Subject Access Request Team
Health Records Department
Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN

NHS
Greater Glasgow and Clyde

MMA LEGAL
STOK, 43 - 59 PRINCES STREET,
STOCKPORT,
SK1 1RY

Date: 27TH MAY 2026
Your Ref: 100281
Our Ref: SAR/TEAM/TH
Enquiries to: Tracy Hunter
Direct Line: 0141 211 0667
Email: tracy.hunter3@nhs.scot

Dear Sir/Madam

Re: Subject Access Request under the General Data Protection Regulation

Patient: BRIAN Mac KENZIE Date: 31.08.1958

Thank you for your request received **11TH MAY 2026** in which you seek a copy of your client's personal information.

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

NEW VICTORIA INFIRMARY - QUEEN ELIZABETH UNIVERSITY HOSPITAL RECORDS

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

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

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

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

- Complaints files
- Emails

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

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

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

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

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

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

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

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

Yours sincerely

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 AMBULATORY CARE HOSPITAL	☐		
WESTERN INFIRMARY RECORDS	☐		

Including:

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

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL
1345 GOVAN ROAD, GLASGOW
G51 4TF
TEL: 0141 201 1100

DEPARTMENT OF ORTHOPAEDICS
PLASTER ROOM REPORT

CONSULTANT: MR MARC BRANSBY-ZACHARY DATE: 27/10/09

PATIENT: BRIAN MACKENZIE
12 ORCHARD STREET
RENFREW
PA4 8RL

DOB: 31/08/58 UNIT NO: SG00375441
ACCT NO: OP0338356/09
CHI NO: 3108583158
GP: DR JUDITH JM ANDERSON

Type of Cast: REMOVAL OF CAST Instructions given for care of Plaster: N

Walking Aids: NOT APPLICABLE Instructions given for Walking Aids: N

Other: NOT APPLICABLE

Further information:

SIGNED: NU.WILMR WILLIAMS,MARGARET DATE: 27/10/09

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL
1345 GOVAN ROAD, GLASGOW
G51 4TF
TEL: 0141 201 1100

DEPARTMENT OF ORTHOPAEDICS
TREATMENT ROOM REPORT

CONSULTANT: MR MARC BRANSBY-ZACHARY DATE: 27/10/09

PATIENT: BRIAN MACKENZIE DOB: 31/08/58 UNIT NO: SG00375441
12 ORCHARD STREET ACCT NO: OP0338356/09
RENFREW CHI NO: 3108583158
PA4 8RL GP: DR JUDITH JM ANDERSON

Procedure: REMOVAL OF WIRES Dressings: MEPORE

Further information: WOUND HEALED DISCHARGE FROM CLINIC WITH ADVICE.

SIGNED: NU.CALJA MCCALMAN,JACQUELINE DATE: 27/10/09

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL
1345 GOVAN ROAD, GLASGOW
G51 4TF
TEL: 0141 201 1100

DEPARTMENT OF ORTHOPAEDICS
TREATMENT ROOM REPORT

CONSULTANT: MR MARC BRANSBY-ZACHARY DATE: 13/10/09

PATIENT: BRIAN MACKENZIE DOB: 31/08/58 UNIT NO: SG00375441
12 ORCHARD STREET ACCT NO: OP0334606/09
RENFREW CHI NO: 3108583158
PA4 8RL GP: DR JUDITH JM ANDERSON

Procedure: REMOVAL OF SUTURES Dressings: MEPORE

Further information: WIRE TO REMAIN IN SITU FURTHER 2/52. BENNETT'S CAST APPLIED

SIGNED: NU.WILMR WILLIAMS,MARGARET DATE: 13/10/09

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL
1345 GOVAN ROAD, GLASGOW
G51 4TF
TEL: 0141 201 1100

DEPARTMENT OF ORTHOPAEDICS
PLASTER ROOM REPORT

CONSULTANT: MR MARC BRANSBY-ZACHARY DATE: 13/10/09

PATIENT: BRIAN MACKENZIE
12 ORCHARD STREET
RENFREW
PA4 8RL

DOB: 31/08/58

UNIT NO: SG00375441
ACCT NO: OP0334606/09
CHI NO: 3108583158
GP: DR JUDITH JM ANDERSON

Type of Cast: BRUNNER'S CAST

Instructions given for care of Plaster: Y

Walking Aids: NOT APPLICABLE

Instructions given for Walking Aids: N

Other: NOT APPLICABLE

Further information: CAST REMOVED TO ALLOW REMOVAL OF SUTURES,
CAST REPLACED.

SIGNED: PLA.GILVA GILLESPIE,VALERIE DATE: 13/10/09

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS DIVISION
SOUTHERN GENERAL HOSPITAL
1345 GOVAN ROAD, GLASGOW
G51 4TF
TEL: 0141 201 1100

DEPARTMENT OF ORTHOPAEDICS
PLASTER ROOM REPORT

CONSULTANT: MR MARC BRANSBY-ZACHARY DATE: 08/10/09

PATIENT: BRIAN MACKENZIE
12 ORCHARD STREET
RENFREW
PA4 8RL

DOB: 31/08/58 UNIT NO: SG00375441
ACCT NO: OP0334601/09
CHI NO: 3108583158
GP: DR JUDITH JM ANDERSON

Type of Cast: BRUNNER'S CAST

Instructions given for care of Plaster: Y

Walking Aids: NOT APPLICABLE

Instructions given for Walking Aids: N

Other: NOT APPLICABLE

Further information: BENNETS CAST REMOVED
AND REPLACED WITH BRUNNERS.

SIGNED: PLA.GILVA GILLESPIE,VALERIE DATE: 08/10/09

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

CHI: 3108583158

Queen Elizabeth University Hospital

Total Att: 1

12 Mth Att: 0

Title: MR

MACKENZIE

Brian

DOB: 31/08/1958

Age: 67y

Sex: Male

22 LOMOND AVENUE

Next of kin:
Relationship:

Renfrew
Renfrewshire
PA4 0PG
07966154552

GP: Z Al-Najim
0141 207 7730

Attendance Date: 01/05/2026 Arrival Time: 12:18

Registration Time: 12:18 Date of Incident: 01/05/2026

Major Incident Desc:

Reason for Attendance: dog bite to hand

Affix Label

Nursing Assessment

Alerts: Not Recorded Allergies: Not Recorded Pain Score:

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

Presenting Complaint:

Observation Date: 01/05/2026 12:23 Nurse name: Nurse Karen Hughes

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:

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
	REVAXIS® Batch Y3C7002					

Date

Seen by (Dr) Clenp- Time seen 1300

3108583158 31/08/1958
MACKENZIE
Brian

01/05/26.

PC/ Dog Bite (R) Hand - RHD

HPC/ Bitten by own dog at home today, x2 superficial wound dorsal aspect of hand. Denies other injuries.

PMHx
COPD
HTN.

DHx
see ECS.

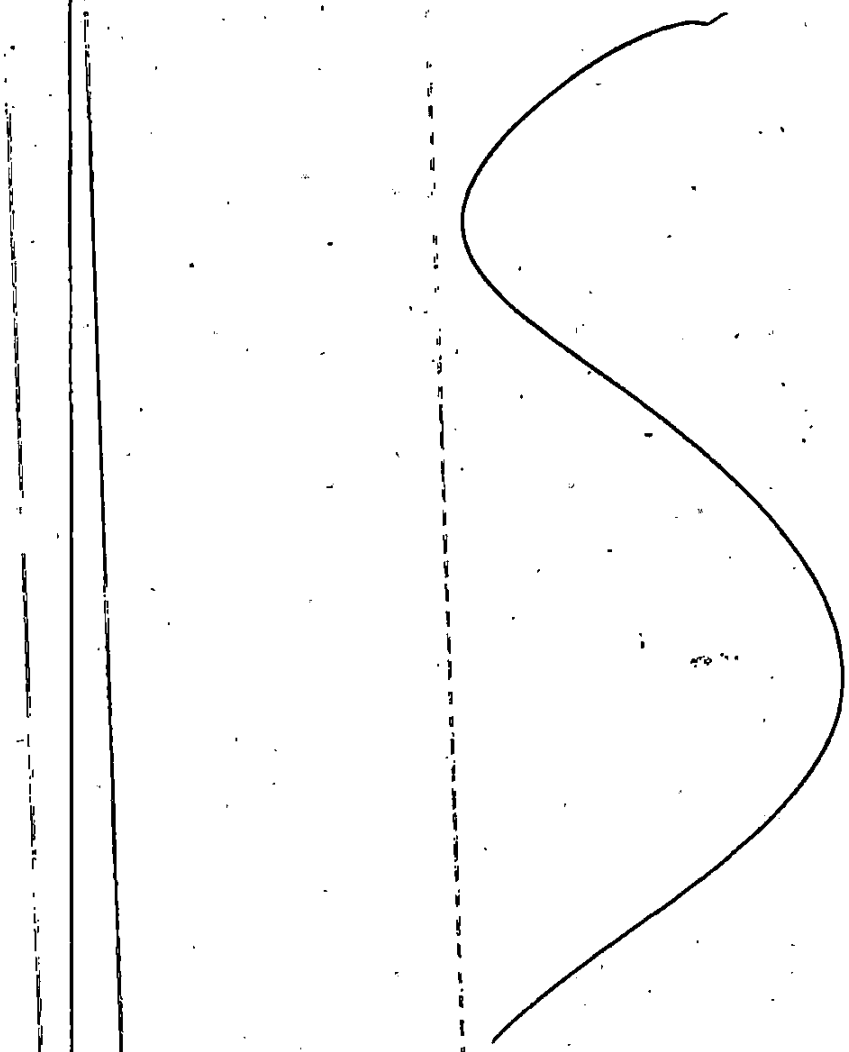
NKDA.

O/E - x2 superficial skin flaps to hand
- No bleeding - No signs of infection
- NVI ✓ CRT <2sec distally
- No swelling / Bruising / abrasions
- Full ROM wrist + digits.
- wound care given.
- cleansed NSS 0.9%, Inadine and crepe bandage applied.
- Tetanus administered + prophylactic co-Amoxiclav.

DIC home with worsening advice

Clenp.

Date	CLINICAL NOTES



Discharge Codes (Please CIRCLE)					Discharge date	01/05/26
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)		Discharge time	
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.		

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
1/5/26	Co Amoxiclav	625mg	PO	TDS 3/7	CL	CL

Plaster room

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow

Queen Elizabeth University Hospital

CHI: 3108583158

Total Att: 0

12 Mth Att: 0

Title: **MR**

MACKENZIE **Brian**

DOB: **31/08/1958** Age: **58y** Sex: **Male**

22 LOMOND AVENUE

Renfrew
Renfrewshire
PA4 0PG
07966154552

Next of kin:
Relationship:

GP: **Z Al-Najim**
0141 207 7730

Attendance Date: **07/05/2017** Arrival Time: **18:33**

Registration Time: **18:33** Date of Incident: **07/05/2017**

Major Incident Desc:

Reason for Attendance: **burn to arm**

Affix Label

Nursing Assessment

Alerts: **Not Recorded**

Allergies: **Not Recorded** Pain Score:

Tetanus up to date/fully immunised:

Triage Category: **2**

Presenting Complaint:

Observation Date: **07/05/2017 19:16**

Nurse name: **Nurse Catherine MacDonald**

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

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **"Petrol burn to L arm."**

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
07/05/17	Co-Codamol 30/500	2 x tabs	Oral	1920		CMS

Date	CLINICAL NOTES
7/5/17	Seen by (Dr) KHAN (Locum SHO) Time seen 1945hrs

BD review

(58) → B/G :- No previous medical history
Active smoker
No ETOH dependence

3108583158 31/08/1958
MACKENZIE
Brian

P/C
Was working in a garden, holding an open can of petrol when suddenly his dog came in front of him and startled him. Spilled petrol on his left arm and overall which caught fire from a nearby source
Put out fire quickly

O/E
Sustained 1%, 1st degree superficial, partial thickness burns to (L) arm on extensor aspect of forearm and upper arm extending to PIP joints, non-circumferential. Small 5x4 cm area of peeled off skin on upper arm with intact underlying tattoos.
Small blisters on mid forearm and upper arm. Palm spared. NROM in joints very painful and tender
Seen by Chris (Spr)

Advised:-
- Burns dressing
- Analgesics
- ED Clinic review on Tuesday

Khan (locum)

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
7/5/17	CO-CODAMOL 30/500	TT	PO	QDS		
7/5/17	IBUPROFEN	400mg	PO	TDS		

Acute Services Division
New Victoria Hospital

NHS Greater Glasgow and Clyde

Day Surgery Unit, ACH
General Anaesthetic / Sedation Patient Care Plan

ORSOS No.:

Note: Please complete this section when referring a patient.
Use addressograph label

3108583158
MACKENZIE M
Brian 31/08/1958
22 LOMOND AVENUE
Renfrew, Renfrewshire PA4 0PP

Telephone:
Mobile:

☐ Pending
☐ ECG
☐ Bloods
☐ Other (state):

☐ Rejected
☐ BMI
☐ BP
☐ ECG
☐ Other (state):
☐ Letter sent to Consultant re:

☐ Accepted
Date:

Cancellation? ☐ Yes ☐ No
Holiday dates:

Consultant: Spencer

Planned operation (please PRINT):
Left knee Arthroscopy

☑ General Anaesthetic ☐ Sedation

Proposed date: / / ☐ TBA
3 12 14

Referring Surgeon (please PRINT)

Contact Name: Margaret Mackenzie
Relationship: wife
Telephone: on Trak

Escort Name: 07966 154 552
Relationship: A/A
Telephone:

C Z Al-Najim
Aydeview Medical Practice
enfrew Health Centre
) Ferry Road
enfrew
A4 8RU

Interpreter ☑ N/A ☐ Yes
Language:
Organised for (date): / /
Time from: hrs until: hrs
☐ GIS ☐ Global ☐ Other (state):
Company Ref or Reject No:

Additional Requirements / Comments

MIS • DAY SURGERY • 209537

Admission Observations and Pre-operative Instructions

Name	Observations	Time	1205	
3108583158	% Sat O_2		97%	
MACKENZIE M Brian 31/08/1958 22 LOMOND AVENUE Renfrew, Renfrewshire PA4 0PG	BP		131/81	
	Pulse rate Regular / Irregular		73	
		Signature	MacA	
	Locker number:		Temp: 36·1	

Any change in health / circumstances since pre-assessment?	☐ No ☐ Yes (State):
Date of last menstrual period	
Are you or could you be pregnant?	NA
Pregnancy test performed in DSU	Result:
Blood Group	

Pre-operative Checklist	Admit Nurse	Anaes Nurse	Comments
Pre-op questionnaire signed	Yes	✓	
Escort arranged	Yes	✓	
Carer arranged for 24 hours	Yes	✓	
Patient last ate: 10·30 pm hours last night	✓	✓	State: snack
Patient last drank: 10·30 pm hours last night	✓	✓	State: tea + juice
Consent form signed	Yes	✓	
Identification band	Yes	✓	
Confirm operation and site (state)	Yes	✓	Left knee ATKA
Operation site marked	Yes	Yes	
Wound Site prepped	NA	NA	
Has passed urine	Yes	yes	
Any known allergies (list)	No	no	Nil known
Premedication given	Yes	yes	Ranitidine 150
Dentures	Yes	yes	top partial plate
Any caps, crowns, loose teeth, etc (list)	No	no	
Contact lenses, glasses	No	no	
Artificial aids (specify)	No	no	
Make-up, nail polish	NA	NA	
Jewellery/piercings removed/ wedding ring taped	No	no	
Diathermy / IV sites may be shaved	NA	—	
Signature	[signature]	STL	Date 8/12/14

Intra-operative Information

3108583158
MACKENZIE M
Brian 31/08/1958
22 LOMOND AVENUE
Renfrew, Renfrewshire
PA4 0PG
Use on Rheumatology label

ALLERGIES: Nil

Surgeon(s)	Mr Malsh
Anaesthetist(s)	Dr Bater Dr McGuire
Scrub nurse(s)	SR Wilson
Anaes. nurse(s)	SSN Thomson

Patient position	Left arm secured	Right arm secured	Eyes taped	Warming blanket
☑ Supine	☐ On board	☐ On board	☐ Yes	☐ Yes (Temp:)
☐ Prone	☑ Across	☐ Across	☐ No	☑ No
☐ Lithotomy	☐ At side	☐ At side		

☐ Other (specify):

Tourniquet	Time on	Time off	Site satisfactory	Comments
Site: left thigh	14.07		☑ Yes ☐ No	
Site:			☐ Yes ☐ No	
Diathermy sites/s (state):			☐ Yes ☐ No	☐ Mono ☐ Bi
			☐ Yes ☐ No	
Pressure Area Policy followed			☑ Yes ☐ No	

Operation Performed

left knee Arthroscopy / Partial Medial
20 mcs/1m Meniscectomy
Chirocaine 0.5% MB

☑ GA ☐ LA ☐ Sedation: ☐ Regional block:

Specimens:

Sutures:

Dressings: Melolee wool + crepe

Packing:

Follow-up ☐ N/A ☐ Required (state): Return to clinic ☐ Organised

DSU discharge prescription ☐ N/A ☐ Prescribed 6 weeks

Primary Recovery

Time	14.40	14.45	14.50	14.55	15.00	15.05
BP	132/81	132/81	132/81	131/79	128/81	129/78
Pulse rate: Regular/Irregular	72	72	78	68	76	71
ECG rhythm	SR	SR	SR	SR	SR	SR
Respiratory rate	22	22	15	16	16	16
Airway	own	own	own	own	own	own
Oxygen	6L	6L	6L	6L	6L	6L
% Sat O_2	100%	100%	100%	100%	100%	99%
Colour: Satis / Pale / Cyanosed	Satis	Satis	Satis	Satis	Satis	Satis
Sedation score 0/1/2/3	1	1	1	1	1	1
Nausea score S/0/1/2/3	0	S	0	0	0	0
Pain score S/0-10	0	S	6	6	5-6	5/6
PV bleeding						
1. Wound (site:)		dry				
1. Colour/Sensitivity/Movement		N N				
2. Wound (site:)						
2. Colour/Sensitivity/Movement						
Temperature	35.4					
Signature	JBell	JBell	JBell	JBell	JBell	

Patient transferred to Recovery at 15.05 hrs

Discharge Criteria

Name

3108583158
MACKENZIE M
Brian 31/08/1958
22 LOMOND AVENUE
Renfrew, Renfrewshire
PA4 0PG

Vital Signs Pre-Mobilisation

Time	1630	
BP	125/78	
Pulse (Regular / Irregular)	64	
1. Wound Site	SATS 96%	
2. Wound Site		
Signature	[signature]	

Time hours	Yes	N/A	Comments
Stable vital signs	✓		BP 128/80 Pulse 61
Pain score satisfactory (score 0)	✓		
Sedation score satisfactory (alert / orientated ✓)	✓		
Nausea score satisfactory (score 0)	✓		
1. Wound site satisfactory (site Sutrs)	✓		
2. Wound site satisfactory (site)		✓	
PV bleeding satisfactory		✓	
Tolerating light diet	✓		
Tolerating oral fluids	✓		
Voided urine postoperatively	✓		
Advice given if not passed urine		✓	
Anti-D given		✓	
ECG electrodes and ID Bracelet removed	✓		
IV cannula removed	✓		
Packing / dressing removed	N/A		72hrs
Follow-up arranged	✓		☑ By post ☐ Given 6/52
District Nurse arranged		✓	
Letter to GP given	✓		
Discharge medication given	✓		
Verbal and written post-op instructions given	✓		
Responsible adult escort			

16⁰⁰ - 8/12/14 - All discharge advice fully given to patient. Bandage intact. MJC

Patient discharged by: [signature] at: 16⁰⁰ hrs

Patient left DSU at: 17¹⁵ hrs Destination: Home

Discharged into the care of: Relationship: Wife

3108583158
MACKENZIE
Brian 31/08/1958
22 LOMOND AVENUE
Renfrew, Renfrewshire
PA4 0P

ACH

ADDRESSOGRAPH

ADDITIONAL RECORDINGS

PRIMARY RECOVERY

TIME	15[10]	15[15]	15[20]	15[25]				
BP	127/74	128/86	140/85	138/86				
PULSE RATE ;	90	68	69	67				
ECG	S.R	S.R	S.R	SR				
RESP.RATE	16	16	16	14				
AIRWAY	Own	Own	own	own				
OXYGEN	6L	2L	nil	nil				
SAO2 %	100%	100%	98%	97%				
COLOUR	Satis	Satis	Satis	Satis				
SEDATION SCORE 0/1/2/3	1	1	1	1				
NAUSEA SCORE 0/1/2/3	0	0	0	0				
PAIN SCORE 0---10	4-5.	2-3	2	2.				
PV BLEEDING								
1.WOUND (SITE:)								
C.S.M	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
2.WOUND(SITE:)								
C.S.M	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
TEMPERATURE								
SIGNATURE	[illegible]	[illegible]	[illegible]	[illegible]				

Recovery Nurses

Comments:

15[00] Patient details on photographs from operation noted to be incorrect, Correct Chi number but first name incorrect & spelling of Surname incorrect. Photographs confirmed to be correct by S/S Wilson, Addressograph label with correct details now on photographs [illegible].

Once only prescriptions

Date	Medicine (BLOCK CAPITALS)	Dose	Route	Time for administration	Prescribers signature (full)	Administered by	Time given
8/12/14	RANITIDINE	150mg	O	12.30.			1312

As required prescriptions - Other medicines, incuding oxygen where flow rate, concentration and type of mask must be specified

Date	Medicine (BLOCK CAPITALS)	Dose	Route	Symptom	Minimum interval (hours)	Max. 24 hour dose	Prescribers signature (full)	Administered by	Time given
8/12/14	PARACETAMOL	1g	IV	PAIN	6	QID			
8/12/14	TRAMADOL	50mg	O	PAIN	6	QID			

As required prescriptions - Injections

Date	Medicine (BLOCK CAPITALS)	Dose	Route	Symptom	Minimum interval (hours)	Max. 24 hour dose	Prescribers signature (full)	Administered by	Time given
8/12/14	ONDANSETRON	4mg	IV	N+V	8	TID			

Discharge prescriptions

Date	Medicine (BLOCK CAPITALS)	Dose	Route	Symptom	Minimum interval (hours)	Number of days supply	Prescribers signature (full)	Issued by
8/12/14	PARACETAMOL	1g	O	PAIN	6	1 PACK		
8/12/14	DIHYDROCODEINE	30mg	O	PAIN	6	1 PACK		

If medicine discontinued because of adverse reaction, enter below

Medicine	Adverse reaction
1.	
2.	

Known medicine senstivities

1.
2.

Ward	Name of patient	Age / DOB	Height	Weight	Unit number	Consultant

Acut
The 108583158
MACKENZIE M
Irlan 31/08/1958
Da 2 LOMOND AVENUE
Renfrew, Renfrewshire
PA4 0P
Pre
Valid only on the following date: / /

NHS Glasgow & Clyde

3108583158
MACKENZIE , M
Brian 31/08/1958
22 LOMOND AVENUE
Renfrew, Renfrewshire
PA4 0P

EW VICTORIA HOSPITAL

Day Surgery Unit

Pre-operative patient Questionnaire

For the attention of patients receiving a general anaesthetic/ sedation

Have you arranged a carer for 24hrs at home?	Yes /No
Do you have a cough, cold or nose trouble?	Yes/ No
What time did you last have something to eat?	Last night 10:30 pm
What time did you last have something to drink?	A/A
Have you had any alcohol in the last 24hrs? If yes how much?	Yes/ No
Are you or could you be pregnant	Yes/No/ Not sure
Do you require a sick line or self certificate	Yes/No

Patient Agreement

I understand that following day surgery I must

- **Have a carer for the next 24 hrs**

I understand that following day surgery I MUST NOT:

- **Drive a vehicle or ride a bicycle for 24 hrs**
- **Drink any alcohol for 24 hrs**
- **Be alone in charge of a baby or child for 24 hrs**
- **Operate machinery, use a cooker or kettle for 24hrs**
- **Climb a ladder or work at heights for 24 hrs**
- **Sign any important documents for 24 hrs**

I certify that I understand and will comply with these Restrictions

Patient's signature:..... **Date:** 8/12/14

Nurse's signature:..... **Date:** 8/12/14

CG 10/09

THE VICTORIA INFIRMARY

OPERATION SHEET

3108583158
MACKENZIE
Brian
22 LOMOND AVENUE
Renfrew, Renfrewshire
PA4 0PG

M
31/08/1958

FIRST NAMES (Block Letters)

ERATION PERFORMED

Left Knee Arthroscopy
+ Partial Medial Meniscectomy

AGE | REGISTRATION NUMBER

SURGEON	ASSISTANT	ANAESTHETIST
MR A. MARSH		DR BAKER.

Post-op

1. Mobilise full weight bearing
2. Reduce dressing at 3 days post-op
3. Leave dressing to cover port site wounds for 10-14 days post-op
4. OP dr. 6 weeks Mr Mohammed clinic

A. MARSH.
Clinical Fellow

VIC 695
FORM 0166282

NHS Greater Glasgow and Clyde — Intraoperative Accountable Items Count Record

Date: 8/12/14

ADDRESSOGRAPH

3108583158
MACKENZIE M
Brian 31/08/1958
22 LOMOND AVENUE
Renfrew, Renfrewshire
PA4 0PG

WARD

HOSP- ACH VIC

THEATRE- 3

COUNTS	Scrub Nurse(s) - Print Name	Circulating Nurse(s) - Signature & Print name
PRE - OP SWAB COUNT CORRECT	SWILSON	RJARDINE
PRE - OP INSTRUMENT COUNT CORRECT	SWILSON	RJARDINE
FINAL SWAB COUNT CORRECT	SWILSON	K. BAILEY KB
FINAL INSTRUMENT COUNT CORRECT	SWILSON	K. BAILEY KB
FINAL SWAB DISPATCH COUNT CORRECT	SWILSON	K. BAILEY KB

SCRUB NURSE VERIFICATION - PLEASE SIGN ON PAGE UNDERNEATH.

I have reviewed this count sheet and can verify my count(s) correct

SCRUB NURSE 1- SIGNATURE -

SCRUB NURSE 2 SIGNATURE -
To be signed by replacement scrub nurse if applicable

HANDOVER COUNT IN EVENT OF REPLACEMENT OF SCRUB NURSE DURING PROCEDURE

	Outgoing Scrub Nurse - Print Name	Incoming Scrub Nurse - Print Name	Circulating Nurse(s) - Signature & Print name
OUTGOING COUNT *To be completed for permanent and temporary replacement*			
INCOMING COUNT *To be completed for temporary replacement*			

OPERATION: LEFT KNEE ARTHROSCOPY

TALLY OF EACH ITEM USED - ADD ANY ITEMS SPECIFIC TO YOUR SPECIALITY

						ITEMS REMAINING IN SITU (Type & Number)
Swabs (2x2)	✓	Tapes	✓			
Swabs (10x10)	10	Sloops/Slings	✓			
Abdominal packs	✓	Bulldogs	✓			
Sutures	✓	Shods	✓			
Blades	1	Tibbs Cannula	✓			
IV needles	2	Ports	✓			
Syringes	1	Staple Gun Inserts	✓			
Discard-a-pad	1	Spears	✓			
Diathermy pencil	✓	Throat packs - Anae	✓			
Diathermy tips	✓	Throat packs - Scrub	✓			
Scratch pad	✓	Retrieval Bag (Bert)	✓			
Reels	✓	Digital Tourniquets	✓			
Patties	✓					
Pledgelets	✓					

DISCREPANCY IN COUNT - ACTIONS AND OUTCOME

COUNT IN WHICH DISCREPANCY OCCURRED

DETAILS

ACTIONS TAKEN AND OUTCOME (I.E. SWABS ISOLATED, SEARCH UNDERTAKEN, WOUND EXPLORED, X - RAY TAKEN) -

SCRUB NURSES SIGNATURE IF COUNT STILL INCORRECT FOLLOWING ALL POSSIBLE ACTIONS

SURGEONS SIGNATURE IF COUNT INCORRECT FOLLOWING ALL POSSIBLE ACTIONS

PLEASE INSERT TRACEABILITY STICKERS ON BACK OF COPY- TO STAY IN THEATRE.

SGH DVT PROPHYLAXIS PATHWAY

Patient Label

3108583156
MACKENZIE
Brian M
22 LOMOND AVENUE 31/08/1958
Renfrew, Renfrewshire
PA4 0PG

STANDARD RISK	INCREASED RISK	BLEEDING RISK
☐ Acute trauma/surgical admission	☐ Critical care admission	☐ Concurrent use of therapeutic anticoagulants
☐ Dehydration	☐ BMI > 30	☐ Acute bacterial endocarditis
☐ Age > 60 years	☐ Active cancer or cancer treatment	☐ Proliferative diabetic retinopathy
☐ Total anaesthetic/surgery >90 mins	☐ Thrombophilia	☐ Untreated inherited bleeding disorder
☐ Lower limb anaesthetic/surgery >60 mins	☐ Varicose veins with phlebitis	☐ Active Risk of bleeding New onset stroke Platelet count < 75 X 10^9/L Acute liver failure Active gastric or duodenal ulcer
☐ Significant reduced mobility from normal > 2days	☐ Personal history or first degree relative with history of VTE	
	☐ Pregnancy or ≤ 6 weeks post partum	
	☐ Oestrogen containing contraceptive pill	
	☐ Hormone replacement therapy/Tamoxifen	
	☐ Current significant medical condition	

LOW RISK ☑ NO prescription required BLEEDING RISK ☐ Discuss with senior clinical staff

Anti-Embolic Stockings YES ☐ NO ☐

STANDARD/INCREASE RISK ☐

PRESCRIPTION until discharge CLEXANE 40mg (4 hours post op for surgical cases)

If < 50Kg or eGFR ,<30ml/min 20mg only

DISCHARGE PRESCRIPTION

STANDARD RISK ☐ ASPIRIN 150 mg o.d. for 35 days

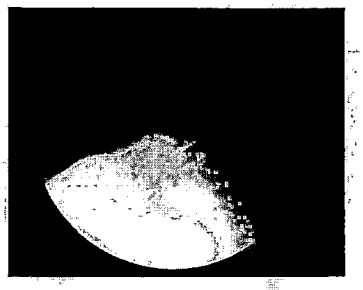
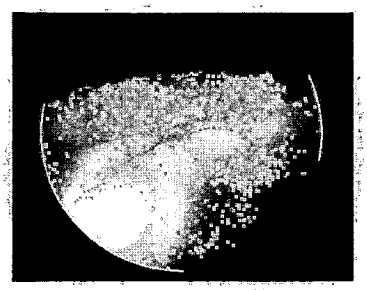
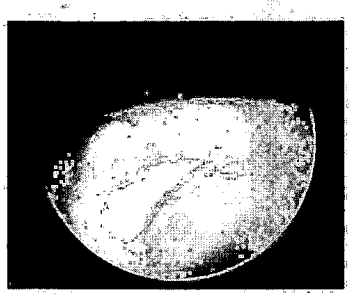
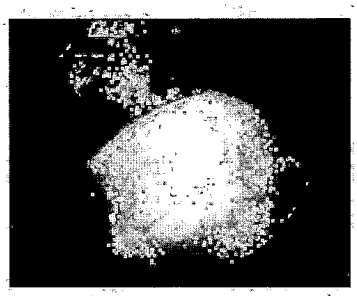
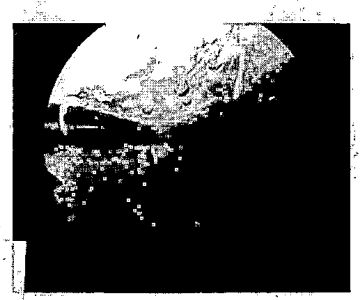
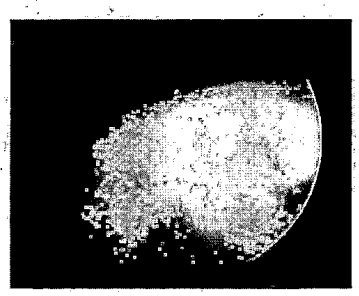
INCREASED RISK Major Arthroplasty or Hip Fracture ☐ Minor Procedure ☐

CLEXANE 40 mg for 35 days ASPIRIN 150 mg o.d. for 35 days

If < 50Kg or eGFR ,<30ml/min 20mg only

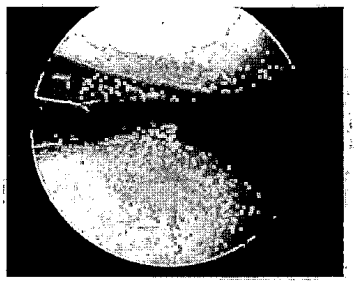
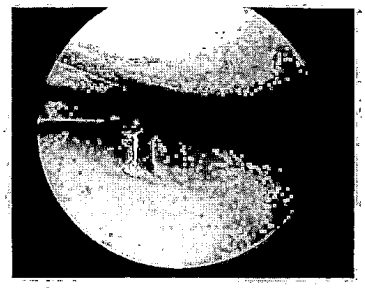
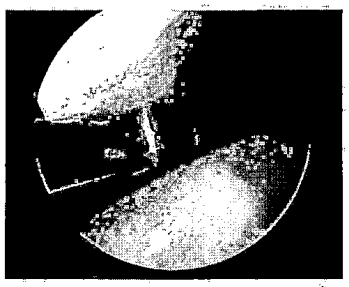
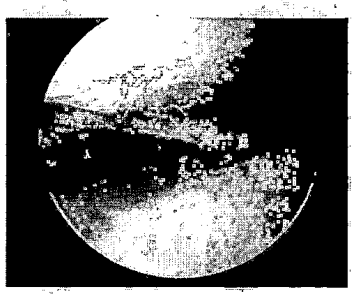
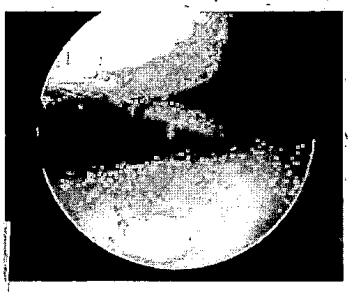
Risk Assessment Result

ADMISSION PRE OP	DAY 3	DAY 6
VTE Risk factor assessed YES ☑ NO ☐	VTE Risk factor assessed YES ☐ NO ☐	VTE Risk factor assessed YES ☐ NO ☐
Bleeding Risk Assessed YES ☑ NO ☐	Bleeding Risk Assessed YES ☐ NO ☐	Bleeding Risk Assessed YES ☐ NO ☐
Patient Informed YES ☑ NO ☐	Patient Informed YES ☐ NO ☐	Patient Informed YES ☐ NO ☐
Information Leaflet YES ☑ NO ☐	Information Leaflet YES ☐ NO ☐	Information Leaflet YES ☐ NO ☐
Assessor Name A. Marsh	Assessor Name	Assessor Name
Signature	Signature	Signature
Date	Date	Date
Kardex documented YES ☐ NO ☐	Kardex documented YES ☐ NO ☐	Kardex documented YES ☐ NO ☐
Presriber Name	Presriber Name	Presriber Name

3108583158
MACKENZIE M
Brian 31/08/1958
22 LOMOND AVENUE
Renfrew, Renfrewshire
PA4 0P

Procedure Date: 08/12/2014
Procedure: LEFT KNEE ARTHROSCOPY

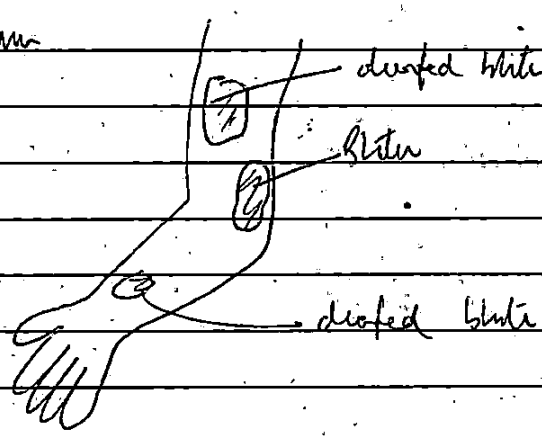

3108583158
MACKENZIE M
Brian 31/08/1958
22 LOMOND AVENUE
Renfrew, Renfrewshire
PA4 0PG

NHS GREATER GLASGOW & CLYDE

3108583158
MACKENZIE
Brian
M
31/08/1958

(1)

CLINICAL NOTES - MEDICAL

Date & Time		Signature, Print Name & Designation
9.5.17		
	(L) arm base pelvis	
		
	clean, dressing noted	
	(D) Ex practice nurse	

83949

Acute Services Division

Surgery and Anaesthetics Directorate

Department: Pre Op Assessment Unit

Specialty: Trauma and Orthopaedic Surgery

NHS Greater Glasgow and Clyde

Hospital Name	Southern General

Patient Details		GP Details	
Name	MacKenzie, Brian	Name	AL-NAJIM, ZIAD
Address	22 LOMOND AVENUE Renfrew Renfrewshire PA4 0PG	Address	Renfrew Health Centre 10 Ferry Road Renfrew
Correspondance Address		Telephone	
Correspondance Postcode		CRN Number	SG00375441, DYK3108583158, ZNC12566884
Telephone		Consent	Yes
Patient Contact Number	07966154552	Sensitivity	Sensitive
CHI Number	3108583158	Consultant Name	MARSH
Sex	Male	Requires Transport	No
Date of Birth	31/08/1958	Religion	Christian

Next of Kin / Person to Notify	Next of Kin	Person to Notify
Name	MARGARET MACKENZIE	
Address		
Landline		
Mobile	07973435422	
Relationship	WIFE	

Assessor

Patricia Campbell Date Assessed: 20/11/2014

POA First Line

Surgery / Procedure: ARTHROSCOPY LEFT KNEE -
Admission - DSU
TCI Date -
Fasting information provided

Availability

Reason -
Details -

Examination

Age: 56	Weight (kg): 67.0	Height (m): 1.67	BMI: 24
BP: /mmHg	Pulse: 67/ min	Rhythm: Regular	SaO2: 97%

Patient has had an anaesthetic before. There is not a family history of anaesthetic problems.
Patient has had surgery before. HAEMORROID SURGERY ,HERNIA SURGERY
Patient is currently taking the following medication:

CETIRIZINE 10mg daily
TRAMADOL 100MG AM

Patient has the following allergies:

Current Drug Allergies and Adverse Reactions

Current Non-Drug Allergies and Sensitivities					
Category	Plants, Wood, etc	Drug	POLLEN	Reaction(s)	Skin Rash

Patient does not suffer from heartburn or indigestion.
Patient does not have any heart conditions
Patient does not have high blood pressure
Patient does not have diabetes. .
Patients best level of fitness is - climbs 1 flight of stairs without stopping.
Patient does not have breathing problems
Patient does not have kidney / liver problems
Patient has not been notified that they are at risk of CJD, vCJD.
Patient smokes 20.00 cigarettes per day. Patient drinks 0.00 units or alcohol per week.
Patient does not have any Implants / Prothesis
MRSA Screening - Patient requires a Clinical Risk Assessment.

Referrals and Type of admission - Recommended Admission pathway		
Type of Admission:	DSU	
Admission Deferred:	No	

Further Details:

Attended POA today
pre and post op care discussed
Information sheets given.
Advise given to call us if admitted to hospital before procedure.
Does not want referred to smoking cessation clinic

PMH
Haemorroidectomy
Hernia surgery

Investigations done
Bloods
MRSA screen
ECG

TCI 08/12/14 ACH 1200

Consent form signed

26/11/14
Blood and MRSA results satisfactory consent form in pack PC

There is no further information for this patient.

Acute Services Division

Surgery and Anaesthetics Directorate

Department of Pre Op Assessment Unit

Specialty: Trauma and Orthopaedic Surgery

NHS Greater Glasgow and Clyde

PreAdmission Form Release 1.0

Hospital Name:

Patient Details		GP Details	
Name:	MCKENZIE, BRIAN	**Name:**	AL-NAJIM, ZIAD
Address:	22 Lomond Avenue ROAD RENFREW	**Address:**	CLYDEVIEW MEDICAL PRACTICE RENFREW HEALTH CENTRE 10 FERRY ROAD RENFREW PA4 8RU
Postcode:	PA4 0PG	**Telephone:**	
Correspondence Address 1:		**Consent:**	Yes
Correspondence Address 2:		**Sensitivity:**	Sensitive
Correspondence Postcode:		**Consultant Name:**	
Telephone:	07966154552	**Admission Date:**	
CHI Number:	3108583158	**Time:**	
CRN:	SG00375441, DYK3108583158, ZNC12566884	**Ward:**	
D.O.B:	31/08/1958	**Procedure/Operation:**	

Observations					
Temperature (celcius)		**Resps (per min)**		**Heart Rate (bpm)**	
Blood Pressure (mmHg)		**O2 Sats (%)**		**S/Mews Score**	
Changes Since POA?	*Yes*		*No*		

There are no allergies to display

Emergency Contact Numbers	
Name	
Relationship	
Phone	

Discharge	Yes	No
Estimated Date		
Transport Required		
Supervising Adult for Discharge		

Home Circumstances			Yes	No
Lives with Family Carer				
Lives Alone				
Elderly/Disabled Partner				
District Nurse		**days/wks**		
Home Help				
Other Services				

Medicines	Yes	No
Own Supplied		

Valuables	Yes	No
Valuables Returned		

MRSA			
Positive	**Negative**	**Unknown**	

Activities of Daily Living	NOTE: NOT REQUIRED FOR DAY SURGERY
Safety and Comfort	
Breathing and circulation	
Maintaining Body Temp	
Personal Hygiene	
Elimination	
Sleep	
Mobility	
ing and drinking	
Skin Condition/Waterlow score	
Communication (including anxiety & fear) Aids worn?	

Date		Admitted By	

CHI Number: 3108583158 Patient Name: MCKENZIE, BRIAN

Acute Services Division

Surgery and Anaesthetics Directorate

Department: Pre Op Assessment Unit

Specialty: Trauma and Orthopaedic Surgery

NHS Greater Glasgow and Clyde

Hospital Name	Victoria Infirmary

Patient Details		GP Details	
Name	MCKENZIE, BRIAN	Name	AL-NAJIM, ZIAD
Address	22 Lomond Avenue ROAD RENFREW PA4 0PG	Address	CLYDEVIEW MEDICAL PRACTICE RENFREW HEALTH CENTRE 10 FERRY ROAD RENFREW PA4 8RU
Correspondance Address		Telephone	
Correspondance Postcode		CRN Number	SG00375441, DYK3108583158, ZNC12566884
Telephone	07966154552	Consent	Yes
Patient Contact Number	0	Sensitivity	Sensitive
CHI Number	3108583158	Consultant Name	MR A D SHAW
Sex	Male	Requires Transport	No
Date of Birth	31/08/1958	Religion	Christian

Next of Kin / Person to Notify	Next of Kin	Person to Notify
Name	MAGRET MACKENZIE	
Address	SA	
Landline		
Mobile	07973435422	
Relationship	WIFE	

Assessment Details					
Assessor	C/N JANICE FERGUSON	Grade	BAND 6	Date	13/03/2012
Ward	CLINIC F V I ACH				

Surgery / Procedure Attending For
® KNEE ARTHROSCOPY + PMM + CHONDROPLASTY OF PATELLA

Availability	
Are you available at short notice?	

CHI Number: 3108583158 Patient Name: MCKENZIE, BRIAN

Period of unavailability	
Reasons for unavailability	
Details	

Anaesthetic History

1. Previous GA	
Have you had a General Anaesthetic before?	Yes
Were there any problems?	No

2. Previous LA	
Have you had a Local Anaesthetic before?	Yes
Were there any problems?	No

3. Dentition Risk	
Do you have any loose teeth, caps or dentures?	Yes
Details	UPPER ® MOLAR LOOSE, PARTIAL UPPER FIXED BRIDGE

4. Reduced neck movement	
Do you have any neck or jaw stiffness?	No

5. Other Risk	
Has anybody in your family had a serious reaction to an anaesthetic?	No

6. Heartburn	
Do you suffer from heartburn or indigestion?	No

7. Sickle Cell Disease (risk factor)	
Do you have sickle cell disease?	No
Are there risk factors for sickle cell disease?	No

Surgical History

8. Affects suitability for DSU or SDA	
Have you ever had surgery?	Yes
Details of relevant surgical history	K-WIRING ® THUMB2011 HAEMORRHOIDECTOMY 1989 VASECTOMY 1986

CHI Number: 3108583158 Patient Name: MCKENZIE, BRIAN

Will this affect the suitability for DSU?	
Have you ever had a serious surgical or anaesthetic complication?	No

Cardiovascular

9. Hypertension	
Do you have high blood pressure?	No

10. Arrhythmias					
Symptoms:	Irregular heartbeat	No	Palpitations	No	Atrial Fibrillation No
How often does it occur?					
Are they assosciated with exercise?					
Does it cause you to faint?					

11. Angina	
Do you suffer from Angina?	No

12. Heart Attack	
Have you had a heart attack?	No

13. Heart Murmur	
Do you have a heart murmur?	No

14. Blackouts	
Do you suffer from blackouts?	Yes
14a. Are the blackouts assosciated with exercise?	No
14b. Is the patient older than 60 years?	No
How often does it occur?	Less often than monthly

15. Heart Failure	
Have you been diagnosed with heart failure?	No

Respiratory

16. Asthma / Bronchitis / COPD / Emphysema	
Do you have asthma, bronchitis, COPD, or emphysema?	No

CHI Number: 3108583158 Patient Name: MCKENZIE, BRIAN

17. URTI (Upper Respiratory Tract Infection)	
Have you recently had a cold?	No

Neurological	
18. Stroke	
Have you had a stroke or TIA?	No

19. Epilepsy	
Do you have epilepsy?	No

20. Neurological Disease	
Do you have any neurological or muscular disease?	No

21. Physical Disability	
Do you have a physical disability?	No

Haemotological	
22. Bleeding Disorder	
Do you suffer from prolonged bleeding or excessive bruising?	No

23. Previous DVT	
Have you had a DVT?	No

24. Anaemia	
Do you suffer from anaemia?	No

Miscellaneous	
25. Kidney Disease	
Do you have renal failure?	No

26. Liver Disease	
Do you have liver disease or suffer from jaundice?	No

27. Diabetes	
Do you have diabetes?	No

CHI Number: 3108583158 Patient Name: MCKENZIE, BRIAN

28. Arthritis	
Do you have arthritis?	No

29. CJD	
Has the patient ever been notified that they are at increased risk of CJD or vCJD for public health purposes?	No

30. Other	
Do you have any serious physical / psychiatric illness or learning difficult not already mentioned?	No

Exercise Tolerance	
31. What best describes your level of fitness?	Climbs stairs without stopping

Social History		
32. How many units of alcohol each week?	0.00	units/week

33. Smoker	
Do you smoke?	Yes
How many each day?	30.00

34. Drug Abuse	
Do you currently or have you ever used intravenous or recreational drugs?	Yes
Details	SMOKES CANNABIS X 70 JOINTS P/W
34a. Do you take methadone?	No

35. Pregnant	
LMP	
Are you pregnant?	No
Could you be pregnant?	No
Details	

36. Language	
Can the patient speak English?	Yes

Drug History
37. Drugs

CHI Number: 3108583158 Patient Name: MCKENZIE, BRIAN

List all drugs (including herbal remedies and complimentary medicines)
TRAMADOL 50MGS THIAMINE 100MGS

Does the patient take any of the following?	
Anticoagulants	No
Clopidogrel	No
Aspirin	No
OCP	No
Digoxin	No
Amiodarone	No
Lithium	No
Diuretics	No
MAOIs	No

38. Herbal Remedies	
Are you taking any herbal remedies or complimentary medicine?	No

39. Steroids	
Have you taken regular oral steroids in the last year?	No

40. Allergies	
Does patient have any allergies?	No

Implants	
41. Pacemaker	
Do you have a pacemaker?	No

42. Prosthesis	
Do you have any implants?	No

43. Coronary stents	
Have you had coronary artery stents inserted?	No

Examination			
44. Age (years)	53		
Weight (kg)	73		

CHI Number: 3108583158 Patient Name: MCKENZIE, BRIAN

Height (m)	1.71	BMI	25

45. Risk of sleep apnoea

Do you suffer from daytime sleepiness, restless sleep or witnessed breath-holding during sleep?	No

How likely are you to fall asleep or doze in the following situations?			
a) Sitting and reading	No Chance		
b) Watching TV	No Chance		
c) Sitting inactive in a public place	No Chance		
d) As a passenger in a car for an hour without a break	No Chance		
e) Lying down to rest in the afternoon when circumstances permit	No Chance		
f) Sitting and talking to someone	No Chance		
g) Sitting quietly after lunch without alcohol	No Chance		
h) In a car while stopped for a few minutes in traffic	No Chance		
Status based on sleep apnoea score	No risk of sleep apnoea	Score	0

46. Blood Pressure

Systolic/Diastolic BP	136	/	79

47. Pulse

Pulse Rate	67	/ min
Rhythm	Regular	

48. Oxygen Saturation

	97	%

49. Urine Analysis

Result	Normal
Details	

50. VTE Risk

Is patient at risk of VTE?	Yes	Do they require prophylaxis?	Yes

Day Surgery Criteria

51. Day Surgery Criteria

Is the procedure suitable for day surgery?	No

CHI Number: 3108583158 Patient Name: MCKENZIE, BRIAN

52. Admission Criteria	
Appropriate admission based on nursing assessment	SDA

53. MRSA Screening	
Does the Patient require a Clinical Risk Assessment? (for patients > 23 hours)	Yes
Has the patient ever had a previous positive MRSA result?	No
Has the patient been admitted from a care home/institutional setting or another hospital?	No
Does the patient have a wound/ulcer or invasive device which was present prior to admission?	No

Has patient is to be admitted to any of the following:

Orthopaedics	Yes	Vascular		Renal		Critical Care	

MRSA Lab Test Results

Nose	Yes	Perineum	Yes	Throat	Yes	Other		Patient refused	

Other details:

Investigations Required

Investigation	Required	Ordered	Investigation Date	Med Staff Informed	Action Required	Re-Test Required
Ferritin	No	No		No	No	
Folate	No	No		No	No	
B12	No	No		No	No	
HbA1c	No	No		No	No	
Group & Save	No	No		No	No	
Cross Matching	No	No		No	No	
Coagulation Screen	No	No		No	No	
Thrombophilia Screen	No	No		No	No	
Sickle Dex Test	No	No		No	No	
Hb Electrophoresis	No	No		No	No	
TFT	No	No		No	No	
Lithium level	No	No		No	No	
Digoxin level	No	No		No	No	
Amylase	No	No		No	No	
Calcium/Bone	No	No		No	No	
ECHO	No	No		No	No	
PEFR	No	No		No	No	
PFT	No	No		No	No	
C-Spine X-Ray	No	No		No	No	
Chest X-Ray	No	No		No	No	
Pregnancy Test	No	No		No	No	
Temperature	No	No		No	No	
FBC	Yes	Yes	13/03/2012	No	No	
Glucose	Yes	Yes	13/03/2012	No	No	
U&Es	Yes	Yes	13/03/2012	No	No	
LFTs	Yes	Yes	13/03/2012	No	No	
CRP	Yes	Yes	13/03/2012	No	No	
ECG	Yes	Yes	13/03/2012	No	No	

CHI Number: 3108583158 Patient Name: MCKENZIE, BRIAN

Investigations Required						
Investigation	Required	Ordered	Investigation Date	Med Staff Informed	Action Required	Re-Test Required
MRSA Screen	Yes	Yes	13/03/2012	No	No	

Pre-op Assessment Summary	
Assessor	C/N JANICE FERGUSON
Grade	BAND 6

Summary

TCI 19/3/12 UNDER MR SHAW
BLOODS,ECG AND MRSA SCREEN OBTAINED
PREVIOUS ALCOHOL ABUSE NIL SINCE SEPTEMBER 2011
SMOKES CANNABIS JOINTS X70 P/W ADVISED TO AVOID 24 HRS PRE/OP
CLAIMS X 2 EPISODES OF BLACKOUT AFTER COUGHING FITS - NIL IN PAST YEAR

Referrals and Type of admission - Recommended Admission pathway		
Referral by Nurse to:	Anaesthetist	Yes
	Surgeon	Yes
	Haematologist	No
	Cardiologist	No
	GP	No
	Cardiac Technician Pace Reset	No
	Cardiac Technician Pace Check	No
Nurse to arrange the attendance of:	Carer	No
	Interpreter	No
Nurse to:	Inform ward staff regarding the risk of alcohol withdrawl	No
Referral by Anaesthetist to:	Surgeon	No
	Haematologist	No
	Cardiologist	No
	Cardiac Technician	No
	GP	No
Type of admission to be decided by:		
Type of Admission:	SDA	
Admission Deferred:	No	

Advise to take usual anti-reflux medication	No
Dispensed Ranitidine as per PGD directive	No
Refer to smoking cessation clinic	No
Advise not to take "intravenous or recreational drug(s)" during the 24 hours before surgery (related to 33. Drug Abuse)	Yes
Anticoagulant advice	No

CHI Number: 3108583158 Patient Name: MCKENZIE, BRIAN

Clopidogrel advice	No
Aspirin advice	No
OCP advice	No
Provide Herbal Medicine Advice	No
Arrange for dialysis the day before surgery	No
Ensure facilities for dispensing methadone are available, if the patient is taking methadone	No
Print PEFR Advice Sheet	No
Print ECG Advice Sheet	No

Anaesthetist Assessment	
Anaesthetist	
Grade	
Summary	

CHI Number: 3108583158 Patient Name: MCKENZIE, BRIAN

Acute Services Division

Surgery and Anaesthetics Directorate

Department: Pre Op Assessment Unit

Specialty: Trauma and Orthopaedic Surgery

NHS Greater Glasgow and Clyde

Hospital Name	Victoria Infirmary

Patient Details		GP Details	
Name	MCKENZIE, BRIAN	Name	AL-NAJIM, ZIAD
Address	22 Lomond Avenue ROAD RENFREW PA4 0PG	Address	CLYDEVIEW MEDICAL PRACTICE RENFREW HEALTH CENTRE 10 FERRY ROAD RENFREW PA4 8RU
Correspondance Address	,	Telephone	
Correspondance Postcode		CRN Number	SG00375441, DYK3108583158, ZNC12566884
Telephone	07966154552	Consent	Yes
Patient Contact Number	0	Sensitivity	Sensitive
CHI Number	3108583158	Consultant Name	MR A D SHAW
Sex	Male	Requires Transport	No
Date of Birth	31/08/1958	Religion	Christian

Next of Kin / Person to Notify	Next of Kin	Person to Notify
Name	MAGRET MACKENZIE	
Address	SA	
Landline		
Mobile	07973435422	
Relationship	WIFE	

Assessment Details					
Assessor		Grade		Date	

Surgery / Procedure Attending For
®

Short Notice Availability	Yes/No	Details
Available at short notice?		

CHI Number: 3108583158 Patient Name: MCKENZIE, BRIAN

Anaesthetic	Yes/No	Details/Problems
Previous GA	Yes	
Previous LA	Yes	
Detention Risk	Yes	UPPER ® MOLAR LOOSE, PARTIAL UPPER FIXED BRIDGE
Neck/Jaw Stiffness	No	
Other Risk	No	
Heartburn	No	
Sickle Cell Disease	No	Risk factors for sickle cell disease: No
Sleep Apnoea Score		

Surgical History	Yes/No	Details/Problems
Affects suitability for DSU		
Relevent details of surgical history		
Any serious surgical or anaesthetic complication	No	

Cardiovascular	Yes/No	Details/Problems
Hypertension	No	
Arrhythmias		
Angina	No	
Heart Attack	No	
Murmur	No	
Blackouts	Yes	Occurence is Less often than monthly
Heart Failure	No	

Respiratory	Yes/No	Details/Problems
Asthma/Bronchitis/COPD/Emphysema	No	
URTI	No	

Neurological	Yes/No	Details/Problems
Stroke	No	
Epilepsy	No	
Neurological Disease	No	
Physical Disability	No	

Haematological	Yes/No	Details/Problems
Bleeding Disorder	No	
Previous DVT	No	
Anaemia	No	

CHI Number: 3108583158 Patient Name: MCKENZIE, BRIAN

Miscellaneous	Yes/No	Details/Problems
Kidney disease	No	
Liver disease/jaundice	No	
Diabetes	No	
Arthritis	No	
CJD Risk	No	

Any serious illness not already mentioned?	No

Exercise Tolerance	Yes/No		Yes/No		Yes/No
Climbs stairs without stopping	Yes	Climbs stairs with stopping	No	Cannot climb stairs	No

Social	Yes/No				
Alcohol (units/week)		0			
Smoker	Yes	30 cigs/day			
Ex Smoker					
IV drug abuser	Yes	SMOKES CANNABIS X 70 JOINTS P/W		Methadone Req:	No
Pregnant	No	LMP		Could Be Pregnant:	No

Drug History
List of all drugs (including herbal remedies and complimentary medicine)
TRAMADOL 50MGS THIAMINE
Patient takes the following drugs

Taking herbal remedies or complimentary medicine	No
Oral Steroids in past year	No

Does patient have any allergies?	No

Prosthesis/Implants	Yes/No				
Pacemaker	No	Date of last Check		Date of Insertion	
		Reason for insertion			
		Other Reason			
Prosthesis/Other	No				

Examination							
Weight (kg)	73	Height (m)	1.71	BMI	25	Temp	
Pulse (bpm)	67	Regular		BP	136/79		

CHI Number: 3108583158 Patient Name: MCKENZIE, BRIAN

SaO2 (%)	97

Investigations

The below investigations are required.

FBC
Glucose
U&Es
LFTs
ECG

VTE Risk

Is patient at risk of VTE?	Yes	Do they require prophylaxis?	Yes

MRSA Screening

Does the Patient require a Clinical Risk Assessment?(for patients > 23 hours)	Yes
Has the patient ever had a previous positive MRSA result?	No
Has the patient been admitted from a care home/institutional setting or another hospital?	No
Does the patient have a wound/ulcer or invasive device which was present prior to admission?	No

Has patient is to be admitted to any of the following:

Orthopaedics	No	Vascular	No	Renal	No	Critical Care	No

MRSA Lab Test Results

Nose	No	Perineum	No	Throat	No	Other	No	Patient refused	No

Other details:	

Admission Criteria

Appropriate admission based on nursing assessment	SDA

Pre-operative Assessment Summary

Assessor: Grade:

Recommended Admission Pathway

Referral by nurse to:	
Nurse to arrange the attendance of:	
Nurse to:	
Referral by Anaesthetist to:	
Type of admission to be decided by:	
Type of Admission:	
Admission Deferred:	No

CHI Number: 3108583158 Patient Name: MCKENZIE, BRIAN

Anaesthetic Assessment	Anaesthetist:	Grade:

Acute Services Division

Surgery and Anaesthetics Directorate

Department of Pre Op Assessment Unit

Specialty: Trauma and Orthopaedic Surgery

NHS Greater Glasgow and Clyde

PreAdmission Form Release 1.0

Hospital Name:

Patient Details		GP Details	
Name:	MCKENZIE, BRIAN	**Name:**	AL-NAJIM, ZIAD
Address:	22 Lomond Avenue ROAD RENFREW	**Address:**	CLYDEVIEW MEDICAL PRACTICE RENFREW HEALTH CENTRE 10 FERRY ROAD RENFREW PA4 8RU
Postcode:	PA4 0PG	**Telephone:**	
Correspondence Address 1:		**Consent:**	Yes
Correspondence Address 2:		**Sensitivity:**	Sensitive
orrespondence Postcode:		**Consultant Name:**	
Telephone:	07966154552	**Admission Date:**	
CHI Number:	3108583158	**Time:**	
CRN:	SG00375441, DYK3108583158, ZNC12566884	**Ward:**	
D.O.B:	31/08/1958	**Procedure/Operation:**	

Observations					
Temperature (celcius)		**Resps (per min)**		**Heart Rate (bpm)**	
Blood Pressure (mmHg)		**O2 Sats (%)**		**S/Mews Score**	
Changes Since POA?	*Yes*	*No*			

There are no allergies to display

Emergency Contact Numbers	
Name	
Relationship	
one	

Discharge	Yes	No
Estimated Date		
Transport Required		
Supervising Adult for Discharge		

Home Circumstances		Yes	No
Lives with Family Carer			
Lives Alone			
Elderly/Disabled Partner			
District Nurse	**days/wks**		
Home Help			
Other Services			

Medicines	Yes	No
Own Supplied		

Valuables	Yes	No
Valuables Returned		

MRSA			
Positive	**Negative**	**Unknown**	

Activities of Daily Living	NOTE: NOT REQUIRED FOR DAY SURGERY
Safety and Comfort	
Breathing and circulation	
Maintaining Body Temp	
Personal Hygiene	
Elimination	
Sleep	
Mobility	
Eating and drinking	
Skin Condition/Waterlow score	
Communication (including anxiety & fear) Aids worn?	
Date	Admitted By

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 01/05/2026

Consultant: Dr Cieran McKiernan

Z Al-Najim
Clydeview Medical Practice
Renfrew Health Centre
10 Ferry Road
Renfrew
Renfrew
PA4 8RU

Dear Z Al-Najim

Re: **MacKenzie Brian** DOB: **31/08/1958** CHI: **3108583158**
22 LOMOND AVENUE
Renfrew PA4 0PG

Attended on: **01/05/2026 at 12:18 hrs.** Departed on: **at hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
dog bite to hand

Nursing Assessment:

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Bitten Or Struck By Dog In Unspecified Place		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:

Presents to MIU dog bite to (R) hand sustained today by own dog. On exam x2 superficial wounds noted to dorsal aspect hand. No signs of infection, bleeding, swelling or deformity. Wound irrigated and inadine dressing applied. Tetanus administered and prophylactic co-amoxiclav given for 3/7 days. D/C home with worsening advice.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Cara Loomes
Charge Nurse

Copies to:

1. Z Al-Najim (GP)

School Address:

SOUTHERN GENERAL HOSPITAL
1345 GOVAN ROAD
GLASGOW G51 4TF
Accident & Emergency Dept
Phone (0141) 201 1456 Fax (0141) 201 2997

DR. JUDITH JM ANDERSON
RENFREW HEALTH CENTRE
10 FERRY ROAD
RENFREW

PA4 8RU
0141 207 7730

Dear Dr. JUDITH JM ANDERSON,

Your Patient
Name : BRIAN MACKENZIE
DOB : 31/08/1958
Address : 22 LOMOND AVENUE
RENFREW
RENFREWSHIRE
PA4 0PG

Consultant : DR JASON LONG

Account # : AE0044302/11 Unit # : SG00375441 CHI # : 310

Attended at : 1928 on 25/05/2011
Left A&E at : 2120 on 25/05/2011

Reason for Visit : RIGHT KNEE INJURY

Diagnosis : Dislocation : RIGHT : Knee

Investigations : Knee X-Ray

Treatments : Knee Splint
: Crutches

Prescribed Drugs :

DRUGS	DIRECTIONS
Co-codamol	1-2 Tabs 6 Hrly

Tetanus Given :

Additional Notes:
DOG RAN INTO LATERAL ASPECT RIGHT KNEE, FELL TO GROUND AND STATED OBVIOUS DEFORMITY - WHEN STRAIGHTENED LEG KNEE 'CLICKED' BACK INTO PLACE. FULL ROM BUT BONY TENDERNESS OVER PATELLA AND MED/LAT JOINT LINES. SMALL MEDIAL EFFUSION PRESENT. NO NV DEFECIT DISTALLY. TREATED AS CLINICAL PATELLAR DISLOCATION. PLACED IN KNEE SPLINT. DC WITH ANALGESIA AND ORTHO OPD

Follow Up : HOME

Yours sincerely

BARRY BLYTH

If you require any further information please quote this attendance number: AE00

SOUTHERN GENERAL HOSPITAL
1345 GOVAN ROAD
GLASGOW G51 4TF
Accident & Emergency Dept
Phone (0141) 201 1456 Fax (0141) 201 2997

DR. JUDITH JM ANDERSON
THE HEALTH CENTRE
103 PAISLEY ROAD
RENFREW

PA4 8LH
0141 314 4646

Dear Dr. JUDITH JM ANDERSON,

Your Patient
Name : BRIAN MACKENZIE
DOB : 31/08/1958
Address : 12 ORCHARD STREET
RENFREW
RENFREWSHIRE
PA4 8RL

Consultant : DR NICOLA LITTLEWOOD

Account # : AE0086541/09 Unit # : SG00375441 CHI # : 310

Attended at : 0704 on 03/10/2009
Left A&E at : 0725 on 03/10/2009

Reason for Visit : THUMB INJURY ? FOR DEBRIDING THIS AM

Diagnosis :

Investigations :

Treatments :

Prescribed Drugs : DRUGS DIRECTIONS

Tetanus Given :

Additional Notes:

Follow Up : WD2

Yours sincerely

DR.

If you require any further information please quote this attendance number: AE00

SOUTHERN GENERAL HOSPITAL
1345 GOVAN ROAD
GLASGOW G51 4TF
Accident & Emergency Dept
Phone (0141) 201 1456 Fax (0141) 201 2997

DR. JUDITH JM ANDERSON
THE HEALTH CENTRE
103 PAISLEY ROAD
RENFREW

PA4 8LH
0141 314 4646

Dear Dr. JUDITH JM ANDERSON,

Your Patient
Name : BRIAN MACKENZIE
DOB : 31/08/1958
Address : 12 ORCHARD STREET
RENFREW
RENFREWSHIRE
PA4 8RL

Consultant : MR MALCOLM W G GORDON

Account # : AE0086422/09 Unit # : SG00375441 CHI # : 310

Attended at : 1743 on 02/10/2009
Left A&E at : 2135 on 02/10/2009

Reason for Visit : HEAD INJURY RIGHT THUMB INJURY

Diagnosis : Compound Fracture Dislocation : RIGHT : Thumb

Investigations : Hand X-Ray

Treatments :

Prescribed Drugs : DRUGS DIRECTIONS

Tetanus Given :

Additional Notes:
ALLEGEDLY ASSAULTED WTH GOLF CLUB. MINOR HEAD INJURY - CLOSED WITH 2 STAPLES. HAS OPEN DISLOCATION OF RIGHT THUMB INTERPHALANGEAL JOINT. REFERRED TO ORTHO FOR FURTHER TREATMENT.

Follow Up : #

Yours sincerely

DR. DAVID FINN

If you require any further information please quote this attendance number: AE00

SOUTHERN GENERAL HOSPITAL
1345 GOVAN ROAD
GLASGOW G51 4TF
Accident & Emergency Dept
Phone (0141) 201 1456 Fax (0141) 201 2997

DR. JUDITH JM ANDERSON
THE HEALTH CENTRE
103 PAISLEY ROAD
RENFREW

PA4 8LH
0141 314 4646

Dear Dr. JUDITH JM ANDERSON,

Your Patient
Name : BRIAN MACKENZIE
DOB : 31/08/1958
Address : 12 ORCHARD STREET
RENFREW
RENFREWSHIRE
PA4 8RL

Consultant : MR MALCOLM W G GORDON

Account # : AE0086422/09 Unit # : SG00375441 CHI # : 310

Attended at : 1743 on 02/10/2009
Left A&E at : 2135 on 02/10/2009

Reason for Visit : HEAD INJURY RIGHT THUMB INJURY

Diagnosis : Compound Fracture Dislocation : RIGHT : Thumb

Investigations : Hand X-Ray

Treatments :

Prescribed Drugs : DRUGS DIRECTIONS

Tetanus Given :

Additional Notes:
ALLEGEDLY ASSAULTED WTH GOLF CLUB. MINOR HEAD INJURY - CLOSED WITH 2 STAPLES. HAS OPEN DISLOCATION OF RIGHT THUMB INTERPHALANGEAL JOINT. REFERRED TO ORTHO FOR FURTHER TREATMENT.

Follow Up : #

Yours sincerely

DR. DAVID FINN

If you require any further information please quote this attendance number: AE00

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Main Switchboard: 0141 201 1100
Department: General Surgery
Contact Tel: 0141 201 1674
Enquiries to: Hazel Ward

Dr. Z Al-Najim
The Health Centre
103 Paisley Road
Renfrew
PA4 8LH

Letter Date: 30/07/2014
Reference: GS/CB
Dictated Date: 26/07/2014
Transcribed Date: 28/07/2014

Dear Dr Al-Najim,

Brian MacKenzie; D.O.B: 31/08/1958; CHI: 3108583158
22 LOMOND AVENUE, Renfrew, Renfrewshire, PA4 0PG

Mr McKenzie's scan does not show any evidence of a hernia and shows some normal looking lymph nodes in the groin only.

Yours sincerely

Mr Graeme Smith

Consultant Surgeon

Electronically Signed: Mr Graeme Smith, Consultant

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

Dr. Z Al-Najim
The Health Centre
103 Paisley Road
Renfrew
PA4 8LH

Main Switchboard: 0141 201 1100
Department:
Contact Tel: 0141 201 1674
Enquiries to: hazel.ward@ggc.scot.nhs.uk
Letter Date: 03/06/2014
Reference: Dr Aileen Rooney
Dictated Date: 03/06/2014
Transcribed Date: 04/06/2014

Dear Dr. Z Al-Najim,

Brian MacKenzie; D.O.B: 31 Aug 1958; CHI: 3108583158
22 LOMOND AVENUE, Renfrew, Renfrewshire, PA4 0PG

Attendance: Specialty - General Surgery; Clinic - SGGSGS4-MR SMITH SURG TUE PM
Date and Time of Appointment - 03/06/2014 15:20

Clinical Comments:

Many thanks for your referral of this 55 year old gentleman who complains of a swelling in his left groin. He tells me that he was aware of this swelling which was mildly tender in January of this year. It was quite a firm swelling which was there constantly. He works as a gardener but could not attribute this to any heavy lifting just prior to the appearance of this swelling. He has had no change in bowel habit and is otherwise fit and well. He has previously had an umbilical hernia repair. His past medical history includes a meniscal tear, scarlet fever and he is a current smoker of 20 cigarettes per day.

On examination today he had a slight recurrence of his umbilical hernia but he was asymptomatic from this and it was fully reducible. There was no obvious hernia on the left side of his groin. Testicular examination revealed some simply cysts which was confirmed on ultrasound last year.

He was reviewed by Mr Smith and we have arranged for him to have an outpatient ultrasound of the left groin ?femoral hernia ?lymph node. We have not arranged to review him again routinely however if he runs into any problems or there is a hernia on the scan we would be happy to see him at this point. Likewise if he develops any problems or pain from the umbilical hernia we have advised him to attend A&E if it becomes incarcerated. If not we are happy to review that again as an outpatient.

Yours sincerely,

Ms Aileen Rooney

Electronically Signed: Dr Aileen Rooney, Doctor

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Dr. Z Al-Najim
The Health Centre
103 Paisley Road
Renfrew
PA4 8LH

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

Main Switchboard: 0141 201 1100
Email Inquiries to:
Contact Tel Details: 0141 232 7866

Dictated Date: 19/05/2014
By: MR A KER
Transcribed Date: 29/05/2014
By: Carine Halliday

Dear Dr. Z Al-Najim,

Patient

Name:	MacKenzie Brian
CHI:	3108583158
DOB:	31 Aug 1958
Address:	22 LOMOND AVENUE Renfrew PA4 0PG

Attendance

Attended:	19/05/2014 10:10
New/Return:	S R LOWER LIMB
Referral Source:	General Practitioner
Consultant:	Mr Aslam Mohammed
Specialty:	Orthopaedics
Clinic:	SGAMOR1-MR MOHAMMED ORTHO MONDAY AM

Clinical Comments:

I saw this man in the Clinic today for the results of an MRI scan of his left knee. He works as a Gardener and presented with worsening left knee pain. This is worse over the medial aspect of the knee and he was having difficulty with activties where he had to kneel or squat. He denied any history of trauma. He said that the knee occasionally clicks and feels unstable. However, it has never given way. There is no history of locking. He is taking Tramadol as required. He is otherwise fit and healthy and is a smoker of 20 cigarettes per day.

Mr MacKenzie went for an MRI scan of his left knee which has been reported as showing a probable tear of the posterior horn of the media meniscus extending into the body and also an irregular fibrillation of the free edge of the lateral meniscus in keeping with a degenerative tear.

On examining Mr MacKenzie's knee today there is no obvious effusion or deformity. He is tender over the medial and lateral joint lines. He has a full active pain free range of movement of the knee. All ligaments are intact.

I explained to Mr MacKenzie his diagnosis of a meniscal tear. The scan also shows some early degenerative changes. I have explained to him that we could perform an arthroscopic procedure and possible partial meniscectomy which may help with his symptoms. However, this is not guaranteed. I also explained that there is small risk of undergoing this procedure of infection. Mr MacKenzie tells me that he is a seasonalt worker and cannot afford to be off work. However, he is still keen to go ahead with the procedure. He says he would not be able to have this until after the summer season in October. I have therefore advised him to take some regular Paracetamol and Tramadol as required and to stay active.

He will be seen back in four months time to see if his symptoms have changed. At this point we can have a further discussion about putting his name on the Waiting List at that point.

Electronically Signed: Dr Andrew Ker, Doctor

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Dr. Z Al-Najim
The Health Centre
103 Paisley Road
Renfrew
PA4 8LH

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

Main Switchboard: 0141 201 1100
Email Inquiries to:
Contact Tel Details:

Dictated Date: 02/04/2014
By: Aslam Mohammed
Transcribed Date: 17/04/2014
By: Natalie Moffat

Dear Dr. Z Al-Najim,

Patient

Name:	MacKenzie Brian
CHI:	3108583158
DOB:	31 Aug 1958
Address:	22 LOMOND AVENUE Renfrew PA4 0PG

Attendance

Attended:	02/04/2014 13:50
New/Return:	S N LOWER LIMB
Referral Source:	General Practitioner
Consultant:	Mr Aslam Mohammed
Specialty:	Orthopaedics
Clinic:	SGAMOR6-MR MOHAMMED ORTHO NEW WED PM

Clinical Comments:

Thank you for referring this 45 year old gentleman who works as a gardener. His job is seasonal and he finds that during very busy times in the summer his left knee causes him a lot of discomfort. He complains of medial sided knee pain and intermittent swelling affecting his left knee. He also complains of the knee clicking when he is kneeling or squatting and this is very troublesome when he is at work.

He has previously undergone a right knee arthroscopy and debridement a couple of years ago.

On examination of his left knee today he had a mild effusion. He had slight wasting of the quadriceps muscles. Movements of the knee were full and the knee was clinically stable. He was markedly

tender over the medial joint line and x-rays of his knee taken today demonstrated some early degenerative change affecting the patella articular surface.

I have requested an MRI scan to exclude a medial meniscal tear and he will be reviewed once this has been carried out.

Yours sincerely

Aslam Mohammed

Consultant Orthopaedic Surgeon

Electronically Signed: Mr Aslam Mohammed, Consultant

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF
0141 201 1100

Dr. Z Al-Najim
Clydeview Medical Practice
Renfrew Health Centre
10 Ferry Road
Renfrew
PA4 8RU

Main Switchboard:	
Department:	Respiratory
Contact Tel:	0141 451 6159
Enquiries to:	Liz Porteous
Letter Date:	04/06/2018
Reference:	DR/LP
Dictated Date:	04/06/2018
Transcribed Date:	05/06/2018

Dear Dr. Z Al-Najim,

Brian MacKenzie; D.O.B: 31 Aug 1958; CHI: 3108583158
22 LOMOND AVENUE, Renfrew, Renfrewshire, PA4 0PG

Attendance: Specialty - Respiratory Medicine; Clinic - SUDRREI-DR RAESIDE RESP EXTRA CLINIC
Date and Time of Appointment - 04/06/2018 17:50

Clinical Comments:

Thank you for your urgent referral of this man to Chest Clinic.

Chest x-ray had shown a diffuse lesion at the left base, which is confirmed on CT as a fat pad. Other than emphysema, the scan shows no other important abnormality and he was clearly relieved to hear this tonight.

Following these investigations he has stopped smoking and you have given him an inhaler, which he feels has helped substantially. On auscultation the lung fields are clear.

I have discharged him from further review.

Yours sincerely

DR DAVID RAESIDE
Consultant in Respiratory Medicine

Electronically Signed: Dr David Raeside, Consultant

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF
0141 201 1100

Dr. Z Al-Najim
Clydeview Medical Practice
Renfrew Health Centre
10 Ferry Road
Renfrew
PA4 8RU

Main Switchboard:	
Department:	Emergency Department
Contact Tel:	0141 452 2810/1
Enquiries to:	SecretariesSGH.EmergencyDepartment@ggc.scot.nh
Letter Date:	09/05/2017
Reference:	JG/JW
Dictated Date:	09/05/2017
Transcribed Date:	09/05/2017

Dear Dr. Z Al-Najim,

Brian MacKenzie; D.O.B: 31 Aug 1958; CHI: 3108583158
22 LOMOND AVENUE, Renfrew, Renfrewshire, PA4 0PG

Attendance: Specialty - Emergency Medicine; Clinic - SGEDED3-A&E RETURNS TUESDAY
Date and Time of Appointment - 09/05/2017 09:15

Diagnosis:
Burn of shoulder and upper limb - Partial thickness (ICD10: T22.2)

Clinical Comments:

Diagnosis: Partial thickness burns to left arm.

This gentleman sustained petrol burns to his left arm 2 days ago. He has had blistering de-roofed and his wounds appear clean and non infected. We have applied non adherent dressings and I have him it will take approximately 3 weeks for this to fully settle.

He has been discharged with advice.

Yours sincerely

DR J GORDON
CONSULTANT IN EMERGENCY MEDICINE

Electronically Signed: Dr Jonny Gordon, Consultant

cc.

Electronically Signed: Dr Elizabeth Crighton, Doctor

cc.

ORTHOPAEDIC DEPARTMENT
VICTORIA INFIRMARY
LANGSIDE ROAD
GLASGOW G42 9TY
TEL: 0141 201 5185
FAX: 0141 201 5082

ADS/AC /SG00375441
CHI NUMBER: 3108583158

MR. A. D. SHAW'S ORTHOPAEDIC RETURNS CLINIC

SEEN: 03/05/12
DICTATED: 03/05/12
TYPED: 03/05/12

DR AL-NAJIM
RENFREW HEALTH CENTRE
RENFREW
PA4 8RU

Dear Dr

BRIAN MACKENZIE DOB: 31/08/58
22 LOMOND AVENUE, RENFREW, PA4 0PG

This gentleman is now 6 weeks following right knee scope and partial medial meniscetomy. We also performed a chondroplasty of his patella. He reports a lot of benefit from the procedure. His knee feels much steadier and less painful. He is now back working. He tells me he wrenched his left knee just before his surgery. There is no tenderness around the joint lines, a full range of motion, but there is some patellofemoral crepitus. I think it is likely he has some degenerate symptoms in the left knee as well. He is happy with progress to-date and I have discharged him from routine attendance.

Yours sincerely,

Mr. A.D. Shaw, F.R.C.S.Ed.(Tr. Orth.),
Consultant Orthopaedic Surgeon

ORTHOPAEDIC DEPARTMENT
VICTORIA INFIRMARY
LANGSIDE ROAD
GLASGOW G42 9TY
TEL: 0141 201 5185
FAX: 0141 201 5082

ADS/AC /SG00375441
CHI NUMBER: 3108583158

MR. A. D. SHAW'S ORTHOPAEDIC RETURNS CLINIC

SEEN: 23/02/12
DICTATED: 23/02/12
TYPED: 23/02/12

DR AL-NAJIM
RENFREW HEALTH CENTRE,
RENFREW
PA4 8RU

Dear Dr

BRIAN MACKENZIE DOB: 31/08/58
22 LOMOND AVENUE, RENFREW, PA4 0PG

This man's MRI scan of his right knee has been reported showing a flapped tear running into the inferior surface of the medial meniscus. There has also been damage to the central aspect of the patella particularly articular surface with underlying cystic change.

He is presently unable to work as a gardener, because of the pain which is felt mainly at the front of the knee, on bending the knee and on rising.

This is a very difficult situation - the scan has shown a medial meniscal tear, and it is possible some of the feeling of giving way and instability could be due to this tear, but I think it is on balance more likely that his symptoms are all caused by his patella surface damage. This of course occurred when he unfortunately suffered a lateral dislocation of his patella.

he operative options are not good at this stage other than trying arthroscopy - it may be possible to improve his medial meniscal tear and stabilise articular surface around a defect, but in my experience the results are poor and he is likely to have ongoing knee pain. He is young and has a demanding job, and the prospect of a future partial joint replacement to remedy this are not good, indeed this is something I would try to avoid if possible. I have put him on our waiting list for a right knee arthroscopy and partial medial meniscetomy and chondroplasty of the patella as necessary at time of surgery.

Yours sincerely,

Mr. A.D. Shaw, F.R.C.S.Ed.(Tr. Orth.),
Consultant Orthopaedic Surgeon

ORTHOPAEDIC DEPARTMENT
VICTORIA INFIRMARY
LANGSIDE ROAD
GLASGOW G42 9TY
TEL: 0141 201 5185
FAX: 0141 201 5082

ADS/AC /SG00375441
CHI NUMBER: 3108583158

MR. A. D. SHAW'S NEW PATIENT ORTHOPAEDIC CLINIC

SEEN: 13/12/11
DICTATED: 13/12/11
TYPED: 13/12/11

DR AL-NAJIM
RENFREW HEALTH CENTRE
RENFREW
PA4 8RU

Dear Dr

BRIAN MACKENZIE DOB: 31/08/58
22 LOMOND AVENUE, RENFREW, PA4 0PG

Thanks for referring up this 57 year old self employed gardener to the clinic today. He had an incident in May of this year where it sounded like he was stuck by his dog by the side and sustained a patella dislocation which he self reduced and afterwards managed to attend casualty where he was treated with a knee splint and referred on for physio for which he was unable to attend. His work over the past months has been almost impossible for him and he had to hire in some help which has meant he has lost a great deal of his business and earnings over this period. He was unable to attend the physio and now that his work has died down he was hoping something could be done as the knee has remained symptomatic. His problems are that of pain along the lateral aspect of the knee. He only manages to walk a couple of hundred yards a couple of times a day with his dog and otherwise keeps the knee pretty much straight and remains stationary in the house. Occasionally he drives and he finds this difficult with pain around the knee and he can't walk on uneven ground or up and down slopes due to pain again occurring in the same place in the knee. He feels that the does swell up and it has given way on him in the past.

On examination today, this gentleman has marked quads wasting of the right knee. He had pain on stressing of the patella femoral joint and palpation of the patella facet. There was no real discomfort along the tibiofemoral joint lines. A small effusion was present. He would only comfortable flex to about 90 deg after which he felt pain which seemed to be arising from the patellofemoral joint. The knee was ligamentously stable.

I reviewed his old x-rays and the report had made a comment about an irregularity in the patella surface so I repeated the x-rays today. This doesn't seem quite so evident but the question is whether there is a large osteochondral defect here as a result of patella dislocation or whether that is causing some of his symptoms. There certainly doesn't seem to be a loose body and the rest of the knee is in good condition. I have explained to Mr. MacKenzie that in the first instance I

BRIAN MACKENZIE
31/08/58

would like to arrange a MRI to delineate any further pathology in the knee but I have cautioned him that similar patients quite often fail to show any dramatic improvement in symptoms and he should be aware of that at this time given how it will impact on his future self employment. In the meantime, we will arrange for the MRI and will see him back with the results of this in due course and will let you know how he gets on.

Yours sincerely

r. Calum Cree
SPR in Orthopaedics

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR MARC BRANSBY-ZACHARY FRCS
Orthopaedic Hand Upper Limb Service

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Direct Tel: 0141 201 1473

Our Ref: MB-Z/CD
Enquiries To: Helen Carlisle

Seen Dict: 26/05/11
Typed: 02/06/11
CHI: 3108583158

R JUDITH JM ANDERSON
RENFREW HEALTH CENTRE
RENFREW
PA4 8RU

Dear Dr Anderson

BRIAN MACKENZIE DOB: 31/08/58 (SG00375441)
22 LOMOND AVENUE, RENFREW, PA4 0PG

This patient was walking his dog and the dog jumped up causing him to fall twisting his right knee. He appears to have from his description sustained a patella dislocation which spontaneously reduced. He's been struggling to weight bear since and noticed significant swelling of the knee therefore.

On examination there was a significant fusion with tenderness in the medial aspect of the patella and significant patella apprehension. He was able to straight leg raise. Range of motion was from 0 to 80 degrees flexion with no ligamentus instability.

adiographs show no evidence of fracture.

He's a first time patella dislocation and therefore physiotherapy has been arranged.

Yours sincerely

Mr Mullen
Specialist Registrar

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR COLIN R C WALKER FRCS
FRACTURE CLINIC

Our Ref: CRW/LM
Enquiries To: Lillian McInnes

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Direct Tel: 0141 201 1465

Seen Dict: 27/10/09
Typed: 03/11/09
CHI: 3108583158

R JUDITH JM ANDERSON
HE HEALTH CENTRE
RENFREW
PA4 8LH

Dear Dr

BRIAN MACKENZIE DOB: 31/08/58 (SG00375441)
12 ORCHARD STREET, , RENFREW, PA4 8RL

I reviewed this patient in the clinic today. His K wires came out today and he has now been discharged with advice.

Yours sincerely

Kalpesh Shah,
rthopaedic Registrar

Highly Sensitive Document Y/N N Patient consent to share information Y/N Y

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR COLIN R C WALKER FRCS
FRACTURE CLINIC

Our Ref: CRW/MJ
Enquiries To: Lillian McInnes

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Direct Tel: 0141 201 1465

Seen Dict: 13/10/09
Typed: 15/10/09
CHI: 3108583158

R JUDITH JM ANDERSON
HE HEALTH CENTRE
RENFREW
PA4 8LH

Dear Dr Anderson

BRIAN MACKENZIE DOB: 31/08/58 (SG00375441)
12 ORCHARD STREET, , RENFREW, PA4 8RL

This gentleman is now ten days following his open dislocation of right IP joint of the thumb. He had his sutures removed today including the two clips in his scalp laceration. He should return in two week's time for consideration of removal of k wires.

Yours sincerely

Tom Nunn
Orthpaedic Registrar

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR D J Martin FRCS
Orthopaedic Upper Limb Service

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Direct Tel: 0141 232 7839

Our Ref: DJM/CD
Enquiries To: Clare Davidson

Seen Dict: 08/10/09
Typed: 14/10/09
CHI: 3108583158

R JUDITH JM ANDERSON
HE HEALTH CENTRE
RENFREW
PA4 8LH

Dear Dr Anderson

BRIAN MACKENZIE DOB: 31/08/58 (SG00375441)
12 ORCHARD STREET, RENFREW, PA4 8RL

Diagnosis: Open Fracture Dislocation of Right Thumb IP Joint had Exploration Washout and K-Wiring of IP Joint done on the 3 October 2009

This gentleman is only five days since the above operation the wound looks clean and dry there is no signs of infection. It is too early to remove the stitches so we have redressed the wounds today and put him into a Bier's cast and we will see him back on Tuesday 13th October 2009 for removal of sutures and further application of plaster and k-wires to remain in for four weeks. Check x-ray of his right thumb on his next visit.

ours sincerely

Ms A Augustine
Specialist Registrar

ORTHOPAEDIC DEPARTMENT
VICTORIA INFIRMARY
LANGSIDE ROAD
GLASGOW G42 9TY
TEL: 0141 201 5185
FAX: 0141 201 5082

ADS/AC /SG00375441
CHI NUMBER: 3108583158

MR. A. D. SHAW'S ORTHOPAEDIC UNIT

DICTATED: 22/03/12
TYPED: 22/03/12

DR AL-NAJIM
RENFREW HEALTH CENTRE
RENFREW
PA4 8RU

ear Dr

BRIAN MACKENZIE DOB: 31/08/58
22 LOMOND AVENUE, RENFREW, PA4 0PG

ADMITTED: 19/03/12
DISCHARGED: 19/03/12
OPERATION: Right knee arthroscopy and partial medial meniscetomy and chondroplasty of the patella
FOLLOW UP: 03/05/12

This gentleman was an elective admission for the above procedure. Arthroscopy confirmed a posterior horn tear to the periphery which was trimmed back using the ArthroWand to leave a stable rim. The lateral compartment was normal. The procedure was carried out without complications and he will be followed-up as above.

Yours sincerely,

Dr Stephanie Campbell
PST1 in Orthopaedics

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

0141 201 1100

ORTHOPAEDIC DEPARTMENT

Typed: 08/07/11
CHI: 3108583158

DR JUDITH JM ANDERSON
RENFREW HEALTH CENTRE
ENFREW
PA4 8RU

Dear Dr Anderson

BRIAN MACKENZIE DOB: 31/08/58 (SG00375441)
12 ORCHARD STREET, , RENFREW, PA4 8RL

Consultant: DAVID MARTIN

Admitted: 03/10/09

Discharged: 04/10/09

Diagnosis: OPEN DISLOCATION RIGHT THUMB IPJ

Procedures: WASHOUT AND K-WIRING IPJ 03/10/09

Follow Up: OUTPATIENT CLINIC

ours sincerely

Mr Bilal Jamal
Specialist Registrar

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No
Consent for Sharing Withheld: No

ZIAD AL-NAJIMClydeview Medical Practice,Renfrew Health Centre,10 Ferry Road, Renfrew, PA4 8RU

Main Switchboard:
Date of Completion: 23-Oct-2019

Dear ZIAD AL-NAJIM,

Name	CHI	DoB	Address
Brian MacKenzie	**3108583158**	**31-Aug-1958**	**22 LOMOND AVENUE, Renfrew, Renfrewshire, PA4 0PG**

Admitted	Type	Discharged	Destination
03-Oct-2009 12:04	IP	23-Oct-2019	Private Residence - no additional detail added

Specialty	Consultant	Ward	Telephone
Orthopaedics	MARTIN, DAVID	S02	

Primary Diagnosis
There is no data to display.

Secondary Diagnosis
There is no data to display.

Significant Operations / Procedures:
Umbilical hernia repair under G/A

Last Discharge Review: Jessica Elliott (Jessica Elliott - FY1) on 23 Oct 2019 13:40

Discharge Medication:

Active Drug Name	Route	Dose	Disp	Reason	Further Details	ECS	Since Admission
Co-codamol 30mg/500mg tablets	oral	2 tablets four times daily when required , TAKE 2 TABLETS UP TO 4 TIMES DAILY AS REQUIRED FOR PAIN , Fixed Period 1 Week(s) from 23 Oct 2019	Yes				Added
Fluticasone furoate 92microg/ Vilanterol 22microg/dose	inhalation	ONE PUFF TO BE INHALED ONCE DAILY,	No	Patient's own drugs at home		Y	
Salbutamol 100micrograms/ dose inhaler CFC free	inhalation	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY,	No	Patient's own drugs at home		Y	

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

Dispensing Comments
There is no data to display.

Withheld Medication:

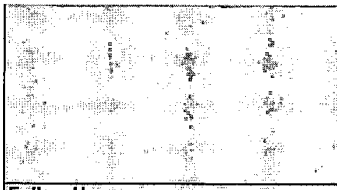
Date	Withheld Drug Name	Route	Dose	Note	Withheld Reason
There is no data to display.					

Stopped Medication:

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

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

Clinical Comments:	Dear Doctor, Patient attended 23/10/19 for umbilical hernia repair with mesh, carried out under GA.

	No issues postoperatively, patient recovered well. PLAN: Home with 1 week analgesia. No follow-up required. Kind regards J Elliott FY1 General Surgery, IRH
Follow Up:	No
Results Awaited:	No
Pharmacist Comments:	
Final Discharge Letter to Follow:	Yes

Yours sincerely,

Jessica Elliott

Prescription Review
Checked by: Kirstie Williamson (Staff Nurse Rehabilitation and Assessment)
Discharged by: Kirstie Williamson (Staff Nurse Rehabilitation and Assessment)

Letter to Patient:

NHS
Greater Glasgow and Clyde

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Main Switchboard: 0141 201 1100
Department: General Surgery
Contact Tel: 0141 201 1674
Enquiries to: Hazel Ward

Brian MacKenzie
22 LOMOND AVENUE
Renfrew
Renfrewshire
PA4 0PG

Letter Date: 30/07/2014
Reference: GS/CB
Dictated Date: 26/07/2014
Transcribed Date: 28/07/2014

Dear Mr MacKenzie,

Your ultrasound examination has not shown any areas of concern. Specifically there is no evidence of a hernia present. There are some normal lymph glands in this area, again they do not have any worrying features. I hope this reassuring.

Yours sincerely

Mr Graeme Smith

Consultant Surgeon

Electronically Signed: Mr Graeme Smith, Consultant

cc.



Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Respiratory Medicine GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Queen Elizabeth University Hospital 1345 Govan Road Glasgow G51 4TF	——	**Hospital** and **hospital address** Hospital location code. G405H Email address -

Urgency of referral Urgent - Suspected Cancer CXR lesion
Date of referral 25-May-2018 **Date sent** 25-May-2018

PATIENT DETAILS

Surname	MacKenzie
Forename(s)	Brian
Title	Mr
Sex	Male
Date of birth	31-Aug-1958
CHI no.	3108583158
Area of Residence	-

Patient's address

22 Lomond Avenue
RENFREW
PA4 0PG

Contact number(s)

Voice: 07966154552

1010162035121

Unique Care Pathway Number: 1010162035121

REGISTERED GP DETAILS

Name	Dr Ziad Al-Najim		
GMC code	5198897	GP code	39586
Practice name	Clydeview Medical Practice (14577)		
Practice code	87700		

Practice address

Renfrew Health Centre
10 Ferry Road
Renfrew
Glasgow
PA4 8RU

Contact number(s)

Voice: 0141-207-7730
Facsimile: 0141-207-7740

REFERRING GP DETAILS

Name	Dr. Iain Harrison		
GMC code	7071040	GP code	36374
Practice name	Clydeview Medical Practice (87700)		
Practice code	87700		

Practice address

Renfrew Health Centre
10 Ferry Road
Renfrew
PA4 8RU

Contact number(s)

Voice: 0141 207 7730
Facsimile: 0141-207-7740

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: ?lung malignancy

Comment: This 59 year old smoker (cigarette and cannabis) presented to my colleague with dry cough, dyspnoea and wheeze.

CXR was arranged, the report suggesting further investigation by CT (copied below). I have arrnaged for him to have U&Es checked on 29/5/18 and would be grateful for your assistance organising CT.

"XR Chest :
Comparison made with 28/10/2010.

The cardiomediastinal contours are within normal limits, without cardiomegaly. Blunting of the left costophrenic angle is longstanding unchanged. There is an ill-defined opacity abutting the left cardiac border, measuring 2.2 cm. Whilst this could simply represent a pericardial fat pad, it was not identified previously in 2010. No further focal or diffuse pulmonary abnormality.

Given the patient's smoking history, respiratory referral with a view to CT would prudent."

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

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

Description	Comment	Date of onset	Date recorded
Umbilical hernia	-	03-Jun-2014	03-Jun-2014
Acute meniscal tear, medial	-	19-Mar-2012	19-Mar-2012
Scarlet fever - scarlatina	-	31-Aug-2007	31-Aug-2007
Neurotic depression reactive type	and anxiety	27-Jul-2007	27-Jul-2007
Chronic gastritis	Mild Start Date: 29/03/1994	29-Mar-1994	29-Mar-1994
Poisoning	libriumStart Date: 07/06/1984	07-Jun-1984	07-Jun-1984
Mental disorders NOS	Start Date: 30/04/1981	30-Apr-1981	30-Apr-1981
Nondependent alcohol abuse, unspecified	Start Date: 30/04/1981	30-Apr-1981	30-Apr-1981
Misuse of drugs NOS	cannabis, cocaine, alcoholStart Date: 01/01/1972	01-Jan-1972	01-Jan-1972

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
[SO]Posterior horn of medial meniscus (Left)	-	20-Nov-2014	20-Nov-2014
Haemorrhoidectomy	Start Date: 15/08/1989	15-Aug-1989	15-Aug-1989

Family conditions (All priorities)

Description	Comment	Date of Onset
No FH: Ischaemic heart disease	Disease: SPICE Basic Health Values, priority=2	06-Jul-2007
No family history diabetes	Disease: SPICE Basic Health Values, priority=2	06-Jul-2007

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

No current medications recorded

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Salbutamol Cfc-free inhaler 100 micrograms/puff	1	1 INHALER	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY	-	18-May-2018	18-May-2018

Blood Pressure

Date Recorded	Systolic	Diastolic
06-Jul-2007	146	100
06-Jul-2007	146	100

Body Measurements

Date Recorded	Height	Weight	BMI
06-Jul-2007	173	65	-

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		10-Feb-2014
Current smoker 10 :		31-Jan-2014
Current smoker:	Disease: SPICE Basic Health Values, priority=2	19-Sep-2011
Current smoker:	priority=2	28-Oct-2010
Current smoker:	Disease: SPICE Basic Health Values, priority=2	06-Jul-2007
Alcohol intake above recommended sensible limits:	Disease: SPICE Basic Health Values, priority=2	06-Jul-2007
Enjoys light exercise:	Disease: SPICE Basic Health Values, priority=2	06-Jul-2007

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

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

Referred By:Referring GP

Electronic Attachment Present:No

Social circumstances

Ethnic Origin: (White) Scottish

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Trauma & Orthopaedic - Knee GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Southern General Hospital 1345 Govan Road Glasgow G51 4TF	——	**Hospital** and **hospital address** Hospital location code. G405H Email address

Urgency of referral ROUTINE
Date of referral 31-Jan-2014 **Date sent** 31-Jan-2014

PATIENT DETAILS

Surname	MacKenzie
Forename(s)	Brian
Title	Mr
Sex	Male
Date of birth	31-Aug-1958
CHI no.	3108583158
Area of Residence	-

Patient's address

22 Lomond Avenue
RENFREW
PA4 0PG

Contact number(s)

Voice: 07966154552

101006657624D | Unique Care Pathway Number: 101006657624D

REGISTERED GP DETAILS

Name	Dr Ziad Al-Najim		
GMC code	5198897	GP code	39586
Practice name	Clydeview Medical Practice (14577)		
Practice code	87700		

Practice address

Renfrew Health Centre
10 Ferry Road
Renfrew
Glasgow
PA4 8RU

Contact number(s)

Voice: 0141-207-7730
Facsimile: 0141-207-7740

REFERRING GP DETAILS

Name	Dr. Paul Climie		
GMC code	4093873	GP code	39021
Practice name	Clydeview Medical Practice (87700)		
Practice code	87700		

Practice address

Renfrew Health Centre
10 Ferry Road
Renfrew
PA4 8RU

Contact number(s)

Voice: 0141 207 7730

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: Knee problem

Comment: Meniscal tear in R knee 2012, treated with arthroscopic surgery by yourselves. Says at the time was also having problems in his left knee and these are now worse. Pain on walking, no locking, but gets swollen at times. Some crepitus in knee, no effusion. As his work as a gardener involves a lot of walking and bending he is keen to see if surgery is required now on the left knee

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

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

Description	Comment	Date of onset	Date recorded
Acute meniscal tear, medial	-	19-Mar-2012	19-Mar-2012
Scarlet fever - scarlatina	-	31-Aug-2007	31-Aug-2007
Neurotic depression reactive type	and anxiety	27-Jul-2007	27-Jul-2007
Chronic gastritis	Mild Start Date: 29/03/1994	29-Mar-1994	29-Mar-1994
Poisoning	libriumStart Date: 07/06/1984	07-Jun-1984	07-Jun-1984
Mental disorders NOS	Start Date: 30/04/1981	30-Apr-1981	30-Apr-1981
Nondependent alcohol abuse, unspecified	Start Date: 30/04/1981	30-Apr-1981	30-Apr-1981
Misuse of drugs NOS	cannabis, cocaine, alcoholStart Date: 01/01/1972	01-Jan-1972	01-Jan-1972

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Haemorrhoidectomy	Start Date: 15/08/1989	15-Aug-1989	15-Aug-1989

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

No current medications recorded

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Flucloxacillin Capsules 500 mg	28	28 CAPSULE	ONE TO BE TAKEN FOUR TIMES A DAY	-	31-Jan-2014	31-Jan-2014
Co-Codamol 30/500 Tablets	100	100 TABLET	TWO TAB NOCTE PRN	-	31-Jan-2014	31-Jan-2014
Tramadol Hydrochloride Capsules 50 mg	100	100 capsule	ONE TABLET FOUR TIMES DAILY	-	31-Jan-2014	31-Jan-2014

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:	Disease: SPICE Basic Health Values, priority=2	19-Sep-2011
Current smoker:	priority=2	28-Oct-2010
Current smoker:	Disease: SPICE Basic Health Values, priority=2	06-Jul-2007
Ex smoker:	Disease: SPICE Smoking, priority=2	06-Jul-2007
Alcohol intake above recommended sensible limits:	Disease: SPICE Basic Health Values, priority=2	06-Jul-2007

Enjoys light exercise:

Disease: SPICE Basic Health Values, priority=2 06-Jul-2007

Clinical warnings

Additional Support Needs
No known ASN requirements

Additional relevant information
Administrative information
OK to send correspondence to home address?:Yes
Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Patient has disability or requires wheelchair access:No
Referred By:Referring GP
Electronic Attachment Present:No

Social circumstances
Ethnic Origin: (White) Scottish

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

General Surgery GGC General Referral		**Consultant / receiving practitioner** and/or **specialty clinic**
Southern General Hospital 1345 Govan Road Glasgow G51 4TF		**Hospital** and **hospital address** Hospital location code. G405H Email address -

Urgency of referral ROUTINE
Date of referral 31-Jan-2014 **Date sent** 31-Jan-2014

PATIENT DETAILS

Surname	MacKenzie
Forename(s)	Brian
Title	Mr
Sex	Male
Date of birth	31-Aug-1958
CHI no.	3108583158
Area of Residence	-

Patient's address

22 Lomond Avenue
RENFREW
PA4 0PG

Contact number(s)

Voice: 07966154552

1010066575972 Unique Care Pathway Number: 1010066575972

REGISTERED GP DETAILS

Name	Dr Ziad Al-Najim		
GMC code	5198897	GP code	39586
Practice name	Clydeview Medical Practice (14577)		
Practice code	87700		

Practice address

Renfrew Health Centre
10 Ferry Road
Renfrew
Glasgow
PA4 8RU

Contact number(s)

Voice: 0141-207-7730
Facsimile: 0141-207-7740

REFERRING GP DETAILS

Name	Dr. Paul Climie		
GMC code	4093873	GP code	39021
Practice name	Clydeview Medical Practice (87700)		
Practice code	87700		

Practice address

Renfrew Health Centre
10 Ferry Road
Renfrew
PA4 8RU

Contact number(s)

Voice: 0141 207 7730

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: ?inguinal hernia

Comment: Tender swelling appeared in L groin 2 weeks ago, has reduced since then. On examination swelling in lower inguinal region L side, reducible. Appearances of an inguinal hernia. Works over the summer months as a gardener and keen to try to get this sorted as fearful that his work will make it worse.

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

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

Description	Comment	Date of onset	Date recorded
Acute meniscal tear, medial	-	19-Mar-2012	19-Mar-2012
Scarlet fever - scarlatina	-	31-Aug-2007	31-Aug-2007
Neurotic depression reactive type	and anxiety	27-Jul-2007	27-Jul-2007
Chronic gastritis	Mild Start Date: 29/03/1994	29-Mar-1994	29-Mar-1994
Poisoning	libriumStart Date: 07/06/1984	07-Jun-1984	07-Jun-1984
Mental disorders NOS	Start Date: 30/04/1981	30-Apr-1981	30-Apr-1981
Nondependent alcohol abuse, unspecified	Start Date: 30/04/1981	30-Apr-1981	30-Apr-1981
Misuse of drugs NOS	cannabis, cocaine, alcoholStart Date: 01/01/1972	01-Jan-1972	01-Jan-1972

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Haemorrhoidectomy	Start Date: 15/08/1989	15-Aug-1989	15-Aug-1989

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

No current medications recorded

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Flucloxacillin Capsules 500 mg	28	28 CAPSULE	ONE TO BE TAKEN FOUR TIMES A DAY	-	31-Jan-2014	31-Jan-2014
Co-Codamol 30/500 Tablets	100	100 TABLET	TWO TAB NOCTE PRN	-	31-Jan-2014	31-Jan-2014
Tramadol Hydrochloride Capsules 50 mg	100	100 capsule	ONE TABLET FOUR TIMES DAILY	-	31-Jan-2014	31-Jan-2014

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:	Disease: SPICE Basic Health Values, priority=2	19-Sep-2011
Current smoker:	priority=2	28-Oct-2010
Current smoker:	Disease: SPICE Basic Health Values, priority=2	06-Jul-2007
Ex smoker:	Disease: SPICE Smoking, priority=2	06-Jul-2007
Alcohol intake above recommended sensible limits:	Disease: SPICE Basic Health Values, priority=2	06-Jul-2007
Enjoys light exercise:	Disease: SPICE Basic Health Values, priority=2	06-Jul-2007

Clinical warnings

Additional Support Needs
No known ASN requirements

Additional relevant information
Administrative information
OK to send correspondence to home address?:Yes
Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Patient has disability or requires wheelchair access:No
Referred By:Referring GP
Electronic Attachment Present:No

Social circumstances
Ethnic Origin: (White) Scottish

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

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments
Trauma and Orthopaedic Surgery - 26052011_Clinical Letter_278615
Trauma and Orthopaedic Surgery - 25052011_Clinical Letter_274713

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Trauma & Orthopaedic - Knee GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Southern General Hospital 1345 Govan Road Glasgow G51 4TF	——	**Hospital** and **hospital address** Hospital location code. G405H Email address

Urgency of referral ROUTINE
Date of referral 21-Sep-2011 **Date sent** 21-Sep-2011

PATIENT DETAILS

Surname	MacKenzie
Forename(s)	Brian
Title	Mr
Sex	Male
Date of birth	31-Aug-1958
CHI no.	3108583158
Area of Residence	-

Patient's address

22 Lomond Avenue
RENFREW
PA4 0PG

Contact number(s)

Voice: 07966154552

101002561932N | Unique Care Pathway Number: 101002561932N

REGISTERED GP DETAILS

Name	Dr Z Al Najim		
GMC code	5198897	GP code	C39586
Practice name	Clydeview Medical Practice		
Practice code	87700		

Practice address

Renfrew Health Centre
10 Ferry Road
Renfrew
PA4 8RU

Contact number(s)

Voice: 0141-207-7730
Facsimile: 0141-207-7740

REFERRING GP DETAILS

Name	Dr. Judith Anderson		
GMC code	3171783	GP code	34860
Practice name	Clydeview Medical Practice (87700)		

Practice address

Renfrew Health Centre
10 Ferry Road
Renfrew

Practice code	87700	Contact number(s)
		Voice: 0141 207 7730

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: knee problem

Comment: mr mackenzie was seen in A & E following what was presumed to be a dislocated patella. he was followed up at the orthopaedic clinic where it was decided that as was "first dislocation" physio was arranged. due to work commitments mr mackenzie could not complete all the physio. he continues to have significant pain in his knee. he admits to come "locking" and has significant quadriceps wasting ?? meniscal injury

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

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

Description	Comment	Modifier	Date of onset	Date recorded
Dislocation or subluxation of knee	dislocation of right knee	-	25-May-2011	01-Jun-2011
Poisoning	librium	-	07-Jun-1984	31-Aug-2007
Mental disorders NOS	-	-	30-Apr-1981	31-Aug-2007
Nondependent alcohol abuse, unspecified	-	-	30-Apr-1981	31-Aug-2007
Scarlet fever - scarlatina	-	-	-	31-Aug-2007
Chronic gastritis	-	Mild	29-Mar-1994	31-Aug-2007
Misuse of drugs NOS	cannabis, cocaine, alcohol	-	01-Jan-1972	27-Jul-2007
Neurotic depression reactive type	and anxiety	-	-	27-Jul-2007

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Dislocation reduct.-upper limb	right thumb - washout and K wiring	03-Oct-2009	20-Jul-2011
Haemorrhoidectomy	-	15-Aug-1989	31-Aug-2007
Bilateral vasectomy for contraception	-	25-Jun-1986	31-Aug-2007

Family conditions (All priorities)

Description	Date of Onset
No FH: Ischaemic heart disease	06-Jul-2007
No family history diabetes	06-Jul-2007

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

No current medications recorded

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Co-Codamol	50	30mg/500mg TABS	1 or 2 Tabs	up to max qid	19-Sep-2011	19-Sep-2011

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		19-Sep-2011
Alcohol intake above recommended sensible limits:		06-Jul-2007
Enjoys light exercise:		06-Jul-2007

Clinical warnings

Additional Support Needs
No known ASN requirements

Additional relevant information
Administrative information
OK to send correspondence to home address?:Yes
Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Patient has disability or requires wheelchair access:No
Referred By:Referring GP
Electronic Attachment Present:Yes

Trauma and Orthopaedic Surgery - 26052011 Clinical Letter 278615
Trauma and Orthopaedic Surgery - 25052011 Clinical Letter 274713

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

South Glasgow Hospitals

ANAESTHETIC RECORD

NHS Greater Glasgow and Clyde

Date: 8/12/14

Pre-op instructions:

Patient details

Name:

Unit No:. 108583158

MACKENZIE M

Address: Brian 31/08/1958

12 LOMOND AVENUE

Renfrew, Renfrewshire

PA4 0P

DOB

Fast for: AM Lunchtime PM List

Proposed operation:

Arthroscopy

Assessor: JM°Guire

Ward:

Pre-op assessment

Previous G.A.'s:

(Y) 2012 → knee operation.

CVS: HR BP /

Nil

Resp: Smokes 20/day. Daily cough.

Other (specify):

Hayfever.

Has small ?pouch in oesophagus / trachea, → food occasionally gets stuck.

Fasted: 8:00 food + water.

Reflux: Occasional reflux w spicy food.

Drugs:

Tramadol 50mg QID.

N.S.A.I.D's OK.

Allergies:

NKDA

BMI:

Weight (kg):

Airway: MP 2, TM distance > 6.5cm. TMJ ✓

Dentition: Partial upper plate + crowns.

Investigations

Na+:	Hb:	Others (specify):
K+:	WCC:	
Cl-:	Plts:	
HCO3-:	ECG:	
Urea:	CXR:	
Creat:	Glucose	

Urgency		A.S.A.
Elective	☐	1
Scheduled	☐	2
Urgent	☐	3
Emergency	☐	4
		5

Comments / Warnings

Material risks explained ☐

Risk of GA → N+V, sore throat, dental damage.

Anaesthesia

Date: 8/12/16

Machine check: ☐ Circuit check ☐

Cannula: 20 G, L/R Hand Arm Foot

Cannula: G, L/R Hand Arm Foot

Arterial site: | CVP site:

Patient position: SUPINE

ECG ☐	NIBP ☐	S_pO_2 ☐
E_TCO_2 ☐	FiO_2 ☐	E_AAA ☐
ALL ABOVE ☑		
TOF ☐	CVP ☐	IABP ☐
Blood warmer ☐	Patient warmer ☐	
Anti DVT ☐	U/O ☐	Temp ☐

Fluids

(1) HARTMANNS 500ml
+75mg diclofenac

Pre O_2 ☑ | Cricoid ☐ | Airway - Oral / Nasal

ETT size: | LMA size: #5

Oral / Nasal | Type:

Cuffed / Uncuffed | Pack: In / Out

Ventilation - Spontaneous / Controlled

Circle	Air/N_2O
Bain	SEVO
T-piece	ISO
ADE	DES

Laryngoscopy Grade: 1 2 3 4

Time 13:15

FENTANYL	100			
PROPOFOL	200			
DEXAMETHASONE	4			
DICLOFENAC		75		
SpO_2	100	99	99	
FiO_2	1.0	0.63	0.7	
$ETCO_2$	–	5.5	5.3	
E_AAA	–	2.1	2.2	
Fluids	(1)		(2)	
Temperature				
CVP				
Blood loss				
Urine output				

180 160 140 120 100 80 60 40 20

Regional Anaesthesia / Other Procedures / Comments

Difficulty sizing LMA. Evidence of obstruction / tracheal leg postoperatively. LMA resited → persistent leak / obstruction. No discernable difference with proseal. Able to ventilate throughout. Extubated in theatre.

Operation Details **Theatre:**

Arthroscopy.

Operation as proposed on page 1 ☐ Reversal given: Yes ☐ No ☐

Anaesthetist(s): A. McCUNE / A. BAKER	Surgeon(s): A. MARSH
Named Consultant: A. BAKER.	Discussed with Consultant: Yes ☐ No ☐

Post Operative Care

A. **Oxygen** 2-6 **L/min OR** **% for** **hours** **OR SpO_2** 97 **% on air.**

B. **Routine observations / postoperative care as per local protocol.**

C. **Appropriate DVT prophylaxis precribed: Yes** ☑ **N/A** ☐ DEXAMETHASONE

D. **Anti-emetic given: Yes** ☑ **No** ☐ **Drug given:**

E. **Analgesia:**

I.V. Morphine as per Recovery Algorithm - Sign		
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:

OR

I.V. Fentanyl as per Recovery Algorithm - Sign		
40 µm bolus - Time: 14 56	Sign:	Witness:
40 µm bolus - Time: 15 05	Sign:	Witness:
40 µm bolus - Time: 15 13	Sign:	Witness:
40 µm bolus - Time:	Sign:	Witness:
40 µm bolus - Time:	Sign:	Witness:

F. **Post Operative fluids**

Fluid (additive)	Volume	Rate	Sign	Start	Lot No.	Initials
HARTMANNS	500	40				

Post operative notes / Comments

Post Operative Care

Time																	
SpO_2																	
O_2 L/min																	
Resp Rate																	
Airway																	
180																	
160																	
140																	
120																	
100																	
80																	
60																	
40																	
20																	
Temperature																	
CVP																	
Wound site																	
Affected limb pulse: +ve/-ve																	
Circulation Satisfactory:S Poor: P																	
Sensation +ve/-ve																	
Movement +ve/-ve																	
Sedation/Pain score																	
Nausea score																	

Time	Fluid In	Urine	Drain 1	Drain 2

Blood results / Drug given

Additional nursing comments

Waterlow Score ☐ **Intervention required:**

Discharge criteria met:	Discharged to:	Recovery Nurse name:	Ward Nurse name:
Yes ☐ NO ☐	Ward:	.....	.....
Comments:	HDU ☐ ITU ☐	Signature:	Signature:
		.....	.....

VIC 638 Cat. No. 0163149 VI MEDICAL ILLUSTRATION • ANAES • 1985/6.05

Patient Agreement to Investigation or Treatment
Consent Form

NHS Greater Glasgow and Clyde

Patient details (or pre-printed label)

Hospital / clinic / GP practice

3108583158
MACKENZIE M
Brian 31/08/1958
22 LOMOND AVENUE
Renfrew, Renfrewshire
PA4 0PG

Patient's surname / family name

Patient's first name

Date of birth

Gender Male ☐ Female ☐

CHI number

Special requirements (e.g. other language / communication method)

Statement for practitioner
(to be filled in by practitioner with appropriate knowledge of proposed procedure)

Describe proposed operation, investigation or other treatment.
Where appropriate specify site or side (write in full).

LEFT KNEE ARTHROSCOPY +
PARTIAL MEDIAL MENISECTOMY +/-
PARTIAL LATERAL MENISECTOMY.

Specific risks / complications
Please detail any specific risk/complications related to the procedure that were discussed.

Infection / Nerve or vessel injury / Swelling / DVT

I have explained the procedure named on this form to the patient in terms which, in my judgement, are suited to their understanding. In particular, I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure and any extra procedures which may become necessary during the procedure (please specify major procedures above). I have explained who will be doing the procedure if not myself.

Signature of practitioner

Name / Designation (print) A. MARSH

Date 20/4/16

00526

Statement to be completed by patient / parent*
(*parental responsibility for a minor without capacity)

You should read this form and the notes below carefully. If there is anything you do not understand ask the Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

I understand

- The procedure, important risks and appropriate alternatives which have been explained to me by the practitioner named on this form.
- Who will be performing my procedure on the day
- That any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to the medical treatment proposed, to safeguard or promote physical or mental health.
- That examination for the purpose of teaching will not be undertaken without my consent.

I have been told about additional procedures which may become necessary during treatment. I have listed below **any procedures which I do NOT wish to be carried out without further discussion.**

I agree

- to the administration of an anaesthetic or to sedation if required,
- to the procedure named on this form,
- to the emergency administration of blood or blood products.

Additionally you have to agree or disagree to the following	**Agree**	**Disagree**
to photographic images and video recordings being held in records, and made available for teaching, audit and ethically-approved research purposes, to improve the quality of patient care.	☐	☐
that surplus tissue or other biological material not essential for my diagnosis or future treatment may be used for medical education and ethically approved medical research.	☐	☐

Patient / parent agreement to treatment

Signature	Date
[signature]	30/11/14.
Name (print)	

Patient refusal for blood products

Please sign here if you refuse to consent to the emergency administration of blood or blood products, **even if this results in death.**

Signature	Date
Signature of practitioner	Date

MACKENZIE, Brian ID:3108583158 20-NOV-2014 10:25:05 GREATER GLASGOW SITE-SGOROP ROUTINE RECORD

31-AUG-1958 (56 yr)
Male Caucasian

Room:
Loc:361

Vent. rate	57	BPM
PR interval	152	ms
QRS duration	86	ms
QT/QTc	440/428	ms
P-R-T axes	75 48	46

Sinus bradycardia
Nonspecific T wave abnormality

Technician:SGH 316
Test ind:PRE OP

Referred by: SGOROP MR SPENCER

UNCONFIRMED ECG REPORT Sys Admin 2

COMMENTS:



25mm/s 10mm/mV 100Hz 7.1.1 12SL 237 CID: 6

SID: 2210206 EID:21002 EDT: 15:46 20-NOV-2014 ORDER:

Direct Access Spirometry Report

Outreach Spirometry Service
Outreach Spirometry Service

Pre vs. Post Report

Patient Information

Name: MacKenzie, Brian	ID: 3108583158	Birthdate: 31/08/1958
Height at test (cm): 168.2	Sex: Male	Smoking history (pk-yrs):
Weight at test (kg): 75.5	Age at test: 59	Predicted set: ECCS 1983/93, Polgar(Peds)197

Comments: G.P:87700 Smoker:Yes (PA4 0PG) MRC:1 SpO2:95% Inhalers: NT
Diagnosis:

Interpreted by:

Interpretation

MODERATE OBSTRUCTIVE PILMONARY IMPAIRMENT. Bronchodilator produces no significant response. Results are consistent with COPD (Stage 2 NICE). R Vaughn

Site: KoKo971064
Physician: Outreach
Technician: A.Wood

Effort protocol: ATS/ERS 2005
Bronchodilator: Nebulised Salbutamol 2.5mg-BD

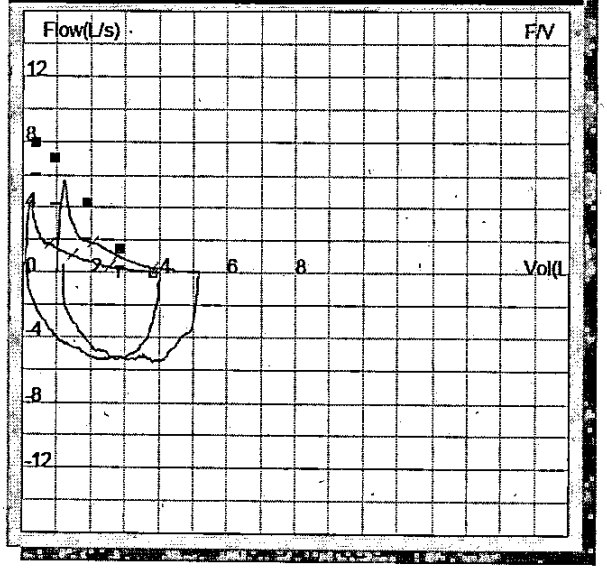
Test date/time: 19/06/18 17:23:31
Number of efforts performed: 7
Post-BD Number of efforts performed: 5

Results

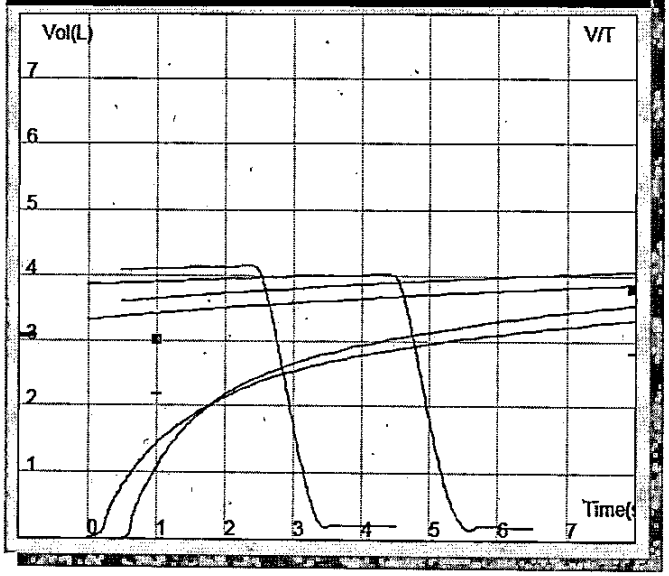
Result	Pred	Pre	%Prd	Post	%Prd	%Chg
FVC (L)	3.80	4.01	105%	4.12	108%	3%
FEV1 (L)	3.03	¤1.61	53%	¤1.86	61%	16%
FEV1/FVC	0.77	¤0.40		¤0.45		12%
FEF25-75% (L/s)	3.43	¤0.43	13%	¤0.55	16%	27%
PEFR (L/s)	7.95	¤4.13	52%	¤5.06	64%	23%
Vext %	—	1.75	—	0.73	—	-58%

Comments: G.P:87700 Smoker:Yes (PA4 0PG) MRC:1 SpO2:95% Inhalers: NT

FVC Flow vs. Volume



FVC Volume vs. Time



XR Chest

Performed	19-Feb-2024 10:18	Received	25-Feb-2024 15:17
Reported	25-Feb-2024 15:15	Order Number	G405H40634137
Status	Final	Source System	MiSys

XR Chest Final
Brian MacKenzie
Clinical History :

Worsening breathlessness + fatigue. Raised ESR 67. Examination unremarkable. Stopped smoking few years ago

XR Chest :
Comparison made with previous. The heart and mediastinal contours are satisfactory. No focal active pulmonary disease is seen.

Reported by: Dr Ross MacDuff
Verified by: Dr Ross MacDuff

XR Shoulder Lt

Performed	15-Feb-2024 12:15	Received	26-Feb-2024 11:17
Reported	26-Feb-2024 11:15	Order Number	G405H40624150
Status	Final	Source System	MiSys

XR Shoulder Lt Final
Brian MacKenzie
Clinical History :

Fall in november, landed onto raised concrete striking upper humerus. Limited movement and pain since. Capsular pattern - imp traumatic frozen shoulder and inhibited Rotator cuff but xray to rule out bony injury including post disclocation. Also comment on humeral head position if suggestive of RC insufficiency.

XR Shoulder Lt :
A large osteophyte with evidence of calcification is noted arising from the greater tuberosity. Features likely represent calcific tendinopathy at the degree of subacromial impingement. Does this correlate clinically?
Further osteophytes affect the AC joint consistent with early degenerative change.

Reported by Graham Johnstone, Reporting Radiographer. RA62764

Reported by: Graham Johnstone
Verified by: Graham Johnstone

CT Thorax and abdomen with contrast

Performed	31-May-2018 09:41	Received	31-May-2018 10:16
Reported	31-May-2018 10:14	Order Number	G405H33902835
Status	Final	Source System	MiSys

CT Thorax and abdomen with contrast Final
Brian MacKenzie
Clinical History :

left lung mass for CT. SMOKER

CT Thorax and abdomen with contrast :
No previous relevant cross-sectional imaging available for comparison.

Thorax:
No concerning focal pulmonary mass lesion. There is a relatively prominent pericardiac fat pad adjacent to the left heart border which likely reflects the abnormality identified on recent chest x-ray. Background emphysematous changes. No mediastinal or hilar lymphadenopathy.

Abdomen:
Unremarkable appearances of the solid upper abdominal organs and partially visualised unprepared bowel. No abdominal lymphadenopathy.

Skeleton:
Degenerative changes within the lower thoracic spine. No destructive bony lesion.

Conclusion:
No evidence of malignancy.

Reported by: Dr Robert Fleming
Verified by: Dr Robert Fleming

XR Chest

Performed	21-May-2018 09:26	Received	23-May-2018 11:57
Reported	23-May-2018 11:55	Order Number	G405H33881845
Status	Final	Source System	MiSys

XR Chest Final
Brian MacKenzie
Clinical History :
Ongoing dyspnoea impression, cough. Ex-smoker. Malignancy?

XR Chest :
Comparison made with 28/10/2010.

The cardiomediastinal contours are within normal limits, without cardiomegaly. Blunting of the left costophrenic angle is longstanding unchanged. There is an ill-defined opacity abutting the left cardiac border, measuring 2.2 cm. Whilst this could simply represent a pericardial fat pad, it was not identified previously in 2010. No further focal or diffuse pulmonary abnormality.

Given the patient's smoking history, respiratory referral with a view to CT would prudent.

Tracked report

Reported by: Dr Gordon Cowell
Verified by: Dr Gordon Cowell

US Groin Lt

Performed	16-Jun-2014 15:47	Received	16-Jun-2014 17:08
Reported	16-Jun-2014 17:06	Order Number	G405H29138367
Status	Final	Source System	MiSys

US Groin Lt Final
Brian MacKenzie
Clinical History :
55 year old man. Aware of swelling left groin intermittently since january. Mildly tender. Recuurence of symptoms at present. O/e no obvious hernia. ?lymph node ?femoral hernia

US Groin Lt :
There are a number of small lymph nodes at the indicated site of symptoms in the left groin. They are not pathologically enlarged and have a normal fatty hilum.

No other abnormality is demonstrated. Specifically, there is no evidence of a femoral hernia.

Reported by: Dr Colin Campbell
Verified by: Dr Colin Campbell

MRI Knee Lt

Performed	24-Apr-2014 11:04	Received	08-May-2014 12:55
Reported	08-May-2014 12:53	Order Number	G405H28940417
Status	Final	Source System	MiSys

MRI Knee Lt Final
Brian MacKenzie
Clinical History : Left medial knee pain and tenderness. Meniscal tear?

MRI Knee Lt :

This exam was performed and reported at Golden Jubilee Hospital.

Routine knee protocol.

There is high signal within the posterior horn of the medial meniscus extending into the body. On the coronal images (4-10) this communicates within the inferior articular surface, in keeping with a tear.

There is irregular fibrillation of the free edge of body of lateral meniscus in keeping with degenerative tear/attrition.
ACL, PCL, collateral ligaments and extensor mechanism are intact.

There are multiple foci of subchondral marrow high signal in the lateral femoral condyle and patella with overlying articular cartilage irregularity. Appearances are in keeping with degenerative osteochondritis.

Dictated by: Dr Shiva Koteeswaran.
Verified by: Dr Shiva Koteeswaran.

Reported by: Auto Reporting
Verified by: Kelly Ann Noon (Admin)

XR Knee Lt

Performed	02-Apr-2014 14:19	Received	03-Apr-2014 13:29
Reported	03-Apr-2014 13:29	Order Number	G405H28939310
Status	Final	Source System	MiSys

XR Knee Lt Final
Brian MacKenzie
In line with agreed protocols, a radiological report will not be issued for this examination, unless requested. The interpretation and recording of the findings remain the responsibility of the referrer or a more experienced clinical colleague.

Reported by: Auto Reporting
Verified by: Auto Reporting

MRI Knee Rt

Performed	16-Jan-2012 16:50	Received	17-Jan-2012 10:44
Reported	17-Jan-2012 10:22	Order Number	G306H26460228
Status	Final	Source System	MiSys

MRI Knee Rt Final
Brian MacKenzie
Clinical History :
Patellar dislocation 6 months ago. Persistent pain and swelling. Possible osteochondral fracture or meniscal tear.

MRI Knee Rt :
There is abnormal signal in the medial meniscus at the junction of the posterior horn and body, in keeping with a flap-type tear running to the inferior surface of the meniscus.
The lateral meniscus, cruciate and collateral ligaments are intact.
There is a lateral tilting of the patella and damage to the central aspect of the patellar articular surface with underlying cystic change.
There is no gross bone marrow oedema affecting the lateral femoral condyle or abnormality of the medial patellar ligament/retinaculum.

Opinion:
Flap tear of the medial meniscus at the junction of the posterior horn and body. Lateral patellar tilting and damage to the articular surface centrally.

Reported by: Dr Paul Duffy
Verified by: Dr Paul Duffy

XR Patella Rt

Performed	13-Dec-2011 09:24	Received	14-Dec-2011 09:06
Reported	14-Dec-2011 08:44	Order Number	G306H26456280
Status	Final	Source System	MiSys

XR Patella Rt Final

Brian MacKenzie

In line with agreed protocols, a radiological report will not be issued for this examination, unless requested. The interpretation and recording of the findings remain the responsibility of the referrer or a more experienced clinical colleague.

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Reported by: Auto Reporting
Verified by: Kelly Ann Noon (Admin)

XR Knee Rt

Performed	13-Dec-2011 09:24	Received	14-Dec-2011 09:06
Reported	14-Dec-2011 08:44	Order Number	G306H26456379
Status	Final	Source System	MiSys

XR Patella Rt Final

Brian MacKenzie

In line with agreed protocols, a radiological report will not be issued for this examination, unless requested. The interpretation and recording of the findings remain the responsibility of the referrer or a more experienced clinical colleague.

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In line with agreed protocols, a radiological report will not be issued for this examination, unless requested. The interpretation and recording of the findings remain the responsibility of the referrer or a more experienced clinical colleague.

Reported by: Auto Reporting
Verified by: Kelly Ann Noon (Admin)

XR Knee Rt

Performed	25-May-2011 19:56	Received	06-Jun-2011 12:34
Reported	06-Jun-2011 12:11	Order Number	G405H25907888
Status	Final	Source System	MiSys

XR Knee Rt Final
Brian MacKenzie
Clinical History : Claims knee was dislocated and thinks back in position, complaining of pain.

XR Knee Rt : There is slight irregularity of the posterior cortex of patella, an osteochondral fracture is difficult to exclude here. Otherwise, no other suspected injuries. Moderate knee joint effusion is seen.

Reported by: Dr Rafid Al-Sam (SpR)
Verified by: Dr Rafid Al-Sam (SpR)

XR Chest

Performed	28-Oct-2010 14:55	Received	08-Nov-2010 09:45
Reported	08-Nov-2010 09:24	Order Number	G405H25351593
Status	Final	Source System	MiSys

XR Chest Final
Brian MacKenzie
Clinical History : Breathlessness and pleuritic chest pain.

XR Chest :

The heart is not enlarged. There is no evidence of active pulmonary disease.

Reported by: Dr Paul Duffy
Verified by: Dr Paul Duffy

XR Thumb Rt

Performed	02-Oct-2009 21:19	Received	05-Oct-2009 12:44
Reported	05-Oct-2009 12:17	Order Number	G405H13243034
Status	Final	Source System	MiSys

XR Thumb Rt Final
Brian MacKenzie
Clinical History : Dislocation post reduction.

XR Thumb Rt :
The distal phalanx appears to have been successfully relocated and is now in plaster.

Reported by: DR S KELLY and BLANK CLINICIAN
Verified by: DR S KELLY

XR Thumb Rt

Performed	02-Oct-2009 18:16	Received	15-Oct-2009 19:53
Reported	15-Oct-2009 19:19	Order Number	G405H13242924
Status	Final	Source System	MiSys

XR Thumb Rt Final
Brian MacKenzie
Clinical History : Dislocation right thumb.

XR Thumb Rt :
Dislocation of thumb interphalangeal joint, with no associated fracture demonstrated.

Reported by: DR SJ GOODWIN and BLANK CLINICIAN
Verified by: DR SJ GOODWIN

MANUAL PATIENT RECORDS

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

Including:

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

SG00375441
BRIAN MACKENZIE
CHI:3108583158

GLASGOW SOUTH ... S

Locked for inpatient and daycase admissions from

1st September 2014

WITH THE EXCEPTION OF

OPHTHALMOLOGY

01 SEP 2014
Write/Stamp date here

(GENERAL)

Victoria Infirmary
Case Records

SG00375441
BRIAN MACKENZIE
CHI:3108583158

CK

GREATER GLASGOW HEALTH BOARD – SOUTH-WESTERN DISTRICT

1

SURNAME (Block Letters): mc Kenz ACH 08/12/14

FIRST NAME: Brian

UNIT No.: 375 441

ADDRESS: SG0037544 MACKENZIE, 22 LOMOND AVENUE RENFREW PA4 0PG

OCCUPATION: —

DATE OF BIRTH: 31-8-58

CHI: 3108583158 31/08/1958

NEXT OF KIN (Name and Address): Margaret mc kenzie (WIFE) S/A (886-4935)

Renfrew PA4 OTG.

CHANGE OF ADDRESS: 32 ANGUS AVE GLASGOW G52 3HE

NAME AND ADDRESS OF OWN DOCTOR: JR ~~BLACKWOOD~~ ANDERSON ~~MCQUARRY~~ HEALTH CENTRE 103 PAISLEY ROAD RENFREW PA4 8LH

Dr STRUTHERS CALDOWAN MEDICAL CENTRE 1131 PAISLEY RD WEST GLASGOW G52 3SS 882-5296

BLOOD GROUP:

SENSITIVITY:

UNIT CASE RECORDS

GENERAL	✓	ORTHOPAEDIC	
INSTITUTE		PSYCHIATRIC	✓
MATERNITY		CHEST	

INDEX OF ATTENDANCES

Every NEW out-patient attendance, and EACH in-patient admission must be noted below

DATE	CLINIC / WARD	DOCTOR	DIAGNOSIS / OPERATION	CODED	DISCH. DATE
5/6/84	Med ward 23				
15/4/86	UROL	MR GLEN			
25-6-86	Proctology ORTH			coded	
9/2/89	SURG OP	LITTON			
7/7/89	✓ WD 14		HAEMORRHOIDECTOMY		15/7/89
11/8/89	✓ OP	McBain.			
1/7/03	UROLOGY	AKHTAR			
29.7.03	✓ OP				
4.9.06	PLASTER FT	WALKER			
5.9.06	PLASTER	WALKER			
3.10.06	FT	HUNTER			
3/10/09	WARD 2	MARTIN	Exploration of wound & Hand Kwiring		4/10/09
26/11	PLASTER	MRS MR			
19/3/12	WDD	SHAW.			19/3/12

USE RED INK FOR NOTIFICATION OF DEATH – ALL OTHER ENTRIES IN BLACK

ORTHOPAEDIC DEPARTMENT
VICTORIA INFIRMARY
LANGSIDE ROAD
GLASGOW G42 9TY
TEL: 0141 201 5185
FAX: 0141 201 5082

ADS/AC /SG00375441
CHI NUMBER: 3108583158

MR. A. D. SHAW'S ORTHOPAEDIC RETURNS CLINIC

SEEN: 03/05/12
DICTATED: 03/05/12
TYPED: 03/05/12

DR AL-NAJIM
RENFREW HEALTH CENTRE
RENFREW
PA4 8RU

Dear Dr

BRIAN MACKENZIE DOB: 31/08/58
22 LOMOND AVENUE, RENFREW, PA4 0PG

This gentleman is now 6 weeks following right knee scope and partial medial meniscetomy. We also performed a chondroplasty of his patella. He reports a lot of benefit from the procedure. His knee feels much steadier and less painful. He is now back working. He tells me he wrenched his left knee just before his surgery. There is no tenderness around the joint lines, a full range of motion, but there is some patellofemoral crepitus. I think it is likely he has some degenerate symptoms in the left knee as well. He is happy with progress to-date and I have discharged him from routine attendance.

Yours sincerely,

Mr. A.D. Shaw, F.R.C.S.Ed.(Tr. & Orth.),
Consultant Orthopaedic Surgeon

ORTHOPAEDIC DEPARTMENT
VICTORIA INFIRMARY
LANGSIDE ROAD
GLASGOW G42 9TY
TEL: 0141 201 5185
FAX: 0141 201 5082

ADS/AC /SG00375441
CHI NUMBER: 3108583158

MR. A. D. SHAW'S ORTHOPAEDIC UNIT

DICTATED: 22/03/12
TYPED: 22/03/12

DR AL-NAJIM
RENFREW HEALTH CENTRE
RENFREW
PA4 8RU

Dear Dr

BRIAN MACKENZIE DOB: 31/08/58
22 LOMOND AVENUE, RENFREW, PA4 0PG

ADMITTED:	19/03/12
DISCHARGED:	19/03/12
OPERATION:	Right knee arthroscopy and partial medial meniscetomy and chondroplasty of the patella
FOLLOW UP:	03/05/12

This gentleman was an elective admission for the above procedure. Arthroscopy confirmed a posterior horn tear to the periphery which was trimmed back using the ArthroWand to leave a stable rim. The lateral compartment was normal. The procedure was carried out without complications and he will be followed-up as above.

Yours sincerely,

Dr Stephanie Campbell
GPST1 in Orthopaedics

THE VICTORIA INFIRMARY

OPERATION SHEET

SURNAME (Block Letters)	FIRST NAMES (Block Letters)

DATE	NAME OF OPERATION PERFORMED	AGE	REGISTRATION NUMBER

SURGEON	ASSISTANT	ANAESTHETIST

NAME: BRIAN MACKENZIE
DOB: 31/08/58 **UNIT NO:** SG00375441
OPERATION DATE: 19/03/12
OPERATION: Arthroscopy right knee and partial medial meniscetomy and chondroplasty lesion in trochlea
SURGEON: Mr. Shaw / Mr. Mthethewa
ASSISTANT:
ANAESTHETIST: Dr. A Gillespie
INDICATION: MRI proven medial meniscal tear.

PROCEDURE:
Under general anaesthetic and general nerve block the anticipated portal sites were infiltrated with 1% Xylocaine with adrenalin. Standard anterolateral anteromedial portals established and good visualisation obtained.

Patellofemoral joint: Extensive fibrillation over the patella. Full visualisation of the surface was not possible but it felt very gritty and down to bone in areas. There was a 3x3mm lesion in the centre of the trochlea which corresponded with the reported lesion on MRI scan. There was a small amount of articular cartilage unstable around this which was stabilised using the ArthroWand 50. at the appropriate low setting for the centre of this had exposed bone.

Medial compartment: There was degenerative change on both the femur and tibia visible with some areas of exposed bone particularly in the femur. The meniscus had a deep tear of posterior half mainly in the under surface. This was resected back to leave a stable margin. There was a cleavage component to this extending into the periphery. This was stabilised using the ArthroWand.

Intracondylar notch: ACL intact and stable.

Lateral compartment: In good condition.

Washout with saline. Blue swabs, wool and crepe.

VIC 696
FORM 0168262

THE VICTORIA INFIRMARY

OPERATION SHEET

SURNAME (Block Letters)	FIRST NAMES (Block Letters)

DATE	NAME OF OPERATION PERFORMED	AGE	REGISTRATION NUMBE

SURGEON	ASSISTANT	ANAESTHETIST

NAME: BRIAN MACKENZIE
DOB: 31/08/58 **UNIT NO:** SG00375441

POST OP INSTRUCTIONS:
1. Mobilise as per routine.
2. Home when able.
3. Return Clinic in 6 weeks.

ADS/AC **DATE:** 23/03/12

VIC 696
FORM 0168262

South Glasgow Hospitals
Victoria Infirmary, Glasgow G42 9TY. Tel. 0141 201 6000

Part I Discharge Letter and Medicine Prescription Form - Confidential Ref No: 208969

201 5075

Greater Glasgow and Clyde

VIMI-DISCHARGE - 2725 V/C

Dear Doctor Dr Thomson
Surgery Renfrew HC

Fix ID label to all 4 copies

Patient: .....
Address: SG00375441
MACKENZIE, BRIAN
22 LOMOND AVENUE
RENFREW
PA4 0PG
DOB: 31/08/1958
Weight ..... CHI 3108583158

Ward: D Tel: .....
Consultant: Swan
Specialty Ortho
Named Nurse: 19.3.12.
Admission date: ... / ... / ...
Mode of admission
Source of admission
Discharge date: 19/3/12

Follow-up arrangements
Clinic appointment made: 6/52.
Yes ☐ No ☐ To follow ☑
Clinic name
Date ... / ... / ...
Non-childproof containers required: Yes ☐ No ☐
Medicine compliance aids required: Yes ☐ No ☐
Specify:

Reason for admission, treatment, diagnosis, investigations, operations, complications:
Right Knee Arthroscopy = Medial Meniscal Tear
For Osteoarthritic Knee to Follow

Other information

MEDICINE	Dosage form	Dose	Times for administration: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 8	pm 10	Other times	Recommended duration of treatment after discharge	New Drug ✔	New Dose ✔	Number of days supply	Dispensing Details (Pharmacy only)
Patient Own Meds																	

Medicines discontinued	Reason (if known) e.g. side effects

Clinical Pharmacy check:
All known drug sensitivity / adverse reactions:

Dispensed by: ..... Date: ... / ... / ...
Checked by:

WARD USE ONLY
Med. rec. on ward by: .....
Issued by: ..... Date: ... / ... / ...
Signature of recipient:

Doctor's name: Marwood Signature: ..... Date 19/3/12
Doctor's grade: SJT Pager number: 6479

Number of prescription sheets at discharge:

If you have any problems after discharge, please contact the Ward or your G.P.

ORTHOPAEDIC

SG00375441
MACKENZIE, BRIAN
22 LOMOND AVENUE

RENFREW 31/08/1958
PA4 0PG CHI 3108583158

Unit Number

Date of First Attendance

Date of Birth Sex/ Civil state

Surgeon
SHAW

Diagnosis
Elective admission for a right knee arthroscopy + partial medial meniscectomy + chondroplasty of patella.

Disposal

Report to Dr.

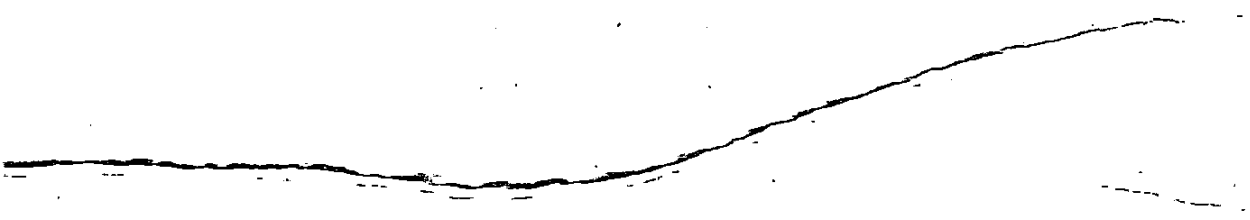
Admit—Immediate
Per Waiting List
Urgent/Soon/Non-Urgent

X-Ray Number

O.P. Treatment
at .....on.....

Date	History and Clinical Findings
13/3/12	CLERK IN - FY1 May had trauma to Right knee resulting in dislocation (Lateral dislocation of patella) - pain over knee, worse at night (at rest) - no swelling / crepitus - slightly unsteady on uneven surfaces - Had splint for 3 weeks now support Bandages MRI ⇒ flapped tear running into the inferior surface of the medial meniscus — PMHx. chronic gastritis — had OGD. As per GP notes ⇒ Alcohol Abuse. Drug Misuse. Narcotic Depression. FHx. IHD. °DM °Angina °MI °Asthma °COPD Past Ops Right thumb wash out + K wiring. Excision of Right knee cyst (10-15yrs ago) Haemorrhoidectomy Bilateral Vasectomy No issues under anaesthetic. Drug Hx. tramadol 50mg 2 in morning 100mg Thiamine tds NKDA.

VIC670
0164355



Social Hx -
Works as Gardener (self employed)
- 20-30 cigarettes per day ; currently smoking Cannabis
- Alcohol XS ⇒ currently attending AA ⇒ not had alcohol since ~~Sept~~ September 2011

Systemic Enquiry
Cardio - nil
Resp - SOB on exertion (minimal exertion)
— productive cough in morning clear sputum.
GI - Nil
U - Nil
N Sys = Nil

O/E.
Cardio - HS I+II+0.
JVP ⇒
ankle swelling
sacral oedema

Resp. clear.
Resonant.
trachea Central.

Abdo. soft
Bowel Sounds ✓

Neuro - grossly intact.

Imp fit for Theatre.

Plan Kurlex
Bloods
ECG.
Nasty function test
DW Anaesthetist.

Rosar
6/3/14

THE VICTORIA INFIRMARY

OPERATION SHEET

SG00375441
MACKENZIE, BRIAN
22 LOMOND AVENUE

RENFREW
PA4 0PG

31/08/1958
CHI 3108583158

FIRST NAMES (Block Letters)

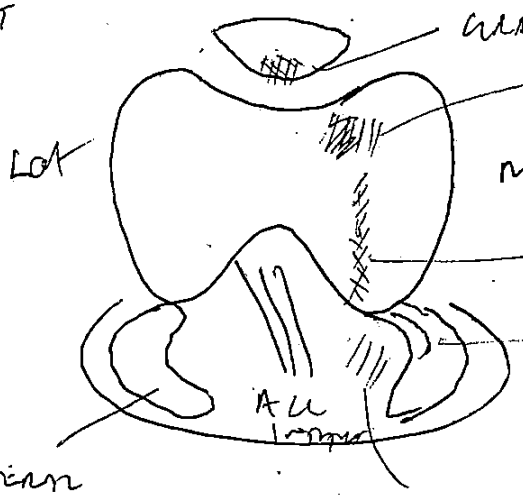
IED
RIGHT KNEE SCOPE

AGE | REGISTRATION NUMBER

SURGEON	ASSISTANT	ANAESTHETIST
MR SHAW	MR MITHETHWA	DR GILLESPIE DR FREER

19.3.19

RIGHT



MEDIAL HOAM TEAR TO PERIPHERY – TRIMMED WITH RADIOWAVES TO STABLE RIM

20ml OF 0.25% CHIVACAINE INFILTRATED

POST OP

1. ANALGESIA
2. CSM
3. MOBILISE FWB
4. PRESSURE DOWN IN 48 hrs
5. STEM-STRIPS – 7 DAYS
6. CLINIC 6/52
7. HOME LATER IF OK

dr's

VIC 696
FORM 0168262

South Glasgow Hospitals

ANAESTHETIC RECORD

NHS Greater Glasgow and Clyde

Date: / /

Pre-op instructions:

Fast for: AM Lunchtime PM List

Patie
Name
Unit N SG00375441
Addre MACKENZIE,BRIAN
22 LOMOND AVENUE

RENFREW 31/08/1958
PA4 0PG CHI 3108583158

DOB

Proposed operation:

Assessor:

Ward:

Pre-op assessment

Previous G.A.'s: Yes

CVS: HR BP 136 / 79

Resp: Gastric

Other (specify): Actus

? Pharyngeal pouch.

Fasted:

Reflux: ✓

Drugs: Tramadol Trimeb

N.S.A.I.D's ? avoid

Allergies: —

BMI:

Weight (kg):

Airway: MP1

Dentition: loose lower bridge

Investigations

Na+:	Hb: 144	Others (specify):
K+:	WCC:	
C1-: ✓	Plts:	
HCO3-:	ECG:	
Urea:	CXR:	
Creat:	Glucose	

Urgency

		A.S.A.
Elective	☒	1
Scheduled	☐	2
Urgent	☐	3
Emergency	☐	4
		5

Comments / Warnings

Material risks explained ☐

Anaesthesia

Date: 19/3/12

Machine check: ☑ Circuit check ☑

Cannula: 20 G, L/R Hand Arm Foot

Cannula: G, L/R Hand Arm Foot

Arterial site: | CVP site:

Patient position: L

ECG ☐	NIBP ☐	S_pO_2 ☐
E_TCO_2 ☐	FiO_2 ☐	E_TAA ☐
ALLABOVE ☑		
TOF ☐	CVP ☐	IABP ☐
Blood warmer ☐	Patient warmer ☐	
Anti DVT ☐	U/O ☐	Temp ☐

Fluids

(1) RL 500

(2) RL 1000

Pre O_2 ☐

Cricoid ☐

Airway - Oral / Nasal

size: LMA size: 4.0

Oral / Nasal Type:

Cuffed / Uncuffed Pack: In / Out

Ventilation - Spontaneous / Controlled

Circle	Air / N_2O
Bain	SEVO
T-piece	ISO
ADE	DES

Laryngoscopy Grade: 1 2 3 4

Time					1600															
Propofol	100+50																			
Fentanyl	75mcg																			
SpO_2		99	99	99	98	98														
FiO_2		.5	.5	.5	.5	.55														
$ETCO_2$		5.0	4.8	4.9	5.1	5.5														
E_TAA		1.8	2.2	2.8	3.1	3.2														
Fluids		(1)			(2)															
Temperature	35°																			
180																				
160																				
140																				
120																				
100		✓	✓	✓	✓	✓	✓	✓												
80																				
60																				
40																				
20																				
CVP																				
Blood loss																				
Urine output																				

2

Regional Anaesthesia / Other Procedures / Comments

① Obturator NB
- asepsis
- US guided + PNS
- 10ml of 0.25% levobupivacaine injected easily
- good fascial spread noted

Operation Details **Theatre:**

Operation as proposed on page 1 ☐ Reversal given: Yes ☐ No ☐

Anaesthetist(s): Freer / Gillespie	Surgeon(s): Shaw
Named Consultant: P	Discussed with Consultant: Yes ☐ No ☐

Post Operative Care until fully awake +

A. **Oxygen** 2-4 **L/min OR** **% for** **hours** **OR SpO_2** >95 **% on air.**

B. **Routine observations / postoperative care as per local protocol.**

C. **Appropriate DVT prophylaxis precribed: Yes ☐ N/A ☐**

D. **Anti-emetic given: Yes ☐ No ☐ Drug given:**

E. **Analgesia:**

I.V. Morphine as per Recovery Algorithm - Sign		
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:
2 mg bolus - Time:	Sign:	Witness:

OR

I.V. Fentanyl as per Recovery Algorithm - Sign		
40 µm bolus - Time:	Sign:	Witness:
40 µm bolus - Time:	Sign:	Witness:
40 µm bolus - Time:	Sign:	Witness:
40 µm bolus - Time:	Sign:	Witness:
40 µm bolus - Time:	Sign:	Witness:

F. **Post Operative fluids**

Fluid (additive)	Volume	Rate	Sign	Start	Lot No.	Initials

Post operative notes / Comments

Post Operative Care

Brian MacKenzie

Time	1635	1640	1645	1650	1655	1700	1705	1710
SpO_2	100	100	100	100	100	100	100	100
O_2 L/min	15	6	6	6	4	4	4	4
Resp Rate	15	17	16	16	17	15	17	15
Airway	LMA	OWN	OWN	OWN	OWN	OWN	OWN	OWN
Temperature		36.3°c.						
BP	NOT APPLICABLE							
Wound site	DRY	DRY	DRY	DRY	DRY			DRY
Affected limb pulse: +ve/-ve	+VE	+VE	+VE	+VE	+VE	+VE	+VE	+VE
Circulation Satisfactory:S Poor: P	S	S	S	S	S	S	S	S
Sensation +ve/-ve	-VE	+VE	+VE	+VE	+VE	+VE	+VE	+VE
Movement +ve/-ve	+VE	+VE	+VE	+VE	+VE	+VE	+VE	+VE
Sedation/Pain score	3/0	1/0	1/0	1/0	3/5	1/5	1/5	0/
Nausea score	0	0	0	0	0	0	0	0

Time	Fluid in	Urine	Drain 1	Drain 2
			NOT APPLICABLE	
	artmans from theatre.			

Blood results / Drug given

Obturator nerve block pre op.
Tramadol 50 mg + Paracetamol 1g orally given @ 17.00

Additional nursing comments

LMA removed @ 16.38. uneventfully.

Waterlow Score ☐ **Intervention required:**

Discharge criteria met:	Discharged to:	Recovery Nurse name:	Ward Nurse name:
Yes ☑ NO ☐	Ward: D.	SN. P. BOAN	
Comments:	HDU ☐ ITU ☐	Signature: P Boan.	Signature:

VI MEDICAL ILLUSTRATION • ANAES • 1985/6.05 VIC 638 Cat. No. 0163149

South Glasgow Hospitals – The Victoria Infirmary

Theatre Care Plan

NHS Greater Glasgow and Clyde

Name	SG00375441
Addr	MACKENZIE, BRIAN
D.O.I	22 LOMOND AVENUE
	RENFREW 31/08/1958
	PA4 0PG CHI 3108583158
Likes to be called/known as:	
Date: 19/3/12 ORSOS No.:	

Baseline observations

Pulse: 59 Temp: 35.7°c BP: 121/77

Weight: 73kg Height: 1.71m

Waterlow score: 4

Ward: D

Consultant: Mr Shaw

Anaesthetic B.P. 137/81 Spo2: 96 on air Pulse: 62

Pre-operative check list

	Ward YES	Ward NO	Ward N/A	Theatre YES	Theatre NO	Theatre N/A
Baseline Observations from ward documented:	✓			✓		
Identification bracelet – details correct:	✓			✓		
Correct case notes including:	✓			✓		
Drug Kardex, X-rays, Blood Results, ECG	✓			✓		
Consent form details checked against theatre list:	✓			✓		
Operation site marked:	✓			✓		
Specify:	R Leg					
Skin preparation/area shaved:		✓				✓
Confirm details of operation with patient and check against theatre list:	✓			✓		
Premedication given at: No pre Med Hours			✓		✓	
Fasted from: 12MN Food 12MN Fluids Hours	✓			✓		
Allergies:		✓			✓	
Specify: NKDA						
False teeth removed:			✓		✓	
Any capped/crowned/veneered/loose teeth:	✓			✓		
Specify: Upper (2) Molar 4 Veneer upper bridge						
All artificial appliances/prosthesis removed:			✓		✓	
Specify:						
Any internal metalwork:			✓		✓	
Specify:						
Nail polish, make-up, jewellery removed:			✓		✓	
Jewellery taped:			✓		✓	
Piercings:			✓		✓	
Specify: Taped ☐ Removed ☐			✓			
assed urine:	✓			✓		
Urinary catheter in situ:		✓			✓	
In-dwelling catheter drained:			✓		✓	
Correct position of patient on tilting trolley i.e. Patient's head at downtilt end and check function:	✓			✓		
Patient has pillow under their head:	✓			(2)		
Specify number of pillows:	2				✓	
Any appliances, e.g.		✓				
Splint, Pumps Type:		✓			✓	
T.E.D. stockings:		✓			✓	
Hearing aid: Removed ☐ In-situ ☐ R ☐ L ☐			✓		✓	
Glasses Removed ☐ In-situ ☐			✓		✓	
Other *Specify:*						

Ward Nurse completing checklist signature: Jones

Ward Nurse handing over patient to theatre staff signature: Cmackenzie

Theatre Nurse signature:

Time patient handed over to theatre staff: 15-05 ***hrs***

Any other relevant information:

BM	Date taken:	Time taken:	hrs
Hb	Date taken:	Time taken:	hrs
U's and E's	Date taken:	Time taken:	hrs

Any Special Requirements:

INTRA OPERATIVE CARE

Named Nurse Team	
Team Leader:	SR Jolly
Pre Operatively:	SN Brown
Peri Operatively:	SSN Taylor
Post Operatively:	

Method of transfer of patient	
Patient slide with maxi-slides	☑
Roll patient	☐
Straight lift	☐
Other– Specify:	

Patient position	
Supine	☑
Prone	☐
Lithotomy	☐
Lloyd-Davis	☐
Left Lateral	☐
Right Lateral	☐
Lower Limb Traction	☐
Knee-Chest Position	☐
eck Chair	☐
Extended Neck	☐
Other– Specify:	

Prevention of injury		
Consent form shown to Scrub Nurse	Signature:	Stroop Rawlins
Eyes taped with Micropore		☐
Heels elevated		☐
Left arm secured:	*On board*	☑
	At side	☐
	Across chest	☐
Right arm secured:	*On board*	☑
	At side	☐
	Across chest	☐
Lateral supports		☐
Padding of bony prominences		☑

Diathermy site N/A	
Left	☐
Right	☐
Thigh	☐
Abdomen	☐
Back	☐
Other– Specify:	

Tourniquet N/A	*Time On*	*Time Off*
Left arm		
Right arm		
Left leg		
Right leg		

Evaluation	Preoperative			Postoperative		
	Yes	*No*	*N/A*	*Yes*	*No*	*N/A*
Pressure areas checked:	✓					
ıeatre pressure area protocol commenced: N.B. if operation >2hrs or patient is high risk category, please follow Theatre Pressure Area Protocol.						
Diathermy site checked:			✓			
Tourniquet site checked:			✓			

Theatre Care		Action
Maintaining normal body temperature	Monitor Temperature half hourly during surgery Pre-op temp.: 35.5°C Peri op temp: 35.3°C Post op temp.:	Warming blanket insitu ☑ Set at high On ☑ ~~Blood warmer insitu~~ ☐ Fluids from Warming cabinet On ☐

Pressure Area Care	Fluid Balance	DVT Prophylaxis
Memory foam mattress	See anaesthetic chart	

PERI OPERATIVE PROCEDURES AND INTERVENTIONS

Surgeon/s: MR SHAW MR MTHETHWA

Anaesthetist/s: DR GILLESPIE DR FREEK

Operation/s: Rt knee arthroscopy + partial medial meniscectomy

Dressings: bluestretch, Stes. Strips, wool, crepe

Drains:

Catheter (Inc. size, type, amount of water in balloon and traceability label)

Naso-gastric tube (size)

ARTHROWAND Ambient™ Super TurboVac 90 Wand IFS REF ASHA4250-01 LOT 0102720-E

ARTHROWAND Ambient™ Super MultiVac™ 50 Wand IFS REF ASHA4830-01 LOT FN03420-A

CVP line (type and location)

Arterial line (type and location)

Estimated blood loss: ***Amount of surgical fluid used intra op:***

Type of anaesthetic	
G.A.:	☑
G.A. + Regional Block	☐
Specify:	
G.A. + Epidural	☐
Lumbar	☐
Thoracic	☐
Spinal	☐
Epidural	☐
Sedation	☐
Regional Block	☑
Specify:	
L.A.:	
Drug: Xylocaine 1% 1 in 200 000 adrenaline	
Amount: 15ml + 20 mls of Chirocaine 0.25% at end of procedure	
Area of Injection: Right knee	

Comments, Instructions for Ward

i.e. CSM, Limb position, Discharge criteria

Observe CSM

PATIENT TRACEABILITY RECORD / INFORMATION

Date of operation / procedure:

Consultant:

Post-op Ward:

SG00375441
MACKENZIE, BRIAN
22 LOMOND AVENUE

RENFREW
PA4 0PG 31/08/1958
CHI 3108583158

Implant Product and Product Identification Labels

Blood Transfusion Stamps:

Washer Disinfector Receipt:

VI MEDICAL ILLUSTRATION • THEATRES • 0775N/SYQUEST 6-5/96

NHS Greater Glasgow and Clyde

Intraoperative Accountable Items Count Record

Date 19/03/12

ADDRESSO

NAME MACKENZIE, BRIAN

DOB 31/08/1958

HOSP /CHI n SG00375441 CHI 310858158

WARD 5

HOSP - U.L.

THEATRE- 2

22 LOMOND AVENUE
RENFREW
PA4 0PG

COUNTS	Scrub Nurse(s) Print Name	Circulating Nurse(s) - Signature & Print name
PRE - OP SWAB COUNT CORRECT	SSN S TAYLOR	R DONNACHEY
PRE - OP INSTRUMENT COUNT CORRECT	SSN S TAYLOR	R DONNACHEY
FINAL SWAB COUNT CORRECT	SSN S TAYLOR	R DONNACHEY
FINAL INSTRUMENT COUNT CORRECT	SSN S TAYLOR	R DONNACHEY
FINAL SWAB DISPATCH COUNT CORRECT	SSN S TAYLOR	

SCRUB NURSE VERIFICATION - PLEASE SIGN ON PAGE UNDERNEATH.

I have reviewed this count sheet and can verify my count(s) correct

SCRUB NURSE 1- SIGNATURE - S. Taylor

SCRUB NURSE 2 SIGNATURE -
To be signed by replacement scrub nurse if applicable

HANDOVER COUNT IN EVENT OF REPLACEMENT OF SCRUB NURSE DURING PROCEDURE

	Outgoing Scrub Nurse - Print Name	Incoming Scrub Nurse - Print Name	Circulating Nurse(s) - Signature & Print name
OUTGOING COUNT *To be completed for permanent and temporary replacement*			
INCOMING COUNT *To be completed for temporary replacement*			

OPERATION
Rt. Knee arthroscopy + Pmm

TALLY OF EACH ITEM USED - ADD ANY ITEMS SPECIFIC TO YOUR SPECIALITY

						ITEMS REMAINING IN SITU (Type & Number)
Swabs (2x2)		Tapes				
Swabs (10x10)		Sloops/Slings				
Abdominal packs		Bulldogs				
Sutures		Shods				
Blades		Tibbs Cannula				
IV needles		Ports				
Syringes		Staple Gun Inserts				
Discard-a-pad		Spears				
Diathermy pencil		Throat packs - Anae				
Diathermy tips		Throat packs - Scrub				
Scratch pad		Retrieval Bag (Bert)				
Reels		Digital Tourniquets				
Patties						
Pledgelets						

DISCREPANCY IN COUNT - ACTIONS AND OUTCOME

COUNT IN WHICH DISCREPANCY OCCURRED

DETAILS

ACTIONS TAKEN AND OUTCOME (I.E. SWABS ISOLATED, SEARCH UNDERTAKEN, WOUND EXPLORED, X - RAY TAKEN) -

SCRUB NURSES SIGNATURE IF COUNT STILL INCORRECT FOLLOWING ALL POSSIBLE ACTIONS

SURGEONS SIGNATURE IF COUNT INCORRECT FOLLOWING ALL POSSIBLE ACTIONS

PLEASE INSERT TRACEABILITY STICKERS ON BACK OF COPY- TO STAY IN THEATRE.

Patient Agreement to Investigation or Treatment

NHS Greater Glasgow and Clyde

CONSENT FORM

PATIENT DETAILS (OR PRE-PRINTED LABEL)

SG00375441
MACKENZIE, BRIAN
31/08/1958
PA4 0PG
Practice Code: 87700
CHI:3108583158

Hospital/Clinic/GP Practice .....

Patient's surname/family name .....

Patient's first name(s): .....

Date of Birth___/___/_____ Gender: Male ☐ Female ☐

NHS/ CHI Number _____

Special requirements (e.g. other language/communication method) .....

.....

Responsible practitioner: Sign.

Job title: .....

STATEMENT FOR PRACTITIONER

(to be filled in by practitioner with appropriate knowledge of proposed procedure- see guidance notes)

Describe proposed operation, investigation or other treatment.
Where appropriate specify site or side: (WRITTEN IN FULL)

Right knee scope + proced.

I have explained the procedure named on this form to the patient in terms which, in my judgement, are suited to their understanding. In particular, I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure (please specify major procedures above).

Signature of practitioner: Sign

Name/Designation (Print) .....

Date 19/3/12

STATEMENT TO BE COMPLETED BY PATIENT/PARENT*

(* parental responsibility for a minor without capacity)

You should read this form and the notes below carefully. If there is anything you do not understand ask the Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

I understand

- the procedure, important risks and appropriate alternatives which have been explained to me by the practitioner named on this form.
- that a practitioner other than the practitioner who has been providing treatment so far might carry out the procedure.
- that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to the medical treatment proposed, to safeguard or promote physical or mental health.
- That examination for the purpose of teaching will not be undertaken without my consent.

I have been told about additional procedures which may become necessary during treatment. I have ted below **any procedures which I do NOT wish to be carried out without further discussion.**

I agree -

- to the administration of an anaesthetic or to sedation if required.
- to the procedure named on this form
- to the emergency administration of blood or blood products

Additionally you have to agree or disagree the following:-	**Agree**	**Disagree**
that information and/or images kept in records may be used anonymously for education, audit, and research with appropriate ethical approval, to improve the quality of patient care.	☐	☐
that surplus tissue or other biological material not essential for my diagnosis or ture treatment may be used for medical education and ethically approved medical research.	☐	☐

PATIENT REFUSAL FOR BLOOD PRODUCTS

Please sign here if you refuse to consent to the emergency administration of blood or blood products. Even if this results in death.

Signature: ..... Date ...../...../.....

Practitioner Signature: ..... Date ...../...../.....

PATIENT/PARENT* AGREEMENT FOR TREATMENT

Signature: B Mackenzie Date 14/3/12

Name (Print): B. MACKENZIE

BIOCHEMISTRY DEPARTMENT

SOUTH GLASGOW ☎ (0141) 201 1681 NHS Greater Glasgow and Clyde **A**

Name **MACKENZIE BRIAN** | CHI Number **3108583158** | Location **Ward D, Victoria**

Unit No. **SG00375441** | Lab Number R,12.4523316.X | Consultant **Mr.A.D.Shaw**

D.O.B. **31.08.58** Sex **M** | Received 13.03.12 at 12:26 | Prov. Diagnosis Pre op

Withdrawal		Na	K	Cl	HCO_3	Urea	Creat	eGFR	Glucose	*	CRP	Amylase	Magnesium	Urate
Date	Time	135–145	3.5–5.0	98–108	23–30	2.5–7.0	40–130				<10	<100	0.70–1.00	0.22–0.45
		mmol/L					umol/L	mL/min	mmol/L		mg/L	U/L	mmol/L	
02.10.09	20:00	138	4.2	105	19	2.8	78	>60			4			
13.03.12	09:30	136	3.9	101	28	3.3	70	>60	4.3	N	5			

Withdrawal		T.Protein	Albumin	Globulins	Bilirubin	Alk. Phos.	AST	ALT	GGT	CK	Calcium	Adj Ca	Phosphate
Date	Time	60–80	32–45	23–38	<20	30–120	<40	<50	<70	<210		2.10–2.60	0.70–1.40
		g/L			umol/L	U/L					mmol/L		
13.03.12	09:30	77	41	36	12	91	20	11					

* Fasting: Y = Yes, N = No

CPA Accredited Medical Laboratory Reference No: 2923

Report authorised by Computer validation

Run No: 881 Issued 13.03.12 at 14:30 Specimen type: Blood

SG00375441
MACKENZIE, BRIAN
22 LOMOND AVENUE

RENFREW 31/08/1958
PA4 0PG CHI 3108583158

OPOC date: 13.3.12
Consultant: ADS
TCI date: 19.3.12

U & E's	Normal values	Date	Date
Sodium	135-145	136	
Potassium	3.5-5.0	3.9	
Chloride	97-107	101	
HCO3/Bic	23-30	28	
Urea	2.5-7.0	3.8	
Creatinine	40-130	70	
Glucose random	3.5-6.0	4.3	
HbA1c	3.4-7.2		
CRP	↓10,	5	
eGFR	>60	760	
LFT's			
Total Protein	62-82	77	
Albumin	32-45	41	
Globulin	23-38	36	
Bilirubin	↓20	12	
Alk Phos	25-110	91	
AST	↓37	20	
ALT	↓40	11	
TFT's			
TSH	0.37-3.51		
Free T4	9.0-21.0		
Free T3	3.8-6.0		
FBC			
WBC	4.0-11.0	6.9	
Haemoglobin	135-175 M / 115-165 F	144	
MCV	74-99	94.8	
Platelets	150-440	293	
Coag. screen			
ESR	0-7		
PT	0.9-1.1 (Prothrombin Time)		
Fibrinogen	1.5-3.8		
APTT	0.77-1.23		
INR			
B12	189 - 883		
Serum Folate	2.7 - 34 (^20 = high)		
	MRSA result	(Neg) / Pos	
	BP reading	136 / 79	/
SIGN:	>>>>>>>>>>	P67 JF	

- Loose Baker Upper Molar

- Prev Alcohol Abuse – Nil 9/2011
- Smokes Cannabis 70 Joints P/W • ?x2 Blackouts 1yrs Ago – Coughing Fi

SOUTH GLASGOW HOSPITALS - HAEMATOLOGY DEPARTMENT

TCI 19/3/12

SURNAME	FORENAME	SEX	HOSP. No.	D.O.B.
MACKENZIE	BRIAN	M	SG00375441	31.08.58
MEDICAL OFFICER	**WARD / HOSPITAL**			**C.H.I. NUMBER**
Mr.A.D.Shaw	Ward D, Victoria			3108583158

Haemoglobin		144	g/l	(130-180)	White Blood Count	6.9	$x10^9/l$	(4.0-11.0)
Red Cell Count	L	4.44	$x10^{12}/l$	(4.50-6.50)	Neutrophils	3.7	$x10^9/l$	(2.0-7.5)
Haematocrit		0.421	l/l	(0.350-0.540)	Lymphocytes	2.2	$x10^9/l$	(1.5-4.0)
MCV		94.8	fl	(78.0-99.0)	Monocytes	0.7	$x10^9/l$	(0.2-0.8)
MCH	H	32.4	pg	(27.0-32.0)	Eosinophils	0.4	$x10^9/l$	(0.0-0.4)
Platelets		293	$x10^9/l$	(150-400)	Basophils	0.1	$x10^9/l$	(0.0-0.1)

Lab No:	Spec:	Collected:	Received:	Reported:	Authorised by:	Work done:
H,12.4055204.Q	Blood	13.03.12 09:30	13.03.12 10:10	13.03.12 11:14		FBC

SGH 115A

BACTERIOLOGY DEPARTMENT
TEL: 0141 201 1703/4/5

SOUTHERN GENERAL HOSPITAL GLASGOW

Name: MACKENZIE BRIAN
Address: 22 LOMOND AVENUE
Consultant/GP: Mr.A.D.Shaw
Ward: Ward D. Victoria
Specimen: SWAB MRSA perineal

Unit No.: S00037541 CHI No.: 3108583159
D.O.B.: 31.08.58 Sex: M
Report to: Ward D. Victoria
Date collected: 13.03.12
Date received: 13.03.12

REPORT: FINAL REPORT

Microscopy:-

Culture:-
METHICILLIN RESISTANT Staph.aureus NOT ISOLATED

Comment:-

Authorised by: J.GUTHRIE 14.03.12 10:16

LAB.NO.M.12.00094331

SGH 115A

BACTERIOLOGY DEPARTMENT
TEL: 0141 201 1703/4/5

SOUTHERN GENERAL HOSPITAL GLASGOW

Name: MACKENZIE BRIAN
Address: 22 LOMOND AVENUE
Consultant/GP: Mr.A.D.Shaw
Ward: Ward D. Victoria
Specimen: SWAB MRSA threat

Unit No.: S90037544I CHI No.: 3108583150
D.O.B.: 31.08.58 Sex: M
Report to: Ward D. Victoria
Date collected: 13.03.12
Date received: 13.03.12

REPORT: FINAL REPORT

Microscopy:-

Culture:-
METHICILLIN RESISTANT Staph aureus NOT ISOLATED

Comments:-

Authorised by: J.GUTHRIE 14.03.12 10:1e

LAB.NO.M,12.0009432

SGH 115A

BACTERIOLOGY DEPARTMENT
TEL: 0141 201 1703/4/5

SOUTHERN GENERAL HOSPITAL GLASGOW

Name: MACKENZIE BRIAN
Address: 22 LOMOND AVENUE
Consultant/GP: Mr.A.D.Shaw
Ward: Ward D. Victoria
Specimen: SWAB MRSA nasal

Unit No.: S900375441 CHI No.: 3106583150
D.O.B.: 31.08.58 Sex: M
Report to: Ward D. Victoria
Date collected: 13.03.12
Date received: 13.03.12

REPORT: FINAL REPORT

Microscopy:-

Culture:-
METHICILLIN RESISTANT Staph aureus NOT ISOLATED

Comments:-

Authorised by J.GUTHRIE 14.03.12 10:17

LAB.NO.M.12.0008433

MACKENZIE, BRIAN ID: 3108583158 13-Mar-2012 10:11:14 Victoria Infirmary

31-Aug-1958
Male

Vent. rate 57 bpm
PR interval 142 ms
QRS duration 84 ms
QT/QTc 436/424 ms
P-R-T axes 47 21 38

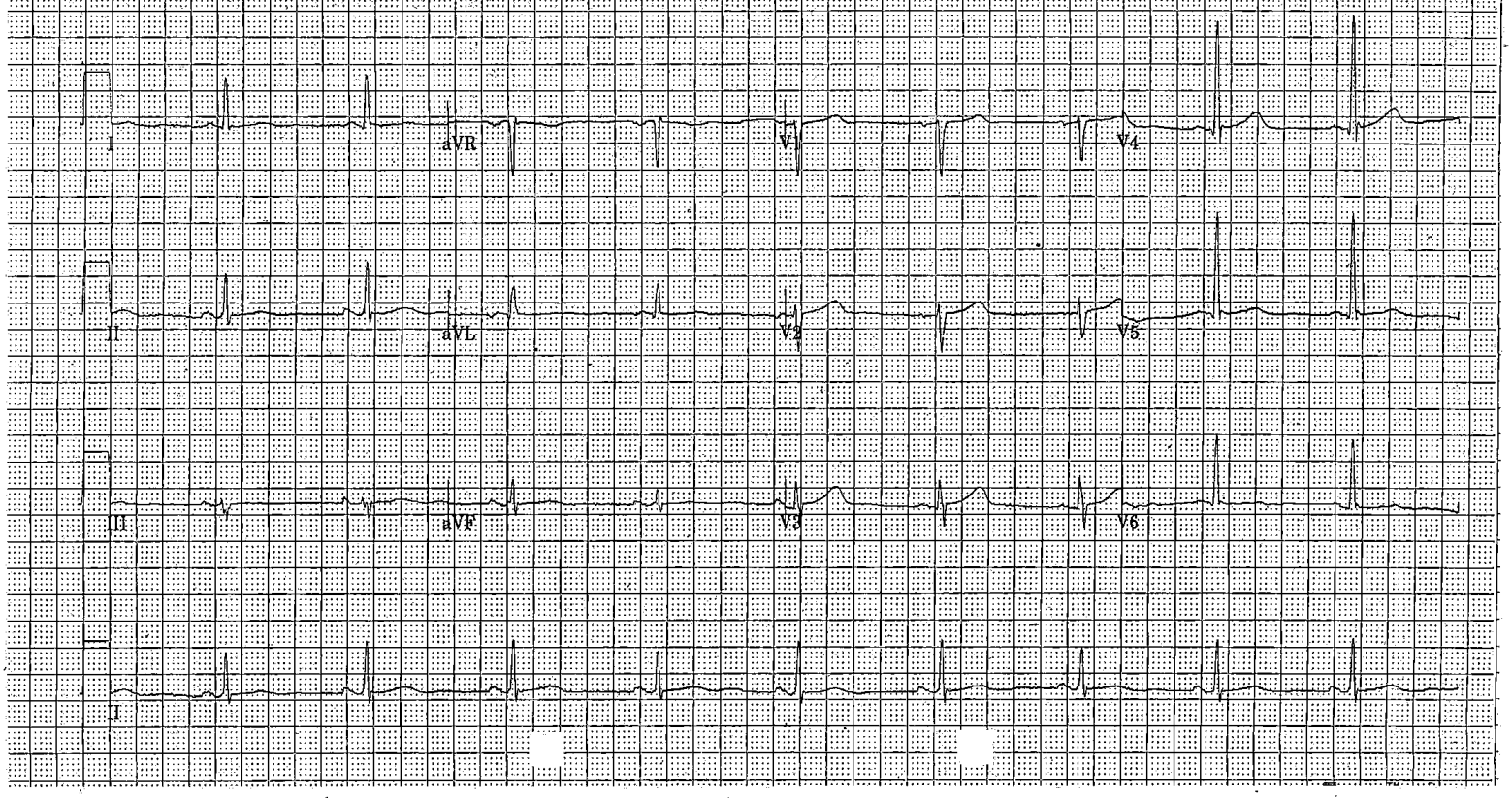
Sinus bradycardia
Nonspecific T wave abnormality

Technician: LW

Referred by: MR SHAW

Unconfirmed

location: WARD D



MACKENZIE, BRIAN ID: 3108583158 13-Mar-2012 10:11:00 Victoria Infirmary

31-Aug-1958
Male

Vent. rate	60 bpm
PR interval	142 ms
QRS duration	82 ms
QT/QTc	426/426 ms
P-R-T axes	62 15 35

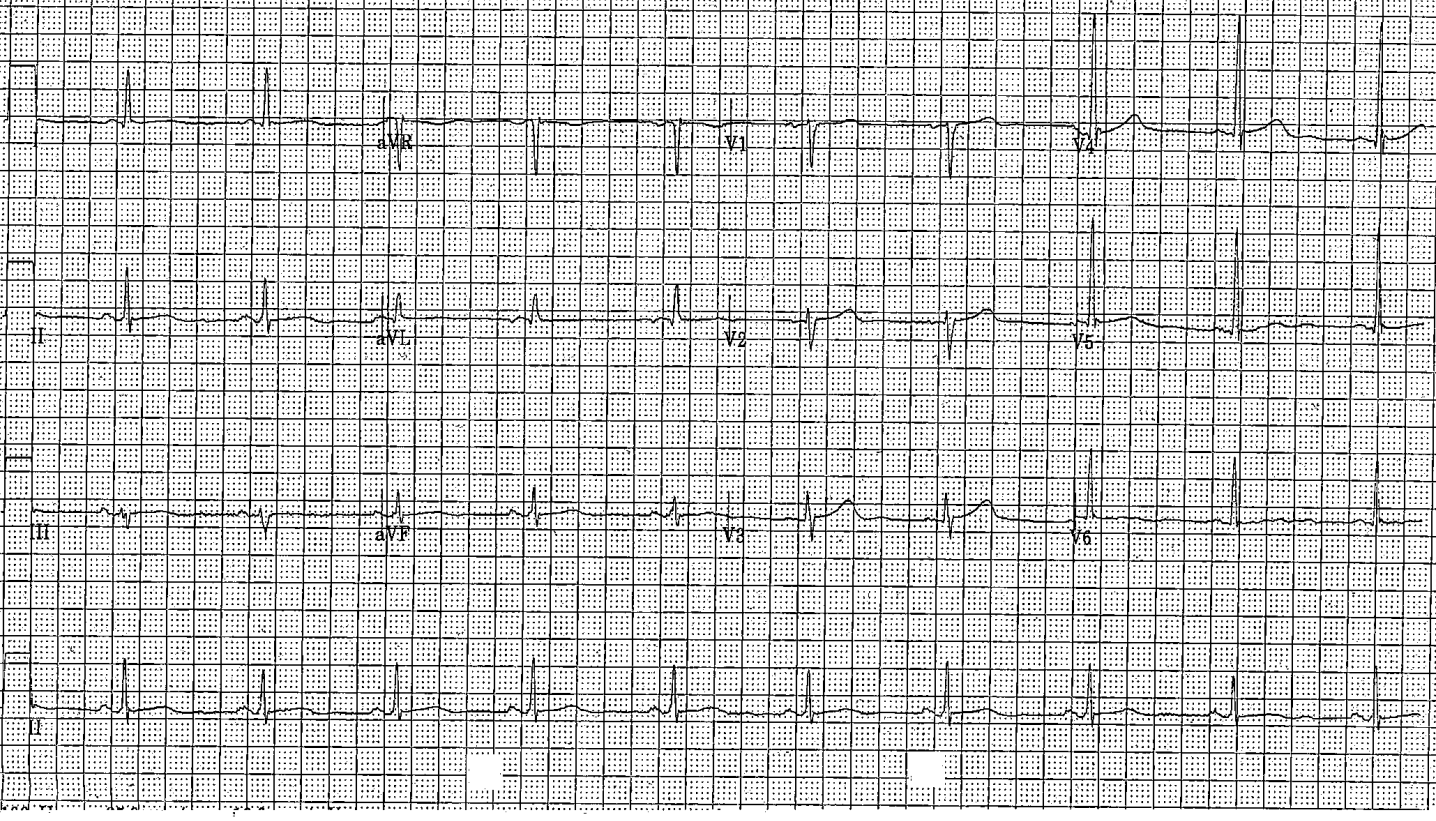
Normal sinus rhythm
Nonspecific T-wave abnormality

Technician: LW

Referred by: MR SHAW

Unconfirmed

location: WARD D



Adult Peripheral Venous Cannulation (PVC) Chart

Please use 1 chart per PVC

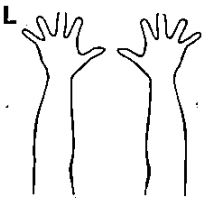
NHS Greater Glasgow and Clyde

PVC Insertion Information

*Ensure the PVC dressing has **date** and **time** of insertion written on it. This implies that appropriate technique has been used for insertion.*

SG00375441
MACKENZIE, BRIAN
22 LOMOND AVENUE

RENFREW 31/08/1958
PA4 0PG CHI 3108583158



Date: _____ (See IV Dressing)

Time: _____

Reason for Insertion: _____

Flushed on insertion ☐ (if known)

Other Site: _____

PVC Maintenance Information

Modified V.I.P (Visual Infusion Phlebitis) Score

IV site appears healthy	0	No Phlebitis	**Observe Cannula**
ONE of the following is evident: - slight pain or redness near site	1	Possible first signs	**Observe Cannula**
TWO of the following are evident: - pain -redness - swelling	2	Early stage of phlebitis	**Re-site Cannula**
ALL of the following are evident: - pain - redness - hardening of the surrounding tissue	3	Phlebitis / Thrombophlebitis **Re-site Cannula & Seek Further Advice**	
As above including: - palpable venous cord	4		
As above including: - pyrexia	5		

Day 1 (24 hours after insertion)

All 5 questions below MUST be answered
The PVC must be monitored at least once per day

1. Continuing clinical indication for PVC?	Yes / No
2. VIP Score?	☐
3. PVC Dressing dry & intact?	Yes / No
4. Was PVC dressing renewed?	Yes / No / NA
5. Was PVC Removed?	Yes / No

Removal Reason: _____

Comments/Actions Taken:

Date: Initials:

Day 2

All 5 questions below MUST be answered
The PVC must be monitored at least once per day

1. Continuing clinical indication for PVC?	Yes / No
2. VIP Score?	☐
3. PVC Dressing dry & intact?	Yes / No
4. Was PVC dressing renewed?	Yes / No / NA
5. Was PVC Removed?	Yes / No

Removal Reason: _____

Comments/Actions Taken:

Date: Initials:

After Day 3 consider removal, if there is still a clinical reason justify rationale for PVC to remain insitu:

Date: Initials:

Day 3

All 5 questions below MUST be answered
The PVC must be monitored at least once per day

1. Continuing clinical indication for PVC?	Yes / No
2. VIP Score?	☐
3. PVC Dressing dry & intact?	Yes / No
4. Was PVC dressing renewed?	Yes / No / NA
5. Was PVC Removed?	Yes / No

Removal Reason: _____

Comments/Actions Taken:

Date: Initials:

Day 4

All 5 questions below MUST be answered
The PVC must be monitored at least once per day

1. Continuing clinical indication for PVC?	Yes / No
2. VIP Score?	☐
3. PVC Dressing dry & intact?	Yes / No
4. Was PVC dressing renewed?	Yes / No / NA
5. Was PVC Removed?	Yes / No

Removal Reason: _____

Comments/Actions Taken:

Date: Initials:

CHI Number: 3108583158 Patient Name: MCKENZIE, BRIAN

Acute Services Division

Surgery and Anaesthetics Directorate

Department: Pre Op Assessment Unit

Specialty: Trauma and Orthopaedic Surgery

NHS Greater Glasgow and Clyde

Hospital Name	Victoria Infirmary

Patient Details		GP Details	
Name	MCKENZIE, BRIAN	Name	AL-NAJIM, ZIAD
Address	22 Lomond Avenue ROAD RENFREW PA4 0PG	Address	CLYDEVIEW MEDICAL PRACTICE RENFREW HEALTH CENTRE 10 FERRY ROAD RENFREW PA4 8RU
Correspondance Address		Telephone	
Correspondance Postcode		CRN Number	SG00375441, DYK3108583158, ZNC12566884
Telephone	07966154552	Consent	Yes
Patient Contact Number	0	Sensitivity	Sensitive
CHI Number	3108583158	Consultant Name	MR A D SHAW
Sex	Male	Requires Transport	No
Date of Birth	31/08/1958	Religion	Christian

Next of Kin / Person to Notify	Next of Kin	Person to Notify
Name	MAGRET MACKENZIE	
Address	SA	
Landline		
Mobile	07973435422	
Relationship	WIFE	

Assessment Details					
Assessor	C/N JANICE FERGUSON	Grade	BAND 6	Date	13/03/2012
Ward	CLINIC F V I ACH				

Surgery / Procedure Attending For
® KNEE ARTHROSCOPY + PMM + CHONDROPLASTY OF PATELLA

Availability	
Are you available at short notice?	

CHI Number: 3108583158 Patient Name: MCKENZIE, BRIAN

Period of unavailability	
Reasons for unavailability	
Details	

Anaesthetic History	
1. Previous GA	
Have you had a General Anaesthetic before?	Yes
Were there any problems?	No
2. Previous LA	
Have you had a Local Anaesthetic before?	Yes
Were there any problems?	No
3. Dentition Risk	
Do you have any loose teeth, caps or dentures?	Yes
Details	UPPER ® MOLAR LOOSE, PARTIAL UPPER FIXED BRIDGE
4. Reduced neck movement	
Do you have any neck or jaw stiffness?	No
5. Other Risk	
Has anybody in your family had a serious reaction to an anaesthetic?	No
6. Heartburn	
Do you suffer from heartburn or indigestion?	No
7. Sickle Cell Disease (risk factor)	
Do you have sickle cell disease?	No
Are there risk factors for sickle cell disease?	No

Surgical History	
8. Affects suitability for DSU or SDA	
Have you ever had surgery?	Yes
Details of relevant surgical history	K-WIRING ® THUMB2011 HAEMORRHOIDECTOMY 1989 VASECTOMY 1986

CHI Number: 3108583158 Patient Name: MCKENZIE, BRIAN

Will this affect the suitability for DSU?	
Have you ever had a serious surgical or anaesthetic complication?	No

Cardiovascular

9. Hypertension

Do you have high blood pressure?	No

10. Arrhythmias

Symptoms:	Irregular heartbeat	No	Palpitations	No	Atrial Fibrillation	No
How often does it occur?					
Are they assosciated with exercise?					
Does it cause you to faint?					

11. Angina

Do you suffer from Angina?	No

12. Heart Attack

Have you had a heart attack?	No

13. Heart Murmur

Do you have a heart murmur?	No

14. Blackouts

Do you suffer from blackouts?	Yes
14a. Are the blackouts assosciated with exercise?	No
14b. Is the patient older than 60 years?	No
How often does it occur?	Less often than monthly

15. Heart Failure

Have you been diagnosed with heart failure?	No

Respiratory

16. Asthma / Bronchitis / COPD / Emphysema

Do you have asthma, bronchitis, COPD, or emphysema?	No

CHI Number: 3108583158 Patient Name: MCKENZIE, BRIAN

17. URTI (Upper Respiratory Tract Infection)	
Have you recently had a cold?	No

Neurological	
18. Stroke	
Have you had a stroke or TIA?	No

19. Epilepsy	
Do you have epilepsy?	No

20. Neurological Disease	
Do you have any neurological or muscular disease?	No

21. Physical Disability	
Do you have a physical disability?	No

Haemotological	
22. Bleeding Disorder	
Do you suffer from prolonged bleeding or excessive bruising?	No

23. Previous DVT	
Have you had a DVT?	No

24. Anaemia	
Do you suffer from anaemia?	No

Miscellaneous	
25. Kidney Disease	
Do you have renal failure?	No

26. Liver Disease	
Do you have liver disease or suffer from jaundice?	No

27. Diabetes	
Do you have diabetes?	No

CHI Number: 3108583158 Patient Name: MCKENZIE, BRIAN

28. Arthritis	
Do you have arthritis?	No

29. CJD	
Has the patient ever been notified that they are at increased risk of CJD or vCJD for public health purposes?	No

30. Other	
Do you have any serious physical / psychiatric illness or learning difficult not already mentioned?	No

Exercise Tolerance	
31. What best describes your level of fitness?	Climbs stairs without stopping

Social History		
32 How many units of alcohol each week?	0.00	units/week

33. Smoker	
Do you smoke?	Yes
How many each day?	30.00

34. Drug Abuse	
Do you currently or have you ever used intravenous or recreational drugs?	Yes
Details	SMOKES CANNABIS X 70 JOINTS P/W
34a. Do you take methadone?	No

35. Pregnant	
LMP	
Are you pregnant?	No
Could you be pregnant?	No
Details	

36. Language	
Can the patient speak English?	Yes

Drug History
37. Drugs

CHI Number: 3108583158 Patient Name: MCKENZIE, BRIAN

List all drugs (including herbal remedies and complimentary medicines)
TRAMADOL 50MGS THIAMINE 100MGS

Does the patient take any of the following?	
Anticoagulants	No
Clopidogrel	No
Aspirin	No
OCP	No
Digoxin	No
Amiodarone	No
Lithium	No
Diuretics	No
MAOIs	No

38. Herbal Remedies	
Are you taking any herbal remedies or complimentary medicine?	No

39. Steroids	
Have you taken regular oral steroids in the last year?	No

40. Allergies	
Does patient have any allergies?	No

Implants	
41. Pacemaker	
Do you have a pacemaker?	No

42. Prosthesis	
Do you have any implants?	No

43. Coronary stents	
Have you had coronary artery stents inserted?	No

Examination			
44. Age (years)	53		
Weight (kg)	73		

CHI Number: 3108583158 Patient Name: MCKENZIE, BRIAN

Height (m)	1.71	BMI	25

45. Risk of sleep apnoea

Do you suffer from daytime sleepiness, restless sleep or witnessed breath holding during sleep?	No

How likely are you to fall asleep or doze in the following situations?			
a) Sitting and reading	No Chance		
b) Watching TV	No Chance		
c) Sitting inactive in a public place	No Chance		
d) As a passenger in a car for an hour without a break	No Chance		
e) Lying down to rest in the afternoon when circumstances permit	No Chance		
f) Sitting and talking to someone	No Chance		
g) Sitting quietly after lunch without alcohol	No Chance		
h) In a car while stopped for a few minutes in traffic	No Chance		
Status based on sleep apnoea score	No risk of sleep apnoea	Score	0

46. Blood Pressure

Systolic/Diastolic BP	136 / 79	121 / 77 on admission

47. Pulse

Pulse Rate	67 / min	59 on admission
Rhythm	Regular	

48. Oxygen Saturation

97 %	96% on admission

49. Urine Analysis

Result	Normal
Details	

50. VTE Risk

Is patient at risk of VTE?	Yes	Do they require prophylaxis?	Yes

Day Surgery Criteria

51. Day Surgery Criteria

Is the procedure suitable for day surgery?	No

CHI Number: 3108583158 Patient Name: MCKENZIE, BRIAN

52. Admission Criteria	
Appropriate admission based on nursing assessment	SDA

53. MRSA Screening	
Does the Patient require a Clinical Risk Assessment?(for patients > 23 hours)	Yes
Has the patient ever had a previous positive MRSA result?	No
Has the patient been admitted from a care home/institutional setting or another hospital?	No
Does the patient have a wound/ulcer or invasive device which was present prior to admission?	No

Has patient is to be admitted to any of the following:							
Orthopaedics	Yes	Vascular		Renal		Critical Care	

MRSA Lab Test Results									
Nose	Yes	Perineum	Yes	Throat	Yes	Other		Patient refused	
Other details:									

Investigations Required

Investigation	Required	Ordered	Investigation Date	Med Staff Informed	Action Required	Re-Test Required
Ferritin	No	No		No	No	
Folate	No	No		No	No	
B12	No	No		No	No	
HbA1c	No	No		No	No	
Group & Save	No	No		No	No	
Cross Matching	No	No		No	No	
Coagulation Screen	No	No		No	No	
Thrombophilia Screen	No	No		No	No	
Sickle Dex Test	No	No		No	No	
Hb Electrophoresis	No	No		No	No	
TFT	No	No		No	No	
Lithium level	No	No		No	No	
Digoxin level	No	No		No	No	
Amylase	No	No		No	No	
Calcium/Bone	No	No		No	No	
ECHO	No	No		No	No	
PEFR	No	No		No	No	
PFT	No	No		No	No	
C-Spine X-Ray	No	No		No	No	
Chest X-Ray	No	No		No	No	
Pregnancy Test	No	No		No	No	
Temperature	No	No		No	No	
FBC	Yes	Yes	13/03/2012	No	No	
Glucose	Yes	Yes	13/03/2012	No	No	
U&Es	Yes	Yes	13/03/2012	No	No	
LFTs	Yes	Yes	13/03/2012	No	No	
CRP	Yes	Yes	13/03/2012	No	No	
ECG	Yes	Yes	13/03/2012	No	No	

CHI Number: 3108583158 Patient Name: MCKENZIE, BRIAN

Investigations Required						
Investigation	Required	Ordered	Investigation Date	Med Staff Informed	Action Required	Re-Test Required
MRSA Screen	Yes	Yes	13/03/2012	No	No	

Pre-op Assessment Summary	
Assessor	C/N JANICE FERGUSON
Grade	BAND 6

Summary

TCI 19/3/12 UNDER MR SHAW
BLOODS,ECG AND MRSA SCREEN OBTAINED
PREVIOUS ALCOHOL ABUSE NIL SINCE SEPTEMBER 2011
SMOKES CANNABIS JOINTS X70 P/W ADVISED TO AVOID 24 HRS PRE/OP
CLAIMS X 2 EPISODES OF BLACKOUT AFTER COUGHING FITS - NIL IN PAST YEAR

Referrals and Type of admission - Recommended Admission pathway		
Referral by Nurse to:	Anaesthetist	Yes
	Surgeon	Yes
	Haematologist	No
	Cardiologist	No
	GP	No
	Cardiac Technician Pace Reset	No
	Cardiac Technician Pace Check	No
Nurse to arrange the attendance of:	Carer	No
	Interpreter	No
Nurse to:	Inform ward staff regarding the risk of alcohol withdrawl	No
Referral by Anaesthetist to:	Surgeon	No
	Haematologist	No
	Cardiologist	No
	Cardiac Technician	No
	GP	No
Type of admission to be decided by:		
Type of Admission:	SDA	
Admission Deferred:	No	

Advise to take usual anti-reflux medication	No
Dispensed Ranitidine as per PGD directive	No
Refer to smoking cessation clinic	No
Advise not to take "intravenous or recreational drug(s)" during the 24 hours before surgery (related to 33. Drug Abuse)	Yes
Anticoagulant advice	No

CHI Number: 3108583158 Patient Name: MCKENZIE, BRIAN

Clopidogrel advice	No
Aspirin advice	No
OCP advice	No
Provide Herbal Medicine Advice	No
Arrange for dialysis the day before surgery	No
Ensure facilities for dispensing methadone are available, if the patient is taking methadone.	No
Print PEFR Advice Sheet	No
Print ECG Advice Sheet	No

Anaesthetist Assessment	
Anaesthetist	
Grade	
Summary	

Acute Services Division
Surgery and Anaesthetics Directorate
Department of Pre Op Assessment Unit
Specialty: Trauma and Orthopaedic Surgery

NHS
Greater Glasgow and Clyde

PreAdmission Form Release 1.0

Hospital Name:

Patient Details		GP Details	
Name:	MCKENZIE, BRIAN	**Name:**	AL-NAJIM, ZIAD
Address:	22 Lomond Avenue ROAD RENFREW	**Address:**	CLYDEVIEW MEDICAL PRACTICE RENFREW HEALTH CENTRE 10 FERRY ROAD RENFREW PA4 8RU
Postcode:	PA4 0PG	**Telephone:**	
Correspondence Address 1:		**Consent:**	Yes
Correspondence Address 2:		**Sensitivity:**	Sensitive
rrespondence Postcode:		**Consultant Name:**	
ephone:	07966154552	**Admission Date:**	
CHI Number:	3108583158	**Time:**	
CRN:	SG00375441, DYK3108583158, ZNC12566884	**Ward:**	
D.O.B:	31/08/1958	**Procedure/Operation:**	

Observations

Temperature (celcius)	**Resps (per min)**	**Heart Rate (bpm)**
Blood Pressure (mmHg)	**O2 Sats (%)**	**S/Mews Score**
Changes Since POA? *Yes* *No*		

There are no allergies to display

Emergency Contact Numbers
Name
Relationship
Phone

Discharge	Yes	No
Estimated Date		
Transport Required		
Supervising Adult for Discharge		

Home Circumstances		Yes	No
Lives with Family Carer			
Lives Alone			
Elderly/Disabled Partner			
District Nurse	**days/wks**		
Home Help			
Other Services			

Medicines	Yes	No
Own Supplied		

Valuables	Yes	No
Valuables Returned		

MRSA		
Positive	**Negative**	**Unknown**

Activities of Daily Living	NOTE: NOT REQUIRED FOR DAY SURGERY
Safety and Comfort	Oriented
Breathing and circulation	No issues
Maintaining Body Temp	Temp 35.7°C
Personal Hygiene	Independent
Elimination	No issues
Sleep	normally sleeps well
Mobility	Independent Mobile
Eating and drinking	normal diet
Skin Condition/Waterlow score	Intact.
Communication (including anxiety & fear) Aids worn?	relaxed mood
Date 19/3/12	Admitted By Dane

THE VICTORIA INFIRMARY
NURSING NOTES

SURNAME MACKENZIE HOSPITAL No.
FORENAME Brian SEX
D. of B.
ADDRESS

NURSING NOTES

WARD/DEPT. D

Date	NURSING NOTES	Signature	Grade
19/7/12 11.50	Patient admitted for theatre Today. for R knee scope Consented + Marked. awaiting theatre Sens on Admission = O Fasted at home prior to admission	JJans	E
19.7.12	Patient returned to ward @ 17° Observations stable sens = 1 (temp 35.7°C). Operation = (R) knee arthroscopy + partial Medial Meniscectomy blue swab Ster Strips wool + crepe in situ. Post op instructions & Observe CSM, Mobilise fully wt bear Dressing down 48 hours Ster Strips off in 7 days OPA in 6/52 May go home later if well & stable. Pain Commenced on paracetamol and co-codamol regularly + diclofenac 50mg 6 hourly PRN	JJans	E
	Patient has a supply of Tramadol @ home and does not require any discharge drugs. has had Diet and fluids, has not yet passed urine		
8pm	pt walked to toilet, Has passed urine CSM intact RH leg, wound Site Dry Tea + toast taken.		
	pt Dressed and NOK will collect pt		
9pm	pt Discharged	L. Baillie	5.

FORM 0164238 VIC 667

Acute Services Division

NHS Greater Glasgow and Clyde

SG00375441
MACKENZIE, BRIAN
22 LOMOND AVENUE

RENFREW
PA4 0PG

31/08/1958
CHI 3108583158

Ward: D

Discharge destination: Home

Estimated Discharge Date (1) 19/3/12

Estimated Discharge Date (2) / /

Final date of discharge : 19/3/12.

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓		NB	
Relative/carer informed	✓		NB	
Others informed: Care Home		✓	NB	
Transport arranged				
Own transport (preferred option)	✓		JJ	
Ambulance-1 man/ 2 man am/pm		✓	NB	
Other: Flight, Air ambulance etc.		✓	NB	
Discharge medication				
Discharge prescription completed	✓		NB	gp letter only
Compliance aids e.g. Dossette Box (involve pharmacist)		✓	NB	
Medication received		✓	NB	
Medication explained to patient and/or relative/carer		✓	NB	
Own medication returned to patient		✓	NB	
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)		✓	NB	
Informed of discharge				
Social work/ Other agencies/Home help		✓	NB	
Physiotherapist	✓		NB	
Occupational Therapist		✓	NB	
Dietician		✓	NB	
Speech and Language Therapist		✓	NB	
Clinical Nurse specialist e.g. Care Home Liaison		✓	NB	
Liaison/ District Nurse/Practice Nurse		✓	NB	
Other discharge items				
Access arrangements (e.g. keys, door entry)	✓		NB	
Patients clothing available for day of discharge	✓		NB	
Valuables e.g. cashier		✓	NB	
Intravenous cannula removed	✓		NB	
Equipment ordered (inc. walking aids) in place for discharge		✓	NB	
Part 2 Discharge letter - Required		✓	NB	
- Completed		✓	NB	
Out patient clinic appointment e.g. Anticoagulation clinic				
Arranged / (To follow)	✓		NB	6/52 to follow
If unknown at time of discharge state reason				
Additional information / leaflets / factsheets				
Time of Discharge: 9pm				
Nurse's signature: L Baillie	Designation: S/N		Date: 19/3/12	

GLASGOW HOSPITALS
AND HANDLING RISK ASSESSMENT

NHS Greater Glasgow and Clyde

SG00375441
MACKENZIE, BRIAN
22 LOMOND AVENUE

RENFREW 31/08/1958
PA4 0PG CHI 3108583158

If patient is totally independent, tick here and go to date box ✓

Obese		Tall	
Above average		Medium	
Average		Short	
Below Average		Weight:	

RISK OF FALLS High | Low

Problems with comprehension, behaviour, co-operation (specify)

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

INTO BATH OR SHOWER

HANDLING AID		WHICH BATH	
Hoist (Specify)		Parker	
Shower chair		Variable height	
		Standard	
		Any	

ASSISTANCE | SUPERVISION | INDEPENDENT

Staff required:

TRANSFERS (including to/from: bed, wheelchair, commode, toilet)

HOIST		MANUAL SUPPORT
Which hoist?		Staff required:
Sling type?		Specify support given
Sling size?		

ASSISTANCE | SUPERVISION | INDEPENDENT

Additional information

TOILETING

HOIST		MANUAL SUPPORT
Which hoist?		Staff required:
Sling type?		Specify support given
Sling size?		

ASSISTANCE | SUPERVISION | INDEPENDENT

Additional information

WALKING

NO WALKING | ASSISTANCE

Staff required:

Walking Aid

SUPERVISION | INDEPENDENT

Distance walked / additional information

MOVE UP/DOWN BED

HOIST		MANUAL SUPPORT	
Which hoist?		Sliding aid	
Sling type?		Rope ladder	
Sling size?		Hand blocks	
		Monkey poles	

ASSISTANCE | SUPERVISION | INDEPENDENT

Additional information (include details of any therapy beds used)

Staff required:

SIT UP OVER SIDE OF BED

Rope ladder | Sliding aid | ASSISTANCE | SUPERVISION | INDEPENDENT

MOVE ON/OFF BED PAN

Hoist | Roll Patient | Patient bridges | Monkey pole | Not used

TRANSFER TO/FROM TROLLEY (or bed etc)

Sliding aid (rigid) | Sliding aid (fabric) | Transfer aid (specify) | Staff required (specify) | INDEPENDENT

Date assessed: 19/5/12 Assessors signature: (signature)

Date reviewed									
Assessors signature									

THERAPEUTIC HANDLING INSTRUCTIONS

Date	Instruction	Therapist's Name

INTO BATH OR SHOWER

HANDLING AID		WHICH BATH	
Hoist (Specify)		Parker	
Shower chair		Variable height	
		Standard	
		Any	

ASSISTANCE		SUPERVISION		INDEPENDENT	
Staff required:					

TRANSFERS (including to/from: bed, wheelchair, commode, toilet)

HOIST	
Which hoist?	
Sling type?	
Sling size?	

MANUAL SUPPORT
Staff required:
Specify support given

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional Information					

TOILETING

HOIST	
Which hoist?	
Sling type?	
Sling size?	

MANUAL SUPPORT
Staff required:
Specify support given

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional Information					

WALKING

NO WALKING		ASSISTANCE		SUPERVISION		INDEPENDENT	
Staff required:				Distance walked / additional information			
Walking Aid							

MOVE UP/DOWN BED

HOIST		MANUAL SUPPORT	
Which hoist?		Sliding aid	
Sling type?		Rope ladder	
Sling size?		Hand blocks	
		Monkey poles	

ASSISTANCE		SUPERVISION		INDEPENDENT	
Additional Information (include details of any therapy beds used)					
Staff required:					

SIT UP OVER SIDE OF BED

Rope ladder		Sliding aid		ASSISTANCE		SUPERVISION		INDEPENDENT	

MOVE ON/OFF BED PAN

Hoist		Roll Patient		Patient bridges		Monkey pole		Not used	

TRANSFER TO/FROM TROLLEY (or bed etc)

Sliding aid (rigid)		Sliding aid (fabric)		Transfer aid (specify)	Staff required (specify)		INDEPENDENT	

Date assessed:	Assessors signature:

Date reviewed									
Assessors signature									

THERAPEUTIC HANDLING INSTRUCTIONS

Date	Instruction	Therapist's Name

MEDICINE **PRESCRIPTION FORM** Hospital Name: Nuffield

MEDICINES RECONCILIATION

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

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

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the symptomatic relief policy & local protocol:
Salbutamol 10ml.
with the following exceptions: _____
Print & Sign: [illegible] 6814 Date: 13/3/12

COMMUNITY PHARMACY INFORMATION

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

PATIENT DETAILS

Hospital Number: SG0031544	Height: 1.71
DOB: 31.8.58	Weight: 73 Kgs
Date of Admission: __/__/__	Surface area: BMI 25
Consultant Name: M. SHAW	Ward: D

ONCE ONLY AND PREMEDICATION DRUGS

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

DATE →
MONTH →

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

IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N

ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N

SIGNATURE OF ASSESSOR

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

Parenteral Drugs : Regular Prescription

Patient's Own Medicine

| | | |

Oral and Other Drugs: Regular Prescription

DATE → 19
MONTH → 3

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

Patient's Own Medicine

BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐

H DRUG: PHARMINE

DOSE: 100mg | ROUTE: PO | DATE: 13/5/12 | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN):

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

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

BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐

J DRUG: TRAMADOL.

DOSE: 100mg | ROUTE: PO | DATE: 13/3/12 | STOPPED DATE: 19/3 | INITIALS: QL

PRESCRIBER (PRINT & SIGN):

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

K DRUG: PANADEINE CO

DOSE: 16 | ROUTE: O | DATE: 13/3/12 | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN): QL

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

1600-1800: BT

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

L DRUG: TRAMADOL

DOSE: 50mg | ROUTE: O | DATE: 13/3 | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN): QL

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

1600-1800: BT

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

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

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

D DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

E DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

F DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

G DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

M DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

N DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

P DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

R DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

S DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

T DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

V DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

W DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

X DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

Y DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

AA DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

BB DRUG

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

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

All Routes: As Required Prescriptions

Patient's Own Medicine

| | | |

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

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

SG00375441
MACKENZIE,BRIAN
22 LOMOND AVENUE

RENFREW 31/08/1958
PA4 0PG CHI 3108583158

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

NKDA

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

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

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

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).
2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).
3. Print & Sign your full name clearly against each prescription entry.
4. Time should be recorded in 24hr format e.g. 0600, 1800.
5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.
6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.
7. The following metric unit abbreviations must be used –

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

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

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

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

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

FOR NURSES

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

Codes for Non-Administration of Drugs

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

Cat. No. 40995 Ver 4, 09/2010

South Glasgow Hospitals

NHS Greater Glasgow and Clyde

STANDARDISED EARLY WARNING SCORING SYSTEM (SEWS)

Patient Observation Chart

N
A SG00375441
MACKENZIE, BRIAN
22 LOMOND AVENUE
H RENFREW 31/08/1958
PA4 0PG CHI 3108583158
DOB

	Date	Ward	Consultant
Admitted	19/3/12	D	Mr Shen
Transferred			
Transferred			
Transferred			

This is Chart Number 1 during this admission

All seven parameters must be assessed with each set of observations to obtain an accurate SEWS score. If a patient has abnormal vital signs please pay particular attention to scoring for urine output.

How to calculate SEWS Score

- Note whether observation falls in shaded "At Risk Zone". Score as per SEWS Key.
- Add points scored and record total "Sews Score" in bottom row of chart.
- Respiratory rate — Write numerical value in appropriate box
- Saturation Sp02 — Write numerical value in appropriate box
- Inspired Oxygen — If the patient's saturation is recorded on air please write A in appropriate box. If patient is on oxygen therapy, please document the amount in appropriate box.
- Temperature — Write numerical value in appropriate box
- Blood pressure — Write numerical values for systolic and diastolic pressure in appropriate box. Remember only the systolic value is considered for the SEWS Score.
- Heart rate — Write numerical value in appropriate box
- Neuro Response — Record patient's best response. If the patient is asleep or demonstrates new confusion, award the same score as verbal response.
- Urine Output — Check that patient has voided urine recently. If yes write PU in box provided. If no write NPU in box provided.
- Urine Output — Check if the patient has passed the equivalent of or more than 30mls/hour for the last three consecutive hours. If yes score 0 in box provided. If no score 3 in box provided and add to total SEWS score.
- SEWS Score — Add up scores for all 7 parameters and write in box provided. If the patient merits an aggregate score of 0 please write 0 in the SEWS score box. Action as per guidelines below.

SEWS KEY

0	1	2	3

SEWS 0-1: Routine observations
SEWS 2-3: Hourly observations and inform nurse in charge
SEWS 4+: Contact PRHO immediately. SHO or more senior doctor must be informed by Junior Doctor. Please record action taken in Nursing Notes

FURTHER SEWS SCORE SHOULD BE CHECKED

- In the event of a sudden worrying *Change*
- If there is a worsening *Trend*
- If concerned the patient looks *Unwell*

The frequency of SEWS scoring is determined by the previous SEWS Score. If the patient continually scores 0-1, the nurse caring for the patient should determine frequency of observations.

A full set of observations and SEWS score should still be carried out.

If SEWS continually 0-1 frequency of observations:

Date	19/3	19/3										
Frequency	4hrly	Prior to OP										

For extra information such as wound, CSM etc. use slanted columns at bottom of page.

SEWS KEY

0	1	2	3

NAME B. MACKENZIE DOB 31.08.1955

Date:			19/3	19/3	19/3	19/3											
Time:			13:30	17:00	17:30	18:35											
RESP. RATE	36+																
	31-35																
	21-30																
	9-20		14	16	14	14											
	≤8																
SpO2	93+		96	95	95	98											
Numerical Value	90-92																
	85-89																
	<85																
Inspired O2%	%		A	A	A	A											
TEMP.	39∞																
	38∞				36.6	36.5											
	37∞																
	36∞		35.7	35.7													
	35∞																
	34∞																
BLOOD PRESSURE	210																
	200																
	190																
	180																
	170																
	160																
	150			136	135												
	140		121			131											
	130																
	120																
	110																
	100																
SEWS SCORE uses Systolic BP	90																
	80			83	81	82											
	70		77														
	60																
	50																
	40																
HEART RATE	150																
	140																
	130																
	120																
	110																
	100																
	90																
	80					66											
	70		59	65	59												
	60																
	50																
	40																
	30																
	20																
NEURO RESPONSE	Alert		A	A	A	A											
	Verbal																
	Pain																
	Unresponsive																
URINE OUTPUT	PU/NPU:		PU	NPU	NPU	NPU											
	UO<30mls/hr (3 hrs +)																
SEWS SCORE:	with all observations		1	0	0	0											
PAIN refer to guideline p4	Severe	7-10			7												
	Moderate	4-6				5											
	Mild	1-3															
	None	0	✓	✓													
	N/V				N/V												

JJ JJ JJ JB

UNIT No. SC-00375441

SEWS KEY			
0	1	2	3
		[redacted]	[redacted]

Date:

Time:

36+

31-35

21-30

9-20

≤8

93+

90-92

85-89

<85

%

39∞

38∞

37∞

36∞

35∞

34∞

210

200

190

180

170

160

150

140

130

120

110

100

90

80

70

60

50

40

150

140

130

120

110

100

90

80

70

60

50

40

30

20

Alert

Verbal

Pain

Unresponsive

PU/NPU:

UO<30mls/hr

7-10

4-6

1-3

0

N/V

Pain Assessment & Management Guidelines

How to score pain:



Pain Score:		Action:
0	NONE	Continue to assess pain with every set of observations (must be at least daily).
1-3	MILD	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.
4-6	MODERATE	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.
7-10	SEVERE	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.

Guidelines

Cancer-related pain:

Always score the worst pain in the last 24hours or since last assessment.

FOR PERSISTANT MODERATE PAIN (4 OR ABOVE) WHICH DISTRESSES THE PATIENT:

Use Cancer Pain Management Algorithm in Palliative Care Resource File. This is distributed to all wards and is also accessible on the intranet. If no improvement in pain score contact hospital palliative care team on **page 1266** at SGH and **page 5742** at VI.

Out of hours advice can be obtained from the Prince and Princess of Wales Hospice on **0141 420 6785.**

Acute pain:

Score current pain on movement e.g. deep breathing

PERSISTENT SEVERE PAIN (7 OR ABOVE), WHICH DISTRESSES THE PATIENT:

Use Acute Pain Manual - distributed to all Operating Theatres areas and Surgical wards throughout Division. Also accessible on Intranet (via anaesthetic department homepage)

If no improvement in pain score contact CNS Pain Management on **page 1186/1157** at SGH and **page 3404/3101** at VI. On Call anaesthetist **page 1658** at SGH and **3004** at VI.

Measuring Sedation

The SEWS system uses the AVPU scoring system for conscious level. AVPU is an acronym for Alert, Verbal Pain, Unresponsive. The AVPU system relates to the previous sedation scale as follows:

Sedation	Descriptor	AVPU
0	Awake	A
1	Asleep, roused by speech	V
2	Physical stimulation (eg shaking) required to waken	P
3	Not roused by speech or shaking	U

Measuring Nausea

Is now recorded as 0 for no nausea or vomiting, N for nausea and V for vomiting
For persistent nausea and/or vomiting see clinical handbook or acute pain manual.

NB: Review Treatment Plan

If Temp>38
blood cultures ☐ other cultures ☐ Start antibiotic therapy if indicated

If Systolic BP<100
Review monitoring (cardiac/oximetry/urine output/invasive BP etc)
IV Access
Review patient/drug kardex. Consider fluid challenge ⟶ Definitive Therapy

Consider:

Hypovolaemia	Cardiac	Obstructive	Distributive
Dehydration	*Arryhthmia*	*PE*	*Sepsis*
Blood loss	*Pump failure*	*Tamponade*	*Anaphylaxis*

If Pulse>130
Review monitoring
IV Access
Review patient/ECG/electrolytes ⟶ Definitive Therapy

If O_2 sats <93%
Review probe ? accurate
Review patient ⟶ prescribe oxygen on kardex if indicated.

If RR>24
Review patient/CXR +/- gases/PEF etc ⟶ Definitive Therapy

If responds to pain only or unresponsive
Assess airway, BM GCS, consider neuro obs chart, review patient/kardex.

If BM<4
Check urgent blood glucose/IV dextrose or oral carbohydrate

0593467-SGH469

Acute Services Division

Hospital / Department Vic

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

SG00375441
MACKENZIE, BRIAN
22 LOMOND AVENUE

RENFREW 31/08/1958
PA4 0PG CHI 3108583158

D

.....Unit/Hospital number .....

Contents

1. Canard Falls Risk Assessment Scoring Form
2. Falls Assessment Care Plan
3. Glossary of terms used in risk assessment

Notes: Risk assessment should be completed within 24 hours of admission to each ward.

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

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

Referral Criteria for Hospital Falls Prevention Co-ordinator

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

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

General Safety Precautions

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

Cannard Falls Risk Assessment

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

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						Date: 19/3 Ward: 0	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			0						
Sex	Male 1	Female 2				1						
Age	13-59 0	60-70 1	71-80 2	81+ 1		0						
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		0						
Medication type*	Drugs for mental illness 1	Blood pressure / water tablets 1	Sleeping tablets 1	None of these 0		0						
Medical history*	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	0						
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed / chair-bound/ wheel-chair 1		1						
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1						
				TOTAL SCORE		3						
				ACTION(S) TAKEN* Enter action code(s) from Care Plan below		1,						
SCORE 13+ = HIGH RISK If patient unconscious score as N/A until patient status improves				NURSE SIGNATURE		[signature]						

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

Cannard Falls Risk Assessment

Glossary of terms used in risk assessment

SIGHT DEFICIT means patient cannot see well even when wearing glasses or is registered blind.

HEARING DEFICIT means person has hearing problems even with a hearing aid or has hearing problems and does not wear a hearing aid.

BALANCE DEFICIT means person is unable to stand without the support of another person or a walking frame.

MEDICINES FOR SOME MENTAL ILLNESSES include Chlorpromazine (Largactil), Risperidone (Risperdal), Lithium (Camcolit or Priadel); Haloperidol, Chloral hydrate (Welldorm), Clomethiazole (Heminevrin), antidepressants, Diazepam, Lorazepam and Amitriptyline.

CARDIOVASCULAR SYSTEM MEDICATION all antihypertensive medication and inotropes including Captopril, atenolol and many others.

WATER TABLETS (DIURETICS) are such as Bendroflumethiazide, Furosemide and Co-amilofruse.

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

INABILITY TO CO-OPERATE includes failure to use walking aids or putting themselves in situations with a high risk of falling (usually due to mental impairment).

RESTRICTED MOBILITY means the person requires supervision and/or help to walk (i.e. is not safe to walk alone even with an aid).

HESITANT IN INITIATING MOVEMENT means difficulty in starting to walk.

POOR TRANSFER means the person requires help and is not safe to do the following alone - get in or out of bed, on or off a chair, move from chair to standing.

NHS
Greater Glasgow and Clyde

NATVNS
SCOTLAND

SG00375441
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ADAPTED WATERLOW PRESSURE AREA RISK ASSESSMENT CHART

More than one score/category can be used: **10+= 'At Risk': 15+= 'High Risk': 20+= 'Very High Risk'**

Complete assessment on admission/1st visit, if there is a change in individuals condition and repeat regularly according to local protocol

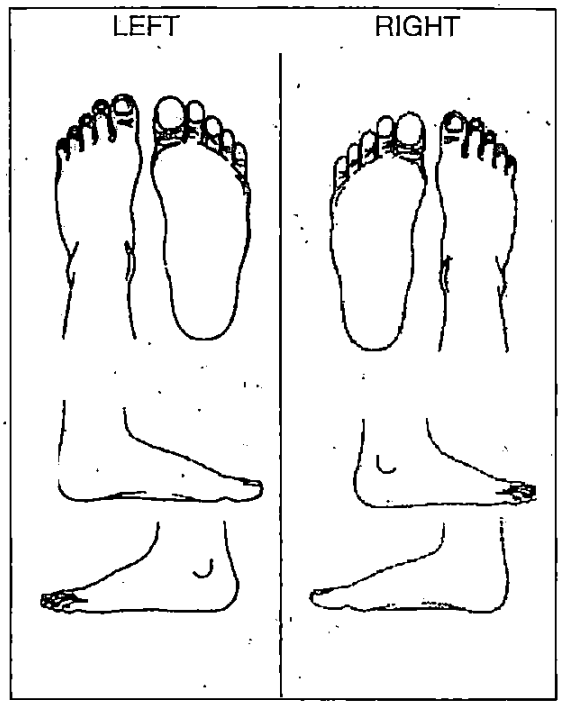
Sex									
Male	1	1	1						
Female	2								
Age									
14 -49	1								
50 -64	2	2	2						
65 - 74	3								
75 - 80	4								
81+	5								
Build/Weight for Height (BMI=weight in Kg/height in m²)									
Average - BMI 20-24.9	0								
Above average - BMI 25-29.9	1	1	1						
Obese - BMI > 30	2								
Below average - BMI < 20	3								
Continence									
Complete/catheterised	0	0	0						
Incontinent urine	1								
Incontinent faeces	2								
Doubly incontinent (urine & faeces)	3								
Skin Type - Visual Risks Area									
Healthy	0	0	0						
Tissue paper (thin/fragile)	1								
Dry (appears flaky)	1								
Oedematous (puffy)	1								
Clammy (moist to touch)/pyrexia	1								
Discoloured (bruising/mottled)	2								
Broken (established ulcer)	3								
Mobility									
Fully mobile	0	0	0						
Restless/fidgety	1								
Apathetic (sedated/depressed/reluctant to move)	2								
Restricted (restricted by sever pain or disease)	3								
Bedbound (unconscious/unable to change position/traction)	4								
Chairbound (unable to leave chair without assistance)	5								
Nutritional Element									
Unplanned weight loss in past 3-6 months									
<5% Score **0**, 5-10% Score **1**, >10% Score **2**	0-2								
BMI > 20 Score **0**, BMI 18.5-20 Score **1**, BMI < 18.5 Score **2**	0-2								
Patient acutely ill or no nutritional intake > 5 days	2								
Special Risks - Tissue Malnutrition									
Multiple organ failure/terminal cachexia	8								
Single organ failure e.g. cardiac, renal, respiratory	5								
Peripheral vascular disease	5								
Anaemia = Hb < 8	2								
Smoking	1	1	1						
Special Risks - Neurological Deficit									
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*	4-6								
Special Risks - Surgery/Trauma									
On table > 6 hours	8								
Orthopaedic/below waist/spinal (up to 48 hours post op)	5								
On table > 2 hours (up to 48 hours post op)	5								
Special Risks - Medication									
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4								
Total Score		5	5						
Date		13.12.19	13						
initials		[illegible]	[illegible]						
Time		1600	1900						

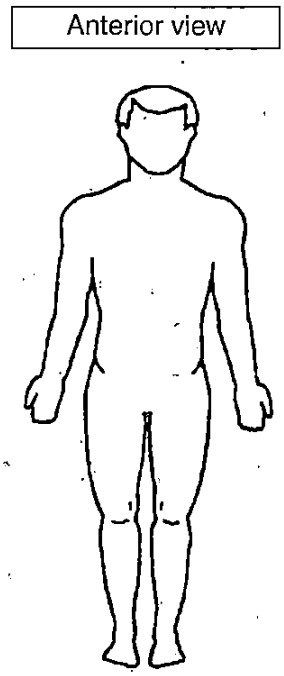
83826

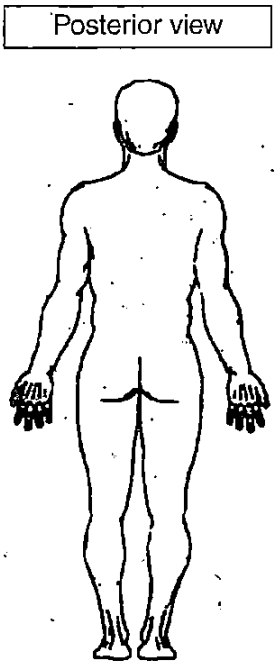
Ensure plan of care is implemented / reviewed for all identified areas of concern.

PRESSURE ULCER RECORD

Indicate by circling and numbering all pressure damage on diagrams, then complete box below. Indicate care plan/wound assessment chart.







SCOTTISH ADAPTED EPUAP PRESSURE ULCER GRADING TOOL

GRADE 1 Non-blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly on individuals with darker skin.

GRADE 2 Partial thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents clinically as an abrasion or blister.

GRADE 3 Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia.

GRADE 4 Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss.

DATE	NUMBER OF ULCER(S)	LOCATION OF ULCER(S)	GRADE OF ULCER(S)	LOCATION OF ULCER(S)

Pressure Ulcers may deteriorate from Grade 1 to Grade 4, but can not be reversed and should be documented as a healing grade of pressure ulcer, eg healing grade 4.

NHS
Greater Glasgow and Clyde

Nutrition Profile

SG00375441
MACKENZIE, BRIAN
22 LOMOND AVENUE

RENFREW 31/08/1958
PA4 0PG CHI 3108583158

CHI number:

Affix patient data label

Date of admission: 19/3/12

Time: 1160

HOSPITAL: VRC

Ward: D

To be recorded within 24 hours of admission*

Height: 1.71 m/ft Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Weight: 73 kgs. kg/stones Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Recent unplanned weight loss: Yes ☐ No ☑

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

Is there evidence of recent weight loss?

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

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

Normal diet

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☐

Please state:

N/A

Are there any contributing factors that may affect food intake such as **physical** (e.g. swallowing difficulties), **physiological** (e.g. nausea), **psychological** (e.g. dementia), **social or environmental?** Yes ☐ No ☐

Please specify all factors:

N/A

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☑

Please state:

Profile completed by: Name (PRINT): [illegible] Signature: [signature] Date: 19/3

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

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

Malnutrition Universal Screening Tool ('MUST')

Date	19/3										
Initials	W										
Height (see page 1)		Weight	73								
*Oedema or ascites present Y/N	N										
BMI	25										

'MUST'

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

Step 5: Management Guidelines

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

Management Plan

FOR ALL PATIENTS

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

Referral Services

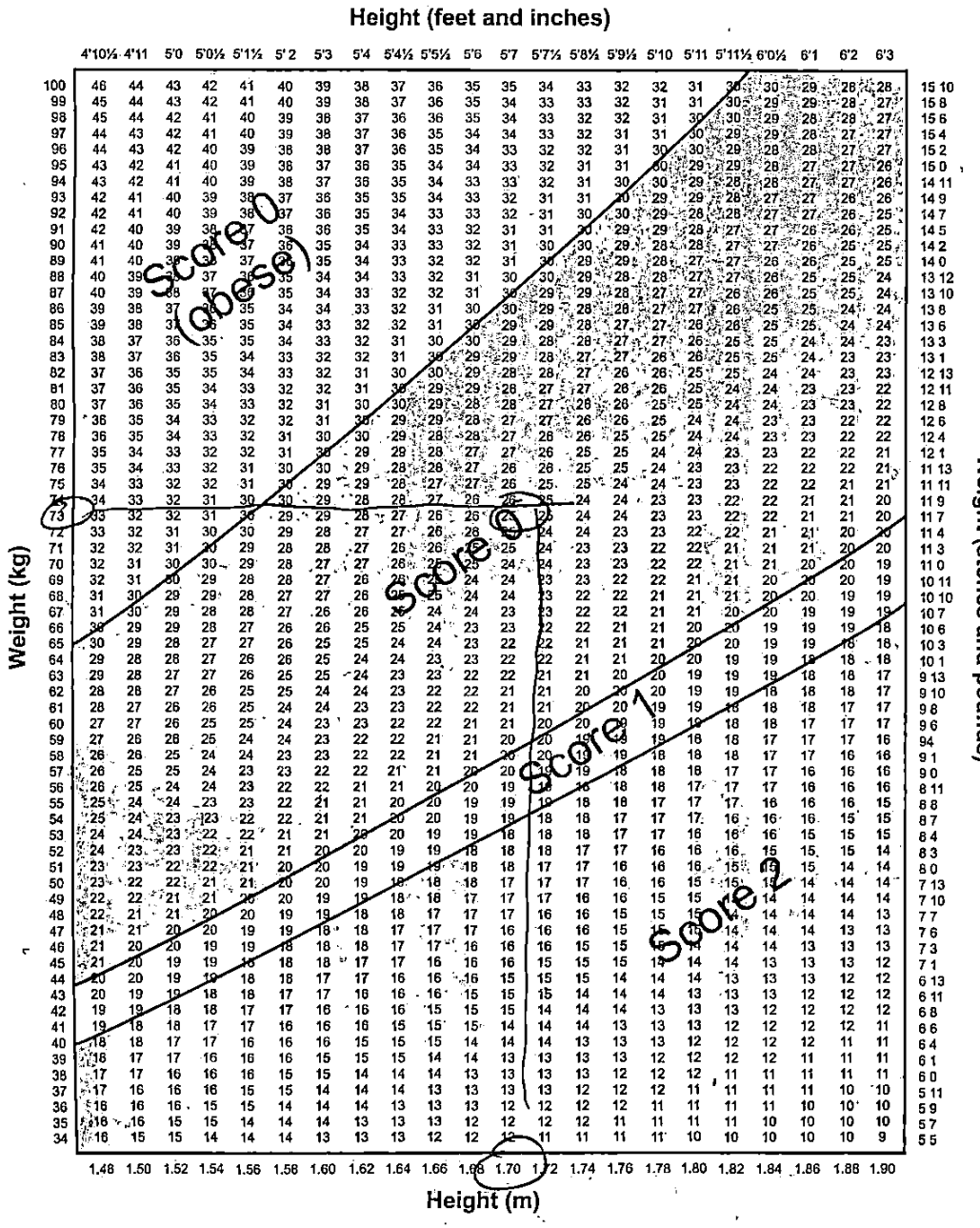
Dietitian	Date: / /	Outcome:
Speech and Language Therapy	Date: / /	Outcome:
Occupational Therapy	Date: / /	Outcome:
Dental Service	Date: / /	Outcome:

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Review date	Name (PRINT) Signature/Designation
19/3	0	No risk reassess in		
		1 weeks if still in		
		hospital	26/3	

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

Step 1 - BMI Score



Step 2 - Weight Loss Score

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

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

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

Falls Assessment Care Plan

Please tick all applicable nursing interventions

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

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

ORTHOPAEDIC DEPARTMENT
VICTORIA INFIRMARY
LANGSIDE ROAD
GLASGOW G42 9TY
TEL: 0141 201 5185
FAX: 0141 201 5082

ADS/AC /SG00375441
CHI NUMBER: 3108583158

MR. A. D. SHAW'S ORTHOPAEDIC RETURNS CLINIC

SEEN: 23/02/12
DICTATED: 23/02/12
TYPED: 23/02/12

DR AL-NAJIM
RENFREW HEALTH CENTRE
RENFREW
PA4 8RU

Dear Dr

BRIAN MACKENZIE DOB: 31/08/58
22 LOMOND AVENUE, RENFREW, PA4 0PG

This man's MRI scan of his right knee has been reported showing a flapped tear running into the inferior surface of the medial meniscus. There has also been damage to the central aspect of the patella particularly articular surface with underlying cystic change.

He is presently unable to work as a gardener, because of the pain which is felt mainly at the front of the knee, on bending the knee and on rising.

This is a very difficult situation - the scan has shown a medial meniscal tear, and it is possible some of the feeling of giving way and instability could be due to this tear, but I think it is on balance more likely that his symptoms are all caused by his patella surface damage. This of course occurred when he unfortunately suffered a lateral dislocation of his patella.

The operative options are not good at this stage other than trying arthroscopy - it may be possible to improve his medial meniscal tear and stabilise articular surface around a defect, but in my experience the results are poor and he is likely to have ongoing knee pain. He is young and has a demanding job, and the prospect of a future partial joint replacement to remedy this are not good, indeed this is something I would try to avoid if possible. I have put him on our waiting list for a right knee arthroscopy and partial medial meniscetomy and chondroplasty of the patella as necessary at time of surgery.

Yours sincerely,

Mr. A.D. Shaw, F.R.C.S.Ed.(Tr. & Orth.),
Consultant Orthopaedic Surgeon

ORTHOPAEDIC

ORTHOPAEDIC DEPARTMENT
VICTORIA INFIRMARY
LANGSIDE ROAD
GLASGOW G42 9TY
TEL: 0141 201 5185
FAX: 0141 201 5082

ADS/AC /SG00375441
CHI NUMBER: 3108583158

MR. A. D. SHAW'S NEW PATIENT ORTHOPAEDIC CLINIC

SEEN: 13/12/11
DICTATED: 13/12/11
TYPED: 13/12/11

MACKENZIE, Brian
Attend: 13/12/11 0924 DOB: 31/08/1958 Sex: M
Ref: Mr Andrew Shaw - VIC ORTHOPAEDIC OUT PATS
XR Patella Rt
XR Knee Rt
Room 10

CRIS: 443724 E-26240356 ChiNo: 3108583158

DR AL-NAJIM
RENFREW HEALTH CENTRE
RENFREW
PA4 8RU

Dear Dr

BRIAN MACKENZIE DOB: 31/08/58
22 LOMOND AVENUE, RENFREW, PA4 0PG

Thanks for referring up this 57 year old self employed gardener to the clinic today. He had an incident in May of this year where it sounded like he was stuck by his dog by the side and sustained a patella dislocation which he self reduced and afterwards managed to attend casualty where he was treated with a knee splint and referred on for physio for which he was unable to attend. His work over the past months has been almost impossible for him and he had to hire in some help which has meant he has lost a great deal of his business and earnings over this period. He was unable to attend the physio and now that his work has died down he was hoping something could be done as the knee has remained symptomatic. His problems are that of pain along the lateral aspect of the knee. He only manages to walk a couple of hundred yards a couple of times a day with his dog and otherwise keeps the knee pretty much straight and remains stationary in the house. Occasionally he drives and he finds this difficult with pain around the knee and he can't walk on uneven ground or up and down slopes due to pain again occurring in the same place in the knee. He feels that the does swell up and it has given way on him in the past.

On examination today, this gentleman has marked ~~quads~~ wasting of the right knee. He had pain on stressing of the patella femoral joint and palpation of the patella facet. There was no real discomfort along the tibiofemoral joint lines. A small effusion was present. He would only comfortable flex to about 90 deg after which he felt pain which seemed to be arising from the patellofemoral joint. The knee was ligamentously stable.

I reviewed his old x-rays and the report had made a comment about an irregularity in the patella surface so I repeated the x-rays today. This doesn't seem quite so evident but the question is whether there is a large osteochondral defect here as a result of patella dislocation or whether that is causing some of his symptoms. There certainly doesn't seem to be a loose body and the rest of the knee is in good condition. I have explained to Mr. MacKenzie that in the first instance I

NHS Greater Glasgow and Clyde

Southern General Hospital

MACKENZIE, Brian
22 Lomond Avenue, , Renfrew, Renfrewshire, PA4 0PG
Referrer: Mr Andrew Shaw - VIC ORTHOPAEDIC OUT PATS

Diagnostic Imaging Report

DoB: **31/08/1958**
Chi No: **3108583158**
CRIS No: 443724
Hosp No: **SG00375441**

VERIFIED Verified By: Dr Paul Duffy 17/01/12 1022.

No APT MADE -

Clinical History :
Patellar dislocation 6 months ago. Persistent pain and swelling. Possible osteochondral fracture or meniscal tear.

MRI Knee Rt :
There is abnormal signal in the medial meniscus at the junction of the posterior horn and body, in keeping with a flap-type tear running to the inferior surface of the meniscus.
The lateral meniscus, cruciate and collateral ligaments are intact.
There is a lateral tilting of the patella and damage to the central aspect of the patellar articular surface with underlying cystic change.
There is no gross bone marrow oedema affecting the lateral femoral condyle or abnormality of the medial patellar ligament/retinaculum.

Opinion:
Flap tear of the medial meniscus at the junction of the posterior horn and body. Lateral

Ref. Src: Victoria Infirmary, Langside Road, Glasgow, G42 9TY
Exams: MRI Knee Rt
Exam Date: 16/01/12 Event: E [redacted]

5290802

NHS Greater Glasgow & Clyde SGH 401 Cat 5290802

NHS Greater Glasgow and Clyde

Southern General Hospital

MACKENZIE, Brian
22 Lomond Avenue, , Renfrew, Renfrewshire, PA4 0PG
Referrer: Mr Andrew Shaw - VIC ORTHOPAEDIC OUT PATS

Diagnostic Imaging Report

DoB: **31/08/1958**
Chi No: **3108583158**
CRIS No: 443724
Hosp No: **SG00375441**

patellar tilting and damage to the articular surface centrally.

Ref. Src: Victoria Infirmary, Langside Road, Glasgow, G42 9TY
Exams: MRI Knee Rt
Exam Date: 16/01/12 Event: E [redacted]

5290802

NHS Greater Glasgow & Clyde SGH 401 Cat 5290802

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

Attachments

Trauma and Orthopaedic Surgery - 26052011_Clinical Letter_278615

Trauma and Orthopaedic Surgery - 25052011_Clinical Letter_274713

REFERRAL TO

Trauma & Orthopaedic - Knee
GGC General Referral

Consultant / receiving practitioner and/or specialty clinic

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

Hospital and hospital address

Hospital location code: G405H

Email address:

Urgency of referral ROUTINE
Date of referral 21-Sep-2011 **Date sent** 21-Sep-2011

PATIENT DETAILS

Surname	MacKenzie
Forename(s)	Brian
Title	Mr
Sex	Male
Date of birth	31-Aug-1958
CHI no.	3108583158
Area of Residence	

Patient's address

22 Lomond Avenue
RENFREW
PA4 0PG

Contact number(s)

Voice: 07966154552

101002561932N Unique Care Pathway Number: 101002561932N

REGISTERED GP DETAILS

Name	Dr Z Al Najim		
GMC code	5198897	GP code	C39586
Practice name	Clydeview Medical Practice		
Practice code	87700		

Practice address

Renfrew Health Centre
10 Ferry Road
Renfrew
PA4 8RU

Contact number(s)

Voice: 0141-207-7730
Facsimile: 0141-207-7740

REFERRING GP DETAILS

Name	Dr. Judith Anderson		
GMC code	3171783	GP code	34860
Practice name	Clydeview Medical Practice (87700)		
Practice code	87700		

Practice address

Renfrew Health Centre
10 Ferry Road
Renfrew

Contact number(s)

Voice: 0141 207 7730

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: knee problem

Comment: mr mackenzie was seen in A & E following what was presumed to be a dislocated patella. he was followed up at the orthopaedic clinic where it was decided that as was "first dislocation" physio was arranged. due to work commitments mr mackenzie could not complete all the physio. he continues to have significant pain in his knee. he admits to come "locking" and has significant quadriceps wasting ?? meniscal injury

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

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

Description	Comment	Modifier	Date of onset	Date recorded
Dislocation or subluxation of knee	dislocation of right knee	-	25-May-2011	01-Jun-2011
Poisoning	librium	-	07-Jun-1984	31-Aug-2007
Mental disorders NOS	-	-	30-Apr-1981	31-Aug-2007
Nondependent alcohol abuse, unspecified	-	-	30-Apr-1981	31-Aug-2007
Scarlet fever - scarlatina	-	-	-	31-Aug-2007
Chronic gastritis	-	Mild	29-Mar-1994	31-Aug-2007
Misuse of drugs NOS	cannabis, cocaine, alcohol	-	01-Jan-1972	27-Jul-2007
Neurotic depression reactive type	and anxiety	-	-	27-Jul-2007

Past procedures (High and medium priority - all)

Description	Comment	Date performed	Date recorded
Dislocation reduct.-upper limb	right thumb - washout and K wiring	03-Oct-2009	20-Jul-2011
Haemorrhoidectomy	-	15-Aug-1989	31-Aug-2007
Bilateral vasectomy for contraception	-	25-Jun-1986	31-Aug-2007

Family conditions (All priorities)

Description	Date of Onset
No FH: Ischaemic heart disease	06-Jul-2007
No family history diabetes	06-Jul-2007

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

No current medications recorded

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Co-Codamol	50	30mg/500mg TABS	1 or 2 Tabs	up to max qid	19-Sep-2011	19-Sep-2011

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		19-Sep-2011
Alcohol intake above recommended sensible limits:		06-Jul-2007
Enjoys light exercise:		06-Jul-2007

Clinical warnings

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Patient has disability or requires wheelchair access:No
Referred By:Referring GP
Electronic Attachment Present:Yes

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

Trauma and Orthopaedic Surgery - 26052011 Clinical Letter 278615
Trauma and Orthopaedic Surgery - 25052011 Clinical Letter 274713

View Report : ORTHO 1510-0053 - Clin/Ltr Mr Walker Fracture

DR JUDITH JM ANDERSON
THE HEALTH CENTRE
RENFREW
PA4 8LH

13-10-09

Dear Dr Anderson

BRIAN MACKENZIE DOB: 31/08/58 (SG000375441)
12 ORCHARD STREET, , RENFREW, PA4 8RL

This gentleman is now ten days following his open dislocation of right IP joint of the thumb. He had his sutures removed today including the two clips in his scalp laceration. He should return in two week's time for consideration of removal of k wires.

Yours sincerely

Tom Nunn

SOUTH GLASGOW HOSPITALS
SOUTHERN GENERAL HOSPITAL

3Y

DOCTOR'S LETTER SHEET

UNIT NUMBER

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

0141 201 1100

ORTHOPAEDIC DEPARTMENT

Typed: 08/07/11
CHI: 3108583158

DR JUDITH JM ANDERSON
RENFREW HEALTH CENTRE
RENFREW
PA4 8RU

Dear Dr Anderson

BRIAN MACKENZIE DOB: 31/08/58 (SG00375441)
12 ORCHARD STREET, , RENFREW, PA4 8RL

Consultant: DAVID MARTIN

Admitted: 03/10/09

Discharged: 04/10/09

Diagnosis: OPEN DISLOCATION RIGHT THUMB IPJ

Procedures: WASHOUT AND K-WIRING IPJ 03/10/09

Follow Up: OUTPATIENT CLINIC

Yours sincerely

Mr Bilal Jamal
Specialist Registrar

Run: 08/07/11-11:42 by DAVIDSON,CLARE

0367709-SGH3Y

DOCTOR'S LETTER SHEET

UNIT NUMBER

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR MARC BRANSBY-ZACHARY FRCS
Orthopaedic Hand & Upper Limb Service

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Direct Tel: 0141 201 1473

Our Ref: MB-Z/CD
Enquiries To: Helen Carlisle

Seen & Dict: 26/05/11
Typed: 02/06/11
CHI: 3108583158

DR JUDITH JM ANDERSON
RENFREW HEALTH CENTRE
RENFREW
PA4 8RU

Dear Dr Anderson

BRIAN MACKENZIE DOB: 31/08/58 (SG00375441)
22 LOMOND AVENUE, RENFREW, PA4 0PG.

This patient was walking his dog and the dog jumped up causing him to fall twisting his right knee. He appears to have from his description sustained a patella dislocation which spontaneously reduced. He's been struggling to weight bear since and noticed significant swelling of the knee therefore.

On examination there was a significant fusion with tenderness in the medial aspect of the patella and significant patella apprehension. He was able to straight leg raise. Range of motion was from 0 to 80 degrees flexion with no ligamentus instability.

Radiographs show no evidence of fracture.

He's a first time patella dislocation and therefore physiotherapy has been arranged.

Yours sincerely

Mr Mullen
Specialist Registrar

DOCTOR'S LETTER SHEET

UNIT NUMBER

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR D J Martin FRCS
Orthopaedic Upper Limb Service

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Direct Tel: 0141 232 7839

Our Ref: DJM/CD
Enquiries To: Clare Davidson

Seen & Dict: 08/10/09
Typed: 14/10/09
CHI: 3108583158

DR JUDITH JM ANDERSON
THE HEALTH CENTRE
RENFREW
PA4 8LH

Dear Dr Anderson

BRIAN MACKENZIE DOB: 31/08/58 (SG00375441)
12 ORCHARD STREET, RENFREW, PA4 8RL

Diagnosis: Open Fracture Dislocation of Right Thumb IP Joint had Exploration Washout and K-Wiring of IP Joint done on the 3 October 2009

This gentleman is only five days since the above operation the wound looks clean and dry there is no signs of infection. It is too early to remove the stitches so we have redressed the wounds today and put him into a Bier's cast and we will see him back on Tuesday 13th October 2009 for removal of sutures and further application of plaster and k-wires to remain in for four weeks. Check x-ray of his right thumb on his next visit.

Yours sincerely

Ms A Augustine
Specialist Registrar

SOUTH GLASGOW UNIVERSITY HOSPITALS DIVISION
SOUTHERN GENERAL HOSPITAL

3Y

DOCTOR'S LETTER SHEET

UNIT NUMBER

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

0141 201 1100

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR COLIN R C WALKER FRCS
FRACTURE CLINIC

Our Ref: CRW/LM
Enquiries To: Lillian McInnes
Direct Line: 0141 201 1465

Seen & Dict: 05/09/06
Typed: 13/09/06
CHI: 3108583158

DR IAN IR STRUTHERS
CARDONALD MEDICAL CENTRE
GLASGOW
G52 3SS

Dear Dr

BRIAN MACKENZIE DOB: 31/08/58 (SG00375441)
32 ANGUS OVAL#, , GLASGOW, G52 3HE

I reviewed this patient in the clinic today. One month ago he fell down some stairs sustaining an injury to his right wrist, left shoulder and head. His head and shoulder injury have settled completely but he has had ongoing pain from his right wrist since then. He re-attended A & E two weeks ago and was given a splint for his wrist but the pain has continued.

On examination today his pain is mainly centred around the dorsal aspect of the centre ulnar side of the wrist and has no specific tenderness on balloting the scaphoid.

X-rays do reveal a fracture across the waist of the scaphoid and I have placed him in a scaphoid cast and will see him in four weeks time with cast off and x-ray on arrival.

Yours sincerely

Mr A. Bennett,
Orthopaedic Registrar

Run: 13/09/06-10:15 by MCINNES,LILLIAN

S.G.H./3Y

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR COLIN R C WALKER FRCS
FRACTURE CLINIC

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Direct Tel: 0141 201 1465

Our Ref: CRW/CB
Enquiries To: Lillian McInnes

Seen & Dict: 03/10/06
Typed: 11/10/06
CHI: 3108583158

DR IAN IR STRUTHERS
CARDONALD MEDICAL CENTRE
GLASGOW
G52 3SS

Dear Dr. Struthers,

BRIAN MACKENZIE DOB: 31/08/58 (SG00375441)
32 ANGUS OVAL#, GLASGOW, G52 3HE

This chap attended for review today. He was removed from the scaphoid cast and has no tenderness over the scaphoid or distal radius. I have provided him with a wrist splint for use at work and discharged him from regular follow-up.

Yours sincerely,

G. Holt,
Specialist Registrar.

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR COLIN R C WALKER FRCS
FRACTURE CLINIC

Our Ref: CRW/CB
Enquiries To: Lillian McInnes

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Direct Tel: 0141 201 1465

Seen & Dict: 03/10/06
Typed: 11/10/06
CHI: 3108583158

DR IAN IR STRUTHERS
CARDONALD MEDICAL CENTRE
GLASGOW
G52 3SS

Dear Dr. Struthers,

BRIAN MACKENZIE DOB: 31/08/58 (SG00375441)
32 ANGUS OVAL#, GLASGOW, G52 3HE.

This chap attended for review today. He was removed from the scaphoid cast and has no tenderness over the scaphoid or distal radius. I have provided him with a wrist splint for use at work and discharged him from regular follow-up.

Yours sincerely,

G. Holt,
Specialist Registrar.

SOUTH GLASGOW HOSPITALS
SOUTHERN GENERAL HOSPITAL

3Y

DOCTOR'S LETTER SHEET

UNIT NUMBER

DEPARTMENT OF ORTHOPAEDIC SURGERY

MR COLIN R C WALKER FRCS
FRACTURE CLINIC

Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF
Direct Tel: 0141 201 1465

Our Ref: CRW/LM
Enquiries To: Lillian McInnes

Seen & Dict: 27/10/09
Typed: 03/11/09
CHI: 3108583158

DR JUDITH JM ANDERSON
THE HEALTH CENTRE
RENFREW
PA4 8LH

Dear Dr

BRIAN MACKENZIE DOB: 31/08/58 (SG00375441)
12 ORCHARD STREET, , RENFREW, PA4 8RL

I reviewed this patient in the clinic today. His K wires came out today and he has now been discharged with advice.

Yours sincerely

Kalpesh Shah,
Orthopaedic Registrar

0367709-SGH3Y

6S395/06

Southern General Hospital, Accident & Emergency Department, Glasgow G51 4TF

Tel Direct: 0141 201 1456/8 Switchboard: 0141 201 1100 Fax: 0141 201 2997

NAME: BRIAN MACKENZIE
AGE:47 DOB:31/08/58
UNIT No: SG00375441
CONSULTANT: JASON LONG
Account No: AE0065395/06
DATE:27/07/06
TIME: 0941
CHI#: 3108583158

GP Name:	IAN IR STRUTHERS GP Phone No: 0141 882 5494 | 1
REASON FOR VISIT:	SHOULDER INJURY
ALERTS:	(1) (2)
ALLERGIES:	(1) NKDA (2)
RELEVENT HISTORY:	
MEDICATIONS:	

TRIAGE CATEGORY: STANDARD TRIAGE NURSE: ELAINE FRASER TRIAGE TIME 0949

TRANSCRIBED ANALGESIA :

OBSERVATION TEXT:

PT FELL DOWN STAIRS LAST NIGHT NOW C/O PAIN IN LEFT SHOULDER
HAS DECREASED ROM

Enter/Edit Vital Signs

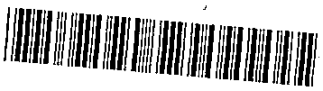
DATE	TIME	COMPLETED BY	DATE	TIME	COMPLETED BY
T.			T		
HR			HR		
R			R		
BP			BP		
Sa02		ON %	Sa02		ON %
BG			BG		
PF			PF		
EPF					
E			E		
V			V		
M			M		

Visual Acuity

Left-6m	Right-6m

Correction Y/N	
Weight (kg)	
Breath Alcohol	
Pain Score	

SOUTHERN GENERAL HOSPITAL
27/07/2006 E-2578292
MACKENZIE, Brian
SGCAS 31/08/1958
CRIS No:443724



D

DISCHARGE CODES: Please Circle
1. Admission 2. Discharge 3. Refer to GP 4. Transfer to other hospital (see below)
5. Died 6. Refer to O.P. Clinic (see below) 7. Irregular Discharge 8. D.O.A.

Discharge Date: 7
Discharge Time: 10-35 am

Ward No. (If admitted)	Transfer to Hospital	Consultant (if admitted)

Follow Up	Not arranged	Arranged	To be arranged

Clinic Referred to	AE	Hand Injury	Fracture	Pop Check	Medical	Surgical	ENT	Others Specify

DATE	CLINICAL NOTES
	SEEN BY (DR) Dick. TIME SEEN 10 - 20pm.

47 ♂ C.H.D. Gardener.

fc:— left shoulder complaint.

Hpc:— tripped down stairs in haste last night ~10-13 stairs — did not tumble over

— Managed to stay upright until bottom of stairs & hit left shoulder + head on wall + carpet.

— No LOC/ amnesia/ vomits/ weakness = paresthesia.

— small scalp wound — steristripped by midge.

— ft. uncovered by scalp injury.

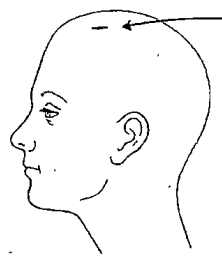
— left shoulder painful. from impact — Movements painful

— No neck pain.

— No previous injuries

— Tetanus up to date.

O/E -



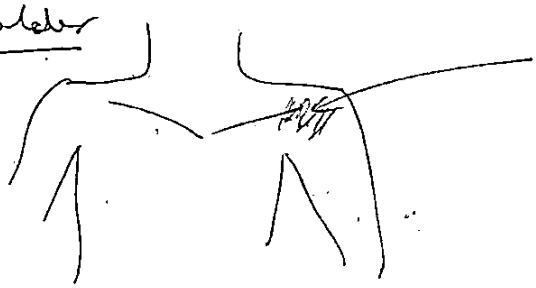
superficial laceration.
No bony tenderness

- SCS 15/15.
- Alert, well.
- orientated.
- Cranial Nerves II-XII intact

Neck — no tenderness
- ROM.

DATE	CLINICAL NOTES

Left shoulder



mild tenderness lateral clavicle, acromion + soft tissue.

Movements - (N)

- No evidence rotator cuff injury.

- Elbow, forearm, wrist - (N) extension, No bony tenderness

- N.V... intact

XRAY - No # or dislocation

Plan:- analgesia

- advised to move shoulder.

M. Grace MO.

06 XR Report noted. No change in Rx

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION	SIGNATURE	GIVEN BY

DISCHARGE PRESCRIPTION PACKS

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	FREQUENCY	SIGNATURE	GIVEN BY
27/1/16	Cocodamol 8/500	2 tabs	O	QDS		MO.

PSAETRIAGE01 From: HUTTON,DUNCAN
Thur Jul 27, 2006 9:41 am Taken by: MEDITECH ()

*** ********** THIS PATIENT REQUIRES TRIAGE **********

Name: MACKENZIE,BRIAN A&E Number: AE0065395/06 Unit Number: SG00375441

Patients Address: 32 ANGUS OVAL GLASGOW G52 3HE Tel:

LOCATION.....SAEO.....

********** THIS PATIENTS REQUIRES TRIAGE **********

Patients GP: STRUTHERS, IAN IR Practice: CARDONALD MEDICAL CENTRE Address: CARDONALD MEDICAL CENTRE Tel: 0141 882 5494

Next of Kin:

Relationship:

Address:

Tel:

65395

SOUTHERN GENERAL HOSPITAL **Radiology Department**

Name - MACKENZIE ,Brian DOB - 31/08/1958 CRIS No - 443724
32 Angus Oval, Renfrewshire, G52 3HE Event No - E-2578292
Ward - SGCAS Ref - Dr Jason Long Hosp No -

SHOULDER, LEFT

VERIFIED **Report by: Dr O THOMAS (SpR)** **28/07/2006**
Typed by: ELISE O'DONNELL **28/07/2006**

Clinical History : Injury to left shoulder, ?fracture

SHOULDER, LEFT : 1/8 PM

The shoulder is in joint. No fracture is identified. There is some minor malalignment of the left AC joint which may indicate an underlying AC joint disruption. If clinical suspicion persists weightbearing views would be advised.

WR

Southern General Hospital, Accident & Emergency Department, Glasgow G51 4TF

Tel Direct: 0141 201 1456/8 Switchboard: 0141 201 1100 Fax: 0141 201 2997

Affix Label

04/72082

NAME: BRIAN MACKENZIE
AGE:47 DOB:31/08/58
UNIT No: SG00375441
CONSULTANT: PHIL MUNRO
Account No: AE0072082/06
DATE:16/08/06
TIME: 2319
CHI#:3108583158

GP Name:	IAN IR STRUTHERS GP Phone No: 0141 882 5494	2
REASON FOR VISIT:	RIGHT HAND AND SHOULDER INJURY 2/52 S/C	
ALERTS:	(1) (2)	
ALLERGIES:	(1) NKDA (2)	
RELEVENT HISTORY:		
MEDICATIONS:		

TRIAGE CATEGORY: STANDARD TRIAGE NURSE: ANNE DAVIDSON TRIAGE TIME 2329

TRANSCRIBED ANALGESIA :

OBSERVATION TEXT:

GARDENER REATTENDING S.C RIGHT WRIST AND SHOULDER PAIN POST FALL 2/52, SEEN HERE.

Enter/Edit Vital Signs

DATE	TIME	COMPLETED BY	DATE	TIME	COMPLETED BY
T	35.9		T		
HR			HR		
R			R		
BP			BP		
Sa02		ON %	Sa02		
BG			BG		
PF			PF		
EPF					
E			E		
V			V		
M			M		

Visual Acuity

Left-6m	Right-6m

Correction Y/N	
Weight (kg)	
Breath Alcohol	
Pain Score	

SOUTHERN GENERAL HOSPITAL
04/09/2006 E-2600261 CRIS No:443724
MACKENZIE, Brian
SGCAS 31/08/1958

DISCHARGE CODES: Please Circle
1. Admission 2. Discharge 3. Refer to GP 4. Transfer to other hospital (see below)
5. Died 6. Refer to O.P. Clinic (see below) 7. Irregular Discharge 8. D.O.A.

Discharge Date: 17/8/6
Discharge Time: 2400

Ward No. (If admitted)
Transfer to Hospital
Consultant (if admitted)

Follow Up: Not arranged | Arranged | To be arranged

Clinic: AE | Hand Injury | Fracture | Rec Check | Medical | Others Specify

DATE	CLINICAL NOTES
	SEEN BY (DR) LITTLEWOOD TIME SEEN 2400

PC/ Painful (R) wrist

HPC/ leaning on wall to lift himself up (all weight on both wrists), felt (R) wrist give way. c/o ↑ pain since. No numbness/paraesthesia

(R) handed gardener.

OE Little swelling
Mild tenderness dorsum of wrist-
full ROM NV (N)
No ASB tenderness

Xray - NAD.

Plan/ Reassure.
(H) Splint

NAD (SpR)

DATE	CLINICAL NOTES
	29/8/6 ~~GHD~~ Xray report noted. Return clinic
4/9/06	RTW self employed gardener. Original injury 26/7/06 when fell down flight of stairs whilst under influence of alcohol. At that time more pain of ① shoulder & WI. 2/52+ ago tried to take full wt. on hand ① & got severe pain ⑯ wrist. Pain since. More ⑯ than wrist with ↓ down ↓/52 No swelling. More tenderness ⑯ down ↓ wrist to elbow with. No apparent scaphoid tenderness XR scaphoid; No definite #. widening of scapholunate ↓. Gpad

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION	SIGNATURE	GIVEN BY

DISCHARGE PRESCRIPTION PACKS

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	FREQUENCY	SIGNATURE	GIVEN BY

NHS Greater Glasgow and Clyde

Southern General Hospital — Diagnostic Imaging Report

MACKENZIE, Brian **31/08/1958** **CHI: 3108583158**
32 Angus Oval, Renfrewshire, G52 3HE Hosp: SG00375441
Source: **SGH CASUALTY DEPARTM** **Age: 47yr Sex: M** **CRIS: 443724**
Ref: **DR P MUNRO (A&E)** **ACCIDENT & EMERGENCY** **Event: E-2589978**

WRIST, RIGHT

Reported by: Dr S KELLY (Cons). Verified

Clinical History : ? fracture.

WRIST, RIGHT :

There is a lucency extending across the distal portion of the right scaphoid. The appearances are suspicious of a scaphoid fracture. Please correlate findings clinically as the request card specifically queries a radial fracture.

NHS Greater Glasgow & Clyde SGH 401 Cat 3290802

Exam: 16/08/2006 DR P MUNRO (A&E) (ACCIDENT & EMERGENCY
Reported: 21/08/2006 SGH CASUALTY DEPARTMENT
Typed: 25/08/2006 DONET

08964

5

Southern General Hospital, Accident & Emergency Department, Glasgow G51 4TF

Tel Direct: 0141 201 1456/8 Switchboard: 0141 201 1100 Fax: 0141 201 2997

NAME: BRIAN MACKENZIE
AGE:51 DOB:31/08/58
UNIT No: SG00375441
CONSULTANT: NICOLA LITTLEWOOD
Account No: AE0086541/09
DATE 03/10/09
TIME: 0704
CHI#:3108583158

GP Name:	JUDITH JM ANDERSON GP Phone No: 0141 314 4646 | 5
REASON FOR VISIT:	THUMB INJURY ? FOR DEBRIDING THIS AM
ALERTS:	(1) (2)
ALLERGIES:	(1) NKDA (2)
RELEVENT HISTORY:	THUMB INJURY IN LAST NIGHT ? FOR FURTHER ORTHO REP
MEDICATIONS:	

TRIAGE CATEGORY: STANDARD TRIAGE NURSE: MAUREEN SHILLINGLAW TRIAGE TIME 0714

TRANSCRIBED ANALGESIA :

OBSERVATION TEXT:

SEEN BY ORTHO LAST NIGHT SERIOUS THUMB INJURY HIT BY GOLF CLUB. DECLINED ADMISSION TOLD TO COME BACK THIS A,M FOR I/VS

Enter/Edit Vital Signs

DATE	TIME	COMPLETED BY	DATE	TIME	COMPLETED BY
T	36.8		T		
HR	95		HR		
R			R		
BP	135/80		BP		
Sa02	95	ON %	Sa02		ON %
BG			BG		
PF			PF		
EPF					
E			E		
V			V		
M			M		

Visual Acuity

Left-6m	Right-6m

Correction Y/N	
Weight (kg)	
Breath Alcohol	
Pain Score	

DISCHARGE CODES: Please Circle

1. Admission 2. Discharge 3. Refer to GP 4. Transfer to other hospital (see below)
5. Died 6. Refer to O.P. Clinic (see below) 7. Irregular Discharge 8. D.O.A.

Discharge Date
Discharge Time

Ward No. (If admitted) 2
Transfer to Hospital
Consultant (if admitted)

Follow Up	Not arranged	Arranged	To be arranged

Clinic Referred to	AE	Hand Injury	Fracture	Pop Check	Medical	Surgical	ENT	Others Specify

SGH 430

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

DIRECTION OF FEED THROUGH PRINTER

DO

E

SE!

BRIAN MACKENZIE
SG00375441 31/08/58
CHI: 3108583158 M
Date_____ Time_____
Spec./Sig._____

BRIAN MACKENZIE
SG00375441 31/08/58
CHI: 3108583158 M
Date_____ Time_____
Spec./Sig._____

BRIAN MACKENZIE
SG00375441 31/08/58
CHI: 3108583158 M
Date_____ Time_____
Spec./Sig._____

BRIAN MACKENZIE
SG00375441 31/08/58
CHI: 3108583158

BRIAN MACKENZIE
SG00375441 31/08/58
CHI: 3108583158 M
Date_____ Time_____
Spec./Sig._____

BRIAN MACKENZIE
SG00375441 31/08/58
CHI: 3108583158 M
Date_____ Time_____
Spec./Sig._____

BRIAN MACKENZIE
SG00375441 31/08/58
CHI: 3108583158 M
Date_____ Time_____
Spec./Sig._____

BRIAN MACKENZIE
SG00375441 31/08/58
12 ORCHARD STREET
RENFREW PA4 8RL
CHI: 3108583158 M

South Glasgow Hospitals
NEUROLOGICAL OBSERVATION CHART

NHS Greater Glasgow and Clyde

Name Brian Mackenzie

Record no. 150

Date 5/12

Time 0900

Glasgow Coma Scale

Eyes open
- Spontaneously X
- To speech
- To pain
- None

Eyes closed by swelling = C

Best motor response
- Obeys commands X
- Localise pain
- Normal flexion to pain
- Abnormal flexion to pain
- Extension to pain
- None

Usually record the best arm response.

Verbal response
- Orientated X
- Confused
- Inappropriate words
- Incomprehensible sounds
- None

Endotracheal tube or tracheostomy = T

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

Blood pressure and Pulse rate
240 230 220 210 200 190 180 170 160 140 130 120 110 90 80 70 60 40 30 20 10

Respiration
X

Temperature °C
40 39 38 37 36 35 34 33 32 31 30

Pupils

Right	Size	3
	Reaction	+
Left	Size	3
	Reaction	+

+ reacts
- no reaction
c. eye closed

Limb Movement

Arms
- Normal power X ½
- Mild weakness
- Severe weakness
- Spastic flexion
- Extension
- No response

Legs
- Normal power + ½
- Mild weakness
- Severe weakness
- Spastic flexion
- Extension
- No response

Record right (R) and left (L) separately if there is a difference between the two sides.

Basic Guide for Performing Neurological Observations

1. Frequency of performing observations: **This is the minimum recommended.**

   More frequent observations should be carried out if the clinical condition requires it.

- On arrival i.e. following transfer from another area. Should be compared to previous recording and any deterioration discussed with medical staff.
- At half hourly intervals for 2 hours.
- At hourly intervals for 4 hours.
- At 2 hourly intervals for 6 hours.
- At 4 hourly intervals until fit for discharge.

2. Examples of neurological deterioration that should be reported immediately to medical staff:

- Development of agitation or abnormal behaviour. (Do not automatically ttribute to effects of alcohol or drug abuse.)
- Sustained decrease in conscious level of at least one point in the motor or verbal response, or two points in the eye opening response.
- Development of severe or increasing headache.
- Persisting vomiting.
- New or evolving neurological signs i.e. pupil inequality, asymmetry of limb or facial movement.

Eyes Open

- Conscious patients sense your approach and open their eyes spontaneously.
- Verbal stimulus may be normal, repeated or loud, recognisably use their name (beware not to touch at this time- use only verbal).
- Painful stimulus is applied by trapezius squeeze (use thumb and two fingers to hold and squeeze 2 inches of trapezius muscle where the head/neck meets the shoulder). If eyes do not open in response, squeeze the side of the patient's finger (3rd or 4th) between your thumb d a pen.

Best Motor Response

- **Obey commands.** The patient understands and carries out instructions e.g. lift up arms, hold up thumb, squeeze hands - always ask patient to release grip in order to eliminate primitive reflex. Be aware of possible hearing/speech disorders.
- **Localise pain.** The patient must bring hand up beyond level of the clavicle in response to central painful stimulus (trapezius, finger squeeze).

  Patients may localise to irritants such as O_2 masks or N/G tubes. Best arm response is used as leg response may be a spinal reflex only.
- **Flexion to pain.** The patient may flex or bend their arm towards source of pain but do not actually localise or try to remove the source. Response is variable with each stimulus.
- **Abnormal flexion.** The patient may flex or bend the arm at elbow and rotate wrist (spastic posture) whilst drawing arm across chest. Response is slower than in normal flexion to pain.
- **Extension to pain.** The patient may extend or straighten arm at elbow or may rotate arm towards.
- **No response to pain.** Beware absence of response may be due to high spinal injury or muscle paralysing drugs.

Best Verbal Response

- **Orientation.** The patient knows who they are, where they are, month and year and why they are where they are.
- **Confusion.** The patient holds a conversation but cannot answer accurately, talks in sentences, unaware of self or environment.
- **Inappropriate words.** The patient replies in words said at random, often shouts or swears.
- **Incomprehensible sounds.** You may have to use both verbal and painful stimulus to get a response. Patient may moan or groan (beware of English language ability).
- **No response.** Beware of possible hearing/speech disorders.

Pupils

- **Size.** Look at pupil before shining light into the eye. Both should be equal in size (beware drugs affecting size). Beware pre-existing irregularities e.g. cataracts, blindness etc. Shape is normally round.
- **Reaction.** Should be 'consensual' reaction i.e. where both eyes constrict as light shone into one (bring light in from side of eye).

Vital Signs

- **Temperature.** Alterations may be due to damage to hypothalamus. Raised temperature also increases demand for O_2 by brain cells so regulation is important.
- **Blood pressure and pulse.** Haemorrhage from an extra-cranial site may lead to falling blood pressure and rising pulse and if under treated, shock may cause neurological deterioration. Rising blood pressure and slowing of pulse can be a sign of increasing intra-cranial pressure.
- **Respirations.** Reduced conciousness may cause hypoxia through inadequate respiration or an obstructed airway. Hypoxia may cause neurological deterioration. Changes in rate and pattern may indicate a rise in intra-cranial pressure.

Limb movement

- **Normal power.** The patient matches resistance applied to any joint movement (pulls you towards them or pushes you away).
- **Mild weakness.** The patient moves against resistance but is easily overcome.
- **Severe weakness.** The patient able to move limb but not against resistance.
- **Spastic flexion.** The patient may flex or bend the arm at elbow and rotate wrist (spastic posture) whilst drawing arm across chest. Response is slower than in normal flexion to pain.
- **Spastic extension.** The patient may extend or straighten arm at elbow or may rotate arm towards.
- **No response.** Beware absence of response may be due to high spinal injury or muscle paralysing drugs.

References

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ompiled by Mrs. B. Wellington, Clinical Nurse Specialist (Orthopaedics) on behalf of SGUH SIGN No 46 Local Guideline Development Group, March 200

ead Clinician Mr. T. Parke, Clinical Director for A&E.

ext review date: March. 2003

SOUTH GLASGOW HOSPITALS
SOUTHERN GENERAL HOSPITAL

7

BRIAN MACKENZIE
31·8·58
SG 00375461

CLINICAL NOTES

DATE	
3/10/09	REF: OS216100 K-WIRE DOUBLE TROCAR 1.6MM X 100MM LOT 00992158 2013-10

09
51
58

0367691-SGH7

10

Southern General Hospital, Accident & Emergency Department, Glasgow G51

Tel Direct: 0141 201 1456/8 Switchboard: 0141 201 1100 Fax: 0141 201 2997

NAME: BRIAN MACKENZIE
AGE 51 DOB:31/08/58
UNIT No. SG00375441
CONSULTANT: MALCOLM W G GORDON
Account No: AE0086422/09
DATE 02/10/09
TIME 1743
CHI# 3108583158

GP Name:	JUDITH JM ANDERSON GP Phone No: 0141 314 4646 | 4
REASON FOR VISIT:	HEAD INJURY RIGHT THUMB INJURY
ALERTS:	(1) (2)
ALLERGIES:	(1) NKDA (2)
RELEVENT HISTORY:	
MEDICATIONS:	

TRIAGE CATEGORY: STANDARD TRIAGE NURSE: GILLIAN CURRAN TRIAGE TIME 1758

TRANSCRIBED ANALGESIA :

OBSERVATION TEXT:

HIT ON HEAD SEVERAL TIMES BY GOLF CLUB NO LOC WOUND TO RIGHT SIDE HEAD, RIGHT THUMB IS DISLOCATED WITH ? COMPUND WOUND

? returning fam. — irreg. discharge

Enter/Edit Vital Signs						Visual Acuity	
DATE	TIME	COMPLETED BY	DATE	TIME	COMPLETED BY	Left-6m	Right-6m
02/10/09	1759	NU.CURGI	02/10/09	1759	NU.CURGI		

T			T			Correction Y/N	
HR	100		HR			Weight (kg)	
R	21		R			Breath Alcohol	
BP	168/89		BP			Pain Score	
Sa02	96% ON	%	Sa02		ON %		
BG			BG				
PF			PF				
EPF							
E			E				
V			V				
M			M				

MACKENZIE, Brian

Attend: 02/10/09 2119 DOB: 31/08/1958 Sex: M
Ref: MR MW GORDON - SGH CASUALTY DEPARTMEN
XR Thumb Rt

CRIS: 443724 E-11947972 ChiNo: 3108583158

DISCHARGE CODES: Please Circle

1. Admission 2. Discharge 3. Refer to GP 4. Transfer to other hospital (see below)
5. Died 6. Refer to O.P. Clinic (see below) 7. Irregular Discharge 8. D.O.A.

Discharge Date
Discharge Time 2150

ird No. (If admitted)	Transfer to Hospital	Consultant (if admitted)

low Up	Not arranged	Arranged	To be arranged

nic ferred to	AE	Hand Injury	Fracture	Pop Check	Medical	Surgical	ENT	Others Specify

DATE	CLINICAL NOTES

(12) hand, Open dislocation of (R) thumb ~~DIP~~ ~~joint~~ interphalangeal joint.

Laceration (N) } distally.
CRT (N) }

Imp, Minor hand injury + ↑ X-ray - dislocation of IP joint.

↳ cleaned + closed with 2x sutures.

(P) (1) Analgesia
(2) IV access + bloods
(3) Ring block
(4) Irrigation
(5) Abx - cefuroxime
(6) Betadine dressing

} As o/w Dr Miller-White.

VZ-ST1
D. Firm

(7) o/w ortho regarding reduction vs non-reduction

Under Ring block & thumb - wound swab of 1% lidocaine
Wound irrigated with 1 litre of NaCl 0.9% + betadine swab.

(8) Tetanus prophylaxis.

REVAXIS®
PA: 544/35/1
PL: 06745/0123
D0821-1
07-2011

Thumb spica & betadine soak BAS. 2 clock

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION	SIGNATURE	GIVEN BY
2/10/9	CEFUROXIME	1.5g	IV	1950	VZ	[illegible]
2/10/9	PARACETAMOL	1g	O	1950	VZ	PF
2/10/9	REVAXIS	0.5ml	IM	2020	VZ	PF

DISCHARGE PRESCRIPTION PACKS

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	FREQUENCY	SIGNATURE	GIVEN BY

DATE	CLINICAL NOTES
	SEEN BY (DR) D. FINN TIME SEEN 1845.

PC, (R) hand injury. + head injury.

HPC, Allegedly assaulted with golf club.
- hit on head + (R) hand.

(L) hand dominant.
Unemployed.
LAST ATE 1200
" DRANK 1700

Head,
- no LOC
- no N+V
- not drowsy
- no C-spine injury
- no visual disturbance
- no headache.
- no blood from ears/nose
- sustained wound to scalp.

Has had 6 cider today.

(R) hand,
- Wound to (R) thumb - pain +.
- bone apparent through skin.
- no ↓ sensation

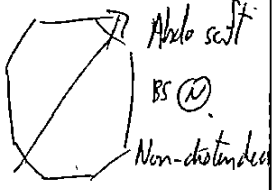
PMH, Nil
DH, Nil.
NKDA.

SH, Smokes cannabis - continuously almost.
Drinks to XS every day.

O/E, GCS 15/15.
HR 100.
RR 21
BP 168/89.
SpO, 98%.

Resp, Guarding.
°Crepe °bilat.

CV, Good CRT
HS 1+11+0.

Abdo,


Cranial nerves (N)
PERRL
°C-spine tenderness.
°Haemotympanum
°Blood in nose.

Head,


Tone/Power/Sensation (N) (L) arm. (R) arm not tested but fully int. sensation (N) + power (N) at elbow.

For: PSAETRIAGE01 From: CAMPBELL,JULIE
Sat Oct 3, 2009 7:04 am Taken by: MEDITECH ()
Subject: ********** THIS PATIENT REQUIRES TRIAGE **********

********** THIS PATIENT REQUIRES TRIAGE **********

Name: MACKENZIE,BRIAN A&E Number: AE0086541/09 Unit Number: SG00375441

Patients Address: 12 ORCHARD STREET RENFREW PA4 8RL Tel: 07966154552

LOCATION.....SAEO.....

********** THIS PATIENTS REQUIRES TRIAGE **********

Patients GP: ANDERSON, JUDITH JM Practice: THE HEALTH CENTRE Address: THE
ALTH CENTRE Tel: 0141 314 4646

Next of Kin: MACKENZIE,MARGARET

Relationship: WIF

Address: NFI

Tel: 07973435422

SOUTHERN GENERAL HOSPITAL **Against Advice**

SURNAME (Block Letters)	FIRST NAMES (Block Letters)	UNIT NUMBER
MACKENZIE	BRIAN SG	00375441

This is to cerify that I go out/take out .....

on my own responsibility, having been warned by the medical staff of the risk involved.

Witnessed ..... Signature B. Mackenzie

Designation ..... ST1 Gen Surg Address .....

.....

Date ..... 2/10/9.....

AGAINST ADVICE

SGH 283

For: PSAETRIAGE01 From: MCNAB,MARION
Fri Oct 2, 2009 5:43 pm Taken by: MEDITECH ()
Subject: ********** THIS PATIENT REQUIRES TRIAGE **********

********** THIS PATIENT REQUIRES TRIAGE **********

: MACKENZIE,BRIAN A&E Number: AE0086422/09 Unit Number: SG00375441

ents Address: 12 ORCHARD STREET RENFREW PA4 8RL Tel: 07966154552

ION.....SAEO.....

********** THIS PATIENTS REQUIRES TRIAGE **********

nts GP: ANDERSON, JUDITH JM Practice: THE HEALTH CENTRE Address: THE
H CENTRE Tel: 0141 314 4646

N OF
OUGH of Kin: MACKENZIE,MARGARET

tionship: WIF

ess: NFI

07973435422

SOUTH GLASGOW UNIVERSITY HOSPITALS DIVISION
SOUTHERN GENERAL HOSPITAL

7

BRIAN MACKENZIE
SG00375441
31/08/58 M
Date____ Time____
Spec./Sig.____

CLINICAL NOTES

DATE	Cont'd
4/9/06	Dx ? ligament rupture & unstable wrist
	# clinic for orthopaedic hand surgeon opinion
	Splint & analgesia
	M Gordon SHO

SOUTH GLASGOW HOSPITALS
SOUTHERN GENERAL HOSPITAL

7

BRIAN MACKENZIE
SG00375441 31/08/58
CHI: 3108583158 M
Date____ Time____
Spec./Sig.____

CLINICAL NOTES

DATE	
ARTU	Cont...
2.10.09	Closed reduction with ease Stable once reduced able to flex & extend. Not fasted until midnight at earliest Still seems intoxicated. & last drank ~6 pm approx. Plan: - Check XR. - betadine soak - Slab to include thumb - Admit for elevation IV ABS - ~~for~~ for Review mane? for further wash out & debridement - Also needs tetanus ? to HI & intoxication.
	- for repeat XR - Betadine soaked swab. Slab to include thumb - Refusing to stay in dept. Says he will return in AM. - Note head injury → wife (who is responsible) will collect pt from hospital. Give head injury instructions - Irreg d/c form signed. [illegible], ST1 #7032

0367691-SGH7

7

DATE	3/10/9 07:30 CLINICAL NOTES (Continued)
	Patient represented to A&E
	T/F wd 2
	Cetro
11/9	→ Seen Post op.
	→ well
	→ Pain free.
	→ Start C/S Phlebotomy

SOUTH GLASGOW HOSPITALS
SOUTHERN GENERAL HOSPITAL

7

BRIAN MACKENZIE
SG00375441 31/08/58
CHI: 3108583158

CLINICAL NOTES

DATE

2./10/9 ST1 Cen Surg 20:30

(ST)→

R - (R) hand injury
head injury

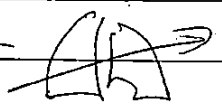
HPC - Alleged assault today 1730 - 1800 with golf club. Hit on head & (R) hand. c/o some pain (R) thumb.
°LOC, °nausea/°vomiting, °PTA, °otorrhoea/rhinorrhoea, °visual/hearing disturbance, °headache. °Neck pain/stiffness
Admits to x10 units ETOH today (last at 1730)
Denies any further injury.
(L) hand dominant.

PMHx - Previous epigastric hernia repair, Alcohol xs
Nil else of note

DHx - NKDA
Nil reg

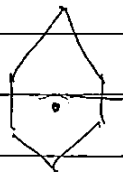
SHx - Smokes cannabis
Drinks x10 pints/day.
Unemployed

O/E - HR - 100bpm, reg RR - 21 BP - 168/89.
Sats - 98% on air. GCS 15/15.

RS -  Chest clear
Nil added
good A/E
L = R.

CVS - HS I+II+0
JVP ↔

Abdo - Soft NT
BS ✓
°bruising



DATE | CLINICAL NOTES (Continued)

Neuro - (L) UL (L) LL (R) UL (R) LL

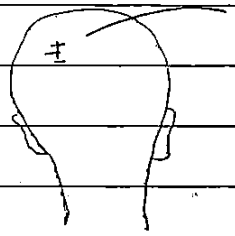
Tone	Norm	Norm	Norm	Norm
Power	5/5	5/5	5/5	5/5
Reflexes	✓	✓	✓	✓

CNs intact. Reads small print.

°C spine tenderness.

Eye movements (N).

°Signs basal skull ##

Head —  wound approx 1–15cm. No palpable ##.

→ Stapled by A&E.

(R) hand :- Obvious deformity (R) thumb

Open dislocation IP joint → bone visible.

Given ring block by A&E.

CRT < 2secs, warm well perfused.

Plan — XR : no #, dislocation as above.

Analgesia

IV access + bloods.

Irrigated + ring block by A&E.

Tetanus ✓ (by A&E)

2/10/09 SpR ORTHO: NVNN

- As above.

open dislocation (R) Thumb IPJ - Radio dorsal, condyl. & prox phalynx exposed

Washout ++ by A&E. Nav looks clear

further ring block administered at pomfret.

5mls (1% Lignocaine / 0.5 Marcain (50/50) good analgesia

Southern General Hospital, Accident & Emergency Department, Glasgow G5[redacted]

Tel Direct: 0141 201 1456/8 Switchboard: 0141 201 1100 Fax: 0141 201 [redacted]

NAME: MACKENZIE, BRIAN — DATE 25/05/11
AGE 52 DOB 31/08/58 — CONSULTANT: JASON LONG — TIME 1920
UNIT No: SG00375441 SR — Account No: AE00443021/11 — CHI#:3100583150

GP Name:	JUDITH JM ANDERSON GP Phone No: 0141 2C7 7730 | 6
REASON FOR VISIT:	RIGHT KNEE INJURY
ALERTS:	(1) (2)
ALLERGIES:	(1) NKDA (2)
RELEVENT HISTORY:	
MEDICATIONS:	

TRIAGE CATEGORY: STANDARD — TRIAGE NURSE: GILLIAN CURRAN — TRIAGE TIME 1946

TRANSCRIBED ANALGESIA :

OBSERVATION TEXT:

DOG RAN INTO PT THIS AFTERNOON PT STATES THAT HIS RIGHT KNEE DISLOCATED, PT ?TRIED TO STRAIGHTEN LEG OUT SAYS IT WENT BACK INTO JOINT??. C/O PAIN++

Enter/Edit Vital Signs

DATE	TIME	COMPLETED BY	DATE	TIME	COMPLETED BY
25/05/11	1946	NU.MACDO	25/05/11	1946	NU.MACDO

T			T			Correction Y/N	
HR			HR			Weight (kg)	
R			R			Breath Alcohol	
BP		....	BP			Pain Score	
Sa02		ON %	Sa02				
BG			BG				
PF			PF				
EPF							
E			E				
V			V				
M			M				

Visual Acuity

Left-6m	Right-6m

MACKENZIE, Brian
Attend 25/05/11 1956 DOB. 31/08/1958 Sex: M
Ref: DR JR LONG - SGH CASUALTY DEPARTMENT
XR Knee Rt

CRIS: 443724 E-25774141 ChiNo: 3108583158

DISCHARGE CODES: Please Circle

1. Admission 2. Discharge 3. Refer to GP 4. Transfer to other hospital (see below)
5. Died 6. Refer to O.P. Clinic (see below) 7. Irregular Discharge 8. D.O.A.

Discharge Date	T
Discharge Time	2120

Ward No. (If admitted)	Transfer to Hospital	Consultant (if admitted)

Follow Up	Not arranged	Arranged	To be arranged

Clinic Referred to	AE	Hand Injury	Fracture	Pop Check	Medical	Surgical	ENT	Others Specify

DATE 23/5/11 CLINICAL NOTES

SEEN BY (DA) S/N [redacted] (ENP) TIME SEEN 20[50]

(52) ♀ with right knee injury.

HPC- Was walking dogs in park this am, largest dog hit lateral aspect right knee causing pt to fall to floor landing on right leg. States knee was sitting at 'weird' angle - when straightened knee 'clunked back into place' - managed to get home but ↑ pain and ↓ mobility last 6 hrs.

PMHx- nil stated DHx- nil stated
Allergies - NKDA ATT- Covered SHx- self employed gardener.

OE (R) knee - swollen medially ° bruising ° obvious deformity ° wounds.

Very tender over patella on palpation with medial & lateral joint line tenderness. Can SLR from tray with full range of flexion / extension. °N defect distally

DATE	CLINICAL NOTES
	MCL/ACL - pain on stressing but no joint laxity PCL/ACL) - painfree on stress-testing with no joint laxity. XRAY (R) knee - No # evident Imp Clinical patellar dislocation Plan Camp splint Crutches analgesia # clinic review made S/N

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	TIME OF ADMINISTRATION	SIGNATURE	GIVEN BY

DISCHARGE PRESCRIPTION PACKS

DATE GIVEN	DRUG (BLOCK CAPITALS)	DOSE	METHOD OF ADMINISTRATION	FREQUENCY	SIGNATURE	GIVEN BY
25/5/11	Co-Codamol 30/500 #1		oral	OD	[illegible]	[illegible]

To: PSAETRIAGE01 From: COLEMAN,JEANETTE
Wed May 25, 2011 7:28 pm Taken by: MEDITECH ()
Subject: ********** THIS PATIENT REQUIRES TRIAGE **********

********** THIS PATIENT REQUIRES TRIAGE **********

Name: MACKENZIE,BRIAN A&E Number: AE0044302/11 Unit Number: SG00375441

Patients Address: 22 LOMOND AVENUE RENFREW PA4 0PG Tel: 07966154552

LOCATION.....SAEO.....

********** THIS PATIENTS REQUIRES TRIAGE **********

Patients GP: ANDERSON, JUDITH JM Practice: RENFREW HEALTH CENTRE Address: RENFREW HEALTH CENTRE Tel: 0141 207 7730

Next of Kin: MACKENZIE,MARGARET

Relationship: WIF

Address: 22 LOMOND AVENUE RENFREW

Tel: 07966154552

INTRA-OPERATIVE CARE PLAN

TIME OF ARRIVAL IN ANAESTHETIC ROOM 1630

TIME OF ARRIVAL IN THEATRE 1650

THEATRE	ANAESTHETIST	ASSISTANT	ANAES. NURSE
ORTHO 1	DR MAY	DR HARDING	SN ROBERTS

SURGEON	IST ASSISTANT	SCRUB NURSE	CIRCUL. NURSE
MR FRAME		SN PONSOTES	NA BURNS

I.V. INFUSIONS		ARTERIAL LINE		CVP-MONITORING	
COMMENCED	IN-SITU	COMMENCED	IN-SITU	COMMENCED	IN-SITU
✓					

AIRWAY MANAGEMENT	SYRINGE/PCA PUMP			
GENERAL ETT 9 ☑	COMMENCED	IN-SITU	COMMENCED	IN-SITU
LM ☐				
FM ☐				

SPINAL				
EPIDURAL	COMMENCED	IN-SITU	COMMENCED	IN-SITU
REGIONAL				
LOCAL				

EYES TAPED

POSITION	Supine	Prone	Lithotomy	Right Lateral	Left Lateral	Jack Knife	Other
RIGHT ARM	At Side	On Board	Across Chest	Other			
LEFT ARM	At Side	On Board	Across Chest	Other			
PATIENT PROTECTION SAFETY	Padding	Pillows	Gel Pad	Warming blanket	Other		

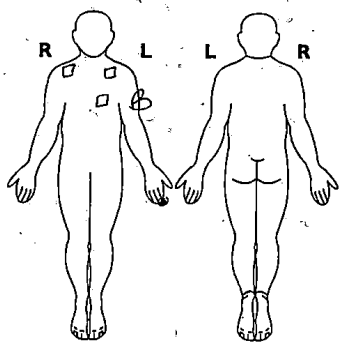
TOURNIQUET		
Arm ✓ °	Leg °	Ankle °
Right ✓ °	Left °	
Inflated 1907 Hrs	Pressure 250 MM	
Deflated 1930 Hrs	23 mins	

SWAB/NEEDLE/INSTRUMENT COUNT	
Correct	✓
Incorrect	

Appropriate Action Taken	

PATIENT MONITORING

- PERIPHERAL IVI — X
- IV CANNULAE — C
- ECG ELECTRODES — ☐
- C.V.P. — Z
- ARTERIAL LINE — A
- BP/MANUAL/AUTO — B
- PULSE OXIMETER — •
- DIATHERMY PLATE — Δ
- SKIN CONDITION — S



IMPLANTS	BATCH NO.	SERIAL NO.
REF: OS216100 K-WIRE DOUBLE TROCAR 1.6MM X 100MM	00992158 2013-10	

SPECIMENS TAKEN

THEATRE CARE PLAN

Theatre:

NHS Greater Glasgow and Clyde

WARD NAM	SG00375441 BRIAN MACKENZIE 12 ORCHARD STREET	**DATE**	3/10/19
PATIENT'S N		**WARD**	2
D.O.B.	RENFREW 31/08/1958 PA4 8RL CHI 3108583158	**UNIT NO.**	SG 00375441

PROPOSED OPERATION

PRE-OPERATIVE CARE PLAN			
1. Obtain and record baseline vital signs	BP 139/93 R 16	SAT 96% TEMP 37.1 P 86	
2. Note and record significant past medical history		✓	✓
3. Capped/loose teeth-number and position	UPPER TOP BRIDGE — SECURE		✓
4. Pre-op teaching carried out	✓ ✓ ✓	✓	✓
5. Pre-op investigations carried out i.e. ECG, Bloods, X Rays		✓	✓
6. Skin shave and preparation required		N/A	—
7. Remove make-up nail, varnish		N/A	—
8. Remove prosthesis, dentures, hair pieces, lenses		N/A	—
9. Jewellery - Tape rings	RING TAPED — EARRINGS REMOVED		Ring taped
10. Ensure patient has fasted (No less than 6 hours)		~~FASTED FROM~~ 7am	0700
11. Identification band		✓	Checked
12. Empty bladder/catheter in situ		✓	✓
13. Naso-Gastric Tube		N/A	—
14. Blood in Theatre Fridge		N/A	—
15. Case Notes		A/E CARD	A/E Card
Drugs kardex/charts		✓	✓
X Rays		ON SYSTEM	—
16. Theatre gown & cap		✓	✓
17. Premedication given		40mg omeprazole 0920	✓
18. Consent form signed		✓	Checked
19. Allergies		? HAYFEVER	hayfever
20. Waterlow Score		5	
		Ward Nurse Sig	**Theatre Nurse Sig**

RELEVANT INFORMATION

PMH — HERNIA REPAIR, ② FOOT WASHOUT.
TONSILLECTOMY, ② KNEE ABSCESS DRAINED.
REGULAR CANNABIS/OCCASIONAL USER, XS ALC, SMOKES 20 C.P.D.

NAMED NURSES

NAMED ANAESTHETIC NURSE	Sn Rogers
NAMED THEATRE NURSE	Sn Parsons
NAMED RECOVERY NURSE	Sn Watson

POST OPERATIVE CARE PLAN | **TIME OF ARRIVAL IN RECOVERY ROOM** 1235

OPERATION

GA:- EXPLORATION WOUND RIGHT HAND + K WIRING OF THUMB

WOUND DRAINAGE	SKIN CLOSURE	DRESSING
	3/0 DERMALON	IODINE, BLUE SWABS, WOOL ROLL + PAL BACKSLAB
LA INFILTRATION	**URINARY CATHETER**	**PACKS IN SITU**
LIGNOCAINE 0.5% 20ML RADIAL + MEDIAN BLOCK		

CONSCIOUS LEVEL	AIRWAY	OXYGEN	I.V. ACCESS	DRAINS	WOUND
A). Unconscious	A). Guedel	A). Hudson Mask	A). Infusion Running	A). Patent	A). Dry
B). Conscious/Drowsy	B). E.T.T.	B). Nasal Canulae	B). Capped Can in SITU	B). Blocked	B). Slight Staining
C). Conscious/ Responsive	C). Laryngeal Mask	C). Other UC	C). Discontinued	C). Drainage in Mls	C). Heavy Staining
D). Ventilated				D). Irrigation	

TIME HOURS	MINS	1735 0	1740 5	1745 10	1750 15	1755 20	1800 25	1805 30	1820 45	1835 60	75	90
RESPIRATORY FUNCTION												
Able to breath and cough	= 2	2	2	2	2	2	2	2	2	2		
Maintain own airway	= 1											
Airway needs support	= 0											
COLOUR												
Pink & Warm	= 2	2	2	2	2	2	2	2	2	2		
Pale, Dusky, Peripheral cyanosis	= 1											
Central Cyanosis, cold	= 0											
RECOVERY OF NEURO-MUSCULAR FUNCTION												
5 secs Head lift	= 2	2	2	2	2	2	2	2	2	2		
Moves limbs	= 1											
No move (Except Resp)	= 0											
CONSCIOUS LEVEL												
Responds to command	= 2	2	2	2	2	2	2	2	2	2		
Responds	= 1											
No Response	= 0											
BLOOD PRESSURE												
Within 30mmHg of Pre-op	= 2	129	126	119	125	127	127	124	128	133		
30-90 from Pre-op	= 1	78	74	74	75	78	71	76	65	62		
< 70mmHg	= 0											
O_2 SATURATION		100	100	100	100	100	100	100	100	100		
PULSE		80	75	71	76	74	67	73	62	66		
RESPIRATION RATE		19		16	18	18	16	15	19	18		
TEMPERATURE (If indicated)		36°C										

POST OPERATIVE CARE PLAN

SPECIFIC PRE/INTRA & POST OPERATIVE COMPLICATIONS

COMPLICATION	ACTION TAKEN	OUTCOME
Post Op Pain	3mg IV Morphine by	
Pain Score 7/8	Dr Mey @ 1755	Pain Score ~~7~~
Right Thumb	2x30/500mg Colodamol	
"Throbbing"	@ 1800hrs	Pain Score 7
	10mg S/C Morphine	
	(left shoulder) @ 1823	Pain Score 1/2
		@ 1835
		Returned to ward

NURSING REPORT

Colour, sensation & movement @ 1735 ✓ RIGHT THUMB NOT SITED | COVERED
@ 1745 ✓ " " " " | "
@ 1800 ✓
@ 1830 ✓

IV fluids to be discontinued. Eat + Drinks normal

POST RECOVERY TRANSFER REPORT

CONSCIOUS LEVEL	OXYGEN	I.V. ACCESS	DRAINS	PAIN LEVEL
A). Unconscious B). Conscious/Drowsy C). Conscious/ Responsive D). Ventilated	A). Hudson Mask B). Nasal Canulae C). Other ul	A). Infusion Running B). Capped Can in SITU C). Discontinued	A). Patent B). Blocked C). Drainage in Mls D). Irrigation	A). Pain free B). Mild C). Moderate D). Severe
WOUND	**CVP MONITORING**	**ARTERIAL LINE**	**SYRINGE PCA PUMP**	**WATERLOW SCORE PLEASE SPECIFY AMOUNT**
A). Dry B). Slight Staining C). Heavy Staining	A). Commenced B). In Situ	A). Commenced B). In Situ	A). Commenced B). In Situ	A). 10+ At Risk B). 15+ High Risk C). 20+ Very High Risk

RECOVERY NURSES SIGNATURE

WARD NURSE SIGNATURE

SGH99 0099099 MG\080198

South Glasgow Hospitals
Department of Anaesthesia, Southern General Hospital

Date 3/10/9

Name:	
Address:	SG00375441 BRIAN MACKENZIE 12 ORCHARD STREET
Unit No:	
Date of B	RENFREW 31/08/1958
Ward:	PA4 8RL CHI 3108583158

PRE-OPERATIVE INSTRUCTIONS

Omeprazole preop
ECG preop

PRE-OPERATIVE NOTES

C2H5OH ++
pain epigastrium
CP or SOB on 2 flights of stairs
otherwise well

FCO at 7am

Current Medication
pabrinex
diazepam - CIWA
OF118
paracetamol
ibuprofen *

Regional Block proposed ☐

Risk discussed ☐

20 u alcohol/d
smokes cannabis
smokes 20/d
occ cocaine (not for 2/52)

broken upper front incisor - seen
MP I/II, red ok

Allergies
nil

ASA Grade: 1 (2) 3 4 5 E Reflux ☒

Hb: 17	WCC: 8.6	Na: 138	K: 4.7	Height (M):	ECG:
Platelets: 260		Cl: 105	Bic: 19	Weight (Kg):	CXR:
Xmatch:		U: 7.8	Cr: 78	Pre-op BP:	Urinalysis:

Operation Performed:	Anaesthetists: MAY / HARDMAN Responsible Consultant: HUME.
Surgeons:	Informed? Yes ☐ No ☑

POST-OPERATIVE INSTRUCTIONS AND NOTES

Oxygen: 4L/m for 24° then ensure sats ≥ 96%.
See accompanying charts:
Drug Kardex ☑
PCA chart ☐
Epidural ☐
IV fluid chart ☑

Problems for Future Reference:

Monitoring — Machine & Circuit Check ☑

- ECG / SpO_2 / NIBP ☑ — TOF ☐
- $EtCO_2$ ☐ — IBP ☐ — Urine ☐
- EtAA ☐ — CVP ☐ — Temp ☐

AIRWAY

- ☐ Oral/Nasal ☐ Mask
- ☐ Cuff ☐ Pack ☐ Phar. Airway
- (Tube) / LMA Size: # 9.0
- Laryngoscopy Grade: (1) 2 3 4

VENTILATION

- ☐ Spontaneous — V_t 580
- ☑ I P P V — f 12
- Circuit (○) — P_{AW} 18
- Ventilator

IV SITES

- Eyes taped closed ☑
- (L) Hand 18G ☑
- Warming Blanket ☑
- Blood Warmer ☑

POSITION

- ☑ Supine
- ☐ Lateral L/R
- ☐ Prone
- ☐ Lithotomy
- ☐ Other

Time	16:30	16:45	17:00	17:15	17:30
FENTANYL (mcg)	100				
PROPAFOL (mg)	360				
SUXAMETHONIUM (mg)	100				
ROCURONIUM (mg)	35		10		
MORPHINE (mg)	5				
NEOSTIGMINE / GLYCO				2.5/0.5	

(1) Hartmanns 1000ml

Local Infiltration

- ☐ Arterial line
- ☐ Central line
- ☐ Ultrasound guided

SpO_2	99	99	100	100
FiO_2	.56	.52	.49	.83
$EtCO_2$	4.4	4.3	4.3	6.7
EtAA	2.1	2.1	2.3	0.5
Temp				
Fluid	(1)			

Fentanyl 100 — VSLIV

5mg Morphine inj 17:55

210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0

CVP
Blood Loss
Urine Output

Pre-operative marking recommendations

The National Patient Safety Agency (NPSA) and the Royal College of Surgeons of England (RCSEng) strongly recommend pre-operative marking to indicate clearly the intended site for elective surgical procedures.

1. How to mark?

An indelible marker pen should be used. The mark should be clear such as an arrow that extends to, or near to, the incision site and remain visible after the application of skin preparation. It is desirable that the mark should also remain visible after the application of theatre drapes. Some procedures may require marking to assist with the surgery (plastic surgery) and therefore this may be more extensive.

2. Where to mark?

Surgical operations involving side (laterality) should be marked at, or near, the intended incision (some surgeons do not like the mark to be exactly where the actual incision will be). For digits on the hand and foot the mark should extend to the correct specific digit. Ascertain intended surgical site from reliable documentation and images.

3. Who makes the mark?

Marking should be undertaken by the operating surgeon, or nominated deputy, who will be present in the operating theatre at the time of the patient's procedure.

4. With whom?

The process of pre-operative marking of the intended site should involve the patient and/or family members/significant others wherever possible.

5. Time and place

The surgical site should be marked on the ward or day care area prior to patient transfer to the operating theatre. Marking should take place before pre-medication.

6. Verify

The surgical site mark should subsequently be checked against reliable documentation to confirm it is (a) correctly located, and (b) still legible. This checking should occur at each transfer of the patient's care and end with a final verification prior to commencement of surgery. All team members should be involved in checking the mark.

Acute Services Division

NHS
Greater Glasgow and Clyde

Pre-operative marking Checklist for Surgery that can be performed on either side of the body

The operating surgeon should mark the intended site of operation prior to the patient leaving the ward area and before any pre-medication is given.

Affix label Patient's Hospital Date of B	SG00375441 BRIAN MACKENZIE 12 ORCHARD STREET RENFREW PA4 8RL CHI 3108583158 31/08/1958	Date of procedure: 03/10/09 Proposed procedure: EXPLORATION/WASHOUT OF (R) THUMB ± TENDON REPAIR/K-WIRE STABILISATION

Check 1 - Ward

To be checked by ward staff before patient goes to theatre.

• Check the patient's identity • The mark is inspected and confirmed against the patient's supporting documentation. • Check reliable imaging will accompany the patient to theatre	Signed: [signature] Print name: G MAY Ward: 2 Date: 03 / 10 / 09

Check 2 - Theatre/ Anaesthetic Room

To be checked by operating surgeon in the theatre department, prior to anaesthesia.

• The mark is inspected and checked against the patient's supporting documentation	Signed: Print name:

Check 3 - Theatre Nurse

The senior theatre nurse must ensure that the surgical, anaesthetic and theatre team involved in the intended operative procedure pause prior to commencement of surgery to verbally confirm the following points:

• Presence of the correct patient • Marking of the correct site • Procedure to be performed	Signed: [signature] Print name: [illegible]

If an error is identified during the pre-operative checks, the surgeon in charge should assess the situation, review documentation and either return the patient to the ward or note and sign a decision to proceed at risk in the box below.

Signed	Date

SOUTHERN GENERAL HOSPITAL

ORTHOPAEDIC OPERATION NOTE

PATIENTS DETAILS:

Name: BRIAN MACKENZIE
DOB: 31/08/58
Unit No: SG00375441
CHI: 3108583158

DATE:
03/10/09
DIAGNOSIS:
DISLOCATED RIGHT THUMB IPJ OPEN
OPERATION:
EXPLORATION, WASHOUT AND KWIRE STAB. OF JOINT.
SURGEON:
MR M FRAME
ANAESTHETIST:

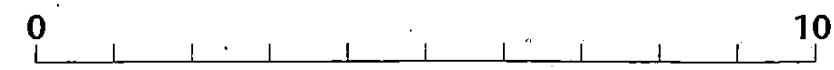
PROCEDURE:
TOURNIQUET CONTROL 250MMHG
STD PREP AND DRAPES.
IPJ UNSTABLE WOUND DEBRIDED AND JOINT IRRIGATED +++
STABILISED WITH 1.6MM KWIRE ACROSS JOINT.
2 LOOSE SUTURES TO OPPOSE WOUND.
DRESSED WITH INADINE, BLUESWABS WOOL AND FULL POP SPICA.

POST OP:
ELEVATE
OBS
HOME WHEN SAFE.
OPC MARTIN IN 1 WEEK FOR WOUND REVIEW AND CHANGE OF POP.
POP FOR 4 WEEKS AND KWIRE REMOVED AND MOBILSED
Dictated by:
FRAME

#CLINIC - 8/10/09
5 days post op
- wound clean + dry - no infection
- (P) - F/U Tuesday 13/10/09
ROS + new plaster
- k-wire in 4/52 in
- For check x-ray
- thumb on arrival (P)

Pain Assessment & Management Guidelines

How to score pain:



Pain Score:		Action:
0	NONE	Continue to assess pain with every set of observations (**must be** at least daily).
1-3	MILD	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.
4-6	MODERATE	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.
7-10	SEVERE	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.

Guidelines

Cancer-related pain:

Always score the worst pain in the last 24hours or since last assessment.

FOR PERSISTANT MODERATE PAIN (4 OR ABOVE) WHICH DISTRESSES THE PATIENT:

Use Cancer Pain Management Algorithm in Palliative Care Resource File. This is distributed to all wards and is also accessible on the intranet. If no improvement in pain score contact hospital palliative care team on **page 1266** at SGH and **page 5742** at VI.

Out of hours advice can be obtained from the Prince and Princess of Wales Hospice on **0141 420 6785.**

Acute pain:

Score current pain on movement e.g. deep breathing

PERSISTENT SEVERE PAIN (7 OR ABOVE), WHICH DISTRESSES THE PATIENT:

Use Acute Pain Manual - distributed to all Operating Theatres areas and Surgical wards throughout Division. Also accessible on Intranet (via anaesthetic department homepage)

If no improvement in pain score contact CNS Pain Management on **page 1186/1157** at SGH and **page 3404/3101** at VI. On Call anaesthetist **page 1658** at SGH and **3004** at VI.

Measuring Sedation

The SEWS system uses the AVPU scoring system for conscious level. AVPU is an acronym for Alert, Verbal Pain, Unresponsive. The AVPU system relates to the previous sedation scale as follows:

Sedation	Descriptor	AVPU
0	Awake	A
1	Asleep, roused by speech	V
2	Physical stimulation (eg shaking) required to waken	P
3	Not roused by speech or shaking	U

Measuring Nausea

Is now recorded as 0 for no nausea or vomiting, N for nausea and V for vomiting
For persistent nausea and/or vomiting see clinical handbook or acute pain manual.

NB: Review Treatment Plan

If Temp>38 — blood cultures ☐ other cultures ☐ Start antibiotic therapy if indicated

If Systolic BP<100 — Review monitoring (cardiac/oximetry/urine output/invasive BP etc)
IV Access
Review patient/drug kardex. Consider fluid challenge ⟶ Definitive Therapy

Consider:

Hypovolaemia	Cardiac	Obstructive	Distributive
Dehydration	*Arryhthmia*	*PE*	*Sepsis*
Blood loss	*Pump failure*	*Tamponade*	*Anaphylaxis*

If Pulse>130 — Review monitoring
IV Access
Review patient/ECG/electrolytes ⟶ Definitive Therapy

If O_2 sats <93% — Review probe ? accurate
Review patient ⟶ prescribe oxygen on kardex if indicated.

If RR>24 — Review patient/CXR +/- gases/PEF etc ⟶ Definitive Therapy

If responds to pain only or unresponsive — Assess airway, BM GCS, consider neuro obs chart, review patient/kardex.

If BM<4 — Check urgent blood glucose/IV dextrose or oral carbohydrate

UNIT No. 375441

SEWS KEY			
0	1	2	3

Date:

Time:

36+

31-35

21-30

9-20

≤8

93+

90-92

85-89

<85

%

39∞

38∞

37∞

36∞

35∞

34∞

210

200

190

180

170

160

150

140

130

120

110

100

90

80

70

60

50

40

150

140

130

120

110

100

90

80

70

60

50

40

30

20

Alert

Verbal

Pain

Unresponsive

PU/NPU:

UO<30mls/hr

7-10

4-6

1-3

0

N/V

SEWS KEY

0	1	2	3

NAME Brian MacKenzie DOB 31/3/58

Date:		3/10					4/10										
Time:		0850	1115	1340	1855	0905	1125										
RESP. RATE	36+																
	31-35																
	21-30																
	9-20	16	16	15	16	14	14										
	≤8																
SpO2	93+	96	96	98	98	94	94										
Numerical Value	90-92																
	85-89																
	<85																
Inspired O2%	%	A	A	4L	4L	A	A										
TEMP.	39∞																
	38∞																
	37∞	37.1 C	36.8 C	36.6 C	37.7 C		36.3 C										
	36∞																
	35∞																
	34∞																
BLOOD PRESSURE	210																
	200																
	190																
	180																
	170																
	160				153												
	150																
	140	139	135	134		136	127										
	130																
	120																
	110																
	100																
SEWS SCORE uses Systolic BP	90	95	90	80	92		85										
	80																
	70					59											
	60																
	50																
	40																
	150																
HEART RATE	140																
	130																
	120																
	110																
	100																
	90	86 C	72 C														
	80			62 C	57 C	69	58 C										
	70																
	60																
	50																
	40																
	30																
	20																
NEURO RESPONSE	Alert	A	A	A	A	A	A										
	Verbal				C	✓											
	Pain				C	✓											
	Unresponsive					✓											
URINE OUTPUT	PU/NPU:	NPU	PU	NPU	NPU	NPU	PU										
	UO<30mls/hr (3 hrs +)																
SEWS SCORE:	with all observations	0	0	0	0	0	0										
PAIN refer to guideline p4	Severe 7-10																
	Moderate 4-6																
	Mild 1-3	✓	✓	✓	✓	0	✓										
	None 0																
	N/V	0	0	0	0	0	0										

South Glasgow Hospitals

STANDARDISED EARLY WARNING SCORING SYSTEM (SEWS)

NHS Greater Glasgow and Clyde

Patient Observation Chart

Name	
Address	SG00375441 BRIAN MACKENZIE 12 ORCHARD STREET
Hospital	RENFREW PA4 8RL
DOB	31/08/1958 CHI 3108583158

	Date	Ward	Consultant
Admitted	3/10/9	2	MARTIN
Transferred			
Transferred			
Transferred			

This is Chart Number 1 during this admission

All seven parameters must be assessed with each set of observations to obtain an accurate SEWS score. If a patient has abnormal vital signs please pay particular attention to scoring for urine output.

How to calculate SEWS Score

- Note whether observation falls in shaded "At Risk Zone". Score as per SEWS Key.
- Add points scored and record total "Sews Score" in bottom row of chart.
- Respiratory rate — Write numerical value in appropriate box
- Saturation Sp02 — Write numerical value in appropriate box
- Inspired Oxygen — If the patient's saturation is recorded on air please write A in appropriate box. If patient is on oxygen therapy, please document the amount in appropriate box.
- Temperature — Write numerical value in appropriate box
- Blood pressure — Write numerical values for systolic and diastolic pressure in appropriate box. Remember only the systolic value is considered for the SEWS Score.
- Heart rate — Write numerical value in appropriate box
- Neuro Response — Record patient's best response. If the patient is asleep or demonstrates new confusion, award the same score as verbal response.
- Urine Output — Check that patient has voided urine recently. If yes write PU in box provided. If no write NPU in box provided.
- Urine Output — Check if the patient has passed the equivalent of or more than 30mls/hour for the last three consecutive hours. If yes score 0 in box provided. If no score 3 in box provided and add to total SEWS score.
- SEWS Score — Add up scores for all 7 parameters and write in box provided. If the patient merits an aggregate score of 0 please write 0 in the SEWS score box. Action as per guidelines below.

SEWS KEY

0	.1	2	3

SEWS 0-1: Routine observations
SEWS 2-3: Hourly observations and inform nurse in charge
SEWS 4+: Contact PRHO immediately. SHO or more senior doctor must be informed by Junior Doctor. Please record action taken in Nursing Notes

FURTHER SEWS SCORE SHOULD BE CHECKED

- In the event of a sudden worrying ***Change***
- If there is a worsening ***Trend***
- If concerned the patient looks ***Unwell***

The frequency of SEWS scoring is determined by the previous SEWS Score. If the patient continually scores 0-1, the nurse caring for the patient should determine frequency of observations.

A full set of observations and SEWS score should still be carried out.

If SEWS continually 0-1 frequency of observations:

Date	3/10											
Frequency	6D											

For extra information such as wound, CSM etc. use slanted columns at bottom of page.

MACKENZIE, BRIAN ID: [redacted]00375441 3-Oct-2009 8:18:53 SOUTHERN GENERAL HOSPITAL

31-Aug-1958
Male Caucasian

Loc: 0

[redacted]

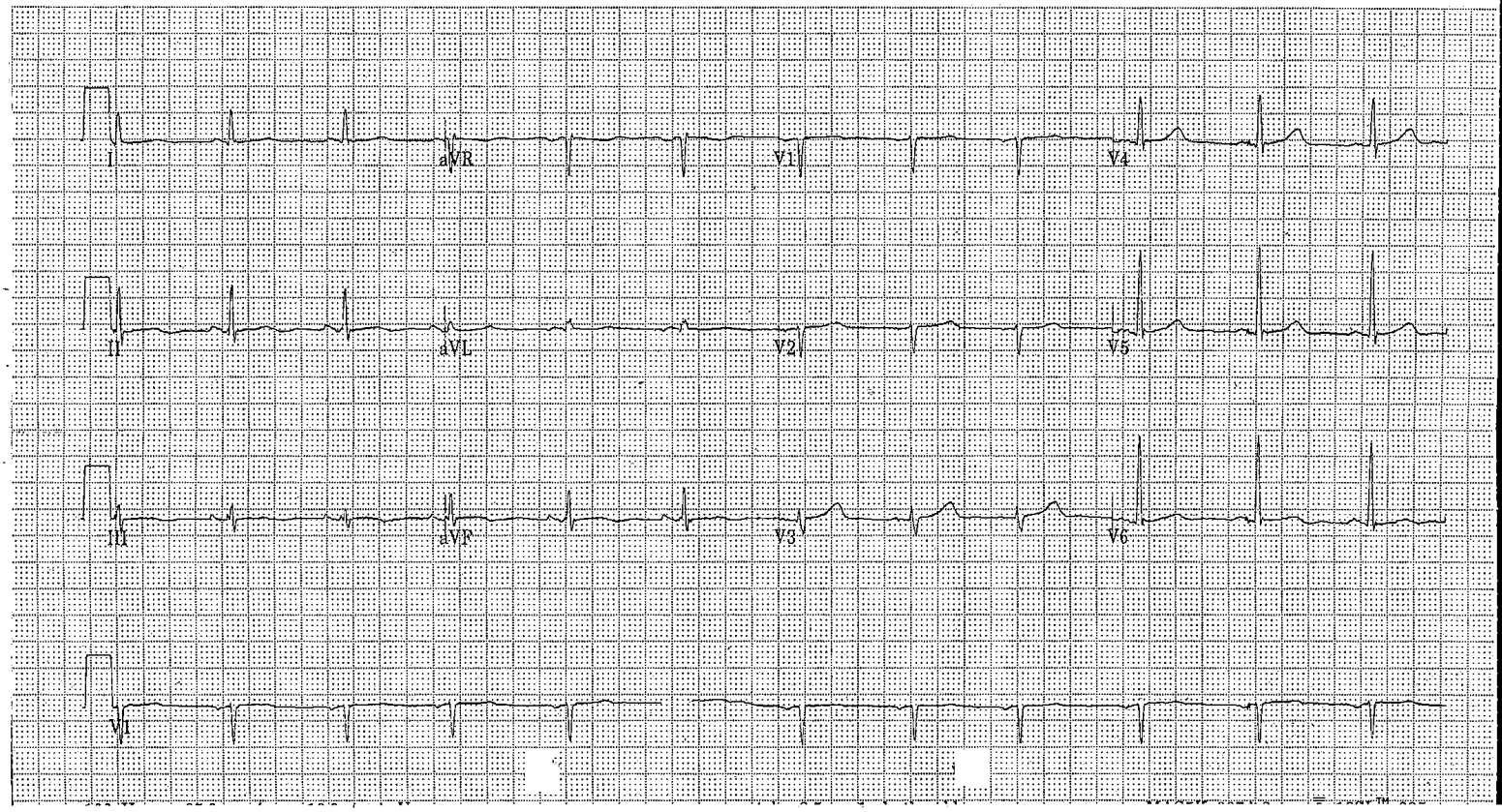
Technician:
Test ind:

Vent. rate	70 bpm
PR interval	130 ms
QRS duration	74 ms
QT/QTc	406/438 ms
P-R-T axes	60 37 14

Normal sinus rhythm
Normal ECG

Referred by:

Unconfirmed



atient's Name: _____

.o.B.: _____

nit number: _____

'ard: _____

Use addressograph label

South Glasgow Hospitals

24 Hour Fluid Balance Chart

NHS Greater Glasgow and Clyde

Instructions

Date: **Previous 24 hour fluid balance -** Intake: Output:

	Intake					Output		
Time	IV infusions	Volume	Enteral / Oral	Volume	Running Total	Urine	Drains (D), Vomit (V), Aspirate (A) etc	Running Tot
01								
02								
03								
04								
05								
06								
07								
08								
09								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
	Individual Totals:							
				Total Intake:			**Total Output:**	

Final Fluid Balance +/-

Patient's Name: BRIAN MACKENZIE

D.o.B.: 31.8.58

Unit number: SG 00375441

Ward: 2

Use addressograph label

South Glasgow Hospitals

24 Hour Fluid Balance Chart

NHS Greater Glasgow and Clyde

Instructions

Date: 3.10.09 | **Previous 24 hour fluid balance -** Intake: | Output:

	Intake					Output		
Time	IV Infusions	Volume	Enteral / Oral	Volume	Running Total	Urine	Drains (D), Vomit (V) Aspirate (A) etc	Running To
01								
02								
03								
06								
07								
08								
09								
10								
11								
12								
13								
16								
17	HARTMANNS	1000			1000			
18								
19								
20								
21								
22							J	
23								
24								
	Individual Totals:							
				Total Intake:			Total Output:	
Final Fluid Balance	+/-							

SOUTHERN GENERAL HOSPITAL — **I.V. THERAPY PRESCRIPTION SHEET**

NAME: B. MACKENZIE WARD: 2 UNIT No.: SG0037544 D.O.B.: 31/08/58

DATE	TIME		FLUID/BLOOD	ADDITIVE	VOLUME OR DOSE	TIMING	DOCTORS SIGNATURE ORDERED BY	DOCTORS SIGNATURE CANCELLED BY	BATCH No	NURSES SIGNATURE DATE	NURSES SIGNATURE TIME	NURSES SIGNATURE GIVEN BY	NURSES SIGNATURE CHECKED BY
	3/9	A	HARTMANNS		500	4°	[illegible]						
		B	STOP FLUIDS WHEN		E+D.								
		C											
		D											
		E											
		F											
		G											
		H											
		I											
		J											
		K											
		L											
		M											
		N											
		O											
		P											
		Q											
		R											

DATE	ADVERSE REACTION	STOP FLUID/BLOOD/ADDITIVE	RECORD BATCH No. BELOW

0368104-SGH 27C

Patient Agreement to Investigation or Treatment

NHS Greater Glasgow and Clyde

CONSENT FORM

PATIENT DETAILS (OR PRE-PRINTED LABEL)

Hospital/Clinic/GP Practice .... SG00375441 .....

Patient's surname/family name BRIAN MACKENZIE .....

Patient's first name(s): ..... 12 ORCHARD STREET .....

RENFREW 31/08/1958

PA4 8RL CHI 3108583158

Date of Birth____/____/_____ Gender: Male ☐ Female ☐

NHS/ CHI Number _____

ecial requirements (e.g. other language/communication method) .....

.....

Responsible practitioner: Martin

Job title: Cons

STATEMENT FOR PRACTITIONER

(to be filled in by practitioner with appropriate knowledge of proposed procedure, see guidance notes)

Describe proposed operation, investigation or other treatment.
Where appropriate specify site or side: (WRITTEN IN FULL)

Exploration + washout of Right thumb
+/- tendon repair
+/- Kwire stabilization

I have explained the procedure named on this form to the patient in terms which, in my judgement, are suited to their understanding. In particular, I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure (please specify major procedures above).

An information leaflet/tape has been provided.

☐ ..... (title)

Signature of practitioner: .....

Name/Designation (Print) FRANE .....

Date 3../10../9.....

STATEMENT TO BE COMPLETED BY PATIENT/PARENT*

(* parental responsibility for a minor without capacity)

You should read this form and the notes below carefully. If there is anything you do not understand ask the Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

I understand

- the procedure, important risks and appropriate alternatives which have been explained to me by the practitioner named on this form.
- that a practitioner other than the practitioner who has been providing treatment so far might carry out the procedure.
- that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to the medical treatment proposed, to safeguard or promote physical or mental health.

I have been told about additional procedures which may become necessary during treatment. I have ;ted below **any procedures which I do NOT wish to be carried out without further discussion**

I agree -

- to the administration of an anaesthetic or to sedation if required.
- to the procedure named on this form
- that the examination for the purposes of teaching will not be undertaken without my consent
- to the emergency administration of blood or blood products

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

Signature ..... Date ...../...../.....

Additionally you have to agree or disagree the following:-	**Agree**	**Disagree**
hat information and/or images kept in records may be used anonymously or education, audit, and research with appropriate ethical approval, to improve the quality of patient care.	☐	☐
that surplus tissue not essential for my diagnosis or future treatment may be used for medical education and ethically approved medical research.	☐	☐

PATIENT AGREEMENT FOR TREATMENT

Signature: ..... Date ...../...../.....

Name (Print): .....

CONFIRMATION OF CONSENT

(to be completed when patient is admitted for procedure if form signed in advance)

I confirm that I have no further questions and wish the procedure to go ahead.

Signature: ..... Print name.....

Date ...../...../.....

GLASGOW HEALTH BOARD

P 103

SOUTHERN GENERAL HOSPITAL
1345 GOVAN ROAD
GLASGOW G51 4TF
Telephone: 041-445 2466

QUEEN
BRIAN McKENZIE Age 30 Unit No. 375441
11 ARD RD
MR McBAIN was discharged from Ward 14 on 14/7/89
of HAEMORRHOIDECTOMY

e letter will follow. The patient was discharged on the drug treatment detailed below.
ration of treatment from date of discharge is shown in "Continuation of Treatment" column.
s supply has/has not been dispensed by the hospital.

e hospital prescriber: (a) In the "Continuation of Treatment" column it is important to state the number of days for which treatment should be continued from the date of discharge.
(b) If treatment is to be for an indefinite period, mark 'INDEFINITE'.
(c) If treatment is to be intermittent or irregular, give FULL DETAILS in the COMMENTS space below.
(d) Mark X in box if child resistant containers are not suitable.
(e) Delete N.P. if name of medicine is not required on label.

NP.

ospital Pharmacist, please supply the following

e	Form of Preparation e.g. tablets	Dose	Times of Administration					Continuation of Treatment from Date of Discharge (Days)	Quantity, Name & Strength Supplied by Pharmacy
			10am	10pm					
LOSE	LIQ	20ml	✓					7	280ml
XAMOL	TABS	2 TABS	4-6 hrly					5	20

itivity

Pharmacist

Date Dispensed 13.7.89

T and COMMENTS (including details of appliances, etc.)

uneventful post op recovery

BE COMPLETED FULLY
LL BE DISPENSED

MEDICAL OFFICER

Hospital use Only	Clinic	Day Date 17 FEB 1986	Time	Hospital No. S.P.H. 375441 N/T	GP112

REQUEST FOR OUT-PATIENT CONSULTATION

Hospital Southern General Date 17.2.86

Urgent Appointment Required YES/NO

Please arrange for this patient to attend the UROLOGICAL clinic of Dr/Mr E. GLEN

PARTICULARS OF PATIENT IN BLOCK LETTERS PLEASE

Patient's Surname MACKENZIE
First Names BRIAN
Address 11 ARD ROAD
RENFREW
Postal Code ..... Telephone Number 886493

Maiden Surname .....
Single/Married/~~Widowed/Other~~
Date of Birth 31.8.58
Patient's Occupation Gardener

Has the patient attended hospital before YES/NO if "YES" please state:
Name of Hospital .....
Year of Attendance ..... Hospital No .....
If the patient's name and/or address has/have changed since then please give details:

Name, Address and Telephone Number of MEDICAL/DENTAL PRACTITIONER

DR. J.A. BLACKWOOD
HEALTH CENTRE
103 PAISLEY ROAD
RENFREW PA4 8LH
TEL. No. 041-886 2455

Please use rubber stamp

I would be grateful for your opinion and advice on the above named patient. A brief outline of history, symptoms and signs is given below:

Thank you for seeing the abv. Patient. who presented today with a request for Vasectomy

He has two children aged 9 + 4 years
His wife was delivered by L.U.S.C.S and has also had one miscarriage

The marriage appears to be stable

The applicant has had an alcohol problem, in the past, but it is presently under control.

Diagnosis/provisional diagnosis: .....

Present drug treatment and potential special hazards: .....

X-ray 10 day rule (women of childbearing age). Date of first day of L.M.P. .....

Relevant X-rays available from: ..... No. (if known) .....

Signature J.A. Blackwood

Bd 8691272 26M Pads 11/82 Barr Printers

Hospital use Only	Clinic	Day Date 30 JAN	Time	Hospital No. 375441	GP112

REQUEST FOR OUT-PATIENT CONSULTATION

Hospital ..... Date 25/1/89

Urgent Appointment Required YES/NO

Please arrange for this patient to attend the Surgical clinic of Dr/Mr .....

PARTICULARS OF PATIENT IN BLOCK LETTERS PLEASE

Patient's Surname ..... Maiden Surname .....

First Names .....

Address .....

Single/Married/Widowed/Other .....

Date of Birth .....

Patient's Occupation .....

Postal Code ..... Telephone Number .....

Has the patient attended hospital before YES/NO if "YES" please state:

Name of Hospital .....

Year of Attendance ..... Hospital No .....

If the patient's name and/or address has/have changed since then please give details:

.....

.....

.....

.....

.....

Name, Address and Telephone Number of MEDICAL/DENTAL PRACTITIONER

DR O J McQUOONEY
RENFREW HEALTH CENTRE
103 PAISLEY ROAD
RENFREW PA4 8LH
TEL. 041-886 2455

Please use rubber stamp

I would be grateful for your opinion and advice on the above named patient. A brief outline of history, symptoms and signs is given below:

Several years history of PUBs
now collapsing abdom and vomiting
at work currently not bleeding.
He has requested referral
I would be obliged if you would see
for us

Diagnosis/provisional diagnosis: Duodenal PUBs

Present drug treatment and potential special hazards: .....

X-ray 10 day rule (women of childbearing age). Date of first day of L.M.P. .....

Relevant X-rays available from: ..... No. (if known) .....

Signature .....

Dd8102300 5M pads 10/87 R.P.(53791)

(L) 375441 CE PS

Hospital Use	Clinic	Day Date	Time	Hospital No.	Appt. Cat.	Routine Soon Urgent
					1 7	

Routine New Opt

REFERRAL

Drs. B. Shapiro, A. Ramage, S. Davidson & J. Anderson
Renfrew Health Centre
103 Paisley Road
RENFREW. PA4 8LH
Tel. 0141~886~2455 Fax. 0141~885~0457
PRACTICE CODE ~ 87700

HOSPITAL ~ S.G.H.
CONSULTANT ~ AICHMAR
CLINIC ~ UROLOGY
DATE ~ 15.05.03

NAME	D.O.B.	CHI.No.	Unit No.	Tel. No.
MACKENZIE, Brian **32 Lobnitz Avenue** **Renfrew. PA4 OTG**	**31.08.58**	**3158**	**375417**	**561 1087**

Thank you for seeing this 44 year old man who presented in March of this year with a swelling in the left scrotum. There is no history of pain. He has a past history of a vasectomy.

On examination there appeared to be a swelling at the lower pole of the left testis, which I thought was probably an epydidymal cyst. An ultrasound was arranged and this was performed on 16 April 2003 at the Southern General, number 443724. This was reported as follows:-

Small cysts are demonstrated in both testes in relation to the mediastinum. There are also cysts related to the epididymi and a left sided varicocele. No solid lesion is demonstrated in either testis.

The palpable swelling is unchanged. I am uncertain whether this requires any further treatment and would be grateful for your opinion.

Thank you for seeing him.

Yours faithfully

Dr B Shapiro

19 MAY 2003

2015 893

DOCTOR'S LETTER SHEET

UNIT NUMBER

ESG/AG/375441

(dict) 15 April 1986
(typed) 16 April 1986

Dr Blackwood
Renfrew Health Centre
103 Paisley Road
RENFREW
PA4 8LH

Dr Blackwood

Brian McKenzie dob 31 8 58
11 Ard Road Renfrew PA4 9DD

Vasectomy clinic letter. Did not attend with wife.

P.S. His wife could not attend with him. Once he has returned the vasectomy consent form to be signed by his wife, I shall put his name on the waiting list for day case vasectomy.

DOCTOR'S LETTER SHEET

UNIT NUMBER

ESG/jw/375441

(dict.) 30th June 1986
(typed) 30th June 1986

Dr. J. Blackwood,
The Health Centre,
103 Paisley Road,
Renfrew, PA4.

Dear Dr. Blackwood,

Brian McKenzie - dob 31.8.58.,
11 Ard Road, Renfrew, PA4.

Vasectomy was performed on a day patient basis on 25th June 1986. He understands that he must continue precautions during intercourse until two consecutive specimens of seminal fluid are reported clear of sperm. I shall only see him again if anything untoward occurs. He will be given instructions by post as to the timing for subsequent specimens.

Yours sincerely,

E.S. Glen, F.R.C.S.,
Consultant Urological Surgeon.

DOCTOR'S LETTER SHEET

UNIT NUMBER

ESG/jw/375441

(dict.) 12th August 1986
(typed) 12th August 1986

Mr. Brian McKenzie,
11 Ard Road,
Renfrew, PA4.

Dear Mr. McKenzie,

Post- Vasectomy

The specimen you submitted on 7th August 1986 showed no sperm. As this is the first specimen clear of sperm, further precautions are required.

Please submit another specimen at your earliest convenience. Specimens should be handed to a member of staff at Pathology, Southern General Hospital between 9.00 am and 4.00 pm on Monday to Friday, except public holidays. Please ensure name, unit number, nature of specimen (seminal fluid) and date of collection are entered on each label. If there is a space for ward number, write OP (this indicates that you are an out-patient).

The Pathology Laboratory is near the Govan Road end of the hospital, adjacent to the Red Cross Building. Please collect a new container each time.

Yours sincerely,

E.S. Glen, F.R.C.S.,
CONSULTANT UROLOGICAL SURGEON.

ESG/jw/375441

(dict.) 25th August 1986
(typed) 28th August 1986

Mr. Brian McKenzie,
11 Ard Road,
Renfrew, PA4.

Dear Mr. McKenzie,

Post- Vasectomy

The specimen you submitted on 20th August 1986 showed no sperm. As this is the second consecutive specimen clear of sperm, no further precautions are required.

However, the tubes occasionally re-join even after several years, in which case a further operation will be required. If your wife ever thinks she might be pregnant tests for pregnancy should be performed.

Yours sincerely,

E.S. Glen, F.R.C.S.,
Consultant Urological Surgeon.

DOCTOR'S LETTER SHEET

UNIT NUMBER

RMcI/JW/375441

13th February 1989

Dr Q J McQuoney
Renfrew Health Centre
103 Paisley Road
RENFREW
PA4 8LH

Dear Dr McQuoney

Brian McKenzie - dob 31.8.68
11 Ard Road
Renfrew PA4 9DD

Thank you for referring this patient to the clinic where he was seen today.
I have added his name to the waiting list for haemorrhoidectomy to be performed.
We will send for him in due course.

Yours sincerely

R McIntyre FRCS
SURGICAL REGISTRAR

DOCTOR'S LETTER SHEET

UNIT NUMBER

GCMacB/JC
Unit No. 375441

15th August, 1989

Dr. McQuoney,
Health Centre,
103 Paisley Road,
RENFREW

Dear Dr. McQuoney,

Brian McKenzie, 11 Ard Road, Renfrew
(dob: 31 8 58)

This patient is well after haemorrhoidectomy and has been discharged from the clinic.

Yours sincerely,

G. C. MacBain, FRCS
Consultant Surgeon

SOUTH GLASGOW UNIVERSITY HOSPITALS NHS TRUST
SOUTHERN GENERAL HOSPITAL

3Y

DOCTOR'S LETTER SHEET

UNIT NUMBER

DEPARTMENT OF UROLOGY

Direct line: 0141-201-1511
Fax: 0141-201-2987

MNA/CA/375441

(Dict) 29 July 2003
(Typed) 01 August 2003

Mr. Brian Mackenzie
32 Lobmitz Avenue
Renfrew
PA4 0TG

Dear Mr. Mackenzie

This is to inform you that you have not attended my Urology Out-patient Clinic (New) on the 29 July 2003. I have not arranged for any further appointment but if you wish to see us please contact your general practitioner.

Thank you.

Yours sincerely

M N Akhtar FRCS (Urol)
Consultant Urological Surgeon

C.C. Dr. McQuoney
Renfrew Health Centre
103 Paisley Road
Renfrew
PA4 8LH

S.G.H./3Y

DATE | CLINICAL NOTES (Continued)

PMH - Vasectomy 1982
°TB °RF °DM °HBP ° asthma

DH - nil:
no known allergies

SH - married
lives with wife + 2 children
self- employed gardener.
smoker 20/d - smokes Cannabis regularly
alcohol ~ 30 units /wk.

S/E
CVS - nil
Resp - nil
GIT - nil
GUS - nil
CNS - nil.

O/E - Well
no J no pallor no CNS no oedema

CVS: P 74 reg JVP ↓ BP 120/70
HS I+II+0 no murmurs

Resp: tenderness
chest clear

Abdo: soft non-tender ?Hepatosplenomegaly BS ✓
PR - NAD.
CNS: not formally tested.

BRIAN McKENZIE

375491.

CLINICAL NOTES

DATE	
09 FEB 1989	O. P. D. SURGICAL — 30yrs
	'Piles' – 2yrs
	– Prolapsing
	— only bleeds when takes alcohol.
	— no soiling.
	FH – healthy. No medical. No allergy.
	Vasectomy – 1988.
	O/E – Abdo — NAD
	PR — NAD
	Root — 2° piles — 11 o'clock
	WL. Haemorrhoidectomy.
7/7/89.	30yr.
	A/A. for haemorrhoidectomy.
	piles for ~ 2yrs –
	prolapse after every bowel motion
	manually reducible.
	only bleeds after alcohol.
	no mucus.
	bowel motions regular – not constipated.
	cause some discomfort.

GLASGOW SOUTH WESTERN DISTRICT
HOSPITALS

7

BRIAN MCKENZIE.
375441.

CLINICAL NOTES

DATE	
	Imp. 30 yr dd man for haemorrhoidectomy.
	- heavy alcohol consumption.
	FBC ✓ U&Es ✓ gluc ✓
	consent.
	Alh Jamp (SHO)
11/7/89	well post-op haemorrhoidectomy
	Alh Jamp (SHO)
13/7/89.	Bowels still not moving, otherwise well
	Alh Jamp (SHO)
14/7/89.	Bowels moved today - allow home.
	Alh Jamp (SHO)
	Discharge Summary
	A/A 7/7/89 for haemorrhoidectomy
	operation 10/7/89
	Uneventful post-op recovery - bowels sluggish
	discharged 14/7/89
	Alh Jamp (SHO)

[redacted]

3G00375441
MACKENZIE, BRIAN
22 LOMOND AVENUE

RENFREW 31/08/1958
PA4 0PG CHI 3108583158

aedics Clinic Outcome Form South Glasgow

Date 13/12
Consultant AS
Site

NHS

New Patient ☐
Return Patient ☐

Section 1 Please ensure that ONE 12 week outcome (boxes 1 – 9 below) is ticked for every NEW and RETURN patient that attends the clinic

	OP ASSESSMENT (15wk PTT Clock stops)		ADD TO WAITING LIST		
1	Treatment Started (Treatment started or recommended, e.g. prescription issued or to be issued by GP)		6	For investigation as	IP ____ DC ____ OP ____
	Discharge			Discharge	
2	No treatment required (Clinical judgement that determines that no treatment is required at this time)		7	For treatment as	IP ____ DC ____ OP ____
	Discharge				
3	Patient declines treatment		8	Patient considering treatment options (Requires resolution within 11 weeks e.g. return OP appointment add to WL, discharge PTT clock will cause)	
	Discharge				
4	Observe and Review (Where clinically appropriate to review and monitor the patient rather than undergo tests, treatment or other interventions at this time)		9	Onward referral for same condition to (Patient referred to another member of staff for an opinion +/- treatment)	Consultant Nurse AHP Other
5	Supply and or fit of medical device (e.g. orthotics this would be regarded as definitive treatment)		10	DNA - Discharge	
	Discharge			DNA – Further Appointment	

Section 2

Admitted from clinic Yes ☐ No ☐
Discharged from clinic Yes ☐ No ☐
Ambulance required for next visit Yes ☐ No ☐

[redacted] tick if further appointment required ☐ If yes please state when _____ weeks / months / years

If patient added to WL Proposed procedure _____

Anticipated points for surgery _____ (0.25 points = 15mins 0.5 = 30mins 0.75 = 45mins 1 = 1 hour

Is patient suitable for 23hr bed ☐ Daycase ☐ Inpatient ☐ Golden Jubilee ☐

List patient for Pooled List ☐ Other Surgeon ☐ Individual Consultant ☐

Section 3

Please complete the following section if an outpatient procedure was performed

		TICK			TICK
A735	Carpal tunnel injection		T59.1	Excision of ganglion wrist	
S54.1	Excision of nail bed		T59.2	hand	
S54.2	Chemical destruction of nail bed		T59.3	knee	
S54.5	Destruction of nail bed		T59.4	foot	
S54.6	Unspecified extirpation of nail bed		T59.9	unspecified	
S54.7	Partial excision of nail bed		T62.4	Aspiration of bursa	
S54.8	Excision of nail bed		T62.5	Injection of bursa	
S54.9	Partial excision of nail		T72.5	Trigger injection	
S54.A	Unspecified excision of nail		T74.4	Operation on tendon, including tennis elbow, injection of	
S60.1	Nail avulsed		W28.2	Manipulation of a fracture	
S62.2	Fracture of nail		W90.1	Joint aspiration	
S62.3	Fracture of phalanx of finger or thumb		W90.3	Joint injection of therapeutic substance	
S62.4	Other fracture of finger or thumb		Other (please state)		
S62.5	Fracture of thumb				
S62.6	Fracture of other finger				
S62.7	Multiple fractures of fingers				
S62.8	Fracture of other parts of wrist and hand				
S62.9	Unspecified fracture of wrist and hand				

GLASGOW SOUTH WESTERN DISTRICT

ALS

7U

MALE

375441

MCKENZIE
BRIAN
11. ARD ROAD.
RENFREW PA4 9DD
31.8.08

J McKENZIE.

375441

UROLOGY DEPARTMENT

Date	15/4/86 **MALE**
COMPLAINT	Request vasectomy Duration
HISTORY	2 children 9 yrs & 4 yrs. Good general health. On Vit B comp. Wife not here. On Pill. See referral letter Appetite Weight Bowels
PREVIOUS HISTORY	Ø on foot in Fears. No allergies. Nil.
Examination by ESJ	Tongue Build lean Pulse Abdomen B.P. Genitalia Suitable for GA/LA Prostate
URINE	Reaction acid/alkaline R.B.C. Crystals Casts Albumen present/absent W.B.C. Organisms
X-Ray Findings (Summary)	
Cystoscopic Findings (Summary)	ANAESTHETIC RECORD
Diagnosis	Disposal

SOUTHERN GENERAL HOSPITAL GLASGOW

Mr Glen.
Urology Dept
Southern
General
Hospital
Glasgow
G51 4TF

375441

NAME (BLOCK LETTERS) MCKENZIE
FIRST NAMES BRIAN
ADDRESS 11. ARD ROAD.
RENFREW PA4 9DD
31.8.08

No.
AGE

MALE STERILISATION
(Operation Consent)

Having asked to be sterilized by operation and having been advised that there may be medical reasons which allow the operation to be done within the National Health Service I hereby give authority for this operation to be done on myself.

The nature of the operation (bilateral vas deferens resection and ligation) has been explained to me to my satisfaction.

I understand that it may be quite impossible ever to make me fertile again.

I understand that a period of some months must elapse after the operation before I am sterile and that during that time at least one specimen of my semen must be examined in the Southern General Hospital Laboratory and that further specimens may have to be examined before it can be confirmed that I am sterile.

My wife agrees.

I shall as well sign the routine hospital operation consent form.

SIGNATURE B Mackenzie
WITNESS
DATE 15 APRIL 86

WIFE'S SIGNATURE M Mackenzie
WITNESS
DATE 15 April 86.

SGH/113

SOUTHERN GENERAL
AND ASSOCIATED HOSPITALS

Brian McKenzie 3754441

CLINICAL NOTES

DATE	
25/6/91	A/A Lasectomy.
H/P/C	Wants no more children.
PMH:	°Ser. illnesses.
	Op- to remove glass from ® foot.
	Tonsillectomy.
	°Anaesth - prob.
PAL	°Allg. known. None.
S/H:	IS cpd. Smokes Cannabis.
Syst Enq:	
CVS:	NAD.
Resp:	Cough + phlegm (white) for last 2-3/7.
	NAD else. - Cold last week; now recovered.
O/E	Looks well.
	°JACCD.
CVS:	115/80 Pulse 72/min, reg, gd. vol.
	H S I + II = ®.
	°Murm - /Rub/Sec. ord.
Resp:	Chest clear.
Impr:	Fit for GA.
	Consent ✓
	J Smith

7

CLINICAL NOTES (Continued)

DATE

J FEB 1989 O. P. D. SURGICAL Haemorrhoids cr 3, 7 11.

11 AUG 1989 O.P.D. SURGICAL

Doing well Bowel ok

PR. normal

SOUTHERN GENERAL
AND ASSOCIATED HOSPITALS

ANAESTHESIA RECORD 7X

Date 25 | 6 | 82.

Name Brian McKenzie

Premedication

Nil (oral).

Time

Given by

Address

Unit Number 375441

Age

Ward Urol

Pre-operative Notes

4

Chest [illegible] gm

— [illegible]

no problem

Hb PCV

Blood Group

Units Crossmatched

Na K Cl

Urea

B.P.

Weight

Urine Analysis

ASA 1 2 3 4 5 E

Operation

Vasectomy

Surgeons

Mr Glen

Anaesthetists

[illegible]

Intra-operative Notes

Note: Bradycardia + P waves vanish for a time

Post-operative Instructions and Notes

C O

G.A.	Regional
☑	☐

AIRWAY

- ☐ Orotracheal
- ☐ Nasotracheal
- ☐ Cuff ☐ Pack
- Tube Size
- ☑ Not intubated
- ☑ Mask
- ☑ Phar. airway

VENTILATION

- ☑ Spontaneous V_t
- ☐ IPPV f
- Circuit Bain
- Ventilator

I V SITES

Hand	L R
Wrist	L R
Forearm	L R
Antecub. fossa	L R
Other	L R

POSITION

- ☑ Supine
- ☐ Lateral L/R
- ☐ Prone
- ☐ Lithotomy
- ☐ Other

Drugs & I V Fluids	Time 3 (10)	TOTAL
Fentanyl	1605	0·05
Thioph	1605	300
N2O O2		
Halothane		

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0

MONITORING

- X B.P.
- ● Pulse
- \ C.V.P.
- ☑ ECG
- ☐ Temperature
- ☐ Other

Blood loss

SOUTHERN GENERAL
AND ASSOCIATED HOSPITALS

OPERATION REPORT 8

Brian McKenzie 3754441

SURGEONS: Mr Scott

DATE: 25 June 8[illegible]

OPERATION PERFORMED

Vasectomy

FINDINGS & PROCEDURE

Routine, Surgis steps
Catgut employed

TISSUE SENT FOR PATHOLOGICAL EXAMINATION /

Signature [signature]

SOUTHERN GENERAL
AND ASSOCIATED HOSPITALS

ANAESTHESIA RECORD 7X

Date 10/7/84

Name BRIAN MCKENZIE

Address 11 ARD RD
RENFREW

Premedication
OMNOPON 20mg
SCOPOLAMINE 0.4mg

Time 11.30am

Given by

Unit Number 375441

Age 30

Ward 14

Pre-operative Notes

Hb 14.0 PCV 0.41

Blood Group

Units Crossmatched

Na 140 K 4.1 Cl 106

Urea 5.6

B.P. 120/90

Weight 65.8kg

Urine Analysis
SG - 1.010
pH - 6.5
NAD

ASA 1 2 3 4 5 E

Operation
Haemorrhoidectomy

Surgeons
MR. MACBAIN

Anaesthetists
DR. J. McIntyre
Lanley

Intra-operative Notes

Post-operative Instructions and Notes

4h. mix + oxygen till fully awake.

☑ G.A. ☐ Regional

AIRWAY
☐ Orotracheal ☑ Not intubated
☐ Nasotracheal ☑ Mask
☐ Cuff ☐ Pack ☑ Phar. airway
Tube Size

VENTILATION
☑ Spontaneous V_t
☐ I P P V f
Circuit
Ventilator Bain

I V SITES
Hand L R
Wrist L R
Forearm L R
Antecub. fossa L R
Other L R

POSITION
☐ Supine
☐ Lateral L/R
☐ Prone
☑ Lithotomy
☐ Other

Drugs & I V Fluids	Time 30 45 1300 15	TOT.
Thiop.	350+150mg	
N2O:O2/ 6:4 l		
Enflurane		

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0

MONITORING
(B.P.) ☑ ECG
(Pulse) ☐ Temperature
C.V.P. ☑ Other Sats

Blood loss

SGH 322

SOUTHERN GENERAL HOSPITAL

RECOVERY SCORE SHEET

DATE: 10-7-89

UNIT No.: 375441

NAME: McKENZIE
BRIAN
11 ARD RD
RENFREW
PA4 9DD

AGE: 31/8/58

OPERATION:

ANAESTHETIC:

IPPV + RELAXANT	
SPONTANEOUS RESP. (HAL, ENF, ISO)	
TOTAL INTRAVENOUS	
REGIONAL + (NO SEDATION/SEDATION)	

ASA GRADE

DURATION HRS. MINS.

PRE-OP. B.P. 145/120

TIME HRS. / MINS.	0	5	10	15	20	25	30	35	40	45	50	55	60
RESPIRATORY FUNCTION													
Able to breathe and cough = 2													
Maintains own airway = 1	0	0	2	2									
Airway needs support = 0													
COLOUR													
Pink and Warm = 2													
Pale, Dusky, Peripheral cyanosis = 1	2	2	2	2									
Central cyanosis, cold = 0													
RECOVERY OF NEURO-MUSCULAR FUNCTION													
5 Secs. Head Lift = 2													
Moves limbs = 1	0	0	1	2									
No move (except resp.) = 0													
CONSCIOUS LEVEL													
Responds to command = 2													
Responds = 1	0	0	1	2									
No response = 0													
BLOOD PRESSURE													
Within 30mmHg of pre-op = 2	2												
30-39 from pre-op = 1	49												
< 70mmHg = 0	65												
	4												

COMPLICATIONS:

	Recovery	Ward
AIRWAY		
PAIN		

	Recovery	Ward
SHIVERING		
RESTLESS		

	Recovery	Ward
NAUSEA		
VOMITING		

COMMENT: .....

.....

.....

.....

1st ANALGESIA GIVEN: TIME:

DRUG: .....

ANAESTHETIST: .....

NURSE'S SIGNATURE: .....

SGH167

F PATHOLOGY — SOUTHERN GENERAL HOSPITAL

BRIAN MCKENZIE — UNIT No. 375441

VARD — PHYSICIAN/SURGEON MR. GLEN

CIMEN SEMINAL FLUID

EPORT

atozoa identified.

MENOLOGY

SPECIMEN RECEIVED 7.8.86

REPORT ISSUED 8.8.86

MD

LAB. REF. No. M.2202/86

[redacted]

GLASGOW SOUTH WESTERN DISTRICT HOSPITALS

PATHOLOGY

17

PATHOLOGY REPORTS

SGH167

DEPARTMENT OF PATHOLOGY — SOUTHERN GENERAL HOSPITAL

PATIENT'S NAME BRIAN McKENZIE UNIT No. 375441

AGE 78 WARD – PHYSICIAN/SURGEON MR. GLEN

NATURE OF SPECIMEN SEMINAL FLUID

LABORATORY REPORT

No spermatozoa identified.

INVESTIGATION SEMENOLOGY

PATHOLOGY

SPECIMEN RECEIVED 20.8.86

REPORT ISSUED 21.8.86

MD

LAB. REF. No. M.2309/86

SOUTHERN GENERAL HOSPITAL, GLASGOW

SURNAME (Block Letters) McKenzie

FIRST NAMES Mr. / Mrs. / Miss Brian

Age..... Ward No. U01 Unit No. 375441

OPERATION CONSENT

I BRIAN MCKENZIE of 11 ARD AY

hereby consent to *undergo/~~the submission of my *child/ward~~ RENFREW DAY 900.

to undergo the operation of VASECTOMY,

the nature and purpose of which have been explained to me by

*Dr./~~Mr.~~ SCULLION

I also consent to such further or alternative operative measures as may be found necessary during the course of the above-mentioned operation and to the administration of general, local or other anaesthetics for any of these purposes.
No assurance has been given to me that the operation will be performed by any particular practitioner.

Date 25/6/86 *Signed* [signature]

*Patient/~~Parent/Guardian~~

I confirm that I have explained the nature and purpose of this operation to the *patient/~~parent/guardian~~.

Date 25/6/86 *Signed* [signature]

*Medical Dental Practitioner

**Delete as appropriate*

ANY DELETIONS, INSERTIONS OR AMENDMENTS TO THE FORM ARE TO BE MADE BEFORE THE EXPLANATION IS GIVEN AND THE FORM SUBMITTED FOR SIGNATURE

(SGH 111)

Stick Slips on in Order Received Commencing at the Bottom

SOUTHERN GEN... ASGOW

375441

SURNAME (Block Letters) McKENZIE

FIRST NAMES M BRIAN

Age..... Ward RENFREW

11 ARD RD

PA4 9DD

31/8/68

OPERATION CONSENT

I Brian Mr Kenzie of .....

hereby consent to *undergo/the submission of my ~~*child, ward~~ SELF .....

to undergo the operation of HAEMORRHOIDECTOMY .....

the nature and purpose of which have been explained to me by

*Dr./~~Mr.~~ A JAAP .....

I also consent to such further or alternative operative measures as may be found necessary during the course of the above-mentioned operation and to the administration of general, local or other anaesthetics for any of these purposes.

No assurance has been given to me that the operation will be performed by any particular practitioner.

Date 7/7/88 Signed B McKenzie .....

*Patient/~~Parent/Guardian~~

I confirm that I have explained the nature and purpose of this operation to the *patient/~~parent guardian~~.

Date 7/7/88 Signed A Jaap .....

*Medical ~~Dental~~ Practitioner

**Delete as appropriate*

ANY DELETIONS, INSERTIONS OR AMENDMENTS TO THE FORM ARE TO BE MADE BEFORE THE EXPLANATION IS GIVEN AND THE FORM SUBMITTED FOR SIGNATURE

(SGH 111)

SOUTHERN GENERAL HOSPITAL

SOUTHERN GENERAL HAEMATOLOGY DEPARTMENT

SURNAME	FORENAMES	SEX	D.O.B.	HOSP. No.
MCKENZIE	BRIAN	M	31.08.58	37544

DOCTOR	Ward	HOSPITAL OR G.P. ADDRESS
G.McBain.	14	Southern General

REPORT

DATE OF REPORT	MACHINE DIFF.	NEUT	LYMPH	OTHERS	AUTHORISED BY
7-Jul-89	X10⁹/L	3.5	2.4	1.0	Dr. W.P. Baxter

DATE OF SAMPLE	LAB No.	W.B.C. X10⁹/L	PLAT. X10⁹/L	R.B.C. X10¹²/L	Hb g/dL	P.C.V. L/L	M.C.V. fL	M.C.H. pg	RETIC X10⁹/L
7-Jul-89	32266	6.9	274	4.36	14.0	0.41	94	32.1	

REMOVE THIS STRIP & AFFIX REPORT — TOP EDGE TO LINE ABOVE 2

BIOCHEMISTRY DEPARTMENT

SOUTHERN GENERAL HOSPITAL
GLASGOW

A

Name MCKENZIE BRIAN Sex M D.O.B. 31.08.58 Hospital SGH Ward 14

Address 11 ARD RD Consultant MCBAIN Hospital Number 375441 Tray No./Cup No. 336

Received DATE: 07.07.89 TIME: 1753

Prov. Diagnosis PRE OP Accession Number 21622 E

Withdrawal		Sod. 135-145	Pot. 3.5-5.0	Chlor. 97-107	Tot.CO_2 23-30	Urea 2.5-7.5	Creat. 40-130 umol/l	pH 7.36-7.44	Pco_2 35-45	Po_2 80-100	B.E. O ±3 mmol/l	Glucose 3.3-5.6 mmol/l	Pl.Osm. 270-295	Urine Osmol.	Comment (see over)
Date	Time	mmol/l							mmHg				mmol/kg		
07.07.89	1030	140	4.1	106	24	5.6	106					4.2			1

SGH COMMENT

farlow A7724

SGH 140A

GREATER GLASGOW HEALTH BOARD SOUTHERN GENERAL & ASSOCIATED HOSPITALS

PRESCRIPTION SHEET No.

REGULAR PRESCRIPTIONS—PARENTERAL MEDICINES

Pharmacy Use		Date Started	MEDICINE (Block Capitals)	Metric Dose	Method of Administration	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	md 12	pm 2	pm 6	pm 10	mn 12	Other Times	Prescribers Signature (full)	DISCONTINUED Date	Initials
	A	10/7/89	OMNOPON	20mg	I.M.					3-4 hourly				as need	[signature]	11/7	AJ
	B	10/7/89	STEMETIL	12.5 mg	I.M.					6 hourly				for nausea	[signature]		
	C																
	D																
	E																

REGULAR PRESCRIPTIONS—OTHER MEDICINES

	F	7/7/89	TEMAZEPAM	10mg	ORAL							✓		[signature]		
	G		DOMPERIDONE	2 TABS												
	H	10/7/89	CODROXAMOL	2 TABS	ORAL	4-6 hourly prn pain								[signature]		
	I	7/7/89	LACTULOSE	90 ml	ORAL									[signature]		
	J															
	K															
	L															
	M															
	N															
	O															
	P															

ONCE ONLY PRESCRIPTIONS

DIET:

Date	Time of Admin.	Medicine (Block Capitals)	Metric Dose	Route	Signature	Given By	Time if Different
10/7	2300	CODROXAMOL	2 TABS	O	[signature]	[signature]	

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

DIABETIC		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

If medicine discontinued because of suspected adverse reaction, enter below.

MEDICINE	ADVERSE REACTION
1	
2	

KNOWN DRUG/MEDICINE SENSITIVITY

WARD	NAME OF PATIENT	AGE	UNIT NUMBER	CONSULTANT
	[illegible]			[illegible]

GREATER GLASGOW HEALTH BOARD — SOUTHERN GENERAL AND ASSOCIATED HOSPITALS

MEDICINE RECORDING SHEET

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

DATE	REGULAR PRESCRIPTIONS 6 a.m.	Initial	8 a.m.	Initial	10 a.m.	Initial	12 m.d.	Initial	2 p.m.	Initial	6 p.m.	Initial	10 p.m.	Initial	12 m.n.	Initial	OTHER TIMES Code	Time	Intls.	Code	Time	Intls.	COMMENTS ON DISCREPANCIES
7/7/89													F				6						
8/7/89													F										
9/7/89													F										
10/7/89					HL												AB 13·20						
11/7/89									1								H 17·45						
12/7/89					I				I				H1				H-1100						
25/1									H I														

NAME	UNIT NUMBER	WARD
BRIAN M·KENZIE	375441	14

KEY:- CODE LETTER CIRCLED = MEDICINE REFUSED
CODE LETTER SCORED = PATIENT ABSENT

E.G. (1) (A)
(2) A

Harlow A7725

SGH139/A

GREATER GLASGOW HEALTH BOARD — SOUTHERN GENERAL AND ASSOCIATED HOSPITALS

MEDICINE RECORDING SHEET

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

DATE	REGULAR PRESCRIPTIONS								OTHER TIMES						COMMENTS ON DISCREPANCIES
	6 a.m.	8 a.m.	10 a.m.	12 m.d.	2 p.m.	6 p.m.	10 p.m.	12 m.n.	Code	Time	Intls.	Code	Time	Intls.	
	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial							

NAME

UNIT NUMBER

WARD

KEY:- CODE LETTER CIRCLED = MEDICINE REFUSED
CODE LETTER SCORED = PATIENT ABSENT

E.G. (1) Ⓐ
(2) A

HAEMORRHOIDECTOMY (PART B)

SOUTHERN GENERAL AND ASSOCIATED HOSPITALS

NURSING CARE PLAN

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

DATE AND TIME	PROB NO	PROBLEM	NURSING ACTION	AIMS OF CARE	INTL	REVIEW DATE	DISC
10/7/89		ANAL WOUND DUE TO HAEMORRHOIDECTOMY AND INSERTION OF ~~T-TUBE~~	1. INSPECT WOUND (SAME TIMES AS VITAL SIGNS)	FOR WOUND TO HEAL INFECTION FREE			
			2. THEATRE DRESSING REMAINS INTACT FOR 24 HOURS ON : 88				
			A. IMMERSION BETADINE BATH				
			B ADMINISTER PRESCRIBED ANALGESIA (- PRIOR TO C)				
			C ~~BOWNE T-TUBE~~ (ON SURGEONS INSTRUCTIONS)				
			D. DRESS WITH SOFRATULLE DRESSING AND WOUND PAD SECURE WITH DISPOSABLE PANTS.				
			NB. REPEAT AD. WHEN THERE IS EXCESSIVE STAINING - OR PATIENTS BOWELS OPEN.				

PATIENTS NAME: BRIAN McKENZIE

UNIT NO.

WARD NO. C4

SGH 309

HAEMORRHOIDECTOMY
(PART A)

SOUTHERN GENERAL AND ASSOCIATED HOSPITALS

NURSING CARE PLAN

DATE AND TIME	PROB NO	PROBLEM	NURSING ACTION	AIMS OF CARE	INTL	REVIEW DATE	DISC
10/7/89		GENERAL ANAESTHETIC HAS BEEN ADMINISTERED.	1. SEMI-PRONE POSITION UNTIL PATIENT IS CONCIOUS.	FOR PATIENT TO BE FULLY RECOVERED FROM ANAESTHETIC.			
			2. OXYGEN THERAPY (AS PRESCRIBED) UNTIL :- HRS.				
			3. OBSERVATION OF :- TEMPERATURE, PULSE, BLOOD PRESSURE AND RESPIRATION RATE EVERY 30 MIN UNTIL CONDITION MERITS OTHERWISE.				
		PAIN.	ADMINISTER PRESCRIBED ANALGESIA AND NOTE EFFECT/SIDE EFFECTS.	FOR PATIENT TO BE AS PAINFREE AS CONDITION ALLOWS.			

PATIENTS NAME: BRIAN MCKENZIE UNIT NO. WARD NO. 14

SGH 309

SOUTHERN GENERAL AND ASSOCIATED HOSPITALS

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

NURSING CARE PLAN

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

DATE AND TIME	PROB NO	PROBLEM	NURSING ACTION	AIMS OF CARE	INTL	REVIEW DATE	DISC
		AT RISK OF POST-OP COMPLICATIONS.	1. INSPECT WOUND SITE (SAME TIMES AS VITAL SIGNS)	TO BE COMPLICATION FREE.			
			2. NURSE UPRIGHT AS SOON AS CONDITION MERITS				
			3. ENCOURAGE DEEP BREATHING AND EXPECTORATION (SPUTUM SPECIMEN FOR C&S)				
			4. ENCOURAGE PASSIVE LIMB EXERCISES - MOBILISE GENTLY FROM : :88 (24 HOURS POST-OP)				
			5. NOTE WHEN PATIENT PASSES URINE				

PATIENTS NAME: UNIT NO. WARD NO.

SGH 309

VICTORIA INFIRMARY/SOUTHERN GENERAL HOSPITAL UNIT
SOUTHERN GENERAL AND ASSOCIATED HOSPITALS

PATIENT'S PROFILE

DEPARTMENT: SURG WARD: 14 CONSULTANT: TANNER

NAME: BRIAN MCKENZIE	REFERRAL: A/A
PREFERS TO BE CALLED:	X-RAYS LETTERS NOTES
ADDRESS: 11 Ash Rd TP RENFREW	G.P.'s NAME: DR M. QUINNEY
	ADDRESS/TEL. NO: RENFREW H.C.
TEL NO:	
UNIT NO: 375441	REASON FOR ADMISSION: HAEMORRHOIDS
RELIGION/RELEVANT PRACTICES: C of S	
OCCUPATION:	
AGE: 30 DATE OF BIRTH: 31/8/58 SEX: M	MEDICATIONS ON ADMISSION:
MARITAL STATUS: MARRIED	
DATE OF ADMISSION: 7/7/89 TIME 10AM	
NEXT OF KIN: MARGARET	
RELATIONSHIP: WIFE	
ADDRESS: S/A	
	KNOWN ALLERGIES:
TEL NO: DAY 886 6044	~~Penicillin~~ None known.
TEL NO: NIGHT	
OTHER RELEVANT CONTACT:	ANY OTHER INFORMATION:
	Vasectomy.
	PROSTHESIS:

GENERAL ASSESSMENT ON ADMISSION (INCLUDING STATE OF SKIN AND MOUTH) Skin appears clean and intact, mouth clean and moist. Appears a pleasant well dressed man.

10/7/89 HAEMORRHOIDECTOMY
+ INJECTION OF HAEMORRHOIDS WITH PHENOL

BLOOD PRESSURE: 120/80 PULSE: 78 RESPIRATIONS: TEMPERATURE: 37.2 WEIGHT: 65.8kg HEIGHT:

URINALYSIS: 5-G LOCO PH 6.5 NAD

PATIENT'S PERCEPTION OF CURRENT HEALTH STATUS: unrelated to reason for admission

RELATIVES PERCEPTION OF PATIENT'S HEALTH STATUS: relatives know patient is in hospital.

SOCIAL/HOME BACKGROUND (INCLUDING PROBLEMS RELATED TO ADMISSION) Lives at home with wife and two children, drinks socially. Smokes approx 15 cigarettes a day. Also smokes CANNABIS

NURSES SIGNATURE: R.S. Pollock (STAFF) DATE OF ASSESSMENT:

NURSING ASSESSMENT (Assessment of Activities of Daily Living)

MAINTAINING A SAFE ENVIRONMENT, COMMUNICATING, BREATHING, EATING AND DRINKING, ELIMINATING, PERSONAL CLEANSING AND DRESSING, CONTROLLING BODY TEMPERATURE, MOBILISING, WORKING AND PLAYING, EXPRESSING SEXUALITY, SLEEPING, DYING.

No problems with activities of Daily Activities.

HISTORY OBTAINED FROM: Patient NURSES SIGNATURE: S/N B.J. Pollock

Valuables:	Home ☐	Cashier's Office	☐	Receipt No:	
Clothing:	Home ☐	Clothing Store	☐	Ward	☐

SOUTHERN GENERAL AND ASSOCIATED HOSPITALS

DEPARTMENT:

NAME: BRIAN M'KENZIE UNIT NO. WARD:

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
11/7/89	AM	Heel immersion Bath.	
(1)		Sofratulle and dry dressing applied, secured by paper.	
		tape. Slight Odour present.	
		There appears to be what	
		looks like a haemorroid still	
		Present.	
		Observations stable.	
		Mobilising round ward well	C Thorpe
	pm.	Had big bath this evening. Wound	
		redressed with sofratulle & wound pad.	
		Apyrexial. Bowels inactive.	N Robinson
12-7-89		Settled + slept well. Bowels	O Bassey
		inactive. Observations stable.	
(2)	am.	Immersion bath this morning.	
		Sofratulle & wound pad applied	
		to wound. T-37°C P70.	
	BNO	Bowels inactive.	N Robinson
		Coproxamol x2 tabs at 1600/	
		With effect. Independent	A Atlas
13-7-89		Coproxamol x 2 tabs @ 10p.	
		Slept Well. Bowels inactive	O Bassey
	Am.	Attending to own hygiene.	
(3)	BNO.	Bowels inactive. Sofratulle and	
		dry dressing insitu.	
		T 36.3C. P 69 at 13.50hrs.	C Thorpe
	5pm	Had large Bowel movement	
		Bottle smell ommins of fresh Bleeding	
		Seen by Dr JAAP. For Discharge	
		Home tonight, Patient insists on	
		going home as it is his sons	
		Birthday. Return appointment made	C Thorpe
		for 16/7	

SOUTHERN GENERAL AND ASSOCIATED HOSPITALS

DEPARTMENT:

NAME: BRIAN M'KENZIE UNIT NO. 375441 WARD: 14

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
7.7.89	pm.	Settled into ward. Fully orientated to his surroundings. Sat on Veranda most of afternoon. For theatre on Monday. Vital signs on admission satisfactory.	N Robinson
8.7.89		Slept well	Mosey
	AM.	Giving self care Vital Signs Temp 36.2°c Pulse 80.	
9.7.89		Slept well Independent. Plead prepare for theatre Ops a/Buboe.	
	pm.	Prepared for theatre as per checklist. Please ~~pre~~ FAST overnight.	N Robinson
10-7-89		Good night, settled and slept well. Fasted overnight for theatre today. Comfortable. Omnopon 20 — 13.20	A. Martin
7H	am.	Attended ~~haemorrhoid~~ theatre for haemorrhoidectomy. Returned to ward at 13.00 hrs. BP-120/80 P-82 T-36.4 Resps-12 on return. Wound site covered with large wound pad and T-bandage. Haemostatic sponge insitu. O2 via Hudson mask to remain insitu until fully awake. Omnopon 20mg & Stemetil 12.5mg given I.M at 13.20 hrs.	N Robinson
	PM	Satisfactory ~~poor~~ on recovery. Now discharge clear & fluids, has not passed urine as yet BP 110/60 pulse 60 Dressing Slight oozing on wound pad. Referred Sister Encouraged	
11.7.89		Refusing intramuscular analgesia 2 cephoxamol given with effect slept for long periods. B.P. 120/74 P 64	
(1)		T. 37°C Has passed urine. Slight leakage on wound pad.	C Bosley

SGH 306A

'ATIENTS PROFILE (cont'd)

MEDICATION ON ADMISSION:

~~NIL~~

ANTI - HYSTAMINE

PATIENTS PRECEPTION OF CURRENT HEALTH STATUS:

UNDERSTANDS REASON FOR ADMISSION

RELATIVES PRECEPTIONS OF PATIENTS HEALTH STATUS:

WIFE AWARE OF ADMISSION

EMERGENCY CONTACT NAME: MARGARET

NEXT OF KIN:

RI___IONSHIP: WIFE

ADDRESS:

TELEPHONE NUMBER (DAY): 07973435422 | TELEPHONE NUMBER (NIGHT):

OTHER RELEVANT CONTACT:

G.P.'s NAME: DR ANDERSON

G.P.'s ADDRESS: RGNFREN HEALTH CENTRE

G.P.'s TELEPHONE NUMBER:

Patient / Relative spoken to by	DATE	TIME	DOCTOR	NURSE

VALUABLES: DISPOSAL HOME WARD CASHIER'S OFFICE

CLOTHING: DISPOSAL HOME WARD CASHIER'S OFFICE

NURSES SIGNATURE:

SOUTHERN GENERAL HOSPITAL
PATIENTS PROFILE

WARD / DEPT: 2 – ORTHO		NAMED NURSE: B. MANLY	
CONSULTANT: MARTIN		REFERRAL: A/E	
DATE: 3/10/09		TIME: 0700	
PATIENTS NAME: BRIAN MACKENZIE			
UNIT NUMBER: SG 0057544I			
PREFERS TO BE CALLED:			
ADDRESS: 12 ORCHARD STREET, RENFREW, PA4 8RL			
TELEPHONE NUMBER: 07966154552			
AGE: 51	D.O.B.: 31/2/58	SEX: (M)	MARITAL STATUS: (M)
OCCUPATION: SELF ~~EMPLOYED~~ GARDNER			
RELIGION:	CLERGY / OTHER:	CONTACT REQUIRED:	CONTACTED:

R ON FOR ADMISSION:

? ASSAULT – HIT WITH GOLF CLUB TO (R) HAND – DISLOCATING THUMB/SUCKING HAND OPEN. ALSO HIT ON HEAD WHICH HAS BEEN STAPLED IN A/E.
FOR M.U.A. + WASHOUT AT THEATRE

PI OUS HEALTH HISTORY:

HERNIA REPAIR
(R) KNEE ABSCESS DRAINED
TONSILLECTOMY.
(R) FOOT WASHOUT/DEBRIDEMENT

KNOWN ALLERGIES:

NKDA
? HAYFEVER

NURSING ASSESSMENT (ASSESSMENT OF ACTIVITIES OF DAILY LIVING)

MAINTAINING A SAFE ENVIRONMENT, COMMUNICATING, BREATHING, EATING AND DRINKING, ELIMINATING, PERSONAL CLEANSING AND DRESSING, CONTROLLING BODY TEMPERATURE, MOBILISING, WORKING AND PLAYING, EXPRESSING SEXUALITY, SLEEPING, DYING.

INDEPENDENT WITH ALL ADL'S.

NURSES SIGNATURE:

SOUTHERN GENERAL HOSPITAL
NURSING ASSESSMENT

PATIENTS NAME: BRIAN MACKENZIE	UNIT No.: 375441	WARD: 2

GENERAL ASSESSMENT ON ADMISSION:

ADMITTED FROM A/E (AFTER DISCHARGING HIMSELF OUT LAST NIGHT)
SMELLS OF ALCOHOL/TOBACCO
ALL OWN TEETH — UPPER FRONT BRIDGE WHICH IS SECURE.
CANNABIS USER — COCAINE USER (2/52 AGO).
ALCOHOL — AT PRESENT 15-20 UNITS PER DAY.
SMOKES 20 C.P.D.
SKIN INTACT — NOT VISIBLY CHECKED.
REGULAR BOWELS, NORMAL DIET ? POOR RECENTLY DUE TO INCREASED ALCOHOL INTAKE.

SOCIAL / HOME BACKGROUND (INCLUDING PROBLEMS RELATED TO ADMISSION):

LIVES WITH WIFE (2 GROWN UP KIDS)
NO SOCIAL SERVICE INPUT.
LIVES IN UPPER COTTAGE FLAT (13 STEPS)
SOCIALLY ALONE

BLOOD PRESSURE:	139/93	WEIGHT:	10 st 8 lbs.
PULSE:	86	HEIGHT:	5' 9".
RESPIRATIONS:	16	URINALYSIS:	NORMAL SAMPLE
TEMPERATURE:	37.1	WATERLOW SCORE:	5

96%

SOUTHERN GENERAL HOSPITAL

DEPARTMENT:

NAME: UNIT NO. WARD:

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
		This will be later today. Discharge letter completed and only needs to explained to patient with medications to be booked over. B/O + PU today. To return on thursday 8/10/9 at 1100am (approx) for review at ward at the clinic. Appointment card given to patient. Back office to be informed.	GM
	1505	Patient discharge completed — medication and AVX explained/given to patient. Appointment card for patient to return on thursday 8/10/9 also given. Venflon + subcut line removed. Wife picked patient up from ward. GSM intact, Wound clean.	GM

SOUTHERN GENERAL HOSPITAL

DEPARTMENT: ORTHO

NAME: BRIAN McKENZIE UNIT NO. 375441 WARD: 2

DATE	PROB. NO.	NURSING NOTES/EVALUATION	SIGNATURE
3/10/9	08:30	Patient admitted from A/E — was originally supposed to be admitted last night but discharged himself. Admitted smoking & alcohol (last drink 10 pm last night) + tobacco. Independent with ADL's: Smokes 20 C.P.D. regular cannabis + cocaine user (last time 2/52). Drinks 15-20 units alcohol per day. (R) hand in back-slab. PMH — Hernia repair, Knee abscess drained, tonsillectomy, (R) foot washout. NKDA however takes anti-histamine for hayfever. Lives with wife — has grown up kids. Self employed gardener. Regular bowels and annual diet. ———	GM
	14:45	Patient settled awaiting to go to theatre — checklist completed. Observations satisfactory. ———	GM
	20:00	Patient returned from theatre: Exploration of wound to (R) hand + K wiring of thumb under G.A. with 3/0 Dermalon to close and Ingenuity, blue Steristrips, wool, POP Backslab to dress. Chirocaine 0.5% given via radial + median block. Observations satisfactory in recovery, IV fluids and 4L O^2 given. Patient stated pain at 7/10 with 3mg morphine + 2 x 30/500 Coccodamol and then 10mg s/c morphine given till fully woke control. On return to ward fluids + O^2 continue until bag is finished and patient is fully awake. Observations stable. Patient yet to P.V. and willing to eat/drink soon. POST OP NOTE — to keep hand elevated regular observations and Home when safe. For Outpatient Clinic for Mr. Martin in 1 week for wound review and change of POP — Keep POP for 4/52 and Knife removed and initialed ———	GM
4/10/09	05:30	Settled and slept well. IV antibiotic fluclox started. pt will go home with oral antibiotics. IV patkmeds given. c/o pain 2/. morphine only s/c given with good effect. Urine passed. OBS checked and charted. POP on. Reviewed today.	J. Walker
	13:15	Settled day had (by) patient — independent with ADL's. Hand (R). has POP in-situ — CSM intact. I.V. ABX + Pabmeds continues until discharged.	

Nutrition Profile

NHS Greater Glasgow and Clyde

Name:	Date of admission: 03 / 10 / 09
Address: SG00375441 BRIAN MACKENZIE 12 ORCHARD STREET RENFREW PA4 8RL	Time: 0700
DoB: 31/08/1958	HOSPITAL: SGH
CHI numbe.. CHI 3108583158	Ward: 2
Affix patient data label	

To be recorded within 24 hours of admission*

Height: 5' 9" ~~m~~/ft Actual ☐ Patient/ carer reported ☑ Alternative measurement ☐

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

Recent unplanned weight loss: Yes ☐ No ☑

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

Is there evidence of recent weight loss?

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

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

NORMAL DIET.

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☑

Please state: NORMAL

Are there any contributing factors that may affect food intake such as **physical** (e.g. swallowing difficulties), **physiological** (e.g. nausea), **psychological** (e.g. dementia), **social or environmental?** Yes ☐ No ☑

Please specify all factors:

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☑

Please state:

Profile completed by: Name (PRINT): M'ANS Signature: Date: 3/10/09

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

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

Malnutrition Universal Screening Tool ('MUST')

Date	3/10									
Initials										
Height (see page 1) 5'9" Weight	11 st									
Oedema or ascites present Y/N	N									
BMI	21									

'MUST'

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

Step 5: Management Guidelines

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

Management Plan

FOR ALL PATIENTS

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

Referral Services

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

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Review date	Name (PRINT) Signature/Designation

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

Step 1 - BMI Score

Height (feet and inches)

Weight (kg)	4'10½	4'11	5'0	5'0½	5'1½	5'2	5'3	5'4	5'4½	5'5½	5'6	5'7	5'7½	5'8½	5'9½	5'10	5'11	5'11½	6'0½	6'1	6'2	6'3	Weight (stones and pounds)
100	46	44	43	42	41	40	39	38	37	36	35	35	34	33	32	32	31	30	30	29	28	28	15 10
99	45	44	43	42	41	40	39	38	37	36	35	34	33	33	32	31	31	30	29	29	28	27	15 8
98	45	44	42	41	40	39	38	37	36	36	35	34	33	32	32	31	31	30	29	28	28	27	15 6
97	44	43	42	41	40	39	38	37	36	35	34	34	33	32	31	31	30	29	29	28	27	27	15 4
96	44	43	42	40	39	38	38	37	36	35	34	33	32	32	31	30	30	29	28	28	27	27	15 2
95	43	42	41	40	39	38	37	36	35	34	34	33	32	31	31	30	29	29	28	27	27	26	15 0
94	43	42	41	40	39	38	37	36	35	34	33	33	32	31	30	30	29	28	28	27	27	26	14 11
93	42	41	40	39	38	37	36	35	35	34	33	32	31	31	30	29	29	28	27	27	26	26	14 9
92	42	41	40	39	38	37	36	35	34	33	33	32	31	30	30	29	28	28	27	27	26	25	14 7
91	42	40	39	38	37	36	36	35	34	33	32	31	31	30	29	29	28	27	27	26	26	25	14 5
90	41	40	39	38	37	36	35	34	33	33	32	31	30	30	29	28	28	27	27	26	25	25	14 2
89	41	40	39	38	37	36	35	34	33	32	32	31	30	29	29	28	27	27	26	26	25	25	14 0
88	40	39	38	37	36	35	34	34	33	32	31	30	30	29	28	28	27	27	26	25	25	24	13 12
87	40	39	38	37	36	35	34	33	32	32	31	30	29	29	28	27	27	26	26	25	25	24	13 10
86	39	38	37	36	35	34	34	33	32	31	30	30	29	28	28	27	27	26	25	25	24	24	13 8
85	39	38	37	36	35	34	33	32	32	31	30	29	29	28	27	27	26	26	25	25	24	24	13 6
84	38	37	36	35	35	34	33	32	31	30	30	29	28	28	27	27	26	25	25	24	24	23	13 3
83	38	37	36	35	34	33	32	32	31	30	29	29	28	27	27	26	26	25	24	24	23	23	13 1
82	37	36	35	35	34	33	32	31	30	30	29	28	28	27	26	26	25	25	24	24	23	23	12 13
81	37	36	35	34	33	32	32	31	30	29	29	28	27	27	26	26	25	24	24	23	23	22	12 11
80	37	36	35	34	33	32	31	30	30	29	28	28	27	26	26	25	25	24	24	23	23	22	12 8
79	36	35	34	33	32	32	31	30	29	29	28	27	27	26	26	25	24	24	23	23	22	22	12 6
78	36	35	34	33	32	31	30	30	29	28	28	27	26	26	25	25	24	24	23	23	22	22	12 4
77	35	34	33	32	32	31	30	29	29	28	27	27	26	25	25	24	24	23	23	22	22	21	12 1
76	35	34	33	32	31	30	30	29	28	28	27	26	26	25	25	24	23	23	22	22	22	21	11 13
75	34	33	32	32	31	30	29	29	28	27	27	26	25	25	24	24	23	23	22	22	21	21	11 11
74	34	33	32	31	30	30	29	28	28	27	26	26	25	24	24	23	23	22	22	21	21	20	11 9
73	33	32	32	31	30	29	29	28	27	27	26	26	25	24	24	23	23	22	22	21	21	20	11 7
72	33	32	31	30	30	29	28	27	27	26	26	25	24	24	23	23	22	22	21	21	20	20	11 4
71	32	32	31	30	29	28	28	27	26	26	25	25	24	23	23	22	22	21	21	21	20	20	11 3
70	32	31	30	30	29	28	27	27	26	25	25	24	24	23	23	22	22	21	21	20	20	19	11 0
69	32	31	30	29	28	28	27	26	26	25	24	24	23	23	22	22	21	21	20	20	20	19	10 11
68	31	30	29	29	28	27	27	26	25	25	24	24	23	22	22	21	21	21	20	20	19	19	10 10
67	31	30	29	28	28	27	26	26	25	24	24	23	23	22	22	21	21	20	20	19	19	19	10 7
66	30	29	29	28	27	26	26	25	25	24	23	23	22	22	21	21	20	20	19	19	19	18	10 6
65	30	29	28	27	27	26	25	25	24	24	23	22	22	21	21	21	20	20	19	19	18	18	10 3
64	29	28	28	27	26	26	25	24	24	23	23	22	22	21	21	20	20	19	19	18	18	18	10 1
63	29	28	27	27	26	25	25	24	23	23	22	22	21	21	20	20	19	19	18	18	18	17	9 13
62	28	28	27	26	25	25	24	24	23	22	22	21	21	20	20	20	19	19	18	18	18	17	9 10
61	28	27	26	26	25	24	24	23	23	22	22	21	21	20	20	19	19	18	18	18	17	17	9 8
60	27	27	26	25	25	24	23	23	22	22	21	21	20	20	20	19	19	18	18	18	17	17	9 6
59	27	26	26	25	24	24	23	22	22	21	21	20	20	19	19	19	18	18	17	17	17	16	9 4
58	26	26	25	24	24	23	23	22	22	21	21	20	20	19	19	18	18	18	17	17	16	16	9 1
57	26	25	25	24	23	23	22	22	21	21	20	20	19	19	18	18	18	17	17	16	16	16	9 0
56	26	25	24	24	23	22	22	21	21	20	20	19	19	18	18	18	17	17	17	16	16	16	8 11
55	25	24	24	23	23	22	21	21	20	20	19	19	18	18	18	17	17	17	16	16	16	15	8 8
54	25	24	23	123	22	22	21	21	20	20	19	19	18	18	17	17	17	16	16	16	15	15	8 7
53	24	24	23	22	22	21	21	20	20	19	19	18	18	18	17	17	16	16	16	15	15	15	8 4
52	24	23	23	22	21	21	20	20	19	19	18	18	18	17	17	16	16	16	15	15	15	14	8 3
51	23	23	22	22	21	20	20	19	19	19	18	18	17	17	16	16	16	15	15	15	14	14	8 0
50	23	22	22	21	21	20	20	19	19	18	18	17	17	17	16	16	15	15	15	14	14	14	7 13
49	22	22	21	21	20	20	19	19	18	18	17	17	17	16	16	15	15	15	14	14	14	14	7 10
48	22	21	21	20	20	19	19	18	18	17	17	17	16	16	16	15	15	14	14	14	14	13	7 7
47	21	21	20	20	19	19	18	18	17	17	17	16	16	16	15	15	15	14	14	14	13	13	7 6
46	21	20	20	19	19	18	18	18	17	17	16	16	16	15	15	15	14	14	14	13	13	13	7 3
45	21	20	19	19	18	18	18	17	17	16	16	16	15	15	15	14	14	14	13	13	13	12	7 1
44	20	20	19	19	18	18	17	17	16	16	16	15	15	15	14	14	14	13	13	13	12	12	6 13
43	20	19	19	18	18	17	17	16	16	16	15	15	15	14	14	14	13	13	13	12	12	12	6 11
42	19	19	18	18	17	17	16	16	16	15	15	15	14	14	14	13	13	13	12	12	12	12	6 8
41	19	18	18	17	17	16	16	16	15	15	15	14	14	14	13	13	13	12	12	12	12	11	6 6
40	18	18	17	17	16	16	16	15	15	15	14	14	14	13	13	13	12	12	12	12	11	11	6 4
39	18	17	17	16	16	16	15	15	15	14	14	13	13	13	13	12	12	12	12	11	11	11	6 1
38	17	17	16	16	16	15	15	14	14	14	13	13	13	13	12	12	12	11	11	11	11	11	6 0
37	17	16	16	16	15	15	14	14	14	13	13	13	13	12	12	12	11	11	11	11	10	10	5 11
36	16	16	16	15	15	14	14	14	13	13	13	12	12	12	12	11	11	11	11	10	10	10	5 9
35	16	16	15	15	14	14	14	13	13	13	12	12	12	12	11	11	11	11	10	10	10	10	5 7
34	16	15	15	14	14	14	13	13	13	12	12	12	11	11	11	11	10	10	10	10	10	9	5 5

Score 0 (obese) Score 0 Score 1 Score 2

Height (m)

1.48 1.50 1.52 1.54 1.56 1.58 1.60 1.62 1.64 1.66 1.68 1.70 1.72 1.74 1.76 1.78 1.80 1.82 1.84 1.86 1.88 1.90

Step 2 - Weight Loss Score

Weight before weight loss (kg)	Score 0 W't loss <5%	Score 1 W't loss 5-10%	Score 2 W't loss >10%
34 kg	<1.7 kg	1.7-3.4 kg	>3.4 kg
36 kg	<1.8 kg	1.8-3.6 kg	>3.6 kg
38 kg	<1.9 kg	1.9-3.8 kg	>3.8 kg
40 kg	<2 kg	2-4 kg	>4 kg
42 kg	<2.1 kg	2.1-4.2 kg	>4.2 kg
44 kg	<2.2 kg	2.2-4.4 kg	>4.4 kg
46 kg	<2.3 kg	2.3-4.6 kg	>4.6 kg
48 kg	<2.4 kg	2.4-4.8 kg	>4.8 kg
50 kg	<2.5 kg	2.5-5 kg	>5 kg
52 kg	<2.6 kg	2.6-5.2 kg	>5.2 kg
54 kg	<2.7 kg	2.7-5.4 kg	>5.4 kg
56 kg	<2.8 kg	2.8-5.6 kg	>5.6 kg
58 kg	<2.9 kg	2.9-5.8 kg	>5.8 kg
60 kg	<3 kg	3-6 kg	>6 kg
62 kg	<3.1 kg	3.1-6.2 kg	>6.2 kg
64 kg	<3.2 kg	3.2-6.4 kg	>6.4 kg
66 kg	<3.3 kg	3.3-6.6 kg	>6.6 kg
68 kg	<3.4 kg	3.4-6.8 kg	>6.8 kg
70 kg	<3.5 kg	3.5-7 kg	>7 kg
72 kg	<3.6 kg	3.6-7.2 kg	>7.2 kg
74 kg	<3.7 kg	3.7-7.4 kg	>7.4 kg
76 kg	<3.8 kg	3.8-7.6 kg	>7.6 kg
78 kg	<3.9 kg	3.9-7.8 kg	>7.8 kg
80 kg	<4 kg	4-8 kg	>8 kg
82 kg	<4.1 kg	4.1-8.2 kg	>8.2 kg
84 kg	<4.2 kg	4.2-8.4 kg	>8.4 kg
86 kg	<4.3 kg	4.3-8.6 kg	>8.6 kg
88 kg	<4.4 kg	4.4-8.8 kg	>8.8 kg
90 kg	<4.5 kg	4.5-9 kg	>9 kg
92 kg	<4.6 kg	4.6-9.2 kg	>9.2 kg
94 kg	<4.7 kg	4.7-9.4 kg	>9.4 kg
96 kg	<4.8 kg	4.8-9.6 kg	>9.6 kg
98 kg	<4.9 kg	4.9-9.8 kg	>9.8 kg
100 kg	<5 kg	5-10 kg	>10 kg
102 kg	<5.1 kg	5.1-10.2 kg	>10.2 kg
104 kg	<5.2 kg	5.2-10.4 kg	>10.4 kg
106 kg	<5.3 kg	5.3-10.6 kg	>10.6 kg
108 kg	<5.4 kg	5.4-10.8 kg	>10.8 kg
110 kg	<5.5 kg	5.5-11 kg	>11 kg
112 kg	<5.6 kg	5.6-11.2 kg	>11.2 kg
114 kg	<5.7 kg	5.7-11.4 kg	>11.4 kg
116 kg	<5.8 kg	5.8-11.6 kg	>11.6 kg
118 kg	<5.9 kg	5.9-11.8 kg	>11.8 kg
120 kg	<6 kg	6-12 kg	>12 kg
122 kg	<6.1 kg	6.1-12.2 kg	>12.2 kg
124 kg	<6.2 kg	6.2-12.4 kg	>12.4 kg
126 kg	<6.3 kg	6.3-12.6 kg	>12.6 kg

Weight before weight loss (st/lb)	Score 0 W't loss <5%	Score 1 W't loss 5-10%	Score 2 W't loss >10%
5st 4lb	<4lb	4lb-7lb	>7lb
5st 7lb	<4lb	4lb-8lb	>8lb
5st 11lb	<4lb	4lb-8lb	>8lb
6st	<4lb	4lb-8lb	>8lb
6st 4lb	<4lb	4lb-9lb	>9lb
6st 7lb	<5lb	5lb-9lb	>9lb
6st 11lb	<5lb	5lb-10lb	>10lb
7st	<5lb	5lb-10lb	>10lb
7st 4lb	<5lb	5lb-10lb	>10lb
7st 7lb	<5lb	5lb-11lb	>11lb
7st 11lb	<5lb	5lb-11lb	>11lb
8st	<6lb	6lb-11lb	>11lb
8st 4lb	<6lb	6lb-12lb	>12lb
8st 7lb	<6lb	6lb-12lb	>12lb
8st 11lb	<6lb	6lb-12lb	>12lb
9st	<6lb	6lb-13lb	>13lb
9st 4lb	<7lb	7lb-13lb	>13lb
9st 7lb	<7lb	7lb-13lb	>13lb
9st 11lb	<7lb	7lb-1st	>1st
10st	<7lb	7lb-1st	>1st
10st 4lb	<7lb	7lb-1st	>1st
10st 7lb	<7lb	7lb-1st 1lb	>1st 1lb
10st 11lb	<8lb	8lb-1st 1lb	>1st 1lb
11st	<8lb	8lb-1st 1lb	>1st 1lb
11st 4lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 7lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 11lb	<8lb	8lb-1st 3lb	>1st 3lb
12st	<8lb	8lb-1st 3lb	>1st 3lb
12st 4lb	<9lb	9lb-1st 3lb	>1st 3lb
12st 7lb	<9lb	9lb-1st 4lb	>1st 4lb
12st 11lb	<9lb	9lb-1st 4lb	>1st 4lb
13st	<9lb	9lb-1st 4lb	>1st 4lb
13st 4lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 7lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 11lb	<10lb	10lb-1st 5lb	>1st 5lb
14st	<10lb	10lb-1st 6lb	>1st 6lb
14st 4lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 7lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 11lb	<10lb	10lb-1st 7lb	>1st 7lb
15st	<11lb	11lb-1st 7lb	>1st 7lb
15st 4lb	<11lb	11lb-1st 7lb	>1st 7lb
15st 7lb	<11lb	11lb-1st 8lb	>1st 8lb
15st 11lb	<11lb	11lb-1st 8lb	>1st 8lb
16st	<11lb	11lb-1st 8lb	>1st 8lb
16st 4lb	<11lb	11lb-1st 9lb	>1st 9lb
16st 7lb	<12lb	12lb-1st 9lb	>1st 9lb
16st 11lb	<12lb	12lb-1st 9lb	>1st 9lb

VI MEDICAL ILLUSTRATION • NUTRITION & DIET • 12366/01.09.08

STORES ORDER CODE 41850

SG00375441
BRIAN MACKENZIE
12 ORCHARD STREET

RENFREW 31/08/1958
PA4 8RL CHI 3108583158

South Glasgow Hospitals

Pressure Ulcer Risk Assessment Record

NHS Greater Glasgow and Clyde

Modified Waterlow Risk Assessment

Initials															
Date	3/10														
Date: 03/10/09 — Number	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Body weight for height:															
Average 0 / Above average 1	0														
Obese 2 / Below 3															
Continence:															
Completely / Catheterised 0 / Occasionally incontinent 1	0														
Catheterised / Incontinent of faeces 2 / Doubly incontinent 3															
Skin type - Visual risk areas:															
Healthy 0	0														
Tissue paper/Dry 1															
Oedematous/Clammy (temp. raised) 1															
Discoloured 2															
Broken spot 3															
Mobility:															
Fully 0 / Restless/Fidgety 1	1														
Apathetic 2 / Restricted 3															
Inert/Traction 4 / Chairbound 5															
Sex/Age:															
Male/Female 1/2 / 14-49 1	1														
50-64 2 / 65-74 3	+														
75-80 4 / 80+ 5	2														
Appetite:															
Average 0 / Poor 1	0														
N.G. tubes/fluids only 2 / NBM / Anorexic 3															
Special risks - Tissue malunitrition:															
e.g. Terminal cachexia 8															
Cardiac failure 5															
Peripheral vascular disease 5															
Anaemia 2															
Smoking 1	1														
Neurological deficit:															
e.g. Diabetes, MS, CVA, Motor-sensory paraplegia 4-6	0														
Major surgery /trauma:															
Orthopaedic; Below waist; Spinal 5	0														
On table > 2 hours 5															
Medication:															
Cytotoxics; Highdose steroids; Anti-inflamatory 4	0														
TOTAL SCORE:	5														

Score as follows: <10 = Low risk; 10-14 = At risk; 15-19 = High risk; 20+ = Very high risk.

Refer to Pressure Ulcer Prevention Guidelines (GGHB) for action.

Action Plan

Date	Preventative action to be taken (e.g. turning time; position; support surface/cushion; other)	Signature

urther action

	Date	Signature
Referred to dietitian		
Referred to TVNS		
'Wound and Pressure Area Care Assessment Chart' commenced		

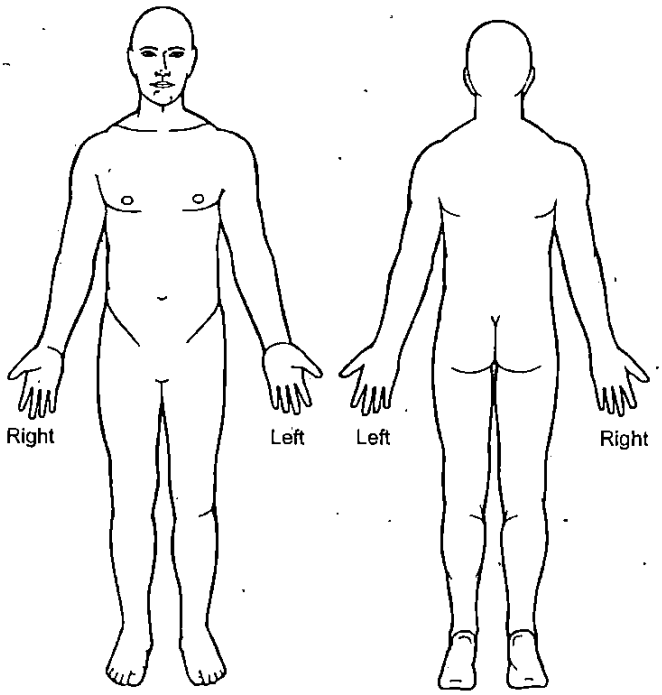
GRADE OF ULCER (Torrance)

GRADE	*DEFINITION*
1.	Blanching hyperaemia.
2.	Non-blanching hyperaemia.
3.	Ulceration progresses through to dermis.
4.	Lesion extends through to subcutaneous fat.
5.	Infective necrosis / necrotic tissue.

RECORDING THE GRADE OF ULCER

On admission, **number site of ulcer** on the diagram opposite and **enter the ulcer number and the grade** in the action plan.

Assessment should be carried out on all patients within 2 - 4 hours of admission and repeated 24 - 48 hours afterwards. Repeat assessment as condition changes or at weekly intervals.



Date Commenced & Signature	SPECIAL NEEDS/MAINTAIN PERSONAL SAFETY	Tick	Date Discontinued & Signature
	Cotsides:		
	Visually Impaired: Removal Hazards		
	TECHNICAL CARE		
	Venflon Insitu:		
	IV Infusion:		
	Check Site:		
	Subcutaneous Cannula Insitu:		
	Oxygen: Mask:		
	Rate:		
	Length of Time:		
	OBSERVATIONS		
	BP:	✓	
3/10/9	Pulse:	✓	
	Temperature:	✓	
	Saturations:	✓	
	Fluid Balance:		
	Glucose Monitoring:		
	C.S.M. (Fingers: R L) (Toes R L)		
	Vascular Observations:		
	Stool Chart:		
	PAR Scoring:		
	Head Injury Observations:		
	WOUND CARE/OTHER CARE		
	Pressure Area Care:		
	Check: Hourly		
	Pressure Cushion:		
	Therapy Mattress:		
	Avant Guard Bed:		
	Wound Assessment Chart:		
	PAIN ASSESSMENT CHART		
	Patient Moving & Handling Risk Assessment		
	MISCELLANEOUS		
	Ted Stockings: Size:		

SG00375441
BRIAN MACKENZIE
12 ORCHARD STREET

RENFREW 31/08/1958
PA4 8RL CHI 3108583158

CTORATES: PATIENT CARE PLAN

UNIT NO:

ID: NARD 2

DATE OF ADMISSION: 03/10/09

Date Commenced & Signature	PERSONAL HYGIENE/DRESSING	Tick	Date Discontinued & Signature
GM 3/10	Independent	✓	
	Bedbath		
	Shower		
	Immersion Bath		
	Basin		
	Assistance Required: No of Staff:		
	Oral Hygiene: Independent Assistance Required:		
	MOBILISATION		
GM 3/10	Independent	✓	
	Assistance Required: No of Staff:		
	Aids Used: Walking Stick:		
	Zimmer:		
	Elbow Crutches:		
	Wheelchair:		
	Other:		
	EATING & DRINKING		
GM 3/10	Normal Diet:	✓	
	Special Diet:		
	Light Diet:		
	Assistance to Eat & Drink:		
	Fluids Only:		
	Dietary Supplements:		
	Parental/Entral Nutrition:		
	Nasogastric Tube:		
	Fasting: From:		
	To:		
	Light Early Breakfast: Time:		
	ELIMINATIONS		
GM 3/10	Independent:	✓	
	Assistance to Toilet: No of Staff:		
	Urinary Catheter:		
	Suprapubic Catheter:		
	Ileal Conduit:		
	Colostomy:		

SOUTH GLASGOW HOSPITALS
PATIENT MOVING AND HANDLING RISK ASSESSMENT

NHS Greater Glasgow and Clyde

Patient's Name:	If patient is totally independent, tick here and go to date box	
Named Nurse:		

BODY BUILD

Obese		Tall		Problems with comprehension, behaviour, co-operation (specify)
Above average		Medium		
Average		Short		Handling constraints,e.g. disability, weakness, pain, skin lesions infusions (specify)
Below Average		Weight:		

RISK OF FALLS — High ☐ Low ☐

INTO BATH OR SHOWER

HANDLING AID		WHICH BATH		ASSISTANCE ☐	SUPERVISION ☐	INDEPENDENT ☐
Hoist (Specify)		Parker		Staff required:		
Shower chair		Variable height				
		Standard				
		Any				

TRANSFERS (including to/from: bed, wheelchair, commode, toilet)

HOIST		MANUAL SUPPORT	ASSISTANCE ☐	SUPERVISION ☐	INDEPENDENT ☐
Which hoist?		Staff required:	Additional information		
Sling type?		Specify support given			
Sling size?					

TOILETING

HOIST		MANUAL SUPPORT	ASSISTANCE ☐	SUPERVISION ☐	INDEPENDENT ☐
Which hoist?		Staff required:	Additional information		
Sling type?		Specify support given			
Sling size?					

WALKING

NO WALKING ☐	ASSISTANCE ☐	SUPERVISION ☐	INDEPENDENT ☐
Staff required:		Distance walked / additional information	
Walking Aid			

MOVE UP/DOWN BED

HOIST		MANUAL SUPPORT	ASSISTANCE ☐	SUPERVISION ☐	INDEPENDENT ☐
Which hoist?		Sliding aid	Additional information (include details of any therapy beds used)		
Sling type?		Rope ladder	Staff required:		
Sling size?		Hand blocks			
		Monkey poles			

SIT UP OVER SIDE OF BED

Rope ladder ☐	Sliding aid ☐	ASSISTANCE ☐	SUPERVISION ☐	INDEPENDENT ☐

MOVE ON/OFF BED PAN

Hoist ☐	Roll Patient ☐	Patient bridges ☐	Monkey pole ☐	Not used ☐

TRANSFER TO/FROM TROLLEY (or bed etc)

Sliding aid (rigid) ☐	Sliding aid (fabric) ☐	Transfer aid (specify)	Staff required (specify) ☐	INDEPENDENT ☐

Date assessed:	Assessors signature:

Date reviewed									
Assessors signature									

THERAPEUTIC HANDLING INSTRUCTIONS

Date	Instruction	Therapist's Name

INTO BATH OR SHOWER

HANDLING AID		WHICH BATH		ASSISTANCE		SUPERVISION		INDEPENDENT	
Hoist (Specify)		Parker		Staff required:					
Shower chair		Variable height							
		Standard							
		Any							

TRANSFERS (including to/from: bed, wheelchair, commode, toilet)

HOIST		MANUAL SUPPORT	ASSISTANCE		SUPERVISION		INDEPENDENT	
Which hoist?		Staff required:	Additional Information					
Sling type?		Specify support given						
Sling size?								

TOILETING

HOIST		MANUAL SUPPORT	ASSISTANCE		SUPERVISION		INDEPENDENT	
Which hoist?		Staff required:	Additional Information					
Sling type?		Specify support given						
Sling size?								

ALKING

NO WALKING		ASSISTANCE		SUPERVISION		INDEPENDENT	
Staff required:				Distance walked / additional information			
Walking Aid							

MOVE UP/DOWN BED

HOIST		MANUAL SUPPORT		ASSISTANCE		SUPERVISION		INDEPENDENT	
Which hoist?		Sliding aid		Additional Information (include details of any therapy beds used)					
Sling type?		Rope ladder		Staff required:					
Sling size?		Hand blocks							
		Monkey poles							

SIT UP OVER SIDE OF BED

Rope ladder		Sliding aid		ASSISTANCE		SUPERVISION		INDEPENDENT	

MOVE ON/OFF BED PAN

Hoist		Roll Patient		Patient bridges		Monkey pole		Not used	

TRANSFER TO/FROM TROLLEY (or bed etc)

ng aid (rigid)		Sliding aid (fabric)		Transfer aid (specify)	Staff required (specify)		INDEPENDENT	

Date assessed:	Assessors signature:

Date reviewed									
Assessors signature									

THERAPEUTIC HANDLING INSTRUCTIONS

Date	Instruction	Therapist's Name

Cannard Falls Risk Assessment

(Must be completed within 24 hours)

3/10/9

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						DATE	DATE	DATE	DATE	DATE	DATE	DATE
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			0						
Sex	Male 1	Female 2				1						
Age	60-70 1	71-80 2	81+ 1			0						
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		0						
Medication type **	Drugs for mental illness 1	Blood pressure / water tablets 1	Sleeping tablets 1	None of these 0		0						
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	0						
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed-bound 1		1						
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1						
				TOTAL SCORE		3						
				ACTION(S) TAKEN: Enter action code(s)		1						
SCORE 2-8 = LOW 9-12 = MEDIUM 13+ = HIGH RISK				NURSE SIGNATURE								

** If you are in any doubt about whether a person's medicine belongs to one of the types listed ask the person or carer or please phone the number on the medicine container and ask the community or hospital pharmacist.

* Please see back page for clarification

Acute Services Division

Hospital / Department

NHS
Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

Patient name: Brian MacKenzie

Ward: 2

CHI number: 3108583168 Unit/Hospital number SG00375441

Contents

1. Canard Falls Risk Assessment Scoring Form
2. Falls Assessment Care Plan
3. Glossary of terms used in risk assessment

Notes: Risk assessment should be completed within 24 hours of admission.

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

Continuing Care Wards: Mobile and 'at risk' patients should have risk assessment and care plan reviewed monthly.

Cannard Falls Risk Assessment

Glossary of terms used in risk assessment

SIGHT DEFICIT means patient cannot see well even when wearing glasses or is registered blind.

HEARING DEFICIT means person has hearing problems even with a hearing aid or has hearing problems and does not wear a hearing aid.

BALANCE DEFICIT means person is unable to stand without the support of another person or a walking frame.

MEDICINES FOR SOME MENTAL ILLNESSES include Chlorpromazine (Largactil), Risperidone (Risperdal), Lithium (Camcolit or Priadel), Haloperidol, Chloral hydrate (Welldorm), Clomethiazole (Heminevin), antidepressants.

BLOOD PRESSURE TABLETS include Captopril, atenolol and many others.

WATER TABLETS (DIURETICS) are such as Bendroflumethiazide, Furosemide and Co-amilofruse.

SLEEPING TABLETS include medicines such as Diazepam, Temazepam, Nitrazepam, Chlordiazepoxide and Zopiclone (Zimovane).

INABILITY TO CO-OPERATE includes failure to use walking aids or putting themselves in situations with a high risk of falling (usually due to mental impairment).

RESTRICTED MOBILITY means the person requires supervision and/or help to walk (i.e. is not safe to walk alone even with an aid.

HESITANT IN INITIATING MOVEMENT means difficulty in starting to walk.

POOR TRANSFER means the person requires help and is not safe to do the following alone - get in or out of bed, on or off a chair, move from chair to standing.

Falls Assessment Care Plan

Please tick all applicable nursing interventions

Action code	NURSING INTERVENTIONS	DATE 3/10/19	DATE	DATE	DATE	DATE	DATE	DATE
	LOW, MODERATE AND HIGH RISK							
1	Prevention and general safety precautions discussed with patient and family.	✓						
	MODERATE AND HIGH RISK							
2	Move to more observable area of ward to optimise supervision.							
3	Refer to Physiotherapist.							
4	Refer to Occupational Therapist.							
5	Patient requires footwear or podiatry referral. (Date referred:)							
6	Commence continence assessment							
7	Monitor lying and standing BP and pulse.							
8	Request medication review.							
9	Select suitable seating (refer to policy).							
10	Non-slip mat on chair/floor following advice of OT.							
11	Bed rails/bumpers to be used (refer to policy).							
12	Falls map in use for seven days.							
13	Bed/chair monitor in use.							
14	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.							
15	Patient to be nursed on mattress on the floor (refer to policy.)							
16	Patient requires one to one nursing care.							
17	Other interventions.							
	HIGH RISK ONLY (Score of 13 or over)							
18	Provide hip protectors to patients being discharged to care homes/longterm NHS facilities							
	SIGNATURE	[signature]						

Review Cannard score weekly / monthly as per policy.

Enter action code(s) selected in action taken section on Falls Risk Assessment.

South Glasgow Hospitals
Southern General Hospital, Glasgow G51 4TF. Tel. 0141 201 1100

Part [illegible]charge Letter and Medicine Prescription [illegible] · Confidential Ref No: 118638

NHS Greater Glasgow and Clyde

VIMI - DISCHARGE - 2725 SGH

Dear Doctor .....
Surgery .....

Fix ID label to all 4 copies

Patient: BRIAN MACKENZIE
Address: .....
.....
.....
DOB: ...../...../..... Unit no: .....
Weight ..... CHI no: .....

Ward: 2 Tel: 201 1633
Consultant: Mr Carter
Specialty .....
Named Nurse: G. MAVOR
Admission date: 03 / 10 / 09
Mode of admission A/E
Source of admission .....
Discharge date: 04 / 10 / 09

Follow-up arrangements
Clinic appointment made:
Yes ☑ No ☐ To follow ☐
Clinic name: .....
Date ...../...../..... 4/7
Non-childproof containers required: Yes ☐ No ☐
Medicine compliance aids required: Yes ☐ No ☐
Specify: .....

Reason for admission, treatment, diagnosis, investigations, operations, complications:
→ Open Dislocation (R) Thumb IPJ
→ Exploration washout & K wire Stabalisation of IPJ (R) thumb (03/10/09)

Other information

MEDICINE	Dosage form	Dose	Times for administration: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 8	pm 10	Other times	Recommended duration of treatment after discharge	New Drug	New Dose	Number of days supply	Dispensing Details (Pharmacy only)
FLUCLOXACILLIN	Cap	500mg		✓		✓			✓		✓		4/52				
CO-CODAMOL 30/500mg	Tab	2		✓		✓			✓		✓					112	

Medicines discontinued	Reason (if known) e.g. side effects

Clinical Pharmacy check:
All known drug sensitivity / adverse reactions:

Dispensed by: [illegible] Date: 04 / 10 / 09
Checked by: [illegible]

WARD USE ONLY
Med. rec. on ward by: .....
Issued by: ..... Date: ...../...../.....
Signature of recipient: .....

Doctor s name: Z SAEED Signature: [signature] Date 04/10/09
Doctor s grade: Z SAEED Pager number: 7555

Number of prescription sheets at discharge:

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

If you have any problems after discharge, please contact the Ward or your G.P.

PRESCRIPTION FORM

Hospital Name: .....

PATIENT DETAILS

Name: BRIAN MACKENZIE	Height:
CHI No: 3108583158.	Weight:
Hospital Number: SG00375441	Surface area:
DOB: 31/08/58.	Date of writing discharge prescription: __/__/__
Date of Admission: 2/10/9	Ward: 2.
Consultant Name:	

Date and time this form prepared:	Sheet No	2nd Prescription in use
2/10/9 Time:_____	.....	Yes or NO

DRUG SENSITIVITIES

NKDA

DVT Risk on Admission (SIGN Guideline)

High ☐ Moderate ☐ Low ☐

Assessed by: Date: __/__/__

OTHER CHARTS IN USE

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

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF PRESCRIBER	GIVEN BY	TIME GIVEN
3/10	OMEPRAZOLE	40mg	IV	09:20			0920

PATIENT'S NAME:

ADMINISTRATION

Parenteral Drugs: Regular Prescription

DATE → 3 04

MONTH → 10 10

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

A DRUG: € PABRINEX

DOSE: (I+II) x2 | ROUTE: IV | DATE: 2/10

STOPPED DATE:

SIGNATURE OF PRESCRIBER

STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

B DRUG: Flucloxacillin

DOSE: 1 Gm | ROUTE: IV | DATE: 03/10/08

STOPPED DATE:

SIGNATURE OF PRESCRIBER

STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

C DRUG

DOSE | ROUTE | DATE

STOPPED DATE:

SIGNATURE OF PRESCRIBER

STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

D DRUG

DOSE | ROUTE | DATE

STOPPED DATE:

SIGNATURE OF PRESCRIBER

STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

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

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

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

E DRUG

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

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

F DRUG

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

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

G DRUG

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

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

H DRUG

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

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

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

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE: 2 3 04
MONTH: 10 10 10

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

J DRUG: PARACETAMOL
DOSE: 1g | ROUTE: PO | DATE: 2/10 | STOPPED DATE:
SIGNATURE OF PRESCRIBER: | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

K DRUG: DICLOFENAC
DOSE: 50mg | ROUTE: PO | DATE: 2/10 | STOPPED DATE: 7/10
SIGNATURE OF PRESCRIBER: | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

L DRUG: Co-codamol 30/500
DOSE: 2 tabs | ROUTE: PO | DATE: 5/10 | STOPPED DATE:
SIGNATURE OF PRESCRIBER: | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: Review analgesia after 24 D.
FOR PRESCRIBERS USE ONLY

M DRUG:
DOSE: | ROUTE: | DATE: | STOPPED DATE:
SIGNATURE OF PRESCRIBER: | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

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

Oral and Other Drugs: Regular Prescriptions

DATE →
MONTH →

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

N DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

P DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

R DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

S DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

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

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE

MONTH

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

T DRUG

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

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

V DRUG

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

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

W DRUG

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

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

X DRUG

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

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Oral and Other Drugs: Regular Prescriptions

DATE →
MONTH →

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

Y DRUG

DOSE | ROUTE | DATE

STOPPED DATE:

SIGNATURE OF PRESCRIBER

INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

AA DRUG

DOSE | ROUTE | DATE

STOPPED DATE:

SIGNATURE OF PRESCRIBER

INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

BB DRUG

DOSE | ROUTE | DATE

STOPPED DATE:

SIGNATURE OF PRESCRIBER

INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

CC DRUG

DOSE | ROUTE | DATE

STOPPED DATE:

SIGNATURE OF PRESCRIBER

INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

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

...and drew a diagonal line through section

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE →
MONTH →

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

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

PATIENT'S NAME:

All Routes: As Required Prescriptions

ADMINISTRATION

MM DRUG: DIHYDROCODEINE — STOPPED DATE: — INITIALS:
DOSE: 30-60mg PO | ROUTE: | INDICATION: PAIN
SIGNATURE OF PRESCRIBER: | MAX.FREQUENCY: 4-6° | DATE: 2/10
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

DATE	
TIME	
DOSE	
GIVEN BY	

NN DRUG: DIAZEPAM — STOPPED DATE: — INITIALS:
DOSE: 10-20mg | ROUTE: PO | INDICATION: ETOH WITHDRAWAL
SIGNATURE OF PRESCRIBER: | MAX.FREQUENCY: ASPER CIWA | DATE: 2/10
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

DATE	
TIME	
DOSE	
GIVEN BY	

PP DRUG: Morphine — STOPPED DATE: — INITIALS:
DOSE: 10mg | ROUTE: S/C | INDICATION: Pain
SIGNATURE OF PRESCRIBER: | MAX.FREQUENCY: 1 | DATE: 3/10
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

DATE	3/10	3/10	4/10
TIME	18[23]	23[00]	1[30]
DOSE	10mg	10mg	10mg
GIVEN BY	[illegible]	[illegible]	[illegible]

RR DRUG: ONDANSETRON — STOPPED DATE: — INITIALS:
DOSE: 4mg | ROUTE: IV | INDICATION: N+V
SIGNATURE OF PRESCRIBER: | MAX.FREQUENCY: MAX dose 24° 16mg | DATE: 3/10
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

DATE	
TIME	
DOSE	
GIVEN BY	

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

Oral and Other Drugs: Regular Prescriptions

DATE →
MONTH →

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

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

LL DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

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

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

(Maximum number of doses as per protocol)

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

DOCTOR'S DECLARATION (if required by Local Protocol)

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

Signature: _____ Date: _____

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

Notes for Users

FOR PRESCRIBERS:

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

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

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

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

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

6. The following metric unit abbreviations must be used –

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

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

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

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

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

FOR NURSES

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

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

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

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

Codes for Non-Administration of Drugs

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

Cat No.00548 Ver 8, 01/2009

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

| | | |

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patient's name: Brian MacKenzie	Ward: 2
Unit number: SG 0037544	Discharge destination: HOME
CHI number:	**Estimated Discharge Date** (1) / /
	Estimated Discharge Date (2) / /
Apply addressograph label	Final date of discharge : 4 / 10 / 9

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓			
Relative/carer informed		✓		
Others informed: Care Home		✓		
Transport arranged				
Own transport (preferred option)	✓			
Ambulance-1 man/ 2 man am/pm		✓		
Other: Flight, Air ambulance etc.		✓		
Discharge medication				
Discharge prescription completed	✓			
Compliance aids e.g. Dossette Box (involve pharmacist)		✓		
Medication received	✓			
Medication explained to patient and/or relative/carer	✓			
Own medication returned to patient		✓		
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)		✓		
Informed of discharge				
Social work/ Other agencies/Home help		✓		
Physiotherapist		✓		
Occupational Therapist		✓		
Dietician		✓		
Speech and Language Therapist		✓		
Clinical Nurse specialist e.g. Care Home Liaison		✓		
Liaison/ District Nurse/Practice Nurse		✓		
Other discharge items				
Access arrangements (e.g. keys, door entry)	✓			
Patients clothing available for day of discharge	✓			
Valuables e.g. cashier.		✓		
Intravenous cannula removed	✓			
Equipment ordered (inc. walking aids) in place for discharge		✓		
Part 2 Discharge letter - Required		✓		
- Completed		✓		
Out patient clinic appointment e.g. Anticoagulation clinic				
Arranged / ~~To follow~~	✓			APPOINTMENT FOR 8/10/9 -
If unknown at time of discharge state reason		✓		11am · # CLINIC
Additional information / leaflets / factsheets				
Time of Discharge: 15.05				
Nurse's signature:	**Designation:** SIN			**Date:** 4 / 10 / 9



M ST NEXT DAY 17/
SG826 01327920-0
SOUTH GLASGOW UNIV
MAIN RECORDS
1345 GOVAN RD
GLASGOW G51 4TF

KAREN PARKER
0375441 -
MCKENZIE

SGE0451232-0019 F



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