James Lowe

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=**
Temp=	36.6	**Peak Flow=**	**GCS=**	**News=**	0

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

3007952S8

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 (circled) U&E (circled) GLU LFT CRP (circled) AMY CLOTTING G&S ESR PARACETAMOL

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

Others:

SIGN: [signature]

BLOODS TAKEN? YES (circled) / NO TIME TAKEN 2240

PRINT: [signature]

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 CRES. 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.

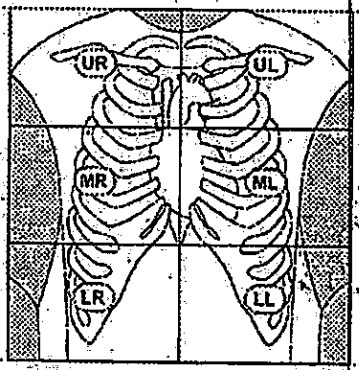
PATIENT ASSESSMENT

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	146/94	<=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)	

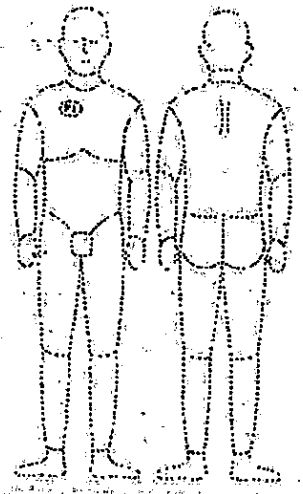
E

[redacted]S A RECONSTITUTED DOCUMENT PRINTED FROM EDRM

[redacted] [redacted] [redacted]

[redacted]

5/27/2026 Incident Number: CR01031114



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
Post 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]

4/20/2024 Incident Number: CR01004114

Site	RIGHT SIDE	Onset	1400 ONWARDS
Character	TIGHT STABBING, Intermittent, Worsening	Radiates	Yes. RIGHT ARM TO FINGER TIPS
Associated Symptoms	CLAMMY, Nausea	Timing	LASTS 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:** **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:	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

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

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 - 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

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

1010152233147

Unique Care Pathway Number: 1010152233147

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 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

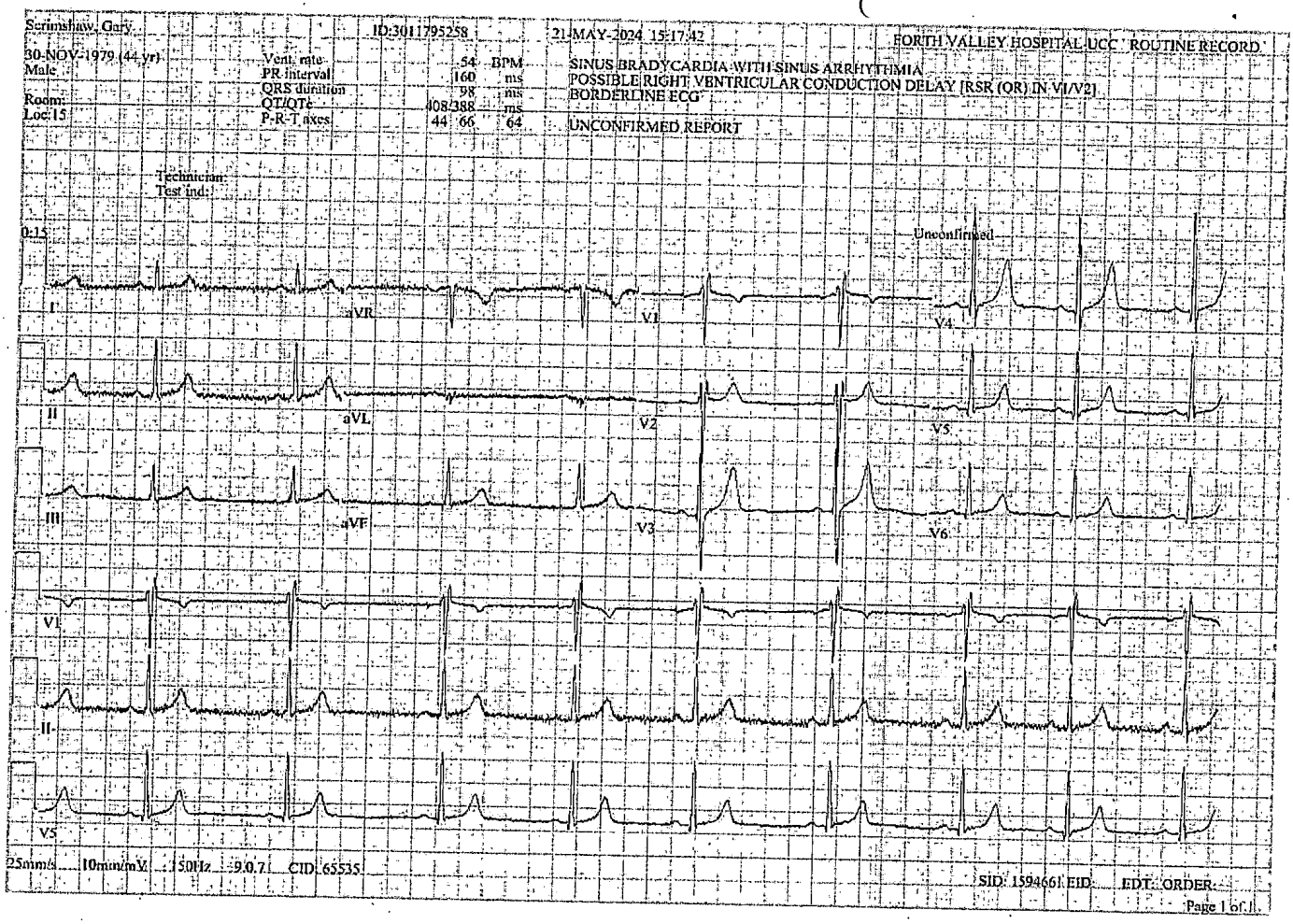
Accession: V213936463501, Examination Date: 21/05/2024, Examination: XR Chest:

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

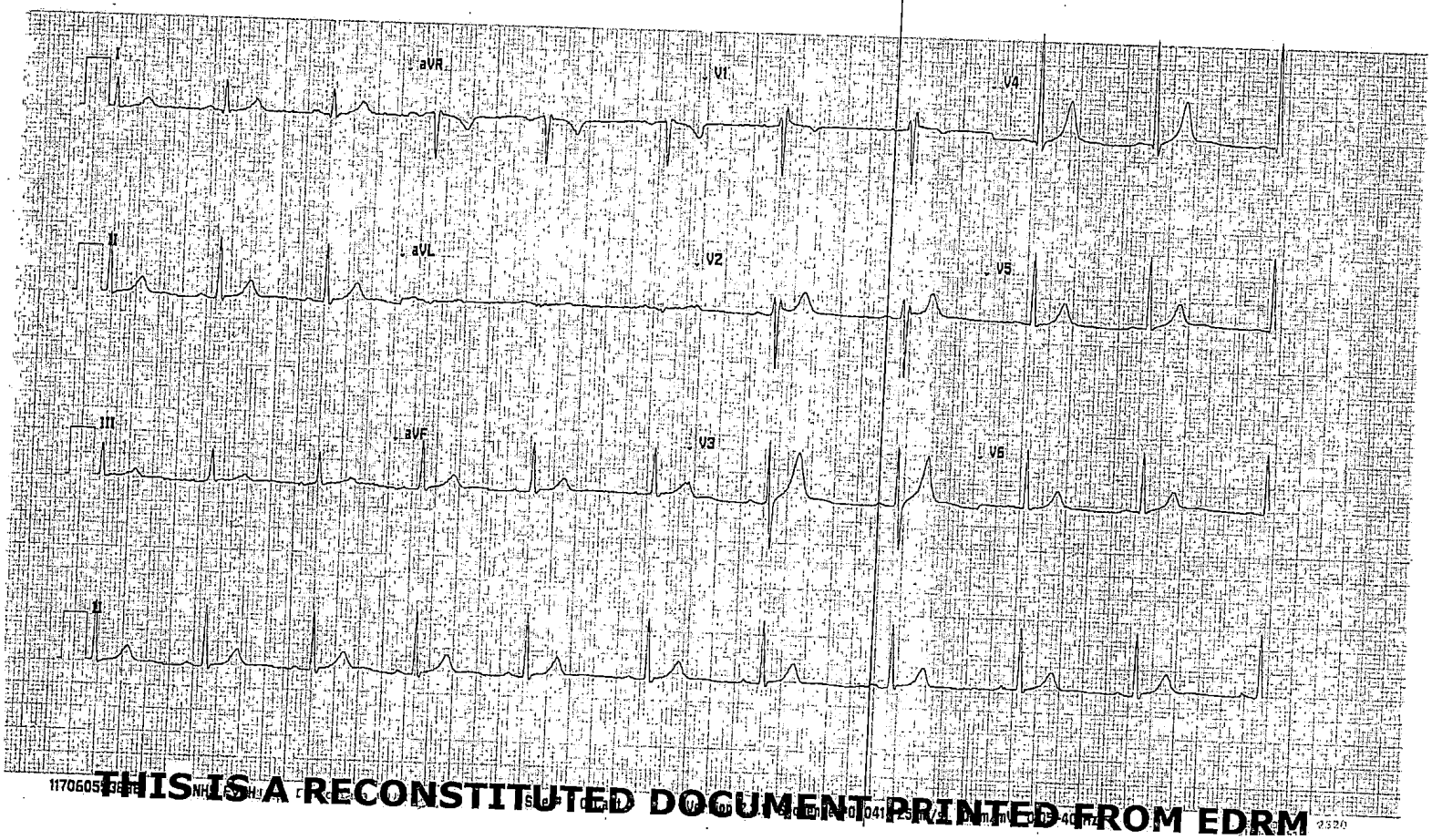
Last: Scrimshaw
First: Gary
ID: 3011795258
DOB: 30-Nov-1979
Age: 44yr Sex: Male
Comment:
Tech:
Ref Phys:

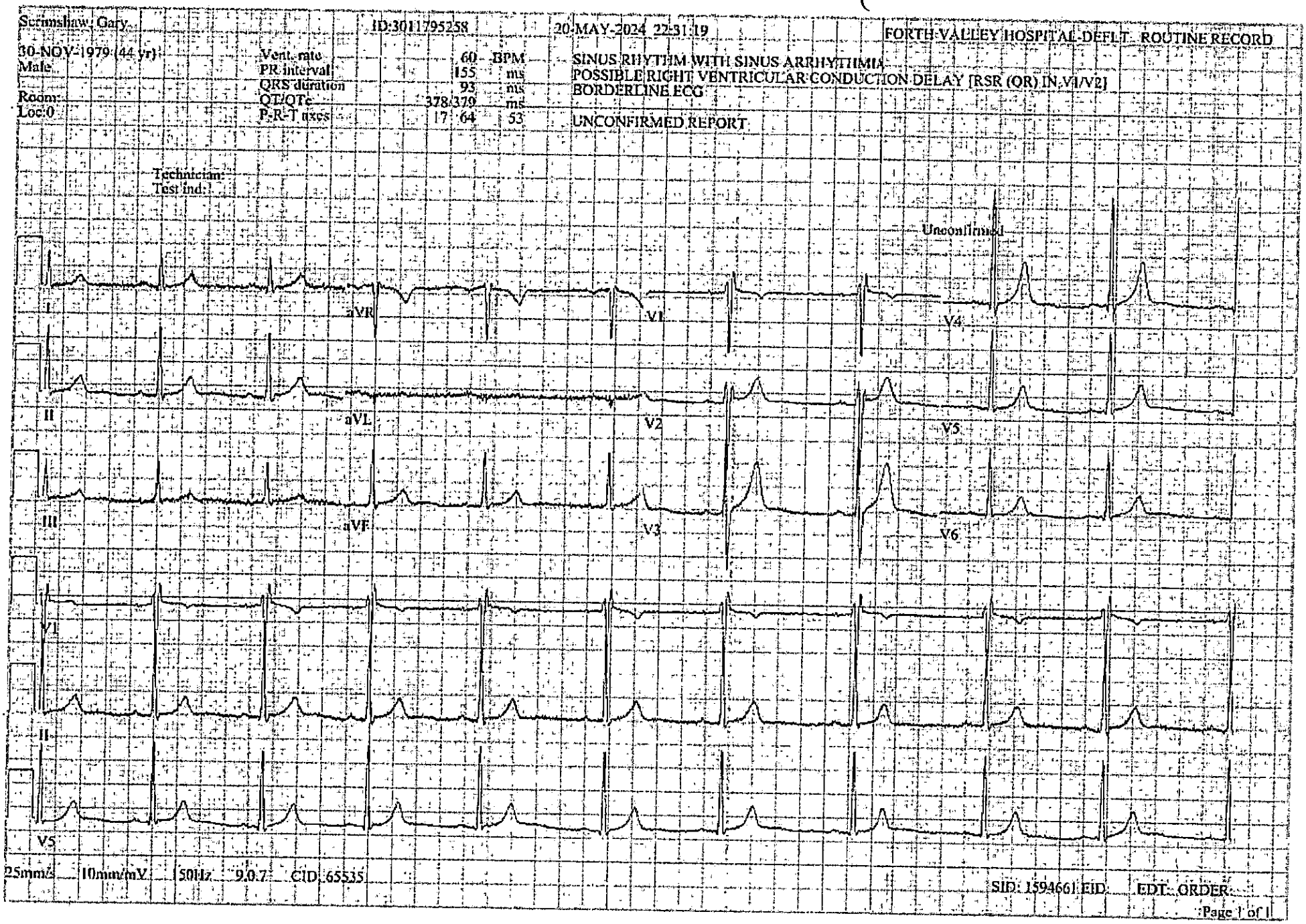
20-May-2024 22:..:19

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





Medication Administration Profile

Patient:	Scrimshaw, Gary			Weight:	kg
Hospital No:	3011795258	National No:	301 179 5258	Height:	cm
Date of Birth:	30-Nov-1979			Body Surface:	m²
Allergies:	***Unknown***				

Sensitivities:

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

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 31/1/18 at 10:15

PHYSIO Peter Reid

LOCATION CCHC

Hospital No.

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

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 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 on 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
[redacted]	Age 11-19 / <10 >55		
[redacted]	Ca/FHX of Ca	✓	
[redacted]	Weight loss >10% / 5-10% / <5%		
	Statins	✓	
	Diabetes	✓	
	Epilepsy	✓	
	Cardiovascular	✓	
	Blood Pressure	✓	
	Previous Strokes / TIA	✓	
	Respiratory / Asthma	✓	
[redacted]	Persistent Cough	✓	
[redacted]	Infection / Fevers / Viruses	✓	
[redacted]	HIV / Drug abuse	✓	
[redacted]	Night Sweating / Severe Pain	✓	
	Anticoagulants	✓	
[redacted]	Thoracic Pain	✓	
	Steroid Use / Osteoporosis	✓	
	RA / FHX of RA	✓	
	Other Joint Pain	✓	
	Allergies - Latex - Elastoplast	✓	

Physiotherapist Name: Peter Lynch - Podiatrist Signature: Peter Lynch

Allan Reid (BSPP)

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 ↓/Elec-wks.	31/01/18			

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

Re-Order Ref: TF/1005/MECR

Review Date: 2019

Alan Pearson (B&PT)

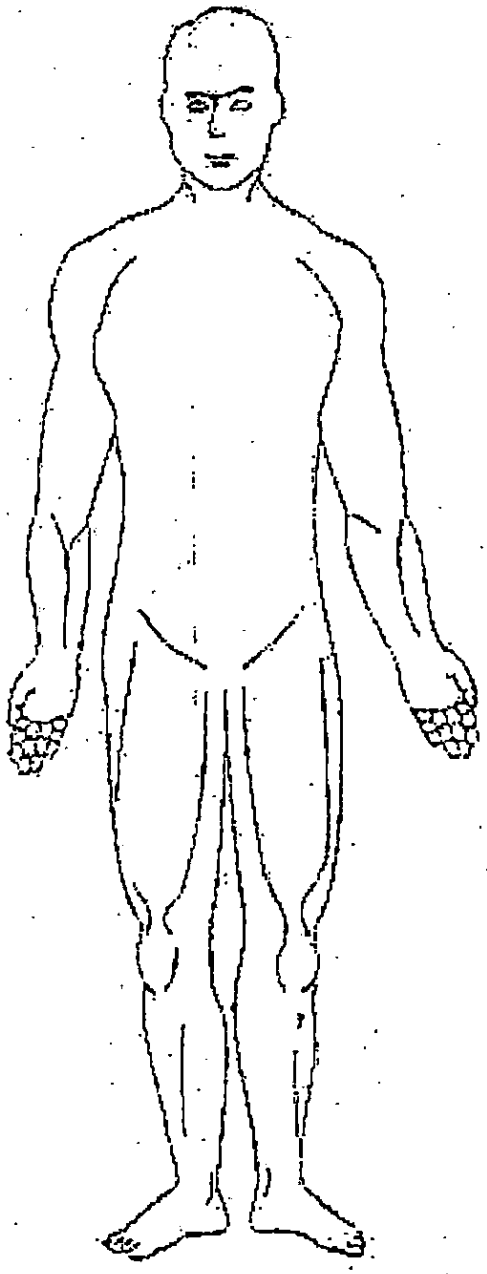
Name: Gary Scrimshaw CHI: 3011795258

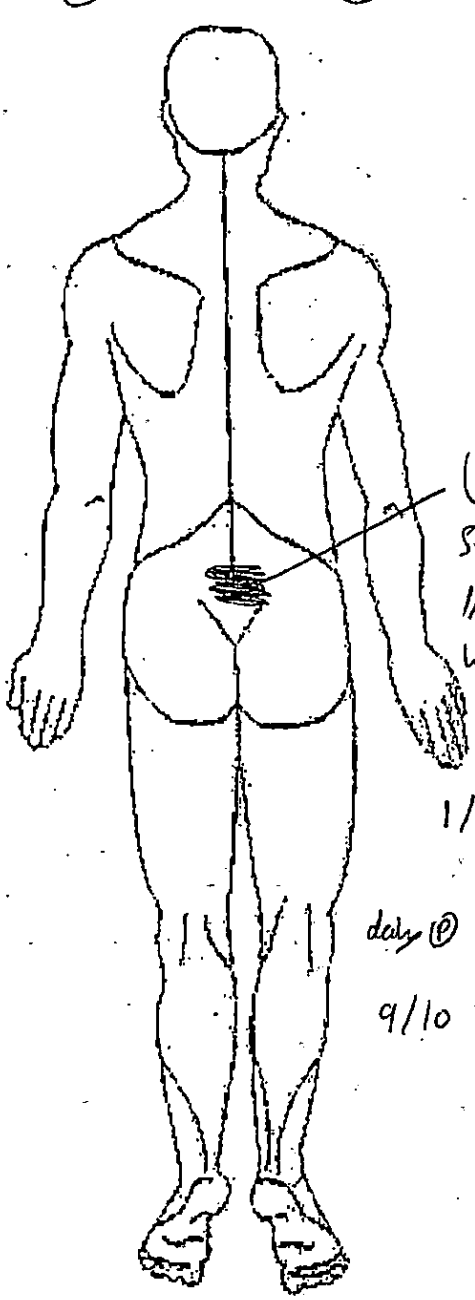
Date: 31/01/18 Page No: 6

NHS Forth Valley

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

Easeg: • Sitting c legs arched c pillow underneath.
"Taking arch out of back"





P1
Sharp / Stabbing
I/M.
Worse c activity + Cold.

1/10 : now c P

daily P 5/10 c/at PKs

9/10 : at worst

24 hour Pattern:
A.m:
P.m: } Depends on activity. ↑ P c ↑ activity

Night: Disturbed sleep. Wakes up couple times in night. Trying to get comfortable.

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

Allan Reid (BGRT)

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 ē 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 ē wife + kids (3 + 11)
- Amazon: In warehouse. Always on feet picking orders. 10 hr shifts.
- Cycling, mountain biking, biking. Restricted i.e. flex is 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 ē (P)
Ext: 1/2 range ē (P)
(R) side flex: 3/4 range ē little (P)
(L) side flex: 1/2 range ē (P) (R) Lx

Hips: ✓✓
Knees: ✓✓
Neuro: ✓✓

Palpn: (P)++ on PAIVMS Lx spinous processes L2 - L5. ~~(R) ...~~ 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 (i.e. x 3 sets throughout day)
+ seated trunk flex / 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 P. Lynch

Re-Order Ref: TF/1005/MECR Review Date: 2019

21/2/18 FTA ——— [signature] (86PT)

T

TC

LD 22/9

Hospital use only | Clinic

SCANNED ☐
APPT DETAILS 9/10/20 1pm
PHYSIO CCHC
LOCATION

Hospital No.

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 - 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

cp 9/9

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 Teasel Dr Dochia FK10 3DP

Contact number(s)

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

REFERRING PRACTITIONER DETAILS

Name:	Dr. Andreas Kolle (GMC: 4269505)
Practice:	Tillicoultry Medical Practice (25544)
Phone:	Voice: 01259 750531

Practice address:

Park Street
Tillicoultry
FK13 6AG

DLC ☐

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	
Telephone: 07340830479			
Date of Birth: 30/11/1979	**Sex:** Male	**Age:** 40 Years	

RECEIVED
05 OCT 2020

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	**Postcode:** FK13 6PZ	
Address: 40 Johnston Crescent Tillicoultry Clackmannanshire	**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

Anxiolytic

Clinical Notes

Seen by:	L YOUNG	Time:	1220

PC (R) shoulder injury

HPC: Cyclist - fell from bike 3 months ago - saw GP.

3 days agos - car in front - cut kerb & hit bollard - shoulder hit bollard

- ↓ ROM since - MIU.

Pain: shoulder / ACJ.

↓ movement

↓ ROM.

Δ: c/o tingling in fingers.

PMH: nil. DH: amitriptyline codeine

Allergies - nil

(R) handed

See Ext Notes

Guidelines Used:

CHI NO: 3011795259 30/11/1979
SRN:
ary SCRIMSHAW M
10 JOHNSTON CRESCENT
TILLICOULTRY
FK13 6PZ

Attach continuation sheets here

Attach here onto face of pocket

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:** **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

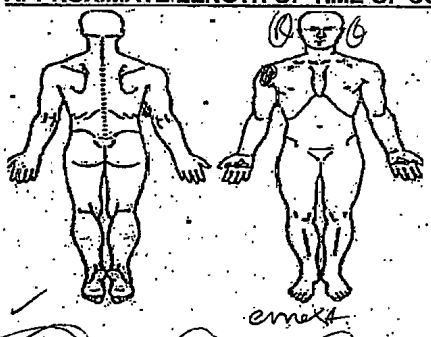
TELEPHONE CONSULT/ NEAR ME CONSULT 09/10/2020

Patient Name: Gary Scrimshaw **CHI:** 3011795258 **Physiotherapist:** Xabier Arietaleta BSPT **Date and Time:** 13:00

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

PROBLEM AREA: (R) sh RC calcification

APPROXIMATE LENGTH OF TIME OF CONDITION:



- Felt from road like another fault (3/12 ago) 30/9/2020 + hit Solland
- Pain started after fist fall, no pain before. Felt like a dead arm (impinging) until last week
- A Pain: since last week
- GP - sign him for 2/52 on light duties

AGG: ASd Flex

EASE: Naproxen x2 Hot Cold

BETTER WORSE — SAME (CIRCLE)

24 HOUR PATTERN: Sleep disturbance

NRPS: 0 1 2 3 4 5 6 7 8 9 10 (15) when moving

INVESTIGATES to DATE:

X-ray - OA / RC calcification

INVESTIGATES PENDING:

Nil to note

Gary Scrimshaw 30/11/79

Scheuermann's disease

PMH: – ⓝ

GH: T.....H.....R.....E.....A.....D.....S (each ticked)

H/o CA self? Y (N)

Recent weight loss? Y (N)

ANY PERTINENT RED FLAG QUESTIONS:

SOS -ve

OBSERVATIONS:

Q ROM: ✓ | GH Flex: 80
Abd 45
HBD L

elbow / wrist / Hand ✓

△ trauma?
calcification?

TREATMENT/DISCUSSION

HEP (email ✓) see cocs sheet
Load management, progression, POLICE + PEACE AND LOVE

PLAN

F2F in 1/52.
pt happy c̄ plan.

Xabier Ariztegieta BGPT
09/10/2020

MEDS: – Amitriptyline (since Age 17) x2-3 (25mg tablets)
– Naproxen
– Co-codamol 30/500 x8 (hours) this is for Scheuermann's

SH:

– Works in Brewery (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.

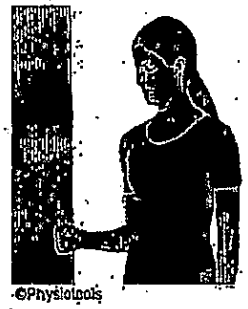
Lean forwards.

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 ans -ve. However pt rescheduled appt afternoons (through the Hub) as he is not comfortable coming to the department

Pt reported feeling 100% better in our t/c

Ⓟ t/c in 1/52. DIC? L. Aristegieta BGH

20/10/2020

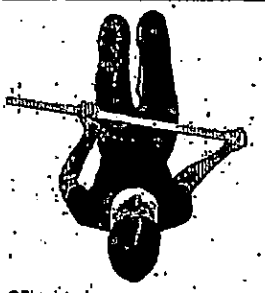
FTA. Unable to left vm on mobile number

Ⓤ on hold for 2/52. LAristegieta

3/11/2020

no further contact made. DIC

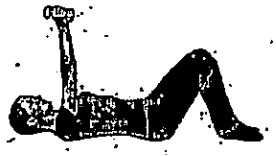
L. Aristegieta



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.

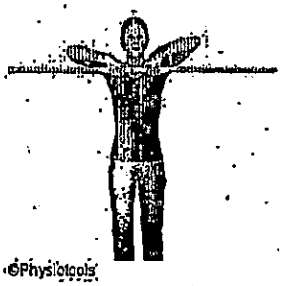
Repeat _____ times.



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

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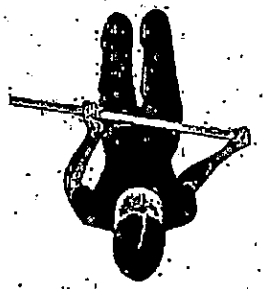

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Lift your hands above your head and stretch your arms as far back as possible.

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:

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

CHI Barcode: 3011795258

Date of Completion: 21-May-2024

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Patient Address:	40 Johnston Crescent Tillicoultry Clackmannanshire FK13 6PZ	**Gender:**	Male
		CHI No:	3011795258
Telephone No:	07340830479		

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Nil records exist

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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

44

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

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
Cyclizine
AM + 20mg ON.

Name: Victory Adebayo

Signature:

Date: 21/05/24

Time: 15:05

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

(addressograph)

COPY

Assessment

Presenting Complaint:

cp + SOB

HPC:

1/52 history of intermittent chest tightness and SOB non exertional
no cough / fevers
feels unsteady
no nausea
E + D ok

severe episode last night.
attended ED.
ECG + bloods
didn't wait for results
assoc clamminess + palpitations

no weight loss

Systemic Enquiry:

~~PU~~ PU overnight more

PMH:

nil

Social History:

Smoking/Vape: No/Yes 20/day pack years

Alcohol: Units/week nil

Live with: wife

Support/carers:

Occupation: works in a brewery

Family History:

dad - stroke

(addressograph)

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

COPY

Impression:

?MSK
exclude PE.

Plan:

Bloods in ED yesterday bnp cs
NUEs, FBC.
no worsening presentation therefore
cardiac ~~de~~ cause unlikely.

CXR → nad
check D. Dimer ⊖.

d/w MSK.

Name:	Sign:	Date:	Time:
		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

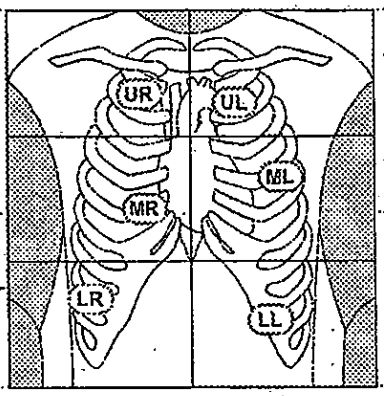
PATIENT ASSESSMENT

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

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

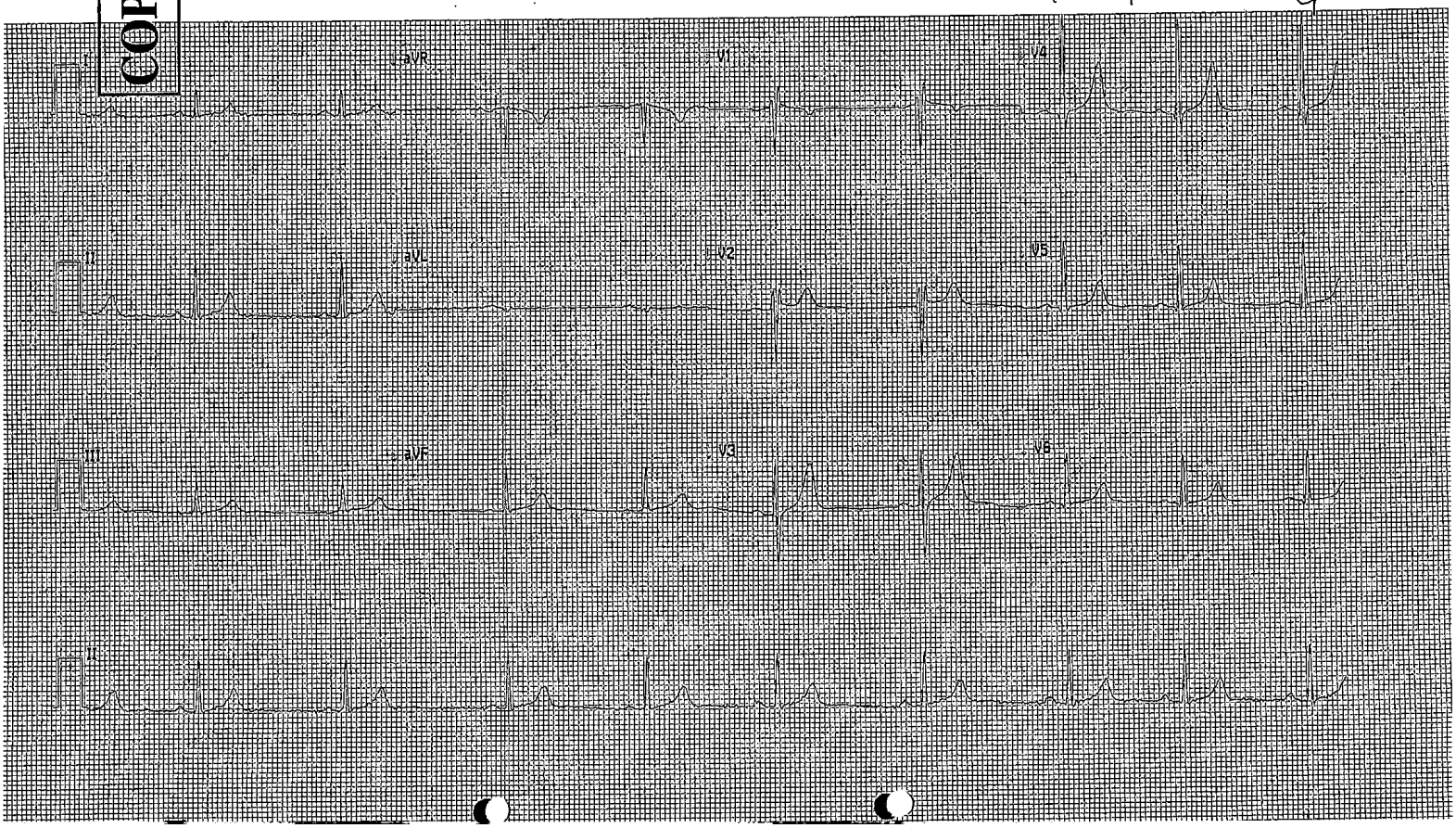
21-May-2024 15:17:42

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 by
from previous EKG



corpuls³ D-ECG (1) 0002447

Mission: 20240521125510 Time: 14:02
Mission start: 21.05.2024 13:_5 UTC+01:00

Patient: GARY SCHMSHAW
ID: -- Case No.: --
Date of birth (Age): 30/11/79 --- (--) (44)
Sex: M -- Weight: --
Height: --

HR: 61 /min NIBP: 139 / 79 (99)? mmHg
CO2: -- kPa RR: -- /min
SpO2: 96 % PR: 66 /min
PI: 3.2 %

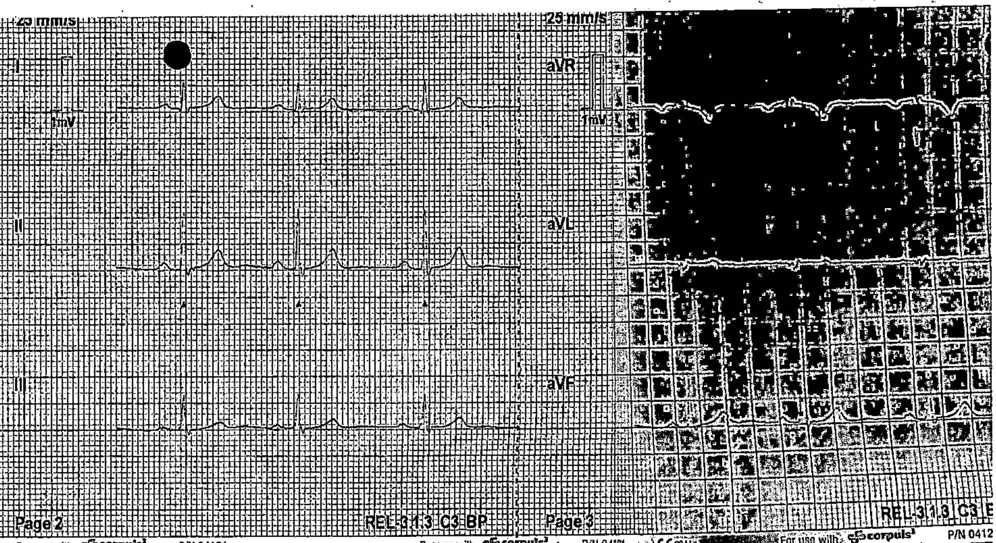
COPY

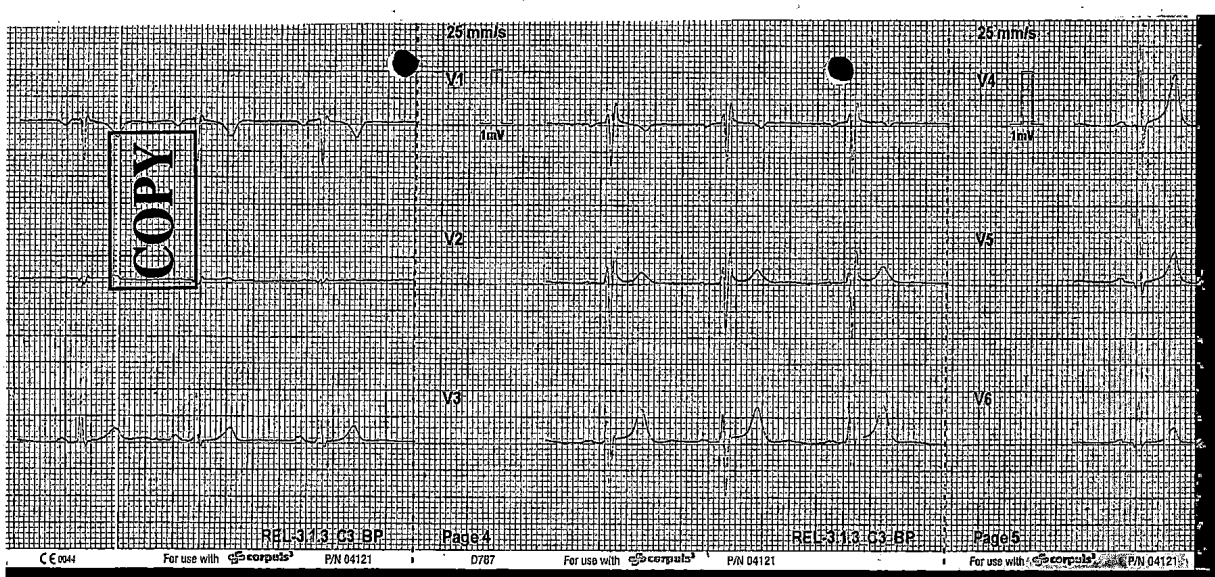
Device: 0002447
Radio: --
Medical team: --
Callback phone: 07920271633

ECG filter: 0.05 - 40 Hz Mains filter: 50 Hz

Page 1 REL 3.1.3 C3 BP

ECG FILTER ACTIVE - INTERPRETABILITY MAY BE AFFECTED




25 mm/s
V1
1mV
V2
V3
25 mm/s
V4
1mV
V5
V6
COPY
CE 0044
For use with corpuls3
P/N 04121
REL-313 C3 BP
Page 4
D787
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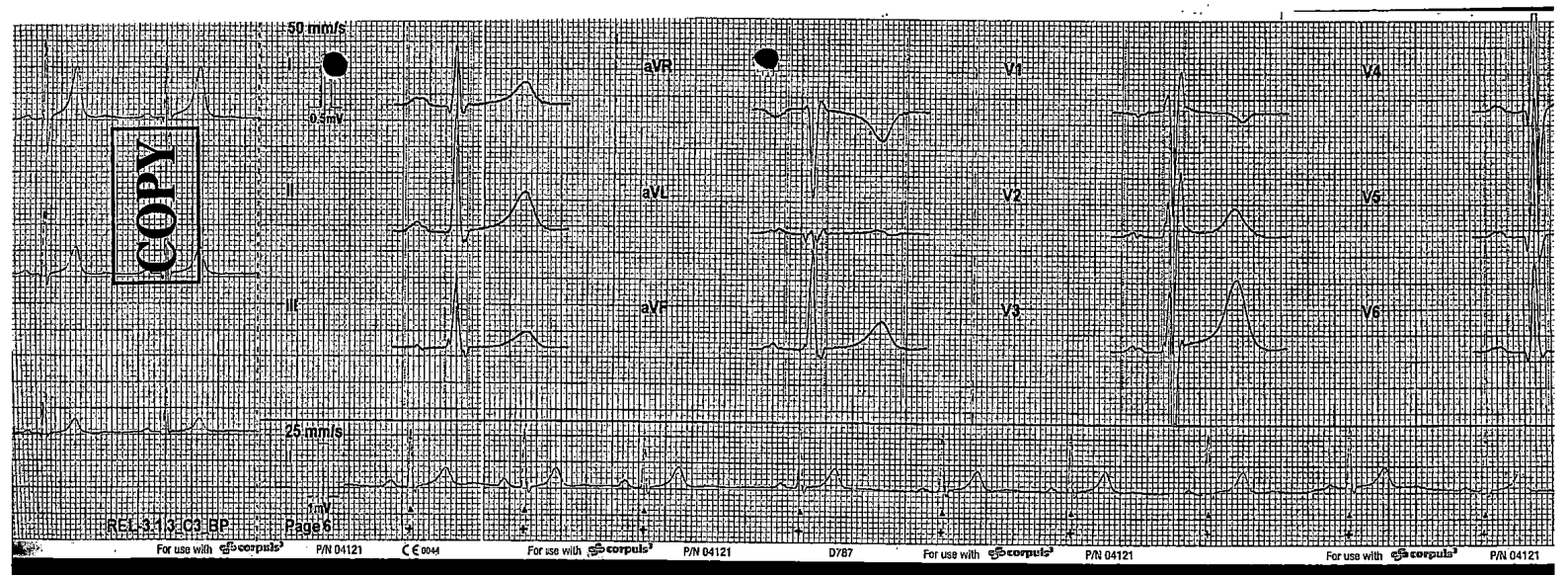
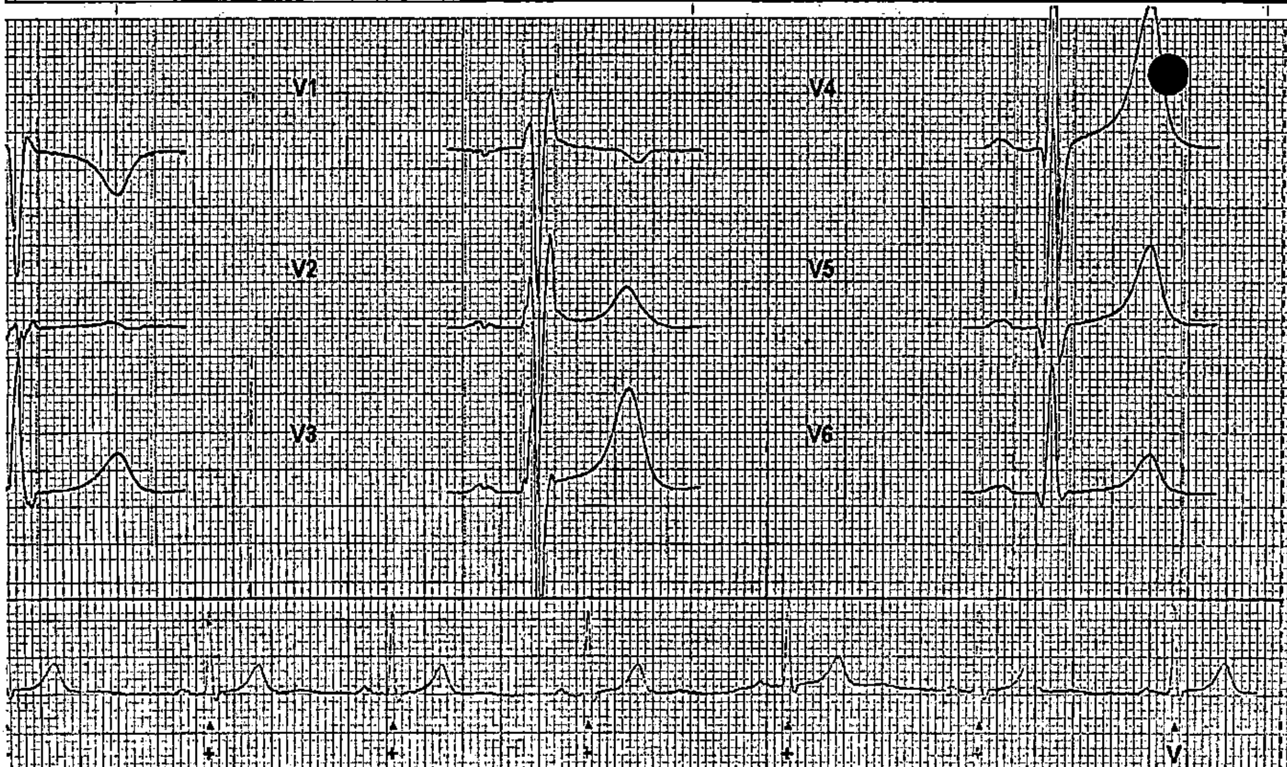
P/N 04121
REL-313 C3 BP
Page 5
For use with corpuls3
P/N 04121


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

[redacted]



hr 59 /min bradycardia front vectors : P 45°
R 92 ms PR 146 ms QRS 67°
QRS 97 ms T 55°
QT 388 ms QTc 385 ms QTn 99 % normal axis

SPECIFIC FINDINGS

noise 10 µV small

RMS	10	9	6	3	4	4	3	7
LI 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 CH leads

remarks: HES EKG 18.24 06 b
checked by doctor:

COPY

END OF PRINTOUT

NEWS key: 1 | 2 | 3

FULL NAME: Gary Scrimshaw

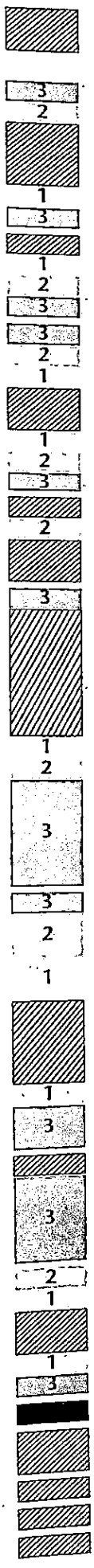
DATE OF BIRTH: 30/11/1979

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 Oxygen saturation (%) Only for patients with target saturation range of 88–92%	≥97 on O_2		
		95-96 on O_2		
		93-94 on O_2		
		≥93 on air		
		88-92		
		86-87		
		84-85		
		≤83%		
	Tick if using Scale 2 ☐ Planned Y was Scale 2 under the direction of a qualified clinician			
	Air or oxygen?	A=Air	A	A
		O_2 L/min		
		Device		
	Pulse Beats/min Use •	≥220		
		201-219		
		181-200		
		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		
		≥131		
		121-130		
		111-120		
		101-110		
		91-100		
		81-90		
		71-80		
		61-70		
		51-60	57	54
		41-50		
		31-40		
		≤30		
C	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		ONA	ONA

Scrimshaw, Gary
40 Johnston Crescent
Tillicoultry
Clackmannanshire
FK13 6PZ
NEW S237397

DATE OF ADMISSION:



COPY

DATE	
TIME	
≥21	3
21-24	2
18-20	
15-17	1
12-14	
9-11	3
≤8	
≥96	1
94-95	
92-93	2
≤91	3
≥97 on O_2	3
95-96 on O_2	2
93-94 on O_2	
≥93 on air	1
88-92	
86-87	1
84-85	2
≤83%	3
A=Air	2
O_2 L/min	
Device	
≥220	3
201-219	
181-200	
161-180	
141-160	1
121-140	
111-120	
101-110	2
91-100	
81-90	3
71-80	
61-70	
51-60	
≤50	
≥131	3
121-130	2
111-120	
101-110	1
91-100	
81-90	
71-80	
61-70	
51-60	
41-50	1
31-40	3
≤30	
Alert	
Confusion	3
V	
P	
U	
≥39.1°	2
38.1-39.0°	1
37.1-38.0°	
36.1-37.0°	1
35.1-36.0°	
≤35.0°	3
TOTAL	
Monitoring	
Escalation	
Blood Sugar	
Pain Score 0-3	
Fits	

National Early Warning Score (NEWS2)

NHS Forth Valley

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

DOB: 40 Johnston Crescent

CHI No: Tillicoultry

Address: Clackmannanshire FK13 6PZ

*** 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:
GCS	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		+ 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
Slight pain on movement
2 = Intermittent pain at rest
Moderate pain on movement
3 = 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™)

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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.

Choosing 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 Cycloplegic/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 problem.

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 ROONEY OPTICIANS 105 HIGH ST TILLICOULTRY

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.

Signature ..... Date .....

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

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. BORLAND
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 podiatry
please copy d/c to
Dr Collins – Consultant
podiatrist
Stirling Royal

Signed: CAD

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	
Read/Approved by:		
Date:	22/08/2010	

COPY

Discharge Ward Nurse:	Murphy, John

Validation/Contact Name: Paterson, Dr Stuart

THIS IS THE FINAL DOCUMENT

Name: Mr Garry Scrimshaw

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

NHS Forth Valley

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

CHI: WARD: 29B

COPY

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

		Date:	26/10	27/10																
		Time:	1540	630																
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	(5)																%
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			60.																70
	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		↓	↓																70
	60			77																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
			SN	B																

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							
			TIME							
INSTRUCTIONS for flush	PHARMACY Clin POD Y N D/C Y N		GIVEN BY							
			TIME							
			GIVEN BY							
SIGNATURE / DATE	DISP₁ DISP₂		TIME							
			GIVEN BY							
APPROVED DRUG NAME DIHYDROCODEINE	DOSE 30mg	ROUTE PO	TIME	02.10						
			GIVEN BY	IB						
			TIME							
INSTRUCTIONS every 4 to 6 hours	PHARMACY Clin POD Y N D/C Y N		GIVEN BY							
			TIME							
			GIVEN BY							
SIGNATURE [signature] / DATE 27/10/06	DISP₁ DISP₂		TIME							
			GIVEN BY							
APPROVED DRUG NAME	DOSE	ROUTE	TIME							
			GIVEN BY							
			TIME							
INSTRUCTIONS	PHARMACY Clin POD Y N D/C Y N		GIVEN BY							
			TIME							
			GIVEN BY							
SIGNATURE / DATE	DISP₁ DISP₂		TIME							
			GIVEN BY							
APPROVED DRUG NAME	DOSE	ROUTE	TIME							
			GIVEN BY							
			TIME							
INSTRUCTIONS	PHARMACY Clin POD Y N D/C Y N		GIVEN BY							
			TIME							
			GIVEN BY							
SIGNATURE / DATE	DISP₁ DISP₂		TIME							
			GIVEN BY							
APPROVED DRUG NAME	DOSE	ROUTE	TIME							
			GIVEN BY							
			TIME							
INSTRUCTIONS	PHARMACY Clin POD Y N D/C Y N		GIVEN BY							
			TIME							
			GIVEN BY							
SIGNATURE / DATE	DISP₁ DISP₂		TIME							
			GIVEN BY							

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 (Y | N | No. of Days); Disp = Supply dispensed labelled and checked (Initials | Date | Quantity)

General Medication Page

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

COPY

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

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

			DATE → / TIME ↓	26/10/06	27/10/06						
APPROVED DRUG NAME: G. EXOCIN	DOSE	ROUTE: I									
INSTRUCTIONS: Deye · ½ hourly	PHARMACY Clin / POD Y N / D/C Y N / DISP₁ / DISP₂										
SIGNATURE	DATE: 26-10-06										
APPROVED DRUG NAME: PARACETAMOL	DOSE: 1g	ROUTE: PO	0800 1200 1600 2000		AMF(8)						
INSTRUCTIONS	PHARMACY Clin / POD Y N / D/C Y N / DISP₁ / DISP₂										
SIGNATURE	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 (Y | N | No. of Days) Disp = Supply dispensed labelled and checked (Initials | Date | Quantity)

Other Charts in use		Pain		Oxygen		Additional Kardex		Other	

[illegible] VALLEY ACUTE HOSPITALS NHS TRUST

[illegible] PRESCRIPTION AND ADMINISTRATION RECORD SHEET

COPY

WARD	CONSULTANT
29B.	DR SABOOR

ALLERGIES [illegible]

PATIENT DETAILS: (Name and Address)

GARY SCRIMSHAW
6 BROOMPARK WEST
MENSTRIE

HEIGHT (m)	WEIGHT (kg)	DATE	SURFACE AREA (m²)

HOSPITAL No: HOSPITAL SITE:

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
Address

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

COPY

Ward / Dept.

19

Date: EXOCIN (R) 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 mn	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
"	04.00	
"	04.30	C Mcdonald
"	0800	C Mcdonald
	0800	C Mcdonald
	0900	C Mcdonald
	0930	
	1000	

RX403

STA109

NURSING NOTES

Write - imprint or Attach Label

Surname Scrimshaw Hospital No.

Forenames Gary Sex M

D. of B. 30.11.79

Address

COPY

Ward / Dept. 29B

Consultant

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 Wotherspoon
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 Berry
	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 CMcDonald Fr.

PATIENT PROFILE

Addressograph:

Name: GARY scrimshaw

Address: 43 East Castle STREET
ALLOA FK10 1BB

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:

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Provisional Diagnosis:

(L) eye injury
? corneal abrasion

Final Diagnosis / Treatment:

Next of Kin:

Name: MRS Scrimshaw

Address: 43 East Castle STREET
ALLOA.

Relationship: wife.
Tel. Day:
Mobile: 07706396071.
Tel. Night:

Name:

Address:

Relationship:
Tel. Day:
Mobile:
Tel. Night:

G.P. DR Borland.

Practice: Alloa 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 awake Relatives spoken to by:

Admitted by: S.J. WOTHERSPOON

Named Nurse on Admission:

Date: 26.10.06.

NAME:	Unit No:

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

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

SUPPLY

KARDEX C

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

SIG

FORTH VALLEY ACUTE SERVICES

COPY

MEDICATION PRESCRIPTION & ADMINISTRATION RECORD SHEET

WARD

ALLERGIC to

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

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6. Given > 30 mins late (state time)
7. Patient allergy
8. Patient refused
9. Withheld - medical indication
10. Given by Patient/relative/carer

PHYSICAL ASSESSMENT OF CONDITION/NEEDS	AIMS AND PLANNED CARE
6. Elimination	
Renal function: Urinary catheter in situ + removed at 1100 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	Maintain safe / effective renal replacement therapy.
Vascath site:	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 ✓
	refused shave today.
Eye condition: eyelids "puffy"	
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) 160/40 MAP: > 90	Change electrodes daily ✓
	12 lead E.C.G. Yes / (No)
Inotropes Yes / (No) Type: Art line position: (R) Radial	Aim for MAP: > 75 Aim for CVP: 8 - 12
Removed - ✓	Titrate Inotropes to ensure set parameters
CVP: + 10	Care of invasive monitoring lines : Flush Lumens x 1 per shift ✓
Temperature: 36-2	: Flush Prescribed: Yes / (No)
	: Record CSM to digits per shift ✓

PHYSICAL ASSESSMENT OF CONDITION/NEEDS	AIMS AND PLANNED CARE
3. Pain/Sedation	
Sedation:	Aim for sedation score: 0
Sedation Holiday (Yes) / No	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 & Deeply	Observe for neurological deterioration and report any changes.
Pupils 6. C5 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 ✓
	Encourage oral fluids / ~~diet supplements:~~ (Yes) / ~~No~~
Blood Sugar: 4-6 mmols	Maintain an accurate fluid balance. ✓
Sliding scale insulin regime prescribed: Yes / (No)	Weekly weight complete nutritional risk screening tool. ✓

MUST - Nutritional Risk Screening

NHS Forth Valley

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Patient Details (or attach ID label)

Name: CHI: 3011795258 30/11/1979 M
SCRIMSHAW
D.O.B: Garry
7 MOSS ROAD,
Unit/Cl TILLICOULTRY,
FK13 6NS

Ward: ONE

Date of Admission: 21.8.10

Normal weight: 10st 8 Source:

Step 1 BMI	Weight (kg)	Measured / Reported / Estimated (circle)	Height (m)	Measured / Reported / Estimated (circle)	BMI (see chart)	Step 1 Score (circle)
	67.25	Reported	5"4	Reported	27	> 20 = 0 (circled) 18.5-20 = 1 < 18.5 = 2
Step 2 Weight Loss over last 3-6 months	Wt Loss * (kg)	Measured / Reported / Estimated (circle)	% Change (see chart)			Step 2 Score (circle)
	3lb	Reported	< 5%.			< 5% = 0 (circled) 5-10% = 1 > 10% = 2

* this refers to the total unplanned weight loss over the last 3 – 6 months

Step 3 Acute Disease Effect	Acute illness AND there has been, or is likely to be, no nutritional oral intake for 5 days Not NBM = score 0 NBM = score 2	Step 3 Score (circle) 0 (circled) 2
Step 4 Overall Risk Score	Add scores from Steps 1 + 2 + 3 = Total	Total Score: 0
Step 5 Management	Develop and Implement appropriate Nutritional Care Plan	Nutritional Care Plan (circle) 0 = Low Risk (circled) 1 = Medium Risk 2+ = High Risk

Screening results reported to: L. Friel

Screening completed by: JReid Date: 22.8.10

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	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

EWS KEY	0	1	2	3	EWS 0-1: Routine Observation - state frequency 2-3: Inform Nurse in Charge 4 or above H

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	DATE:	20/8/10				21/8		22/8
	TIME:	1355	1350	1400	1420	1730	2200	0600
	Is Patient ≥70?							
RESP RATE	>30							
	26-29							
	21-25	22	25	22	24	22		
	9-20						20	20
	≤8							
SpO_2	≥94	99	97	97	97	98	97	99
	92-93							
	86-91							
	<86							
O_2 Device or Air	refer to key	8	1	1	1	A	A	A
O_2 Flow or Rate		8	2	2	2			
pt on O_2 with SpO_2	<95							
TEMP	39°							
	38°							
	37°	36.3						
	36°		35.4			36.1		
	35°							
	34°							
EWS SCORE uses Systolic BP	210							
	≥200							
	190							
	180							
BLOOD PRESSURE	170							
	160							
	150							
	140				Tubed	1144		
	130							
	120							
	110							
	100							
	90							
	80					120		
	70							
	60							
	50							
	>170							
	160							
	150							
HEART RATE	140							
	130							
	120							
	110							
	100					99		
	90							
	80							
	70							
	60							
	50							
	40							
	30							
NEURO RESPONSE	Alert					✓	✓	✓
	Verbal							
	Pain							
	Unresponsive	✓	✓	✓	✓			
EWS SCORE (with all obs)						0	0	0
	Blood Glucose	9.6						
PAIN (guidance for scoring and management overleaf)	No pain	✓	✓	✓	✓	✓	✓	✓
	Mild							
	Moderate							
	Severe							
Nausea Score 0-3		0	0	0	0	0	0	0
Initial		LW	LW	LW	LW	[illegible]	[illegible]	[illegible]

CODES FOR RECORDING OXYGEN DELIVERY ON OBSERVATION CHART

A	Air (not requiring oxygen, or weaning or on "PRN" oxygen)			H28	Humidified oxygen at 28% (also H35, H40, H60 for humidified oxygen at 35%, 40%
N	Nasal cannulae			RM	Reservoir mask
SM	Simple mask			TM	Tracheostomy mask
V24	Venturi 24%	V28	Venturi 28%	V35	Venturi 35%
V40	Venturi 40%	V60	Venturi 60%	CP	Patient on CPAP system

Early Warning Score (EWS) Trigger Protocol

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

ESCALATION POLICY
NOT FOR USE WITHIN
THE EMERGENCY DEPT

NHS
Forth Valley
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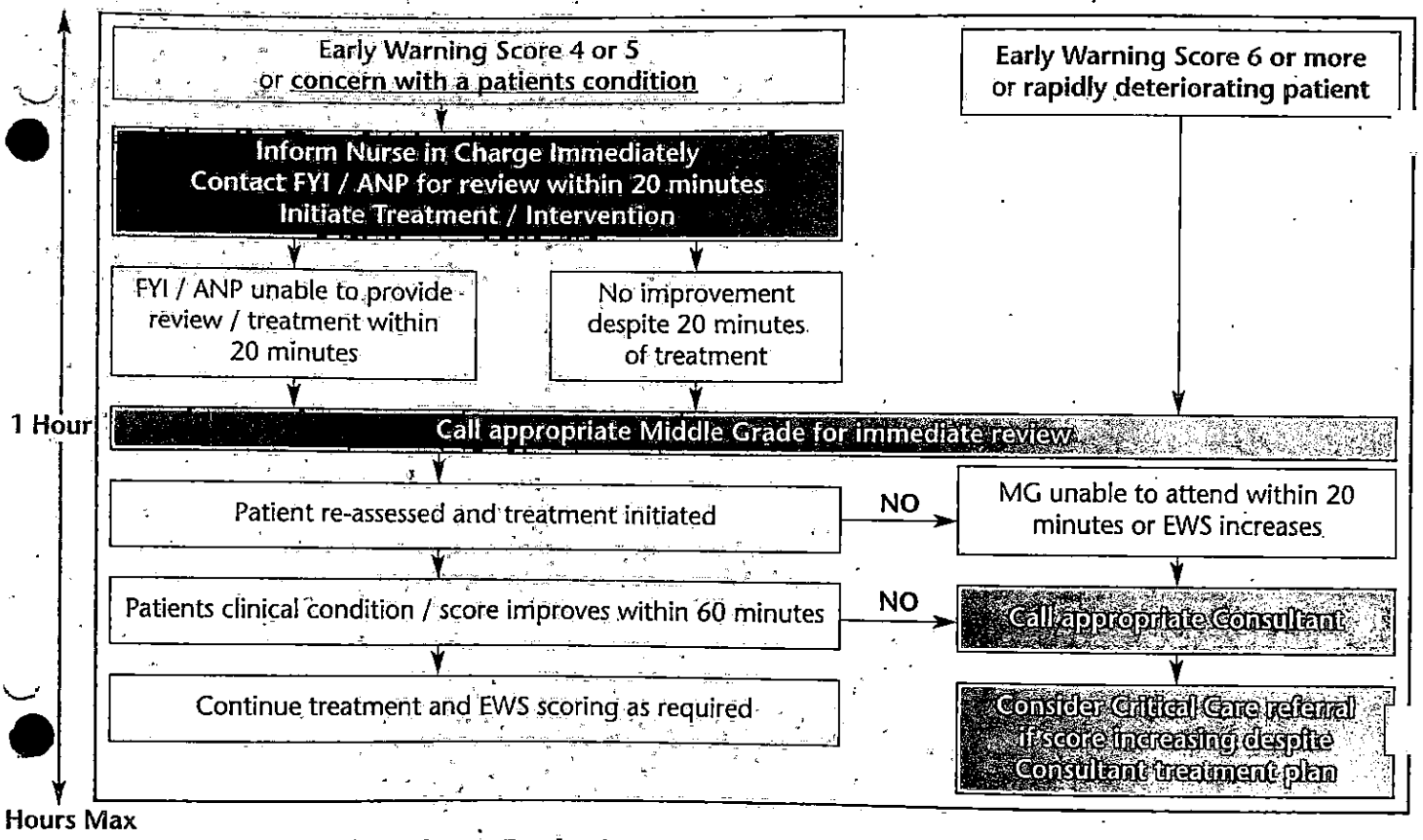
Consultant:_____ Ward:_____ Admission Date:_____

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

Staff should use SBAR in all communications
Definition
- S ituation
- B ackground
- A ssessment
- R ecommendations



Management Plan / Patient Exclusions

Date	Management of EWS Observations	Signed

Family Dialogue

COPY

Consultant: Dr. Muir
Named Nurse:

Surname:
Forenam: MR GARRY SCRIMSHAW
Preferre(7 MOSS ROAD,
Address: TILLICOULTRY,
CLACKMANNANSHIRE

Unit No: FK13 6NS
DOB:

Date	
20/1/10	20⁰⁰ => EX-WIFE JANET, 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.
	J McGrath 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

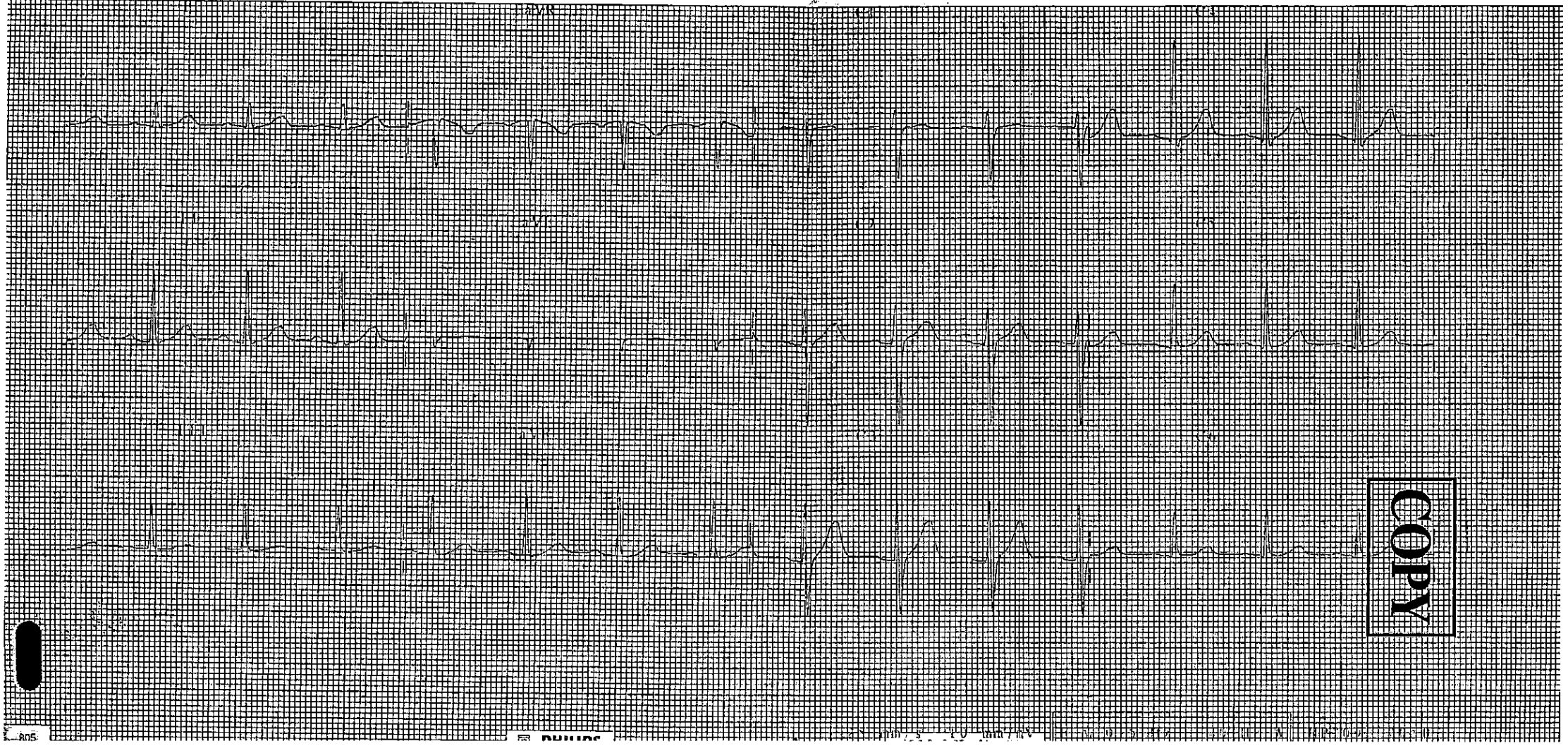
Rate	87	. AGE NOT ENTERED, ASSUMED TO ~~BE 50~~ YEARS FOR PURPOSE OF ECG INTERPRETATION .
PR	195	. NORMAL SINUS RHYTHM, RATE 87..... normal P axis, PR, rate & rhythm
QRSD	90	
QT	339	
QTc	408	

--Axis--

P	57
QRS	65
T	46

- NORMAL ECG -

Unconfirmed diagnosis.



AJQ

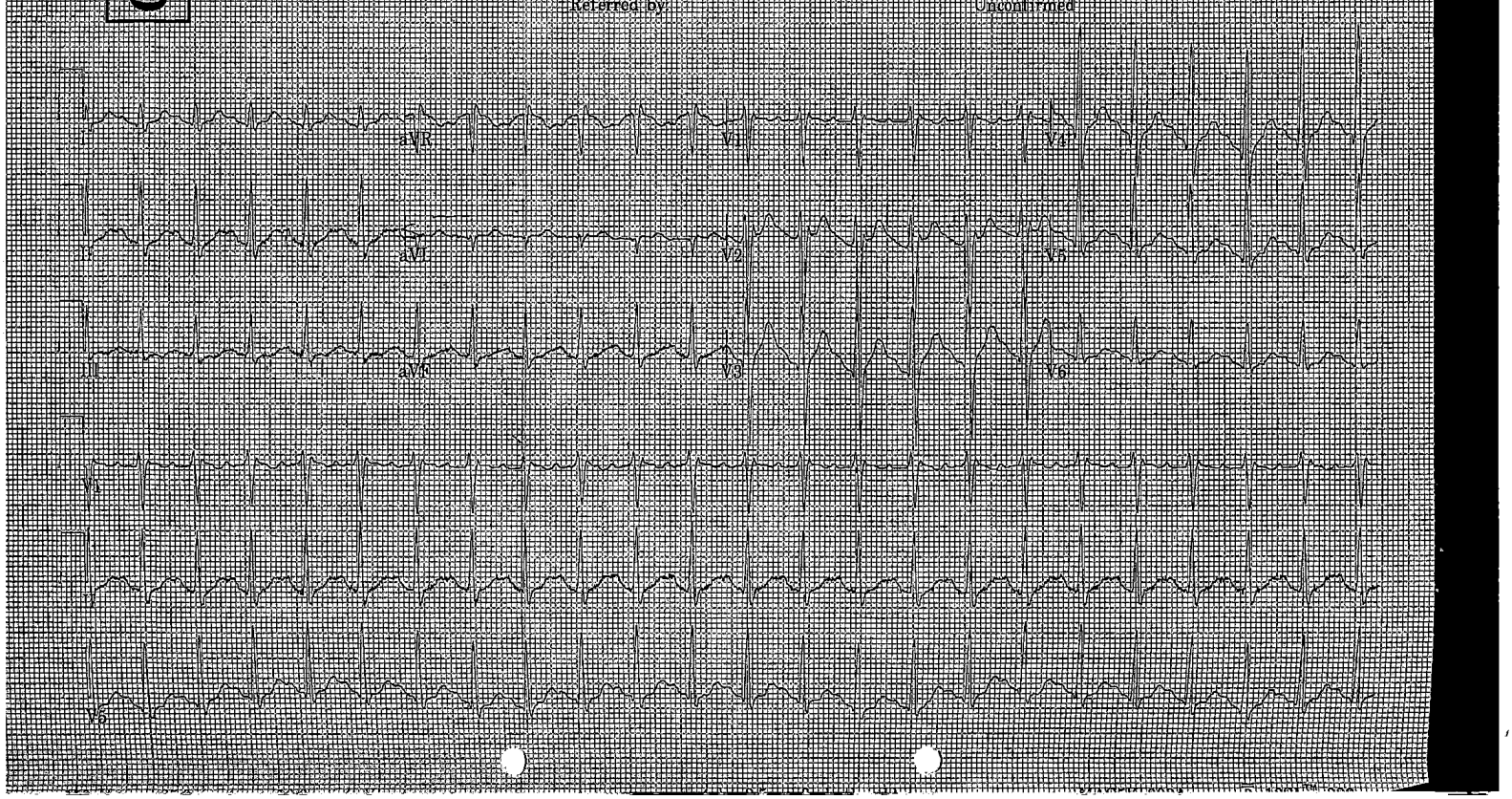
Ventricular rate 140 bpm
PR interval 122 ms
QRS duration 110 ms
QT/QTc 286/439 ms
P-R-T axes 55 74 32

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

Technician
Test Ind

CHI: 3011795256 30/11/1979 M
SCRIMSHAW
GARY
7 MOSS ROAD
TILLICOULTRY
FK13 6NS

Referred by: Unconfirmed



CLINICAL NOTES

Consultant

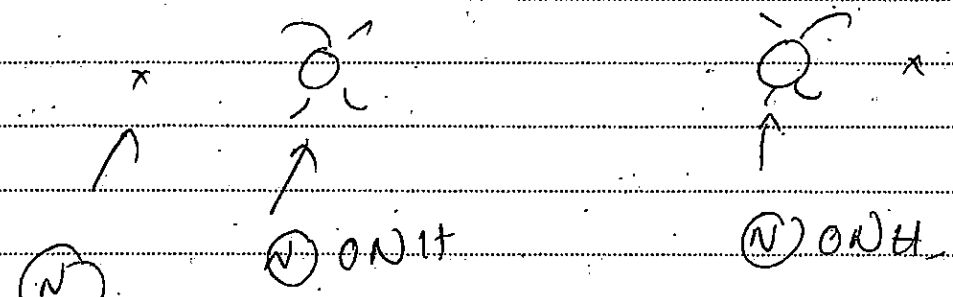
CHI:3011795258
CRN:S237397 30/11/1979
SCRIMSHAW GARRY M
Flat 4, 22 Hill Street,
TILLICOULTRY,
Clackmannanshire
FK13 6HF

label
ital No.
B.

COPY
Ward / Dept.

Date

30-8-10



Imp. ? Ocular pathology

CT g- Exocin x 4/7.

Discharge.

R Ismail
ST2.

STM 069

RX78

CLINICAL NOTES

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

COPY

Consultant AR/JAS

Ward / Dept.

Date

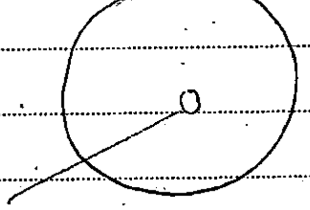
25/8/10 Optician referral with acute (R) red painful eye.

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

Δ 1/ Conjunctivitis 14
? AC activity?

✓ Dx ✓ viral

Plan: 1/ Conj swabs < bacterial / Chlamydial

2/ G. Exocin QID R.E } See 5/7
3/ Oc Viscotears QID R-E }

Show to JAS Thanks

R-E

STM 069 RX78

CLINICAL NOTES

Write - imprint or Attach Label

Surname SCRIMSHAW Hospital No. 23739?

Forenames GARY Sex M

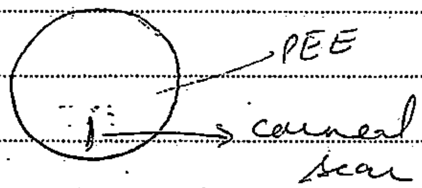
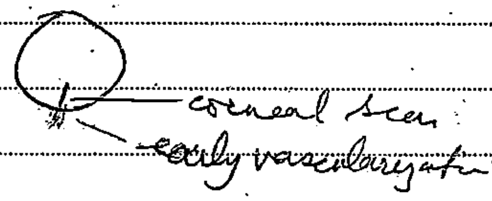
43 EASTCASTLE STREET D. of B. 30/11/1979

Address ALLOA

COPY

Ward / Dept.

Consultant P.C.C CLINIC

Date	
3/11/06 KG.	VR, 6/6 ēgls VL, 6/6
	→ No notes available
	H/O. (L) Corneal ~~ulcer~~ perforation (micro) 26/10/06 (TS oncall)
	~~p/llo~~ Treated c̄ Bandage CL.
	Using G. Exocin QID (L.E)
	
	BCL removed
	Seidel Negative
	G. Exocin } TID (L)E
	G. Vitcosteam }
	See 1/52 PCC.
10/11/06	RVA 6/5 pt LVA 6/5 with GS
	
	G. Exocin B.D } L.E
	Vitcosteam B.D }
	1/52

STM 069 RX78

CLINICAL NOTES

Consultant

Su
Fo
Ad

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

COPY

Ward / Dept.

Date	
30/10/06 LA.	Rv c gls = 6/6+3 Lv c gls + CL = 6/6.

Pt was admitted to SRI ward 29B on Thurs 26/10 + discharged Fri 27/10/06.
Attended SRI eye clinic Fri 27/10 and had soft CL inserted.

LE comfortable

RCL in place

epi microcysts

Arc quinb

pupil round

Review Friday 3/11/06 - PCC eye clinic

CLINICAL NOTES

Consultant

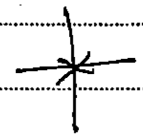
Write ... label
Serial No. ...
S...
F...
CHI: 3011795258
CRN: SZ 237397 30/11/1979
SCRIMSHAW GARRY M
A... 43 EASTCASTLE STREET
ALLOA
FK10 1BB
Ward / Dept.

COPY

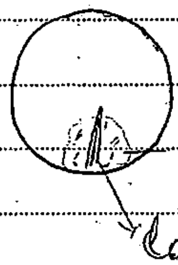
Date

27/10/6 KG
c/o irritation ++ since insertion of lens.
Not painful just very ~~...~~ uncomfortable.
- worse than prior to insertion.

O/E. lens in situ.
°tears,
p✓ c✓ m✓



Vn 6/12
c ph 6/9



X ray orbits done when 1st seen in A&E on the day of injury. ⓪ 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. 8.70:14.40:00 p✓ (initially)
c✓
m✓
Homeon
G Econ x 4 times/day

re Monday prn clinic

AM PCC

STM 069

RX78

Date

FHO: Clerk (cont'd)

COPY

DHx: None
NKDA

FHx: CVA

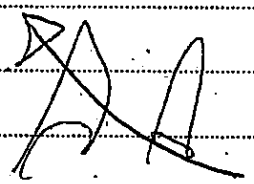
SHx: Live w/ wife
Unemployed
Retired.
Smoke <10/day.

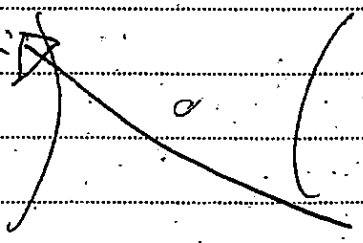
GE: Systemically well.

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
BS ✓ Pulses ✓
°Hernias.

-JC McCall
293

CLINICAL NOTES

Consultant

Write - imprint or Attach Label

Surname Scrimshaw Hospital No S237397

Forenames Gary Sex M

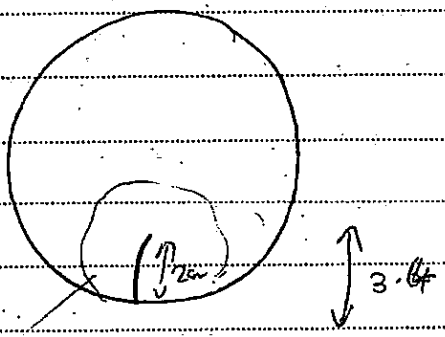
D. of B. 30/11/79

Address 6 Broompark West

Menstrie

Ward / Dept.

Date	
	Inj to (L) eye while removing 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 18mm.

Exocin 4 hrly

Review Tomorrow in clinic.

Dr. Tamrar 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 Soft Tissues

Gary Scrimshaw 5257541

~~[struck-through address]~~

43 ~~East~~ Castle Street Alloa

STIRLING ROYAL INFIRMARY

COPY

EYE NOTES 26/10/06

SN | TS

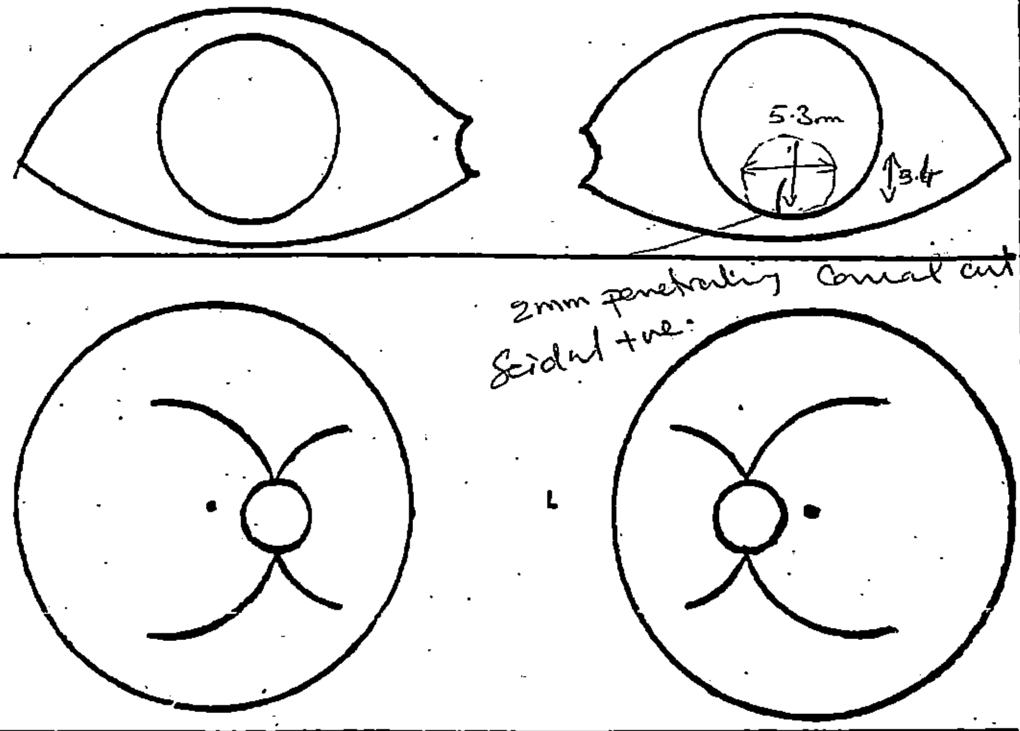
D.O.B 30/11/79

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

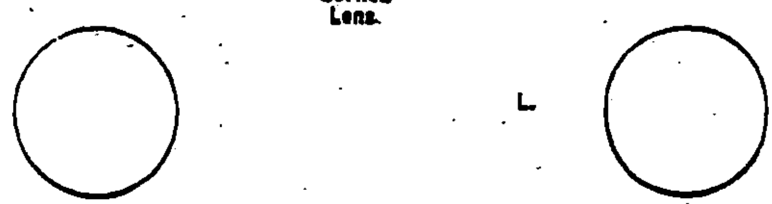
Vision: Rt eye 6/12 PH 6/9 with out glasses Lt eye 6/12 PH 6/9 with glasses

has glsses - not with him

Ext Rt Lt



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 ⑨ c/c inserted.

Flare

KP

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 watery

Pozi -

RMH -

Treatment

D/W Dr - Saboor. admit BCL 18mm. Exocin ½ hourly.

Review Tomorrow

R/L

Atropine HC Eucatropine

Phenylephrine Mydrilate Others

[signature]

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

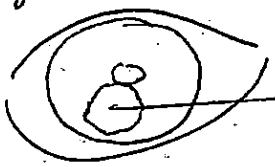
3011795258
Scrimshaw, Gary
30/11/1979 M
43 Eastcastle Street
ALLOA
55344 Dr Borland

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, Gary.

S237397

DR HUDA

THURS 11AM

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:
d.o.b. 30.11.79 Forename: GARY.
Address (optional): Phone no: 01259. 218581.

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 VOLTAREL 100DIS. ABRASION

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. [signature]
	(Will forward copy of full assessment to overall care in due course) 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

Date

arrived safetly 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 pts belongings. Pt quite anxious re same.

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 [illegible] 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

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

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: 6 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) SN. (Job title) 12° (Time)

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

Critical Care Department Care Plan

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

DAY NO: 2
CRITICAL CARE CONSULTANT(S): D. Nair
REFERRING CONSULTANT: D.

PREVIOUS 24 HOUR SUMMARY (NIGHT SHIFT TO COMPLETE):
Ventilated + sedated overnight
One episode of haemodynamic instability - resolved - use pulses
Now - 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 RA.		Maintain patent/airway. Auscultate regularly. Pre-oxygenate: Yes (No)
RR 16 - 19 SaO2 > 95%.		Ensure optimum respiratory function / ventilation. ✓
		Sit Up 45° ✓
Chest Secretions: Nil		Aim for SpO2 > 93%
Regular Physio (Yes) / No	Suctioning Required Yes (No)	Monitor ABG's and act accordingly. ✓
ABG's:		
		Weaning: Yes / No
Tracheostomy: Yes / No		Weaning plan: N/A
Oxygen Therapy Yes (/ No)	Prescribed Yes / No	
Oxygen Percentage:	Delivery System:	Reduce risk of lung infection ✓

COPY

		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	P.SIMV	(P) SIMV	SV
	FIO_2	50.	35.	35.	35.	35.	25%	21.	21%	21%	8L
	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	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15	
	Peep/CPAP	5	5	5	5	+5	5	5	+5	+5	
	T.Vol.Exp./I.PAP	591	597	580	604	601	580	597	580	598	
	M.Vol Exp./E.PAP	6.9	7.7	7.8	7.8	7.8	7.5	7.9	7.8	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	✓ ✓									
	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	3.5	4.4	4.4	4.4	3.9	
ABGS	H+ IONS		39.5				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+		3.0				3.6				
	Lactate		0.5				0.5				
			35.6°C				35.5		36.1		
	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	PROPOFOL	2 | 28	2 | 26	2 | 24	2 | 22	2 | 20	2 | 18	2 | 16	2 | 14	2 | 12	2 | 11
	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
	PROTOFOL	8 | 7	8 | 16	8 | 24	8 | 31	8 | 40	10 | 8	10 | 19	10 | 33	10 | 42	10 | 49
	/	7	9	8	7	9	8	11	14	9	7
	PROPOFOL	32 | 29	32 | 70	32 | 100	32 | 127	32 | 162	32 | 189	32 | 22	32 | 257	32 | 284	32 | 318
	/	29	41	30	27	35	27	32	36	27	34
	NG FEED	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]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
IN	Colloid										
	Drugs			50	50		20	50	50		
	Ng / Oral										
	Hourly Total	52	173	190	199	171	125	149	213	124	149
	Running Total	52	225	415	614	785	910	1059	1322	1446	1595
OUT	Urine	55	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						

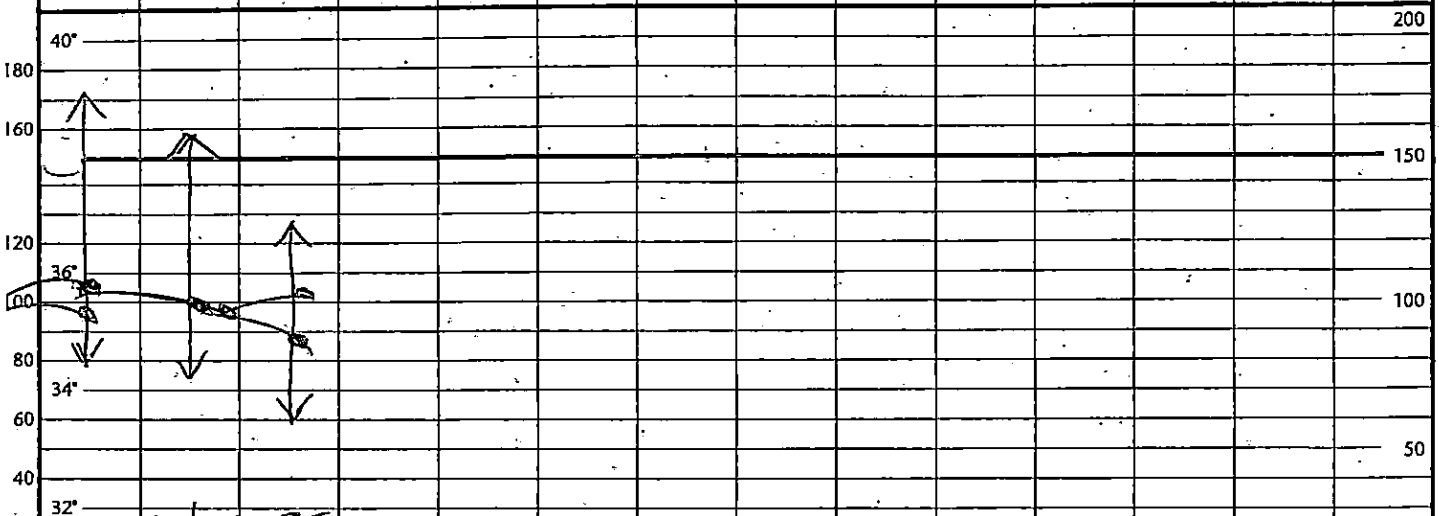
V5L.

OFF

OFF

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 OFF
112

32 350 32 379 32 443
32 29 34

(L) ✓ B ✓

150 200
294 29 34
1889 1918 1952
35

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 as per protocol	250ml	IV	5mins				
B		Gelofusin as per protocol	250ml	IV	5mins				
C		Gelofusin as per protocol	250ml	IV	5mins				
D		Gelofusin as per protocol	250ml	IV	5mins				
E	21/8/10	Hartmans	500	IV	5°		10E06[illegible] 4/13	1:00	
F	21/8/10	Hartmans	500	IV	5°		10E12 TSA. 04/13	00 90	
G									
H									
I									
J									
K									
L									
M									
N									
O									
P									
Q									

Events

COPY

		Initials
01.00	7AC => (R)	
02.00	KCL replacement – 40 mmols	
03.00		
04.00		
05.00	Propofol ↑ Wnd/hr – waking up, moving – unresponsive	
06.00	PAC => (B), KCL replacement 20mmols	
07.00		
08.00	Bed checks.	MA
09.00 30	Sedation break	
10.00	Extubated at 09:55. RR. 19. SaO2 88% → 96%	MA.
11.00	From 5 L/min	
12.00	Urinary catheter out. Taking oral fluids	A.
13.00	Refused lunch.	MA
14.00		
15.00		
16.00		
17.00		
18.00		
19.00		
20.00		
21.00		
22.00		
23.00		
00.00		

	AM	PM
Admitting team aware Y / N		
APACHE II score complete Y / N	NA	NA
Wardwatcher up to date Y / N		
Is patient ventilated Y / N (if N go to blood sugars)		
HOB > 30° Y / N		
Sedation Holiday appropriate Y / N / L.Ex / NA		
Ventilatory Weaning considered Y / N / L.Ex		
Weaning plan considered Y / N / NA		
Chlorhexidine prescribed Y / N.		
Subglottic aspiration tube Y / N / Lx		
HMEF appropriate Y / N		
Is wet circuit required?		
Blood sugar - Is insulin required Y / N /L.Ex		
Is Insulin prescribed Y / N		
Does patient have a central line Y / N (if N go to sepsis)		
New CVC line today Y / N		
Documentation completed Y / N		
Is CVC still required Y / N-If N remove (R) & send Tip for C&S		
Is dressing intact Y / N		
Sepsis Screen - Is patient pyrexia Y / N		
Has sepsis screen been completed Y / N		
Are there outstanding microbiology results Y / N		
MRSA eradication therapy required Y / N		

	AM	PM
Does patient have a PVC Y / N (if N go to AB's)		
New PVC today		
Documentation/sticker completed Y / N		
Is PVC still required Y / N (If N then remove-R)		
Evidence of inflammation / erythema Y / N		
Dressing intact Y / N		
Has PVC been in situ >72 hours Y / N		
Is pt on AB's Y / N (if N go to other activities)		
Are antimicrobials still required Y / N		
Antimicrobials prescribed as per guidelines Y / N		
Do antimicrobials require de-escalation Y / N		
Other activities		
DVT prophylaxis prescribed Y / N		
Peptic ulcer prophylaxis prescribed Y / N / L.Ex		
Patient up to sit Y / N / /Lx		
Daily goals / Plan written in medical notes		
Kardex reviewed and re written as required Y / N		
Blood results reviewed and actioned Y / N		
Assessed as per mobility chart Y / N		
Is patient ready for discharge Y / N		
Receiving informed of discharge Y / N / NA		
Discharge planning complete Y / N		
Discharge documentation completed Y / N		

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

Night Report: ① FiO_2 weaned overnight to 21%, RR ↓ 13 bpm due to ↓ CO_2. Will [illegible] changes in ventilation.
② HR 70 bpm, normotensive, Temp 35.5 – 35.7 [illegible] adequate [illegible] in [illegible].
③ Propofol ↑ 10 ml/hr => waking up – uncooperative, at risk of self-extubation.
④ Waking up, [illegible] (moves all limbs) [illegible] of [illegible].
⑤ NGT on free drainage overnight – 200 mls out. Bowels [illegible], IV fluids + Dextrose overnight.
⑥ Adequate U/O.
⑦ Regular oral care [illegible] – [illegible]. Both [illegible] [illegible]. [illegible] on [illegible] (just [illegible]). Mg [illegible] replacement [illegible], KCl replacement 80 mmols in total overnight.
Wife visited @ 20⁰⁰ – [illegible] by [illegible], expressed her 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.
[signature] S/N

Day Report:
Condition improved over morning.
Extubated and now S/V on R.A. RR 14-20 SaO_2 > 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.
C/n transfer to Ward when bed available.
To have ~~[illegible]~~ Psych review before discharge.
[signature] S/N.
(THOMSON)

3⁴⁵pm. 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.
[signature]

Critical Care Unit

NHS Forth Valley

Date: 21/8/10	Day No: 2	D.O.B.	Surname: CHI:3011795258 CRN:S237397 30/11/1979 SCRIMSHAW GARRY M 7 Moss Road, TILLICOULTRY, Clackmannanshire FK13 6NS	CHI No. COPY
Date of Admission: 20/8/10				
Diagnosis: mixed overdose				Age: 30
Critical Care Consultant: Dr. Nisi 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: 00.00 - 08.00 / 20.00 - 08.00
Urinalysis	

Fluid Balance

Intake	Output
Oral	Urine
	Gastric
	Bowel/Stoma
	Drain 1
	Drain 2
	Drain 3
Total in 2629 (1pm)	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

	D	N
Appropriate to switch off / reduce sedation? (see exclusions)		
SaO_2 (Target 94%)		
$FiO_2 \leq 0.35$?		
Secretions manageable?		
Adequate cough?		
RSB Index < 100? (F+ Vt)		
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 swab 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: 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: at risk, limited compliance	Explain all plans procedures to patients and family.
	Give reassurance / support to patient.
Sleep/rest: day / night unsure	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: G. Warwick **(Signature)** C. Norman **(PRINT NAME)** NN **(Job title)** 6:30 **(Time)**

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Critical Care Department Care Plan

COPY

PHYSICAL ASSESSMENT OF CONDITION/NEEDS	AIMS AND PLANNED CARE
6. Elimination	
Renal function: Urine catheter (Size 16 / 10 ml 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 Vascath site:	Maintain safe / effective renal replacement therapy. 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. Drains:	Redress: Aim for healthy granulation of wounds Reduce Infection

2. Cardiovascular Care	Aims Maintain Cardiac Stability
Cardiac Rhythm: ST / AF Brady 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: RA	Aim for MAP: > 60 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 infusions 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:	Drainage	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 Normal		Weekly weight complete nutritional risk screening tool.

Critical Care Department Care Plan

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

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 Psimv: FiO_2 @ 50%; PC/PS = 15; PEEP +5. SaO_2 > 94%. , FiO_2 ↓ 21%.		Maintain patent airway. Auscultate regularly. Pre-oxygenate: Yes / No
		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: as charted.		
		Weaning: (Yes) / No Aim to reduce FiO_2 / PC/PS
Tracheostomy: Yes / (No)		Weaning plan: as able
Oxygen Therapy Yes / No	Prescribed Yes / No	
Oxygen Percentage:	Delivery System:	Reduce risk of lung infection ✓ prophylactic

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NHS Forth Valley Acute Services Mobility Chart

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

NI Forth

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

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

Date / Transfers	OK 2/5	No. of staff		No. of staff		No. of staff		No. of staff		No. of staff		No. of staff		No. of staff	Comments
Move up bed	RAO	2/3													
Turning in bed	RW	2/3													
Lying→sitting over edge of bed	BE	—													
Sit to Stand	BE	—													
Trolley↔bed	PS	4													
Toileting	CATHETER	YES													
Bathing	BB	2													
Walking	BE	—													
Signature/Initial															

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

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NHS
Forth Valley

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

raden 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.

COPY

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 Hp ✓ CVP line Hp ✓

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

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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	29/3/10 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
ALLERGIES - Please use RED INK		

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

COPY

DATE OF BIRTH: AGE:

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

- 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: N. Saline 0.9%.		TOTAL VOLUME: 1000		TIME STARTED: 1335	
DOCTORS SIGNATURE:	DATE: 20/8/10.	RATE: STAT		PUMP NO.	BATCH NO. 10D1H1N 03/13
B	APPROVED DRUG NAME	DOSE	ROUTE	START TIME	INFUSION STARTED BY:
INFUSION FLUID: N. Saline 0.9%.		TOTAL VOLUME: 500		TIME STARTED: 1405	
DOCTORS SIGNATURE	DATE: 20/8/10	RATE		PUMP NO.	BATCH NO. 10E2JJSM 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

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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	Lactate										
1 2 3 4 5 6 7 8	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 /										
	PARALEX /										
	$NaHCO_3$ /										
	/										
	/										
	/										
	/										
	/										
	/										
	/										
	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										

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	P-SIMV	P-SIMV	P-SIMV	P-SIMV	P-SIMV	P-SIMV	P-SIMV
				50%	50%	50%	50%	50%	50%	50%	35%	30	25
				15 0	15 0	15 0	15 0	15 0	15 0	15 0	15 0	15 0	15
				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	5	5
				675	660	644	644	608	592	561	561	561	576
				10.1	9.9	9.6	9.6	9.0	8.8	8.4	8.4	8.4	8.7
				19	19	19	19	20	20	20	20	20	20
				HMEF	→	→	HMEF	HMEF	→	→	HMEF	→	→
								48 ↓	↓			↓	
								IMP					
				99%	99%	99%	99	99%	99%	99%	99%	99%	99%
				3.7	3.7	3.6	3.5	4.0	3.6	3.7	3.7	3.9	4.4
					35.9			36.6				36.1	
					4.04			3.94				3.88	
					95.1			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°				36.2	
				ST	ST	SR	SR	SR	VR	ST	SR	VR	VR
							+4	+4	+6	+5	5	9	+10
				5	-5	-5	-3	-5	-4	-4	-4	-4	-4
				10 45	OFF		8 18	8 16	8 16	8 14	8 21	8 29	8 38
				5			27	12	6	8	7	8	4
				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
						145 0	125 175	125 242	126 413	132 505	132 29	132 62	132 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
											Bgd 4	16 2	16 17
											Kde	50	50
												50	50
				B ✓	B ✓			B ✓	G ✓	B ✓	B ✓	B ✓	L ✓
				M	M			SM	M	J	J	J	J
				500	500								
						250							
				505	500	379	~~350~~	152	262	195	130	201	198
				505	1005	1284	1491	1643	1905	1100	1230	1431	1629
					550	460	180	80	65	65	50	50	60
											200		
					350	460	180	80	65	65	250	50	60
					550	1010	1190	1270	1335	1400	1650	1700	1760
										+200			+869

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

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

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	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	Na. Rco3	1·26% / 5004	IV	100ml/h			17[30]	M
F									
G									
H									
I									
J									
K									
L									
M									
N									
O									
P									
Q									

Events

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		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 ITU – Urinary catheter inserted	
16.00	+ BP 50/30, HR + 70; 6mg Ephedrine + 1g Metaraminol given	
17.00	C/L insertion ✓	
18.00		
19.00	PPI care taken over.	
20.00	Safety checks ✓ alarms ✓	
21.00		
22.00	TAL → (L), FiO2 & CJT, Pmax 22 & 13	
23.00	KCl 20mmols + MgSO4 2g mmols	
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:

Day Report:

1/ Ventilation - Continues on P-SIMV, FiO_2 ↓ 35%, otherwise settings unchanged SaO_2 >97%.
A/E audible bilaterally all lung fields - minimal yield of management secretions on suctioning
ABG's on chart
2/ Cardiovascularly labile at times; x1 episode of hypotension, bolus and slow bolus of calcium gluconate, no inotropic support required at present
HR 80 - 120 bpm, monitoring in sinus rhythm (12 lead ECG completed)
3/ ↓ of RASS -4/-5, on Propofol / Alfentanil infusions in progress.
4/ N/G tube in situ - ? for enteral feed - 8ml, stable
Fentanyl infusion in progress, Na HCO_3 infusion in progress
6/ Good diuresis
7/ ↓ S/ Pressure areas intact.
9/ N.I new MRSA screen obtained
10/ Family info visit this evening

SEN M Cahill
M CORKISH

Critical Care Unit

NHS Forth Valley

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Date: 20/8/10	Day No: (1)	D.O.B.	Surnam
Date of Admission: 20/8/10			First Na
Diagnosis: OVERDOSE OF TRICYCLIC ANTIDEPRESSANTS + GCS.			Address
Critical Care Consultant: Dr MAIR.			Referring Consultant:

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

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 Screened	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

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

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

	D	N
Appropriate to switch off / reduce sedation? (See exclusions)		Y
SaO_2 (Target 94%)		Y
$FiO_2 \leq 0.35$?		Y
Secretions manageable?		Y
Adequate cough?		NO
RSB Index < 100? ($F_f + V_T$)		Y
PEEP ≤ 5?		Y
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:	

Kg

Weight chart

120											
110											
100											
90											
80											
70											
60	67.25kg										
50											
40											
30											
20											
Date	22.8.10										

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Monitoring

- Complete 1-day Dietary Intake Chart on Saturdays
- Repeat Screening on Sundays or if condition deteriorates

Date	BMI Score	Wt Change over last 3-6 months Score	Acute disease effect Score	"MUST" Score	Risk Category H / M / L	Treatment Aims being met? Y/N	Action taken	Signed
22/8/10	0 +	0 +	0 =	0	L	Y		

Low Risk Nutritional Care Plan

NHS
Forth Valley
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Patient Details (or attach ID label)

Name :
D.O.B :
Unit/CH

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

Date: 21.8.10

Completed by: J. Reid.

Low Risk Actions	√
Low Risk **Set treatment aims:** • Weight maintenance • Maintain current nutritional intake	✓ ✓
Actions • Provide help and advice on food choices, eating and drinking if required. • Repeat Screening on Sunday or if condition deteriorates.	✓ ✓
Refer to the dietitian if: • Enteral Feeding is required • Specialist dietary advice is required following a diagnosis of Type 1 diabetes, renal disease, Coeliac disease. • Consistency modified diet is required e.g. smooth, soft/moist. • Patient has pressure sores grade 3 or over. • Patient has multiple fractures.	✓ ✓ ✓ ✓ ✓