultry Clackmannanshire FK13 6PZ	**Gender:**	Male
		CHI No:	3011795258
Telephone No:	07340830479		

GP Practice

GP Name:	G Campbell	**GP GMC:**	7277373
GP Practice Address:		**GP Practice Code:**	7277373/25544
		GP Clinic Code:	25544
		GP Telephone:	

Admission Details

Patient Location:	Acute Medicine	**Admission Care Provider:**	Dr Daniel Beckett
Admission Date:	21-May-2024	**Admission Time:**	15:11
Admission Method:	Emergency Admission, no additional detail added	**Ward:**	FVRH UCC SDEC
Source Of Admission:	GP Non Obstetrics - other Provider		

Discharge Details

Discharge Specialty:	Acute Medicine	**Discharge Care Provider:**	Dr Daniel Beckett
Discharge Date:	21-May-2024	**Ward:**	FVRH UCC SDEC
Discharge Time:	16:49	**Discharge Destination:**	Private Residence - no additional detail added
Discharge Method:	Regular discharge, no additional detail added		

Clinical Summary including History

Dear Dr,

Gary attended RACU with 1/52 history of chest tightness and SOB intermittent in nature. Non exertional. Describes episode yesterday severe with associated clamminess with palpitations whilst at work.
No cough/ feverish symptoms/ nausea.

Obs/ BP 131/82 hr 54 rr16 O2 98% ra. temp 36.3C
OE/ pulse reg HS I+II+O chest clear
ECG nsr.
CXR nad
Bloods checked in ED 20/5 no change in presentation normal FBC, UES, LFTs, troponin. D dimer checked today normal.

Imp/ MSK injury / stress

Plan/
Home with worsening statement

Should you require any further information please contact RACU.

Kind regards, Dr Catriona Parker GPWSI acute medicine

Safety Alerts

Nil records exist

Allergy/Intolerance -

Allergy records are as recorded at time and date of printing
Nil records exist

Medications -

Drug Information:

Drug	Dose	Route	Frequency	GP to Continue	POD	Days Supply

Nil records exist

Drug Notes:

Drug	Drug Notes

Nil records exist

Additional Medicine Information:

Medicines discontinued during admission (Medicines that patient was recorded as admitted on only)

Drug	Discontinued Reason

Nil records exist

GP Communications:

Outstanding Results -

Responsibility of Hospital

Nil records exist

Person completing record

Authorised by
Name:
Designation or role:
Specialty:
Date completed: 21-May-2024

Clinically completed by
Name:
Designation or role:
Specialty:

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
G Campbell	GP	Tillicoultry Medical Practice

Emergency Discharge Letter (Authorised)

FVRH Emergency Department
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

AE Kolle
Tillicoultry Medical Practice
Park Street
Tillicoultry
Tillicoultry
FK13 6AG

CHI Barcode: 3011795258

Date of Completion: 27-May-2021

GP Practice

GP Name:	AE Kolle	**GP GMC:**	4269506
GP Practice Address:	Tillicoultry Medical Practice Park Street Tillicoultry Tillicoultry FK13 6AG	**GP Practice Code:**	4269506/25544
		GP Clinic Code:	25544/1
		GP Telephone:	01259 750531

Patient Demographics

Patient Name:	SCRIMSHAW, Gary	**Date Of Birth:**	30-Nov-1979
Patient Address:	40 Johnston Crescent Tillicoultry Clackmannanshire FK13 6PZ	**Gender:**	Male
		CHI No:	3011795258
Telephone No:	07340830479		

Admission Details

Patient Location:	FVRH Emergency Department	**Admission Date:**	26-May-2021
Admission Care Provider:	Dr Laura Muir	**Admission Time:**	12:07
Source Of Admission:	Self referral		

Presenting Complaint

r knee inj

Diagnosis

Diagnosis	Site	Laterality
ED diagnosis - Redirection - ED nurse redirection (as per policy)		

Procedures

No Procedure Results

Medications

Nil records exist

Discharge Details

Discharge Type:	With follow up	**Discharge Date:**	26-May-2021
Discharge Destination:	Private Residence - Usual place of residence	**Discharge Time:**	12:24

Referred To:

Notes for GP

referred to UCC for L knee inj, app time 1230

Person completing record

Name:	Dr Emma Elliott	**Specialty:**	
Designation or role:	Consultant	**Date completed:**	27-May-2021

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
AE Kolle	GP	Tillicoultry Medical Practice

Emergency Discharge Letter (Authorised)

FVRH Urgent Care Centre
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

AE Kolle
Tillicoultry Medical Practice
Park Street
Tillicoultry
Tillicoultry
FK13 6AG

CHI Barcode: 3011795258

Date of Completion: 26-May-2021

GP Practice

GP Name:	AE Kolle	**GP GMC:**	4269506
GP Practice Address:	Tillicoultry Medical Practice Park Street Tillicoultry Tillicoultry FK13 6AG	**GP Practice Code:**	4269506/25544
		GP Clinic Code:	25544/1
		GP Telephone:	01259 750531

Patient Demographics

Patient Name:	SCRIMSHAW, Gary	**Date Of Birth:**	30-Nov-1979
Patient Address:	40 Johnston Crescent Tillicoultry Clackmannanshire FK13 6PZ	**Gender:**	Male
		CHI No:	3011795258
Telephone No:	07340830479		

Admission Details

Patient Location:	FVRH Urgent Care Centre	**Admission Date:**	26-May-2021
Admission Care Provider:	Urgent Care Centre Clinician	**Admission Time:**	12:27
Source Of Admission:	Self referral		

Presenting Complaint

Right leg inj appt 12.30

Diagnosis

Diagnosis	**Site**	**Laterality**
ED injury - soft tissue - Other Soft tissue injury		

Procedures

No Procedure Results

Medications

Nil records exist

Discharge Details

Discharge Type:	With no follow up	**Discharge Date:**	26-May-2021
Discharge Destination:	Private Residence - Usual place of residence	**Discharge Time:**	13:27

Referred To:

Notes for GP

1. P/C -Right knee injury
Brought in on wheelchair. Attends with wife. Normally independant. Works in Brewery
2. H/P/C -Standing on equipment at work, part of machinery gave way, foot slipped and right lower leg slippedbetween gap in metal machinery supsending pt by right knee about 11am today. Ongoing knee pain and abrasions to knee. Applied ice at time
3. Relevant PMH/Meds - Back pain Meds - Amytriptyline, Co-codamol 30/500 NKDA
4. O/E -Superfical wound to medial aspect right knee, 2x superficial/partial thickness abrasions/wounds to lateral aspect right knee. Woundbed visible, no FB/underlying structures, no discharge, no signs of infection. No NV deficit. CRT <2secs. No obvious swelling or bruising to knee. No deformity. No effusion. No popliteal swelling. Tender over medial aspect right knee. No bone tenderness foot, ankle, fibia, tibia, fibular head, tibial tuberosity, tibial plateaux, lateral condyls, patella, femur. FROM of ankle no pain. Able to straight leg raise. Able to fully extend - but with pain. Active flexion 165 degrees, L=R=N, but with pain. ACL, PCL, LCL, MCL intact, no laxity or increased pain on resisted testing. Pt able to independently mobilse around department
5. Ix -
6. Dx -Soft tissue injury right knee
7. Tx -Wounds cleaned and dressed with siloflex and mepore dressings. Wound and dressing advice given. Given knee injury advice sheet. Advised mobilise knee ++ as able. Advised regular analgesia. Advised to monitor for signs of infection.
8. Plan -Discharge.If signs of infection or ongoing concerns return G.P or NHS 24
9. GP note -

Person completing record

Name:	Ms Catriona Quirk	**Specialty:**	
Designation or role:	Emergency Nurse Practitioner	**Date completed:**	26-May-2021

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
AE Kolle	GP	Tillicoultry Medical Practice

NHS Forth Valley
Musculoskeletal Physiotherapy Service

NHS Forth Valley

Dr Andreas Kolle
Tillicoultry Medical Practice
Park Street
Tillicoultry
FK13 6AG

Date Dictated 16 November 2020
Date Typed 16 November 2020

Our Ref XA//3011795258
CHI 3011795258

Discharge Summary

Dear Dr Kolle

Gary Scrimshaw 30/11/1979
40 Johnston Crescent Tillicoultry Clackmannanshire FK13 6PZ

Diagnosis: Right shoulder pain after falling from road bike

Outcome

	Much better / Problem resolved
	Improved
	No change
	Worse
X	Patient did not complete course of treatment
	Patient did not attend initial appointment
	Patient failed to respond to offer of appointment letter
	Patient declined initial appointment

Additional Comments:
Number of sessions: 1 (telephone)
Pain started after a bike fall on 30/09/2020. Patient reported decreased movement due to pain. Attended A&E –X-ray (no fracture, but showed tendon calcification). I offered him a face to face consultation. Unfortunately, he did not attend this appointment and has no contacted the department since. Therefore, outcome is unknown.

Yours sincerely

(Electronically checked by Xabier Ariztegieta)

Xabier Ariztegieta
HCPC Registered Physiotherapist

For NHS Forth Valley physiotherapy appointments and queries contact the AHP MSK Hub on 01324 673890 or FV-UHB.AHPMskHub@nhs.net

Emergency Discharge Letter (Authorised)

SCH Minor Injuries
Livilands Gate
Stirling
Stirling
Stirlingshire
FK8 2AU

Dept. Contact Details:

AE Kolle
Tillicoultry Medical Practice
Park Street
Tillicoultry
Tillicoultry
FK13 6AG

CHI Barcode: 3011795258

Date of Completion: 02-Oct-2020

GP Practice

GP Name:	AE Kolle	**GP GMC:**	4269506
GP Practice Address:	Tillicoultry Medical Practice Park Street Tillicoultry Tillicoultry FK13 6AG	**GP Practice Code:**	4269506/25544
		GP Clinic Code:	25544/1
		GP Telephone:	01259 750531

Patient Demographics

Patient Name:	SCRIMSHAW, Gary	**Date Of Birth:**	30-Nov-1979
Patient Address:	40 Johnston Crescent Tillicoultry Clackmannanshire FK13 6PZ	**Gender:**	Male
		CHI No:	3011795258
Telephone No:	07340830479		

Admission Details

Patient Location:	SCH Minor Injuries	**Admission Date:**	02-Oct-2020
Admission Care Provider:	Dr Joanne Mitchell	**Admission Time:**	10:14
Source Of Admission:	Not Known		

Presenting Complaint

r shoulder inj

Diagnosis

Diagnosis	Site	Laterality
Calcific Tendinitis of Shoulder		

Procedures

No Procedure Results

Medications

Nil records exist

Discharge Details

Discharge Type:	With referral	**Discharge Date:**	02-Oct-2020
Discharge Destination:	Private Residence - Usual place of residence	**Discharge Time:**	13:17

Referred To: Physiotherapy

Notes for GP

PC: Right shoulder injury.
HPC: Fall from bike hitting bollard. Pain in right shoulder since. Already has pain in shoulder since previous fall. No head injury.
PMH: Nil
Symptoms: Pain anterior right shoulder. No altered neuro
OE: No obvious swelling, erythema, bruising, deformity.

Neck NAD

Shoulder- flex 90, Abd 90 LR full. Pain with hand behind back.

MP 5/5 with pain on abd and LR.

Drop arm -ve

NV intact.
X-RAY: No # seen. RC calcification.
Treatment: Collar and cuff. 1 - 2 days. Shoulder advice sheet.
Plan: Physio
GP Action: Nil

Person completing record

Name:		**Specialty:**	
Designation or role:		**Date completed:**	02-Oct-2020

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
AE Kolle	GP	Tillicoultry Medical Practice

Hospital use only	Clinic	Day Date	Time	Hospital No.

Date Referral Submitted
(This date is fixed at hospital end):
08-Sep-2020

REFERRAL LETTER

MEDICAL IN CONFIDENCE

?

3011795258

CHI No: 3011795258

101021629631U

Unique Care Pathway Number: 101021629631U

REFERRAL TO

Physiotherapy - MusculoskletalR5V5
FV Physio - Musculoskeletal

? Consultant / receiving practitioner and/or specialty clinic

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR

? Hospital and hospital address

Hospital location code.
V217H

Urgency of Referral

Routine Physiotherapy - General Musculoskeletal Referral?? ?

Administrative Information

Patient has special requirements:No

Ethnic Origin: (White) British

?

PATIENT DETAILS

Surname	Scrimshaw
Forename(s)	Gary
Title	-
Sex	Male
Previous Surname	-
Date of birth	30-Nov-1979
CHI no.	3011795258

Patient's address

40 Johnstone Crescent
Tillicoultry
FK13 6PZ

Contact number(s)

Voice: 07340830479
E-mail: garyscrimshaw@gmail.com

REFERRING PRACTITIONER DETAILS

Name:	Dr. Andreas Kolle (GMC: 4269506)
Practice:	Tillicoultry Medical Practice (25544)
Phone:	Voice: 01259 750531

Practice address:

Park Street
Tillicoultry
FK13 6AG

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting Complaint

Description: Assessment.

Comment: This 40 year old gentleman works in a factory filling bottles. He has a 4 month history of a painful right shoulder. He points to the regimental badge area on the top of the shoulder, at the back as well. He has limited arc, being able to elevate the arm sideways up to 80 degrees and is unable really to move to a position if he wanted to pour out bottle.

I would be grateful for your further assessment and advice. He asked for some exercises to do and I gave him a link to NHS.inform - musculo skeletal zone to start with. He is already on Co-codamol and Amitriptyline for back problems and I have added some Naproxen today.

Thank you very much.

Kind regards.

Dr A E Kolle
Typed 08.09.2020 - FG

Examinations and Investigations

Murmur present:	Not Recorded	-
Is a 12 lead ECG:	Not done	-
Recent CXR:	Not done	-
FBC:	Not Recorded	-
Urea and Electrolytes:	Not Recorded	-
LFT:	Not Recorded	-
TFT:	Not Recorded	-
Lipid Profile:	Not Recorded	-
Glucose:	Not Recorded	-
Known risks:	None	-

Patient Measurements

Diastolic	Systolic	Height	Weight	BMI	Date Recorded
109	60				17-Aug-2010

Reason for referral

Care type requested: Out Patient
Expected outcome: Investigate

Medical history

Pre-existing Conditions (High Priority)

Description	??	Laterality	??	Modifier	??	Extension	??	Date Started	??
[X]Heroin addiction	??	-	??	-	??	PRIORITY=1	??	26-May-2004	

Past Procedures (High priority)

Description	??	Laterality	??	Extension	??	Date Recorded
Medication commenced for pain	??	-	??	-	??	23-Feb-2010
New medication added	??	-	??	-	??	20-Oct-2008

Active Repeat Therapy

Some Repeats may be Active but not Issued. In these instances, the Date Last Issued field contains the date authorised by the GP.

Drug name	??	Drug code	??	Formulation	??	Dosage	??	Frequency	??	Last Issued	??
Naproxen Tablets 500 mg	??	1001010P0AAAEAE	??	56 tablet	??	ONE TO BE TAKEN TWICE A DAY	??	-	??	-	?? -
Co-Codamol 30/500 Tablets	??	0407010F0AAAHAH	??	3*224 TABLET	??	TWO TO BE TAKEN UP TO A MAXIMUM OF FOUR TIMES A DAY WHEN REQUIRED FOR PAIN	??	-	??	-	?? -
Amitriptyline Hydrochloride Tablets 25 mg	??	0403010B0AAAHAH	??	3*84 TABLET	??	ONE TABLET ONCE TO THREE TIMES A DAY DEPENDING ON SEVERITY	??	-	??	-	?? -

Issued Scripts for Acutes and Inactive Repeats (in last 90 days)

No recent medications recorded

Clinical warnings

Smoking status: Number per day: ? (not known)

Description	Comment	Date Recorded
Cigarette smoker, 20 Cigarettes/day	-	26-Jul-2018
Cigarette smoker	Smoking status on date of event: Y	06-Apr-2009

Alcohol status: Units per day: ? (not known)

Exercise status: Not Known

Allergies

Description	?? Comment	?? Modifier	?? Start Date	?? Recorded Date
Adverse reaction to Tramadol Hydrochloride	?? -	?? -	?? -	?? -

Additional relevant information
?

Signature of referring doctor (or other professional) **Date** 08-Sep-2020

NHS Forth Valley
Musculoskeletal Physiotherapy Service

NHS Forth Valley

Dr David Borland
Dr Borland & Partners Cchc
Hallpark Road
Sauchie
FK10 3JQ

Date Dictated
Date Typed 16 March 2018

Our Ref PR//3011795258
CHI 3011795258

Discharge Summary

Dear Dr Borland

GARY SCRIMSHAW 30/11/1979
96 TENACRES SAUCHIE ALLOA FK10 3DP

Diagnosis: Chronic back pain

Outcome

	Much better / Problem resolved
	Improved
	No change
	Worse
X	Patient did not complete course of treatment
	Patient did not attend initial appointment
	Patient failed to respond to offer of appointment letter
	Patient declined initial appointment

Additional Comments:
Gary attended with a 22 year history of chronic back pain. He was given chronic pain advice, exercises and we discussed strategies to manage his pain better. He did not attend his review appointment and has not been back in touch.

Yours sincerely

(Electronically checked by Peter Reid)

Peter Reid

HCPC Registered Physiotherapist

For NHS Forth Valley physiotherapy appointments and queries contact the AHP MSK Hub on 01324 673890 or FV-UHB.AHPMskHub@nhs.net

Hospital use only	Clinic	Day Date	Time	Hospital No.

Date Referral Submitted
(This date is fixed at hospital end):
10-Jan-2018

REFERRAL LETTER

MEDICAL IN CONFIDENCE

3011795258

CHI No: 3011795258

1010152233142

Unique Care Pathway Number: 1010152233142

REFERRAL TO

Physiotherapy - MusculoskletalR5V5
FV Physio - Musculoskeletal

Consultant / receiving practitioner and/or **specialty clinic**

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR

Hospital and hospital address

Hospital location code.
V217H

Urgency of Referral

Routine Physiotherapy - General Musculoskeletal Referral??

Administrative Information

Patient has special requirements:No

Ethnic Origin: White Scottish

PATIENT DETAILS

Surname	Scrimshaw
Forename(s)	Gary
Title	- Sex Male
Previous Surname	-
Date of birth	30-Nov-1979
CHI no.	3011795258

Patient's address

96 Ten Acres
Sauchie
Alloa
FK10 3DP

Contact number(s)

Voice: 07341940869
E-mail: garyscrimshaw@gmail.com

REFERRING PRACTITIONER DETAILS

Name:	Dr. Catriona Lamb (GMC: 2956464)
Practice:	Dr Borland & Partners CCHC (25031)
Phone:	Voice: 01259 216701

Practice address:

Hallpark Road
Sauchie
FK10 3JQ

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting Complaint

Description: Query

Comment: Dear Team,

This gentleman has had ongoing back problems for some considerable time. They seem to be of a mechanical nature having presented to me in May 2017 having overstretched at work causing acute back spasm.

He has been taking Amitriptyline and Co-codamol for some considerable time and was keen to try and come off them however he does suffer significant back pain when does stop his medication.

He was referred to your service in 2015 but failed to respond to offer of an appointment.

His problems date from his time in the Army and the symptoms can vary from left lumbar pain (2015 this caused numbness).

There are no current red flags but I suspect this gentleman needs some general education regarding chronic back pain. Thank you for considering seeing him.

Yours sincerely,

Dr Catriona B Lamb

Examinations and Investigations

Murmur present:	Not Recorded -
Is a 12 lead ECG:	Not done -
Recent CXR:	Not done -
FBC:	Not Recorded -
Urea and Electrolytes:	Not Recorded -
LFT:	Not Recorded -
TFT:	Not Recorded -
Lipid Profile:	Not Recorded -
Glucose:	Not Recorded -
Known risks:	None -

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Medical history

Active Repeat Therapy

Some Repeats may be Active but not Issued. In these instances, the Date Last Issued field contains the date authorised by the GP.

Drug name	?? Drug code	?? Formulation	?? Dosage	?? Frequency	?? Last Issued	??
Amitriptyline Hydrochloride Tablets 25 mg	?? 0403010B0AAAHAH	?? 168 TABLET	?? 3 Daily	?? -	?? -	?? -

Issued Scripts for Acutes and Inactive Repeats (in last 90 days)

No recent medications recorded

Clinical warnings

Lifestyle risks

Exercise status: Not Known

Smoking status	Alcohol consumption
Not Known	Units per day ? ?(not known)

Additional relevant information

?

Signature of referring doctor (or other professional) Date 10-Jan-2018

NHS Forth Valley

NHS Forth Valley Radiology Report

Patient Name:	Scrimshaw, Gary (Mr)	Exam Date:	21/05/2024
Patient ID:	3011795258	Consultant:	BECKETT,DR DANIEL CONS MEDIC
Patient Date of Birth:	30/11/1979	Report Date and Time:	22/05/2024 12:54:32
Patient Address	40 JOHNSTON CRESCENT TILLICOULTRY CLACKMANNANSHIRE FK13 6PZ	Referring Dept/Location:	FV RACU MEDICAL

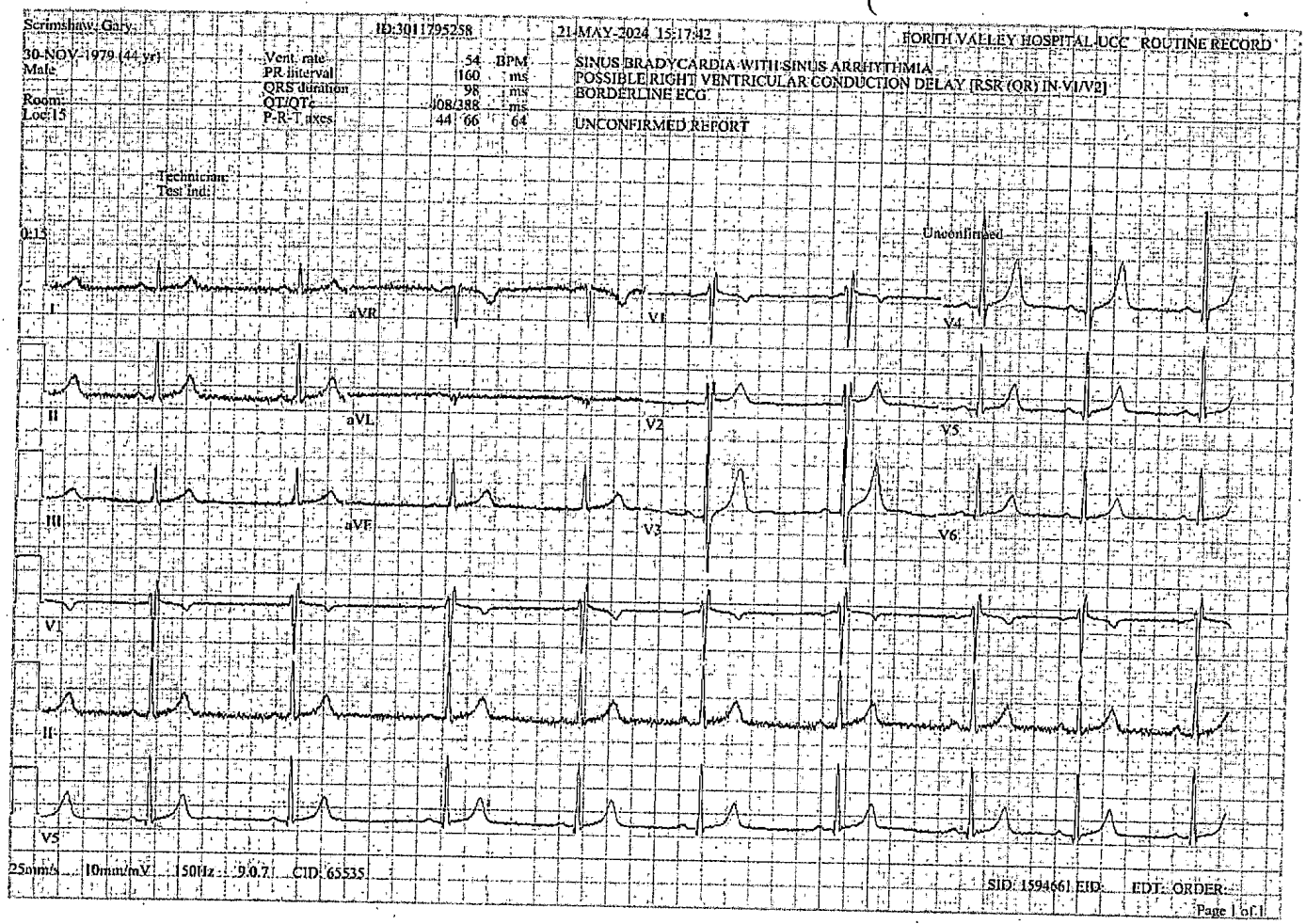
Accession: V213936463501, Examination Date: 21/05/2024, Examination: XR Chest:

Indication:
Clinical Details :
increasing sob and chest tightness
Provisional Diagnosis :
/?pe

Findings:
PA chest:

-
Comparison is made with chest radiographs dated 20/08/2010.
-
Cardiomediastinal contours are within normal limits.
-
Lungs and pleural spaces are clear.
No focal areas of consolidation or collapse.
No pleural effusion.
-
Unremarkable bony thorax.
-
No radiographic evidence of active pulmonary disease.
-

Final Report By: Jonathan Mayers Reporting Radiographer HCPC RA78096 at 22/05/2024 12:54:32
Email Address: **jonathan.mayers@nhs.scot**.



THIS IS A RECONSTITUTED DOCUMENT PRINTED FROM EDRM

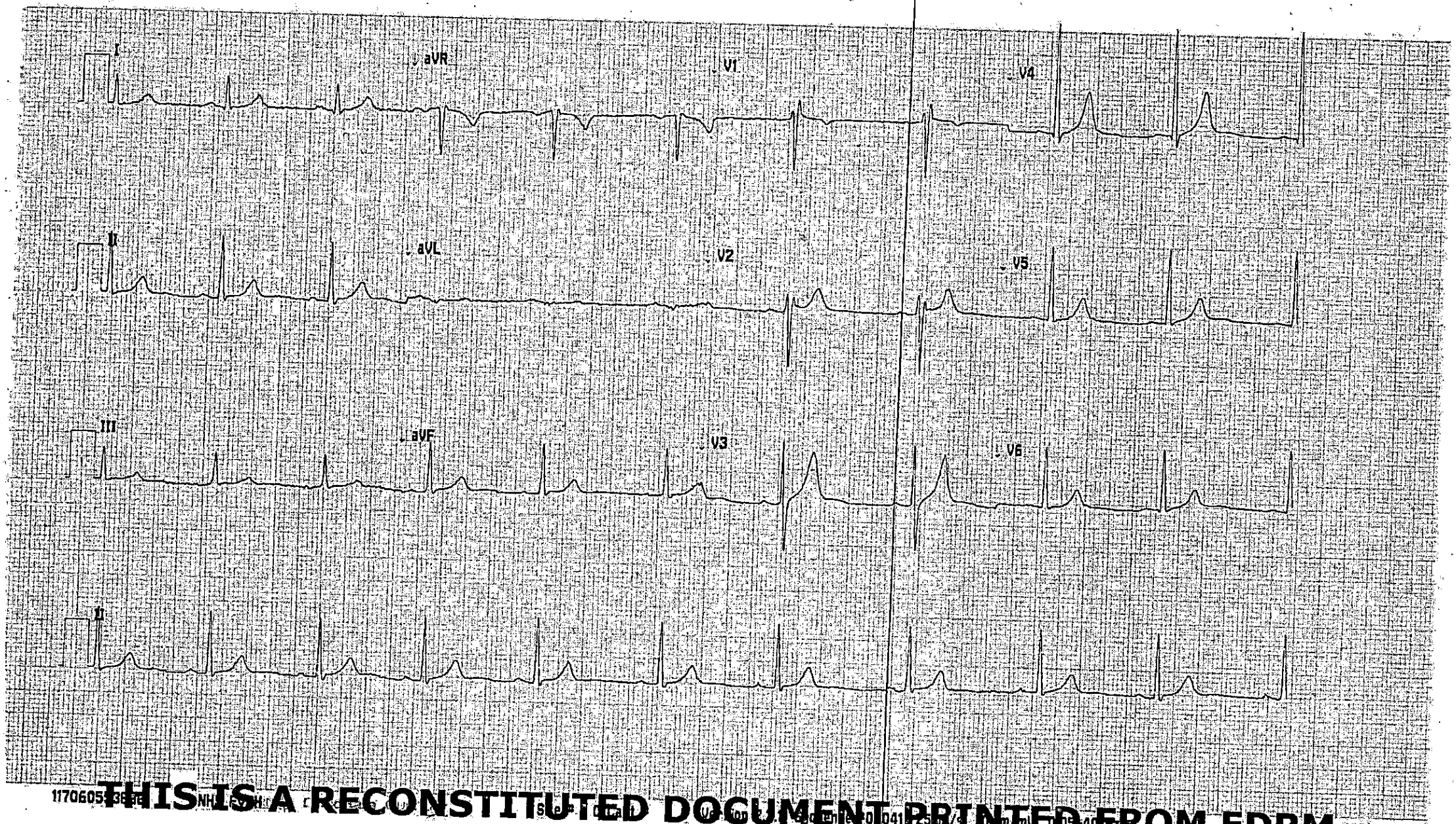
Last: Scrimshaw
First: Gary
ID: 3011795258
DOB: 30-Nov-1979
Age: 44yr Sex: Male
Comment:
Tech:
Ref Phys:

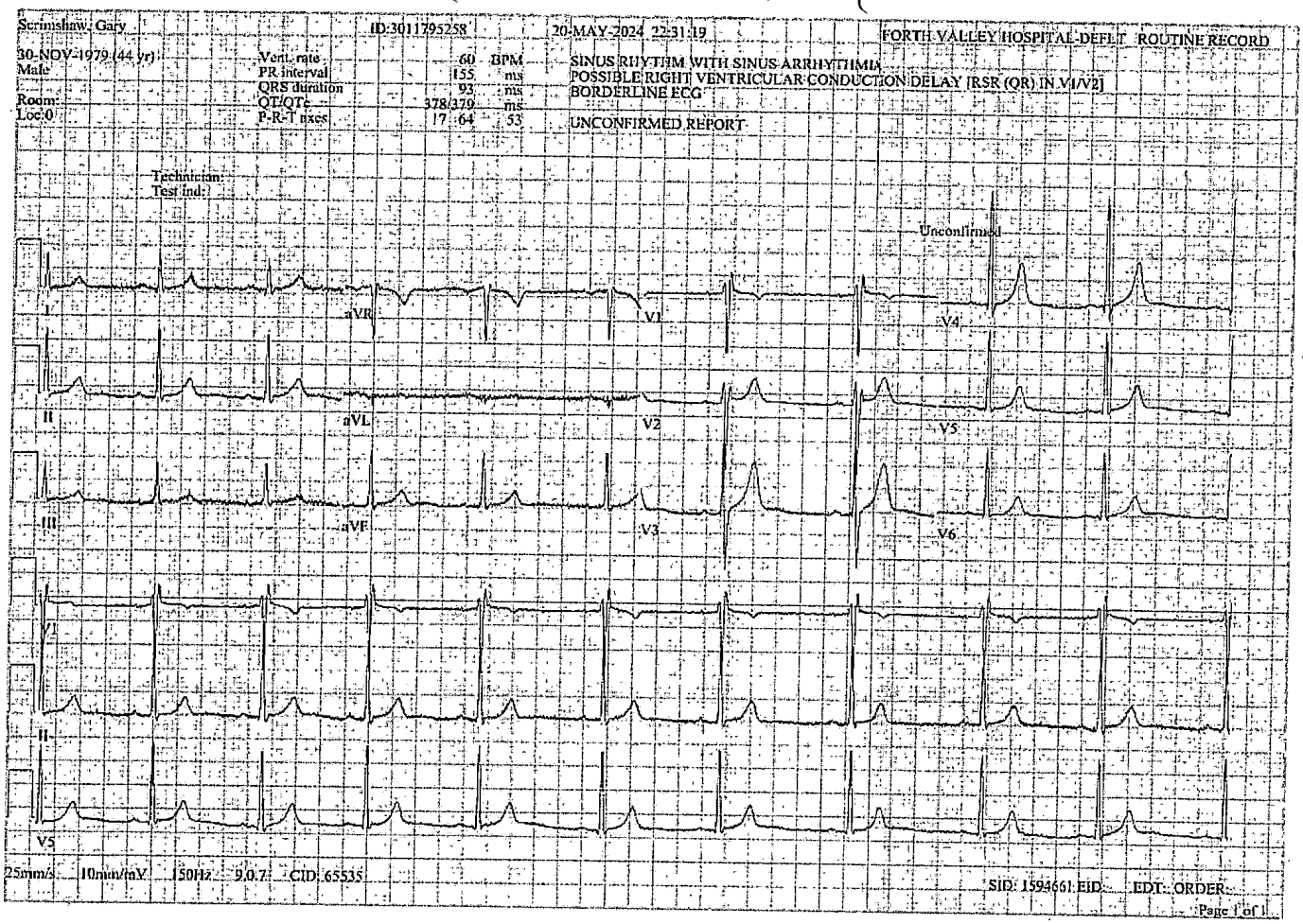
20-May-2024 22:..19

Vent rate	60 BPM
PR int	155 ms
QRS dur	93 ms
QT/QTc	378/378 ms
P-R-T axes	17 64 53

SINUS RHYTHM WITH SINUS ARRHYTHMIA
POSSIBLE RIGHT VENTRICULAR CONDUCTION DELAY (RSR (QR) IN V1/V2)
BORDERLINE ECG

UNCONFIRMED REPORT





THIS IS A RECONSTITUTED DOCUMENT PRINTED FROM EDRM

Medication Administration Profile

Patient: Scrimshaw, Gary
Hospital No: 3011795258 National No: 301 179 5258
Date of Birth: 30-Nov-1979
Allergies: ***Unknown***

Weight: kg
Height: cm
Body Surface: m²

Date of Report: 20-Apr-2026 at 14:27
Type of Report: Since Admission
Requested By: JRAE2
Current Status: Discharged

Admitted On: 21-May-2024
Discharged On: 21-May-2024

Sensitivities:

Episode History:
Consultant: DR DANIEL BECKETT from 21-May-2024 15:11 to 21-May-2024 16:50

Transfer History:
Admitted to Ward: UCC SDEC (FVRH) on 21-May-2024 at 15:11

There are no active medications for this patient.

CCHC

S/237397

L/S 7/Jn

Hospital use only	Clinic

SCANNED ☐ APPT DETAILS 31/1 8at 10.15

PHYSIO Peter Reid

LOCATION CCHC

Hospital No.

Date Referral Submitted
(This date is fixed at hospital en
10-Jan-2018

3011795258

1010152Z3314Z*

Unique Care Pathway Number: 1010152233142

REFERRAL TO

Physiotherapy - MusculoskeletalR5V5
FV Physio - Musculoskeletal

— Consultant / receiving practitioner and/or specialty clinic

Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR

— Hospital and hospital address

Hospital location code. V217H

Urgency of Referral

Routine Physiotherapy - General 11/1/18 LC
Musculoskeletal Referral veteran - send letter out

Administrative Information

Patient has special requirements:No

Ethnic Origin: White Scottish

PATIENT DETAILS

Surname	Scrimshaw
Forename(s)	Gary
Title	-
Sex	Male
Previous Surname	-
Date of birth	30-Nov-1979
CHI no.	3011795258

Patient's address

96 Ten Acres
Sauchie
Alloa
FK10 3DP

Contact number(s)

Voice: 07341940869 / 07511670402
E-mail: garyscrimshaw@gmail.com

REFERRING PRACTITIONER DETAILS

Name:	Dr. Catriona Lamb (GMC: 2956464)
Practice:	Dr Borland & Partners CCHC (25031)
Phone:	Voice: 01259 216701

Practice address:

Hallpark Road
Sauchie
FK10 3JQ

DLC a eDMS

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting Complaint

Description: Query

Comment: Dear Team,

This gentleman has had ongoing back problems for some considerable time. They seem to be of a mechanical nature having presented to me in May 2017 having overstretched at work causing acute back spasm.

He has been taking Amitriptyline and Co-codamol for some considerable time and was keen to try and come off them however he does suffer significant back pain when does stop his medication.

He was referred to your service in 2015 but failed to respond to offer of an appointment.

His problems date from his time in the Army and the symptoms can vary from left lumbar pain (2015 this caused numbness).

There are no current red flags but I suspect this gentleman needs some general education regarding chronic back pain. Thank you for considering seeing him.

Yours sincerely,

Dr Catriona B Lamb

Examinations and Investigations

Murmur present:	Not Recorded -
Is a 12 lead ECG:	Not done -
Recent CXR:	Not done -
FBC:	Not Recorded -
Urea and Electrolytes:	Not Recorded -
LFT:	Not Recorded -
TFT:	Not Recorded -
Lipid Profile:	Not Recorded -
Glucose:	Not Recorded -
Known risks:	None -

Patient Measurements

Diastolic	Systolic	Height	Weight	BMI	Date Recorded
120	70				13-Jan-2011
110	70				30-Jun-2006
110	70				30-Jun-2006
		169	67.55	23.65	13-Jan-2011
		171	64		30-Jun-2006

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Medical history

Active Repeat Therapy

Some Repeats may be Active but not Issued. In these instances, the Date Last Issued field contains the date authorised by the GP.

Drug name	Drug code	Formulation	Dosage	Frequency	Last Issued
Amitriptyline Hydrochloride Tablets 25 mg	0403010B0AAAHAH	168.TABLET	3 Daily		

Issued Scripts for Acutes and Inactive Repeats (in last 90 days)

No recent medications recorded

Clinical warnings

Smoking status: Number per day: ? (not known)

Description	Comment	Date Recorded
Current smoker	-	29-Dec-2017
Current smoker	-	03-Jul-2015
Current smoker	-	24-Sep-2013
Trying to give up smoking	-	13-Jan-2011
Cigarette smoker, 10 Cigarettes/day	-	13-Jan-2011

Alcohol status: Units per day: ? (not known)

Description	Comment	Date Recorded
Alcohol consumption, 0 units/week	-	13-Jan-2011
Teetotaller	Disease: SPICE Basic Health Values, priority=2	30-Jun-2006

Exercise status: Not Known

Description	Comment	Date Recorded
Aerobic exercise 0 times/week	-	13-Jan-2011
Enjoys moderate exercise	Disease: SPICE Basic Health Values, priority=2	30-Jun-2006

Additional relevant information

Signature of referring doctor (or other professional) **Date** 10-Jan-2018

NHS Forth Valley
Physiotherapy Service

NHS Forth Valley

Screening Assessment

Patient's Name: Gary Scrimshaw CHI/DOB: 3011795258 Page: 4

Date: 31/01/18

General Health	"Alright"
Investigations	Nil
Hospital Appts	Nil
PMH	Nil of note
Drug History	Co-codamol

✓ = No problem, ✗ = Problem identified, N/A = Not applicable to patient, Do not leave blanks

Number of Red Flags	Health Parameters	✓/✗/NA	Comments
■ ■/■ ■ ■	Age 11-19 / <10 >55		
■ ■ ■	Ca/FHX of Ca	✓	
■ ■ ■/■ ■/ ■	Weight loss >10% / 5-10% / <5%	✓	
	Statins	✓	
	Diabetes	✓	
	Epilepsy	✓	
	Cardiovascular	✓	
	Blood Pressure	✓	
	Previous Strokes / TIA	✓	
	Respiratory / Asthma	✓	
■	Persistent Cough	✓	
■	Infection / Fevers / Viruses	✓	
■ ■ ■	HIV / Drug abuse	✓	
■ ■ ■	Night Sweating / Severe Pain	✓	
	Anticoagulants	✓	
■	Thoracic Pain	✓	
	Steroid Use / Osteoporosis	✓	
	RA / FHX of RA	✓	
	Other Joint Pain	✓	
	Allergies - Latex - Elastoplast	✓	

Physiotherapist Name: Peter Lynch - Student Pt Signature: Peter Lynch

Alan Reid (B6PT)

Patient's Name: Gary Scrimshaw CHI/DOB: 301179 5258 Page: 5

Number of Red Flags	Health Parameters	✓/✗/NA	Comments
	LUMBAR SPINE		
[redacted]	Bladder / Bowel	✓	
[redacted]	Saddle Anaesthesia	✓	
	Cough / Sneeze	✓	
[redacted]	Cord Signs	✓	
[redacted]	Inability To Lie Supine	✓	
	CERVICAL SPINE		
[redacted]	Dizziness		
[redacted]	Diplopia		
[redacted]	Dysphagia		
[redacted]	Dysphasia		
[redacted]	Drop Attacks		
[redacted]	Cord Signs		
	PERIPHERAL JOINTS		
	Locking		
	Giving Way		
	Immediate Swelling		

Yellow Flags	Comments
Worries/Anxieties	Not Particularly. Learned to live with it.
Perceptions	Muscular.
Quality of Life	↓ QoL. Limits activities

Blue Flags	Comments
Currently Off Work	Please Circle: Yes (No) N/A
Time Off	
What Changes will Allow You To Work?	

Shared Goals	Date Set	Target Date	Barriers	Achieved Y/N
Manage ↓/Elim -ms.	31/01/18			

Physiotherapist Name: Peter Lynch - Student PT Signature: Peter Lynch

Re-Order Ref: TF/1005/MECR

Review Date: 2019

Allan Pearson (BPT)

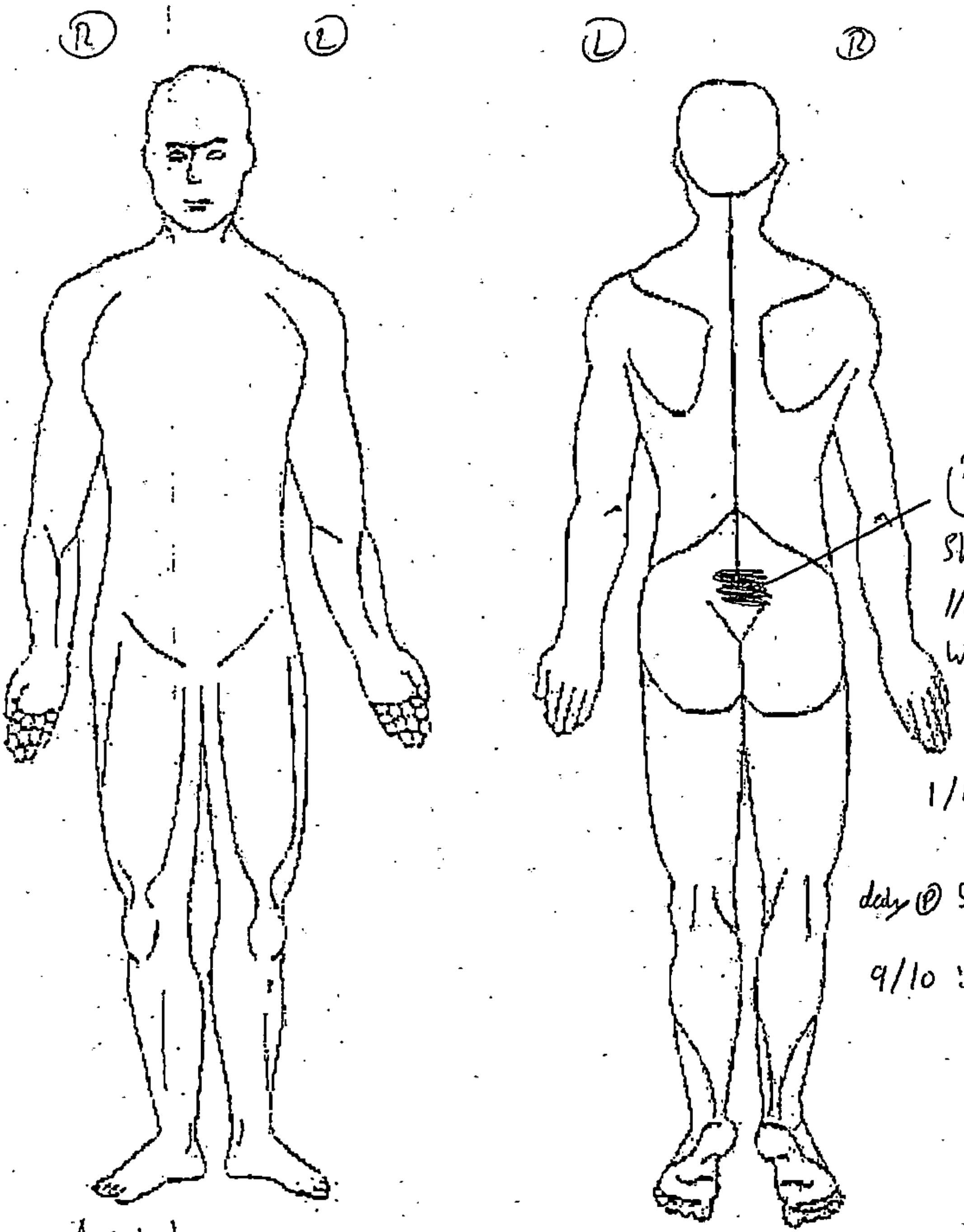
Name: Gary Scrimshaw CHI: 3011795258

Date: 31/01/18 Page No. 6

NHS Forth Valley

Aggs: • Cold weather
• Bending forward / twisting / rotate

Eases: • Sitting c̄ legs arched c̄ pillow underneath.
"Taking arch out of back".



(P1) Sharp / Stabbing
I/M.
Worse c̄ ↑ activity + cold.

1/10 : now c̄ (P)

daily (P) 5/10 c̄ / at pk's

9/10 : at worst

24 hour Pattern: A.m: / P.m: } Depends on activity. ↑ (P) c̄ ↑ activity.

Nights: Disturbs sleep. Wakes up couple times in night. Trying to get comfortable.

Physiotherapist Name: Peter Lynch - Student PT Signature: Peter Lynch

[illegible]

Name Gary Scrimshaw **CHI** 3011795258

S/E: **Date** 31/01/18 **Page No** 7

P.C. Back (P)

H.P.C. 22/1 ago. In army. Carrying weights on back. collapsed one day when running/training, stretchered away. Sudden onset of (P) in Lx. Had felt niggles c previous training but this event was very painful. Army PTs said Pt had ↑ Lx lordosis which predisposed problem.

S.H. Multiple scans. NAD. ↑ lordosis caused "trapped nerves". Tried swimming, heat, yoga poses, ex's, nothing really helped.

- Lives c wife + kids (3 + 11).
- Amazon. In warehouse. Always on feet picking orders. 10 hr shifts.
- Cycling. Mountain biking. Restricted if flare-ups.

O/E: Obs: - Pt looked quite lethargic. Looked generally unwell.

- ↓ Lx lordosis. Straight back posture.
- ↑ erector spinae activation. (R) > (L).

Lx: AROM

Flex: Hands to knees c (P)

Ext: 1/2 range c (P)

(R) Side flex: 3/4 range c little (P)

(L) Side flex: 1/2 range c (P) (R) Lx

Hips: ✓✓

Knees: ✓✓

Neuro: ✓✓

Palpn: (P)++ on PAIVMS Lx spinous processes L2 - L5. ~~(R) about PL~~

Imp: Mechanical LBP.

Rx: (1) Explanation of findings

(2) Advice + discussion R.E. Pacing activities when feeling "twinge" prior to flare-up.

(3) HEP: knee hugs (30 sec holds x 3 throughout day), childs pose (x x 3 sets throughout day) + seated trunk flexe / touch the floor (30 sec holds x 3 sets throughout day)

(4) Explanation for reasoning for particular exc's, emphasis + of importance of undertaking exc's regularly.

P: R/V 1/52. ↑ exc's as able.

Physiotherapist Name Peter Lynch - student PT **Signature** Peter Lynch

Re-Order Ref: TF/1006/MECR

Review Date: 2019

21/2/18 FTA ——— [signature] (86PT)

(T)

TC

L) 22/9

Hospital use only	Clinic		Hospital No.

SCANNED ☐
APPT DETAILS 9/10/20 1pm
PHYSIO
LOCATION CGH, C

Date Referral Submitted
(This date is fixed at hospital ...
08-Sep-2020

MEDICAL IN CONFIDENCE

Dupatt.

3011795258. CHI No: 3011795258

101021629631U
Unique Care Pathway Number: 101021629631U

REFERRAL TO

Physiotherapy - MusculosketalR5V5 FV Physio - Musculoskeletal	Consultant / receiving practitioner and/or specialty clinic
Forth Valley Royal Hospital Stirling Road Larbert FK5 4WR	Hospital and hospital address Hospital location code. V217H

cp9/9.

Urgency of Referral	**Routine Physiotherapy - General Musculoskeletal Referral**

Administrative Information

Patient has special requirements:No

Ethnic Origin: (White) British

PATIENT DETAILS

Surname	Scrimshaw		
Forename(s)	Gary		
Title	-	Sex	Male
Previous Surname	-		
Date of birth	30-Nov-1979		
CHI no.	3011795258		

Patient's address

40 Johnstone Crescent
Tillicoultry
FK13 6PZ

✓ 96 Terrace ... FK10 3D...

Contact number(s)

Voice: 07340830479
E-mail: garyscrimshaw@gmail.com

REFERRING PRACTITIONER DETAILS

Name:	Dr. Andreas Kolle (GMC: 4269506)
Practice:	Tillicoultry Medical Practice (25544)
Phone:	Voice: 01259 750531

Practice address:

Park Street
Tillicoultry
FK13 6AG

O/C ☐

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting Complaint

Description: Assessment.

Comment: This 40 year old gentleman works in a factory filling bottles. He has a 4 month history of a painful right shoulder. He points to the regimental badge area on the top of the shoulder, at the back as well. He has limited arc, being able to elevate the arm sideways up to 80 degrees and is unable really to move to a position if he wanted to pour out bottle.

I would be grateful for your further assessment and advice. He asked for some exercises to do and I gave him a link to NHS Inform - musculo skeletal zone to start with. He is already on Co-codamol and Amitriptyline for back problems and I have added some Naproxen today.

Thank you very much.

Kind regards.

Dr A E Kolle
Typed 08.09.2020 - FG

Examinations and Investigations

Murmur present:	Not Recorded -
Is a 12 lead ECG:	Not done -
Recent CXR:	Not done -
FBC:	Not Recorded -
Urea and Electrolytes:	Not Recorded -
LFT:	Not Recorded -
TFT:	Not Recorded -
Lipid Profile:	Not Recorded -
Glucose:	Not Recorded -
Known risks:	None -

Patient Measurements

Diastolic	Systolic	Height	Weight	BMI	Date Recorded
109	60				17-Aug-2010

Reason for referral

Care type requested: Out Patient

Expected outcome: Investigate

Medical history

Pre-existing Conditions (High Priority)

Description	Laterality	Modifier	Extension	Date Started
[X]Heroin addiction	-	-	PRIORITY=1	26-May-2004

Past Procedures (High priority)

Description	Laterality	Extension	Date Recorded
Medication commenced for pain	-	-	23-Feb-2010
New medication added	-	-	20-Oct-2008

Active Repeat Therapy

Some Repeats may be Active but not Issued. In these instances, the Date Last Issued field contains the date authorised by the GP.

Drug name	Drug code	Formulation	Dosage	Frequency	Last Issued
Naproxen Tablets 500 mg	1001010P0AAAEAE	56 tablet	ONE TO BE TAKEN TWICE A DAY	-	-
Co-Codamol 30/500 Tablets	0407010F0AAAHAH	3*224 TABLET	TWO TO BE TAKEN UP TO A MAXIMUM OF FOUR TIMES A DAY WHEN REQUIRED FOR PAIN	-	-
Amitriptyline Hydrochloride Tablets 25 mg	0403010B0AAAHAH	3*84 TABLET	ONE TABLET ONCE TO THREE TIMES A DAY DEPENDING ON SEVERITY	-	-

Issued Scripts for Acutes and Inactive Repeats (In last 90 days)

No recent medications recorded

Clinical warnings

Smoking status: Number per day: ? (not known)

Description	Comment	Date Recorded
Cigarette smoker, 20 Cigarettes/day	-	26-Jul-2018
Cigarette smoker	Smoking status on date of event: Y	06-Apr-2009

Alcohol status: Units per day: ? (not known)

Exercise status: Not Known

Allergies

Description	Comment	Modifier	Start Date	Recorded Date
Adverse reaction to Tramadol Hydrochloride	-	-	-	-

Additional relevant information

Signature of referring doctor (or other professional) **Date** 08-Sep-2020

: Routine 5/10/2020 wp

1

SCH Minor Injuries Stirling Community Hospital

Date of attendance: 02/10/2020 10:14
Presenting complaint: r shoulder inj

Surname: Scrimshaw	**Forename:** Gary	**Title:** Mr	
Address: 40 Johnston Crescent Tillicoultry Clackmannanshire	**Postcode:** FK13 6PZ	**CHI:** 3011795258	RECEIVED 05 OCT 2020
Telephone: 07340830479			
Date of Birth: 30/11/1979	**Sex:** Male	**Age:** 40 Years	

GP Name: AE Kolle
Address: 25544/1
Tillicoultry Medical Practice
Park Street
Tillicoultry
Tillicoultry
FK13 6AG
Telephone: 01259 750531

Next of Kin
Name: Tracey Scrimshaw
Relationship: Wife
Address: 40 Johnston Crescent
Tillicoultry
Clackmannanshire
Postcode: FK13 6PZ
Telephone: 07423556817

Triage Information

Observations

P= **BP=/** **RR=** **Sat=** **BM=** **Temp=**
Peak Flow= **GCS=** **News=**

Emergency Department / Pre-Hospital Drugs **Allergies**

Date	Drug	Dose	Route	Signature	Given by	Time

MXIO
Ref
RtMC

Clinical Notes

Seen by: L YOUNG **Time:** 1220

PC (R) shoulder injury
HPC: Cyclist - fell from bike 3 months ago - saw GP.
3 days ago - car in front - cut kerb & hit bollard - shoulder hit bollard
- ↓ ROM since - MIU.
Pain: shoulder / ACJ.
↓ movement.
↓ ...
? : c/o tingling in fingers.
PMH: nil. DH: amitriptyline
co-codamol
Allergies - nil
(R) handed

See over

Guidelines Used:

CHI NO: 3011795269
SRN:
[?]ARY SCRIMSHAW
10 JOHNSTON CRESCENT
TILLICOULTRY
FK13 6PZ
30/11/1979
M

Attach continuation sheets here

Attach here onto face of pocket

Emergency Discharge Letter (Authorised)

AE Kolle
Tillicoultry Medical Practice
Park Street
Tillicoultry
Tillicoultry
FK13 6AG

SCH Minor Injuries
Livilands Gate
Stirling
Stirling
Stirlingshire
FK8 2AU

Dept. Contact Details:

CHI Barcode: 3011795258

Date of Completion: 02-Oct-2020

GP Practice

GP Name:	AE Kolle	**GP GMC:**	4269506
GP Practice Address:	Tillicoultry Medical Practice Park Street Tillicoultry Tillicoultry FK13 6AG	**GP Practice Code:** **GP Clinic Code:** **GP Telephone:**	4269506/25544 25544/1 01259 750531

Patient Demographics

Patient Name:	SCRIMSHAW, Gary	**Date Of Birth:**	30-Nov-1979
Patient Address:	40 Johnston Crescent Tillicoultry Clackmannanshire FK13 6PZ	**Gender:** **CHI No:**	Male 3011795258
Telephone No:	07340830479		

Admission Details

Patient Location:	SCH Minor Injuries	**Admission Date:**	02-Oct-2020
Admission Care Provider:	Dr Joanne Mitchell	**Admission Time:**	10:14
Source Of Admission:	Not Known		

Presenting Complaint

r shoulder inj

Diagnosis

Diagnosis	Site	Laterality
Calcific Tendinitis of Shoulder		

Procedures

No Procedure Results

Medications

Nil records exist

Discharge Details

Discharge Type:	With referral	**Discharge Date:**	02-Oct-2020
Discharge Destination:	Private Residence - Usual place of residence	**Discharge Time:**	13:17

Referred To: Physiotherapy

Notes for GP

PC: Right shoulder injury.
HPC: Fall from bike hitting bollard. Pain in right shoulder since. Already has pain in shoulder since previous fall. No head injury.
PMH: Nil
Symptoms: Pain anterior right shoulder. No altered neuro
OE: No obvious swelling, erythema, bruising, deformity.

Neck NAD

Shoulder- flex 90, Abd 90 LR full. Pain with hand behind back.

MP 5/5 with pain on abd and LR.

Drop arm -ve

NV intact.
X-RAY: No # seen. RC calcification.
Treatment: Collar and cuff. 1 - 2 days. Shoulder advice sheet.
Plan: Physio
GP Action: Nil

Person completing record

Name:		**Specialty:**	
Designation or role:		**Date completed:**	02-Oct-2020

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
AE Kolle	GP	Tillicoultry Medical Practice

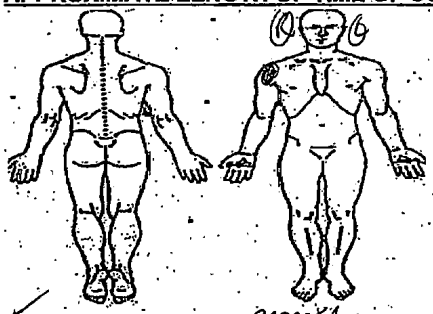
TELEPHONE CONSULT/ NEAR ME CONSULT 09/10/2020

Patient Name: Gary Scrimshaw **CHI:** 3011795258 **Physiotherapist:** Xabier Aristegui BOPT **Date and Time:** 13:00

PLEASE refer to SCI/CLINICAL PORTAL/ ATTACHED for full details of HPC

PROBLEM AREA: (R) sh RIC calcification

APPROXIMATE LENGTH OF TIME OF CONDITION:



- Felt from road like another fall (3/12 ago) 30/9/2020 + hit Shoulder
- Pain started after last fall, no pain before. Felt like a dull ache (improving) until last week
- A Pain since last week
- GP - sign him for 2/52 on light duties

AGG: ABd Flex

EASE: Naproxen x2 Hot Gel

BETTER WORSE SAME (CIRCLE)

24 HOUR PATTERN: Sleep disturbance

NRPS: 0 1 2 3 4 5 6 7 8 9 10 (5) when moving

INVESTIGATES to DATE:

X-ray - R/C calcification

INVESTIGATES PENDING:

Nil to note

Gary Scrimshaw 30/11/79

Schermans disease

PMH: –

Ⓝ

GH: T.....H.....R.....E.....A.....D.....S

H/o CA self? Y Ⓝ

Recent weight loss? Y Ⓝ

ANY PERTINENT RED FLAG QUESTIONS:

SO's -ve

OBSERVATIONS:

C RoM: ✓ | GH Flex: 80
Abd 45
HBB Lx

elbow / wrist / Hand ✓

△ trauma ?
calcification?

TREATMENT/DISCUSSION HEP (email) : see ccs sheet
Load management, progression, POLICE + PEACE ~~AND~~ LOVE

PLAN

R2F in 4/52.
pt happy c plan.

Xabier Arizteguieta BGPT
09/10/2020

MEDS: - Amitriptyline (since Age 17) x2-3 (25mg tablets)
- Naproxen
- Co-Codamol 30/500 x8 (hours) this is for Schevermanns

SH:

- Works in Surrey (physical +)
- Cycle
- Has x2 children (5, 13)

PHYSIOTOOLS

Personal exercise program

Physiotherapy exercises

8-20 x2-3

As able

NHS Forth Valley
NHS Forth Valley
Unit 2 Colquhoun Street, FK10 3BJ, Stirling, United Kingdom

Provided by Xabier Ariztegieta
Provided for Gary Scrimshaw.

Sit. Hold a stick upright in front of you as far away as possible from your body with the end of the stick resting on the floor.

Lean forwards.

Repeat _____ times.

Lying on your back with elbows straight.

Use one arm to lift the other arm up keeping it as close to the ear as possible.

Repeat _____ times.

Stand with your upper arm close to your side, elbow at a right angle and the back of your hand against a wall.

Push the back of your hand against the wall. Hold approx. _____ secs.

Repeat _____ times.

Stand or sit. Hold your upper arm close to your body with your elbow at a right angle.

Try to move your hand outward, resisting the movement with the other hand. There should be no movement.

Hold _____ seconds.
Repeat _____ times.

Gary Scrimshaw 30/11/79

16/10/11

t/c in am -ve COVID19 Qus -ve. However pt rescheduled appt afternoons (although the Hus) as he is not comfortable coming to the department.

Pt reported feeling 100% better in our t/c

(P) t/c in 1/52. D/C? X. Arizteguieta B6PT

20/10/2020

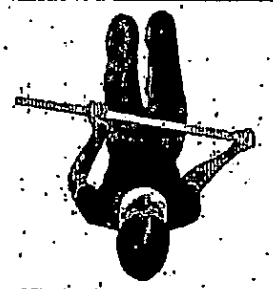
FTA. unable to left vm on mobile number

(P) on hold for 2/52. X Arizteguieta

3/11 2020

no further contact made. D/C

X. Arizteguieta



Lying on your back with elbows against your body and at a right angle. Hold a stick in your hands.

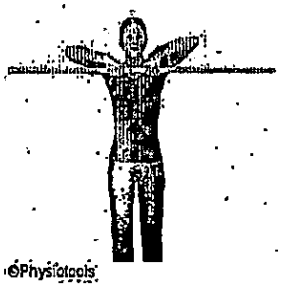
Move the stick sideways thus pushing the arm to be exercised outwards.

Repeat _____ times.

Lie on your back. Hold a _____ kg weight.

Lift your arm keeping your elbow straight.

Repeat _____ times.



Stand with feet apart. Hold a stick or weight with both hands close together.

Lift the stick/weight to your chin. Your elbows should point outwards and upwards while doing the exercise.

Repeat _____ times.

Sit or stand with hands clasped in front of you.

Lift your hands above your head and stretch your arms as far back as possible.

Repeat _____ times.

PHYSIOTOOLS

Personal exercise program

Physiotherapy exercises

NHS Forth Valley
NHS Forth Valley
Unit 2 Colquhoun Street, FK10 3BJ, Stirling, United Kingdom

Provided by Xabier Ariztegieta
Provided for Gary Scrimshaw

©Physiotools

Sit. Hold a stick upright in front of you as far away as possible from your body with the end of the stick resting on the floor.

Lean forwards.

Repeat _____ times.

©Physiotools

Lying on your back with elbows straight.

Use one arm to lift the other arm up keeping it as close to the ear as possible.

Repeat _____ times.

©Physiotools

Stand with your upper arm close to your side, elbow at a right angle and the back of your hand against a wall.

Push the back of your hand against the wall. Hold approx. _____ secs.

Repeat _____ times.

©Physiotools

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Hold _____ seconds.
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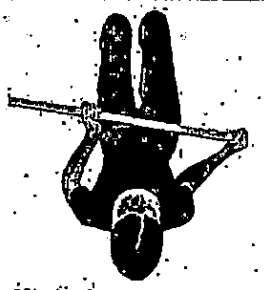

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Repeat _____ times.

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Lift the stick/weight to your chin. Your elbows should point outwards and upwards while doing the exercise.

Repeat _____ times.

Sit or stand with hands clasped in front of you.

Lift your hands above your head and stretch your arms as far back as possible.

Repeat _____ times.

Immediate Discharge Letter (Authorised)

COPY

Acute Medicine
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

G Campbell
Tillicoultry Medical Practice
Park Street
Tillicoultry
Tillicoultry
FK13 6AG

CHI Barcode: 3011795258

Date of Completion: 21-May-2024

Patient Demographics

Patient Name:	SCRIMSHAW, Gary	**Date Of Birth:**	30-Nov-1979
Patient Address:	40 Johnston Crescent Tillicoultry Clackmannanshire FK13 6PZ	**Gender:**	Male
		CHI No:	3011795258
Telephone No:	07340830479		

GP Practice

GP Name:	G Campbell	**GP GMC:**	7277373
GP Practice Address:		**GP Practice Code:**	7277373/25544
		GP Clinic Code:	25544
		GP Telephone:	

Admission Details

Patient Location:	Acute Medicine	**Admission Care Provider:**	Dr Daniel Beckett
Admission Date:	21-May-2024	**Admission Time:**	15:11
Admission Method:	Emergency Admission, no additional detail added	**Ward:**	FVRH UCC SDEC
Source Of Admission:	GP Non Obstetrics - other Provider		

Discharge Details

Discharge Specialty:	Acute Medicine	**Discharge Care Provider:**	Dr Daniel Beckett
Discharge Date:	21-May-2024	**Ward:**	FVRH UCC SDEC
Discharge Time:	16:49	**Discharge Destination:**	Private Residence - no additional detail added
Discharge Method:	Regular discharge, no additional detail added		

Clinical Summary including History

Dear Dr,

Gary attended RACU with 1/52 history of chest tightness and SOB intermittent in nature. Non exertional. Describes episode yesterday severe with associated clamminess with palpitations whilst at work.
No cough/ feverish symptoms/ nausea.

Obs/ BP 131/82 hr 54 rr16 O2 98% ra. temp 36.3C
OE/ pulse reg HS I+II+O chest clear
ECG nsr
CXR nad
Bloods checked in ED 20/5 no change in presentation normal FBC, UES, LFTs, troponin. D dimer checked today normal.

Imp/ MSK injury / stress

Plan/
Home with worsening statement

Should you require any further information please contact RACU.

Kind regards, Dr Catriona Parker GPWSI acute medicine

Safety Alerts

Nil records exist

Allergy/Intolerance

Allergy records are as recorded at time and date of printing
Nil records exist

Medications

Drug Information:

Drug	Dose	Route	Frequency	GP to Continue	POD	Days Supply

Nil records exist

Drug Notes:

Drug	Drug Notes

Nil records exist

Additional Medicine Information:

Medicines discontinued during admission (Medicines that patient was recorded as admitted on only)

Drug	Discontinued Reason

Nil records exist

GP Communications:

Outstanding Results

Responsibility of Hospital

Nil records exist

Person completing record

Authorised by
Name:
Designation or role:
Specialty:
Date completed: 21-May-2024

Clinically completed by
Name:
Designation or role:
Specialty:

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
G Campbell	GP	Tillicoultry Medical Practice

Immediate Discharge Letter (Authorised)

COPY

Acute Medicine
Stirling Road
Larbert
Larbert
Stirlingshire
FK5 4WR

Dept. Contact Details:

CHI Barcode: 3011795258

Date of Completion: 21-May-2024

G Campbell
Tillicoultry Medical Practice
Park Street
Tillicoultry
Tillicoultry
FK13 6AG

Patient Demographics

Patient Name:	SCRIMSHAW, Gary	**Date Of Birth:**	30-Nov-1979
Patient Address:	40 Johnston Crescent Tillicoultry Clackmannanshire FK13 6PZ	**Gender:**	Male
		CHI No:	3011795258
Telephone No:	07340830479		

GP Practice

GP Name:	G Campbell	**GP GMC:**	7277373
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Patient Location:	Acute Medicine	**Admission Care Provider:**	Dr Daniel Beckett
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Bloods checked in ED 20/5 no change in presentation normal FBC, UES, LFTs, troponin. D dimer checked today normal.

Imp/ MSK injury / stress

Plan/
Home with worsening statement

Should you require any further information please contact RACU.

Kind regards, Dr Catriona Parker GPWSI acute medicine

Safety Alerts

Nil records exist

Allergy/Intolerance

Allergy records are as recorded at time and date of printing
Nil records exist

Medications

Drug Information:

Drug	Dose	Route	Frequency	GP to Continue	POD	Days Supply

Nil records exist

Drug Notes:

Drug	Drug Notes

Nil records exist

Additional Medicine Information:

Medicines discontinued during admission (Medicines that patient was recorded as admitted on only)

Drug	Discontinued Reason

Nil records exist

GP Communications:

Outstanding Results

Responsibility of Hospital

Nil records exist

Person completing record

Authorised by
Name:
Designation or role:
Specialty:
Date completed: 21-May-2024

Clinically completed by
Name:
Designation or role:
Specialty:

Distribution List

Recipient Name	Recipient Type	Recipient Organisation
G Campbell	GP	Tillicoultry Medical Practice

Forth Valley Royal Hospital Rapid Assessment & Care Unit

NHS Forth Valley

Date of arrival: 21/05/24 Time of arrival: 15:00

Source of referral: GP ED (Other) SAS

GP Practice: Tillicoultry

CHI: 3011795258 30/11/1979 M

Name: SCRIMSHAW, Gary

Address: 40 Johnston Crescent
Tillicoultry
Clackmannanshire
FK13 6PZ

COPY

44

Telephone Number: 07340830479

NOK Name: Tracey

Address:

Telephone Number: 074235 56817

Relationship: Wife

ALLERGIES:

NKA

Reason for assessment:

chest pain

Medications:

co-codamol 30/500 x2
naproxen 500mg BD
omeprazole 10mg
Caparal
AMT 20mg ON.

Name: Victory Adebayo

Signature: Victory

Date: 21/05/24

Time: 15:05

(addressograph)

3011795258 30/11/1979 M
SCRIMSHAW, Gary
40 Johnston Crescent
Tillicoultry
Clackmannanshire
FK13 6PZ

COPY

Assessment

Presenting Complaint:

CP + SOB

HPC:

1/52 history of intermittent chest tightness and SOB non exertional
severe episode last night.
attended ED.
ECG + bloods
didn't wait for results
assoc clamminess + palpitations
no cough / fevers
feels nauseous
no nausea
E+D ok

no weight loss

Systemic Enquiry:

~~[illegible]~~ PU overnight more

PMH:

nil

Social History:

Smoking/Vape: No/Yes (circled) 20/day pack years

Alcohol: Units/week nil

Live with: wife

Support/carers:

Occupation:
works in a brewery

Family History: dad - stroke

NHS Forth Valley

(addressogram)

3011795258 30/11/1979 M
SCRIMSHAW, Gary
40 Johnston Crescent
Tillicoultry
Clackmannanshire
FK13 6PZ

COPY

Impression:

?MSK
exclude PE.

Plan:

bloods in ED yesterday trop <5
NDUEs, FBC.
no worsening presentation therefore
cardiac cause unlikely.

CXR → nad
check D-Dimer ⊖.

A) ~WSG.

Name:	Sign:	Date:	Time:
[illegible]	[illegible signature]	2/5/24	1545

Patient Information

GARY SCRIMSHAW

Age/Gender:	44y Old
Address:	40 JOHNSTON CRESCENT TILLICOULTRY,FK13 6PZ
DOB:	30/11/1979
CHI:	3011795258
Ethnicity:	

Date:	21/05/2024
Incident Number:	CR010942614
Incident Type:	EMG
Incident Location:	40 JOHNSTON CRESCENT TILLICOULTRY, FK13 6PZ

Presenting Complaint

CHEST PAIN

Additional Comments

Nhs 24 call for a 44yom o/a pt was sitting outside with family, pt gcs 15, alert, orientated, good colour and talking in full sentences. Pt has had ongoing chest pain for the past week, pt work called for an ambulance yesterday as pt felt he was going to pass out and had chest pain radiating down his arms, pt was taken to fvrh where he self discharged due to needing to be home for child care, pt had bloods and ecg but did not recieve any results. Pt called nhs 24 this morning due to ongoing chest tightness and the feeling his heart is bruised. Pt is under alot of stress at work but normally is not effected by stress o/e all obs are as charted below, pt ecg NSR, chest clear in all fields, pt has not been doing any unusal heavy lifting from his normal amount, pt has not had and blunt force trauma to his chest,pt does not have a cough or bringing up phlegm, socrates filled out, crew called low risk chest pain who accepted pt at racu. Not aware of any family history of cardiac problems, Pt transported to racu for further assessment. nok-wife- tracey-07423556817

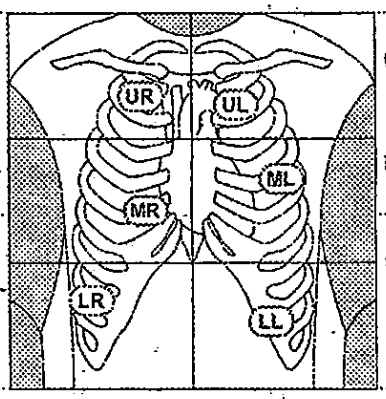
PATIENT ASSESSMENT

ACVPU Alert <C> No

A Clear

B Breathing Adequately: Yes | Respiratory Rate: 16 | SPO2: 98

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	Normal Breath Sounds, Normal Air Entry
Normal Breath Sounds, Normal Air Entry	LR		LL	Normal Breath Sounds, Normal Air Entry

C

Pulse Rate	BP	Cap Refill	ECG Rhythm
74	139/79	<=2 Secs	Sinus Rhythm

Rhythm	Arm	Central/Peripheral	ECG
Reg	Right	Peripheral	12 Lead

D

GCS	Eyes	Voice	Motor	PEARL
15	Spontaneously (4)	Orientated (5)	Obeys Commands (6)	N/A

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
14:20	68	16	130/75	97	<=2s	15	Alert		36.8	6.9	Sinus Rhythm				E9886022
13:57	74	16	139/79	98	<=2 Secs	15	Alert		36.8	6.9	Sinus Rhythm				E9886022

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
14:20	16 (0)	97 (0)		0	130 (0)	68 (0)	Alert (0)	36.8 (0)	0

As Required Medication Page

(Prescribers **MUST** enter **indication, dosage interval** and **maximum daily dose**) **COPY**

- enter dosage times as 24hour clock
- please write in block capitals in black pen

- Maximum of 3 continuation sheets (or 5 for long stay patients with Consultants approval).
- please ensure patient details on each sheet

	DATE →	27/10/6						
APPROVED DRUG NAME: Sodium Chloride 0.9% / DOSE: / ROUTE: IV	TIME							
	GIVEN BY							
INSTRUCTIONS: for flush / PHARMACY: Clin; POD Y N; D/C Y N	TIME							
	GIVEN BY							
SIGNATURE / DATE / DISP1 / DISP2	TIME							
	GIVEN BY							
APPROVED DRUG NAME: DIHYDROCODEINE / DOSE: 30mg / ROUTE: Po	TIME	02.10						
	GIVEN BY	IB						
INSTRUCTIONS: Every 4 to 6 hours / PHARMACY: Clin; POD Y N; D/C Y N	TIME							
	GIVEN BY							
SIGNATURE: [signature] / DATE: 27/10/06 / DISP1 / DISP2	TIME							
	GIVEN BY							
APPROVED DRUG NAME / DOSE / ROUTE	TIME							
	GIVEN BY							
INSTRUCTIONS / PHARMACY: Clin; POD Y N; D/C Y N	TIME							
	GIVEN BY							
SIGNATURE / DATE / DISP1 / DISP2	TIME							
	GIVEN BY							
APPROVED DRUG NAME / DOSE / ROUTE	TIME							
	GIVEN BY							
INSTRUCTIONS / PHARMACY: Clin; POD Y N; D/C Y N	TIME							
	GIVEN BY							
SIGNATURE / DATE / DISP1 / DISP2	TIME							
	GIVEN BY							
APPROVED DRUG NAME / DOSE / ROUTE	TIME							
	GIVEN BY							
INSTRUCTIONS / PHARMACY: Clin; POD Y N; D/C Y N	TIME							
	GIVEN BY							
SIGNATURE / DATE / DISP1 / DISP2	TIME							
	GIVEN BY							

Pharmacy Codes: Clin = Professional Clinical Check | POD = pt own drugs available and suitable for use | D/C = drug to be continued on discharge | Disp = Supply dispensed labelled and checked

Initial	Date

General Medication Page

(General Medication starts at front and works forward. Intravenous Medication starts at back and works forward)

- enter dosage times as 24hour clock
- please write in block capitals
- please write in black pen

- Maximum of 3 continuation sheets (or 5 for only patients with Consultants approval).
- please ensure patient details on each sheet

COPY

DATE → / TIME ↓	26/10/06	27/10/06						

APPROVED DRUG NAME	DOSE	ROUTE
G. EXOCIN		1

INSTRUCTIONS: Drops · ½ hourly

PHARMACY: Clin / POD Y N / D/C Y N / DISP₁ / DISP₂

SIGNATURE: [illegible] DATE: 26-10-06

APPROVED DRUG NAME	DOSE	ROUTE	TIME
PARACETAMOL	1g	PO	0800, 1200, 1600, 2000

27/10/06 column: AMF (8)

INSTRUCTIONS:

PHARMACY: Clin / POD Y N / D/C Y N / DISP₁ / DISP₂

SIGNATURE: [illegible] DATE: 27/10/06

APPROVED DRUG NAME	DOSE	ROUTE

INSTRUCTIONS:

PHARMACY: Clin / POD Y N / D/C Y N / DISP₁ / DISP₂

SIGNATURE: DATE:

APPROVED DRUG NAME	DOSE	ROUTE

INSTRUCTIONS:

PHARMACY: Clin / POD Y N / D/C Y N / DISP₁ / DISP₂

SIGNATURE: DATE:

APPROVED DRUG NAME	DOSE	ROUTE

INSTRUCTIONS:

PHARMACY: Clin / POD Y N / D/C Y N / DISP₁ / DISP₂

SIGNATURE: DATE:

APPROVED DRUG NAME	DOSE	ROUTE

INSTRUCTIONS:

PHARMACY: Clin / POD Y N / D/C Y N / DISP₁ / DISP₂

SIGNATURE: DATE:

APPROVED DRUG NAME	DOSE	ROUTE

INSTRUCTIONS:

PHARMACY: Clin / POD Y N / D/C Y N / DISP₁ / DISP₂

SIGNATURE: DATE:

Pharmacy Codes: Clin = Professional Clinical Check (Initial | Date); POD = pt own drugs available and suitable for use (Y | N | Quantity); D/C = drug to be continued on discharge; Disp = Supply dispensed labelled and checked

Last: Scrimshaw
First: Gary
ID: 3011795258
DOB: 30-Nov-1979
Age: 44yr Sex: Male
Comment:
Tech:
Ref Phys:

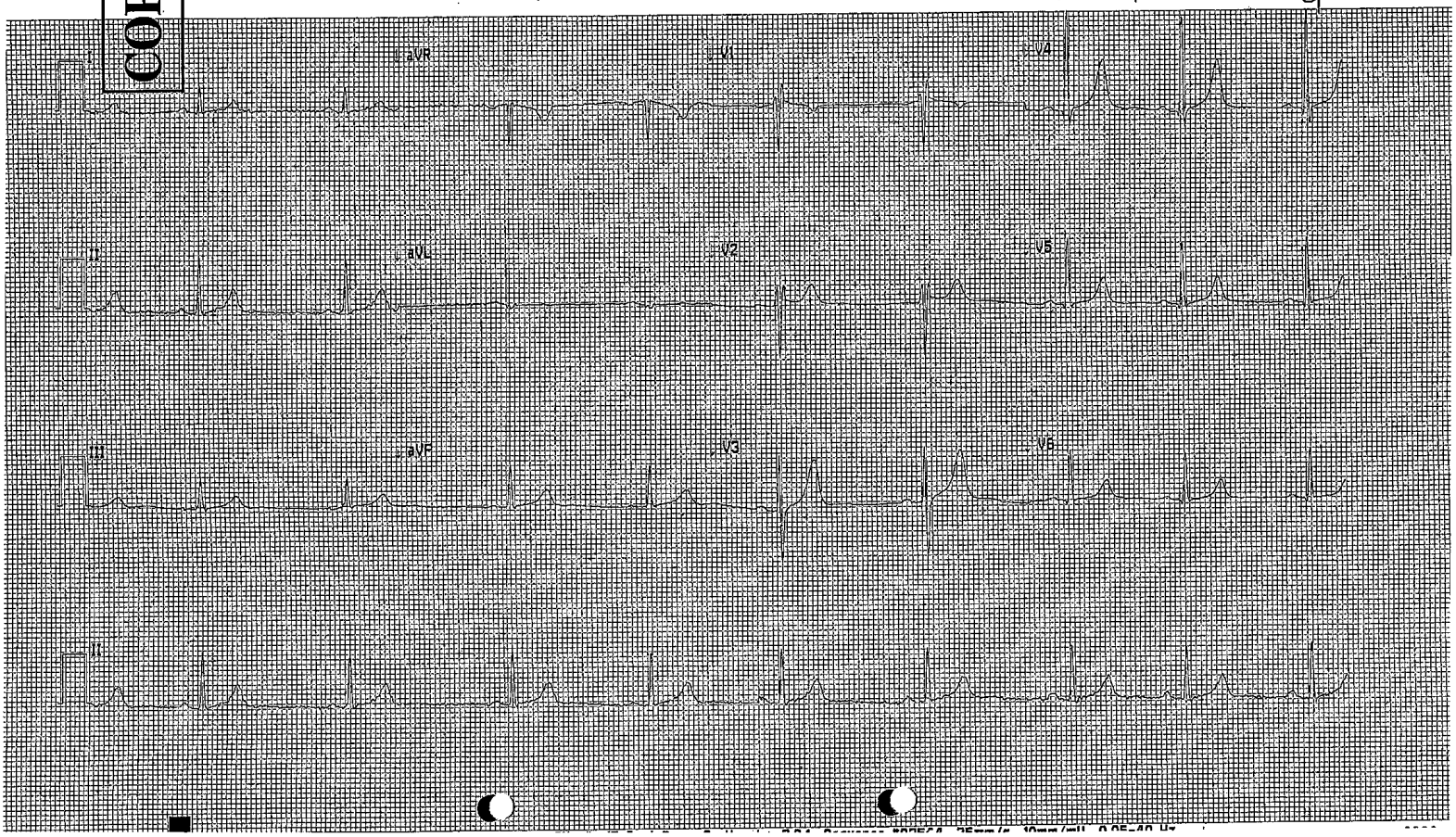
21-May-2024 15:17:42

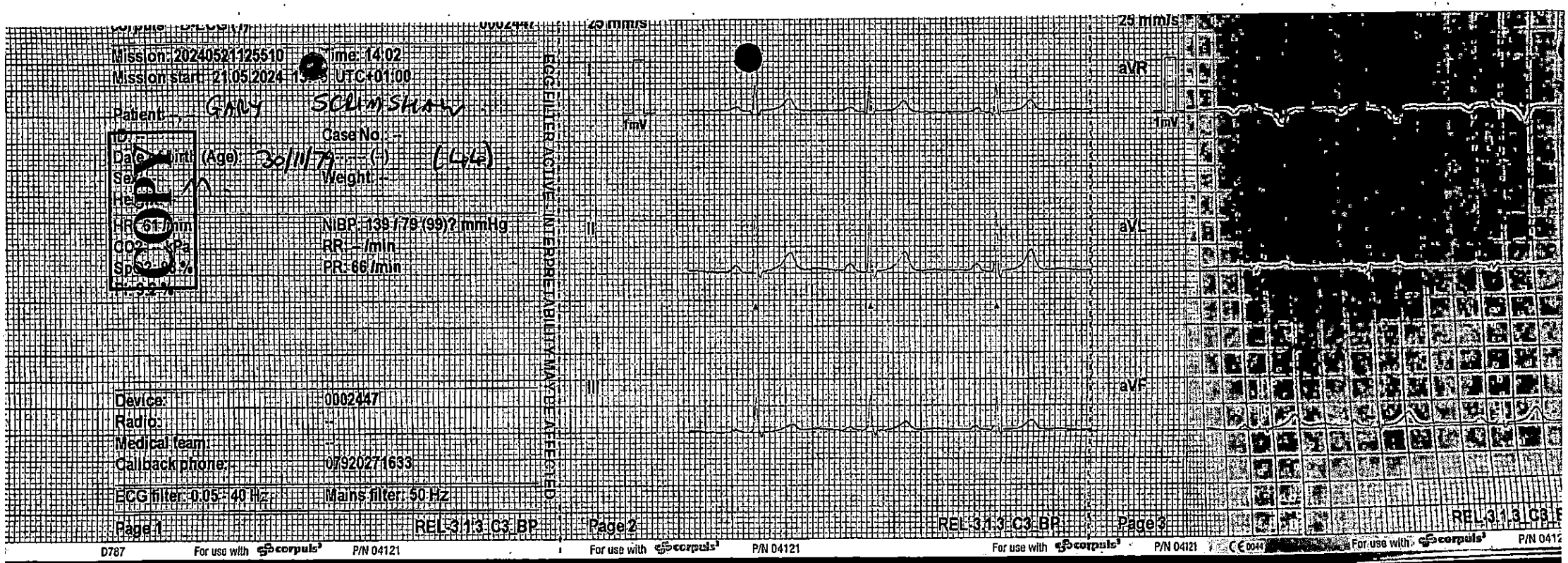
Vent rate	54 BPM
PR int	160 ms
QRS dur	98 ms
QT/QTc	408/394 ms
P-R-T axes	44 66 64

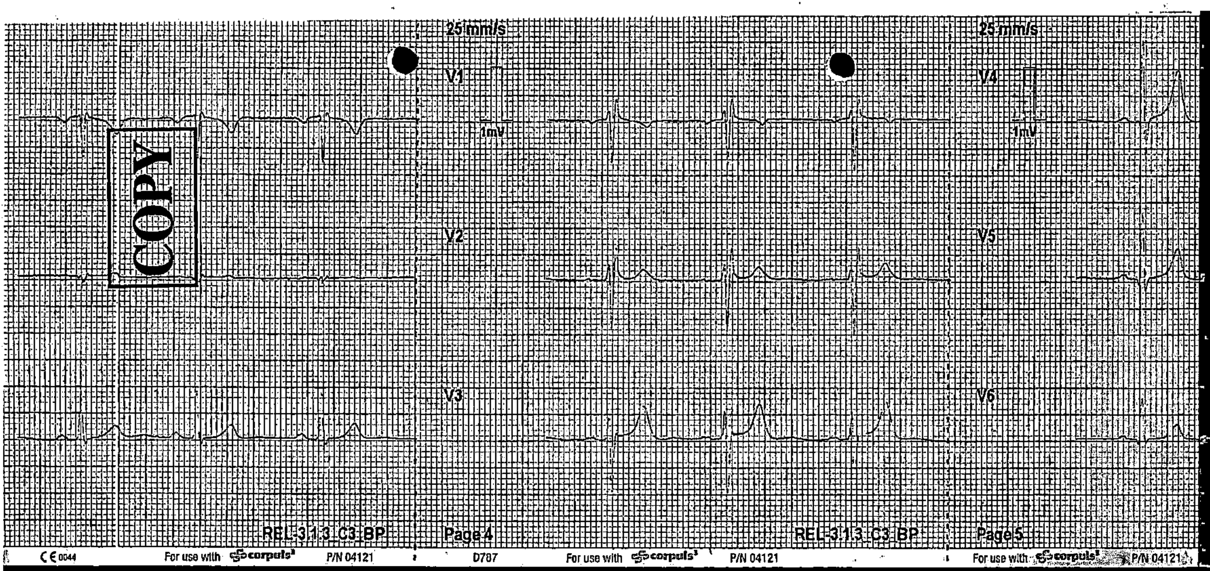
SINUS BRADYCARDIA WITH SINUS ARRHYTHMIA
POSSIBLE RIGHT VENTRICULAR CONDUCTION DELAY [RSR (QR) IN V1/V2]
BORDERLINE ECG

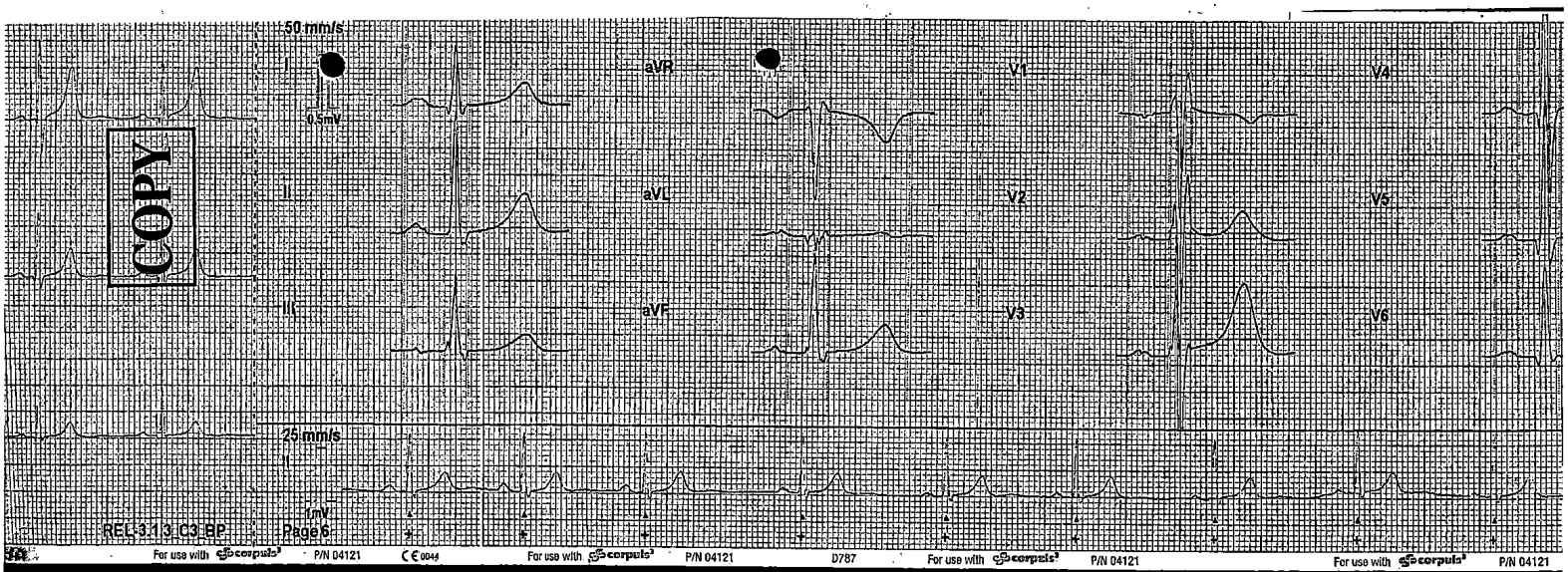
UNCONFIRMED REPORT

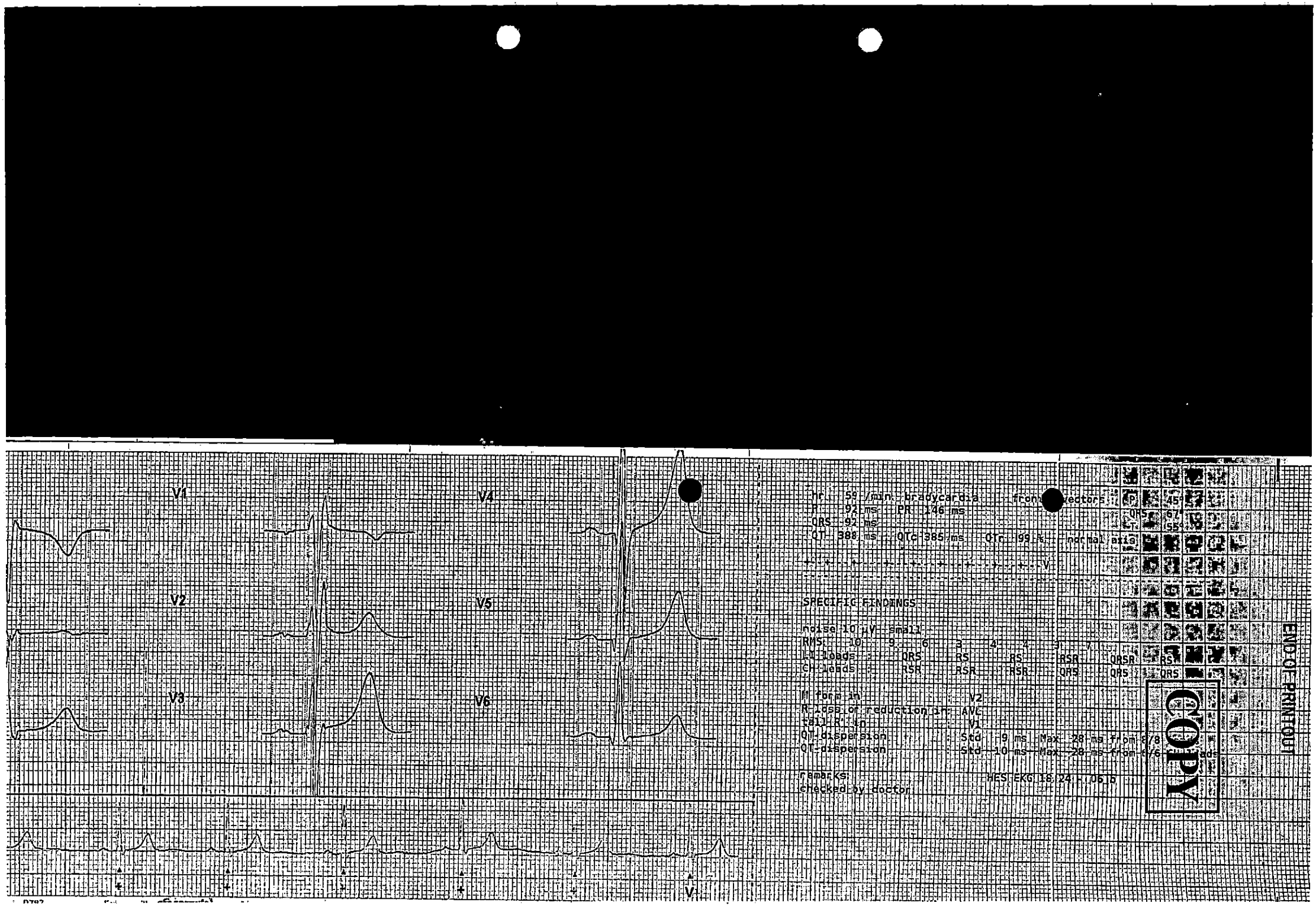
?LVH
?RBBB
unchanged
from previous




Mission: 20240521125510
Time: 14:02
Mission start: 21/05/2024
UTC+01:00
Patient: GARY SCLIMSHAW
Case No: --
Date of birth (Age): 30/11/79 (-)
Sex:
Height:
Weight: --
HR: 61 /min
NIBP: 139 / 79 (99)? mmHg
RR: -- /min
PR: 66 /min
Device: 0002447
Radio:
Medical team:
Callback phone: 07920271633
ECG filter: 0.05 - 40 Hz
Mains filter: 50 Hz
ECG FILTER ACTIVE IN INTERPRETABILITY MAY BE AFFECTED
25 mm/s
I
aVR
1mV
II
aVL
III
aVF
Page 1
REL 3.1.3 C3 BP
Page 2
REL 3.1.3 C3 BP
Page 3
REL 3.1.3 C3 BP
D787
For use with corpuls³
P/N 04121


COPY
25 mm/s
V1
1mV
V2
V3
V4
V5
V6
REL-313_C3_BP
Page 4
Page 5
For use with corpuls
P/N 04121
D707


50 mm/s
0.5mV
I
II
III
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6
25 mm/s
1mV
REL-3.1.3.C3.BP
Page 6
For use with corpuls³ P/N 04121
CE 0044
For use with corpuls³ P/N 04121
D787
For use with corpuls³ P/N 04121
For use with corpuls³ P/N 04121


V1
V2
V3
V4
V5
V6
V
hr 59 /min bradycardia
P 92 ms PR 146 ms
QRS 92 ms
QT 388 ms QTc 385 ms QTc 99 %
normal axis
SPECIFIC FINDINGS
noise 10 µV small
RMS 10 9 6 3 4 4 9 7
I-III leads QRS RS RS RSR QRSR RS
CH leads RSR RSR RSR QRS QRS QRS
M form in V2
R loss or reduction in AVL
tall R in V1
QT-dispersion : Std 9 ms Max 28 ms from 8/8
QT-dispersion : Std 10 ms Max 28 ms from 6/6 leads
remarks
checked by doctor
HES EKG 18.24 F 0618
END OF PRINTOUT

NEWS key: 0 | 1 | 2 | 3

FULL NAME: Gary Scrimshaw

DATE OF BIRTH: 30/11/1979

COPY

		DATE	21/5	21/5
		TIME	15:00	15:05
A–E	Respirations Breaths/min	≥25		
		21-24		
		18-20		
		15-17	16	16
		12-14		
		9-11		
		≤8		
	SpO_2 Scale 1 Oxygen saturation (%)	≥96	97	98
		94-95		
		92-93		
		≤91		
	SpO_2 Scale 2	≥97 on O_2		
		95-96 on O_2		
		93-94 on O_2		
		≥93 on air		
	Tick if using Scale 2 ☐	88-92		
	Signed	86-87		
	...se Scale 2 under the ...tion of a qualified clinician	84-85		
		≤83%		
	Air or oxygen?	A=Air	(A)	(A)
		O_2 L/min		
		Device		
		≥220		
		201-219		
		181-200	(2)	(2)
		161-180		
		141-160		131
		121-140	120	↑
		111-120	↑	
		101-110		
		91-100		
		81-90		↓
		71-80	↓	82
		61-70	71	
		51-60		
		≤50		
	Pulse Beats/min	≥131		
		121-130		
		111-120		
		101-110		
		91-100		
		81-90		
		71-80		
		61-70		
	Use •	51-60	•57	•54
		41-50		
		31-40		
		≤30		
	Consciousness Score for NEW onset of confusion (no score if chronic)	Alert	✓	✓
		Confusion		
		V		
		P		
		U		
	Temperature °C	≥39.1°		
		38.1-39.0°		
		37.1-38.0°		
		36.1-37.0°	36.3	36.3
		35.1-36.0°		
		≤35.0°		
	NEWS TOTAL		0	0
	Monitoring frequency		4hr	4hr
	Escalation of care Y/N		N	N
	Blood Sugar		/	/
	Pain Score 0-3		1	1
	Initials		KJ/VA	KJ/VA

SCRIMSHAW, Gary
40 Johnston Crescent
Tillicoultry
Clackmannanshire
FK13 6PZ
NHS 923 739 7

DATE OF ADMISSION:

																		DATE
																		TIME
3																		≥21
2																		21-24
																		18-20
1																		15-17
																		12-14
3																		9-11
																		≤8
1																		≥96
2																		94-95
																		92-93
3																		≤91
3																		≥97 on O_2
2																		95-96 on O_2
1																		93-94 on O_2
																		≥93 on air
1																		88-92
2																		86-87
																		84-85
3																		≤83%
2																		A=Air
																		O_2 L/min
																		Device
3																		≥220
																		201-219
																		181-200
																		161-180
																		141-160
																		121-140
																		111-120
1																		101-110
2																		91-100
																		81-90
3																		71-80
																		61-70
																		51-60
																		≤50
3																		≥131
2																		121-130
																		111-120
1																		101-110
																		91-100
																		81-90
1																		71-80
																		61-70
																		51-60
3																		41-50
																		31-40
																		≤30
																		Alert
3																		Confusion
																		V
																		P
																		U
2																		≥39.1°
1																		38.1-39.0°
																		37.1-38.0°
1																		36.1-37.0°
																		35.1-36.0°
3																		≤35.0°
																		TOTAL
																		Monitoring
																		Escalation
																		Blood Sugar
																		NEWS Score10-3
																		Initials

National Early Warning Score (NEWS2)

NHS Forth Valley

COPY

Name: 3011795258 30/11/1979 M
SCRIMSHAW, Gary

DOB: 40 Johnston Crescent
Tillicoultry

CHI No: Clackmannanshire
FK13 6PZ

Address:

*** Regardless of NEWS always escalate if concerned about a patient's condition**

Total NEWS	Frequency of Monitoring	Clinical Response
0 *	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations
1 - 4 *	Minimum 4 - 6 hourly	• Inform registered nurse who must assess the patient • Registered Nurse to decide if increased frequency of monitoring and / or escalation of clinical care is required
5 - 6 * or 3 in one Parameter	Increased frequency to a minimum of 1 hourly	• Registered nurse to urgently inform the medical team caring for the patient • Urgent assessment by a clinician with core competencies to assess acutely ill patients • Ensure structured Response Stickers A & B are completed *(Not Applicable in Emergency Dept)*
7* or more	Continuous monitoring of vital signs (3 lead ECG and continuous SpO2 monitoring, 15 minute BP cycling - document observations every 30 minutes)	• Registered nurse to immediately inform the medical team caring for the patient • Emergency assessment by clinical team with core competencies to assess acutely unwell patients • Ensure structured Response Stickers A & B are completed *(Not Applicable in Emergency Dept)* • Consider transfer of clinical care to ITU

Exclusion Criteria

Anaesthesia and/or sedation may result in reduced conscious levels for a period of time. Scores that are increasing post-procedure and those including "P" or "U" always require escalation. The post-procedure NEWS score and post procedure plan that will include the frequency of observations should be communicated to the ward staff on transfer/handover of the patient.

Target O2 Saturation

Target SpO2 for most patients should be 94-98%.
Selected patients may require target SpO2 88-92% (Appropriate in specific patients with severe chronic respiratory disease who either have established chronic Type 2 respiratory failure, or are felt to be at significantly increased risk of CO_2 retention from oxygen therapy). These patients should use the modified (chronic hypercapnia) EWS. Arterial blood gases should be repeated at 30–60 min to check for rising CO_2 or H^+ after initiation of oxygen in this context.

Acute Respiratory Failure is a life threatening emergency
Severe Hypoxia (Requiring >60% O2 to maintain target SpO2)
Acute Hypercapnia (pCO_2 >6 and H^+ >45)
Urgent ST3 (or equivalent) review is required to optimise management.
Duty or on call consultant should be contacted if advice required.
Critical care referral and ventilatory support may be needed.

Pain Score
0 = no pain
1 = mild pain
2 = moderate pain
3 = severe pain

Codes For Recording Oxygen Delivery On NEWS Chart

A = Air (not requiring oxygen or weaning or on PRN oxygen)
N = Nasal Canulae
SM = Simple Mask
V24 =Venturi 24% V28 = Venturi 28% V35 = Venturi 35% V40 = Venturi 40% V60 = Venturi 60%
H28 = Humidified oxygen at 28% (also H35, H40 & H60 = Humidified Oxygen at 35%, 40% & 60%)
RM = Reservoir Mask
TM = Tracheostomy Mask
CP = Patient on CPAP System
NIV = Patient on NIV System
OTH = Other Device:_____ (specify which)

Sepsis Screening Tool

NHS Forth Valley

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Patient triggering NEWS ≥ 5 OR Clinical Concern
Neutropenia suspected OR MEWS triggering for obstetric patients

Is this likely to be due to infection?

Cough/sputum
Abdominal pain/distension/diarrhoea
Line infection
Endocarditis
Dysuria
Cellulitis
Headache with neck stiffness
Wound infection

Obstetric patients (Refer to FV protocol: Sepsis in Maternity Patients)
Perineal trauma Vaginal discharge Prolonged SRM Sore Throat

YES

Escalate to Doctor/ANP with "suspected sepsis"
Place Sepsis 6 sticker in notes
Prepare giving set/IV fluids

NO

Escalate to Doctor/ANP
Repeat NEWS/MEWS in max 60 mins

ASSESS FOR OTHER CAUSES OF TRIGGERING

Two people work together to deliver the Sepsis 6 within 60 mins of patient first triggering

- Correct Hypoxia
- Take Blood Cultures
- Give IV antibiotics according to NHS FV Protocol
- Measure whole blood Lactate
- Assess urine output (catheter if obstetric patient)
- Start IV fluids - 20ml/kg, minimum 500mls in the first hour

ASSESS FOR SEVERE SEPSIS

SEVERE SEPSIS

Sepsis with ≥ organ dysfunction:
- Hypotension
- Renal
- Respiratory
- Hepatic
- Hematologic
- CNS
- Metabolic acidosis

IF SEVERE SEPSIS
Contact middle grade Doctor (Consultant if obstetric patient)
Catheter mandatory if evidence of AKI

NO EVIDENCE OF SEVERE SEPSIS
Assess response to sepsis 6
Continue regular NEWS

SEPTIC SHOCK

- Hypotension despite fluid resuscitation
- Organ dysfunction

HIGH RISK FACTORS
- Hypotension
- Lactate > 4
- Unexplained INR > 1.5
- APTT > 60 secs
- Bilirubin > 34 (70 if obstetric)
- Platelets < 100

Conscious Level Chart (only as required for head injury observation)

				DATE:	DATE:
				TIME:	TIME:
COMA SCALE	Eyes Open	Spontaneously	4		Eyes closed by swelling = C
		To speech	3		
		To pain	2		
		None	1		
	Best verbal response	Orientated	5		Endotracheal tube or tracheostomy = T
		Confused	4		
		Inappropriate words	3		
		Incomprehensible sounds	2		
		None	1		
	Best motor response	Obey commands	6		Usually record the best arm response
		Localise pain	5		
		Withdraws to pain	4		
		Flexion to pain	3		
		Extension to pain	2		
		None	1		
				1 2 3 4 5 6 7 8 Pupil Scale (mm)	
PUPILS	right	Size			+ reacts - no reaction c. eye closed
		Reaction			
	left	Size			
		Reaction			
LIMB MOVEMENT	ARMS	Normal power			Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness			
		Severe weakness			
		Spastic flexion			
		Extension			
		No response			
	LEGS	Normal power			
		Mild weakness			
		Severe weakness			
		Extension			
		No response			

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Pain Assessment & Management Guidelines

Pain Score:

0 = No pain
1 = No pain at rest
2 = Slight pain on movement
3 = Intermittent pain at rest
4 = Moderate pain on movement
5 = Continuous pain at rest

For Acute and Chronic Pain:
For mild (1), moderate (2) or severe (3) pain refer to Pain Management Guidelines Forth Valley Formulary Appendix 27 & 28. Implement Pain Assessment Chart

For Cancer Related Pain:
For mild (1), moderate (2) or severe (3) pain score, refer Palliative Guidelines.

Supportive and Palliative Care Indicators Tool (SPICT™)

COPY

The SPICT™ is a guide to identifying people at risk of deteriorating and dying. Assessment of unmet supportive and palliative care needs may be appropriate.

Look for two or more general indicators of deteriorating health.

- Performance status poor or deteriorating, with limited reversibility. (needs help with personal care, in bed or chair for 50% or more of the day).
- Two or more unplanned hospital admissions in the past 6 months.
- Weight loss (5 - 10%) over the past 3 - 6 months and/or body mass index < 20.
- Persistent, troublesome symptoms despite optimal treatment of any underlying condition(s).
- Lives in a nursing care home or NHS continuing care unit, or needs care to remain at home.
- Patient requests supportive and palliative care, or treatment withdrawal.

Look for any clinical indicators of advanced conditions

Cancer

Functional ability deteriorating due to progressive metastatic cancer.

Too frail for oncology treatment or treatment is for symptom control.

Dementia / frailty

Unable to dress, walk or eat without help.

hoosing to eat and drink less; difficulty maintaining nutrition.

Urinary and faecal incontinence.

No longer able to communicate using verbal language; little social interaction.

Fractured femur; multiple falls.

Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease

Progressive deterioration in physical and/or cognitive function despite optimal therapy.

Speech problems with increasing difficulty communicating and/or progressive dysphagia.

Recurrent aspiration pneumonia; breathless or respiratory failure.

Heart / vascular disease

NYHA Class III/IV heart failure, or extensive, untreatable coronary artery disease with:

- breathlessness or chest pain at rest or on minimal exertion.

Severe, inoperable peripheral vascular disease.

Respiratory disease

Severe chronic lung disease with:

- breathlessness at rest or on minimal exertion between exacerbations.

Needs long term oxygen therapy.

Has needed ventilation for respiratory failure or ventilation is contraindicated

Kidney disease

Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.

Kidney failure complicating other life limiting conditions or treatments.

Stopping dialysis.

Liver disease

Advanced cirrhosis with one or more complications in past year:

- diuretic resistant ascites
- hepatic encephalopathy
- hepatorenal syndrome
- bacterial peritonitis
- recurrent variceal bleeds

Liver transplant is contraindicated.

Assess and plan supportive & palliative care

- Review current treatment and medication so the patient receives optimal care.
- Consider referral for specialist assessment if symptoms or needs are complex and difficult to manage.
- Agree current and future care goals/plan with the patient and family.
- Plan ahead if the patient is at risk of loss of capacity.
- Handover: care plan, agreed levels of intervention, CPR status.
- Coordinate care (eg. with a primary care register).

Review Date: 2025
Re-order Ref: TF/1013/SS
NEWS2

Ophthalmology Department
Consultant: J. Angus Scott
Tel: 01786 434000 Ext.4637
Fax:

Stirling Royal Infirmary
Livilands
Stirling
FK8 2AU

COPY

Ref: RI/RR/S237397
CHI: 3011795258

Clinic Date: 30 August 2010
Date: 07 September 2010

Dr Andreas Kolle
Tillicoultry Medical Practice
Park Street
Tillicoultry
FK13 6AG

Dear Dr Kolle

GARY SCRIMSHAW 30/11/1979
22/4 HILL STREET TILLICOULTRY CLACKMANANSHIRE FK13 6HF

I reviewed this gentleman today who had an acute right painful eye last week. His conjunctival swabs came to be negative today.

On examination today his right visual acuity was 6/12 improved to 6/9 with pinhole. Left visual acuity was 6/6. He has a right small healing corneal abrasion with otherwise unremarkable inferior and posterior segments. In addition there is no relative afferent pupillary defect and colour vision was full in both eyes. I have advised him to continue using the Exocin eye drops for a further four days. I have discharged him from the clinic.

Yours sincerely

Dr Rehab Ismail
ST2 in Ophthalmology to
J Angus Scott
Consultant Ophthalmologist

NHS GENERAL OPHTHALMIC SERVICES

30/8

GOS(S)(M)

PLEASE USE BLOCK CAPITALS EXCEPT FOR SIGNATURE

Referral/Notification of Patient to GMP

SECTION ONE: To Be Sent To GMP

To: Dr. PCC 30/08/10 SRV

COPY

PATIENT'S DETAILS

SURNAME (Mr, Mrs, Miss, Ms) SCRIMSHAW

OTHER NAME(S) GARY

ADDRESS FLAT 4, 22 HILL STREET, TILLICOULTRY

POSTCODE FK13 6HF TEL. No.

PRESCRIPTION DETAILS FROM CURRENT SIGHT TEST-DATE:

	Uncorrected V	Sph	Cyl	Axis	Prism	Base	VA	Add	Near VA
R									
L									

Previous corrected V.A. Date

Date of Birth 30.11.79

Specify Cyclopegic/Mydriatic if used.

POINTS REQUIRING ATTENTION - FOR INFORMATION (AND POSSIBLE REFERRAL):

This gentleman attended today with a very sore R eye. He says this started yesterday and his vision has dropped to about 20% today. He is also very photophobic. IOPs are R 22 L 25 mmHg @ 930am today. I instilled fluorescein but was unable to shine any light in his eye to determine pattern.

I agree / do not agree that any Ophthalmologist to whom I am referred for medical consultation and / or treatment may make information relevant to my eye condition and its treatment available to my Optometrist / Ophthalmic Medical Practitioner.

Sign ..... Date .....

Optic discs

IOP R mmHg L mmHg

Tonometer used: Applanation/Tonometer

Visual Fields R L

Plot attached . . . Y/N

Name and Address of Optometrist/OMP

MARY ROCHESTY
OCHILEYES
105 HIGH ST
TILLICOULTRY

Signed (Optometrist/OMP) [signature] Date 25.8.10

SECTION TWO: To Be Completed By General Medical Practitioner (if not accompanied by formal referral letter)

To: Dr. / Mr. / Mrs. / Miss / Ms

RELEVANT CLINICAL HISTORY - INCLUDE MEDICAL/FAMILY/OPHTHALMIC AND DETAILS OF MEDICATION:

Urgency Rating: Urgent/Soon/In turn

Blood Pressure: mmHg

Urinalysis:

Provisional Diagnosis:

Name and Address of GMP

Signed (GMP) Date

Part One - This part must accompany any referral and be retained by the Ophthalmologist

ted for RRD 861857 8/09 (71412)

STIRLING ROYAL INFIRMARY
LIVILANDS
STIRLING
FK8 2AU

GASTROENTEROLOGY UNIT – Fax: 01786 434461

COPY

NHS
Forth Valley

Consultant: **Dr. Stuart Paterson**
Consultant Physician – Gastroenterologist

Secretary: Julie McCormack - Tel: 01786 433661

Dr Peter Bramley
Dr Hugh Dalziel
Dr David Watts
Dr David Oliver
Dr Stuart Paterson

Associate Specialist: Dr Patrick Law

Patient Details:

MR GARRY SCRIMSHAW
7 MOSS ROAD,
TILLICOULTRY,
CLACKMANNANSHIRE

FK13 6NS

G.P. Details DR BOWLAND
Health Centre 3
Hall Park ROAD
Sauchie
FK10 3JQ

Date: 26/08/10

Dear Doctor

Following this patient's recent hospital admission, the case notes have been reviewed together with the Immediate Discharge Summary. We consider the discharge summary to be accurate and please accept it as a complete and final summary of this patient's recent admission.

Any outstanding issues are listed below:

Discharge Date: 22/8/10

Follow Up Required: No ☐ Yes ☑ Arranged / To Be Arranged

Results Outstanding: Nil

As per psychiatry
please copy d/c to
Dr Collins – Consultant
psychiatrist
Stirling Royal

Signed: CMO

Page No: 096

Immediate Discharge Letter

NHS Forth Valley

COPY

Hospital: Stirling Royal Infirmary

Tel (SRI): 01786 434 000 Fax (SRI): 01786 430 588
Tel (FVRH): 01324 566 000
Tel (FDRI): 01324 624 000 Fax (FDRI): 01324 617 421

Consultant: Paterson, Dr Stuart
Specialty: General Medicine

Discharging Ward: SRI - Ward 1

GP Details		Patient Details		Admission Details	
Practice Code:	25031	Patient CHI No:	3011795258	Admission Date:	20/08/2010
		Patient Hospital No:	S237397		
GP Name:	Dr David S Borland	Surname:	Scrimshaw	Admission Type:	Emergency - Injury - Self Inflicted (Injury or Poisoning)
Address:	Health Centre Practice 3, Hallpark Road, Sauchie, K10 3JQ	Forename:	Garry	Presenting Complaint:	Overdose and Poisoning
		Date of Birth:	30/11/1979		
		Address:	7 Moss Road,, Tillicoultry,, Clackmannanshire, FK13 6NS	Discharge Date:	22/08/2010
				Discharge To:	Private Residence - Living Alone

Diagnosis/Problem List

Xa6Dd - Intentional amitriptyline overdose

Additional comment (Progress, Investigations, Procedures, Complications etc)

Admitted to ITU after being found face down on floor unconscious. Empty blister packs in the immediate area suggested mixed overdose. Intubated in ITU overnight due to reduced conscious level. Central line and arterial line inserted for supportive treatment and monitoring.

Paracetamol level - 236
Salicylate - undetected
Routine bloods - U&E, LFT, FBC all normal. Coag normal

Treated with IV parvolex. Extubated the morning after admission and transferred to the ward later that day. Seen by psychiatric SHO on call - no ongoing suicidal ideation. They will arrange urgent follow up with Dr Collins.

Plan: allow home. No medications.

Procedure	Performed	Time
Mechanical ventilation	20/08/2010	

Results Outstanding (Y/N) If yes, give details:	No

Information to patient/carer (Y/N):	Patient: Yes Carer (If applicable): No

Follow up arrangements

There are no Reviews planned

File

Authorisor's name: L Fabisiak	**Doctor's Signature:**
Authorisor's grade: Advanced Nurse Practitioner	
Lead/Approved by:	
Date: 22/08/2010	

COPY

Discharge Ward Nurse:	Murphy, John

Validation/Contact Name: Paterson, Dr Stuart

Name: Mr Garry Scrimshaw

THIS IS THE FINAL DOCUMENT

CHI: 3011795258

File

Forth Valley Acute Hospitals Acute Division
Medications Discharge Summary

COPY

Name:	Mr Garry Scrimshaw	Patient's Tel No:	
Address:	7 Moss Road,, Tillicoultry,, Clackmannanshire, FK13 6NS	Patient's Tel Eve:	
Admission Date:	20/08/2010	Discharge Date:	22/08/2010

PATIENT ALERTS

Alert Group	Alert	Alert Comment	When Added	Added By

PATIENT DRUG REACTIONS

CURRENT PRESCRIPTION (all medicines currently prescribed) **e.g. clinical indication for prescription monitoring*

MEDICINES DISCONTINUED

Nurse check on discharge:

Signature 1:

Signature 2:

Name: Mr Garry Scrimshaw

CHI: 3011795258

File

Name: Gary Scrimshaw DOB: 30.11.79

Pain Score (on movement)
0 = no pain ; 1 = mild pain
2 = moderate pain ; 3 = severe pain

CHI: WARD: 29B

NHS
Forth Valley

COPY

CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE RED OR TWO YELLOW SCORES AT ANY OTHER TIME

	Date:	26/10	2/10	
	Time:	1540	6 30	
RESP (write rate in corresp. box)	>30			>30
	21-30			21-30
	11-20	16	16	11-20
	0-10			0-10
Saturations	90-100%	97%	99	90-100%
	<90%			<90%
02 Conc.	%	AIR	(A)	%
Temp	39			39
	38			38
	37			37
	36	36.5	36.4	36
	35			35
HEART RATE	170			170
	160			160
	150			150
	140			140
	130			130
	120			120
	110			110
	100			100
	90			90
	80	84		80
	70			70
	60		60.	60
	50			50
	40			40
BLOOD PRESSURE (score on systolic)	200			200
	190			190
	180			180
	170			170
	160			160
	150			150
	140	133	132	140
	130			130
	120			120
	110			110
	100			100
	90			90
	80			80
	70		77	70
	60			60
	50	64		50
NEURO RESPONSE (√)	Alert	✓	✓	Alert
	Voice			Voice
	Pain			Pain
	Unresponsive			Unresponsive
Pain Score (no.)	2-3		2	2-3
	0-1	1-2		0-1
Nausea (√)	YES (√)			YES (√)
	NO (√)	✓	✓	NO (√)
Looks Unwell	YES (√)			YES (√)
Looks Unwell	NO (√)	✓	✓	NO (√)
Total Yellow Score			2	Yellow
Total Red Score			0	Red
Dr Called (√)	YES	✓		YES
	NO		✓	NO
		SJN	B	

Re-order Ref:TF/14001/CF Issue Date: 2006 Review Date: 2007

Other Charts in Use (Please tick)			Pain	Oxygen	Additional Kardex	Other

[illegible] VALLEY ACUTE HOSPITALS NHS TRUST

[illegible] PRESCRIPTION AND ADMINISTRATION RECORD SHEET

COPY

WARD	CONSULTANT	PATIENT DETAILS: (Name and Address)
29B.	DR SABOOR	GARY SCRIMSHAW 6 BROOMPARK WEST MENSTRIE
ALLERGIES [illegible]		HOSPITAL No: HOSPITAL SITE:
HEIGHT (m)	WEIGHT (kg) / DATE / SURFACE AREA (m²)	DATE OF BIRTH: 30.11.79 AGE 26

INSTRUCTIONS FOR USING THIS SHEET

- Doctors and Nurses must ONLY write in black ink (except for allergies)
- Pharmacists must ONLY use green ink
- Use the approved drug name and write in BLOCK CAPITALS
- Enter the specified times and write additional information in the instruction box.
- ONLY use the listed abbreviated routes of administration. Where abbreviation not listed, write route in full.
- Dose must be stated in either metric or SI units. Quantities less than 1mg must be written in full eg. micrograms.
- To cancel a drug draw a diagonal line through the entire entry, initial and date.
- TWO nurses must initial each drug administration for ALL Parenteral and Paediatric Medicine.
- When a drug is not given - enter the not given code (see list)
- ALL of the above MUST be adhered to

ROUTES

- IV - intravenous
- IM - intramuscular
- SC - subcutaneous
- PO - oral
- INH - inhaled
- NEB - nebulised
- SL - sublingual
- PR - by rectum
- PV - by vagina
- TOP - topical

NOT GIVEN CODES

1. Patient not on ward
2. Patient unable to take
3. Patient vomited
4. Drugs not available
5. Drugs not required
6. Given > 30 mins late
7. Patient allergy
8. Patient refused
9. Withheld - medical indication
10. Given by Patient/relative/carer

ONCE ONLY MEDICATION

PHARMACY	DATE	APPROVED DRUG NAME	DOSE	ROUTE	TIME/ INSTRUCTIONS	DR SIGNATURE	GIVEN BY	TIME GIVEN

DRUG LEVEL NOTES

DATE	TIME	DRUG	DOSE	LEVEL	PEAK/TROUGH	SIGNATURE

NURSING NOTES
(Also to be used for Short Term Patients instead of Nursing Profile)

Surname
Forenames
CHI: 3011795258
CRN: SZ 237397 30/11/1979
SCRIMSHAW GARRY M
Address 43 EASTCASTLE STREET
ALLOA
FK10 1BB
Ward / Dept.

149

Date: EXOCIN (L) EYE ½ HRLY

DATE	TIME	SIGNATURE
26.10.06	9.30	H Berry
	10.00	H Berry
	10.30	H Berry
	11.00	H Berry
	11.30	H Berry
	12 nn	H Berry
27/10/06	00.30	H Berry
"	01.00	H Berry
"	01.30	H Berry
"	02.00	H Berry
"	02.30	H Berry
"	03.00	H Berry
"	03.30	H Berry
"	04.00	JMc
"	04.30	JMc
"	05.00	H Berry
"	05.30	H Berry
"	06.00	H Berry
"	06.30	H Berry
"	07.00	
"	07.30	C Mcdevitt
"	0800	C Mcdevitt
	0830	C Mcdevitt
	0900	C Mcdevitt
	0930	
	1000	

RX403

STA109

NURSING NOTES

Consultant

Write - imprint or Attach Label

Surname Scrimshaw Hospital No.

Forenames Gary Sex M

D. of B. 30-11-79

Address

COPY

Ward / Dept. 29B

Date	
26:10:06 1500 HRS	Admitted to ward 29B via eye clinic. Reported to eye clinic by GP with (L) eye injury. For 1½ hourly eye drops. Cleared in by Jho. All observations stable on admission. Settled since admission. For review in the am. SJ Witherspoon
27/10/06 ND	Eyedrops given ½hrly throughout night so patient not had much sleep. Eye red slightly swollen and weepy. Has been very uncomfortable overnight. Dihydrocodeine 30mgs given at 02.10. H Simm
a.	Attended eye clinic. Lens changed to a smaller size. Eyedrops (ofloxacin) to continue 6x daily. May be discharged home. Patient has eye clinic appt for Monday 30/10/06 CM Sendall Fr.

STM 012

RX81

PATIENT PROFILE

Addressograph:
Name: GARY scrimshaw
Address: 43 East Castle STREET
AIIOA FKIO IBB
DoB: 30.11.79 Unit No: 237397
Prefers to be addressed as: Age: 26

Consultant:
Ward: 29B
Pre-op Date:
Date of Admission:
Time of Admission:
Readmission Date:

COPY

Provisional Diagnosis:
(L) eye injury
? corneal abrasion

Final Diagnosis / Treatment:

Next of Kin:
Name: MRS Scrimshaw
Address: 43 East Castle STREET
AIIOA.
Relationship: wife.
Tel. Day:
Mobile: 07706396071.
Tel. Night:

Name:
Address:
Relationship:
Tel. Day:
Mobile:
Tel. Night:

G.P. DR Borland.
Practice: AIIoa Medical Centre
Transport req. for discharge: YES: Ref.No:
NO: ..... will collect.

Own Medication: Y: (N:)
In Cupboard: Y: (N:)
Returned to relatives: Y: (N:)

Urinalysis: Date:
Uroblinogen: Bilirubin:
Protein: Sp.Grav:
Blood: Glucose:
PH: Ketone:

Bladder:
Continent/Incontinent:
LMP:
Pregnancy Test: REQ: YES: N/A:
Date:

Bowel: Normal.
BLO:
Stoma Nurse Referral: N/A: YES: Date:

Diet: Normal **Weight:** Kg
Appetite:
Dietetic Referral: YES: Date: ..... N/A:

Teeth:
Eyesight: } no problems.
Hearing:

Religion: NIK.
Marital Status: married
Occupation: Chef

Understanding of Illness / Surgery
Patient spoken to by: fully aware Relatives spoken to by:

Admitted by: S.J. WOTHERSPOON
Named Nurse on Admission:
Date: 26.10.06.

NAME: | Unit No: | 2

PHARMACY USE ONLY

General Medication Oral and other routes (regular)

(General Medication starts at page 2 and works forward. Parenteral Medication starts at page 4 and works forward)

- enter dosage times as 24hour clock
- please write in block capitals
- please write in black pen

- Maximum of 3 continuation sheets
- please ensure patient details are on each sheet

COPY

ALLERGIES - Please use RED INK (one of these boxes must be filled in)	N K D A (Please circle if appropriate)	DATE → / TIME ↓	22/8/10

Drug OXYGEN

Circle target oxygen saturation

88-92% 94-98% Other ____

Starting device/flow rate ____

PRN/continuous (refer to O_2 guideline)

Tick here if saturation not indicated* ☐

Date and signature

Print name

SUPPLY

APPROVED DRUG NAME	DOSE	ROUTE
NICOTINE PATCH	15mg	TRANS DERMAL
INSTRUCTIONS	Clin Pharm.	Reg/New
REMOVE AT NIGHT	Date stopped	
SIGNATURE	DATE 21/8/10	Reason for stopping

Administration grid entry (22/8/10): 8 (circled)

SUPPLY

APPROVED DRUG NAME	DOSE	ROUTE
INSTRUCTIONS	Clin Pharm.	Reg/New
	Date stopped	
SIGNATURE	DATE	Reason for stopping

SUPPLY

APPROVED DRUG NAME	DOSE	ROUTE
INSTRUCTIONS	Clin Pharm.	Reg/New
	Date stopped	
SIGNATURE	DATE	Reason for stopping

SUPPLY

APPROVED DRUG NAME	DOSE	ROUTE
INSTRUCTIONS	Clin Pharm.	Reg/New
	Date stopped	
SIGNATURE	DATE	Reason for stopping

SUPPLY

APPROVED DRUG NAME	DOSE	ROUTE
INSTRUCTIONS	Clin Pharm.	Reg/New
	Date stopped	
SIGNATURE	DATE	Reason for stopping

Other Charts in use (Please tick)	Insulin		Anticoagulant	Pain		Additional Kardex		Other	

FORTH VALLEY ACUTE SERVICES

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MEDICATION PRESCRIPTION & ADMINISTRATION RECORD SHEET

WARD

ALLERGIES

NKDA (Please circle if appropriate)

(one of these boxes must be filled in)

PATIENT DETAILS (and Address)

CHI: 3011795258 30/11/1979 M
SCRIMSHAW
GARY
7 MOSS ROAD
TILLICOULTRY
FK13 6NS

HOSPITAL

DATE OF BIRTH:

Initial here when informed verbal consent to use/destroy P.O.D.'s is received from the patient.

Drugs administered prior to hospital arrival

Date	Approved Drug Name	Dose	Route	Given by (e.g. SAS, GP)	Time given
	Naloxone	400mg	IV	SAS	1255h

ONCE ONLY MEDICATION

PHARMACY	DATE	APPROVED DRUG NAME	DOSE	ROUTE	TIME/ INSTRUCTIONS	DR SIGNATURE	GIVEN BY	TIME GIVEN
		Sodium bicarbonate 8.4%	50ml					1338

KARDEX C

INSTRUCTIONS FOR USING THIS SHEET

- Doctors and Nurses must ONLY write in black ink (except for allergies)
- Pharmacists must ONLY use ***green ink***
- Use the approved drug (RINN) name and write in BLOCK CAPITALS
- Enter the specified times and write additional information in the instruction box.
- ONLY use the listed abbreviated routes of administration. Where the abbreviation is not listed, write the route in full.
- Dose must be stated in either metric or SI units. Quantities less than 1mg must be written in full eg. micrograms.
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ROUTES

IV	- intravenous
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3. Patient vomited
4. Drug not available
5. Drug not required
6. Given > 30 mins late (state time)
7. Patient allergy
8. Patient refused
9. Withheld - medical indication
10. Given by Patient/relative/carer

Critical Care Department Care Plan

PHYSICAL ASSESSMENT OF CONDITION/NEEDS	AIMS AND PLANNED CARE
6. Elimination	
Renal function: Urinary catheter insitu - removed at 4pm - Urinary output adequate. U & E's satisfactory	Care of urinary catheter ✓ (Hourly Volumes / ~~Free Drainage~~)
	Daily urea and electrolytes ✓ Daily Urinalysis ✓
	Aim for a +ve / -ve balance of: neutral
	Maintain an accurate fluid balance ✓
Renal replacement therapy: Yes (No)	
IV Anticoagulant	
Vascath site:	Maintain safe / effective renal replacement therapy.
	Care of renal replacement lines / maintain patient safety. N/A
	Maintain APPT ratio of:
Drains / Output	
Abdomen Distended (Soft) Bowels last open: pre admission	Prevent Constipation
Colostomy / Ileostomy / Mucoid Fistula	
Stoma Condition: Appliance Type:	? Refer to Stoma Care Team.

7. Personal	
General body condition: Skin clean & intact	Maintain appropriate hygiene standards and dignity.
Mouth condition:	Bed bath / shave / hair wash / finger nails / toe nails / catheter care ✓
Eye condition: eyelids "puffy"	refused shave today.
Arterial Line site: (R) radial - satisfactory	Ensure occlusive dressing is intact to all line sites. ✓
Central Line: (R) I.J. - satisfactory	
Venflon site/s: N/A	
Wound (s): N/A	Redress:
Drains:	Aim for healthy granulation of wounds
	Reduce Infection

2. Cardiovascular Care	Aims Maintain Cardiac Stability
Cardiac Rhythm: Sinus Rhythm Rate: 80 - 96	Monitor vital signs and pressure traces frequency ✓
Blood Pressure: NIBP / (APB) 160/70 MAP: > 90	Change electrodes daily ✓
Inotropes Yes / (No) Type: Art line position: (R) Radial Removed ✓	12 lead E.C.G. Yes / (No)
	Aim for MAP: > 75 Aim for CVP: 8 - 12
CVP: + 10	Titrate Inotropes to ensure set parameters
Temperature: 36.2	Care of invasive monitoring lines : Flush Lumens x 1 per shift ✓
	: Flush Prescribed: Yes / (No)
	: Record CSM to digits per shift ✓

PHYSICAL ASSESSMENT OF CONDITION/NEEDS	AIMS AND PLANNED CARE
3. Pain/Sedation	
Sedation:	
Sedation Holiday (Yes) / No	Aim for sedation score: 0 Drowsy
Pain: No c/o pain.	Observe for non-verbal signs of pain frequency ✓
	Assess effectiveness of analgesia and characteristics of pain. ✓
	Aim for pain score 0
4. Neurological Care	
Neurological State: Drowsy & sleepy	Observe for neurological deterioration and report any changes.
Pupils 6.5 15	Record GCS AVPU Score x 1 per shift ✓
5. Nutrition/Hydration	
NBM/Feeding / (Oral Fluids) Diet Type Normal ✓	Liase with the dietician and the anaesthetist re feeding regime
Feed Enteral / Parenteral Tube type: Ryles / ~~Fine Bore~~	(Encourage) / Provide adequate nutrition ✓
Feed Type Position: Removed, 11:00	Change NG fixing tape daily. N/A
Gastric Aspirates: — PH: —	Record blood glucose DAILY ~~hourly~~.
	Aim for Blood Glucose: 3.8 - 8.5 ✓
Blood Sugar: 4-6 mmol/s	Encourage oral fluids / ~~diet supplements~~: (Yes) / ~~No~~
Sliding scale insulin regime prescribed: Yes / (No)	Maintain an accurate fluid balance. ✓
	Weekly weight complete nutritional risk screening tool. ✓

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8. Mobility	Aim
Pressure areas: Intact	Reassess all pressure areas 3-4 hourly.
	Turning / repositioning required 3-4 hourly.
Sunderland Score / Waterlow	Therapeutic Mattress: Yes / (No) Type:
Mobility: Bed Rest / Up to sit	Manual handling technique: 5 L. + 2 nurses
Teds in situ: Size: Length:	Mobility Chart Falls Risk Assessment
LMWH (Yes) No Prescribed:	Reduce Risk Factors of DVT

9. Infection	
WCC elevated: Yes (No) 8.2	Damp dust bedspace **each** shift.
	Inform relatives about hand washing
MRSA + ve: Yes / No awaited. Site/s:	
Microbiology Sites:	
Patient isolation: yes (no)	
10. Psychological / Cultural	**Aim**
Patient's psychological condition:	Communication tools: lip reading / alphabet / speaking tube N/A
	Orientate patient to time, place and person. ✓
Family: Ex-wife updated by phone.	Explain all plans procedures to patients and family. ✓
	Give reassurance / support to patient. ✓
Sleep/rest:	Encourage involvement in decision making: ✓
	Maintain the environment conducive to sleep / rest periods. ✓
Spirituality:	Reduce unnecessary noise / alarms. ✓
	Accommodate religious / cultural / spiritual needs. ✓
	Maximise stimulation when appropriate - visitors
	TV / radio / newspapers / photographs

Day shift assessed by: Margaret C Thomson (Signature) M C THOMSON (PRINT NAME) S/N. (Job title) 12:00 (Time)

Night shift assessed by: (Signature) (PRINT NAME) (Job title) (Time)

COPY

Critical Care Department Care Plan

NAME: CHI:3011795258

CRN:S237397 30/11/1979

PREFERRED NAME: SCRIMSHAW GARRY M

7 Moss Road,
TILLICOULTRY,
Clackmannanshire

CHI NO: FK13 6NS

AGE: 30

DAY NO: 2

CRITICAL CARE CONSULTANT(S): Dr [illegible]

REFERRING CONSULTANT: Dr

PREVIOUS 24 HOUR SUMMARY (NIGHT SHIFT TO COMPLETE):

Ventilated + sedated overnight
One episode of haemodynamic instability - resolved - one further episode
[illegible] - woke up, re-assess.

DATE: 21/8/2010

All nursing care documented in this care plan, is in accordance with Stirling Royal Infirmary NHS Trust procedures and guidelines and is used in conjunction with the Critical Care patient observation chart. Please delete as appropriate. Document care using a black pen (day duty). Use a green pen (night duty) when changes to patient assessment are found.

PHYSICAL ASSESSMENT OF CONDITION/NEEDS	AIMS AND PLANNED CARE
1. Respiratory Care	✓ ✓
Ventilation: Self-ventilating on R.A	Maintain patent/airway. Auscultate regularly. Pre-oxygenate: Yes/No (No circled)
RR 16-19 SaO2 >95%	Ensure optimum respiratory function / ~~ventilation~~. ✓
	Sit Up 45° ✓
Chest Secretions: Nil	Aim for SpO2 >93%
Regular Physio Yes/No (Yes circled) Suctioning Required Yes/No (No circled)	Monitor ABG's and act accordingly. ✓
ABG's:	
	Weaning: Yes / No
Tracheostomy: Yes / No	Weaning plan: N/A
Oxygen Therapy Yes/No (No circled) Prescribed Yes / No	
Oxygen Percentage: Delivery System:	Reduce risk of lung infection ✓

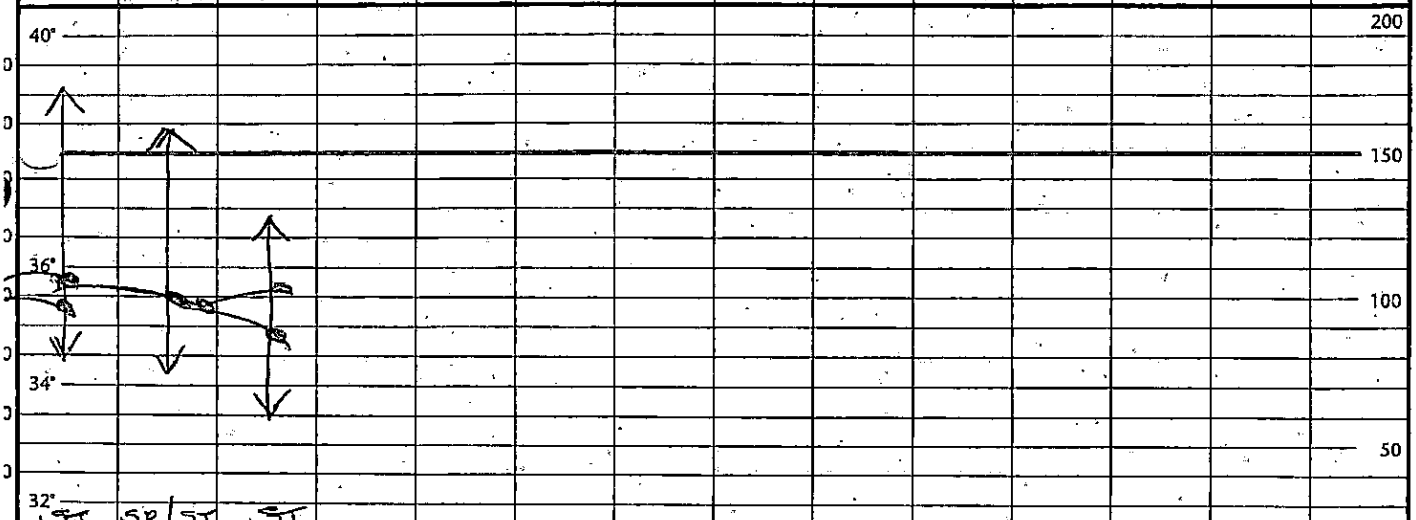
COPY

ING1012

		01:00	02.00	03.00	04.00	05.00	06.00	07.00	08.00	09.00	10.00
RESPIRATION	Vent.Mode	PSIMV	PSIMV	PSIMV	PSIMV	PSIMV	PSIMV	PSIMV	PSIMV	PSIMV	SV
	FIO2	25.	25.	25.	25	25.	25%	21%	21%	21%	8L ↓5L
	Rate/Set/Spont.	13 0	13 0	13 0	13 0	13 —	13 0	13 0	13 0	13 0	19
	Press.Support/Cont	15/15 5	15/15 5	15/15 5	15/15 5	15/15 +5	15/15 5	15/15 5	15/15 +5	13/15 +5	
	Peep/CPAP										
	T.Vol.Exp./I.PAP	591	597	580	604	601	580	597	556	694	
	M.Vol Exp./E.PAP	6.9	7.7	7.8	7.8	7.8	7.5	7.8	7.4	7.4	
	Peak Airway PR.	20	20	20	20	20	20	20	20	20	
	I:E / Humid Temp.	HMEF	→	→	→	HMEF	→		HMEF	→	
	Air Entry L R / L R	✓ ✓									
	Hrly E.T./O.Ph/S.G. Aspirate						2m				
	O_2 Sats	96%	98%	97%	99%	98%	97%	97%	97%	97%	93%
	End Tidal CO_2	4.4	4.4	4.0	3.8	3.8	4.4	4.4	4.4	3.9	
ABGS	H+ IONS		39.9				37.6				
	PCO_2		4.06				3.85				
	PO_2		14.1				14.8				
	HCO_3S		19.7				20.5				
	BE		-3.8				-2.6				
	Glucose/BM		5.4				5.2				
sepsis screen	K^+		0.0				3.6				
	Lactate		0.5				0.5				
	NIBP		35.6°C				35.5		36.1		
	ABP										
	HR Red										
	Temp Green										
	M.A.P. Black										
	Pupils: +/- Rhythm	SR	SR	SR	SR	SR	SR	SR	SR	SR	ST
	CVP	+9	+7	+9	+8	+8	+8	+8	+8	+7	+7
	Rass/Pain	-4	-4	-4	-4	-4	-4				
	2 hrly Oral Hygiene	✓		✓			✓				
INFUSIONS	PANTOPRAZOLE	2 | 28	2 | 26	2 | 24	2 | 22	2 | 20	2 | 18	2 | 16	2 | 14	2 | 12	2 | 11 OFF
	Concentration/Pump No.	2	2	2	2	2	2	2	2	2	1
	IV FLUIDS	100 | 0	100 | 120	100 | 205	100 | 304	100 | 412	100 | 480	100 | 104	100 | 215	100 | 301	100 | 408
	/	—	120	85	99	108	68	104	111	86	107
	PROPOFOL	8 | 7	8 | 16	8 | 24	8 | 31	8 | 40	10 | 8	10 | 19	10 | 33	10 | 42	10 | 49 OFF
	/	7	9	8	7	9	8	11	14	9	7
	FENTANYL	32 | 29	32 | 70	32 | 100	32 | 127	32 | 162	32 | 189	32 | 221	32 | 257	32 | 284	32 | 318
	/	29	41	30	27	35	27	32	36	27	34
	MIDAZOLAM 50mg	16 | 14	16 | 35	16 | 50	16 | 64	16 | 81	OFF	—			
	/	14	21	15	14	17					
	/										
	/										
	/										
	/										
	/										
	Position R/L/B head of bed >30°	R ✓	L ✓	L ✓	L ✓	R ✓	R ✓	B ✓	B ✓	B ✓	B ✓
	Initials	[illegible]	[illegible]	[illegible]	[illegible]	LB	NB	[illegible]	[illegible]	[illegible]	[illegible]
IN	Colloid										
	Drugs			50	50		20	50	50		
	Ng / Oral										
	Hourly Total	52	173	190	199	171	125	199	213	124	149
	Running Total	52	225	415	614	785	910	1109	1322	1446	1595
OUT	Urine	58	80	60	90	35	25	20	35	30	25
	Gastric										
	Bowels / Stoma										
	Drain										
	CVVH										
	Hourly Total	55	80	60	90	35	25	20	35	30	25
	Running Total	55	135	215	305	340	365	385	420	450	475
	Balance		+90		+309						

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	00.00
SV	SV	SV											
3L	RA.	RA											
~~15~~	~~14~~	~~16~~											

95%	95%	94%											



ST	SR/ST.	ST											
+10	+ 9	—											

100/520	OR												
112													
32/350.	32/379	32/413											
32	29	34											
(L) ✓	B ✓												
150		200											
294	29	34											
1889	1918	1952											
35.	[illegible]												
35													
510													
	+1408												

Enteral Nutrition: Route: + T.P.N. Prescription

Feed No.	Feed / T.P.N. Additive	Volume	Rate	Signature	Suggested Start Time	Begun at	Given By

COPY

	Date	Fluid (Use Block Letters) Additive Medicine	Vol. (ml) Dose (mg)	Route of Admin.	Dur. of Admin.	Signature	Serial No. Batch No.	Time Begun	Given By Added By
A		Gelofusin	250ml	IV	5mins				
		as per protocol							
B		Gelofusin	250ml	IV	5mins				
		as per protocol							
C		Gelofusin	250ml	IV	5mins				
		as per protocol							
D		Gelofusin	250ml	IV	5mins				
		as per protocol							
E	21/8/10	Hartmans	500	IV	5°		10E12 TSA. 04/13	1:00	
F	21/8/10	Hartmans	500	IV	5°		10E12 TSA. 04/13	9:00	
G									
H									
I									
J									
K									
L									
M									
N									
O									
P									
Q									

Events

COPY

		Initials
01.00	PAC => Ⓡ	
02.00	KCL replacement — 40 mmols	
03.00		
04.00		
05.00	Propofol ↑ [illegible] – waking up, moving – unresponsive	
06.00	PAC => Ⓡ , KCL replacement 20mmols	
07.00		
08.00	Bed checks.	
09.~~00~~30	Sedation break.	
10.00	Extubated at 09.55. RR. 19. SaO_2 88% → 96% Fio2 5L/min	
11.00	Urinary catheter out. Taking oral fluids	
12.00	Refused lunch.	
13.00		
14.00		
15.00		
16.00		
17.00		
18.00		
19.00		
20.00		
21.00		
22.00		
23.00		
00.00		

	AM	PM		AM	PM
Admitting team aware Y / N			Does patient have a PVC Y / N (if N go to AB's)		
APACHE II score complete Y / N	NA	NA	New PVC today		
Wardwatcher up to date Y / N			Documentation/sticker completed Y / N		
Is patient ventilated Y / N (if N go to blood sugars)			Is PVC still required Y / N (If N then remove-R)		
HOB > 30° Y / N			Evidence of inflammation / erythema Y / N		
Sedation Holiday appropriate Y / N / L.Ex / NA			Dressing intact Y / N		
Ventilatory Weaning considered Y / N / L.Ex			Has PVC been in situ >72 hours Y / N		
Weaning plan considered Y / N / NA			Is pt on AB's Y / N (if N go to other activities)		
Chlorhexidine prescribed Y / N			Are antimicrobials still required Y / N		
Subglottic aspiration tube Y / N / Lx			Antimicrobials prescribed as per guidelines Y / N		
HMEF appropriate Y / N			Do antimicrobials require de-escalation Y / N		
Is wet circuit required?			Other activities		
Blood sugar - Is insulin required Y / N /L.Ex			DVT prophylaxis prescribed Y / N		
Is Insulin prescribed Y / N			Peptic ulcer prophylaxis prescribed Y / N / L.Ex		
Does patient have a central line Y / N (if N go to sepsis)			Patient up to sit Y / N / /Lx		
New CVC line today Y / N			Daily goals / Plan written in medical notes		
Documentation completed Y / N			Kardex reviewed and re written as required Y / N		
Is CVC still required Y / N-If N remove (R) & send Tip for C&S			Blood results reviewed and actioned Y / N		
Is dressing intact Y / N			Assessed as per mobility chart Y / N		
Sepsis Screen - Is patient pyrexia Y / N			Is patient ready for discharge Y / N		
Has sepsis screen been completed Y / N			Receiving informed of discharge Y / N / NA		
Are there outstanding microbiology results Y / N			Discharge planning complete Y / N		
MRSA eradication therapy required Y / N			Discharge documentation completed Y / N		

Y = Yes N = No Lex = Local Exclusion NA = Not Applicable

Night Report: (1) FiO2 weaned overnight to 21%, RR ↓ 13 bpm due to ↓ CO2. Will alter changes in ventilation.
(2) HR 70 bpm, normotensive, Temp 35.5 – 35.7. [illegible] allergic ... in situ.
(3) Propofol ↑ 10 ml/hr => waking up – uncooperative, at risk of self-extubation.
(4) Waking up, MAE (moves all limbs), unaware of surroundings.
(5) NGT on free drainage overnight – 200 mls out. Bowels [illegible], IV fluids + Tazocin overnight.
(6) Allergic [illegible] h/o.
(7) Regular oral care [illegible] – mouth dry. Both lungs [illegible] in situ (not [illegible]).
Mg SO4 replacement 20mmols, KCl replacement 80 mmols in total overnight.
Wife visited @ 20:00 – upset [illegible], informed she wishes to be the only point of contact. Expressed worries regarding [illegible] mental health prior to OD – feels it will need addressed. All care given.

Day Report:
Condition improved over morning.
Extubated and now S/V on R.A. RR 14-20 SaO2 > 95%.
C.V.S stable. Apyrexial. Central line & A-line can be removed when venflon inserted.
No c/o pain.
Remains drowsy and "weepy" at times
Oral fluids and diet as desired
H.N.P.U. since catheter removed
Wife has visited
For transfer to Ward when bed available
To have ~~[illegible]~~ Psych review before discharge
M C Thomson S/N
(THOMSON)

3.45 pm. Central line removed, tip sent for C&S
Pink venflon inserted
Tried to get out of bed & stumbled but caught by wife before he hurt himself.
Becoming more tearful and wanting to go home

Critical Care Unit

NHS Forth Valley

Date: 21/8/10	Day No: 2	D.O.B.	Surname:	C.H.I. No.
Date of Admission: 20/8/10			CHI:3011795258 CRN:S237397 30/11/1979 SCRIMSHAW GARRY M 7 Moss Road TILLICOULTRY, Clackmannanshire FK13 6NS	COPY
Diagnosis: mixed overdose				Age: 30
Critical Care Consultant: Dr. Nair V			Referring Consultant:	

Ventilator: NEO				
Date Ventilation started: 20/8/10				
Date Ventilation finished:				
E/T Tube Length at Lips: 22cm	subgloltic drain / (non-subgloltic drain)			
Trachy - Inner tube change				
Cuff Pressure:	8am	2pm	8pm	2am
NG Tube Length at Nose:				
CVVH Commenced				
CVVH Discontinued				
MRSA status screened 0/7	Site:			
Day Nurse	Night Nurses:			
Urinalysis	00.00 - 08.00 green 20.00 - 08.00			

Fluid Balance

Intake	Output
Oral	Urine
	Gastric
	Bowel/Stoma
	Drain 1
	Drain 2
	Drain 3
Total in 2629 (1mL)	Total out 1760
Previous 24 Hour Balance: +869	Cummulative Balance: +869

Daily Plan:-

CVC Maintenance Bundle - INSERTED 20/8/10

		D	N
Is CVC still required?	Y / N		
If NO then remove & send tip for C&S. Aseptic technique for procedure.			
Is CVC dressing intact?	Y / N		
If NO or older than 7 days re-dress. Aseptic technique for procedure.			
Insertion site very inflammed or pus present?	Y / N		
If YES seek advice, remove line, send tip for C&S. Aseptic technique for procedure.			
CVC Bungs insitu>3 days? (NEW 20/8/10)	Y / N		
If YES change bungs & 3-way taps. Aseptic technique for procedure.			

Aseptic Technique = 1. Level 2 hand wash
2. Dressing pack & sterile gloves
3. Chlorhexidine 2%

Reduce support using ventilation management Flow Chart

Yes / No (see exclusions below)

*Cooling
*Head injury
*Airway issue

12hrly Ventilation Screen

Appropriate to switch off / reduce sedation? (see exclusions)	D	N
SaO_2 (Target 94%)		
$FiO_2 \leq 0.35$?		
Secretions manageable?		
Adequate cough?		
RSB Index < 100? ($F+V_T$)		
PEEP ≤ 5?		
Tube comp on?		
Haemoglobin > 70?		

Sepsis Screen if temp >38° (unless screened in last 48hrs)	Microbiology Results
Peripheral Blood Cultures:	
C.S.U.: ✓ 20/8	
E.T. Aspirate: ✓ 20/8	
Other Sites: nasal screen 20/8	

8. Mobility	Aim
Pressure areas: upper back	Reassess all pressure areas 4 hourly.
	Turning / repositioning required 4 hourly.
Sunderland Score / Waterlow / Braden	Therapeutic Mattress: Yes / No Type:
Mobility: Bed Rest / Up to sit	Manual handling technique:
Teds in situ: Yes Size: Length:	Mobility Chart Falls Risk Assessment
LMWH: Yes / No Prescribed:	Reduce Risk Factors of DVT

9. Infection	
WCC elevated: Yes / No	Damp dust bedspace each shift.
	Inform relatives about hand washing
MRSA + ve: Yes / No screened Site/s:	
Microbiology Sites:	
Patient isolation: yes / no	
10. Psychological / Cultural	**Aim**
Patient's psychological condition: Sedated + ventilated	Communication tools: lip reading / alphabet / speaking tube
	Orientate patient to time, place and person.
Family: aware + visited + updated.	Explain all plans procedures to patients and family.
	Give reassurance / support to patient.
Sleep/rest: day / might unable	Encourage involvement in decision making.
	Maintain the environment conducive to sleep / rest periods.
Spirituality: Not discussed	Reduce unnecessary noise / alarms.
	Accommodate religious / cultural / spiritual needs.
	Maximise stimulation when appropriate - visitors
	TV / radio / newspapers / photographs

Day shift assessed by: M Cobb (Signature) M CORKISH (PRINT NAME) SCN (Job title) 17:30 (Time)

Night shift assessed by: J. Warner (Signature) C. DANNER (PRINT NAME) NOV (Job title) 6:30 (Time)

COPY

COPY

PHYSICAL ASSESSMENT OF CONDITION/NEEDS	AIMS AND PLANNED CARE
6. Elimination	
Renal function: Urinary catheter (Size 16 / 10 cm in balloon) inserted using aseptic technique	Care of urinary catheter Hourly Volumes / Free Drainage
	Daily urea and electrolytes Daily Urinalysis
Good urine output	
	Aim for a +ve / -ve balance of:
	Maintain an accurate fluid balance
Renal replacement therapy: Yes / (No)	
IV Anticoagulant	Maintain safe / effective renal replacement therapy.
Vascath site:	Care of renal replacement lines / maintain patient safety.
	Maintain APPT ratio of:
Drains / Output	
Abdomen Distended / (Soft) Bowels last open:	Prevent Constipation
Colostomy / Ileostomy / Mucoid Fistula	
Stoma Condition: Appliance Type:	? Refer to Stoma Care Team.

7. Personal	
General body condition: Satisfactory	Maintain appropriate hygiene standards and dignity.
Mouth condition: Dry	Bed bath / shave / hair wash / finger nails / toe nails / catheter care
Eye condition: OK	
Arterial Line site: OK	Ensure occlusive dressing is intact to all line sites.
Central Line: OK	
Venflon site/s: Satisfactory => removed	
Wound (s): N/A.	Redress:
Drains:	Aim for healthy granulation of wounds
	Reduce Infection

Critical Care Department Care Plan

2. Cardiovascular Care	Aims Maintain Cardiac Stability
Cardiac Rhythm: ST / AF Tachy Rate: 100 - 110	Monitor vital signs and pressure traces frequency ✓
Blood Pressure: NIBP / (APB) MAP:	Change electrodes daily
1 episode of hypotension ? cause	12 lead E.C.G. (Yes) / No done in A+E
Inotropes Yes / No: Type: Art line position: CVP	Aim for MAP: > 40 Aim for CVP: N/A
	Titrate Inotropes to ensure set parameters
CVP: for CL insertion. +8 - +14	Care of invasive monitoring lines : Flush Lumens x 1 per shift ✓
Temperature: 35.5 - 35.7 °C	: Flush Prescribed: Yes / (No)
	: Record CSM to digits per shift

PHYSICAL ASSESSMENT OF CONDITION/NEEDS	AIMS AND PLANNED CARE
3. Pain/Sedation	
Sedation: RASS = -5	Aim for sedation score: RASS = 0
Sedation Holiday ~~Yes / No~~ N/A	
Propofol / Alfentanil infusion in progress	
Pain: No obvious signs of pain / discomfort	Observe for non-verbal signs of pain frequency
	Assess effectiveness of analgesia and characteristics of pain. ✓
	Aim for pain score
4. Neurological Care	
Neurological State: PERL 4+/4+	Observe for neurological deterioration and report any changes.
Pupils	Record GCS AVPU Score x 1 per shift (4)
5. Nutrition/Hydration	
NBM/Feeding / Oral Fluids / Diet Type	Liase with the dietician and the anaesthetist re feeding regime
Feed Enteral / Parenteral | Tube type: Ryles / Fine Bore	Encourage / Provide adequate nutrition
Feed Type Position:	Change NG fixing tape daily.
? for N/G tube On face	
Gastric Aspirates: PH: PLAIN TUBE	Record blood glucose 2-3 hourly.
	Aim for Blood Glucose: 3.8 - 8.5
	Encourage oral fluids / diet supplements: Yes / (No)
Blood Sugar: on chart	Maintain an accurate fluid balance. ✓
Sliding scale insulin regime prescribed: (Yes) / No NOT USED	Weekly weight complete nutritional risk screening tool.

Critical Care Department Care Plan

NAME: CHI:3011795258
CRN:S237397 30/11/1979
PREFERRI SCRIMSHAW GARRY M
7 Moss Road
TILLICOULTRY,
Clackmannanshire
CHI NO: FK13 6NS OF BIRTH: AGE:

DAY NO: (1)
CRITICAL CARE CONSULTANT(S): Dr Mair
REFERRING CONSULTANT:

PREVIOUS 24 HOUR SUMMARY (NIGHT SHIFT TO COMPLETE):

Admitted from A+E following an overdose of tricyclic antidepressants & paracetamol & GCS - requiring intubation & ventilation.

DATE: 20/8/10

All nursing care documented in this care plan, is in accordance with Stirling Royal Infirmary NHS Trust procedures and guidelines and is used in conjunction with the Critical Care patient observation chart. Please delete as appropriate. Document care using a black pen (day duty). Use a green pen (night duty) when changes to patient assessment are found.

PHYSICAL ASSESSMENT OF CONDITION/NEEDS		AIMS AND PLANNED CARE
1. Respiratory Care		
Ventilation: on P-SIMV FiO2 @ 50% ; PC/PS = 15 ; PEEP 5.		Maintain patent airway. Auscultate regularly. Pre-oxygenate: Yes / No
SaO_2 > 94%. ; FiO_2 to 21%.		Ensure optimum respiratory function / ventilation.
		Sit Up 45° ✓
Chest Secretions: Nil		Aim for SpO_2 > 94%
Regular Physio Yes / No	Suctioning Required Yes / No	Monitor ABG's and act accordingly. ✓
ABG's: on demand.		
		Weaning: (Yes) / No Aim to reduce FiO_2 / PC/PS
Tracheostomy: Yes / (No)		Weaning plan: on able
Oxygen Therapy Yes / No	Prescribed Yes / No	
Oxygen Percentage:	Delivery System:	Reduce risk of lung infection VAP protocol

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NHS Forth Valley Acute Services Mobility Chart

Has the patient fallen in the past year:	Yes / No
Is the patient over 65 years of age	Yes / No
If yes to any of the above:	
• complete the falls risk assessment chart	Yes
• refer to physiotherapist as soon as possible	Yes
• supervise patients mobility	Yes
• provide a wheeled zimmer for patients use (refer to checklist on action plan)	Yes / No

Patient Nai CHI:3011795258
CRN:S237397 30/11/1979
SCRIMSHAW GARRY M
7 Moss Road
TILLICOULTRY,
Unit Numb Clackmannanshire
FK13 6NS

NI Forth

Ward/Dept..... Weight.....

Date / Transfer	01/ 2018	No of staff		No of Staff		No of staff		No of staff		No of staff		No of staff	Comments
Move up bed	R4O	2/3											
Turning in bed	R+W	2/3											
Lying ->Sitting over edge of bed	BR	—											
Sit to Stand	BR	—											
Trolley <-> bed	PS	4											
Toiletting	CATHETER	NIL											
Bathing	BB	2											
Walking	BR	—											
Signature/Initial	[signature]												

Codes

Assistance Required

- Independent Ind
- Supervised Sup
- Requires Help of 1/2/3/4...
- Hoist (specify) H
- Standaid S
- Bedrest BR
- Other - Specify

Method of Assistance

- Glide Sheet GS
- Multimover MM
- Folding Back Rest FBR
- Posterior Hold PH
- Combination Hold CH
- Patslide/Rollerboard PS/RB
- Other - Specify

Mobility and mobility aids

- NM not to be mobilised
- NWB Non weight bearing
- PWB Partial Weight bearing
- FWB Full Weight bearing
- Walking Sticks WS
- Mobilator M
- Gutter Rollator GR
- Wheelchair W
- Zimmer Z
- Delta Rollator DR
- Crutches C

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Date	Time	Score	Signature

NHS
Forth Valley

COPY

CHI:3011795258
CRN:S237397 30/11/1979
SCRIMSHAW GARRY M
7 Moss Road
TILLICOULTRY,
Clackmannanshire
FK13 6NS

Braden Risk Assessment Chart

Individuals with a total score of 16 or less are considered at risk:
15 - 16 = low risk, 13 - 14 = moderate risk, 12 or less = high risk.

Undertake and document risk assessment within 6 hours of admission or on first home visit.
Reassess if there is a change in individual's condition and repeat regularly according to local protocol

Date:

Sensory Perception - Ability to respond meaningfully to pressure related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body surface.	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment that limits the ability to feel pain or discomfort over 1/2 of body.	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or need to be turned. OR has some sensory impairment that limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or voice pain or discomfort.	1
Moisture - Degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient/client is moved or turned.	**2. Very Moist** Skin is often, but not always, moist. Linen must be changed at least once a shift.	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist.** Skin is usually dry. Linen only requires changing at routine intervals.	3
Activity - Degree of physical activity	**1. Bedfast** Confined to bed.	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance.. Spends majority of each shift in bed or chair.	**4. Walks Frequently** Walks outside the room at least twice a day and inside the room every 2 hours during waking hours.	1
Mobility - Ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance.	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No limitations** Makes major and frequent changes in position without assistance.	1

Infection Surveillance Documentation.

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Routine sampling on days documented, samples should be taken out with these days as clinical condition requires.

- Please document date and time of sample collection for routine samples.
- Samples taken at other times require date, time and site of sampling recorded.

Sunday .....(date)	Inse CHI:3011795258 CRN:S237397 30/11/1979 SCRIMSHAW GARRY M 7 Moss Road TILLICOULTRY, Clackmannanshire FK13 6NS
Monday .....(date) Routine MRSA screen (complete separate form with all sample sites) Tracheal Aspirate / Sputum. CSU	Tuesday .....(date)
Wednesday .....(date) Tracheal Aspirate / Sputum. CSU	Thursday .....(date)
Friday 20/8/10 .....(date) Tracheal Aspirate / Sputum. CSU MRSA screen	Saturday 21/8/10 .....(date) A line tip ✓ CVP line tip ✓

Routine admission sampling:

- CSU / Tracheal Asp or sputum /
- Wound / open skin sites for C & S.
- MRSA screen nose / throat / axila / groin plus all open skin sites.

The MRSA screen must be completed within 48 hours of admission as any positive results after this time are considered Hospital Acquired Infections and therefore ICU acquired.

STIRLING ROYAL INFIRMARY NHS TRUST
INTENSIVE THERAPY UNIT

COPY

CHI:3011795258
CRN:S237397 30/11/1979 M
SCRIMSHAW GARRY
7 Moss Road
TILLICOULTRY,
Clackmannanshire
FK13 6NS

MRSA SCREENING RECORD

All ITU patients will be screened on admission and thereafter on a weekly basis. Additional screening should only be taken at a minimum interval of 48 hours after treatment has been discontinued. A further 2 full screens should be taken at intervals of no less than 48 hours between each screen. 3 full consecutive sets of screening swabs are required before the patient is considered free of MRSA carriage. [Infection Control Manual, SRI NHS Trust, September 2000]. Specimens are sent to microbiology accompanied by "white" form.

PLEASE TICK THE APPROPRIATE SPECIMEN BOX BELOW

SPECIMEN	20/3/15 Date	Result	Action	Date	Result	Action	Date	Result	Action
Nose - both nostrils	✓								
Throat	✓								
Axilla - 1 swab for both	✓								
Groins - 1 swab for both	✓								
CSU	C+S								
Tracheal secretions	C+S								
Invasive sites:									
1) Arterial Line	.....	.....	.....	.....	.....	.....	.....	.....	.....
2) Central line	.....	.....	.....	.....	.....	.....	.....	.....	.....
3) CVVH Line	.....	.....	.....	.....	.....	.....	.....	.....	.....
4) PA Catheter	.....	.....	.....	.....	.....	.....	.....	.....	.....
5) Venflon 1	.....	.....	.....	.....	.....	.....	.....	.....	.....
6) Venflon 2	.....	.....	.....	.....	.....	.....	.....	.....	.....
7) Venflon 3	.....	.....	.....	.....	.....	.....	.....	.....	.....
8).....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Wound/Skin Lesions:									
1) Abdo wound	.....	.....	.....	.....	.....	.....	.....	.....	.....
2) Trache site	.....	.....	.....	.....	.....	.....	.....	.....	.....
3) Stoma	.....	.....	.....	.....	.....	.....	.....	.....	.....
4) Drain 1	.....	.....	.....	.....	.....	.....	.....	.....	.....
5) Drain 2	.....	.....	.....	.....	.....	.....	.....	.....	.....
6).....	.....	.....	.....	.....	.....	.....	.....	.....	.....
7).....	.....	.....	.....	.....	.....	.....	.....	.....	.....
8).....	.....	.....	.....	.....	.....	.....	.....	.....	.....

RE-SCREEN DATES IF MRSA POSITIVE

Date 1: **Date 2:** **Date 3:**

FORTH VALLEY ACUTE HOSPITALS
Infusion Fluids / Blood Products Page

NHS Forth Valley

WARD	CONSULTANT	PATIENT DETA

CHI: 3011795258 30/11/1979 M
SCRIMSHAW
GARY
7 MOSS ROAD
TILLICOULTRY
HOSPITAL No: FK13 6NS

COPY

ALLERGIES - Please use RED INK

HEIGHT (m)	WEIGHT (kg)	DATE	SURFACE AREA (m^2)

DATE OF BIRTH: AGE:

- enter dosage times as 24hour clock
- please write in block capitals in black pen
- IV site MUST be checked prior to and after IV administration

	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
A					
INFUSION FLUID		TOTAL VOLUME	TIME STARTED	
N. Saline 0.9%.		1000	1335	L Whyte.
DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.
	20/8/10.	STAT		10D1HTIN1 03/13
B	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
INFUSION FLUID		TOTAL VOLUME	TIME STARTED	
N. Saline 0.9%.		500	1405	L Whyte.
DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.
	20/8/10			10E2JJ5M 04/13
C	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
INFUSION FLUID		TOTAL VOLUME	TIME STARTED	
DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.
D	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
INFUSION FLUID		TOTAL VOLUME	TIME STARTED	
DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.
E	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
INFUSION FLUID		TOTAL VOLUME	TIME STARTED	
DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.
F	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
INFUSION FLUID		TOTAL VOLUME	TIME STARTED	
DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.
G	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
INFUSION FLUID		TOTAL VOLUME	TIME STARTED	
DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.
H	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
INFUSION FLUID		TOTAL VOLUME	TIME STARTED	
DOCTORS SIGNATURE	DATE	RATE	PUMP NO.	BATCH NO.

Wound / Stoma / Drains: N/A

COPY

General Body Condition: No problems.

Mobility: no Problems

Infection Status: Awaiting MRSA screen results. WCC normal

Today's Blood Results:

Na	138	Urea	3.0	HB	120	PT/Control	11/11.5
K+	3.7	Creatinine	89	WCC	8.2	APTT/Control	27/31
Chloride	111			Platelets	182	Fibrinogen	1.8

Patient and relatives understanding of health and ongoing care: Fully updated

Any Other Relevant Details: Awaiting psychiatric review.

Discharge Checklist:

Case notes:	
Date of blood transfusion added to case notes:	
Leaflet re blood transfusion given to patient:	
Nursing notes:	
X-Rays:	
Patient's own medication:	
Patient's belongings / clothing list completed:	
Check ward safe:	
Next of kin informed:	
Computer data completed:	

Patient ready for HDU / Ward transfer

Transferring Nurse: Margaret Thomson

Date: 21/8/10

Date: «EPISODE_DISCHARGE_DATE»

Name: Mr Garry Scrimshaw Date of Birth: 30/11/1979 CHI No: 3011795258

NHS Forth Valley

Patient Nursing Transfer from Critical Care

Nursing Summary

Patient Details		GP Details	
Patient CHI No:	3011795258	**Practice Code:**	25031
Patient Name:	Mr Garry Scrimshaw	**GP Name:**	Dr David S Borland
Date of Birth:	30/11/1979	**GP Address:**	Health Centre Practice 3, Hallpark Road, Sauchie, FK10 3JQ
Address:	7 Moss Road,, Tillicoultry,, Clackmannanshire, FK13 6NS		

Consultant: Paterson, Dr Stuart
Date admitted to ICU / HDU:20/08/2010
Date discharged from ICU / HDU: 21/08/2010

Details of Stay in ICU / HDU: Intubated for airway management. Ventilated overnight. Given IV Parvolex as per regime.

Patient Details at Time of Discharge:

Respiratory: Extubated at 09:30.Now self ventilating on room air.

Cardiovascular: Sinus rhythm. Normotensive.

Pain sedation: No sedation. Takes diclofenac and paracetamol for back pain

Neurological: GCS 15

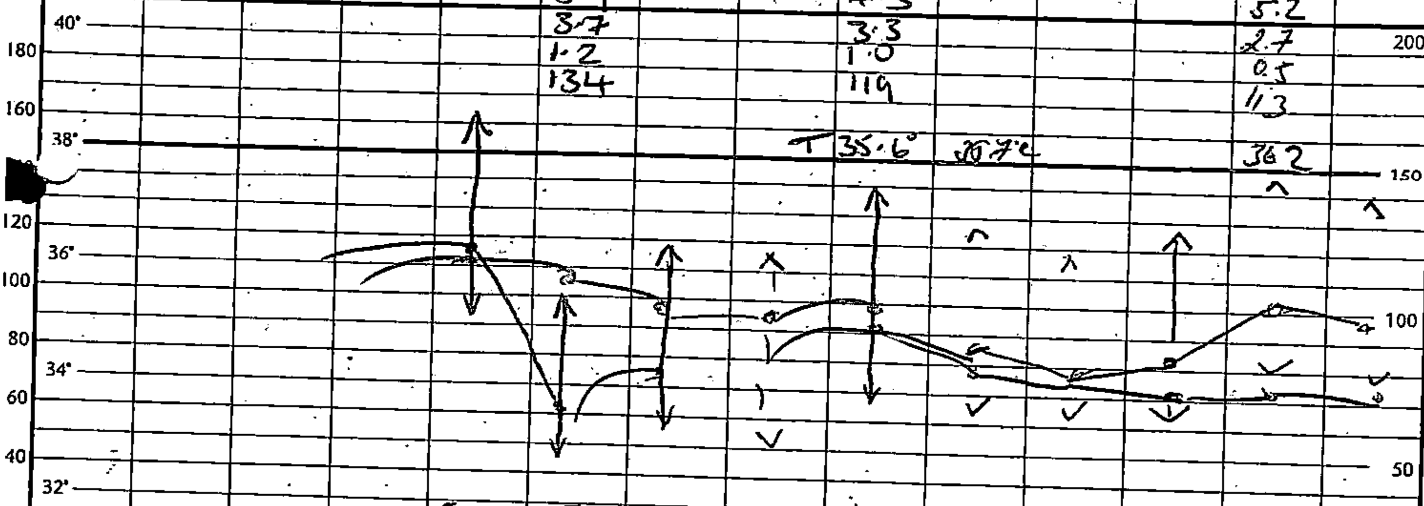
Nutrition / Hydration: Free fluids and diet.

Elimination: Urinary catheter removed this a.m. still to pass urine.

		01.00	02.00	03.00	04.00	05.00	06.00	07.00	08.00	09.00	10.00
RESPIRATION	Vent.Mode										
	FIO_2										
	Rate/Set/Spont.										
	Press.Support/Cont										
	Peep/CPAP										
	T.Vol.Exp./I.PAP										
	M.Vol Exp./E.PAP										
	Peak Airway PR.										
	I:E / Humid Temp.										
	Air Entry L R / L R										
	Hrly E.T./O.Ph/S.G. Aspirate										
	O_2 Sats										
	End Tidal CO_2										
ABGS	H+ IONS										
	PCO_2										
	PO_2										
	HCO_3S										
	BE										
	Glucose/BM										
Sepsis screen	K^+										
Pupil Scale 1 2 4 5 6 7 8	Lactate										
	NIBP										
	ABP										
	HR Red										
	Temp Green										
	M.A.P. Black										
	Pupils: +/- Rhythm										
40° 39° 38° 37° 36° 35° 34° 33° 32°	180 160 140 120 100 80 60 40										
	CVP										
	Rass/Pain										
	2 hrly Oral Hygiene										
INFUSIONS	Drug PROPOFOL										
	Concentration/Pump No.										
	ALFENTANIL /										
	PIPACLEX /										
	$Na\ HCO_3$ /										
	/										
	/										
	/										
	/										
	/										
	/										
	Position R/L/B head of bed >30°										
	Initials										
IN	Colloid										
	Drugs										
	Ng / Oral										
	Hourly Total										
	Running Total										
OUT	Urine										
	Gastric										
	Bowels / Stoma										
	Drain										
	CVVH										
	Hourly Total										
	Running Total										
	Balance										

COPY

	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	00.00
					P-SIMV	P-SIMV	P-SIMV	PSIMV	PSIMV	PRVC? [illegible]	[illegible]	[illegible]	[illegible]	[illegible]
					50%	50%	50%	50%	50%	40%	35%	35%	30%	25%
					15 / 0	15 / 0	15 / 0	15 / 0	15 / 0	15 / 0	15 / 0	15 / 0	15 / 0	[illegible]
					15/15	15/15	15/15	→	15/15	15/15	15/15	15/15	15/15	15/15
					+5	+5	+5	→	+5	5	5	5	6	[illegible]
					675	660	644	644	608	592	561	[illegible]	[illegible]	[illegible]
					10.1	9.9	9.6	9.6	9.0	8.8	8.4	[illegible]	[illegible]	6.7
					19	19	19	19	20	20	20	20	20	20
					HMEF	→	→	HMEF	HMEF	→	→	HMEF	→	→
									✓	✓	✓		✓	✓
									IMP					
					99%	99%	99%	99	99%	98%	99%	99%	99%	97%
					3.7	3.7	3.6	3.5	4.0	3.6	3.7	3.7	3.9	4.4
						36.9			36.6				36.1	
						4.04			3.94				3.48	
						25.1			35.0				24.2	
						20.5			19.6				18.3	
						-2.1			-3.2				-4.3	
						5.9			7.3				5.2	
						3.7			3.3				2.7	
						1.2			1.0				0.5	
						134			119				113	
									T 35.6°	35.7°C			36.2	



	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	00.00
					ST	ST	SR	SR	SR	VR	VT	SR	VR	VR
					—	—	—	+4	+4	+6	+5	5	9	+10
					-5	-5	-5	-3	-3	-4	-4	-4	-4	-4
					10 45 OFF			8 18	8 6	8 6	8 14	8 21	8 29	8 38
					5			27	12	6	8	7	8	9
					2 48 OFF			2 43	2 40	2 37	2 35	2 33	2 31	2 30
					0			5	3	3	2	2	2	1
							125 0	125 175	125 272	125 413	32 505	32 29	32 62	32 95
							29	175	97	141	92	29	33	33
									100 0	100 112	100 205	100 297	100 383	100 473
									40	112	93	92	86	90
												MgSO4	16 2	16 17
													2	15
												KCl	50	50
													50	50
					B ✓	B ✓		B ✓	B ✓	B ✓	B ✓	B ✓	B ✓	L ✓
					M	M		M	M	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
					500	500								
							250							
					505	500	279	207	152	262	195	130	201	198
					505	1005	1284	1491	1643	1905	2100	2230	2431	2629
						550	460	180	80	65	65	50	50	60
												200		
						550	460	180	80	65	65	250	50	60
						550	1010	1190	1270	1335	1400	1650	1700	1760
											1750			

Enteral Nutrition: Route: + T.P.N. Prescription

Feed No.	Feed / T.P.N. Additive	Volume	Rate	Signature	Suggested Start Time	Begun at	Given By

COPY

	Date	Fluid (Use Block Letters) Additive Medicine	Vol. (ml) Dose (mg)	Route of Admin.	Dur. of Admin.	Signature	Serial No. Batch No.	Time Begun	Given By Added By
A		Gelofusin	250ml	IV	5mins				
		as per protocol							
B		Gelofusin	250ml	IV	5mins				
		as per protocol							
C		Gelofusin	250ml	IV	5mins				
		as per protocol							
D		Gelofusin	250ml	IV	5mins				
		as per protocol							
E	20/8/10	Na_2CO_3	1·26g / 50ml	IV	100ml/h			17^{30}	M
F									
G									
H									
I									
J									
K									
L									
M									
N									
O									
P									
Q									

Events

		COPY Initials
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	Transferred to [illegible] – Urinary catheter inserted	
16.00	↓BP 50/30, HR ↓70; 6mg ephedrine + 1mg Metaraminol given	[initials]
17.00	C/L insertion ✓	[initials]
18.00		
19.00	Pt's care taken over.	
20.00	Safety checks ✓ Alarms ✓	[initials]
21.00		[initials]
22.00	7AC → (C), FiO_2 ✗ [illegible], Present 22 ↓ 13	[initials]
23.00	KCl 20mmols + $MgSO_4$ 20 mmols	[initials]
00.00		[initials]

	AM	PM		AM	PM
Admitting team aware Y / N			Does patient have a PVC Y / N (if N go to AB's)		
APACHE II score complete Y / N	NA	NA	New PVC today		
Wardwatcher up to date Y / N			Documentation/sticker completed Y / N		
Is patient ventilated Y / N (if N go to blood sugars)			Is PVC still required Y / N (If N then remove=R)		
HOB > 30° Y / N			Evidence of inflammation / erythema Y / N		
Sedation Holiday appropriate Y / N / L.Ex / NA			Dressing intact Y / N		
Ventilatory Weaning considered Y / N / L.Ex			Has PVC been in situ >72 hours Y / N		
Weaning plan considered Y / N / NA			Is pt on AB's Y / N (if N go to other activities)		
Chlorhexidine prescribed Y / N			Are antimicrobials still required Y / N		
Subglottic aspiration tube Y / N / Lx			Antimicrobials prescribed as per guidelines Y / N		
HMEF appropriate Y / N			Do antimicrobials require de-escalation Y / N		
Is wet circuit required?			Other activities		
Blood sugar - Is insulin required Y / N /L.Ex			DVT prophylaxis prescribed Y / N		
Is Insulin prescribed Y / N			Peptic ulcer prophylaxis prescribed Y / N / L.Ex		
Does patient have a central line Y / N (if N go to sepsis)			Patient up to sit Y / N / /Lx		
New CVC line today Y / N			Daily goals / Plan written in medical notes		
Documentation completed Y / N			Kardex reviewed and re written as required Y / N		
Is CVC still required Y / N-If N remove (R) & send Tip for C&S			Blood results reviewed and actioned Y / N		
Is dressing intact Y / N			Assessed as per mobility chart Y / N		
Sepsis Screen - Is patient pyrexia Y / N			Is patient ready for discharge Y / N		
Has sepsis screen been completed Y / N			Receiving informed of discharge Y / N / NA		
Are there outstanding microbiology results Y / N			Discharge planning complete Y / N		
MRSA eradication therapy required Y / N			Discharge documentation completed Y / N		

Y = Yes N = No Lex = Local Exclusion NA = Not Applicable

Night Report:

COPY

Day Report:

1/ Ventilation – Continues on P-SIMV, FiO_2 ↓ 35%, otherwise settings unchanged SaO_2 > 97%
A/E audible throughout all lung fields – minimal yield of mucopurulent secretions on suctioning
ABG's as charted
2/ Cardiovascularly labile at times, x1 episode of hypotension, has had slow bolus of calcium gluconate, no inotropic support required at present
HR 80 – 120 bpm, monitoring in sinus rhythm (12 lead ECG completed)
3/ & 4/ RASS –4/–5, on Propofol / Alfentanil infusions in progress.
5/ N/G tube in situ – ? for enteral feed – BM's stable
Fenoldex infusion in progress, Na HCO_3 infusion in progress
6/ Good diuresis
7/ & 8/ Passive aeros intact.
9/ Nil new MRSA screen obtained
10/ Family into visit this evening

SCN M Caird
M CORKISY

Critical Care Unit

NHS Forth Valley

COPY

Date: 20/8/10	Day No: 1	D.O.B.	Surnam	I. No.
Date of Admission: 20/8/10			First Na	CHI:3011795258 CRN:S237397 30/11/1979
Diagnosis: OVERDOSE OF TRICYCLIC ANTIDEPRESSANTS + GCS.			Address:	SCRIMSHAW GARRY M 7 Moss Road, TILLICOULTRY, Clackmannanshire FK13 6NS
Critical Care Consultant: Dr MAIR.			Referring Consultant:	30 yrs

Ventilator: GALILEO	
Date Ventilation started: O/A.	
Date Ventilation finished:	
E/T Tube Length at Lips: 22cm.	subgloltic drain / non-subgloltic drain
Trachy - Inner tube change	
Cuff Pressure: 8am / 2pm / 8pm: 60cm H2O / 2am	
NG Tube Length at Nose:	
CVVH Commenced	
CVVH Discontinued	
MRSA status pending	Site:
Day Nurse	Night Nurses: 00.00 - 08.00
Urinalysis	20.00 - 08.00

Fluid Balance	
Intake	Output
Oral	Urine
	Gastric
	Bowel/Stoma
	Drain 1
	Drain 2
	Drain 3
Total in	Total out
Previous 24 Hour Balance:	Cummulative Balance:
Daily Plan:-	

CVC Maintenance Bundle NEW INSERTED TODAY

		D	N
Is CVC still required?	Y / N		Y
If NO then remove & send tip for C&S. Aseptic technique for procedure.			
Is CVC dressing intact?	Y / N		Y
If NO or older than 7 days re-dress. Aseptic technique for procedure.			
Insertion site very inflammed or pus present?	Y / N		N
If YES seek advice, remove line, send tip for C&S. Aseptic technique for procedure.			
CVC Bungs insitu>3 days?	Y / N		NEW
If YES change bungs & 3-way taps. Aseptic technique for procedure.			

Aseptic Technique = 1. Level 2 hand wash
2. Dressing pack & sterile gloves
3. Chlorhexidine 2%

Reduce support using ventilation management Flow Chart

Yes / No (see exclusions below)

*Cooling
*Head injury
*Airway issue

12hrly Ventilation Screen

Appropriate to switch off / reduce sedation? (see exclusions)	D	N
SaO_2 (Target 94%)		Y
FiO_2 ≤ 0.35?		Y
Secretions manageable?		X
Adequate cough?		NO
RSB Index < 100? ($F_f + V_T$)		Y
PEEP ≤ 5?		X
Tube comp on?		Y
Haemoglobin > 70?		Y

Sepsis Screen if temp >38° (unless screened in last 48hrs)	Microbiology Results
Peripheral Blood Cultures:	
C.S.U.:	
E.T. Aspirate:	
Other Sites:	

Conscious Level Chart (only as required for head injury observation)

			DATE: 20/8/10	DATE:
			TIME: 1313 1350	TIME:

COPY

COMA SCALE			
Eyes Open	Spontaneously	4	Eyes closed by swelling = C.
	To speech	3	
	To pain	2	
	None	1	
Best verbal response	Orientated	5	Endotracheal tube or tracheostomy = T
	Confused	4	
	Inappropriate words	3	
	Incomprehensible sounds	2	
	None	1	
Best motor response	Obey commands	6	Usually record the best arm response
	Localise pain	5	
	Withdraws to pain	4	
	Flexion to pain	3	
	Extension to pain	2	
	None	1	

Pupil Scale (mm)

PUPILS				
	right	Size	5	+ reacts - no reaction c. eye closed
		Reaction	+	
	left	Size	5	
		Reaction	+	

LIMB MOVEMENT			
ARMS	Normal power		Record right (R) and left (L) separately if there is a difference between the two sides
	Mild weakness		
	Severe weakness		
	Spastic flexion		
	Extension		
	No response		
LEGS	Normal power		
	Mild weakness		
	Severe weakness		
	Extension		
	No response		

Pain Assessment and Management Guidelines

Pain Score:
No pain
Mild = No Pain at Rest
Slight Pain on Movement
Moderate = Intermittent Pain at Rest
Moderate Pain on Mover
Severe = Continuous Pain at Rest

Nausea Score (0-3):
0 = No nausea or vomiting
1 = Nausea only
2 = Vomiting once
3 = Vomiting more than once

For Acute and Chronic Pain:
For mild, moderate or severe pain refer to Pain Management Guidelines *Forth Valley Formulary Appendix 27 & 28*
Implement Pain Assessment Chart

For Cancer Related Pain:
For a mild, moderate or severe pain score, refer to Palliative Guidelines.

CHI: 3011795258 30/11/1979 M
SCRIMSHAW
GARY
7 MOSS ROAD
TILLICOULTRY

Re-order Ref: TF/1013/SS

Review Date: 2012

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ly observations — See flow chart overleaf and monitor patient

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	≥30
	26-29
	21-25
	9-20
	≤8
	≥94
	92-93
	86-91
	<86
	refer to key
	<95
	39°
	38°
	37°
	36°
	35°
	34°
	210
	≥200
	190
	180
	170
	160
	150
	140
	130
	120
	110
	100
	90
	80
	70
	60
	50
	>170
	160
	150
	140
	130
	120
	110
	100
	90
	80
	70
	60
	50
	40
	30
	Alert
	Verbal
	Pain
	Unresponsive
	EWS
	Blood Glucose
	No pain
	Mild
	Moderate
	Severe
	Nausea Score 0-3
	Initial

60%)

NIV Patient on NIV system
OTH Other device:_____
(specify which)

Name:
DOB:
Chi No:
Address:

CHI: 3011795258 30/11/1979 M
SCRIMSHAW
GARY
7 MOSS ROAD
TILLICOULTRY
FK13 6NS

Early Warning Score (EWS) Trigger Protocol

NHS
Forth Valley

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SCRIMSHAW
GARY
7 MOSS ROAD
TILLICOULTRY
FK13 6NS

ESCALATION POLICY
NOT FOR USE WITHIN
THE EMERGENCY DEPT

Consultant:_____ Ward:_____ Admission Date:_____

Staff should use SBAR in all communications

Score 0-1 Routine observation - state frequency
2-3 Inform nurse in charge and initiate appropriate treatment

Definition
- S ituation
- B ackground
- A ssessment
- R ecommendations

Clock Starts
00 Mins

Early Warning Score 4 or 5 or concern with a patients condition

Early Warning Score 6 or more or rapidly deteriorating patient

Inform Nurse in Charge Immediately
Contact FYI / ANP for review within 20 minutes
Initiate Treatment / Intervention

FYI / ANP unable to provide review / treatment within 20 minutes

No improvement despite 20 minutes of treatment

1 Hour

Call appropriate Middle Grade for immediate review

Patient re-assessed and treatment initiated — NO → MG unable to attend within 20 minutes or EWS increases

Patients clinical condition / score improves within 60 minutes — NO → Call appropriate Consultant

Continue treatment and EWS scoring as required

Consider Critical Care referral if score increasing despite Consultant treatment plan

2 Hours Max

Management Plan / Patient Exclusions

Date	Management of EWS Observations	Signed

Family Dialogue

Consultant: Dr. Muir
Named Nurse:

Surname:
Forename: MR GARRY SCRIMSHAW
Preferred:
Address: 7 MOSS ROAD, TILLICOULTRY, CLACKMANNANSHIRE FK13 6NS
Unit No:
DOB:

COPY

Date	
20/1/10	20:00 => EX-WIFE TRACEY, NOK OF GARRY - WHO EXPRESSED HER WISHES TO BE THE ONLY ONE TO BE UPDATED OVER THE PHONE RE. GARRY'S CONDITION. ALL INQUIRIES TO BE ADVICED TO CONTACT HER FOR AN UPDATE.
	[signature] Sox.

(1)

NHS Forth Valley

RADIOLOGY REPORT- Stirling Royal Infirmary

CHI NUMBER: 3011795258 **Examination Number:** 30701658

Name: Scrimshaw, Gary DOB: 30/11/1979

Address: 22/4 HILL STREET, TILLICOULTRY, CLACKMANANSHIRE, FK13 6HF -- CC: -

Examination: XR Chest

Examination Date: 20/08/2010 **Examination Time:** 18:20

Dictating Radiologist: DR PAUL KELLY

Typed by: None

Referring Consultant: MAIR W DR ANAESTHETIST

Referring Department / Location: STIRLING INTENSIVE CARE UNIT

Clinical history: Overdose with reduced coma scale and right IJ line inserted.

Findings: Portable supine film. Mediastinal and pulmonary contours consistent with this. Minor consolidation noted in right cardiophrenic angle. ET tube and right internal jugular line in satisfactory position.

Examination Date: 20/08/2010
Examination: XR Chest
Date Reported: 31/08/2010
Dictating Radiologist / Clinical Specialist By DR PAUL KELLY

Verified by: DR PAUL KELLY on 31/08/2010

20-Aug-2010 18:43:0 CORONA CARE

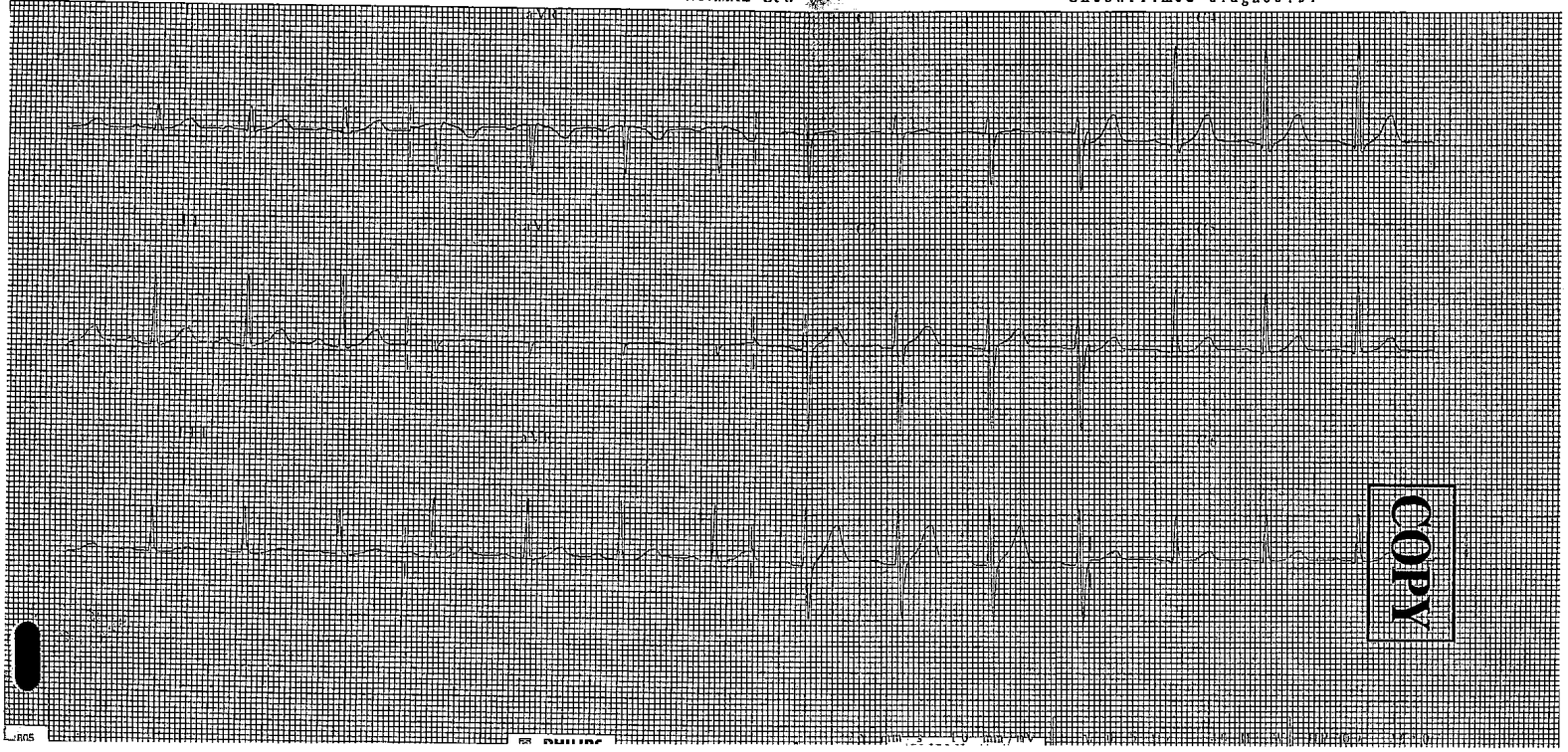
GARY SCRIMSHAW

Rate	87
PR	195
QRSD	90
QT	339
QTc	408
--Axis--	
P	57
QRS	65
T	46

. AGE NOT ENTERED, ASSUMED TO ~~BE 50~~ YEARS FOR PURPOSE OF ECG INTERPRETATION
. NORMAL SINUS RHYTHM, RATE 87.....Normal P axis, PR, rate & rhythm

- NORMAL ECG

Unconfirmed diagnosis.



COPY

ID: 20-Aug-2010 13:41:44 STIRLING ROYAL INFIRMARY

Vent. rate 140 bpm
PR interval 132 ms
QRS duration 110 ms
QT/QTc 288/439 ms
P-R-T axes 55 74 32

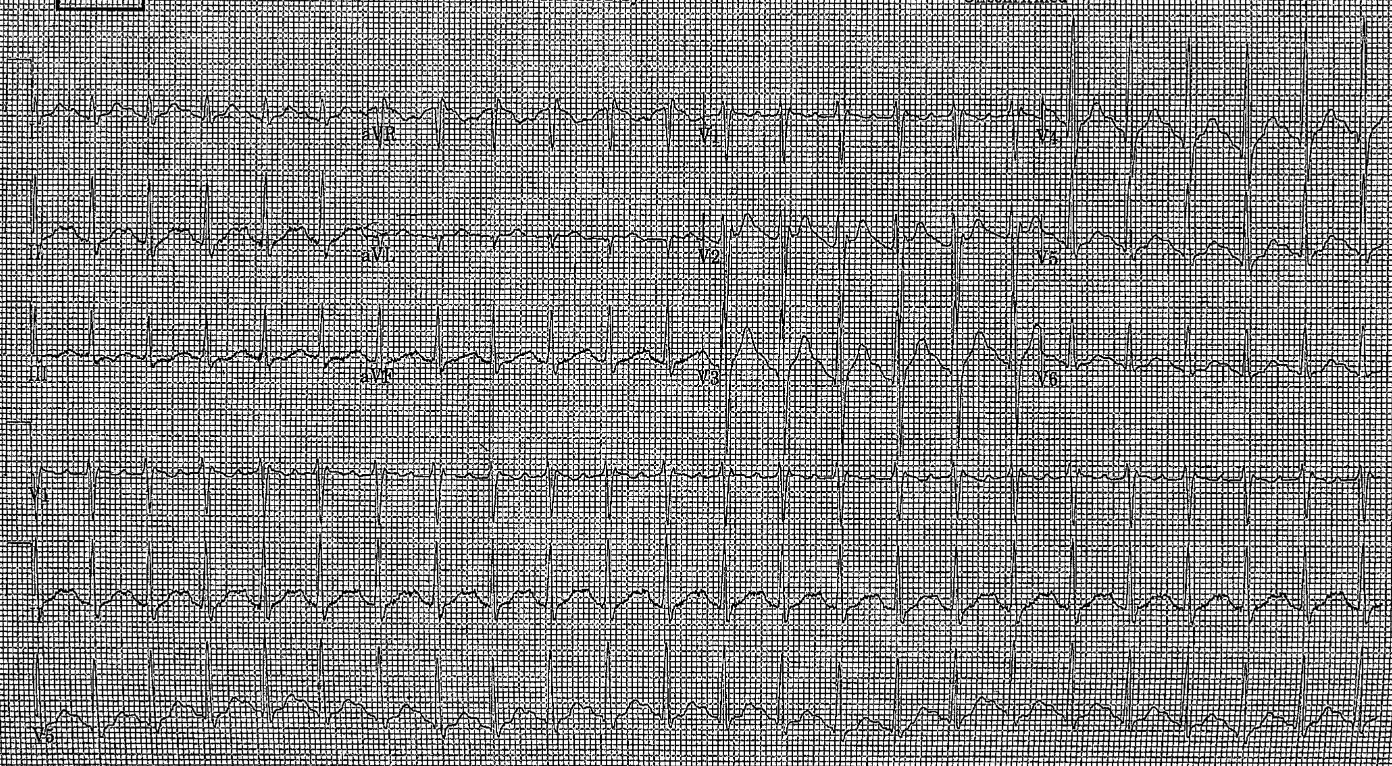
Sinus tachycardia
Cannot rule out Anterior infarct, age undetermined
Abnormal ECG

CHI: 3011795258 30/11/1979 M
SCRIMSHAW
GARY
7 MOSS ROAD
TILLICOULTRY
FK13 6NS

COPY

Technician:
Test ind:

Referred by: Unconfirmed



CLINICAL NOTES

CHI:3011795258
CRN:S237397 30/11/1979
SCRIMSHAW GARRY M
Flat 4, 22 Hill Street,
TILLICOULTRY,
Clackmannanshire
FK13 6HF

abel
ital No.
B.

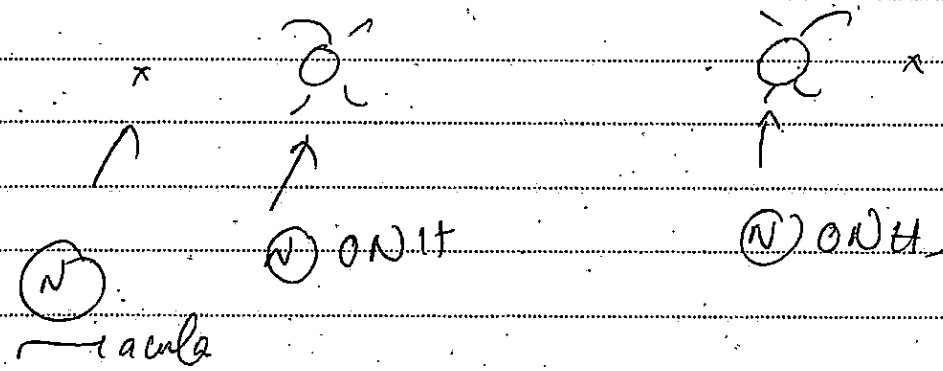
COPY

Consultant

Ward / Dept.

Date

30-8-10



Imp. Ocular pathology

CT g- Exocin x 4/7.

1 today.

R Ismail
ST2.

CLINICAL NOTES

Consultant AR/JAS

Sur CHI:3011795258
For CRN:S237397 30/11/1979
SCRIMSHAW GARRY M
Flat 4, 22 Hill Street,
Ad TILLICOULTRY,
Clackmannanshire
FK13 6HF

el
l No.
30.11.79

COPY
Ward / Dept.

Date

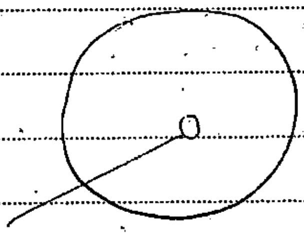
25/8/00 Optician referral with acute (R) red painful eye.

Meds Allergy PMH
Nil Nil Nil

VAR 6/36 u/A VAL 6/9 u/A
6/18 PH 6/6 PH.

Sticky sore R-E 2/7
Blurred vision 2/7

A/S ✓



defect in Decemet's memb?

Diffuse PEE

cells+ AC

A
14

Δ 1/ Conjunctivitis
2. AC activity?

✓ Disc ✓

Plan: 1/ Conj swabs ≤ viral / bacterial / Chlamydial

Shown to JAS, Thanks

2/ G. Exocin QID R.E
3/ Oc Viscotears QID R-E

See 5/7 RCC

SRE

STM 069

RX78

Write - imprint or Attach Label
Surname SCRIMSHAW Hospital No. 23739?
Forenames GARY Sex M
43 EASTCASTLE STREET D. of B. 30/11/1979
Address ALLOA

COPY

Ward / Dept.

CLINICAL NOTES

Consultant P.C.C CLINIC

Date

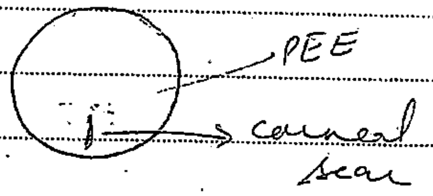
3/11/06 KG. VR, 6/6 c̄ g/s VL, 6/6

→ No notes available

H/O (L) Corneal ~~ulcer~~ perforation (micro) 26/10/06 (TS oncall)

~~f/u~~ Treated c̄ Bandage CL.

Using G-Exocin QID (L.E)



BCL removed

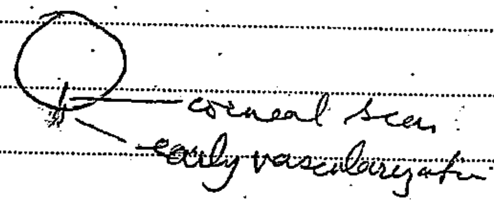
Seidel Negative

G. Exocin } TID L.E

G. Viscotears

See 1/52 PCC.

10/11/06 RVA 6/5 pt LVA 6/5 with g/s



G. Exocin B.D } L.E

Viscotears B.D

1/52

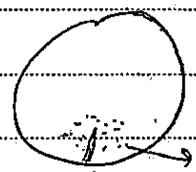
STM 069 RX78

CLINICAL NOTES

Consultant

CHI: 3011795258
CRN: SZ 237397 30/11/1979
SCRIMSHAW GARRY M
43 EASTCASTLE STREET
ALLOA
FK10 1BB

COPY
Ward / Dept.

Date	
30/10/06 LA.	Rv ē gls = 6/6+3 Lv ēgls + CL = 6/6.
	Pt was admitted to [SRI] ward 29 B on Thurs 26/10 + discharged Fri 27/10/06.
	Attended SRI eye clinic Fri 27/10 and had soft CL inserted.
	(LE) comfortable
	BCL in place
	 → epi microcysts
	A/C quiet
	pupil round
	[signature]
	review Friday 3/11/06 - PCC eye clinic
	[signature]

CLINICAL NOTES

Consultant

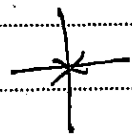
CHI: 3011795258
CRN: SZ 237397 30/11/1979
SCRIMSHAW GARRY M
43 EASTCASTLE STREET
ALLOA
FK10 1BB

COPY

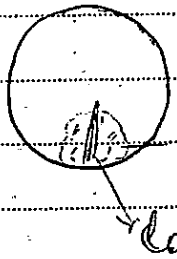
Ward / Dept.

al No.

Date	
27/10/6 KG	c/o irritation ++ since insertion of lens - Not painful just very ~~[illegible]~~ uncomfortable - worse than prior to insertion.
	O/E . lens in situ . °tears, pv cv mv
	Vn 6/12 cph 6/9



X ray orbits done when 1st seen in A&E on the day of injury. ⊘ FB seen



A/C odd cell
A/C deep
pupil round
BCL in place (18mm)

pt c/o irritation ++ since insertion of BCL.
- ? try smaller BCL

Precision UV 8.70 : 14.40 : ∞ p✓ c✓ m✓ (initially)

However

G Exocin x 4 times / day

[signature]

r/v Monday pm clinic

[signature]

AM PCC

STM 069

RX78

Date

HPI: Clerk (cont'd)

COPY

DHx: None
NKDA

FHx: CVA

SHx: Live w/ wife
Unemployed
Teetotal.
Smoke <1 ppd/day.

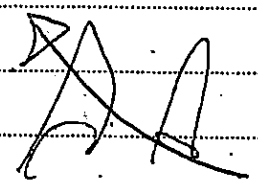
ROS: Systemically well.

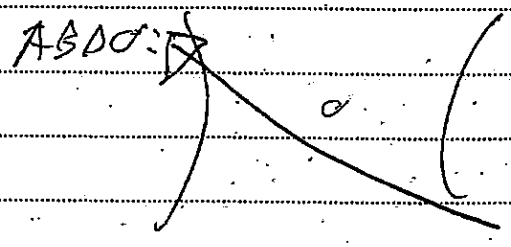
12
6

Hands: Warm
No Stig Mata

CVS: Pulse ≥2 (N)
°Apex – undisplaced.
°oedema
HS I+II+0.

RESP: Expansion
Percussion
Resonance
} R=L=(N)



ABDO: 

SNT
°Masses
°Fluid
BSV Pulses ✓
°Hernias.

JC McCall
293

CLINICAL NOTES

Consultant

Write - imprint or Attach Label

Surname Scrimshaw Hospital No. S237397

Forenames Gary Sex M

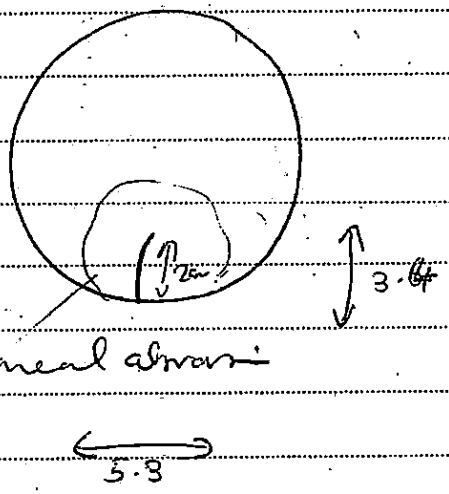
D. of B. 30/11/79

Address 6 Broompark West Menstrie

Ward / Dept.

COPY

Date	
	Inj to (L) eye with Removig Stable from wood slabs. one went to Eye. — 1wk duration
26.10.06	Admitt
	(L) penetrating Corneal Wound.
	2mm long Inf.



D/W. Dr T.S.

BCL 16mm.

Exocin ½ hrly

Review Tomorrow in clinic.

Dr. Zamora to see.

26/10/06 1633 JHO CLERK-IN

PC: As above

PMH: 1996: Thyroglossal Cyst Removal

1996: Appendicectomy

1996: Repair to Cut Thumb — Tendons Nerves

Gary Scrimshaw 325/541

~~[illegible]~~
~~[illegible]~~
43 ~~East~~ Castle Street
Alloa

COPY

STIRLING ROYAL INFIRMARY

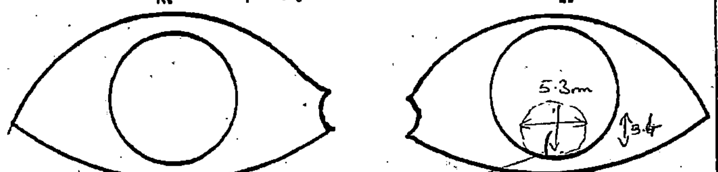
EYE NOTES 26/10/06 SN/TS D.O.B 30/11/79

Diagnosis: (L) penetrating corneal injury **Allergy:**

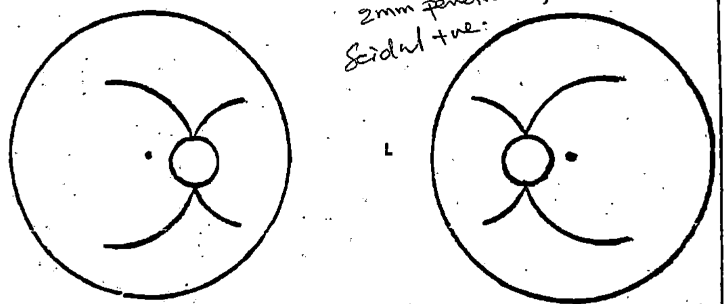
Vision: Rt eye 6/12 ph 6/9 with out glasses Lt eye 6/12 ph 6/9 with glasses

has glasses - not with him

Ext Rt Lt



2mm penetrating corneal cut
Seidel +ve.



Slit Lamp: **Cornea Lens.**

	R	L
Pupils		
A C	AC quiet	
Tension		
Cornea		
Iris		
Lens		
Vitreous		
Discs		
Vessels		
Macula		

(L) NaCl Fluo washout ✓

Simplon 72 Plano 18.50 - 0 D c/c inserted.

Flare
K P
Synechiae
Angles
Others loose epith tissue removed.

History: picking slabs of wood when a pin struck (L) eye while trying to remove it a week ago. given AB drops & oint at A/E eye still painful watering

POTT –
RMH –

Treatment

D/W Dr. Saboor.
admit
BCL 18mm.
Exocin 1/2 hourly.

Review Tomorrow

R/L

Atropine – **H C.** **Eucatropine**
Phenylephrine **Mydrilate** **Others**

[signature]

ING297

COPY

ALLOA HEALTH CENTRE

Dr D S Borland
Dr C B Lamb
Dr F Green
Dr G Riddle

Marshill
ALLOA
FK10 1AB
Telephone No: 01259-216701
Fax No: 01259-724790

PRACTICE ACCREDITATION
RCGP Scotland
2003-2006

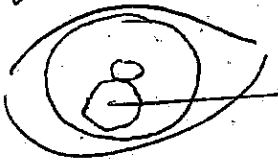
3011795258
Scrimshaw, Gary
30/11/1979 M
43 Eastcastle Street
ALLOA
55344 Dr Borland

26.10.06.

On-call ophthalmologist.

Dear Dr, Many thanks for seeing this man who was struck in the (L) eye last wednesday by a nail. He was seen in A+E & given chloramphenicol & ibuprofen drops.

Today his VA is only 6/18, his eye is watering & uncomfortable.

O/E -  Corneal opacity & staining.

? corneal abscess.

Regards,

5237397

DR HUDA

THURS 1PM

COPY

ACUTE OPHTHALMOLOGY TELEPHONE REFERRAL INFORMATION FORM
(CIRCLED FORCED CHOICE ENTRIES AS APPROPRIATE)

CALL TAKEN BY: Dr SIN GAUN **AT:** SRI / FDRI
DATE: 26/10/06 **TIME:** 10.05 am / pm

FROM: Dr BOLELAND of SRI A&E/FDRI A&E/Ward
GP Optician
Other

PATIENT DETAILS

Surname: SCRIMSHAW C/s no:
Forename: GARY.
d.o.b. 30.11.79
Phone no: 0125? 21858 1.
Address (optional):

Previous Eye Clinic Contact: Yes / No
If yes, under which Consultant: AC/ DH/ TS/ AS/ unknown

(If yes, fix appointment with relevant Dr/clinic unless urgency dictates otherwise.)

REFERRING DIAGNOSIS / SYMPTOMS AND CURRENT Rx

WKD. 18/10/06 SEEN @ SRI A/E CHLOR GIVEN ? CORNEAL ABRASION
VOLTAREL 100DS.
SEEN BY GP TODAY EYE PAINFUL ON EXAM ? CORNEAL ULCER

APPOINTMENT WITH RECEIVING OPHTHALMOLGOIST

To be seen by: Clinic SHO / Duty SHO / Dr
To be seen at: SRI Clinic / SRI Ward 21 / FDRI
Date: 26/10/06. Time: 1PM.

FAX OR SEND TO THE DOCTOR RECEIVING THIS PATIENT

Dr seeing patient at above time/place then enters next stage information:

RECEIVING OPHTHALMOLGOSIT'S DIAGNOSIS AND Rx

Patient: Seen, Discharged / Seen, to be reviewed / Admitted / FTS
Consultant advice sought – by phone / in person / No

CHI: 3011795258 30/11/1979 M
SCRIMSHAW
Garry
7 MOSS ROAD,
TILLICOULTRY,
FK13 6NS

COPY

◆ PROGRESS NOTES

Date and Time	
22/8/10.	Psych R/W
	Summary 30y/o ♂ impulsive overdose in context of social stressors. Denies suicidal intent. Remorseful. Thankful for treatment. No objective evidence of underlying mental illness. Denies suicidal ideation or thoughts of harm. No immediate psychiatric input required
	Plan happy for d/c when medically fit. Will arrange urgent o/p f/u with Dr Collins
	Please inform GP on discharge.
	Would suggest controlled dispensing of amitriptyline ~~on dis~~ if to continue on discharge.
	Happy to r/w if required.
	(Will forward copy of full assessment to overall care in due course) [signature] BOYD CT1.
1240	ACT ANP
	Much improved. Seen by Ψ as above - Does not wish to continue on amitriptyline.
	Bloods normal.
	Plan: chase today's coag
	(H) if normal with f/u as above [signature]
1300	Coag normal. Home [signature] ANP JOB

FORTH VALLEY ACUTE HOSPITALS NHS TRUST RX1561

Date

arrived safely from HDU ..

16.00 - Pt very unsteady on feet, requiring assistance x2 when mobilising

COPY

At high risk of falls.

Spoke to NOK state pt has not eaten since last Friday?

Ice cream taken at tea-time + ½ MINCE & POTATOES.

Wanting to go out for cigarette.

NOK states unable to access B&B to get pt's belongings. Pt quite anxious re same. [signature]

Unsettled overnight & slept very little

Mobilising independently within ward & appears more steady.

Appears vague & confused.

Didn't appear to know what time of day/night it is

Wanting to get ready for work at 1am.

Also looking for his wife in the ward

22/8/10 3am. went to bed & appeared to sleep for couple of hours D.I. Stirling SN

Slip No. 15d

Against Advice

SURNAME (Block Letters)	FIRST NAME (Block Letters)	UNIT NUMBER

This is to certify that I am leaving this Hospital at my own request, at my own risk, and on my own responsibility, and against the advice of the Medical Staff.

Signature [signature]

Address ....

Date 22.8.10

AGAINST ADVICE (Patient)

STB044

CLINICAL NOTES

Consultant

CHI:3011795258
CRN:S237397 30/11/1979
SCRIMSHAW GARRY M
7 Moss Road,
TILLICOULTRY,
Clackmannanshire
FK13 6NS

COPY

Date	
	Plan – Stop sedation – aim to wean / extubate – Pantex infusion continues as prescribed. WRV
21/8/10 1230	ST3 FRASER SEVERAL ATTEMPTS MADE TO CONTACT LIAISON PSYCH. NO ANSWER TO REGISTRAR (MEDICAL TEAM) SWITCHBOARD DON'T HAVE NUMBER FOR SPECIALIST PSYCHIATRIC NURSE BAM. NO ANSWER AT USUAL NUMBER CONTAINED IN LIAISON PSYCH FOLDER. PLEASE CAN WARD DOCTOR MAKE REFERRAL WHEN PATIENT TRANSFERRED? NURSING DIAGNOSIS, FRASER ST3 984
21/8/10 1315	PATRICK – MED REC CONS. – OD as above Amitriptyline & Para – plan as above – ? trf tomorrow to medical ward.

IV Cannula Insertion/Removal Record

Name: [redacted] Ward: ICU

Inserted by: DONNA FRASER Date: 21/8/10

Size/Colour: 20G (PINK) Batch No:

Insertion Site: (L) HAND.

Removed by: Date:

STM 069

RX78

CLINICAL NOTES

Consultant

CHI: 3011795258 30/11/1979 M
SCRIMSHAW
GARY
7 MOSS ROAD
TILLICOULTRY
FK13 6NS

COPY

Date	
	5) AWAIT PARACETAMOL / SALICYLATE LEVELS
20/8/10 1315	6) [illegible] BICARBONATE IF BECOMES ACIDOTIC
	7) CXR FOR ETT
	8) REPEAT ECG IN 1 HOUR
	9) UPDATE NEXT OF KIN
	[signature] FRASER ST3 984
	NOTE: TELEPHONE CALL FROM A+E
	→ PARACETAMOL 236
	→ SALICYLATE UNDETECTABLE
	→ FOR PARVOLEX.
	[signature] FRASER ST3 984
20/8/10 1730	ST3 FRASER - RETROSPECTIVE
	DRAMATIC FALL IN BP TO 50/10, UNPROVOKED
	HEART RHYTHM UNCHANGED.
	6mg EPHEDRINE + 1mg METARAMINOL + SEDATION OFF
	BP SLOWLY UP TO 140/70 AGAIN.
	10ml 10% CALCIUM GLUCONATE PLUS RESTART 500ml
	(125ml/hr) SODIUM BICARBONATE 1.26%.
	R IJ INSERTED - FRASER
	US GUIDED - SEVERAL ATTEMPTS - CLOSE
	PROXIMITY TO CAROTID ARTERY.
	ASEPSIS AS PROTOCOL
	ALL LINES FLUSHING/ASP.
	CXR - APPROPRIATE PLACEMENT
	[signature] FRASER ST3 984

STM 069

RX78

ate

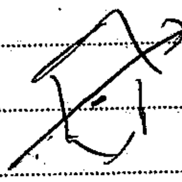
A= SIZE 8.0 ETT, CLEAR ON SUCTION

B= PSIMV FiO_2 0.5 15/5 SATU PARALYSED. 4 600x15

CHEST CLEAR

C= WARM + WELL PERFUSED
TACHYCARDIC – SINUS TACHY QRS 110 QTc 439
RATE ~115-140 ↓BP
CATHETERISED LW –
HAD 2000ml IV FLUID IN A+E
HS I+II+O -

D= GCS 3 PRE RSI
PUPILS SIZE 4, SLUGGISH
BM 4.4 TEMP 35.6


→ ABDOMEN SOFT.
NAD.

ECG: SINUS TACHY 140bpm QRS 110 QTc 439.
OTHERWISE NIL.

LINES: ART LINE 20/8/10 (R) RADIAL
16G VENFLON (L) HAND
18G VENFLON (R) HAND.

PLAN ① VENT SIMPLE
② WAKE + WEAN AS ABLE
③ ADD CK TO BLOODS
④ MAP >65 AND U/O > 60ml/hr PLEASE
↳ GELOFUSINE / BACKGROUND FLUID.

CLINICAL NOTES

CHI: 3011795258 30/11/1979 M
SCRIMSHAW
GARY
7 MOSS ROAD
TILLICOULTRY
FK13 6NS

ospital No. .....
ex .....
. of B. .....

COPY

Consultant

Ward / Dept.

Date	
20/8/10 1515.	ICU ADMISSION - ST3 FRASER - REGISTRAR. 30♂ ADMITTED ATE RESUS @ 1330 NO FIXED ABODE - LIVES IN B+B/SHELTER FOUND FACE DOWN ON FLOOR, UNCONSCIOUS, SURROUNDED BY EMPTY TABLET PACKS. NOT KNOWN TO ABUSE DRUGS, NO DRUG PARAPHERNALIA NEARBY. ONLY PRESCRIBED MEDS ARE ① AMITRIPTYLINE ② DICLOFENAC ③ PARACETAMOL } UNKNOWN QUANTITIES INGESTED. DOES NOT SMELL OF ALCOHOL. GCS 3 ON ARRIVAL, MAINTAINING OWN AIRWAY IN (R) LATERAL POSITION C GUEDEL AIRWAY + TRAUMA MASK GIVEN SODIUM BICARBONATE 50ml 8.4%, ALTHOUGH NOT ARRHYTHMIC. NO RESPONSE TO 400mcg NALOXONE. MODIFIED RSI BY MYSELF FOR AIRWAY PROTECTION. 1mg ALFENTANYL, 50mg PROPOFOL, 100mg SUXAMETHONIUM GRADE 1 LARYNX, SIZE 8.0 ETT SUCCINYLCHOLINE → NO CONTRAINDICATION. UNCOMPLICATED. ATRACURIUM 50mg + 40mg TO FACILITATE VENTILATION AND TRANSFER. PROPOFOL 1% @ 10ml/hr. ART LINE SITED BY DR THOMSON - ABSENT. TRANSFER ICU FULL MONITORING - URGENT.

IV Cannula:

Inserted by: Time: Site: Left + Right

Size/Colour: grey & green Batch No:

COPY

Pressure Area Assessment / Mobility:

Absolute Risk (Score 2)	Relative Risk (Score 1)	
Unconsciousness	Age over 70	Pronounced Emaciation
Dehydration	Restricted Mobility	Redness over bony areas
Paralysis	Incontinence	

(Trolley) Chair Mobile

Pain Score: 0 /10 **Analgesia Given?** Y (N)

Own Meds? Y (N) **Name Band** (Y) N

Investigations

FBC	GLU	CLOTTING	TROP	URINALYSIS	XRAY	CXR
U&E	CRP	G&S	D DIMER	HCG		AXR
LFT	AMY	ESR	ABG	CATHETER	ECG	
PARACETAMOL		SALICYLATE		ETHANOL	CULTURES	

Troponin 0hr result: Troponin 12hr due:

Gary Scrimshaw
30/11/79.

Relative/Carer Informed ? YES NO

Present YES NO

AMT 4

1. How old are you?
2. What is your date of birth?
3. What is this place?
4. What year is it?

If score is 3 or less proceed to Delirium screen

		Box 1	
I	**Acute Onset and fluctuating course** **a)** Acute change in baselines?	☐ Yes	☐ No
	b) Did the (abnormal) behaviour fluctuate	☐ Yes	☐ No
II	**Inattention** e.g. difficulty focusing attention, easily distractible	☐ Yes	☐ No
		Box 2	
III	**Disorganised Thinking (box 2)** e.g. disorganised thinking or incoherant speech such as rambling or irrelevant conversation, unclear or illogical flow of ideas	☐ Yes	☐ No
IV	**Alternative Level of Consciousness (box 2)** E.g. Alert, drowsy	☐ Yes	☐ No

If all items in Box 1 are checked and at least one item in Box 2 is checked a diagnosis of delirium is suggested.

DIAGNOSIS

PATIE

CHI: 3011795258 30/11/1979 M
SCRIMSHAW
GARY
7 MOSS ROAD
TILLICOULTRY
FK13 6NS

COPY

TREATMENTS

Patient/Legal Guardian Permission to release info for legal purpose including Police

Patient Signature..... Print Name..... Date.....

NURSING DOCUMENTATION

Named Nurse: whyte.

Assessment / Intervention

Found unconscious in bedroom ? Overdose
- Medication found lying around room amitryptaline and Paracetamol
IV Fluids ✓
Referred medics ✓
Anaesthetics called ✓

Outstanding Plan:

Admission to ITU

Date: 20/8/10

Clinical Notes

Patient Name:

Macmillan 1605

Remains GCS 3
Self ventilating
SaO_2 97%
HR 122

Given history - likely TCA OD

I think he needs RSI + ventilation

Anaesthetics called

RSI by anesthetic ST3.
uneventful

→ ITU

WG.

20/8/10

3011795258
SCRIMSHAW
GARY
30/11/1979 M

Clinical Notes

DATE: TIME:
SIGNATURE

COPY

Seen by: KAVANAGH.

Found collapsed face down
in room.
Seen c 0900h → Shop →
back to bedroom in B+B

Someone found him c
called 999.

SHS - ↓ L.O.C.
tolerating guedel airway
BM 4.4
Given naloxone 400mg

NOT DRUG USER
NO DRUG PARAPHERNALIA

O/E -
A - tolerating guedel.
B - AE N = L
C - Bp 130/88
IVA x2 ? - bloods -
IVF ✓
D - GCS 3/15
but starting to sigh,
swallow + some spont
mumb.
BM - 9.6

Plan - ECG - QRS 118 → borderl ✓
50mmol Na bic IV ✓
IV Fluids ✓
Right lateral positioning ✓

ABG - H+ 42.6 + rest ?

Guidelines Used:

Neuro-ex - tone ↑ / reflexes ↑
[illegible]

Accident and Emergency Department
Stirling Royal Infirmary

3011795258

A&E No. 1004728T

COPY

Surname	SCRIMSHAW	**Forename**	GARY	**Title:**	
Address:	7 MOSS ROAD	**Postcode**	FK3 0AJ		
	TILLICOULTRY CLACKMANNANSHIRE	**Telephone:**			
Date of Birth:	30.11.79	**Sex:**	M	**Age:**	30 yrs

GP Name:	KOLLE ANDREAS		
Address:	TILLICOULTRY MEDICA... PARK STREET TILLICOULTRY	**Postcode**	FK13 6AG
		Telephone:	01259 750531 07935 630569

Next of Kin	TRACEY SCRIMSHAW		
Relationship:			
Address:	FLAT 4, 22 HILL STREET	**Postcode**	FK13 6HF
	TILLICOULTRY CLACKMANNANSHIRE	**Telephone:**	[redacted]
Manual CHI Entry:			0754 6967107

Date of Attendance: 20.08.10 13:37
Date of Incident:
Presenting Complaint: UNCONCIOUS

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

OPHTHALMOLOGY DEPARTMENT

Consultants: Dr J A Scott (Lead Clinician)
Dr J D Huggan
Dr T Saboor
Dr J Gillen

Stirling Royal Infirmary
Livilands
Stirling
FK8 2AU
Tel: (01786) 434000
www.show.scot.nhs.uk/nhsfv

COPY

AR/JP/ S237397
CHI No: 3011795258

24th November 2006

Dr Borland
Health Centre
Marshill
Alloa
FK10 1AB

Dear Dr Borland

Gary Scrimshaw (30.11.79) 43 East Castle Street Alloa

This patient had left corneal micro-perforation about 4 weeks ago. He has attended the clinic several times since then. He failed to attend today and also on the 17th November.

When last seen there was a small corneal scar affecting his left eye. Visual acuity was 6/6 and he was still on Exocin drops and Viscotears gel drops twice a day to the left eye. Presumably his symptoms have now resolved. I have therefore discharged him. No further treatment is required. If there is a further problem please refer him again.

Yours sincerely

A Ramsay
Locum Staff Grade in Ophthalmology