Clyde SAR Team
Level E
Inverclyde Royal Hospital
Larkfield Road
Greenock
PA16 0XN

NHS
Greater Glasgow and Clyde

PRIVATE

MMA LEGAL LTD
23 GOODLASS ROAD
BUILDING B
SPEKE LIVERPOOL
L24 9HJ

Date: 23.6.2026
Your Ref: 100086
Our Ref: SART / JM / LM / 1605783439
Enquiries to: Lynne McEldowney
Direct Line: 01475 504786

E-mail: lynne.mceldowney@nhs.scot

Dear Sir/Madam

Subject Access Request under the General Data Protection Regulation

Patient: COLIN WOTHERSPOON **DOB: 16/05/1978**

Thank you for your request for records received 5th June 2026 in which you seek a copy of your client's personal information.

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

COPY INVERCLYDE ROYAL HOSPITAL MEDICAL RECORDS

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

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

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

- patient health records, photographs or Radiology images;
- video/telephone recordings, including CCTV images;
- Witness Statements;
- Incident reports

- Complaints files
- Emails

The source of our data includes patients, General Practitioners, healthcare, social and welfare organisations, legal representatives and police forces.
We sometimes need to share the personal information we process with the individual themselves and also with other organizations as listed above. Where this is necessary we are required to comply with all aspects of the General Data Protection Regulation.

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

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

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

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

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

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

Yours sincerely

Lynne McEldowney
SAR Team

ELECTRONIC PATIENT RECORDS

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

Including:

BADGERNET	☐
CAREVUE	☐
MEDICAL ILLUSTRATION	☐
METAVISION	☐
PHYSIOTHERAPY	☐
RADIOLOGY	☐
WEST MARC	☐
LABS	☐
OPEN EYES	☐
PODIATRY	☐
ORTHOTICS	☐

My Admission Record

NHS Greater Glasgow and Clyde

Nam 1605783439
Addi WOTHERSPOON
Colin M
91 NELSON STREET 16/05/1978
Largs, Ayrshire
Dol KA30 9AD
CHI.
Affix patient ID label

Hospital: iRU Ward: LS
Date of Admission: 17/1/26 Time: 0110
Information obtained from: Name:
Patient ☑ Relative ☐ Other ☐ _____
Preferred Name:
Age: 47 Telephone Number:
Consultant: Dr Jones

Communication

What is your first language? English
Do you require an interpreter? Yes ☐ No ☑
If yes, provide details of arrangements made _____
Do you use British Sign Language (BSL)? Yes ☐ No ☑
Do you need someone to help you to communicate? Yes ☐ No ☑ If yes, who _____

Preferred first contact

Name: Vera
Relationship: Mother
Address:

Telephone:
Is this person aware of your admission? ?
Yes ☐ No ☐
Can we share information with this person?
Yes ☐ No ☐

Preferred second contact

Name:
Relationship: Partner
Address:

Telephone:
Is this person aware of your admission?
Yes ☐ No ☐
Can we share information with this person?
Yes ☐ No ☐

Presenting Complaint / Diagnosis

overdose of amitriptyline

Explained to the patient? Yes ☐ No ☐ Not Applicable ☐
Do you understand the reason for your admission? Yes ☐ No ☐

Allergies / Sensitivities (Record food allergies in the Hydration and Nutrition section)

No known allergies ☑

Relevant past medical history

overdoses
x2

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place
Yes ☐ No ☐ If yes, Who asked for a copy? _____
Date they asked for a copy __/__/__ Date Obtained __/__/__

Power of Attorney / Guardianship / Adult with Incapacity

Name: _____
Address _____
_____
DoB: __
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Does someone have Power of Attorney (POA) for you?

Yes ☐ No ☐

OR

Does someone have Guardianship?

Yes ☐ No ☐

If yes, is this for:- Finance ☐ Welfare ☐ Both ☐

Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

Please obtain a copy and place in the patient's notes

Who asked for a copy?_____ Date they asked for a copy __/__/__ Date Obtained __/__/__

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

N.B. If you think the patient may lack capacity inform Medical Staff to assess and, if required, consider the need for an 'Adult with Incapacity' Section 47

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:	Yes	No
1. Been an inpatient in a hospital outside Scotland?	☐	☐
2. Received holiday dialysis outside Scotland?	☐	☐
3. Been told that you have CPE?	☐	☐
4. Been in close contact with a person with CPE?	☐	☐

If the answer is yes to **ANY** of the questions in this section, you must

- Isolate the patient in a side room ☐
- Obtain Rectal swab marked 'for CPE' ☐
- If patient refuses rectal swab, obtain a stool specimen marked 'for CPE' ☐
- **and inform the IPCT** ☐

MRSA Screening

	Yes	No	Unsure
Will the patient be an inpatient for more than 23 hours	☐	☐	☐
If **YES** complete the following section			
1. Have you ever been told that you have MRSA?	☐	☐	☐
2. Have you been admitted from another hospital/ residential setting or care home?	☐	☐	
3. Do you have a wound / skin ulcer or invasive device which you had before admission?	☐	☐	☐

If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabs

Nasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

	Yes	No	Unsure
Have you ever been informed that you are at increased risk of CJD or vCJD?	☐	☐	☐

If **YES inform the IPCT** ☐

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Lifestyle

Smoking

Are you a: smoker ☐ ex- smoker ☐ when did you stop?_____

Never smoked ☐

Do you use eCigarettes? Yes ☐ No ☐ ?

If a smoker, the NHSGGC Smokefree policy has been explained and Nicotine Replacement Therapy (NRT) has been offered

Yes - administered NRT ☐ Yes - patient declined NRT ☒

If declined - Why:_____

Do you want to talk to someone about your smoking? Yes ☐ No ☐

If yes, refer to Smokefree Services (Trakcare) Date referred: ___/___/___

Drugs

Do you use recreational or illicit drugs or are you receiving opiate replacement therapy (ORT / Methadone / Suboxone)? Yes ☐ No ☐ ?

If yes, please specify and refer to the NHSGGC Guidelines for the Management of Drug Users in Glasgow and Clyde Acute Hospitals

_____

_____

Alcohol

Do you drink alcohol? Yes ☐ No ☐ ?

How often do you have more than 6 units of alcohol on one occasion:

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

NB: If daily or almost daily commence the Glasgow Assessment and Management of Alcohol (GAMA), complete FAST Tool and take further action as per guidance.

Name (Please PRINT): ROOCUERTU Signature: ROOC

Designation: ROOV Date: 17/1/26.

My Assessment Record

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1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems	✓	✓	
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			

Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems	✓	✓	
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

	Yes ✓	No ✓	Assessment of the patient's communication needs
Do you have any difficulties communicating your needs?		✓	
Do you have any difficulties with your speech?			
Do you have a Learning Disability?			
Do you have support from a Learning Disability Team? Contact details: _____			

Name:
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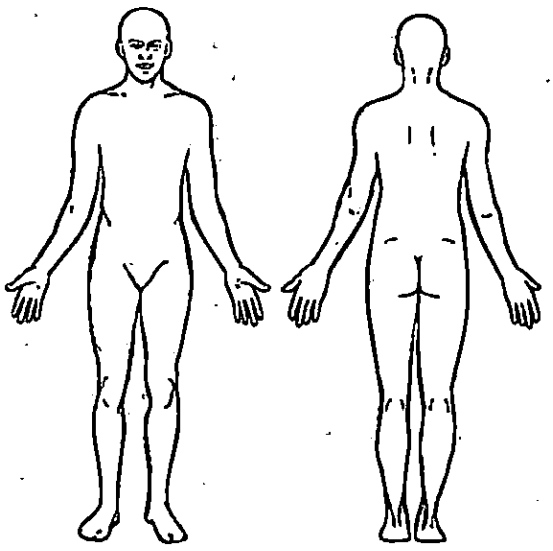
3. Senses

Vision	**Yes** ✓	**No** ✓	Assessment of the patient's vision
Do you have any problems with your vision?			
Do you wear glasses?			Distance ☐ Reading ☐ Both ☐
Do you have your glasses with you?			
Do you wear contact lenses?			
Do you have your lenses with you?			
Do you wear a prosthesis?			
Hearing	**Yes** ✓	**No** ✓	Assessment of the patient's hearing
Do you have any problems with your hearing?			
Do you have any hearing loss?			
Do you use a hearing aid?			
Do you have your hearing aid(s) with you?			
Pain	**Yes** ✓	**No** ✓	Assessment of the patient's pain
Do you have pain?			

Can you describe where and what the pain is like?

Mark current pain on body chart



Have you had treatment / intervention for the pain?

N.B. Complete generic pain assessment chart. If unable to self report complete Abbey Pain Scale.

Can you describe any chronic pain that you have?

What makes the pain better?

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4. Cognitive Status THINK DELIRIUM

	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's cognitive status
Alert and orientated		✓	
Impaired conscious level			
Confused	✓		
Dementia			
Stressed / Distressed			

N.B. Think Delirium

Complete 4AT for all patients 65 and over, AND for patients of any age with one or more of the following:

- existing cognitive impairment
- previous delirium
- current hip fracture
- severe illness

and follow the guidance

N.B. 'Getting to Know Me' and 'What Matters to Me' should be completed for all patients with dementia, cognitive impairment or complex needs

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

What do you like to eat and drink?

What do you not like to eat and drink?

N.B. Malnutrition Universal Screening Tool (MUST) to be completed for all patients within 24 hours of admission

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓
Normal diet and fluids	✓	✓
Therapeutic diet		
Cultural, ethnic or religious diet		
Texture Modified Diet Please state _____		
Thickened Fluid Please state _____		
Oral Nutritional supplements Preferred flavour _____		
Enteral Nutrition		
Parenteral Nutrition		
Nil by Mouth		

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Assessment of the patient's hydration and nutrition needs

N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharnygeal Swallow Symptoms (STOPSS) within 4 hours of admission

Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓
Independent (Green)		
Prompting / encouragement / opening packets/cutting up food (Amber)		
Full assistance with eating and drinking (Red)		

Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?

6. Elimination

Bladder	Admission Presentation ✓	Normal for the patient ✓
Pass urine with no problems	✓	✓
Frequently pass urine during the day		
Frequently pass urine overnight		
Sense of urgency when need to pass urine		
Urine retention		

Assessment of the patient's elimination needs

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓
Haematuria		
Incontinent		

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_____
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N.B. If new incontinence report to medical staff to rule out infection or physiological cause

What products do you normally use for this continence issue?

No urinary catheter ☒ Urinary catheter in situ: Urethral ☐ Suprapubic ☐

Date urinary catheter last changed ___/___/___

N.B. If Urinary Urethral Catheter (UCC) in situ commence NHSGGC Adult UCC Insertion and Maintenance Care Plan

Bowels

When did your bowels last move?

How often in a day/week do you have a bowel movement? Per day ☐ Per week ☐

Do you use any medication e.g. laxative to help your bowels move? Yes ☐ No ☐

Bowel Habit	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Regular			?
Constipated			
Diarrhoea / loose stools			
Blood in stools			
Incontinent			

What products do you normally use for this continence issue?

N.B. If concerned about bowel patterns (e.g. infrequent movement or frequent loose stools) consider using the Bristol Stool Chart

Stoma	Yes ✓	No ✓	Assessment of the patient's needs in relation to their stoma
Do you have a stoma?			?
Do you require assistance with your stoma care?			
Have you brought any of your stoma products with you?			

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7. Personal Hygiene, Oral Health, Skin Care and Wound Care

Personal Hygiene	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's personal hygiene needs
Independent		✓	
Requires assistance with washing and dressing	✓		
Oral Health	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's oral health needs
No problems	✓	✓	
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			
Dental work	**Yes** ✓	**No** ✓	Description of any dental work
Do you wear dentures?		✓	
Do you have your dentures with you?			
Are your dentures a good fit?			
Do you have any other dental work that we need to be aware of?			
Skin Care	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's skin care needs
No problems			
Skin broken			
Skin oedematous			
Skin discoloured / red			

N.B. Complete PUDRA for all patients within 8 hours of admission

Pressure ulcer identified on admission: Yes ☐ No ☐

Pressure Ulcer Grade: _____

Pressure Ulcer Site: _____ **Adult wound assessment and management chart required**

N.B If Grade 2 pressure damage on ankle or below refer to Podiarty via TrakCare

Wound Care	Yes ✓	No ✓
Do you have any wounds? **N.B. If yes, complete an assessment chart for wound management**		✓

Name: ___
Address: ___
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Colin
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Affix patient

8. Mobility

Mobility	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's mobility needs
Fully mobile and independent			AOR patient at arrival. ? baseline
Unsteady when walking			
Do you use a mobility aid	Yes ☐	No ☐	
Do you have your mobility aid with you?	Yes ☐	No ☐	

N.B. If not fully mobile and independent on admission complete moving and handling assessment within 24 hours of admission

9. Maintaining a Safe Environment

N.B. Complete a falls risk assessment for all patients within 24 hours of admission. If a falls risk is identified complete the falls intervention checklist and document all nursing actions in the care plan.

Safety	Yes ✓	No ✓	Assessment of the patient's ability to maintain a safe environment
Is the patient at risk of falling, rolling, slipping or sliding from the bed?		✓	
Would you like bedrails to be used while in hospital?	✓		

N.B. If yes, to either of the two questions above complete a bedrail risk assessment

10. Sleep and Rest

Sleep	Yes ✓	No ✓	Assessment of the patient's sleep and rest needs
Do you have any difficulties with sleeping?		✓	
Do you do or use anything to help you sleep?		✓	

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11. Social Circumstances

Do you:

Live alone	☐	Live with family/ friend/ other	☐
Live in a nursing home	☐	Live in a care home	☐
Live in residential supported care	☐	Live in student accommodation	☐
Live in 'homeless' accommodation	☐	Have no fixed abode	☐

Other please specify_____ ☐

Dependants	**Yes** ✓	**No** ✓
Do you have any dependants?		
Do you support anyone (e.g. partner, children, relatives, animals)?		
Do they need support from someone else whilst you are in hospital?		
Would someone else be able to provide this support when you are in hospital? If yes, who?		

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

Services	**Yes** ✓	**No** ✓
Do you have support from social work, social services or a care package?		✓
If yes, please provide details:		
If yes, has contact been made to cancel arrangements during admission?		

12. Emotional and Spiritual Care

Do you have a religion or beliefs that we can help you observe while you are in hospital?

Is there anything else with regards to your values, religion or culture that we can support you with during your stay in hospital (e.g. prayer meditation)?

Would you like to talk to someone (e.g. Hospital Healthcare Chaplain) about you, your loved ones, your values and beliefs, or any worries you have? Yes ☐ No ☐

Healthcare Chaplain informed Yes ☐ N/A ☐

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Address
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13. Person Centred Care

What matters and is important to you whilst you are in hospital?
This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

N.B. Participating in 'What Matters to Me' should be offered to all patients

Informal Support

Who is important to you, to help support you whilst you are in hospital?

NB. If the person who helps is not a preferred contact please ensure their details are listed below.

Name: .....

Contact Details: .....

.....

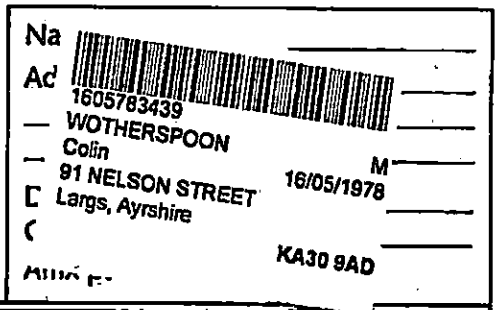
.....

How do you want the people who matter to you to be involved in your care?

Do you have someone who looks after you or someone that helps you, i.e. an informal carer?

Yes ☐ No ☐

If yes, has the help or support listed above been confirmed with the patient's family/ friends? (please tick) Yes ☐ No ☐



Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?

Yes ☐ No ☐

Referrals can be made via the central phone number: 0141 452 2387

Has the carer been advised of the Carers Information Line?

Yes ☐ No ☐ Not appropriate at this time ☐

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐ No ☐

Are you:

Employed ☐ Unemployed ☐

Self-employed ☐ Retired ☐

Full time education ☐

Has your health had an impact on your ability to carry out your day to day activities at work?

Yes ☐ No ☐ Not applicable ☐

Do you have any money worries?

Yes ☐ No ☐ Not appropriate to ask at this time ☐

If yes would you like referred to a money advice service that can offer confidential advice/ support?

Yes ☐ No ☐ If yes when was patient referred ___ /___/___

Would you like a referral to a service that can support you with employment / education/ training/ skills volunteering?

Yes ☐ No ☐ Not applicable ☐ Not appropriate to ask at this time ☐

If yes when was patient referred ___ /___/___

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Risk Assessments/Other Documentation

Additional NHSGGC Documentation	Required		Required documents completed		Date, Print and Sign when completed
	Yes ✓	No ✓	Yes ✓	No ✓	
Glasgow Assessment and Management of Alcohol (GAMA)					
Generic Pain Scale Assessment Chart					
Abbey Pain Scale (if unable to self report pain)					
4AT and TIME for Detection, Management and Prevention of Delirium					
Getting to Know Me – Relatives to complete					
What Matters to Me					
Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)					
Malnutrition Universal Screening Tool (MUST)	✓				
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan					
Bristol Stool Chart					
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓				
Adult Wound Assessment and Management Chart					
Moving and Handling Assessment					
Falls Risk Assessment	✓				
Bedrail Risk Assessment					

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
	Patient admitted to LS via ED.	
	BIBA with overdose - partner	
	found patient with ↓ ACS	
	and empty packets of	
	amitryptyline around him.	
	On arrival LS NOVS (5)	
	PR 96, now cyanosed + temp	

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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
	35.6, GCS 14/15	
	medical R/V	
imp-	Amitriptyline OD.	
plan-	monitor BM → if ↓ needs	
	glucogel / IV glucose if	
	uncooperative	
-	↓ R/V in AM	
-	? D/C have AM - think	
	he remains medically fit.	[illegible]
	patient not answering any	
	questions for admission - will	
	need hx. from family	[illegible]
0050	NEWS (3) for new confusion.	
	Patient has refused BM	
	checks - medics aware	[illegible]
1000	Pt remains asleep.	
17/11/26.	↓ referral made.	
	voicemail message left	[illegible]
1200	Partner called +	
	voiced concerns re	
	pt's mental state,	
	is due in court soon	
	receiving threats +	
	staying in Largs.	
	Pt refused to talk	
	to ↓. Told them +	
	nursing staff to "F---off"	

Name: _____
Address: _____
_____
_____
DoB: _____
CHI: _____
Affix patient ID label

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KA30 9AD

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
	medics aware	
	able to carry out	
	assessment will rv	AO
	if pt changes mind.	AOAgnew RGN
1500	dlw Dr Jones.	
	pt for discharge	
	refusing. ↓ partner	
	informed. hospital	
	ten booked. pt	
	threatening to (sve)	
	hospital. Then	
	faked a seizure	
	Alert talking	
	throughout.	AO
		AOAgnew RGN

Patient Label

Care Plan

NHS Greater Glasgow and Clyde

Date Commenced and Signature	7. Personal Hygiene, oral care, skin care and wound care	Date Discontinued and Signature	Date Commenced and Signature	9. Maintaining a safe environment, Technical Care	Date Discontinued and Signature
RD 17/1/16	ROL ? baseline		RD 17/1/16	Ensure bed space kept clear.	
				10. Sleep and Rest	
			RD 17/1/16	Promote sleep/rest	
	8. Mobility				
RD 17/1/16	ROL patient at arrival ? baseline			12. Privacy, dignity and sexuality	
			RD 17/1/16	Respect at all times	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

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Care Plan

NHS Greater Glasgow and Clyde

Care discussed with patient ☐ Yes ☐ No ☐ Unable			If unable, give reason:			
Care discussed with family ☐ Yes ☐ No ☐ Unable			If unable, give reason:			
Date commenced & signature	1. Breathing and circulation		Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
RD 17/1/26	Obs as per NEWS			RD 17/1/26	getting better	
					5. Hydration and Nutrition	
				RD 17/1/26	Normal diet + fluids	
	2, 3. Communication and senses					
RD 17/1/26	?					
					6. Elimination	
	4. Cognitive status			RD 17/1/26	independent	
RD 17/1/26	confused @ present GCS 14/15					

Care Rounds Checklist

Date: 17/1/26

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

1. Signed [signature] Name [illegible] Designation Nurse
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach Address Label

1605783439
WOTHERSPOON M
Colin 16/05/1978

Ward:

NHS Greater Glasgow and Clyde

'Must dos ... ere is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	01/10	04/20	08/08	09/20	12/15														
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	S	N	N	N														
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N		N	N	N														
S	3	**SKIN INSPECTION** Pressure areas checked:	N	N	N	Y	Y														
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	-	-	/																
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y														
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	R	L	R	B	R														
		Chair Assist to walk or stand (W/ST)	ST																		
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		S	S	I	I														
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N														
		Drink taken?	NT	S	S	Y	Y														
		Food, snack, or supplement taken?	NT	S	S	A	A														
		Has oral hygiene been carried out as per care plan?	N	S		N	I														
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y														
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	N	N	N	N	N														
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	N	S	N	N	N														
		Care provider / role	FR	FR	RN	RN	RN														

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

1605783439
WOTHERSPOON M
Colin 16/05/1978
91 NELSON STREET
Largs, Ayrshire
KA30 9AD

GI IS
TC PATIENTS

FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission and on Transfer to Another Ward

NHS Greater Glasgow and Clyde

Action the following safety precautions on admission to your ward.
Update weekly or on change of condition.

	Ward: LS Date: 17/1/26 Time: 21:40	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	✓				
2. Check walking aid (if required) is in reach and in use.	no				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	✓				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	✓				
5. If glasses are worn, check they are available and in use.	?				
6. If hearing aid/s are worn, check they are working and in use.	?				

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).
Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.
ALL patients in older people's wards must have an interventional plan in place (overleaf)

Tick Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has the patient fallen in the last 6 months – including during this admission?		✓								
2. Does the patient have cognitive impairment or a possible delirium?		✓								
3. Does the patient attempt to walk alone although unsteady or unsafe?		✓								
4. Does the patient or their relative have a fear or anxiety of the patient falling?		✓								
5. Based on your clinical judgement, is this patient at high risk of falling?		✓								
Signature of nurse completing assessment / update		[illegible]								

Highlight risk of fall at the ward safety brief.

Patient Details

FALLS INTERVENTION CHECKLIST

NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----
BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)					
Assess if a low bed is required (Patient care plan 9)					
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)					
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)					
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.					
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)					
Document continence problems and link to care rounding (Patient care plan 6)					
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)					
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.					
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)					
Update the ward team of the patient's mobility status. (Patient care plan 8)					
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)					
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)					
Signature of nurse completing Interventional plan / or update					

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

1605783439 M
WOTHERSPOON
Colin
16/05/1978

Att

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

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

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

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Check Skin	Signature
17/16	0155	~	y	~	~	~	~	4 hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	

Patient Centred SSKINS care plan

Aim: to provide effective pressure ulcer prevention strategies to reduce/eliminate potential for pressure ulcer development.

NB. Avoid patients lying on back/sitting for prolonged episodes, a total change of position is required, standing only is not sufficient

Attach Addressograph

NHS Greater Glasgow and Clyde

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

Person [redacted] Moving and Handling Assessment Form

1605783439

Person's Name:	WOTHERSPOON Colin 91 NELSON STREET Largs, Ayrshire	M 16/05/1978	Person is totally Independent (tick here and go to date box)

1. General In

Bo

Weight

Kg

cm

BMI

KA30 9AD comprehension, behaviour, co-operation (specify):

Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):

Risk of Falls: Yes | No

2. Sit to Stand to Sit Transfers (including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 / 2 / ≥3	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 / 2 / ≥3	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N/A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 / 2 / ≥3	Additional Information:	
	Monkey pole			
	Independant bridging			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 / 2 / ≥3	Additional Information:	
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 / 2 / ≥3	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify)			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 / 2 / ≥3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 / 2 / ≥3	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Ateo)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 / 2 / ≥3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

AOZ pat slid on arrival ? baseline

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

Continuation Sheet

1. General Information (Only complete this section if changed from over page)

Body Build		Problems with comprehension, behaviour, co-operation (specify):
Weight	Height	
Kg	cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
BMI		
Risk of Falls: Yes ☐ No ☐		

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist ☐	Standaid ☐	Walking Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
Model		Aid Type	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist ☐	Standaid ☐	Walking Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information:	

4. Move on / off bed pan

Hoist ☐	Manoeuvre ☐	Assistance ☐	Supervision ☐	N/A ☐
See No 2 Sit to Stand Transfers for details	Roll patient ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information:	
	Monkey pole ☐			
	Person bridges ☐			

5. Move up / down bed

Hoist ☐	Handling Aids ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details	Sliding sheets ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information:	
	Monkey pole ☐			
	Rope ladder ☐			

6. Lateral Transfer to / from trolley / bed

Hoist ☐	Handling Aids ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify) ☐			

7. Sit up over side of bed

	Bed Rest ☐	Assistance ☐	Supervision ☐	Independent ☐
		People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment ☐	Handling Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
Shower ☐	Shower chair ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath ☐	Shower trolley ☐			
Bed bath ☐	Bathing hoist (eg Alent) ☐			

9. Walking

No Walking ☐	Walking Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
	see 'sit to stand transfers'	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	4th Assessment	5th Assessment	6th Assessment
Recording Symbol:	☐ / Forward slash	☐ X Where a forward slash exists, add a back slash to make a cross	☐ * Where a slash or cross exists add slashes to make a star
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

NHSGGC Bedrail Risk Assessment

1605783439
WOTHERSPOON
Colin
91 NELSON STREET
Largs, Ayrshire
KA30 9AD
M
16/05/1978
NHS Greater Glasgow and Clyde

This Risk Assessment Tool is an aide memoire for staff. It should be used in conjunction with the Bedrail Guidance (see reverse) and Guidelines for Falls Prevention and Management (Adults).

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

Patient Nam
CHI Number

Use guidance on the reverse of this document when completing this Risk Assessment									
	DATE	17/1/16							
	TIME	0145							
	WARD	LS							
	HOSPITAL	URU							
SECTION ONE – GENERAL		Y	N	Y	N	Y	N	Y	
1	Is the patient likely to fall, roll, slip or slide from the bed?		✓						
2	Has the patient requested the use of bedrails?		✓						
IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED									
SECTION TWO – COGNITIVE AND PHYSICAL STATUS									
3	Is the patient at risk of climbing out of bed?		✓						
4	Is the patient stressed, delirious or restless?		✓						
5	Is the patient small in stature?		✓						
6	Does the patient have an unusually large or small head that might present an entrapment issue?		✓						
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?		✓						
IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
SECTION THREE – COMMUNICATION									
8	Has the patient been consulted regarding the use of bedrails?	✓							
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition	✓							
10	Has the use of bedrails been discussed with relatives/carers?		✓						
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?		✓						
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?		✓						
IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
SECTION FOUR – DECISION MAKING		Y	N	Y	N	Y	N	Y	N
13	Will bedrails be used for this patient at the present time?	✓							
14	Rationale for use of bedrails: (Please insert code in the box on the right)								
	A – Risk of falling from the bed								
	B – Risk of rolling from the bed								
	C – Risk of slipping from the bed								
	D – Risk of sliding from the bed								
	E – Patient request								
15	Bedrail risk assessment completed by:	RD							
16	Bedrails checked by:	RD							
17	Date	17/1/16							

Any issues relating to the use of bedrails including discussion with family/relatives/carers should be recorded here

A. Alternatives to bed rails:-

- Move the patient to a more observable area
- Increase patient observation
- Ensure the bed is returned to the lowest height appropriate to the patient needs, after care delivery
- Ensure patient needs are anticipated e.g. drinks are accessible, regular toileting, call bell to hand
- Nursing patient on mattress on the floor should be the last resort, and safety checks should be made for hot pipes, trailing wires, electrical sockets etc
- A generic moving and handling assessment must be carried out for staff caring for patients nursed on mattress on the floor.
- Contact Hospital Falls team for advice where appropriate

B. If bedrails are to be used, please consider the following:-

Is patient:-

- Stressed, delirious or restless
- At risk of entrapment
- At risk of climbing over the top of the bed rail
- At risk of being psychologically affected by the use of the bed rail

C. Safe use and application of bedrails:-

- If bedrail is fitted and there is a gap between the lower rail and the mattress then a bedrail should not be used
- If the gap between the bars on the bedrail is greater than 12cm then a bedrail should not be used
- If the bedrail moves away from the side of the mattress then a bedrail should not be used
- If the gap between the bedrail and the headboard is between 6cm and 25cm then a bedrail should not be used
- If the gap between the bedrail and the footboard is between 6cm and 25cm then a bedrail should not be used
- If the bedrail has not been fitted correctly then the bedrail should not be used
- If the bedrail is not secure then the bedrail should not be used
- If the bedrail is not compatible with the frame it will be fitted to then a bedrail should not be used
- If the bedrail is not in good working order then the bedrail should not be used

D. Record keeping:-

All of the following should be recorded:-

- Date and time of assessment
- Bedrail information leaflet given to patient and-or next of kin
- Rationale for decision in care plan or in AWI treatment plan
- Where bedrails are considered appropriate and patient has declined their use
- Any other actions implemented
- Care planning should be reviewed and updated as per record keeping standards

Bedrail risk assessments should be made as follows:-

- On admission
- If patient's condition changes or fall / suspected fall from bed
- Daily/weekly depending on the patient's status

NHS Greater Glasgow and Clyde

Emergency Department Mental Health Assessment

1605783439
WOTHERSPOON
Colin
91 NELSON STREET
Largs, Ayrshire
KA30 9AD
M
16/05/1978

Nursing Triage

Reason for Attendance	
Overdose (needs medical assessment)	✓
Self-injury (needs wound management)	
Other Mental Health Presentation	
Brief outline ? overdose amytriptiline ↓GCS	
Accompanied by... No one	

Observations

GCS	BM	HR	BP	RR	SaO²	Temp
8/15	3.4	89	114/81	19	99	39.3

Patient description
Small build
Black/grey short hair
tracksuit bottoms
Hospital gown

Police presentations - patients under arrest can often be seen by Police Custody Healthcare - if not they may be suitable for direct referral to MH Hub

Initial Presentation, Appearance and Behaviour — respond yes or no to each question			
Is the patient quiet and withdrawn?	unable to assess ↓GCS	Y	N
Is the patient preoccupied, erratic or impulsive?	↓GCS	Y	N
Is the patient currently expressing suicidal thoughts?	↓GCS	Y	N
Is the patient obviously distressed, markedly anxious or highly aroused?	↓GCS	Y	N
Do you think the patient is behaving inappropriately to their situation?	↓GCS	Y	N
Do you think the patient's thoughts are disordered or illogical?	↓GCS	Y	N
Do you think the patient feels their actions are being controlled?	↓GCS	Y	N
Do you think the patient is likely to abscond prior to assessment?		Y	N
Do you think the patient is an immediate risk to you*, others, or themselves?		(Y)	N
Are you aware of a history of mental illness or previous self-harm?	?	Y	N
Are you aware of a history of violence and aggression?	?	Y	N
Is the patient currently intoxicated with alcohol or other substances?	?	Y	N

*Do not tolerate violent or aggressive patients. Make yourself safe - leave the room, call for help, alert security, etc

these responses indicate Higher Risks

these responses indicate Lower Risks

Other info (record concerns of family, friends, or others.

advise family/friends to inform staff if leaving patient

Immediate Actions

consider GMAWS and pain relief, discuss enhanced observation of the highest risk patients (eg 1:1 supervision) with nurse in charge

Patient placement

Higher risk patients should be accompanied and/or supervised and in the clinical area if possible

Child protection or vulnerable adult concern	
Patient is young person in foster or residential care	

Name A Clark Grade 5

Signature [signature] Date 16/1/16

Medical Assessment of Mental Health

patient name (use sticker)

CHI

notes on ED card? (physical health assessment in overdose or self harm) | Y | N

outline of current presentation and precipitating factors

Current or previous mental health problems - self-harm, problematic alcohol and drug use, contacts with mental health services, existing diagnoses, prescribed medications, etc

Other info - relationships, finances, employment, housing, health, protective factors

patient has childcare responsibilities, or cares for a dependent adult | Y | N

Information from other sources, concerns of relatives, friends, carers, etc

- Relative/Friend
- PRF/Police
- Clinical Portal
- MHhub
- other

Patient factors

- problem alcohol or drug use
- history of self-harm
- lack of social support
- unemployed or retired
- ongoing suicidal intent
- current psych treatment
- previous violent methods
- disengaged / non-compliant
- chronic illness / pain
- family concern about risk
- previous psych treatment
- access to lethal means
- family history of suicide
- planning or concealment

Presentation

Appearance

Behaviour

Mood

Speech

Thought

Insight

patient name (use sticker)

CHI

Audit / QI info

EDC? prehospital / in ED

Intoxicated? alcohol / drugs

Aggressive? physically / verbally

police involved?

ED Management analgesia, sedation, GMAWS, NAC, restraint, refreshments, etc

Careful consideration should be given to patients who present particular risks, including those in the post natal period, those with first presentations of self-harm, especially in adolescence or old age, or those with likely psychotic symptoms.

Plan for further assessment

Referral to Mental Health Hub (includes CAMHS). 0141 211 6627

referral call time | name of CPN

return call time

discussion summary

outcome (tick one)		means of transfer?
	assess at MH Hub*	
	assess within ED	
	alternative support	

Referral/Signposting - other services

- Compassionate Distress Response
- CAMHS - current patient
- CMHT - current patient
- ADRS / CAT - current patient
- Police Custody Nursing
- Liaison Addictions Service
- Navigators
- EPIC card
- Notification of Concern (SW)

Other

*SCAN ED CARD AT DISCHARGE FOR ALL PATIENTS ATTENDING MH HUB

Advice and information given on discharge

ED Senior advice? Discharge Time

If the patient is responsible for childcare a Notification of Concern must be completed. AP1 forms can also be completed if a vulnerable adult is affected. If a young person in foster/residential care attends after self harm, Social Work must be informed independently of any carers present.

Name

Signature

Grade

Date

Write

Name: 1605783439
Address: WOTHERSPOON Colin M
CHI: 91 NELSON STREET 16/05/1978
DOB: Largs, Ayrshire
Hospital & Ward: KA30 9AD

ıeral Venous ıla (PVC) Insertion ntenance

omplete insertion details
PVC inserted
maintenance to be
ken & documentation
ted twice each day.

Modified Visual Infusion Phlebitis (VIP) Score		
PVC site appears healthy	0	No phlebitis: Continue care and maintenance
Either slight pain or redness near site	1	Possible first signs: Observe PVC site
Two or more: pain / redness / swelling	2	Early stage of phlebitis: Remove and resite PVC
All: pain / redness / hardening of surrounding area	3	Phlebitis/thrombophlebitis: Remove and resite PVC
As above and including: palpable venous cord	4	Seek further advice
As above and including: pyrexia	5	

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Insertion details:	Where inserted:	Insertion site:	Side:	Size of cannula:	Inserted by:
Date: ___/___/___ (Day 1) Time: ___:___	☐ ED ☐ Theatre ☐ ITU/HDU ☐ Ward ___ ☐ Unknown	☐ Hand ☐ Arm Other ___	☐ Left ☐ Right	☐ 26G Purple ☐ 24G Yellow ☐ 18G Green ☐ 23G Blue ☐ 16G Grey ☐ 20G Pink ☐ 14G Orange	Print: ___ Signature: ___ Designation: ___

Clinical Indication:	☐ Diagnostics	☐ Resuscitation	☐ IV medications	☐ Fluids	☐ Transfusion

Insertion criteria:	Hand hygiene performed	Skin decontamination (2% chlorhexidine in 70% isopropyl alcohol)	Sterile transparent semi-permeable dressing affixed	PVC explained to patient/carer
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

DRIFT PVCs are associated with an increased risk of phlebitis, thrombosis, infection and S.aureus bacteraemia.

Justify the need for your patient to have a PVC using the DRIFT mnemonic.
- ✓ Diagnostics - Does the patient need the PVC for a diagnostic procedure e.g. CT scan
- ✓ Resuscitation - Is the patient at risk of cardiac or respiratory arrest?
- ✓ Intravenous (IV) - Does the patient require intravenous (IV) medication? Could these be switched to another route?
- ✓ Fluids - Does the patient require IV fluids? Could this be switched or oral fluids?
- ✓ Transfusion - Does the patient require a transfusion of blood products?

Signs of local or systemic infection

Local infection
- Erythema / inflammation
- Exudate
- Hot to touch
- Pain/tenderness

Systemic infection
- Hypotension
- Tachycardia
- Pyrexia

Adult IVOST Guideline:

Always refer to full IV route to Oral route Switch Therapy (IVOST) guidelines

IV → Oral Antibiotic Switch Therapy (IVOST) Guideline

Review need for IV antibiotics daily
Can antibiotic therapy be stopped? (eg: alternative diagnosis)?
If ongoing antibiotics required - document patient progress/IVOST plan within 72 hours

Switch to oral when:

a **CLINICAL IMPROVEMENT** in signs of infection eg: temperature ≤37.9°C, reduction in the NEWS score, improving SEPSIS
a **ORAL ROUTE** is available reliably (eating/drinking no concerns regarding absorption)
a **UNCOMPLICATED INFECTION** i.e. specialist advice not required prior to IVOST: Infection requiring specialist advice includes CNS infection, Cystic fibrosis, S. aureas bacteraemia (minimum 14 days IV), Endocarditis, Vascular graft or bone/joint infection, Undrainable deep abscess.

DO NOT use CRP in isolation to assess IVOST suitability as does not reflect severity of illness
Record the stop date on HEPMA

If IVOST criteria met → Switch to oral
Review MICROBIOLOGY results and NARROW THE SPECTRUM based on cultures
If not responsive MICROBIOLOGY switch to oral as outlined below

Paediatric IVOST Guideline:

Write or affix label
Name:
Address:
CHI:
DOB:
Hospital & Ward:

PVCs should be removed as soon as no longer clinically indicated.

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Maintenance – to be completed twice daily (Observe for signs and symptoms of local or systemic infection)													
Date	Need for PVC reviewed today?		Any sign of PVC site infection?		Is the dressing intact?		Before / after PVC procedures; hand hygiene performed?		PVC patent?		What has been done?		Sign: Print: Designation:
	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	
Day 1 Insertion Date __/__/__	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 2	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 3	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 4	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 5	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 6	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 7	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Removed	Day Night

PVCs should be removed on day 7. Reassess ongoing needs and vessel health for most appropriate vascular access device. Date removed __/__/__					
Reason for removal	☐ Site infection	☐ Infiltration	☐ Extravasation	☐ End of treatment	Other:

Patient name ....

Patient CHI ....

1605783439
WOTHERSPOON M
Colin 16/05/1978
91 NELSON STREET
Largs, Ayrshire
KA30 9AD

NHS
Greater Glasgow and Clyde

Emergency Care Nursing Documentation

Initial Investigations

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

Communication

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

name,relationship, location, particular concerns

Signature:

PVC	Diagnostic Resuscitation Intravenous Fluids Transfusion	Insertion Date: Time:	Insertion Side: L R Insertion Site:	Size of PVC:	Inserted by Signature
Circle reason: D R I F T					DR Elaine.

Hand Hygiene Yes ☐	Skin Decontamination 2% chlorhexidine in 70% isopropyl alcohol Yes ☐	Sterile transparent semi-permeable dressing affixed Yes ☐	PVC Reason Explained Yes ☐

Risk Assessments and Screening Tools

				Required?		Init		Required?		Init
			SEPSIS	Y	N		GMAWS	Y	N	
FAST +VE	Y	N	STOPPS	Y	N		Public Protection Concern (Adult/Child)	Y	N	
			ED Falls Risk Assessment	Y	N		Notification of Concern Completed (NOC)	Y	N	
			Mental Health Triage Assessment	Y	N		Frailty Assessment Completed	Y	N	
			Ligature low room	Y	N		4AT Assessment	Y	N	

SDZ observation

Pause for Discharge

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

Signature:

Pause for Transfer

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

Signature:

Patient name .....

Patient CHI .....

or use sticker

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Greater Glasgow and Clyde

Care Rounds Checklist

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

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

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

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

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

Patient name .....

Patient CHI .....

or use sticker

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

NHS
Greater Glasgow and Clyde

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

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

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

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

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

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

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

Patient name .....

Patient CHI .....

or use sticker

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Nursing notes cont.		
Date and Time		**Name/Signature**

Patient name .....

Patient CHI .....

or use sticker

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Greater Glasgow and Clyde

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

Ongoing Care

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

Patient nam

Patient CHI

1605783439
WOTHERSPOON
Colin
91 NELSON STREET
Largs, Ayrshire
KA30 9AD
M
16/05/1978

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Greater Glasgow and Clyde

Nursing notes

Date and Time		Name/Signature
16/1/26. 2100	Standby ? overdose of amytriptyline. GCS 8.	GP Ward (SIN)

NEWS 2 Key | 1 | 2 | 3

Parameter		Score
Date		
Time		
A + B Respirations Breaths/min	≥25	3
	21-24	2
	12-20	0
	9-11	1
	≤8	3
A + B SpO2 Scale 1 Oxygen saturation (%)	≥96	0
	94-95	1
	92-93	2
	≤91	3
SpO2 Scale 2 Oxygen saturation (%) Use Scale 2 if target range is 88-92% e.g. in chronic hypercapnic respiratory failure	≥97 on O2	3
	95-96% on O2	2
	93-94% on O2	1
	≥93 on air	0
Only use scale 2 under direction of qualified clinician	88-92	0
	86-87	1
	84-85	2
	≤83	3
Air or oxygen?	Air (A) or O2 device	0
	O2 L/min 2	2
C Blood Pressure mmHg Score uses systolic BP	≥220	3
	201-219	0
	181-200	0
	161-180	0
	141-160	0
	121-140	0
	111-120	0
	101-110	1
	91-100	2
	81-90	3
	71-80	3
	61-70	3
	51-60	3
	≤50	3
C Pulse Beats/min	≥131	3
	121-130	2
	111-120	2
	101-110	1
	91-100	1
	81-90	0
	71-80	0
	61-70	0
	51-60	0
	41-50	1
	31-40	3
	≤30	3
D Any changes in neuro response, do GCS. Immediate medical review. Check Blood Glucose. Think Delirium.	A Alert	0
	C New Confusion	3
	V Verbal	3
	P Pressure	3
	U Unresponsive	3
E Temperature	≥39	2
	38.1-39.0	1
	37.1-38.0	0
	36.1-37.0	0
	35.1-36.0	1
	≤35.0	3
NEWS Total	0	
Blood glucose		
Pain / function score	OA	
Time Pt last passed urine	10.20	
Fluid balance chart indicated Y/N	N	
GCS indicated Y/N	N	
Time NEWS due	23.00	
Escalation of care Y/N	N	
Initials	AB	

Abbreviations for recording oxygen device

- A — Room Air
- N — Nasal Cannulae
- SM — Simple Mask
- V — Venturi Mask and % eg. V24
- NIV — Non Invasive Ventilation
- IV — Invasive Ventilation
- T — Tracheostomy
- CP — CPAP Mask
- HFN — High Flow Nasal Oxygen
- NEB — Nebuliser
- RM — Reservoir Mask (Emergency use only)

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NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

1. Give oxygen to target saturation >94% COPD (88-92%)
2. IV fluids up to 20ml/kg
3. Take blood cultures
4. Measure lactate and FBC
5. Give IV antibiotics
6. Monitor urine output and fluid balance chart

Think ACE

A Action: Working diagnosis (consider SEPSIS). Consider frequency of observations. Management plan. Set review time. Document.

C Communicate: Inform nurse of plan. Inform senior medic if necessary. Document the discussion.

E Escalate: Document the treatment escalation plan. Should include need for next level of care & consideration of resuscitation status.

NHSGGC Adult In-Patient National Early Warning Score (NEWS)

NHS Greater Glasgow and Clyde

SD2

1605783439 M
WOTHERSPOON 16/05/1978
Colin

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

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

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed .....

Medical: .....

Date: .....

Glasgow Coma Scale

Pupil Reaction and Size
s = sluggish
f = fixed
n = no reaction
c = eyes closed
Pupil Size (mm) 1 2 3 4 5 6 7 8

Date:
Time:
Eyes closed by swelling = NT
Endotracheal tube or tracheostomy = NT
Always record the best response
TOTAL
Pupil size: Right reaction: Left size: Left reaction:
Record right (R) and left (L) separately if there is a difference between the two sides
Record right (R) and left (L) separately if there is a difference between the two sides

Pain Score

Ask the patient to rate his/her pain by using numerical scale 0 to 10. Use the chart below to assist the patient. If the patient is unable to communicate, use alternative pain scoring tools.

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

Pain Function Score

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

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Colin
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Largs, Ayrshire KA30 9AD

mi = 316454 v5.2 GGC0264

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

resus 2

Inverclyde Royal Hospital

CHI: 1605783439

Total Att: 2

12 Mth Att: 1

Title: **MR**

WOTHERSPOON **Colin**

DOB: **16/05/1978** Age: **47y** Sex: **Male**

91 NELSON STREET

Largs
Ayrshire
KA30 9AD

Next of kin: **BLUNT, Paul**
Relationship: **Partner**

GP: **S Gillespie**
01475 674545

Attendance Date: **18/01/2026** Arrival Time: **13:42**

Registration Time: **13:42** Date of Incident: **18/01/2026**

Major Incident Desc.

Reason for Attendance: **unwell**

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **18/01/2026 13:59** Nurse name: **Nurse Louise Scott**

RR		bpm
Oxygen		%
Air or O2		
SpO2		%
HR		bpm
BP	/	mmHg
CRT		
MAP		mmHg
AVPU		
Temp		C
EWS Total		

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **"BIBA .PT was discharged yesterday following an amitriptyline overdose. Today patient feels lethargic and feeling unwell. " "BM 4.4 " News 0**

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

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

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

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

CLINICAL NOTES

Date	Seen by (Dr)	Time seen

COORD. 1550.

O/E following alleged O/D 17/1.

Represented c/o shaking + lethargy

Declined f(o)r review 17/1.

Not eating + drinking well, but denies ?[illegible]

Moving about trolley without issue. Good pain ?[illegible]

Alert, orientated. No suicidal ideation expressed.

(P) → D/C

No acute medical issues

Advised to return c/o 19/1 if any issues

COORD

?[illegible]

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant (if admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Patient name

Patient CHI

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M
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Greater Glasgow and Clyde

Emergency Care Nursing Documentation

Initial Investigations

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

Communication

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

name, relationship, location, particular concerns

Signature:

PVC

Circle reason: D R I F T

Diagnostic
Resuscitation
Intravenous Fluids
Transfusion

Insertion
Date:
Time:

Insertion Side: L R

Insertion Site:

Size of PVC:

Inserted by
Signature

Hand Hygiene Yes ☐

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

Sterile transparent semi-permeable dressing affixed Yes ☐

PVC Reason Explained Yes ☐

Risk Assessments and Screening Tools

	Required?		Init
SEPSIS	Y	(N)	
FAST +VE Y N STOPPS	Y	(N)	
ED Falls Risk Assessment	Y	(N)	
Mental Health Triage Assessment	Y	(N)	
Ligature low room	Y	(N)	
GMAWS	Y	(N)	
Public Protection Concern (Adult/Child)	Y	(N)	
Notification of Concern Completed (NOC)	Y	(N)	
Frailty Assessment Completed	Y	(N)	
4AT Assessment	Y	(N)	

Pause for Discharge

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

Signature:

Pause for Transfer

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

Signature:

Patient name ....

Patient CHI ....

1605783439
WOTHERSPOON M
Colin 16/05/1978
91 NELSON STREET
Largs, Ayrshire
KA30 9AD

NHS
Greater Glasgow and Clyde

Care Rounds Checklist

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

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

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

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

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

Patient name ...

Patient CHI ...

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Greater Glasgow and Clyde

Nursing notes

Date and Time		Name/Signature
18/1/26 14:00	BIBA PT was discharged yesterday following an amitriptyline overdose. Today patient feels unwell lethargic. BM 4.4 New OV	L Scott

Patient name

Patient CHI

NHS
Greater Glasgow and Clyde

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

Ongoing Care

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

Patient nam

1605783439
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KA30 9AD

Patient CHI

Hospital:

Ward:

Points to consider:

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

NHS
Greater Glasgow and Clyde

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

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

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

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

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

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

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

Patient name

Patient CHI

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Largs, Ayrshire
KA30 9AD

NHS
Greater Glasgow and Clyde

Nursing notes cont.

Date and Time		Name/Signature

COLIN WOTHERSPOON

Scottish Ambulance Service

Age/Gender:	47y, Male
DOB:	16/05/1978
Address:	91 NELSON STREET LARGS, KA30 9AD
CHI Number:	1605783439
Ethnicity:	White Scottish
Incident Date:	18/01/2026 10:34:00
ePCR Number:	9-2-180126-103437
Incident Number:	CR012875452
Incident Type:	EMG
Incident Location:	91 NELSON STREET LARGS, KA30 9AD

PATIENT INFO

Capacity Assessed

Deemed to have Capacity

Clinical Assessment

Consent Decision:	Consent Gained	Clinical Assessment Explained/Discussed:	Benefits of Assessment Explained, Risks of No Assessment Explained

Treatments

Consent Decision:	Consent Gained	Treatment Explained/Discussed:	Benefits of treatment explained, Risks of No treatment explained

ADDITIONAL COMMENTS

Presenting Complaint: shaking/ lethargic

Timestamp	Additional Comment	Crew Name
18/01/2026 12:27:00	as1 call to 47yom who is feeling lethargic and shaky. Pt was discharged yesterday from IRH following an amitriptyline overdose 3 days ago. Pt returned home and has been feeling unwell since. On pt laying in bed with partner in attendance. Pt managing to drink but has not had anything to eat since leaving hospital as he does not feel like eating. Or rr-16, sp02- 99%pa, hr-98reg, no BP as pt refused stating cuff was hurting him, temp-37 and bm was low at 2.8. Pt given 2x tubes of glucose gel 40%. Glucose remained similar so 1mg glucagon given IM. Bm risen to 4.1 and pt encouraged to try and eat some carbohydrate. Crew called hub to discuss pt with Dr. Awaiting call back. Police had initially attended with crew due to previous abusive language towards crew however pt calm today and police left scene.	-
18/01/2026 12:32:00	bm now risen to 8.0 following glucagon.	-
18/01/2026 12:50:00	crew spoken to Dr Andrew Spence for Prof to Prof advice who advised due to hypoglycaemia and no cause as pt not diagnosed diabetic, pt requires to be further assessed in hospital- pt taken to IRH.	-
18/01/2026 13:00:00	Referral made to mental health services however due to travel to hospital, will request mental health support in A/E.	-

ACVPU

Options: Alert

CATASTROPHIC HAEMORRHAGE

Catastrophic Haemorrhage: No

AIRWAY

Assessment: Clear

Breathing Adequately:	Yes	**Initial Respiratory Rate:**	16
Initial SpO2:	99	**Initial SpO2 On Air:**	Yes
Oxygen Given:		No	

Tension Pneumothorax

Tension Pneumothorax Suspected:	No

CIRCULATION

Pulse Rate:	99	**Rhythm:**	Reg

OBSERVATIONS

Observations Assessment

Timestamp	Pulse	PR	BP	SpO2	CR	GCS	AVPU	ETCO2	Temp	BM	ECG	PEFR	Crew
18/01/2026 11:30:00	99	16		99	<=2 Secs	15	Alert		37	2.8	Sinus Rhythm		E9881911
18/01/2026 11:40:00						15	Alert			3.2			E9881911
18/01/2026 12:05:00	99	16		99	<=2 Secs	15	Alert			4.1	Sinus Rhythm		E9881911
18/01/2026 12:30:00										8.0			E9881911
18/01/2026 13:00:00	91	16	135/88	100	<=2 Secs	15	Alert						E9886659

GCS

Timestamp	Eyes Value	Eyes Score	Verb Value	Verbal Score	Motor Value	Motor Score	Final Score
18/01/2026 11:30:00	Spontaneously	4	Orientated	5	Obeys Commands	6	15
18/01/2026 11:40:00	Spontaneously	4	Orientated	5	Obeys Commands	6	15
18/01/2026 12:05:00	Spontaneously	4	Orientated	5	Obeys Commands	6	15
18/01/2026 13:00:00	Spontaneously	4	Orientated	5	Obeys Commands	6	15

AMPLE

Allergies:	None

Medication

Medication:	Amitriptyline Inhaler

Respiratory Disease

Type:	Asthma

Overdose

Other:	Unknown

Last Eaten

Last Eaten:	>4 Hours Ago

Events Prior

Events Prior:	put took amitriptyline overdose 3 days ago. Discharged from hospital yesterday.

SOCIAL HISTORY

General Appearance:	Normal

Occupation

Status:	Does Not Work

Living Arrangement

Lives Alone:	No	**Lives With:**	partner

Mobility

Patient Mobility:	Fully Mobile

Communication

Communication Requirements:	No Help Required

Clinical Risks

Factors:	**None Identified**

Environmental Risks

Factors:	**None Identified**

DRUGS

Drugs Table

Timestamp	Drug	Expiry	Dosage	Quantity	Route	Pain Before	Pain After	Source	Crew
18/01/2026 11:30:00	Glucose 40% Oral Gel	2027-09	25 g	OR			MANUAL	E9886659	
18/01/2026 11:10:00	Glucose 40% Oral Gel	2027-02	25 g	OR			MANUAL	E9886659	
18/01/2026 12:00:00	Glucagon	2027-08	1 mg	IM			MANUAL	E9886659	

CLOSE REPORT

Clinical Response Feedback

On-Scene Clinical Findings	**Non Emergency**

CONVEYANCE

Transport To Hospital	**Normal Driving**	**Pre-Alert**	**No**
Destination Hospital		**INVERCLYDE ROYAL**	

INCIDENT INFORMATION

Dispatch

Dispatch Code	**ICHY**	**Dispatch Description**	**Integrated Clinical Hub Yellow**

Incident Log

Status Time	Status	Callsign	Reason	Location
09:34:22	Call Received Time	KWG5570		
10:35:41	Mobile	KWG5570		
11:14:58	At Scene	KWG5570		

CREW INFORMATION

Additional Crew

Crew ID	Crew Grade
E9886659	Ambulance Paramedic (AP)
E9881911	Ambulance Paramedic (AP)

NEWS 2 Key	1	2	3

	Example	Obs 1	Obs 2	Obs 3
Date 18/01/26	1/11	18/1	18/1	
Time 13.50	11.00	13 50	15 05	15 20

A + B Respirations Breaths/min

Band	Score	Example	Obs 1	Obs 2	Obs 3
≥25	3				
21-24	2				
12-20	0	•	•	•	•
9-11	1				
≤8	3				

A + B SpO2 Scale 1 Oxygen saturation (%)

Band	Score	Example	Obs 1	Obs 2	Obs 3
≥96	0	97	100	97	97
94-95	1				
92-93	2				
≤91	3				

SpO2 Scale 2 Oxygen saturation (%) Use Scale 2 if target range is 88-92% eg in chronic hypercapnic respiratory failure

Only use scale 2 under direction of qualified clinician

Band	Score
≥97 on O2	3
95-96% on O2	2
93-94% on O2	1
≥93 on air	0
88-92	0
86-87	1
84-85	2
≤83	3

Air or oxygen?

Band	Score	Example	Obs 1	Obs 2	Obs 3
Air (A) or O2 device	0	A	A	A	A
O2 L/min 2	2				

C Blood Pressure mmHg (Score uses systolic BP only)

Band	Score	Example	Obs 1	Obs 2	Obs 3
≥220	3				
201–219	0				
181–200	0				
161–180	0				
141–160	0				
121–140	0				
111–120	0		Λ		
101–110	1				Λ
91–100	2			Λ	
81–90	3				
71–80	3		V	V	V
61–70	3				
51–60	3				
≤50	3				

C Pulse Beats/min

Band	Score	Example	Obs 1	Obs 2	Obs 3
≥131	3				
121-130	2				
111-120	2				
101-110	1				
91-100	1				
81-90	0		•		•
71-80	0	•		•	
61-70	0				
51-60	0				
41-50	1				
31-40	3				
≤30	3				

D Any changes in neuro response, do GCS. Immediate medical review. Check Blood Glucose. Think Delirium.

Band	Score	Example	Obs 1	Obs 2	Obs 3
A Alert	0	•	•	•	•
C New Confusion	3				
V Verbal	3				
P Pressure	3				
U Unresponsive	3				

E Temperature

Band	Score	Example	Obs 1	Obs 2	Obs 3
≥39	2				
38.1-39.0	1				
37.1-38.0	0				
36.1-37.0	0	•	•	•	•
35.1-36.0	1				
≤35.0	3				

	Example	Obs 1	Obs 2	Obs 3
NEWS Total	0	0	2	1
Blood glucose	7.0	4.4		/
Pain / function score	0A	6/A	0/A	0/A
Time Pt last passed urine	10.20	[illegible]	NIL	[illegible]
Fluid balance chart indicated Y/N	N	N	N	N
GCS indicated Y/N	N	Y	Y	Y
Time NEWS due	23.00	14 50		16 20
Escalation of care Y/N	N	Y	N	N
Initials	AB	[illegible]	HM	M

NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

1. Give oxygen to target saturation 94-98% (COPD 88-92%)
2. IV fluids up to 20ml/kg
3. Take blood cultures
4. Measure lactate and FBC
5. Give IV antibiotics
6. Monitor urine output and fluid balance chart

Think ACE

A **Action: Working diagnosis (consider SEPSIS). Consider frequency of observations. Management plan. Set review time. Document.**

C **Communicate:** Inform nurse of plan. Inform senior medic if necessary. Document the discussion.

E **Escalate:** Document the treatment escalation plan. Should include need for next level of care & consideration of resuscitation status.

Abbreviations for recording oxygen device:

Code	Device
A	Room Air
N	Nasal Cannulae
SM	Simple Mask
V	Venturi Mask and % eg. V24
NIV	Non Invasive Ventilation
IV	Invasive Ventilation
T	Tracheostomy
CP	CPAP Mask
HFN	High Flow Nasal Oxygen
NEB	Nebuliser
RM	Reservoir Mask (Emergency use only)

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NHSGGC Adult In-Patient National Early Warning Score (NEWS)

NHS Greater Glasgow and Clyde

resus 2

1605783439
WOTHERSPOON
Colin
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Largs, Ayrshire
KA30 9AD
M
16/05/1978

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

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

Document all actions and interventions

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

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

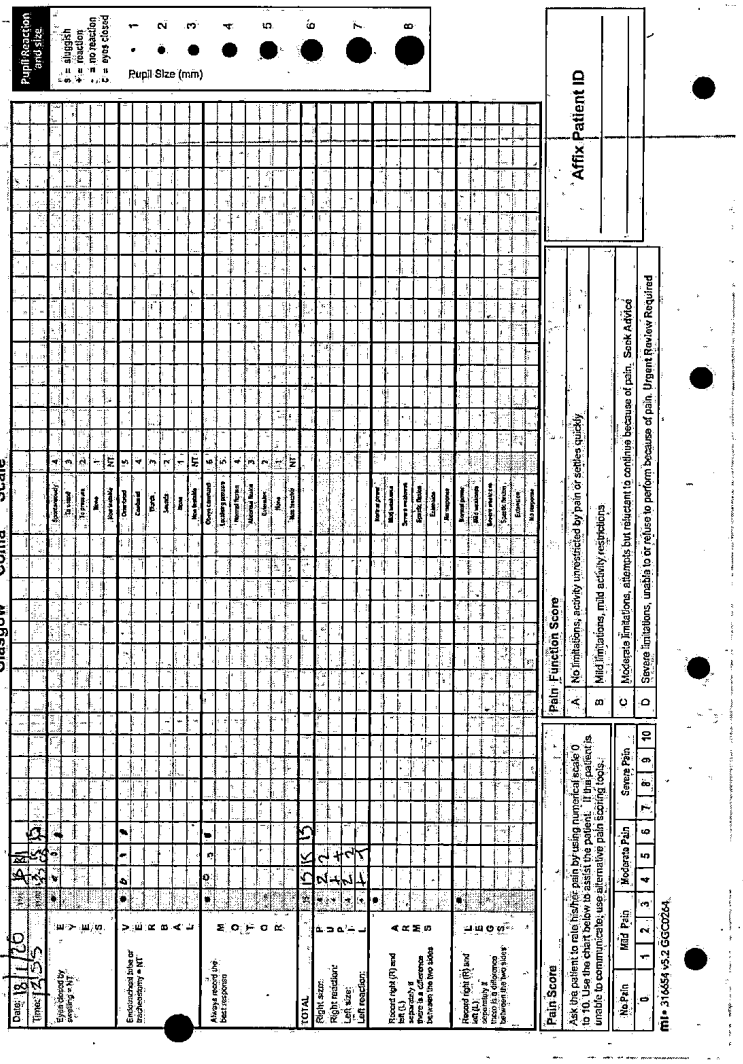
Discontinuation of NEWS

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

Signed .....

Medical .....

Date: .....



NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

SD2

Affix Label

CHI: 1605783439

Inverclyde Royal Hospital

Total Att: 1

12 Mth Att: 0

Title: MR

WOTHERSPOON **Colin**

DOB: **16/05/1978** Age: **47y** Sex: **Male**

91 NELSON STREET

Largs
Ayrshire
KA30 9AD

Next of kin: **VERA**
Relationship: **Mother**

GP: **S Gillespie**
01475 674545

Attendance Date: **16/01/2026** Arrival Time: **19:35**

Registration Time: **19:35** Date of Incident: **16/01/2026**

Major Incident Desc:

Reason for Attendance: **standby**

Affix Label

Nursing Assessment

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

Triage Category: **1** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **16/01/2026 19:36** Nurse name: **Nurse Paul Klar**

RR		bpm
Oxygen		%
Air or O2		
SpO2		%
HR		bpm
BP	/	mmHg
CRT		
MAP		mmHg
AVPU		
Temp		C
EWS Total		

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **STANDBY ? od**

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

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

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

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

Date	CLINICAL NOTES	
	Seen by (Dr)	Time seen

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Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged			Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Cycle 20

NHS Greater Glasgow and Clyde

Acute Medical Unit Admission Proforma

MAU/A&E/AMU

Royal Alexandra Hospital, Paisley/Vale of Leven Hospital/IRH

Patient Details		
Name: **Address:**	1605783439 WOTHERSPOON M Colin 16/05/1978 91 NELSON STREET Largs, Ayrshire KA30 9AD	**Sex:** F ☐ M ☐ **DoB** __/__/__ **Age:**
Telephone:		
GP:	Dr. S Gillespie Largs Medical Group Brooksby Medical & Resource Centre 31 Brisbane Road Largs KA30 8LH	
Next of Kin:		
Telephone:		

Episode Details			
Date patient seen:	16/1/26	**Time seen:**	
Source of referral:	GP ☐ A&E ☑ OPD ☐ Self ☐ Other =		
Admitting Dr:	[signature]	**Grade**	**Bleep**
Consultant:			

Resuscitation Decision

Resuscitation status: (please circle) **FOR RESUSCITATION / DNA CPR**

Signature: _____ **Name:** _____ **Grade:** _____

If DNA CPR → Complete appropriate form

Cycle 20

Presenting Complaint(s)	
Presenting complaint	Overdose.
History of presenting complaint	In cont today. Partner found him with empty blisters of Amitriptyline 25mg tabs ↓GCS E2M5V1 8/15 No good chance No further pckt.

Past Medical History / Review of Old Notes. Review eKIS if available
Overdoses GORD

Systemic Enquiry
/

Cycle 20

MEDICINES RECONCILIATION – Acceptable to staple fully completed Emed Rec

Source of medication history Patient ☐ Relative/carer ☐ GP Phone call ☐ ECS ☐

(>1 source preferred) Patient own drugs ☐ Com. Pharmacist ☐ GP letter/summary ☐ Repeat Script ☐

Other (please specify) .....

Admission Medicines	Dose	Frequency	Plan for medicines (Dr complete) Continue	Amend	Withold	Stop	Comments Reason for alteration

Staple emed-rec to this page

Allergies	List any over-the-counter or alternative medicines
None known ☐ NKMA.	
	Do medicines need further clarification ? Yes ☐ No ☐
List collected by :	Plan approved by :
Designation : Date :	Designation : Date :

Pharmacy review	Comments
Compliance aid : Yes ☐ No ☐	Community pharmacist Phone
Reviewed by : Designation : Date :	

Cycle 20

Social History

Smoking History

Ex-smoker/Smoker _____cpd ___yrs Never smoked

Alcohol History

_____ Units/week FAST score if excess _____

Recreational Drugs Driving Status

Social Circumstances (home, supports, functional status, occupation, travel)

consumptive.

Family History

Observations

RR: 15 bpm Sats: 100% on air FiO2: Temp: – °C BP: 125/87 HR: 84 bpm BM:

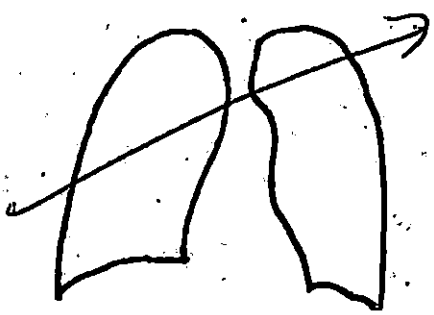
General Examination

General Appearance:

Cyanosis / pallor / jaundice / clubbing / lymphadenopathy

Respiratory

PEFR =



Cycle 20

Cardiovascular

Pulse 84 **Heart Sounds** I+II+0

JVP –

Oedema –

Peripheral Pulses ✓ **cap refill** < 2sec

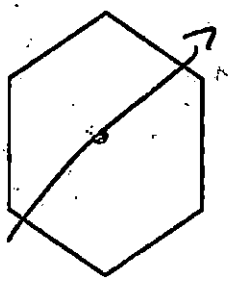
Gastrointestinal system

Masses:

Organomegaly:

Bowel sounds:

PR:



Neurological system

GCS: 7/15 **E:** 2/4 **M:** 5/6 **V:** 1/5 **AMT:** /4 (AMT 4 = age, time, place, year)

Pupils/fundoscopy: PERLA -sncl

Cerebellar and extrapyramidal:

Cranial Nerves:

Neck:

	RUL	LUL	RLL	LLL
Tone	N	N	N	N
Power	5	5	5	5
Co-ordination	✓	✓	–	–
Reflexes	✓	✓	✓	✓
Sensation	✓	✓	✓	✓

Gait:

Locomotor

	Tender	Swollen	Deformity	Which joint?
Arms				
Legs				
Spine				

Cycle 20

Investigations

Bloods
CXR
ECG

H+ 48 HCO_3 25.7
BE -1.5

(Differential) diagnosis

Deliberate o.d.

Management Plan

Observation.
→ medics.
4 [illegible] fit.

Thromboprophylaxis assessed ☐ **Medicine Reconciliation** ☐ **DD6 if required** ☐

Signature [signature]	**PRINT NAME** [illegible]	**PRINT GRADE** [illegible]	**Page:**

Senior/Medical review

20:14 GCS = 14 (M=6; V=3; E=4) [illegible] obeying commands
[illegible] [illegible] [illegible] [illegible]
unknown time and amount of OD taken
unable to clear up medically this patient for MHT
referred to Medical Reg at 20:14

Dr [illegible]
[illegible]

16/1 COF Mitchell - 1st On Medicine

20:32 Pt referred to me after 35 min in dept.

GCS $E_3 V_1 M_5$

Opened eyes to assess pupil response to light + eyes moving to avoid torch.

[signature]

Admission checklist

Investigations reviewed ☐ **Kardex** ☐ **eKIS reviewed** ☐

Thromboprophylaxis assessed ☐ **Medicine Reconciliation** ☐ **DD6 if required** ☐

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

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

NHS

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

Pt Addressograph

Surgical patients start here

Non-operative [mainly medical] patients start here

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

Yes ☐ No ☐

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

Age >60	☐	Use of oestrogen-containing contraceptive therapy	☐
Active cancer or cancer treatment	☐	Use of hormone replacement therapy	☐
Dehydration	☐	Pregnancy or < 6 weeks post partum [seek specialist advice]	☐
Known thrombophilias	☐	Critical care admission eg HDU/ITU	☐
Obesity (BMI>30)	☐	Total anaesthetic + surgical time >90 minutes	☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or Inflammatory disease	☐	Surgery involving pelvis or lower limb with a total anaesthetic + surgical time >60 minutes	☐
Personal history or first degree relative with a history of VTE	☐	Acute surgical admission with inflammatory or intra-abdominal condition	☐
Varicose veins with phlebitis	☐	Hip fracture	☐

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

Yes, 1 or more risk factors identified ☐

No risk factors identified ☐

Does the patient have any contraindications to pharmacological prophylaxis? (tick √ all that apply)

Active bleeding	☐	Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrand)	☐
Acquired bleeding disorders (e.g. acute liver failure)	☐	Neurosurgery, spinal or posterior eye surgery	☐
Concurrent use of anticoagulants (such as warfarin with INR>2)	☐	Lumbar puncture, epidural/spinal anaesthesia expected within the next 12 hours	☐
Acute stroke	☐	Other procedure with high bleeding risk – discuss with senior if unsure	☐
Uncontrolled hypertension (230/120 mmHg or higher)	☐	Lumbar puncture, epidural/spinal analgesia within the previous 4 hours	☐
Thrombocytopenia (<75 x 10^9/l)	☐	Thyroid surgery	☐

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

No contraindications to pharmacological prophylaxis identified ☐

Contraindications to pharmacological prophylaxis identified ☐

Surgical patients – Enoxaparin 40mg + AES ☐*

*prior to application of AES, please check contraindications to AES

Medical patients – Enoxaparin 40mg ☐

Prescribe Enoxaparin at 6pm

[on day of surgery, at the later of either 4h post-op *or* 6pm]

Reduce Enoxaparin to 20mg if <50kg or eGFR <30ml/minute/1.73m² ☐

Discontinue at discharge or when returned to pre-morbid mobility

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

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

Risk assessment result – please tick √ all that apply

VTE risk factors: YES ☐ NO ☐ Contraindications to pharmacological prophylaxis: YES ☐ NO ☐ Prescribed: LMWH ☐ AES ☐ NONE ☐

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

Print Assessor's Name: _____ Signature: _____ Date: _____

DD6 All patients over 64

4AT	Y/N/Na
Carers involved	Y/N/Na
Med rec	Y/N/Na
Sepsis Screen	Y/N/Na
Resuscitation status considered	Y/N
Discharge planning	Y/N/Na

Sepsis Six

Antibiotics within 1 hour	☐
Appropriate Cultures	☐
Fluids	☐
Oxygen	☐
Lactate	☐
Fluid balance, consider catheter	☐

Cycle 20

Results

Baseline										
	Date									
	Time									
	Parameter	Ref Range								
	Hb	130-180								
	WCC	4.0-11.0								
	Plts	150-400								
	MCV	78 - 99								
	Neut	2.0 - 7.5								
	PT	9.0 - 13.0								
	APTT	27.0 - 38.0								
	Fibrinogen	1.5-4gm/L								
	INR	( )								
	Thromb T	11-15 secs								
	D-Dimer	<230								
	ABG/VBG									
	Na^+	135 - 145								
	K^+	3.5 - 5.0								
	Cl^-	97 - 107								
	HCO_3^-	23 - 30								
	Urea	2.5 - 7.5								
	Creat	62 - 124								
	eGFR									
	Glucose	3.5 - 5.9								
	Protein	32 - 82								
	Albumin	37 - 50								
	AlkP	33 - 117								
	Bil	0.5 - 19								
	ALT	11 - 55								
	AST	13 - 42								
	GGT	8-60								
	ESR									
	CRP	<3								
	Troponin I hs	Men 0 - 34 Women 0 - 16								
	CK	23 - 190								
	Corr Ca^{++}	2.25 - 2.60								
	PO_4^-	0.8 - 1.4								
	Mg^{++}	0.7 - 1.1								
	Digoxin	0.5 – 2.0								
	Alcohol									
	Paracetamol	<100 @4 hr								
	Salicylate									
	Amylase	<100								
	LDH	240 - 480								
	Folate	3.1 - 20								
	B12	200 - 900								
	Ferritin	15 - 200								
	TSH	0.35 – 5.00								
	T4	9 - 21								
	Urinalysis									

DON'T MISS AKI Checklist within 24 hrs of admission

D Dipstick Urine: _____

O Obtain Ultrasound: Yes ☐ N/A ☐

(Stage 2/3: within 24 hours of Admission)

N Need for Catheter: Long-term ☐ Yes ☐ No ☐ Refused ☐

T Team Renal to contact: Considered ☐ Done ☐ N/A ☐

M Medicine Reconciliation: ☐

I Intravenous Fluids: Yes ☐ Contraindicated ☐

S Suspected Cause: _____

S Staging of AKI: (Tick Box Below)

☐ 1 (RISK if: Creatinine X 1.5)
☐ 2 (INJURY if: Creatinine X 2)
☐ 3 (FAILURE if: Creatinine X 3)
(compared to baseline)

Signature/Name/Grade _____

Cycle 20

Post Take Ward Round AMU/MAU/OAAU

Consultant: Coons **Date:** 17/1/26 **Time:** 08:20

Summary

OD - Amitriptyline
>12 hours ago.
Now medically well, but not engaging with questioning.
Follows commands.
[illegible] → [illegible] review.

18:00: [illegible] review [illegible]
Patient alert + orientated
Not willing to engage with staff or mental health team.
Discharge.

Coons [illegible]

Temp:
Pulse:
BP:
Sat O2:
FiO2:
RR:

ECG: **Bloods:**

CXR: **Other investigations:**

Imp:

Plan:

AWI considered ☐ Thromboprophylaxis need reviewed ☐ Medicine reconciliation complete ☐
If cardiac or respiratory arrest is considered a possibility for the patient has CPR status been reviewed and documented Yes ☐ No ☐
CPR decision discussed with patient Yes ☐ No (document why) ☐ Advanced directive in situ ☐ Treatment escalation plan (circle) Ward/HDU/ITU
Family informed of CPR/escalation status? – Needs discussed at first opportunity ☐ Has been discussed ☐ Patient does not want family informed ☐

Recommended Destination: ____________
Suitable to board if required Yes ☐ No ☐
Expected Date of Discharge: ____________

Signature: ____________
Designation: ____________
Bleep Number: ____________

Junior/Senior additional notes, communications with relatives

16/1 Mitchell Cont.

From SAS documentation pt was found c amitriptyline packets around him, and nil others.

Bloods + ECG (N).

Imp/ Evidence amitriptyline OD but risk of other drug ingestion.

Behaviour appears more consistent c behavioural issues than true ↓ LoC.

Referral declined for now, have advised ED team to monitor further in ED + re-refer if no interval change at end of monitoring period (22^{00})

E. Mitchell CPE

B. JOHARI FY2 - SEEN IN ED

16/01 22:00 Pt re-referred to medics. Hx noted, 47 ♂ found by partner at 18:00 w/ empty medicine packets, suspected amitriptyline OD.

BG: Overdoses, GORD.

Ix: ECG - NSR

Bloods - Slightly ↓ eGFR (57), paracetamol & salicylate N.

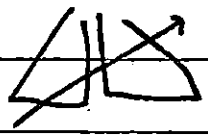
NOTES

VBG - H+ 48, all others unremarkable.

Has completed monitoring for amitriptyline OD: (34 tablets x 25mg).

Today - NEWS 4 for ↓ GCS. T, BP & HR okay.

A - Patent. Responding to verbal commands.

B -  Bilateral AVE. SpO_2 100% RA.
RR 18. Chest clear.

C - Peripheries cool to wrist. HS 1+11 +0. JVP ←→.
Peripheral CRT <2. Colour SNT. No peripheral edema.

D - Abdo SNT. BS ✓. BM 3.8. PEARL.

E - GCS 11/15 E3 V3 M5
Increased tone generally, pupils ~ 6mm.
↑ Reflexes. B/L. Some clonus B/L ankles.
Otherwise unable to assess sensations, but moving all 4 limbs generally.

Inp: Amitriptylline : OD.

(P) 1. Monitor BM → If ↓ needs glucogel / IV glucose if uncooperative.
2. Ψ R/V in AM.
3. ? Discharge home → I think he remains medically fit.

R

NOTES

17/01	Liaison psych on-call : FYI Natasha Nagathavan
11:05	Unable to contact. Left a message. M: FYI
17/1/25 1200	Adult Mental Health liaison/reg Attended L South to review Colin who pulled blanket over his head + told us he was not interested + to F--- off. No contact with Mental health seen at this person dx: pain management Unable to carry out + assessment Advised ward staff we would be happy to review if pt should change his mind MMCin Thanks

Printed: 16/01/2026 20:00:14

Patient Sample Report

Status: **ACCEPTED**
Analyzed: 16/01/2026 20:00:00
Sample Type: Venous
Operator ID: Mairi Patterson0

Patient

ID:	1605783439
Last Name:	WOTHERSPOON
First Name:	COLIN
Gender/Age:	Male, 47 years
Birth Date:	16/05/1978

Cartridge

Lot No.:	250808P
S/N:	00000000501259514
Exp. Date:	30/01/2026

Analyzer

Model:	GEM® *Premier 5000*
Area:	IRHA&E
Name:	IAE
S/N:	17030595

Results

				Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)							
cH	48.6	nmol/L	[	--	--	--	--]
pCO_2	6.8	kPa	[	--	--	--	--]
pO_2	5.2	kPa	[	--	--	--	--]
Na^+	136	mmol/L	[	--	133	146	--]
K^+	4.2	mmol/L	[	--	3.5	5.3	--]
Cl^-	102	mmol/L	[	--	95	108	--]
Ca^{++}	↓ 1.04	mmol/L	[	--	1.15	1.27	--]
Glu	3.8	mmol/L	[	--	3.5	6.0	--]
Lac	1.3	mmol/L	[	--	0.6	2.2	--]
CO-Oximetry							
tHb	166	g/L	[	--	--	--	--]
O_2Hb	↓ 83.3	%	[	--	95.0	98.0	--]
COHb	↑ 3.1	%	[	--	0.5	1.5	--]
MetHb	0.7	%	[	--	0.5	1.5	--]
HHb	↑ 32.9	%	[	--	0.0	5.0	--]
sO_2	↓ 65.8	%	[	--	95.0	98.0	--]
Derived							
BE(B)	-1.5	mmol/L	[	--	--	--	--]
HCO_3^-(c)	25.7	mmol/L	[	--	--	--	--]
Hct(c)	50	%	[	--	--	--	--]

↑↓ Outside Reference Range

Other Information

Operator Entered

Temp	37.0	°C

COLIN WETHERSPOON

Scottish Ambulance Service

Age/Gender:	47 Years, 8 Months, 0 Days, Male	Incident Date:	16/01/2026 18:14:00
DOB:	16/05/1978	ePCR Number:	63-2-160126-181403
Address:	91 NELSON STREET LARGS, KA30 9AD	Incident Number:	CR012870963
CHI Number:		Incident Type:	EMG
Ethnicity:		Incident Location:	91 NELSON STREET LARGS, KA30 9AD

PATIENT INFO

Next Of Kin

Forename:	PAUL	Surname:	BLUNT
Telephone Number:	07359248033	Relationship To Patient:	Civil Partner / Spouse

Capacity Assessed

Time Critical Condition - Unable to assess Capacity

ADDITIONAL COMMENTS

Presenting Complaint:	OVERDOSE

Timestamp	Additional Comment	Crew Name
16/01/2026 19:58:00	AS1 TO 47 Y/O MALE SUSPECTED OF TAKING OVERDOSE OF AMITRIPTYLINE. UNKNOWN DOSE. UNWITNESSED. PT PARTNER STATES LAST SEEING HIM AROUND 4PM THIS AFTERNOON AND FINDING HIM AT 6PM THIS EVENING IN BED NEXT TO EMPTY MED PACKETS. O/A OF CREW, PT GCS 8 - OPENING EYES TO PAIN, NO VERBAL RESPONSE AND MOVING TO LOCALIZED PAIN. PALE BUT NOT CYANOTIC. O/E PUPILS PINPOINT. ALL OBS WITHIN NORMAL RANGE. PT MAKING SPORADIC TWITCHING MOVEMENTS. STANDBY GIVEN AND TRANSFERRED TO IRH.	

ACVPU

Options:	Pain

CATASTROPHIC HAEMORRHAGE

Catastrophic Haemorrhage:	No

AIRWAY

Assessment:	Clear

BREATHING

Breathing Adequately:	Yes	Initial Respiratory Rate:	15
Initial SpO2:	97	Initial SpO2 On Air:	Yes
Oxygen Given:		No	

CIRCULATION

Pulse Rate:	85	Rhythm:	Reg
Most Distal Pulse Found:	Radial	Systolic Pressure:	137
Diastolic Pressure:	109	ECG:	12 Lead

Rhythm

Rhythm:	Sinus Rhythm

Skin

Appearance:	Pale	Skin Texture:	Dry
Skin Temperature:		Warm	

DISABILITY

Initial GCS:

Timestamp	Eyes Value	Eyes Score	Voice Value	Voice Score	Motor Value	Motor Score	Final Score
16/01/2026 20:03:00	To Pain	2	No Response	1	Localised Pain	5	8

Eyes

Left Pupil Size (Mm):	2	**Right Pupil Size (Mm):**	2
Pupils Equal And Reactive To Light (Pearl):		Yes	

Blood Glucose

Blood Sugar Value (MMOL/L):	5.1

OBSERVATIONS

Observations Assessment

Timestamp	Pulse	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	Temp	BM	ECG	P(L | R)	PEF	Crew
16/01/2026 19:30:00	86	15	137/109	99		8	Pain		36.1	5.1	Sinus Rhythm	2|2		E9880278
16/01/2026 19:19:09	68		153/114	96		8	Pain		36.1	5.1	Sinus Rhythm	2|2		E9880278

GCS

Timestamp	Eyes Value	Eyes Score	Voice Value	Voice Score	Motor Value	Motor Score	Final Score
16/01/2026 19:00:00	To Pain	2	No Response	1	Localised Pain	5	8
16/01/2026 19:19:00	To Pain	2	No Response	1	Localised Pain	5	8

NEWS Score

Timestamp	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
16/01/2026 19:00:00	15 (0)	99 (0)	-	0	137 (0)	86 (0)	Pain (3)	36.1 (0)	3

AMPLE

Allergies:	Unknown

Last Eaten

Last Eaten:	Unknown

SOCIAL HISTORY

Other Appearance:	PALE

Living Arrangement

Lives Alone:	No	**Lives With:**	LIVES WITH PARTNER

CLOSE REPORT

Clinical Response Feedback

On-Scene Clinical Findings	Emergency

CONVEYANCE

Transport To Hospital	**Emergency Driving**	**Pre-Alert**	Yes
Destination Hospital		INVERCLYDE ROYAL	

INCIDENT INFORMATION

Dispatch

Dispatch Code	23D02I	**Dispatch Description**	Overdose/Poisoning - Unconscious - Intent to harm self (intentional)

Incident Log

Status Time	Status	Callsign	Reason	Hospital
18:13:17	Call Received Time	GRE4155		
18:14:16	Mobile	GRE4155		
18:14:48	Call Received Time	GRE4155		
18:14:48	Call Received Time	APU5490		
18:23:37	Mobile	APU5490		
18:40:34	At Scene	GRE4155		
19:00:40	At Scene	APU5490		
19:10:40	Leave Scene	GRE4155		INVERCLYDE ROYAL
19:13:09	Clear	APU5490		
19:31:48	At Hospital	GRE4155		

CREW INFORMATION

Additional Crew

Crew ID	Crew Grade
E9880278	Newly Qualified Paramedic (NQP)
E0000070	Ambulance Technician (AT)

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Inverclyde Royal Hospital
Larkfield Rd
Greenock
Renfrewshire
PA16 0XN

Dept. Contact Details:
Tel: 01475 504351
Fax: 01475 504434
Email: inverclyde@nhs.net

Date Completed: 30/01/2026

Consultant: Dr Frances Cameron

S Gillespie
Largs Medical Group
Brooksby Medical & Resource Centre
31 Brisbane Road
Largs
Largs
KA30 8LH

Dear S Gillespie

Re: **Wotherspoon Colin** DOB: **16/05/1978** CHI: **1605783439**
91 NELSON STREET
Largs KA30 9AD

Attended on: **18/01/2026 at 13:42 hrs.** Departed on: **18/01/2026 at 15:55 hrs.**
Discharge Type: **01b - Discharge with follow up by primary care team** Destination: **Private residence**
Previous ED Attendance in last 12 months: **1**

Presenting complaint
unwell

Nursing Assessment:
BIBA .PT was discharged yesterday following an amitriptyline overdose. Today patient feels lethargic and feeling unwell. BM 4.4 News 0

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Malaise and Fatigue		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:

Represented following discharge previous day stating feeling lethargic. Reviewed by Medical Consultant, no new concerns. Discharged with advice.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Frances Cameron
Consultant

Copies to:

1. S Gillespie (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Inverclyde Royal Hospital
Larkfield Rd
Greenock
Renfrewshire
PA16 0XN

Dept. Contact Details:
Tel: 01475 504351
Fax: 01475 504434
Email: inverclyde@nhs.net

Date Completed: 18/01/2026

Consultant: Dr Victoria McWhinnie

S Gillespie
Largs Medical Group
Brooksby Medical & Resource Centre
31 Brisbane Road
Largs
Largs
KA30 8LH

Dear S Gillespie

Re: **Wotherspoon Colin** DOB: **16/05/1978** CHI: **1605783439**
91 NELSON STREET
Largs KA30 9AD

Attended on: **16/01/2026 at 19:35 hrs.** Departed on: **17/01/2026 at 01:10 hrs.**
Discharge Type: **02 - Admitted** Destination: **Admission to this Hospital**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
standby

Nursing Assessment:
STANDBY ? od

Investigations in ED:

1. Full Blood Count	**2. CRP**	**3. Urea and Electrolytes**
4. Bicarbonate	**5. LFT**	**6. Glucose**
7. Coagulation screen	**8. Paracetamol**	**9. Salicylate**
10. CK		

Diagnosis:

Diagnosis	Side	Site
Poisoning By Other and Unspecified Antidepressants		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Elaine Brown
Doctor

Copies to:

1: S Gillespie (GP)

School Address:

Immediate Discharge Letter - Amendments

This version of the document supersedes earlier versions.

Additional Information: Christopher JONES, 29-Jan-2026 12:37
FDL - nil to add

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No
Consent for Sharing Withheld: No

STEPHANIE GILLESPIELargs Medical Group,Brooksby Medical & Resource Centre,31 Brisbane Road, Largs, KA30 8LH

Main Switchboard:
Date of Completion: 17-Jan-2026

Dear STEPHANIE GILLESPIE,

Name	CHI	DoB	Address
Colin Wotherspoon	**1605783439**	**16-May-1978**	**91 NELSON STREET, Largs, Ayrshire, KA30 9AD**

Admitted	Type	Discharged	Destination
17-Jan-2026 01:10	IP	17-Jan-2026	

Specialty	Consultant	Ward	Telephone
General Medicine	Jones	IRH L SOUTH - General Medicine	

Primary Diagnosis
There is no data to display.

Secondary Diagnosis
There is no data to display.

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

Last Discharge Review: Ffyona Gallacher (Ffyona Gallacher - FY1 AUGUST 2025) on 17 Jan 2026 10:54

Discharge Medication:

Active Drug Name	Route	Dose	Disp	Reason	Further Details	ECS	Since Admission
Clenil Modulite 100micrograms/ dose inhaler (Chiesi Ltd)	inhalation	2 doses twice daily	No	Patient's own supply			
Diclofenac sodium 50mg gastro-resistant tablets	oral	1 tablet three times daily	No	Patient's own supply			
Omeprazole 20mg gastro-resistant capsules	oral	1 capsule once daily	No	Patient's own supply			
Salamol 100micrograms/dose Easi-Breathe inhaler (CST Pharma Ltd)	inhalation	1 dose four times daily when required	No	Patient's own supply			

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

Dispensing Comments
There is no data to display.

Withheld Medication:

Date	Withheld Drug Name	Route	Dose	Note	Withheld Reason
2026-01-17	Amitriptyline 25mg tablets	oral	1 to 2 tablets at night		OD

Stopped Medication:

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

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

Clinical Comments:	Dear Doctor, Please be aware that Mr Colin Wotherspoon was admitted under General Medicine at IRH on 17/01/26. He presented after his partner found him with empty blister packets of amitriptyline 25mg tablets. PMHx:

	- Gastro-Oesophageal Reflux Disease Investigations: - Admission Bloods (16/01/26): eGFR 57, Salicylate Level <50, Paracetamol Level <5. All other bloods normal. - Venous Blood Gas (16/01/26): H+ 48, Bicarbonate 25.7, Base Excess -1.5 - ECG (16/01/26): Normal Sinus Rhythm. Nil Acute. Diagnosis: Intentional Amitriptyline Overdose Management: - Period of monitoring after taking 34x25mg amitriptyline tablets. - BM monitoring but no requirement for glucogel/IV glucose. - Mr Wotherspoon refused input from the Psychiatry Team during this admission. Follow Up: No formal follow up required. Medication Changes: Amitriptyline withheld during admission due to overdose. GP Actions: Please review Mr Wotherspoon's amitriptyline requirement due to his presentation with overdose. Mr Wotherspoon is now medically fit to be discharged. Thank you for your ongoing care in the community. General Medical Team L South IRH
Discharge Comments:	
Follow Up:	No No formal follow up required.
Results Awaited:	No
Pharmacist Comments:	
Final Discharge Letter to Follow:	Yes

Yours sincerely,

Ffyona GALLACHER

Prescription Review
Checked by: Erin KERR (Staff Nurse)
Discharged by: Erin KERR (Staff Nurse)

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

General Surgery - Colorectal GGC Colorectal		**Consultant / receiving practitioner** and/or **specialty clinic**
Inverclyde Royal Hospital Larkfield Road Greenock PA16 0XN		**Hospital** and **hospital address** Hospital location code. C313H Email address

Urgency of referral Routine
Date of referral 01-Apr-2026 **Date sent** 01-Apr-2026

PATIENT DETAILS

Surname	Wotherspoon
Forename(s)	Colin
Title	Mr
Sex	Male
Date of birth	16-May-1978
CHI no.	1605783439
Area of Residence	

Patient's address

91 Nelson Street
LARGS
KA30 9AD

Contact number(s)

Voice: 07933459065
Voice: 07933459065

101039544051P

Unique Care Pathway Number: 101039544051P

REGISTERED GP DETAILS

Name	Dr Stephanie Gillespie		
GMC code	7072517	GP code	22284
Practice name	Largs Medical Group (16912)		
Practice code	80857		

Practice address

31 Brisbane Road
LARGS
KA30 8LH

Contact number(s)

Voice: 01475 674545
Facsimile: 01475 676595

REFERRING GP DETAILS

Name	Dr. Andrew Mackay		
GMC code	7277323	GP code	22276
Practice name	Largs Medical Group (80857)		
Practice code	80857		

Practice address

Brooksby Medical & Resource Centre
31 Brisbane Road
Largs
KA30 8LH

Contact number(s)

Voice: 01475 674545

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: See below

Comment: I would be most grateful for your review for this 47 year old man who has been troubled with intermittent fresh red bleeding for years. He has several fleshy type lesions on inspection. He declined PR exam but will be amenable to this in a hospital clinic environment.

Reason for referral

Care type requested: Out Patient

Expected outcome: Investigate

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Intentional overdose of prescription only medication	AMitriptyline - 34 x 25mg	16-Jan-2026	16-Jan-2026
[M]Angiolipoma NOS	-	22-Jun-2024	22-Jun-2024
Lipoma	-	03-Aug-2015	03-Aug-2015
Toe fracture	(Right) 5th toe	13-Apr-2012	13-Apr-2012
[X]Hyperkinetic disorders	-	01-Dec-1986	01-Dec-1986

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
ECG normal	-	16-Jan-2026	16-Jan-2026
Reduction of fracture of zygomatic bones	(Left) ORIF	05-Mar-2014	05-Mar-2014

Family conditions (All priorities)

Description	Comment	Date of Onset
FH: Parkinsonism (Uncle)	07-Jan-2022	
FH: Diabetes mellitus (Mother)	03-Dec-2021	
FH: Ischaemic heart dis. >60 (Mother)	Pacemaker	03-Dec-2021
FH: Kidney disorder (Mother)	23-Mar-2007	

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Soprobec Inhaler 100 micrograms/dose	200	200 DOSE	TWO PUFFS TO BE INHALED TWICE A DAY	-	26-Mar-2025	03-Mar-2026
Salbutamol Cfc-free inhaler 100 micrograms/puff	200	200 DOSE	ONE TO TWO PUFFS TO BE INHALED AS REQUIRED FOR BREATHLESSNESS	-	26-Mar-2025	03-Mar-2026

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Scheriproct Ointment	30	30 GRAM	APPLY THINLY TWICE A DAY AS DIRECTED	-	01-Apr-2026	01-Apr-2026
Omeprazole Capsules (Gastro-Resistant) 20 mg	28	28 CAPSULE	ONE TO BE TAKEN EACH DAY	-	06-Mar-2026	06-Mar-2026
Diclofenac Sodium E/c tablets 50 mg	30	30 tablet	ONE TO BE TAKEN THREE TIMES A DAY WITH OR AFTER FOOD	-	04-Dec-2025	04-Dec-2025
Omeprazole Capsules (Gastro-Resistant) 20 mg	28	28 CAPSULE	ONE TO BE TAKEN EACH DAY	-	04-Dec-2025	04-Dec-2025

Phenoxymethylpenicillin Tablets 250 mg	40	40 TABLET	TWO TO BE TAKEN FOUR TIMES A DAY	-	06-Nov-2025	06-Nov-2025

Blood Pressure

No Blood Pressures Recorded

Body Measurements

Date Recorded	Height	Weight	BMI
06-Mar-2025	172.72	63.5	21.29

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Passive smoker:		06-Mar-2025
Cigarette smoker, 15 Cigarettes/day:		06-Mar-2025
Heavy smoker - 20-39 cigs/day:		20-Nov-2024
Alcohol consumption, 0 units/week:		20-Nov-2024

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

Management of conditions where QFIT not required (e.g. haemorrhoids, fissures):true

QFIT Result:Not indicated

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

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

Referred By:Resident GP

Electronic Attachment Present:No

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

Patient 1605783439 .....
Date of WOTHERSPOON Colin M 16/05/1978 .....
CHI No .....
ent label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued									Administration details - continued				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments
16/1/2015	20:01	Normal Saline 0.9%	1000ml	IV	1000ml/hr		[signature]		16/01/2015		[signature]		
		Glucose 10%	100ml	IV	bolus		[signature]		16/01/2015		[signature]		

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

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height
Weight (kg) ..... Height (cm) .....

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

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

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)		
Calculation:	Example:	
Rate of flow = (drops/min) $\frac{\text{Volume of fluid (ml) x 20}}{\text{Duration of admin (min)}}$	500ml over 1 hour	167 drops/min
	500ml over 4 hours	42 drops/min
	500ml over 6 hours	28 drops/min
NB: 1ml = 20 drops (for a standard giving set)	500ml over 8 hours	21 drops/min

Inpatient prescription & administration record for Colin Wotherspoon (1605783439)

05:25
20/01/26

Admission: 17/01/2026 => 17/01/2026

Patient Demographics

WOTHERSPOON Colin (1605783439)
DOB: 16/05/1978
91 Nelson Street, Largs,
Ayrshire,
KA30 9AD

Admitted: 17/01/2026 01:56
Discharged: 17/01/2026 17:30

Transfer history			Responsible Consultant history		
Admission	2026-01-16 19:36:00	IAE IRH EMERG	Assigned No Consultant	16/01/26	19:36
Transfer	2026-01-17 01:56:00	ILS IRH L SOUTH	Chris Jones	17/01/26	01:56

Allergy

Admission Allergy Check performed by: Bazlaa Johari
Current recorded allergy (reaction): No Known Drug Allergies

Beclometasone 100 micrograms (Clenil Modulite) Inhaler

17/01/26 07:00 200 microgram TWICE daily at 7am and 10pm (Inhalation) — Bazlaa Johari

17/01/26	07:00	17/01/2026	08:49	Amy Dougans	

Diclofenac 50 mg Enteric Coated Tablets

☒ 17/01/26 07:00 50 mg THREE times daily at 7am, 12 noon, and 5pm (Oral) — Bazlaa Johari

17/01/26	07:00	17/01/2026	08:48	Amy Dougans	
17/01/26	12:00			Amy Dougans	Refused by Patient
17/01/26	17:00			Amy Dougans	Other - see patient nursing notes

Enoxaparin (Inhixa) 20 mg in 0.2mL Pre-Filled Syringe

☒ 17/01/26 17:00 20 mg ONCE daily at 5pm (Subcutaneous Bolus Injection) — Bazlaa Johari

17/01/26	17:00		Amy Dougans	Other - see patient nursing notes

Omeprazole 20 mg Capsules

☒ 17/01/26 07:00 20 mg ONCE DAILY MORNING 7am (Oral) — Bazlaa Johari

17/01/26	07:00	17/01/2026	08:48	Amy Dougans

Salbutamol 100 micrograms (MDI) per metered dose

☒ 17/01/26 07:00 200 microgram TWICE DAILY 7am:10pm (Inhalation) — Bazlaa Johari

17/01/26	07:00		Amy Dougans	Other - see patient nursing notes

Discontinued on: 17/01/2026 21:03:00 by: Bazlaa Johari . Reason: Prescribed in error

Salbutamol 100 micrograms (MDI) per metered dose as required

☒ 17/01/26 01:56 200 microgram (Inhalation) FOR BREATHLESSNESS — Bazlaa Johari

Patient level notes

added by **Amy Dougans** on 17/01/2026 at 12:34
Title: AM MEDS 17/01/26
AM MEDS CHARTED AS GIVEN BUT REFUSED 17/01/26

Key: Prescription details | Recorded as "Admitted On" | Prescribed as "Self Administer" | Discontinuation details | HEPMA Prescription additional notes | HEPMA Patient admission notes (admission specific) | HEPMA Patient retained notes (not specific to admission)

Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, NHS Ayrshire & Arran and NHS Greater Glasgow & Clyde

HEPMA MAP v1.0

Male
16.05.1978 (47 Years)
Location: 934

Vent. rate	85
PR interval	156 ms
QRS duration	108 ms
QT/QTc-Baz	360/428 ms
P-R-T axes	70 91 51

Normal sinus rhythm
Rightward axis
Borderline ECG

IRH Cardiology

LOCATION:
COMMENTS:

Unconfirmed

I aVR V1 V4
II aVL V2 V5
III aVF V3 V6
II

25mm/s 10.0mm/mV 0.56-150 Hz ZPD 50 Hz MAC™ 7 1.00 SP02 12SL v23:1 v 2.5s + 1 rhythm Id