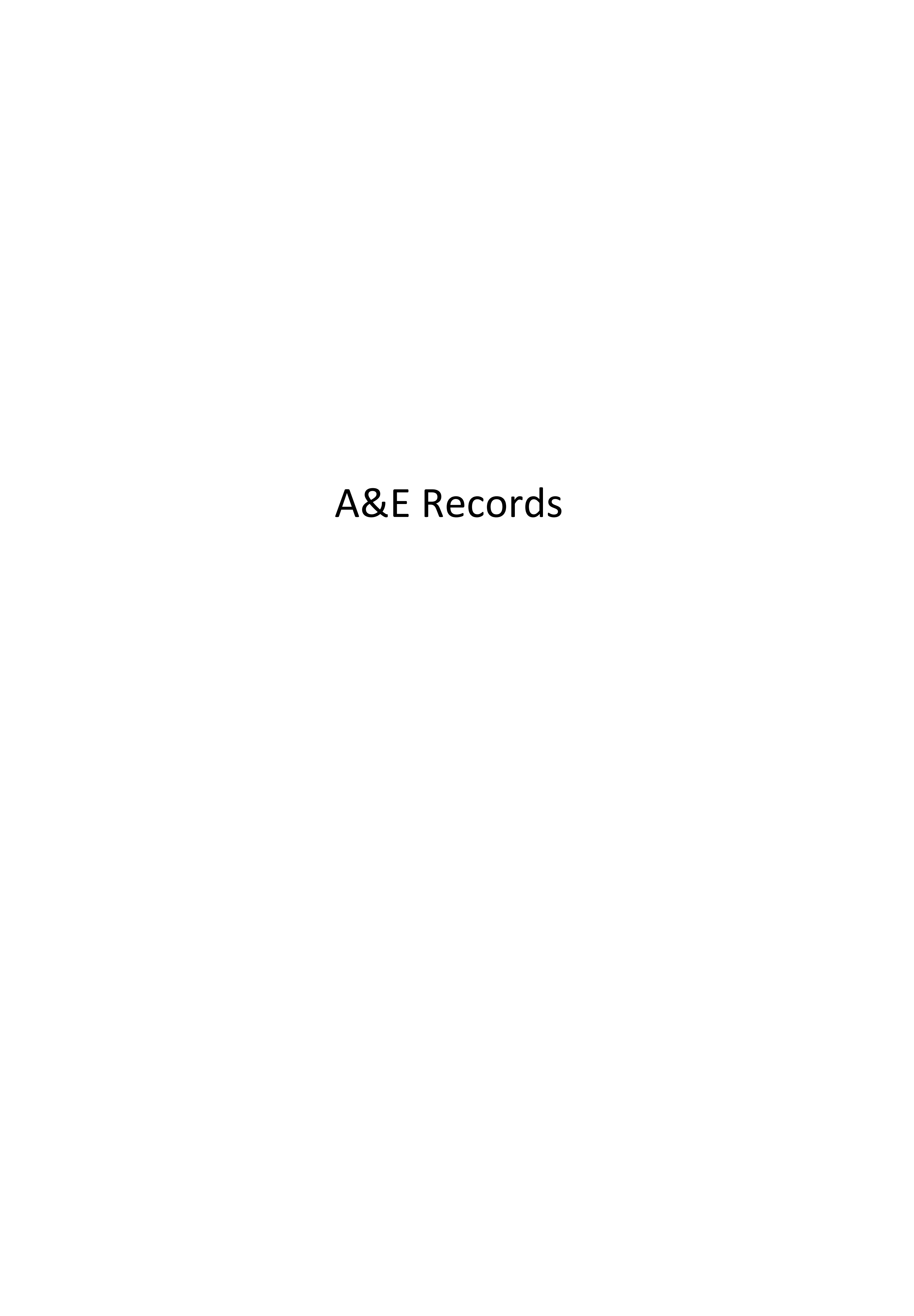

A&E Records

Patient & GP Information

UHPI Number	620045326K
CHI Number	2205671464
Episode Number	E6280830
Surname/Forename	Cross, Angella
Date of Birth	5/22/67
Sex	Female
Patient Address.	44 Woodburn Bank Dalkeith EH22 2EY
Registered GP	VE Aspinall
GP Address.	Newbattle Medical Practice,Blackcot,Mayfield,Midlothian EH22 4AA

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	E6280830

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
A&E Notes Episode/Ref: E6280830 Dr Mike Ingleston 1/18/26 14:29 Dr Mike Ingleston	CLINICAL NOTES: Clinical note: PC - 3/7 of haemoptisis and bi-lateral lower 'rib' pain HPC - has had viral symptoms for 2-3 weeks, main carer for daughter with Down's Syndrome who has had the same, patient thinks both have had 'flu' - last 3/7 has had intermittent flecks of fresh red blood in mucous - mucous started as green, now clear/white - feels feverish on exertion, and has had the odd chill spell - reduced oral intake and nauseated - pain gradually worsened across whole of lower anterior chest, worse the last 3/7, and sore to take deep breath - paracetamol, ibuprofen, aspirin not helping, main concern seems to be the pain PMH - T2DM, HTN, anxiety, Gallstones, partial thyroidectomy, recurrent ear infections Meds - as per ECS, NKDA SH - lives with daughter, acting as daughter's main carer (daughter currently in respite, was due back home today but have been given an extension due to mum being unwell) NEWS - 1 HR 109 ECG sinus tachy CXR - NAD CEPHID -ve Bloods - normal WCC, ALP 145 (chronically raised), CRP 28 O/E - looks well, but in obvious discomfort on mobilising, getting on and off trolley etc - chest clear, good air entry and expansion, dry central cough heard (non-productive when seen) - HS pure, CRT <2s, nil oedema - ASNT, BS present Impression - post-viral symptoms vs PE Wells 2.5 moderate risk - have taken D-Dimer and placed PVC left ACF Discussed with EPIC Dr Robinson Plan 1) Await D-Dimer - if positive could be ambulatory for CTPA in hours tomorrow, to be discussed with Radiology to see what capacity is like today. Otherwise treatment in ED today to come back for scan tomorrow. 2) If D-Dimer negative can go home with worsening advice regards haemoptisis and some codeine for rib pain, to follow-up with GP if (post) viral symptoms persist D-Dimer normal, discharged home with TTO codeine (helped in ED) and given worsening advice and advice on rest/TLC next few days

NHS Lothian

Royal Infirmary of Edinburgh
51 Little France Crescent
Old Dalkeith Road
Edinburgh
EH16 4SA

Dr VE Aspinall
Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA

Date: 19/01/2026

Emergency Discharge Summary

Patient	Angella Cross 44 Woodburn Bank Dalkeith Midlothian EH22 2EY	**CHI** **Date of Birth / Age** **UHPI** **A&E Attendance Number**	**2205671464** 22/05/1967 (58 years) 620045326K E6280830
Attendance Date	18/01/2026	**Contact**	
Attendance Time	10:05		
Mode of Arrival	Private Transport		
Source of Referral	Self Referral to A&E		
Discharge Date	18/01/2026		
Discharge To			

Dear Dr VE Aspinall

Presentation: unwell adult - mod pain t3 flu like symptoms for 10 days, feeling worse, started coughing up blood worsening abdo pain when coughing news 1 pmh htn cephied at triage h.reynolds

CLINICAL NOTES:
Clinical note: PC - 3/7 of haemoptisis and bi-lateral lower 'rib' pain

HPC - has had viral symptoms for 2-3 weeks, main carer for daughter with Down's Syndrome who has had the same, patient thinks both have had 'flu'
- last 3/7 has had intermittent flecks of fresh red blood in mucous
- mucous started as green, now clear/white
- feels feverish on exertion, and has had the odd chill spell
- reduced oral intake and nauseated
- pain gradually worsened across whole of lower anterior chest, worse the last 3/7, and sore to take deep breath
- paracetamol, ibuprofen, aspirin not helping, main concern seems to be the pain

PMH - T2DM, HTN, anxiety, Gallstones, partial thyroidectomy, recurrent ear infections

Meds - as per ECS, NKDA

SH - lives with daughter, acting as daughter's main carer (daughter currently in respite, was due back home today but have been given an extension due to mum being unwell)

NEWS - 1 HR 109

ECG sinus tachy
CXR - NAD
CEPHID -ve
Bloods - normal WCC, ALP 145 (chronically raised), CRP 28

O/E - looks well, but in obvious discomfort on mobilising, getting on and off trolley etc
- chest clear, good air entry and expansion, dry central cough heard (non-productive when seen)
- HS pure, CRT <2s, nil oedema
- ASNT, BS present

Impression - post-viral symptoms vs PE
Wells 2.5 moderate risk - have taken D-Dimer and placed PVC left ACF

Discussed with EPIC Dr Robinson

Plan
1) Await D-Dimer - if positive could be ambulatory for CTPA in hours tomorrow, to be discussed with Radiology to see what capacity is like today. Otherwise treatment in ED today to come back for scan tomorrow.
2) If D-Dimer negative can go home with worsening advice regards haemoptisis and some codeine for rib pain, to follow-up with GP if (post) viral symptoms persist

D-Dimer normal, discharged home with TTO codeine (helped in ED) and given worsening advice and advice on rest/TLC next few days

Yours Sincerely,

Dr Mike Ingleston, Doctor

NHS Lothian
University Hospital Services

Department of Emergency Medicine

Dr. Dave McKean ED Clinical Director
Ray Middlemiss ED Clinical Nurse Manager
The Royal Infirmary of Edinburgh
51 Little France Crescent, Edinburgh, EH16 4SA
Tel: 0131 242 1300 Fax: 0131 242 1344

A/E no.	E6280830
Previous no.	E5992993
UHPI no.	620045326K
CHI no.	2205671464

Patient Information

Surname	Cross	Date of Birth	22/05/1967
Forenames	Angella	Age / Sex	58 Yrs / F
Address	44 Woodburn Bank Dalkeith, Midlothian		
Postcode	EH22 2EY	Telephone	283 8775
Contact Address	[redacted] Edinburgh EH16 5RW		
Complaint	coughing up blood / rib pain	Allergies	

Attendances in last 12 months: 1 School :

General Practitioner

Address	VE Aspinall Newbattle Medical Practice Blackcot Mayfield Midlothian EH22 4AA
Telephone	0131 663 1051

Date and Time of Attendance	18/01/2026 10:05 Incident Date Time:
Mode of Arrival	Private Transport
Source of Referral	Self Referral to A&E

Initial Triage Assessment

Presenting Complaint	
History of Presenting Complaint	
Assessment	

Nursing Observations & Assessments

TEMP	°C	SCORE	MIN. FREQ	(please tick)	Blood Sugar	mmols	Pain Score	/ 10		
HR		NEWS 0-1	Hourly		Peak Flow 1)		Analgesia Given	YES ☐	NO ☐	
BP	/	NEWS 2-4	30mins Min		Peak Flow 2)		Fast Assessment	POS ☐	NEG ☐	
SPO2%	%	NEWS 5-7	15mins Min		Peak Flow 3)		Onset Time:			
RR		NEWS >7	10mins Min		Alcometer		Weight		Height	
AVPU		Special Clinical Instructions								
O2 Therapy In Progress	Yes (= +2) No (= 0)	Please indicate any specific clinical observations to be continued or repeated once patient has left OPP								
NEWS SCORE										

Triaged By: Print Name: Signature: Triage Time:

Opp Care & Discharge Record

PVC Insertion - Please initial when complete			
Handwash		Gloves	
CHD Skin Prep		Aseptic Insertion	
Dressing Labelled		Paperlite Bundle	
Reason for PVC Insertion:			

Blood Samples - Please tick all that apply			
Routine		CRP	
Troponin		Coag	
Amylase		Tox Screen	
BTS		Other (Please state)	

Additional Investigations		
ECG - Please tick		
Required ☐	Done ☐	
Urinalysis - Please tick		
Required ☐	Done ☐	
MSU Sent	Yes ☐	No ☐
HCG Consent	Yes ☐	No ☐
HCG Result	Yes ☐	No ☐
X-Rays - Please tick		
CRX	Yes ☐	No ☐
CT Scan	Yes ☐	No ☐
Other (Please state)		

On Going Care Plan

Speciality Informed (enter time)		Bed Required		Triaged To - Please tick			
Surg:	G.I:	Yes ☐	No ☐	Waiting Room		GP Out of Hours	
Vasc:	Stroke:	Transfer To: (Please tick if required)		Resus		Gynae Triage	
Medics:	Gynae:	WGH		HD		SMMP	
Ortho:	Neuro:	SJH		IC		MIU	
Other (state Speciality)		Other (please state)		Exam		Other (Please state)	

"What Happens To The Patient?"

Clinical Notes

Think:- Other Sources of Information:

Family ☐ Carers ☐ SAS ☐ PRF ☐ EPR ☐ ECS ☐ KIS ☐ GP ☐ Patient Alerts ☐

Care Providers Name: ______________________ Signature: ______________________

NHS LOTHIAN

Emergency Department

Adult Majors

Prescription, Administration & Observation Record

620045326K /E6280830 F
CROSS Angella
22-May-67 **CHI:** 220 567 1464
77106 VE Aspinall
44 Woodburn Bank Midlothian
EH22 2EY

The section below must be completed before any medicine is prescribed/given

Previous Adverse Reactions	NKDA	Weight ___ kgs Actual / Estimate	Date 18/1/726

Once Only Prescription

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber Sign & Print	Time Given	Issued by (Initials)	Checked by if applicable (Initials)
18/1	11.30	Codeine	60mg	PO	[signature]	11.35	[initials]	

Discharge Medication

Date & Time	Medicine (Approved Name)	Dose	Frequency	Route	Quantity	Duration	Prescriber Sign & Print	Issued by (Initials)	Checked by (Initials)
18/1	Codeine	60mg	4° PRN	PO	28	4/7	[signature]	[initials]	[signature]

National Early Warning Score 2 (NEWS2) Chart

NEWS Key	Date:																			
0 1 2 3	Time:																			
A+B	≥25										3									
	21-24										2									
Respirations	18-20																			
Breaths/min	15-17																			
	12-14																			
	9-11										1									
	≤8										3									
A+B	≥96																			
SpO_2 Scale 1	94-95										1									
Oxygen saturation (%)	92-93										2									
Use Scale 1 if target range is 94-98%	≤91										3									
SpO_2 Scale 2*	≥97 on O_2										3									
Oxygen saturation (%)	95-96 on O_2										2									
Use Scale 2 if target range is 88-92% eg. in hypercapnic respiratory failure	93-94 on O_2										1									
	≥93 on air																			
* ONLY use Scale 2 under the direction of a qualified clinician	88-92																			
	86-87										1									
Tick box if using SpO_2 Scale 2	84-85										2									
Sign:	≤83										3									
Air or Oxygen?	A = Air																			
Oxygen is a drug and prescribed by target range	O² L/min or %										2									
	Device																			
C	≥220										3									
	201-219																			
Blood Pressure mmHg	181-200																			
	161-180																			
Score uses Systolic BP only	141-160																			
	121-140																			
	111-120																			
If manual BP mark as M	101-110										1									
	91-100										2									
	81-90																			
	71-80																			
	61-70										3									
	51-60																			
	≤50																			
C	≥131										3									
	121-130										2									
Pulse	111-120																			
Beats/min	101-110										1									
	91-100																			
Manual pulse	81-90																			
	71-80																			
	61-70																			
	51-60																			
	41-50										1									
	31-40										3									
	≤30																			
D	Alert																			
	New Confusion																			
Consciousness	V																			
Score for new onset of confusion	P										3									
(no score if chronic)	U																			
E	≥39.1°										2									
	38.1-39.0°										1									
Temperature	37.1-38.0°																			
°C	36.1-37.0°																			
	35.1-36.0°										1									
	≤35.0°										3									
NEWS TOTAL																				
Monitoring frequency																				
Escalation of care Y/N																				
Blood Glucose reading or N/A																				
Pain score (0-10)																				
Initials																				

Reproduced from: Royal College of Physicians. National Early Warning Score (NEWS) 2: Standardising the assessment of acute-illness severity in the NHS. Updated report of a working party. London: RCP, 2017.

NEWS of 5 or more?
Think Sepsis!

In a patient with a **NEWS of 5 or more** and a known infection, signs and symptoms of infection, or at risk of infection, think **'Could this be sepsis?'** and **escalate care immediately.**

Signs of Infection

- Temperature <36°c or >38°c
- Heart rate >90 beats pm
- Respiratory rate >20 breaths pm
- New confusion
- WCC <4 or >12
- Blood sugar >7.7 in non-diabetic

Addressograph

Name:

DOB:

CHI:

NEWS Total	Monitoring Frequency	Clinical Response
Total 0	Commence on 2 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
Total 1 - 4	Commence on 1 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
3 in one parameter *	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to Nurse In Charge (NIC) and Senior Medic
Total 5 - 6	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Total 7 or more	Commence on 15 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Special Instructions		

*or increase in NEWS score of 2

Conscious Level Chart to be completed when clinically indicated

Section	Category	Item	Score	Note
		Date		
		Time		
GLASGOW COMA SCALE	Eyes Open	Spontaneously	4	Eyes closed by swelling = C
		To speech	3	
		To pain	2	
		None	1	
	Best Verbal Response	Orientated	5	Endotracheal tube or tracheostomy = T
		Confused	4	
		Inappropriate words	3	
		Incomprehensible sounds	2	
		None	1	
	Best Motor Response	Obey commands	6	Always record the best arm response
		Localise to pain	5	
		Flexion to pain	4	
		Abnormal flexion	3	
		Extension to pain	2	
		None	1	
		Total GCS Score		
	Right Pupil	Size		+ reacts - no reaction c. eye closed
		Reaction		
	Left Pupil	Size		
		Reaction		
LIMB MOVEMENT	ARMS	Normal power		Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness		
		Severe weakness		
		Extension		
		No response		
	LEGS	Normal power		
		Mild weakness		
		Severe weakness		
		Extension		
		No response		
		Initials		

Pupil Scale mm 1 2 3 4 5 6 7 8

IV Fluid Prescription

Time Prescribed	Fluid	Volume	Rate	Prescribers Signature	Time Started	Given by (Initials)	Checked by (Initials)	Time Finished

Fluid Balance

INPUT						OUTPUT				
	IV Fluids or SC Fluids IV Medication	**IV Line(s)**	**Oral Input**		**Input**		**Urine**		**Gastric**	
Time	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100ml	Running Total	Time	Volume	Running Total	Volume	Running Total

Drug Infusion

Drug Name:

	Time													
	Rate (ml/hr)													
	Volume in Syringe													
Pump No	Total amount Infused													

Drug Name:

	Time													
	Rate (ml/hr)													
	Volume in Syringe													
Pump No	Total amount Infused													

Patient & GP Information

UHPI Number	620045326K
CHI Number	2205671464
Episode Number	E5992993
Surname/Forename	Cross, Angella
Date of Birth	5/22/67
Sex	Female
Patient Address.	44 Woodburn Bank Dalkeith EH22 2EY
Registered GP	VE Aspinall
GP Address.	Newbattle Medical Practice,Blackcot,Mayfield,Midlothian EH22 4AA

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	E5992993

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
A&E Notes Episode/Ref: E5992993 Dr Alix Margaret Wrighton 4/1/25 10:59 Dr Alix M Wrighton	CLINICAL NOTES: Clinical note: ED Locum SHO Alix Wrighton PC - 57 y/o female, self presenter, right ear ache HPC - Suspected flu a few weeks ago with dry cough and fevers - Over the past week has had right sided earache, unsteadiness and reduced hearing in the right side. Pain sharp in nature and radiates to the right jaw/parotid area. No discharge from ear - No vertigo. No visual changes. No facial droop - went to pharmacy and was told to take simple analgesia - Attending ED this morning due to vomitting overnight and struggling to keep fluids down. Has managed to keep liquids down this morning but ongoing nausea - Ongoing dry cough and feeling feverish. No haemoptysis. No calf pain or swelling - No abdo pain - No urinary symptoms PMHx HTN T2DM Anxiety Gallstones Partial thyroidectomy Grommets as child with recurrent ear infection (verbal hx, no notes of TRAK) SHx Lives with 2 children. Cares for daughter with Down Syndrome Non smoker Non drinker iADLs DHx NKDA OE Looks uncomfortable A: Patent own B: Good AE throughout, no added sounds C: HS I+II+0. WWP. Calves snt D: GCS 15 E: Abdo snt Right ear: Erythematous ear canal with bulging TM ?fluid level seen. Tenderness at the pre-auricular area, minimal post auricular tenderness. No loss of mastoid-auricular swelling, no masteroid redness or boggy swelling. -Minimally swollen of the right parotid gland area, soft, no stones felt, minimal tenderness -Normal power in face, PEARL, normal eye movements. Reduced sensation in the right side of face (whole half of face) Impression 1. AOM with effusion. Plan - Analgesia and antiemetics. Trial fluids after antiemetics to ensure keeping it down - Bloods to check inflammatory ---------------- CRP 26 WCC 6.4 Managing to keep down fluids HR now 93bpm, apyrexial, BP 135/96 Impression 1. AOM with effusion. No indication for urgent ENT review today

Surname/Forename	Cross Angella
UHPI Number	620045326K

Episode Number	E5992993

Note Details	Clinical Notes
	Plan - 5 days amox 500mg TDS + PRN prochlorperazine + PRN codine + regular simple analgesia - Worsenign statement given - If no improvement with the abx to seek medical review (if feverish, vomitting, feeling very unwell and sore --> ED. If feeling no improvement but generally well --> See GP, May need ENT referral if no improvement with abx)

NHS Lothian

Royal Infirmary of Edinburgh
51 Little France Crescent
Old Dalkeith Road
Edinburgh EH16 4SA

Dr VE Aspinall
Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA

Date: 02/04/2025

Emergency Discharge Summary

Patient	Angella Cross 44 Woodburn Bank Dalkeith Midlothian EH22 2EY	**CHI**	**2205671464**
		Date of Birth / Age	22/05/1967 (57 years)
		UHPI	620045326K
		A&E Attendance Number	E5992993
Attendance Date	01/04/2025	**Contact**	
Attendance Time	08:53		
Mode of Arrival	Private Transport		
Source of Referral	NHS 24		
Discharge Date	01/04/2025		
Discharge To			

Dear Dr VE Aspinall

Presentation: Ear problems T3 - Moderate pain <7/7 R ear pain, vomitting, dizziness feels off balance Has been taking own analgesia and home remedies as advised by chemist no success Advised to attend by NHS 24 7/10 Pain declined pain releif NEWA 1

CLINICAL NOTES:
Clinical note: ED Locum SHO Alix Wrighton

PC - 57 y/o female, self presenter, right ear ache

HPC
- Suspected flu a few weeks ago with dry cough and fevers
- Over the past week has had right sided earache, unsteadiness and reduced hearing in the right side. Pain sharp in nature and radiates to the right jaw/parotid area. No discharge from ear
- No vertigo. No visual changes. No facial droop
- went to pharmacy and was told to take simple analgesia
- Attending ED this morning due to vomitting overnight and struggling to keep fluids down. Has managed to keep liquids down this morning but ongoing nausea
- Ongoing dry cough and feeling feverish. No haemoptysis. No calf pain or swelling
- No abdo pain
- No urinary symptoms

PMHx
HTN
T2DM

Anxiety
Gallstones
Partial thyroidectomy
Grommets as child with recurrent ear infection (verbal hx, no notes of TRAK)

SHx
Lives with 2 children. Cares for daughter with Down Syndrome
Non smoker
Non drinker
iADLs

DHx
NKDA

OE
Looks uncomfortable
A: Patent own
B: Good AE throughout, no added sounds
C: HS I+II+0. WWP. Calves snt
D: GCS 15
E: Abdo snt
Right ear: Erythematous ear canal with bulging TM ?fluid level seen. Tenderness at the pre-auricular area, minimal post auricular tenderness. No loss of mastoid-auricular swelling, no masteroid redness or boggy swelling. -Minimally swollen of the right parotid gland area, soft, no stones felt, minimal tenderness
-Normal power in face, PEARL, normal eye movements. Reduced sensation in the right side of face (whole half of face)

Impression
1. AOM with effusion.

Plan
- Analgesia and antiemetics. Trial fluids after antiemetics to ensure keeping it down
- Bloods to check inflammatory

CRP 26
WCC 6.4

Managing to keep down fluids

HR now 93bpm, apyrexial, BP 135/96

Impression
1. AOM with effusion. No indication for urgent ENT review today

Plan
- 5 days amox 500mg TDS + PRN prochlorperazine + PRN codine + regular simple analgesia
- Worsenign statement given - If no improvement with the abx to seek medical review (if feverish, vomitting, feeling very unwell and sore --> ED. If feeling no improvement but generally well --> See GP, May need ENT referral if no improvement with abx)

Yours Sincerely,

Dr Alix Margaret Wrighton, Doctor

NHS24 CONTACT REPORT

PCM ID: 75554949
CHI: 2205671464
Surname: CROSS
Forename: ANGELLA
DOB: 22.05.1967
Gender: F
Address: 44 Woodburn Bank
DALKEITH
EH22 2EY

Caller : Self
Date/Time Call Received: 01.04.2025 07:13:00
Date/Time Call Completed: 01.04.2025 07:32:38

Current Location: 44 Woodburn Bank
DALKEITH
EH22 2EY

Phone Number: 07958055729
Phone Ext.:

Special Directions:
Temporary Resident: NO

GP: VANESSA ASPINALL
NEWBATTLE MED PRACTICE
NEWBATTLE MED PRACTICE
BLACKCOT
DALKEITH EH224AA

Call Classification:

CALL SUMMARY:
FINAL ENDPOINT:
Accident & Emergency (ASAP)
REASON FOR CALL / RELEVANT INFORMATION:
EAR PAIN 6 DAYS
OUTCOME:
Patient advised to go to A&E

620045326K /E5992993 F
CROSS Angella
22-May-67 **CHI:** 220 567 1464
77106 VE Aspinall
44 Woodburn Bank Midlothian
EH22 2EY

Confirmed Symptom(s):
#Facial swelling
#Facial swelling only; not involving eye
#Has Fever

Risk Factor(s):
#No travel outside Europe in last 21 days or to an affected country

Call Detail(s):
#Endpoint Management Selected (CCT)

PAST MEDICAL HISTORY:

NOTES:

01:04:2025 07:15:36 BAKERI1 COLD SYMPTOMS, ATTENDED PHARMACY 1 WEEK AGO AND YESTERDAY. FACE SWOLLEN AND PAINFULL. TAKING REGULAR ANALGESIA. LOSS OF HEARING
LOOSING BALANCE ON STANDING.

01:04:2025 07:26:56 BLAIRL RETURN CALLER SPOKE TO TWO PHARMACISTS OTC MEDS NOT WORKING FACE/JAW NOW SWOLLEN SHOOTING PAIN FROM R EAR DOWN TO JAW PAIN UNBAREABLE DISTRESSED ON CALL
RIGHT SIDE OF FACE TENDER TO TOUCH PAIN 9 NO RELIEF FORM PARACETEMOL AND IBUPROFEN
INTERMITTENT HEADACHE FEELS LIKE LOOSING BALANCE
NO VISUAL CHANGES SYMPTOMS ONGOING FOR 1/52 TRIED SELFCARING NOW WORSENED-A&E ASAP/1HR

NHS24 CONTACT REPORT

Support Line Notes:

NHS Lothian
University Hospital Services
Department of Emergency Medicine

Dr. Dave McKean ED Clinical Director
Ray Middlemiss ED Clinical Nurse Manager
The Royal Infirmary of Edinburgh
51 Little France Crescent, Edinburgh, EH16 4SA
Tel: 0131 242 1300 Fax: 0131 242 1344

Lothian

A/E no. E5992993
Previous no. E5698949
UHPI no. 620045326K
CHI no. 2205671464

Patient Information

Surname	Cross	Date of Birth	22/05/1967
Forenames	Angella	Age / Sex	57 Yrs / F
Address	44 Woodburn Bank Dalkeith, Midlothian		
Postcode	EH22 2EY	Telephone	283 8775
Contact Address	[redacted] Edinburgh EH16 5RW		
Complaint	car pain	Allergies	

Attendances in last 12 months: 1 School :

General Practitioner

Address: VE Aspinall
Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA
Telephone: 0131 663 1051

Date and Time of Attendance: 01/04/2025 08:53
Incident Date Time:
Mode of Arrival: Private Transport
Source of Referral: NHS 24

Initial Triage Assessment

Presenting Complaint	
History of Presenting Complaint	
Assessment	

Nursing Observations & Assessments

TEMP	°C	SCORE	MIN. FREQ	(please tick)	Blood Sugar	mmols	Pain Score	/ 10		
HR		NEWS 0-1	Hourly		Peak Flow 1)		Analgesia Given	YES ☐	NO ☐	
BP	/	NEWS 2-4	30mins Min		Peak Flow 2)		Fast Assessment	POS ☐	NEG ☐	
SP02%	%	NEWS 5-7	15mins Min		Peak Flow 3)		Onset Time:			
RR		NEWS >7	10mins Min		Alcometer		Weight		Height	
AVPU		Special Clinical Instructions								
O2 Therapy In Progress	Yes (= +2) No (= 0)	Please indicate any specific clinical observations to be continued or repeated once patient has left OPP								
NEWS SCORE										

Triaged By: Print Name: Signature: Triage Time:

Opp Care & Discharge Record

PVC Insertion - Please initial when complete

Handwash		Gloves	
CHD Skin Prep		Aseptic Insertion	
Dressing Labelled		Paperlite Bundle	
Reason for PVC Insertion:			

Blood Samples - Please tick all that apply

Routine		CRP	
Troponin		Coag	
Amylase		Tox Screen	
BTS		Other (Please state)	

Additional Investigations

ECG - Please tick		
Required ☐	Done ☐	
Urinalysis - Please tick		
Required ☐	Done ☐	
MSU Sent	Yes ☐	No ☐
HCG Consent	Yes ☐	No ☐
HCG Result	Yes ☐	No ☐
X-Rays - Please tick		
CRX	Yes ☐	No ☐
CT Scan	Yes ☐	No ☐
Other (Please state)		

On Going Care Plan

Speciality Informed (enter time)		Bed Required		Triaged To - Please tick			
Surg:	G.I:	Yes ☐	No ☐	Waiting Room		GP Out of Hours	
Vasc:	Stroke:	Transfer To: (Please tick if required)		Resus		Gynae Triage	
Medics:	Gynae:	WGH		HD		SMMP	
Ortho:	Neuro:	SJH		IC		MIU	
Other (state Speciality)		Other (please state)		Exam		Other (Please state)	

"What Happens To The Patient?"

Clinical Notes

Think:- Other Sources of Information:

Family ☐ Carers ☐ SAS ☐ PRF ☐ EPR ☐ ECS ☐ KIS ☐ GP ☐ Patient Alerts ☐

Care Providers Name: ____________________ Signature: ____________________

5992993.

NHS LOTHIAN

Emergency Department

Adult Majors

Prescription, Administration & Observation Record

620045326K /E599295
CROSS Angella
22-May-67 CHI: 220 567 1464
77106 VE Aspinall
44 Woodburn Bank Midlothian
EH22 2EY

The section below must be completed before any medicine is prescribed/given

Previous Adverse Reactions		Weight	Date
	NKDA	kgs Actual / Estimate	1/4/25

Once Only Prescription

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber Sign & Print	Time Given	Issued by (Initials)	Checked by if applicable (Initials)
01/04/25	10¹⁵	PARACETAMOL	1g	PO	[signature]	10²⁰	LA	
01/04/25	10¹⁵	OCAMORPH	5mg	PO	[signature]	10²⁰	LA	
01/04/25	10¹⁵	CYCLIZINE	50mg	PO	[signature]	10²⁰	LA	

Discharge Medication

Date & Time	Medicine (Approved Name)	Dose	Frequency	Route	Quantity	Duration	Prescriber Sign & Print	Issued by (Initials)	Checked by (Initials)
1/4/25	CODEINE	30mg	PRN QDS	PO	1 BOX	1 week	[signature]	GM	[signature]
1/4/25	AMOXICILLIN	500mg	TDS	PO	1 BOX	5 DAYS	[signature]	GM	[signature]
1/4/25	PROCHLORPERAZINE	5mg	TDS	PO	1 BOX	1 Week	[signature]	GM	[signature]

5992993.

NHS LOTHIAN

Emergency Department

Adult Majors

Prescription, Administration & Observation Record

620045326K /E599295
CROSS Angella
22-May-67 CHI: 220 567 1464
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The section below must be completed before any medicine is prescribed/given

Previous Adverse Reactions	Weight	Date
NKDA	kgs Actual / Estimate	1/4/25

Once Only Prescription

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber Sign & Print	Time Given	Issued by (Initials)	Checked by if applicable (Initials)
01/04/25	10:15	PARACETAMOL	1g	PO	[signature]	10:20	LA	
01/04/25	10:15	OXYCODONE	5mg	PO	[signature]	10:20	LA	
01/04/25	10:15	CYCLIZINE	50mg	PO	[signature]	10:20	LA	

Discharge Medication

Date & Time	Medicine (Approved Name)	Dose	Frequency	Route	Quantity	Duration	Prescriber Sign & Print	Issued by (Initials)	Checked by (Initials)
1/4/25	CODEINE	30mg	PRN QDS	PO	1 BOX	1 week	[signature]	GM	[signature]
1/4/25	AMOXICILLIN	500mg	TDS	PO	1 BOX	5 DAYS	[signature]	GM	[signature]
1/4/25	PROCHLORPERAZINE	5mg	TDS	PO	1 BOX	1 Week	[signature]	GM	[signature]

National Early Warning Score 2 (NEWS2) Chart

NEWS Key: 0 | 1 | 2 | 3

Parameter		Score	Obs 1	Obs 2
	Date:		1/4/25	
	Time:		0940	1135
A+B Respirations Breaths/min	≥25	3		
	21-24	2		
	18-20			
	15-17		17	16
	12-14			
	9-11	1		
	≤8	3		
A+B SpO_2 Scale 1 Oxygen saturation (%) Use Scale 1 if target range is 96-98%	≥96		96	96
	94-95	1		
	92-93	2		
	≤91	3		
SpO_2 Scale 2* Oxygen saturation (%) Use Scale 2 if target range is 88-92%, eg in hypercapnic respiratory failure	≥97 on O_2	3		
	95-96 on O_2	2		
	93-94 on O_2	1		
	≥93 on air			
* ONLY use Scale 2 under the direction of a qualified clinician	88-92			
	86-87	1		
Tick box if using SpO_2 Scale 2	84-85	2		
Sign	≤83	3		
Air or Oxygen? Oxygen is a drug and prescribed by target range	A = Air		A	A
	O² L/min or %	2		
	Device			
C Blood Pressure mmHg Score uses Systolic BP only. If manual BP mark as M	≥220	3		
	201-219			
	181-200		187	
	161-180		^	
	141-160		v	167
	121-140		139	↕
	111-120			
	101-110	1		112
	91-100	2		
	81-90	3		
	71-80			
	61-70			
	51-60			
	≤50			
C Pulse Beats/min Manual pulse	≥131	3		
	121-130	2		
	111-120			
	101-110	1	108	
	91-100			96
	81-90			
	71-80			
	61-70			
	51-60			
	41-50	1		
	31-40	3		
	≤30			
D Consciousness Score for new onset of confusion (no score if chronic)	Alert		A	A
	New Confusion	3		
	V			
	P			
	U			
E Temperature °C	≥39.1°	2		
	38.1-39.0°	1		
	37.1-38.0°			
	36.1-37.0°		36.4	36.3
	35.1-36.0°	1		
	≤35.0°	3		
NEWS TOTAL			1	1
Monitoring frequency			↑	2°
Escalation of care Y/N			N	N
Blood Glucose reading or N/A				
Pain score (0-10)				6/10
Initials			KG	Lo

NEWS of 5 or more? Think Sepsis!

In a patient with a **NEWS of 5 or more** and a known infection, signs and symptoms of infection, or at risk of infection, think **'Could this be sepsis?'** and **escalate care immediately.**

Signs of Infection

- Temperature <36°c or >38°c
- Heart rate >90 beats pm
- Respiratory rate >20 breaths pm
- New confusion
- WCC <4 or >12
- Blood sugar >7.7 in non-diabetic

620045326K /E5992993 F
CROSS Angella
22-May-67 **CHI:** 220 567 1464
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NEWS Total	Monitoring Frequency	Clinical Response
Total 0	Commence on 2 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
Total 1 - 4	Commence on 1 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
3 in one parameter *	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to Nurse In Charge (NIC) and Senior Medic
Total 5 - 6	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Total 7 or more	Commence on 15 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Special Instructions		

*or increase in NEWS score of 2

Conscious Level Chart to be completed when clinically indicated

Section	Sub-section	Item	Score	Observations	Notes
		Date			
		Time			
GLASGOW COMA SCALE	Eyes Open	Spontaneously	4		Eyes closed by swelling = C
		To speech	3		
		To pain	2		
		None	1		
	Best Verbal Response	Orientated	5		Endotracheal tube or tracheostomy = T
		Confused	4		
		Inappropriate words	3		
		Incomprehensible sounds	2		
		None	1		
	Best Motor Response	Obey commands	6		Always record the best arm response
		Localise to pain	5		
		Flexion to pain	4		
		Abnormal flexion	3		
		Extension to pain	2		
		None	1		
		Total GCS Score			
Right Pupil		Size			+ reacts - no reaction c. eye closed
		Reaction			
Left Pupil		Size			
		Reaction			
LIMB MOVEMENT	ARMS	Normal power			Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness			
		Severe weakness			
		Extension			
		No response			
	LEGS	Normal power			
		Mild weakness			
		Severe weakness			
		Extension			
		No response			
		Initials			

Pupil Scale mm 1 • 2 • 3 4 5 6 7 8

IV Fluid Prescription

Time Prescribed	Fluid	Volume	Rate	Prescribers Signature	Time Started	Given by (Initials)	Checked by (Initials)	Time Finished

Fluid Balance

INPUT						OUTPUT				
	IV Fluids or SC Fluids IV Medication	**IV Line(s)**	**Oral Input**		**Input**		**Urine**		**Gastric**	
Time	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100ml	Running Total	Time	Volume	Running Total	Volume	Running Total

Drug Infusion

Drug Name:

	Time													
	Rate (ml/hr)													
	Volume in Syringe													
Pump No	Total amount Infused													

Drug Name:

	Time													
	Rate (ml/hr)													
	Volume in Syringe													
Pump No	Total amount Infused													

Patient & GP Information

UHPI Number	620045326K
CHI Number	2205671464
Episode Number	E5698949
Surname/Forename	Cross, Angella
Date of Birth	5/22/67
Sex	Female
Patient Address.	44 Woodburn Bank Dalkeith EH22 2EY
Registered GP	VE Aspinall
GP Address.	Newbattle Medical Practice,Blackcot,Mayfield,Midlothian EH22 4AA

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	E5698949

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
A&E Notes Episode/Ref: E5698949 Dr Jakub Foytl 5/20/24 22:58 Dr Jakub Foytl	CLINICAL NOTES: Clinical note: ED Review (Pod E) - Foytl (ACCS1) 20/05/24 - 22:56 F56 presents with abdominal & back pain following lifting heavy object *** abbreviated summery with full documentation to follow *** PC: abdo + back pain HPC: - lifting heavy object (concrete) stood up and sudden pain in upper abdomen + back - sharp, cramping, debilitating - initially 6/10 now 8/10 - able to walk and mobilise - denies any neurological symtpoms - no numbness, weakness, parasthesia or loss of sesnation - denies bladder or bwel symptoms: able to feel bladder fill / building urge - able to hold off and control - aware of passing and cessation of urine passage and intact sensation on wiping - no head injury - no fall - no other trauma - has had Co-codamol 30/500 x 3 today but nil else. minimmal relief. does not like taking tablets. Concerned about hernia. PMHx: - HTN - T2DM - anxiety DHX: - Metformin - Ramipril - Mirtazapine - Omeprazole NKDA SHx: - carer (currently not working) - alcohol minimal - smoking no - lives with partner On examination - NEWS = 4 tachycardic 104 223/168 Walking in independently. Clearly in pain. Slower movements. On inspection, no obvious bruising, swelling or deformity. No midline tenderness at any level of spine. Abdomen soft, no masses or lumps, no obvious herniation. No brusing. Pain aggravated by palaption in upper and lower abdomne. Bilaterally painful, swollen and tender erector spinae muscles. Limited thoracic extension and flexion. Limited thoracic rotation. Sensation intact throughout thoracic dermatomes. Sensation intact throughout upper limb dermatomes, bilaterally. Normal tone and power throughout UL bilaterally. ECG - sinus tachy, nil ischemic, long QTc and RsR in II (all seen previously). BLOODS - not indicated Impression: most likely MSK pain due to strain injury - no red flags on Hx or exam so far - needs re-examined ? hearnia

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	E5698949

Note Details	Clinical Notes
	PLAN: 1. Analgesia (given) 2. Re-examine once able - currently too sore a. need to clincally check for hernia 3. Pending D/W senior provisional plan would be D/C with analgesia, PT self-referral and worsening advice. Foytl (ACCS1) Update - D/W Dr B Earle-Wright (EM ST5): in agreement with all above. suggested addition of CXR (requested). Patient settled with Oramorph, Paracetamol and Ibuprofen. Await CXR and aim for DC. Foytl (ACCS1) CXR reviewed - no obvious Pneumothorax, fracture or injury. No consolidation. Impression of MSK type back pain most likely. Given advice leaflet and advice on self-referral to PT. Analgesia improved and given Oromorph as TTO. Discharged from ED. Foytl (ACCS1)

NHS Lothian

Royal Infirmary of Edinburgh
51 Little France Crescent
Old Dalkeith Road
Edinburgh EH16 4SA

Dr VE Aspinall
Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA

Date: 21/05/2024

Emergency Discharge Summary

Patient	Angella Cross 44 Woodburn Bank Dalkeith Midlothian EH22 2EY	**CHI** **Date of Birth / Age** **UHPI** **A&E Attendance Number**	**2205671464** 22/05/1967 (56 years) 620045326K E5698949
Attendance Date	20/05/2024	**Contact**	
Attendance Time	19:51		
Mode of Arrival	Private Transport		
Source of Referral	Self Referral to A&E		
Discharge Date	20/05/2024		
Discharge To			

Dear Dr VE Aspinall

Presentation: ABDOMINAL PAIN IN ADULTS, moderate pain, T3, lifting heavy concrete @ 1100 and felt muscle pull sensation across top of abdomen. Now radiating into rear flank bilaterally and lower back. PU and bowels normal. Nausea but no vomiting. Own analgesia take

CLINICAL NOTES:
Clinical note: ED Review (Pod E) - Foytl (ACCS1)
20/05/24 - 22:56
F56 presents with abdominal & back pain following lifting heavy object

*** abbreviated summery with full documentation to follow ***
PC: abdo + back pain
HPC:
- lifting heavy object (concrete) stood up and sudden pain in upper abdomen + back
- sharp, cramping, debilitating
- initially 6/10 now 8/10
- able to walk and mobilise
- denies any neurological symtpoms - no numbness, weakness, parasthesia or loss of sesnation
- denies bladder or bwel symptoms: able to feel bladder fill / building urge - able to hold off and control - aware of passing and cessation of urine passage and intact sensation on wiping
- no head injury
- no fall
- no other trauma
- has had Co-codamol 30/500 x 3 today but nil else. minimmal relief. does not like taking tablets.

Concerned about hernia.

PMHx:
- HTN
- T2DM
- anxiety
DHX:
- Metformin
- Ramipril
- Mirtazapine
- Omeprazole
NKDA

SHx:
- carer (currently not working)
- alcohol minimal
- smoking no
- lives with partner

On examination - NEWS = 4
tachycardic 104
223/168

Walking in independently. Clearly in pain. Slower movements.

On inspection, no obvious bruising, swelling or deformity.
No midline tenderness at any level of spine.

Abdomen soft, no masses or lumps, no obvious herniation. No brusing.
Pain aggrevated by palaption in upper and lower abdomne.

Bilaterally painful, swollen and tender erector spinae muscles.
Limited thoracic extension and flexion.
Limited thoracic rotation.

Sensation intact throughout thoracic dermatomes.
Sensation intact throughout upper limb dermatomes, bilaterally.
Normal tone and power throughout UL bilaterally.

ECG - sinus tachy, nil ischemic, long QTc and RsR in II (all seen previously).
BLOODS - not indicated

Impression: most likely MSK pain due to strain injury - no red flags on Hx or exam so far - needs re-examined ? hearnia

PLAN:
1. Analgesia (given)
2. Re-examine once able - currently too sore
a. need to clincally check for hernia
3. Pending D/W senior provisional plan would be D/C with analgesia, PT self-referral and worsening advice.

Foytl (ACCS1)

Update - D/W Dr B Earle-Wright (EM ST5): in agreement with all above. suggested addition of CXR (requested).
Patient settled with Oramorph, Paracetamol and Ibuprofen.

Await CXR and aim for DC.

Foytl (ACCS1)

CXR reviewed - no obvious Pneumothorax, fracture or injury. No consolidation.
Impression of MSK type back pain most likely. Given advice leaflet and advice on self-referral to PT.
Analgesia improved and given Oromorph as TTO.

Discharged from ED.

Foytl (ACCS1)

Yours Sincerely,

Dr Jakub Foytl, Doctor

NHS Lothian
University Hospital Services
Department of Emergency Medicine

Dr. Dave McKean ED Clinical Director
Ray Middlemiss ED Clinical Nurse Manager
The Royal Infirmary of Edinburgh
51 Little France Crescent, Edinburgh, EH16 4SA
Tel: 0131 242 1300 Fax: 0131 242 1344

A/E no.	E5698949
Previous no.	E5171135
UHPI no.	620045326K
CHI no.	2205671464

Patient Information

Surname	Cross	Date of Birth		
Forenames	Angella	Age	Sex	22/05/1967
		56 Yrs		F
Address	44 Woodburn Bank Dalkeith, Midlothian			
Postcode	EH22 2EY	Telephone		283 8775
Contact Address	[redacted] Edinburgh EH16 5RW			
Complaint	injury to back/abo/ SOB	Allergies		

Attendances in last 12 months: 0 School :

General Practitioner

Address	VE Aspinall Newbattle Medical Practice Blackcot Mayfield Midlothian EH22 4AA
Telephone	0131 663 1051

Date and Time of Attendance	20/05/2024 19:51
	Incident Date Time:
Mode of Arrival	20/05/2024
	Private Transport
Source of Referral	Self Referral to A&E

Initial Triage Assessment

Presenting Complaint	
History of Presenting Complaint	
Assessment	

Nursing Observations & Assessments

TEMP	°C	SCORE	MIN FREQ	(please tick)	Blood Sugar	mmols	Pain Score	/ 10	
HR		NEWS 0-1	Hourly		Peak Flow 1)		Analgesia Given	YES ☐	NO ☐
BP	/	NEWS 2-4	30mins Min		Peak Flow 2)		Fast Assessment	POS ☐	NEG ☐
SPO2%	%	NEWS 5-7	15mins Min		Peak Flow 3)		Onset Time:		
RR		NEWS >7	10mins Min		Alcometer		Weight	Height	
AVPU		Special Clinical Instructions							
O2 Therapy In Progress	Yes (= +2) No (= 0)	Please indicate any specific clinical observations to be continued or repeated once patient has left OPP							
NEWS SCORE									

Triaged By:	Print Name:	Signature:	Triage Time:

Opp Care & Discharge Record

PVC Insertion - Please initial when complete			
Handwash		Gloves	
CHD Skin Prep		Aseptic Insertion	
Dressing Labelled		Paperlite Bundle	
Reason for PVC Insertion:			

Blood Samples - Please tick all that apply			
Routine		CRP	
Troponin		Coag	
Amylase		Tox Screen	
BTS		Other (Please state)	

Additional Investigations		
ECG - Please tick		
Required ☐	Done ☐	
Urinalysis - Please tick		
Required ☐	Done ☐	
MSU Sent	Yes ☐	No ☐
HCG Consent	Yes ☐	No ☐
HCG Result	Yes ☐	No ☐
X-Rays - Please tick		
CRX	Yes ☐	No ☐
CT Scan	Yes ☐	No ☐
Other (Please state)		

On Going Care Plan

Speciality Informed (enter time)		Bed Required		Triaged To - Please tick			
Surg:	G.I:	Yes ☐	No ☐	Waiting Room		GP Out of Hours	
Vasc:	Stroke:	Transfer To: (Please tick if required)		Resus		Gynae Triage	
Medics:	Gynae:	WGH		HD		SMMP	
Ortho:	Neuro:	SJH		IC		MIU	
Other (state Speciality)		Other (please state)		Exam		Other (Please state)	

"What Happens To The Patient?"

Clinical Notes

Think:- Other Sources of Information:

Family ☐ Carers ☐ SAS ☐ PRF ☐ EPR ☐ ECS ☐ KIS ☐ GP ☐ Patient Alerts ☐

Care Providers Name: ____________________ Signature: ____________________

Essential Scanning Sheet

This sheet should only be used for essential patient information not currently captured electronically (e.g. diagrams).

Anything documented on this sheet will be scanned and made available to view electronically via SCI Store

PATIENT PROGRESS NOTES /COMMUNICATION SHEET

620045326K /E5690949 F
CROSS Angella
22-May-67 CHI: 220 567 1464
77106 VE Aspinall
44 Woodburn Bank Midlothian
EH22 2EY

Unit No

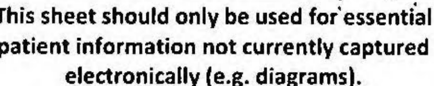
Hospital	☐ OPD	☐ Ward	☑ Clinical area

State Action/s taken After Exception Reporting
Each entry should be dated & timed

Date & Time	Progress notes / Problems Action Taken and Investigations Required	Signature (Print name & designation)
20/05	Independent	AB

Authorised: Nov 2022
Review: Nov 2025

Essential Scanning Sheet



Anything documented on this sheet will be scanned and made available to view electronically via SCI Store

PATIENT PROGRESS NOTES /COMMUNICATION SHEET	Addressograph, or Name DOB Unit No./CHI

Hospital ☐ **OPD** ☐ **Ward** ☐ **Clinical area**

State Action/s taken After Exception Reporting
Each entry should be dated & timed

Date & Time	Progress notes / Problems Action Taken and Investigations Required	Signature (Print name & designation)

Authorised: Nov 2022
Review: Nov 2025

4

NHS LOTHIAN

Emergency Department

Adult Majors

Prescription, Administration & Observation Record

Addressograph
620045326K /E5698949 F
CROSS Angella
22-May-67 CHI: 220 567 1464
77106 VE Aspinall
44 Woodburn Bank Midlothian
EH22 2EY

The section below must be completed before any medicine is prescribed/given

Previous Adverse Reactions		Weight	Date
	NKDA.	kgs Actual / Estimate	20/05/24.

Once Only Prescription

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber Sign & Print	Time Given	Issued by (Initials)	Checked by if applicable (Initials)
20/5/24	22:30	PARACETAMOL	1 gram	Po	[signature]	22:52	[signature]	
"	"	IBUPROFEN	400mg	Po	[signature]	"	[signature]	
"	"	MORPHINE (ORAL)	10 mg	Po	[signature]	"	[signature]	

Discharge Medication

Date & Time	Medicine (Approved Name)	Dose	Frequency	Route	Quantity	Duration	Prescriber Sign & Print	Issued by (Initials)	Checked by (Initials)
20/5/24	OROMORPH	10mg	4-hourly	Po	1 BOTTLE	TBC	[signature] FOTR	[signature]	[signature]
20/5/24	OMEPRAZOLE	20mg	OD	Po	1 PACK	TBC	[signature] FOTR	[signature]	[signature]

National Early Warning Score 2 (NEWS2) Chart

NEWS Key: 0 1 2 3

Parameter	Range	Score	Obs 1	Obs 2
	Date:		20/5	
	Time:		2005	
A+B Respirations Breaths/min	≥25	3		
	21-24	2		
	18-20		20.	19.
	15-17			
	12-14			
	9-11	1		
	≤8	3		
A+B SpO_2 Scale 1 Oxygen saturation (%) Use Scale 1 if target range is 94-98%	≥96		97	96.
	94-95	1		
	92-93	2		
	≤91	3		
SpO_2 Scale 2* Oxygen saturation (%) Use Scale 2 if target range is 88-92% eg. in hypercapnic respiratory failure. * ONLY use Scale 2 under the direction of a qualified clinician	≥97 on O_2	3		
	95-96 on O_2	2		
	93-94 on O_2	1		
	≥93 on air			
	88-92			
	86-87	1		
Tick box if using SpO_2 Scale 2	84-85	2		
Sign	≤83	3		
Air or Oxygen? Oxygen is a drug and prescribed by target range	A = Air			
	O^2 L/min or %	2		
	Device			
C Blood Pressure mmHg Score uses Systolic BP only. If manual BP mark as M	≥220	3	223	
	201-219			
	181-200			
	161-180		168	158.
	141-160			
	121-140			
	111-120			
	101-110	1		105.
	91-100	2		
	81-90	3		
	71-80	3		
	61-70	3		
	51-60	3		
	≤50	3		
C Pulse Beats/min Manual pulse	≥131	3		
	121-130	2		
	111-120	2		
	101-110	1		101
	91-100	1	105	
	81-90			
	71-80			
	61-70			
	51-60			
	41-50	1		
	31-40	3		
	≤30	3		
D Consciousness Score for new onset of confusion (no score if chronic)	Alert		✓	✓
	New Confusion	3		
	V	3		
	P	3		
	U	3		
E Temperature °C	≥39.1°	2		
	38.1-39.0°	1		
	37.1-38.0°			
	36.1-37.0°		36.7	36.6.
	35.1-36.0°	1		
	≤35.0°	3		
NEWS TOTAL			4	1
Monitoring frequency			30m	
Escalation of care Y/N			Y	
Blood Glucose reading or N/A			/	
Pain score (0-10)			6.	
Initials			[illegible]	[illegible]

Reproduced from: Royal College of Physicians. National Early Warning Score (NEWS) 2: Standardising the assessment of acute-illness severity in the NHS. Updated report of a working party. London: RCP, 2017.

NEWS of 5 or more?
Think Sepsis!

In a patient with a **NEWS** of **5 or more** and a known infection, signs and symptoms of infection, or at risk of infection, think **'Could this be sepsis?'** and **escalate care immediately.**

Signs of Infection

- Temperature <36°c or >38°c
- Heart rate >90 beats pm
- Respiratory rate >20 breaths pm
- New confusion
- WCC <4 or >12
- Blood sugar >7.7 in non-diabetic

620045326K /E5698949 F
CROSS Angella
22-May-67 **CHI: 220 567 1464**
77106 VE Aspinall
44 Woodburn Bank Midlothian
EH22 2EY

NEWS Total	Monitoring Frequency	Clinical Response
Total 0	Commence on 2 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
Total 1 - 4	Commence on 1 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
3 in one parameter *	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to Nurse In Charge (NIC) and Senior Medic
Total 5 - 6	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Total 7 or more	Commence on 15 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Special Instructions		

*or increase in NEWS score of 2

Conscious Level Chart to be completed when clinically indicated

Section	Subsection	Item	Score	Note
		Date		
		Time		
GLASGOW COMA SCALE	Eyes Open	Spontaneously	4	Eyes closed by swelling = C
		To speech	3	
		To pain	2	
		None	1	
	Best Verbal Response	Orientated	5	Endotracheal tube or tracheostomy = T
		Confused	4	
		Inappropriate words	3	
		Incomprehensible sounds	2	
		None	1	
	Best Motor Response	Obey commands	6	Always record the best arm response
		Localise to pain	5	
		Flexion to pain	4	
		Abnormal flexion	3	
		Extension to pain	2	
		None	1	
		Total GCS Score		
	Right Pupil	Size		+ reacts - no reaction c: eye closed
		Reaction		
	Left Pupil	Size		
		Reaction		
LIMB MOVEMENT	ARMS	Normal power		Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness		
		Severe weakness		
		Extension		
		No response		
	LEGS	Normal power		
		Mild weakness		
		Severe weakness		
		Extension		
		No response		
		Initials		

Pupil Scale mm 1 2 3 4 5 6 7 8

IV Fluid Prescription

Time Prescribed	Fluid	Volume	Rate	Prescribers Signature	Time Started	Given by (Initials)	Checked by (Initials)	Time Finished

Fluid Balance

INPUT						OUTPUT				
	IV Fluids or SC Fluids IV Medication	**IV Line(s)**	**Oral Input**		**Input**		**Urine**		**Gastric**	
Time	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100ml	Running Total	Time	Volume	Running Total	Volume	Running Total

Drug Infusion

Drug Name:

	Time														
	Rate (ml/hr)														
	Volume in Syringe														
Pump No	Total amount Infused														

Drug Name:

	Time														
	Rate (ml/hr)														
	Volume in Syringe														
Pump No	Total amount Infused														

CROSS, ANGELLA ID:2205671464 20-May-2024 22:37:59 NHS LOTHIAN-RIE_ED ROUTINE RECORD

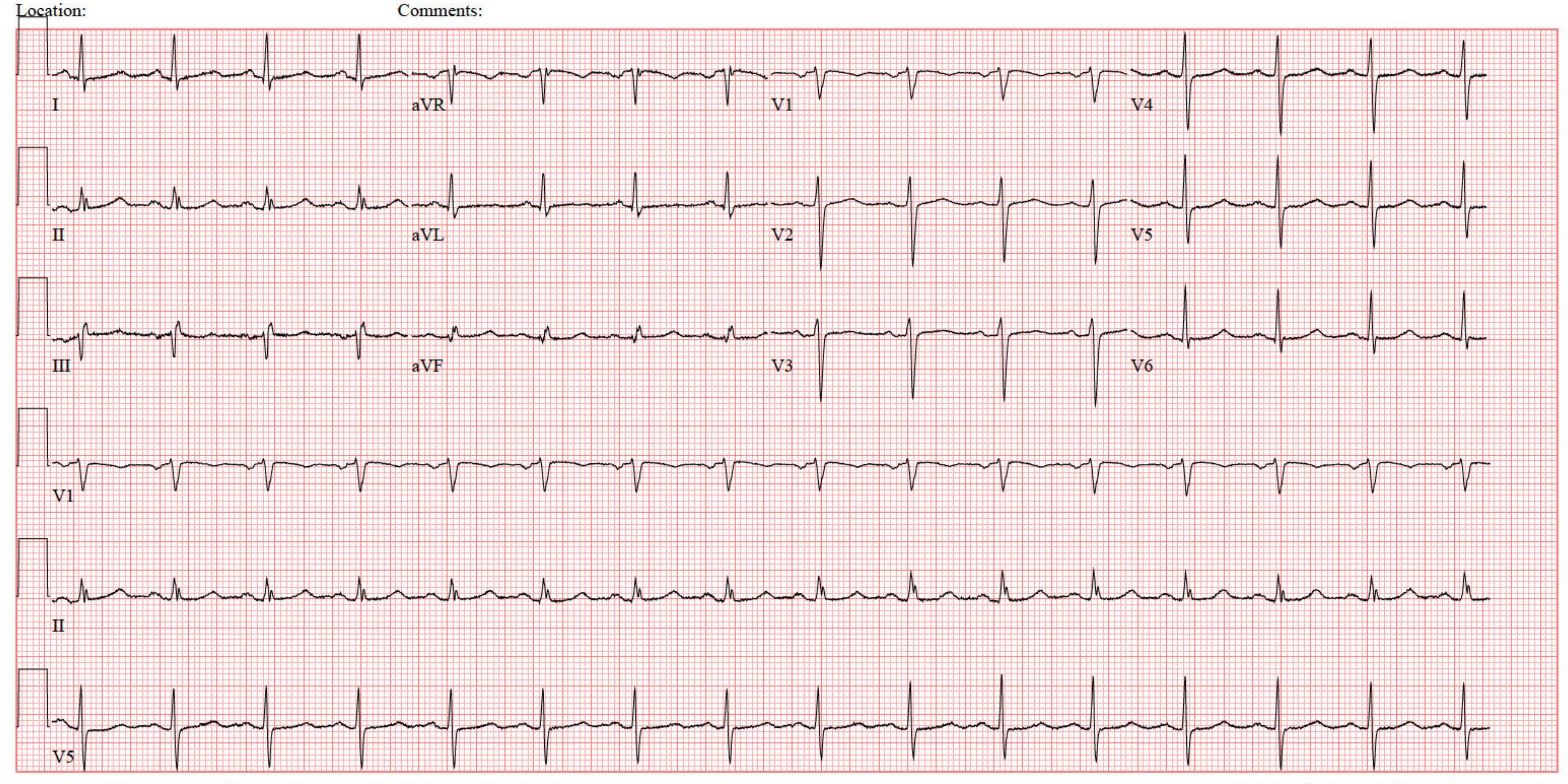
22-May-1967 (56 yr)
Female Caucasian

Room:
Loc:40

Vent. rate	94	BPM
PR interval	146	ms
QRS duration	82	ms
QT/QTcB	390/487	ms
P-R-T axes	29 14	39

Technician:
Test ind:

Location: Comments:



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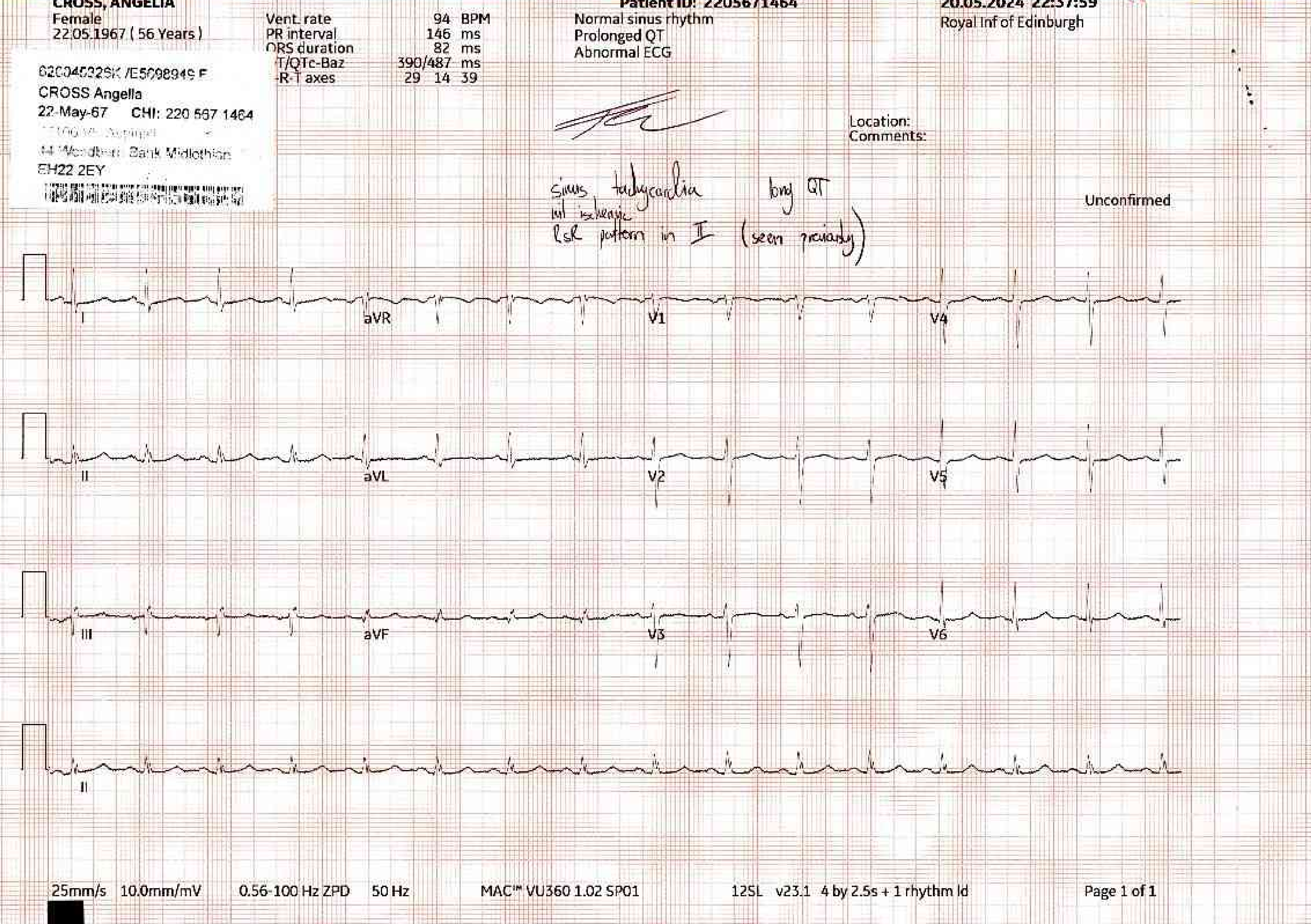

CROSS, ANGELIA
Female
22.05.1967 (56 Years)
Vent. rate 94 BPM
PR interval 146 ms
QRS duration 82 ms
QT/QTc-Baz 390/487 ms
P-R-T axes 29 14 39
Patient ID: 2205671464
Normal sinus rhythm
Prolonged QT
Abnormal ECG
20.05.2024 22:37:59
Royal Inf of Edinburgh
CROSS Angelia
22-May-67 CHI: 220 567 1464
EH22 2EY
Location:
Comments:
sinus tachycardia long QT
RSR pattern in III (seen previously)
Unconfirmed
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
II
25mm/s 10.0mm/mV 0.56-100 Hz ZPD 50 Hz
MAC™ VU360 1.02 SP01
12SL v23.1 4 by 2.5s + 1 rhythm ld
Page 1 of 1

Patient & GP Information

UHPI Number	620045326K
CHI Number	2205671464
Episode Number	E5171135
Surname/Forename	Cross, Angella
Date of Birth	5/22/67
Sex	Female
Patient Address.	44 Woodburn Bank Dalkeith EH22 2EY
Registered GP	VE Aspinall
GP Address.	Newbattle Medical Practice,Blackcot,Mayfield,Midlothian EH22 4AA

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	E5171135

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
A&E Notes Episode/Ref: E5171135 Dr Batya Lepar 10/18/22 15:56 Callum Fitzpatrick	CLINICAL NOTES: Clinical note: ACUTE MEDICINE IN ED CLINICAL ASSESSMENT PC: 55 F presenting with 3/52 worsening SOBOE, cough >> At GP: BP 190/145, Temp 39.4 >> was concerned about malignant hypertension HPC: >> Recently treated for LRTI in community with course of amox, completed full course >> 2 days later reports chest symptoms again >> Shortness of breath: this is her main concern. Feels lethargic, worse when lying down and bending forward. Reports far from baseline 3 months ago, now feels out of breath walking 10m on the flat to the bathroom ('puffing'), needs 3 pillows to sleep, disturbing sleeping patterns. Palpitations when walking. Associated with lightheadeness >> Cough: associated with SOB, worse when lying down. Non-productive of mucus or blood >> Has had COVID twice and feels breathing has deteriorated since then, most recently in summer 2022 >> Denies (pleuritic) chest pain, intermittent claudication >> Measures blood pressure at home and usually sits around SBP 175 >> No CIBH, no urinary symptoms, no abdo pain, no headache, no recent weight loss Background: Hypertension T2DM Anxiety Previous gallstones Partial thyroidectomy Medications: Mirtazapine, ramipril, propranolol Drug allergies: NKDA Social: > Lives at home with daughter (29) who has Down's Syndrome who she is a full time carer for > Previous worked as a peer support worker > Never smoked > No alcohol Temp: 36.6 NEWS 2 A - own, talking in full sentences B - RR 20, Sats 97 OA, chest clear C - WWP, CRT<2, MM, JVPNE, pulse regular, HS I + II + 0, BP 176/122, HR 111 D - Alert E - Abdo SNT, calves SNT, nil pitting oedema Investigation results: Bloods (18/10) Nil anaemia - Hb 153 Inflammatory markers - CRP 11, WCC not raised Renal function NAD Deranged LFTs - ALT 104, Alk-Phos 141, GGT 81 (appears longstanding) Glucose 7.6 CXR (unreported): No focal consolidation, well-demarcated costophrenic angles, raised right hemidiaphragm, ?left heart border irregularity ECG: Sinus tachycardia Problem list: 1. Hypertension 2. Shortness of breath 3. Viral LRTI, ?PE

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	E5171135

Note Details	Clinical Notes
	Treatment and management plan: 1. Chase blood cultures 2. Chase bloods: incl CRP, glucose 3. Await formal CXR report 4. E+S BPs 5. Add on D-dimer 6. Urine dip Destination: Home / Hospital @ Home / OPAT / Ambulatory Care / AMU Batya Lepar F1 Consultant: Dr I Thethy Email inquiries to RIEacutemedicine@nhslothian.scot.nhs.uk -- Update 15:51 Urinalysis: Ketones +; trace leuk/nitrates; trace protein; nil haematuria/glucosuria D-dimer: 152 -- Consultant Review - Dr I Thethy **Draft** Significant Bg of Note: 1. Hypertension on ramipril but noncomplaint with medication 2. Type 2 Diabetes 3. Partial Thyroidectomy - for goitre 4. Previous Gallstones PC/HPC: 1. Shortness of breath and dry cough post covid since summer last with wheeze intermittently. 2. Exercise tolerance is now 5 minutes on flat ground 3. Also has nocturnal symptoms of shortness of breath 4. Has been having palpitations post-covid almost daily sporadic fast and regular with lightheadedness 5. Feels lightheaded on standing up sometimes 6. Having headaches and sometimes tingling in right arm and right legs but no focal neurological deficit as such Regarding her BP admits to intermittently taking her tablets. Denying any symptoms suggesting urgent management with iv therapy. OE: Chest Clear L=R CVS: JVP NE, HS I+II+0, no oedema Abdo: SNT, Nil Masses, BS present Neuro: CN intact. T/P/S/C intact all 4 limbs Significant of note 1. BP 176/122 and 180/130 on repeat 2. D-dimer 152 >> PE excluded 3. CXR (unreported): No focal consolidation, well-demarcated costophrenic angles, raised right hemidiaphragm, ?left heart border irregularity 4. ECG: Sinus tachycardia 5. Bloods (18/10) Nil anaemia - Hb 153 Inflammatory markers - CRP 11, WCC not raised Renal function NAD Deranged LFTs - ALT 104, Alk-Phos 141, GGT 81 (appears longstanding) Glucose 7.6 Issues: 1. Hypertension due to intermittent compliance with medications 2. SOB and dry cough - on ACE-I and post -covid 3. Palpitations post-covid, note previous thyroidectomy for goitre and subclinical hypothyroidism on bloods in June 4. Headaches - in relation to high blood pressure and also r sided tingling upper and lower limb - needs managed. if felt to be post covid can always be referred to Prof Carson's clinic on DC

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	E5171135

Note Details	Clinical Notes
	Plan: 1. Admit as BP and diastolic high with headaches and dizziness - get CTB 2. Stop ramipril and start amlodipine - try solution from tomorrow as says chokes on tablets 3. CT chest and will need PFTs - requested 4. Contact AMB CARE mane and ask if they will get kardia app monitoring for her on DC 5. E+S BPs 6. Resp consult mane please 7. TFTs, K, MG and HBA1c added to bloods I am admitting for control of BP and headaches and investigation of neurological symptoms - can be discharged home for OP investigations after as above on discretion of AMU consultant Dr Thethy Consultant

NHS Lothian

Royal Infirmary of Edinburgh
51 Little France Crescent
Old Dalkeith Road
Edinburgh EH16 4SA

Dr VE Aspinall
Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA

Date: 19/10/2022

Emergency Discharge Summary

Patient	Angella Cross 44 Woodburn Bank Dalkeith Midlothian EH22 2EY	**CHI** **Date of Birth / Age** **UHPI** **A&E Attendance Number**	**2205671464** 22/05/1967 (55 years) 620045326K E5171135
Attendance Date	18/10/2022	**Contact**	
Attendance Time	12:24		
Mode of Arrival	Private Transport		
Source of Referral	Flow Centre		
Discharge Date	18/10/2022		
Discharge To			

Dear Dr VE Aspinall

Presentation: Headache, PC-3 MONTH HX OF COUGH AND BREATHLESSNESS, TEMPATURE, HX-HYPERTENTION, TYPE 2 DIABETIC, ANXIETY OBS-HR107 S96 T39.4 BP190/145 NEWS 3 ?MILLIGNANT HYPERTENTION ?LRTI S: cough and sob for 3/12. SOB worse when lying down. Hypertension,

CLINICAL NOTES:

Clinical note: ACUTE MEDICINE IN ED

CLINICAL ASSESSMENT

PC: 55 F presenting with 3/52 worsening SOBOE, cough

>> At GP: BP 190/145, Temp 39.4 >> was concerned about malignant hypertension

HPC:

>> Recently treated for LRTI in community with course of amox, completed full course >> 2 days later reports chest symptoms again

>> Shortness of breath: this is her main concern. Feels lethargic, worse when lying down and bending forward. Reports far from baseline 3 months ago, now feels out of breath walking 10m on the flat to the bathroom ('puffing'), needs 3 pillows to sleep, disturbing sleeping patterns. Palpitations when walking. Associated with lightheadeness

>> Cough: associated with SOB, worse when lying down. Non-productive of mucus or blood

>> Has had COVID twice and feels breathing has deteriorated since then, most recently in summer 2022

>> Denies (pleuritic) chest pain, intermittent claudication

>> Measures blood pressure at home and usually sits around SBP 175

>> No CIBH, no urinary symptoms, no abdo pain, no headache, no recent weight loss

Background:

Hypertension
T2DM
Anxiety
Previous gallstones
Partial thyroidectomy

Medications:
Mirtazapine, ramipril, propranolol

Drug allergies: NKDA

Social:
> Lives at home with daughter (29) who has Down's Syndrome who she is a full time carer for
> Previous worked as a peer support worker
> Never smoked
> No alcohol

Temp: 36.6
NEWS 2
A - own, talking in full sentences
B - RR 20, Sats 97 OA, chest clear
C - WWP, CRT<2, MM, JVPNE, pulse regular, HS I + II + 0, BP 176/122, HR 111
D - Alert
E - Abdo SNT, calves SNT, nil pitting oedema

Investigation results:

Bloods (18/10)
Nil anaemia - Hb 153
Inflammatory markers - CRP 11, WCC not raised
Renal function NAD
Deranged LFTs - ALT 104, Alk-Phos 141, GGT 81 (appears longstanding)
Glucose 7.6

CXR (unreported): No focal consolidation, well-demarcated costophrenic angles, raised right hemidiaphragm, ?left heart border irregularity
ECG: Sinus tachycardia

Problem list:
1. Hypertension
2. Shortness of breath
3. Viral LRTI, ?PE

Treatment and management plan:
1. Chase blood cultures
2. Chase bloods: incl CRP, glucose
3. Await formal CXR report
4. E+S BPs
5. Add on D-dimer
6. Urine dip

Destination: Home / Hospital @ Home / OPAT / Ambulatory Care / AMU

Batya Lepar F1

Consultant: Dr I Thethy
Email inquiries to RIEacutemedicine@nhslothian.scot.nhs.uk

Update 15:51

Urinalysis: Ketones +; trace leuk/nitrates; trace protein; nil haematuria/glucosuria
D-dimer: 152

Consultant Review - Dr I Thethy **Draft**

Significant Bg of Note:
1. Hypertension on ramipril but noncomplaint with medication
2. Type 2 Diabetes
3. Partial Thyroidectomy - for goitre
4. Previous Gallstones

PC/HPC:
1. Shortness of breath and dry cough post covid since summer last with wheeze intermittently.
2. Exercise tolerance is now 5 minutes on flat ground
3. Also has nocturnal symptoms of shortness of breath
4. Has been having palpitations post-covid almost daily sporadic fast and regular with lightheadedness
5. Feels lightheaded on standing up sometimes
6. Having headaches and sometimes tingling in right arm and right legs but no focal neurological deficit as such

Regarding her BP admits to intermittently taking her tablets. Denying any symptoms suggesting urgent management with iv therapy.

OE:
Chest Clear L=R
CVS: JVP NE, HS I+II+0, no oedema
Abdo: SNT, Nil Masses, BS present
Neuro: CN intact. T/P/S/C intact all 4 limbs

Significant of note
1. BP 176/122 and 180/130 on repeat
2. D-dimer 152 >> PE excluded
3. CXR (unreported): No focal consolidation, well-demarcated costophrenic angles, raised right hemidiaphragm, ? left heart border irregularity
4. ECG: Sinus tachycardia
5. Bloods (18/10)
Nil anaemia - Hb 153
Inflammatory markers - CRP 11, WCC not raised
Renal function NAD
Deranged LFTs - ALT 104, Alk-Phos 141, GGT 81 (appears longstanding)
Glucose 7.6

Issues:
1. Hypertension due to intermittent compliance with medications
2. SOB and dry cough - on ACE-I and post -covid
3. Palpitations post-covid, note previous thyroidectomy for goitre and subclinical hypothyroidism on bloods in June
4. Headaches - in relation to high blood pressure and also r sided tingling upper and lower limb - needs managed. if felt to be post covid can always be referred to Prof Carson's clinic on DC

Plan:
1. Admit as BP and diastolic high with headaches and dizziness - get CTB
2. Stop ramipril and start amlodipine - try solution from tomorrow as says chokes on tablets
3. CT chest and will need PFTs - requested
4. Contact AMB CARE mane and ask if they will get kardia app monitoring for her on DC
5. E+S BPs
6. Resp consult mane please
7. TFTs, K, MG and HBA1c added to bloods

I am admitting for control of BP and headaches and investigation of neurological symptoms - can be discharged home for OP investigations after as above on discretion of AMU consultant

Dr Thethy
Consultant

Yours Sincerely,

Dr Batya Lepar, Doctor

NHS Lothian - Referral Letter

Referral To	Royal Infirmary of Edinburgh at Little France Flow Centre Referral LI Flow Centre Referral
Urgency of referral	Urgent
Date of referral	18/10/2022
Date submitted	18/10/2022
UCPN	101027712470S

PATIENT DETAILS

CHI number:	2205671464	**Contact Details**	
Name:	MS ANGELLA CROSS	44 WOODBURN BANK DALKEITH MIDLOTHIAN EH22 2EY	Voice (Home) : 0131 531 1195 Voice (Mobile) : 07940443239
Date of birth:	22/05/1967		
Sex:	Female		

REFERRING PRACTITIONER DETAILS

Name:	Dr. Madeleine Colmar (GPST1) (GMC: 7420989)	**Practice address** Blackcot Mayfield Midlothian EH22 4AA
Practice:	Newbattle Medical Practice (77106)	
Phone:	Voice : 0131 663 1051	

CLINICAL INFORMATION

Reason for Referral: ?malignant hypertension

Main Referral Text: Many thanks for seeing this 55 year old lady. She presented with a history of cough and breathlessness since covid, but was noted to have high BP (190/145) and I am concerned about malignant hypertension.

Patient had covid in summer and since been affected by cough and SOB.
She had a course of amoxicillin and felt better for 3 days then felt worse again. Cough worse at night. Non productive, no haematemesis. Feels SOB on minimal exertion. Breathless on lying flat or leaning forwards. Non-smoker. No wheeze. No current headache.
Is carer for her daughter who has downs, feels becomes SOB on minimal exertion.
Additionally can have panic attacks. Has anxiety and has had counselling in past, currently on mirtazapine. Not seeking any further input.

BG diabetes, previous attendances to hospital with high blood pressure
Currently on mirtazapine, propranolol and ramipril (10mg). Had been prescribed indapamide but hasn't been taking this.
Previously on amlodipine but stopped due to SEs.

OE
Temp 39.4 BP 220/145 initially, repeated x 3 lowest left arm 180/145, right arm 178/144. HR 107 SATS 96% on air RR 18
Chest clear
HS I+II+0
Fundoscopy - NAD
Urine dip negative for blood and protein
BP recheck after 30mins - 190/137 L 187/150 R

Imp: Given breathlessness/orthopnoea and hypertension ?malignant hypertension.
Fever/cough could be related to LRTI

Plan: Referred to medical team at RIE for consideration of bloods/CXR/ECG +/ echo.

Many thanks,

Dr. Madeleine Colmar
GPST1

Examinations and Investigations

Description	Result	Date
Middle name : ISABELLA		

Investigations

Description	Result	Date
Discussed with Receiving Service? :	Yes	
Receiving Specialty :	Medics	

Pre-existing conditions (High & Medium Priority)

Description	Modifier	Extension	Start Date	Date Recorded
Type 2 diabetes mellitus			21/06/2022	21/06/2022
Gallstones	New event		28/02/2017	28/02/2017
Corneal ulcer	New event	right	15/01/2016	15/01/2016
Essential hypertension			30/09/2013	30/09/2013
Anxiety states			27/08/2013	27/08/2013
Thyroglossal duct cyst			13/06/2001	13/06/2001
Caesarean delivery			25/01/2001	25/01/2001
Miscarriage			17/12/1998	17/12/1998
Iron deficiency anaemias			25/07/1997	25/07/1997
Pneumonia due to unspecified organism			30/11/1994	30/11/1994
Acute pyelonephritis			22/03/1994	22/03/1994
Caesarean delivery			23/07/1993	23/07/1993
Microcytic hypochromic anaemia			28/05/1993	28/05/1993
Miscarriage			20/07/1992	20/07/1992
Spontaneous vaginal delivery			19/12/1988	19/12/1988
Miscarriage			09/02/1988	09/02/1988
Miscarriage			15/11/1987	15/11/1987
Neurotic depression reactive type		-ongoing	11/11/1986	11/11/1986
[X]Intentional self poisoning/exposure to noxious substances			14/08/1983	14/08/1983

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

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Mirtazapine 30mg tablets	tablet	1 TABLET ONCE A DAY AT NIGHT		08/10/2021		12/10/2022
Ramipril 10mg capsules	capsule	1 CAPSULE ONCE A DAY		08/10/2021		12/10/2022
Propranolol 80mg tablets	tablet	TAKE ONE TWICE DAILY		08/10/2021		24/08/2022

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

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Amoxicillin 500mg capsules	capsule	ONE CAP THREE TIMES A DAY		02/08/2022		02/08/2022

Additional information

Patient Blood Pressure (Systolic):152

Patient Blood Pressure (Diastolic):108

CROSS, ANGELLA   ID:2205671464   18-Oct-2022 13:08:52   NHS LOTHIAN-RIE_ED ROUTINE RECORD

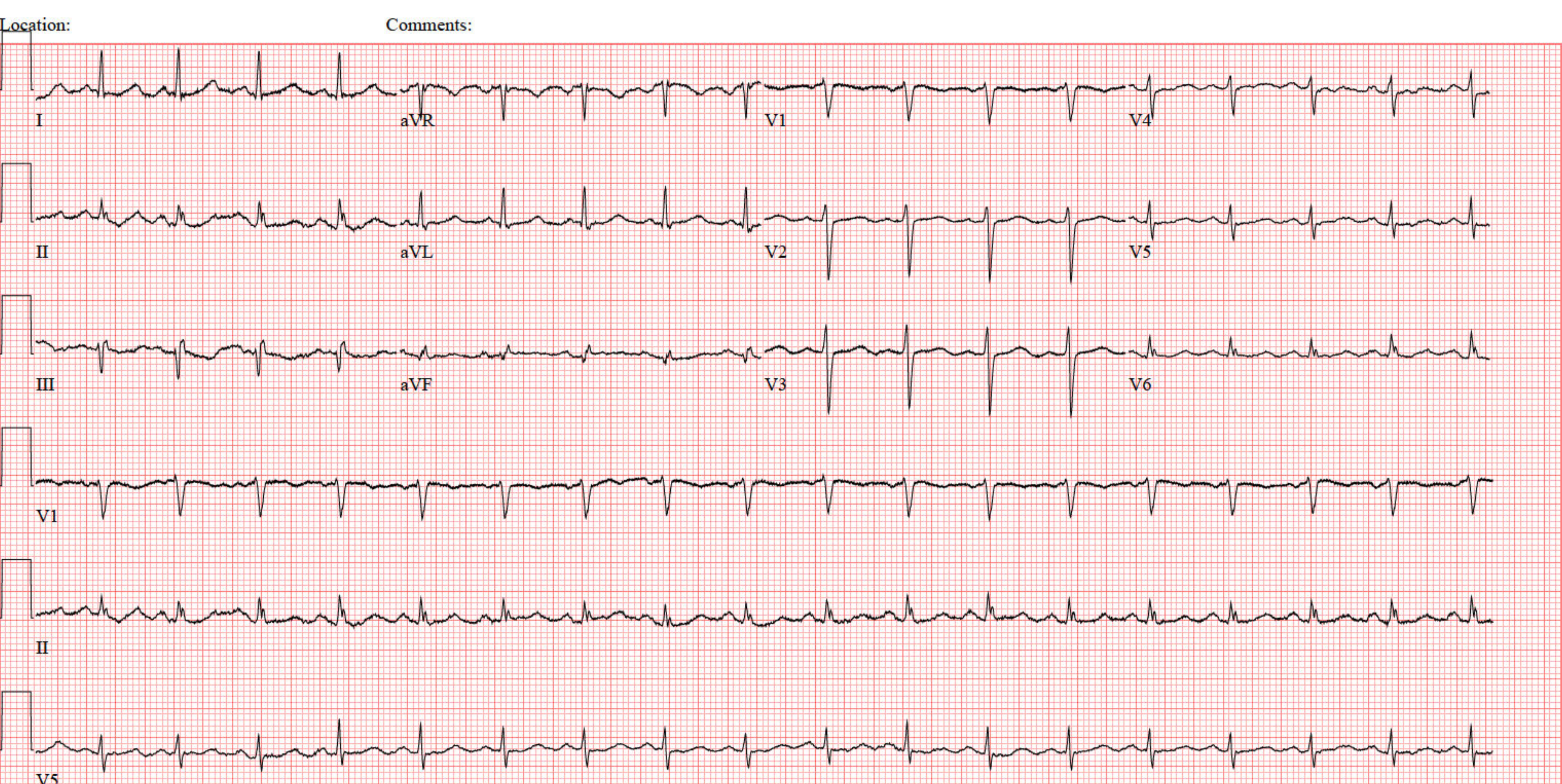
22-May-1967 (55 yr)
Female

Room:
Loc:40

Vent. rate	109	BPM
PR interval	136	ms
QRS duration	78	ms
QT/QTcB	334/449	ms
P-R-T axes	38 11	8

Technician: FIONA
Test ind:

Location: Comments:



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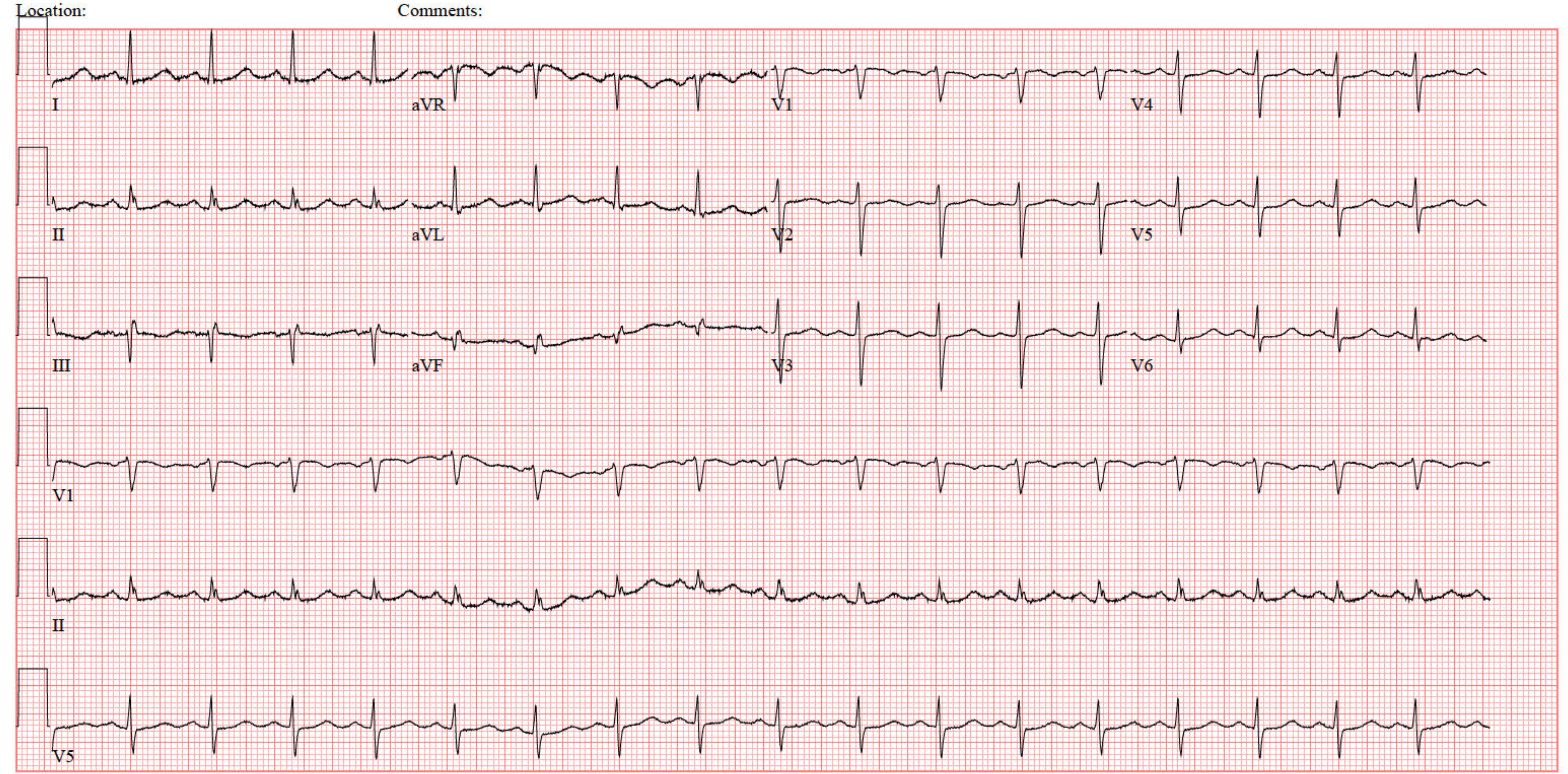
CROSS, ANGELLA ID:2205671464 18-Oct-2022 20:50:11 NHS LOTHIAN-RIE_ED ROUTINE RECORD

22-May-1967 (55 yr)	Vent. rate	107	BPM
Female Caucasian	PR interval	138	ms
	QRS duration	80	ms
Room:	QT/QTcB	364/485	ms
Loc:40	P-R-T axes	33 0	22

Technician:
Test ind:

Location: Comments:



25mm/s 10mm/mV 150Hz 10.1.3 12SL 243 CID: 38527 SID: 1505946 EID: 13 EDT: ORDER:

Patient & GP Information

UHPI Number	620045326K
CHI Number	2205671464
Episode Number	E4819058
Surname/Forename	Cross, Angella
Date of Birth	5/22/67
Sex	Female
Patient Address.	44 Woodburn Bank Dalkeith EH22 2EY
Registered GP	VE Aspinall
GP Address.	Newbattle Medical Practice,Blackcot,Mayfield,Midlothian EH22 4AA

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	E4819058

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Emergency Care Note Episode/Ref: E4819058 Dr Oliver John David Carlill 9/15/21 13:29 Dr Oliver Carlill	PAA DISCHARGE COMMUNICATION Diagnosis: Change to medication: STOP (reason & duration): START (reason & duration): Ramipril 2.5mg OD, propranolol 40mg PRN OD CHANGE to dose (reason): Hospital follow up: Nil Action plan for GP (Do not ask GP to chase results): Please repeat blood pressure measurement in 1/52 and adjust antihypertensives accordingly THE ABOVE INFORMATION MUST BE EXPLAINED TO THE PATIENT BEFORE DISCHARGE DETAILS OF CLINICAL ASSESSMENT FOR GP AVAILABLE BELOW --- PAA CLINICAL ASSESSMENT PC: ?Symptomatic hypertension HPC: No GP letter available. Attended GP today with anxiety/panic attack. GP measured blood pressure and discovered SBP 205 - sent to A + E for assessment. Has had headache 3/7 - gradual onset, mosly R sided 5/10 severity. Feeling of pressure in head. No feeling of pressure behind eyes. No neurology. No nausea, photophobia. Increasing SOB over the last year - now feels SOB after short period of walking on flat. Has been more stressed than usual due to COVID isolation. was +ve in June - has felt tired & 'run down' ever since. Background: HTN - has been on treatment in the past, currently not compliant Depression/anxiety Medications: Mirtazapine 15mg ON Has been on lisinopril & ramipril in the past - not compliant with this at the moment. Drug allergies: NKDA Social: Lives with partner and daughter. no EtOH Non smoker Temp 37.0 SEWS 0 A - Patent B - RR , O2 on RA, Chest clear C - HR regular, BP 178/140 R 205/128 L D - PERL, GCS 15 E - Abdo SNT Fundoscopy - optic disc normal Vessel tortuosity Investigation results: Bloods: LFTs slightly deranged Otherwise nil acute Diagnosis: HTN Anxiety/panic attacks

Surname/Forename	Cross Angella
UHPI Number	620045326K

Episode Number	E4819058

Note Details	Clinical Notes
	Treatment and management plan: ECG - sinus tachycardia Await bloods - add on liver screen Home with ramipril 2.5mg OD & propranolol 40mg PRN Assessed by (name, seniority): Carlill FY2 Consultant: Contact number: Email inquiries to RIEacutemedicine@nhslothian.scot.nhs.uk

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	E4819058

Note Details	Clinical Notes
Progress Notes Episode/Ref: E4819058 Nurse 9/16/21 09:29 Rebecca Trainer	This patient was assessed as eligible and capable of providing informed consent to participate in the Collection of venous and capillary blood samples for the development of new diagnostic devices for cardiovascular conditions. (NOVEL study). Written informed consent was obtained by Caroline Blackstock (EMERGE Research Team). A blood sample was obtained as part of the study. There will be no further research activities beyond this admission. For more information please see the Patient Information Sheet in the patient's medical notes or call EMERGE ext.21284 during office hours.

NHS Lothian

Royal Infirmary of Edinburgh
51 Little France Crescent
Old Dalkeith Road
Edinburgh EH16 4SA

Dr Aspinall
Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA

Date: 16/09/2021

Emergency Discharge Summary

Patient	Angella Cross 44 Woodburn Bank Dalkeith EH22 2EY	**CHI** **Date of Birth / Age** **UHPI** **A&E Attendance Number**	**2205671464** 22/05/1967 (54 years) 620045326K E4819058
Attendance Date	15/09/2021		
Attendance Time	11:54		
Mode of Arrival	Private Transport		
Source of Referral	Flow Centre		
Discharge Date	15/09/2021		
Discharge To		**Final Triage**	9 - Medical Expected
		Attendances in the last 12 months	1

Dear Dr Aspinall

Presentation: PC - HIGHT BP HX - HYPERTENSION , ANXIETY OBS - BP 204/168 , SYMPTOMATIC NO COVID CONCERNS ? HYPERTENSION SYMTOMATIC .
Diagnosis: Hypertension
Procedures: None
Drugs given in A&E: None
Discharge Drugs:

PAA DISCHARGE COMMUNICATION

Diagnosis:

Change to medication:
STOP (reason & duration):
START (reason & duration): Ramipril 2.5mg OD, propranolol 40mg PRN OD
CHANGE to dose (reason):

Hospital follow up: Nil

Action plan for GP (Do not ask GP to chase results): Please repeat blood pressure measurement in 1/52 and adjust antihypertensives accordingly

THE ABOVE INFORMATION MUST BE EXPLAINED TO THE PATIENT BEFORE DISCHARGE
DETAILS OF CLINICAL ASSESSMENT FOR GP AVAILABLE BELOW

PAA CLINICAL ASSESSMENT

PC: ?Symptomatic hypertension

HPC: No GP letter available.
Attended GP today with anxiety/panic attack. GP measured blood pressure and discovered SBP 205 - sent to A + E for assessment.
Has had headache 3/7 - gradual onset, mosly R sided 5/10 severity.
Feeling of pressure in head.
No feeling of pressure behind eyes.
No neurology.
No nausea, photophobia.
Increasing SOB over the last year - now feels SOB after short period of walking on flat.
Has been more stressed than usual due to COVID isolation.
was +ve in June - has felt tired & 'run down' ever since.

Background:
HTN - has been on treatment in the past, currently not compliant
Depression/anxiety
Medications:
Mirtazapine 15mg ON
Has been on lisinopril & ramipril in the past - not compliant with this at the moment.

Drug allergies:
NKDA
Social: Lives with partner and daughter.
no EtOH
Non smoker
Temp 37.0
SEWS 0
A - Patent
B - RR , O2 on RA, Chest clear
C - HR regular, BP 178/140 R 205/128 L
D - PERL, GCS 15
E - Abdo SNT
Fundoscopy - optic disc normal
Vessel tortuosity
Investigation results:
Bloods:
LFTs slightly deranged
Otherwise nil acute

Diagnosis:
HTN
Anxiety/panic attacks
Treatment and management plan:
ECG - sinus tachycardia

Await bloods - add on liver screen

Home with ramipril 2.5mg OD & propranolol 40mg PRN

Assessed by (name, seniority): Carlill FY2
Consultant:
Contact number:
Email inquiries to RIEacutemedicine@nhslothian.scot.nhs.uk

Yours Sincerely,

Dr Oliver John David Carlill, Doctor

PLOT1371

NHS Lothian
University Hospital Services
Department of Emergency Medicine

Clinical Director Dr. David McKean
Clinical Nurse Manager Ms Heidi Byrne
THE ROYAL INFIRMARY OF EDINBURGH
51 Little France Crescent, Edinburgh EH16 4SA
Tel: 0131 242 1300 • Fax: 0131 242 1344

A/E no. E4819058
Previous no. E3497207
UHPI no. 620045326K
CHI no. 2205671464

PATIENT INFORMATION

Surname Cross
Forename Angella
Date of Birth 22/05/1967
Age 54 Yrs Sex F

Called @ 12⁵⁰

Address 44 Woodburn Bank
Dalkeith, Midlothian
Postcode EH22 2EY
Telephone 283 8775

Contact Address [redacted]
Edinburgh EH16 5RW

Complaint PC - HIGHT BP HX - HYPERTE NSION , ANXIETY OBS
Allergies

Attendances in last 12 months: 0 School :

General Practitioner

Address VE Aspinall
Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA
0131 663 1051
Telephone

Date and Time of Attendance 15/09/2021 11:54
Incident Date Time: 15/09/2021 11:29
Mode of Arrival Private Transport
Source of Referral Flow Centre

INITIAL ASSESSMENT

Presenting Complaint	
History of PC	
Assessment	

PAIN SCORE	/ 10	ANALGESIA PRESCRIBED	YES NO	FAST	+ / -	ONSET TIME	:

Temp	HR	BP	RR	SPO2 %	AVPU	NEWS SCORE	ALC	PF (BEST OF 3)	BM
°C		/		%					

Frequency of Observations (Please Tick)		Cardiac Monitoring (Please circle)	SPEICAL INSTRUCTIONS
Hourly		YES	
30 Minutes minimum			
15 Minutes minimum		NO	
10 Minutes minimum			
TRIAGED BY (SIGN)		TRIAGED BY (PRINT)	

PERIPHERAL VENOUS CANNULA INSERTION (Please circle all that applies)						BLOODS (Please tick)			
DATE :		TIME :		STANDARD TECHNIQUE		ROUTINE		CRP	
BLUE	PINK	LEFT	RIGHT	HANDWASH	GLOVES	TROPONIN		COAG	
GREEN	ORANGE	HAND	FOREARM	CHD SKIN PREP	ASEPTIC INSERTION	AMYLASE		TOX SCREEN	
BROWN	GREY	ACF	FOOT	DRESSING LABELLED		BTS		OTHER	
OPERATOR SIGNATURE									

ADDITIONAL INVESTIGATIONS (Please indicate all that applies)

ECG	REQD	DONE	TIME DONE		X-RAYS	CXR		OTHER	
URINALYSIS	REQD	DONE	MSU SENT	YES / NO	HCG	CONSENT	YES / NO	POS / NEG	

ON-GOING CARE PLAN

SPECIALTY INFORMED		SURG	VASC	MEDICS	ORTHO	G.I	STROKE	GYNAE	OTHER
BED REQUIRED	YES	NO	TRIAGE CAT.	(Please Circle) 1 2 3 4 5 6 7					
			TRIAGED TO	W/RM RESUS HD IC EXAM					

Clinical Notes

"WHAT MATTERS TO THE PATIENT?"

THINK:- OTHER SOURCES OF INFORMATION:

FAMILY ☐ CARERS ☐ SAS PRF ☐ EPR ☐ ECS ☐ KIS ☐ GP ☐ PATIENT ALERTS ☐

Care Providers Name:.. Signature:..

620045326K/E4819058 F 22/05/1967
Cross, Angella
44 Woodburn Bank
Dalkeith,
Midlothian, EH22 2EY
CHI 2205671464
77106 VE Aspinall

RIE ED Nursing Care Plan

Admission Nurse Signature........ JCallum

Admission Nurse Print Name........ J McCALLUM.

Date........ 150921.

Presenting History :		

Date/ Time	Progress Notes	Signature
150921. 15.25	ADMITTED TO POD D. NEWS 1	JCallum
16-45hrs	D/C meds given e explained - D/C via pharmacy NO [illegible]	J Cowper S/N

Admission Standard Procedures	Initials	PRN Nursing Procedures	Initials
Vital signs recorded	JM	ECG completed	
Sews Score recorded	JM	CXR ordered	
BM Reading	N/A	Alcometer Reading Recorded	
GCS assessed	JM.	DNAR in situ	
Acuity parameters set	JM	LCP commenced / CP Aware	
Patient made comfortable	JM	Falls / Risk Assessment Require / Complete	
Name band Attached	JM.	Swallow Assessment Required / Complete	
IV Cannula in Situ. Dated (please circle) Yes No		Waterlow Assessment Required / Complete	
Hearing Aid : (please circle) NA In Situ At home		Language Assistance requested (Please inform NIC if applicable)	
Spectacles : (please circle) NA In Situ At home		Vulnerable Adult Concern (Please Inform NIC if applicable)	
Relatives : (please circle) In ED At Home Not Aware		Child protection Concern (Enter on TRAK & inform NIC if applicable)	
Clothing & valuables (please tick) 1) Labelled 2) Documented		4AT test Score = (please enter only if clinically indicated)	

Care Provider must be informed of any clinical changes highlighted from Patient Screening

Time of Round	O/A				
Clinical Area of ED					
Initials of Care Round Leader					
Review frequency of Vital Signs & Cardiac Monitoring					
Vital signs frequency	1°				
Cardiac monitoring required	Y / N	Y / N	Y / N	Y / N	Y / N
Pain Management (Refer to CP for analgesia if required)					
Please note pain score (0-10 Score)	0				
Mobility					
Fully weight bearing	✓				
Requires some assistance and / or uses walking aid					
Non Weight bearing and requires full assistance					
Elimination					
Ask patient if toilet is required	✓				
Patient is Self Caring and can walk to toilet					
Patient is Incontinent and requires to be checked					
Patient has catheter in situ and requires to be checked					
Nutrition / Hydration					
Self Caring	✓				
Patient requires assistance with feeding					
Patient is allowed fluids only					
Patient is NBM					
Patient has IVI in Situ					
Refreshments (Provided / Refused : Please indicate P / R)					
Drink		P / R	P / R	P / R	P / R
Snack		P / R	P / R	P / R	P / R
Catered Meal		P / R	P / R	P / R	P / R
Visual Skin Inspection					
Patient is healthy / no concerns	✓				
Visible areas of redness					
Broken skin and evidence of Pressure Ulcers					
Invasive devices (please tick if in situ)					
PVC /Arterial Line / Central Line / PVC					
Urinary Catheter / Chest Drain					
Infusion Device					
NG tube / PEG tube / Tracheostomy					
Other					
Family Communication (Please tick)					
Patient & Relatives present & made aware of any changes					
Cubicle Tidy (Please tick)					
Ensure area is tidy and free of obstruction					

Receiving Ward		ED Escort	
Nurse Name		Nurse Name	
Nurse Signature		Nurse Signature	
Date		Date	

NHS LOTHIAN

Emergency Department

Adult Majors

Prescription, Administration & Observation Record

Addressograph
62004532[illegible]K /E4819058 F
CROSS Angella
22-May-97 CHI: 220 567 1464
77106 VE Aspinall
44 Woodburn Bank Midlothian
EH22 2EY

The section below must be completed before any medicine is prescribed/given

Previous Adverse Reactions	Weight	Date
NKDA	____ kgs Actual / Estimate	15/9/21

Once Only Prescription

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber Sign & Print	Time Given	Issued by (Initials)	Checked by if applicable (Initials)
15/9	1530	PARACETAMOL	1g	ORAL	[signature]	16-45	[initials]	

Discharge Medication

Date & Time	Medicine (Approved Name)	Dose	Frequency	Route	Quantity	Duration	Prescriber Sign & Print	Issued by (Initials)	Checked by (Initials)
15/9 1600	PROPRANOLOL	40mg	OD PRN	ORAL	7 TABS	1 wk	[signature]		
15/9 1600	RAMIPRIL	2.5mg	OD	ORAL	7 TABS	LT	[signature]	[initials]	[initials]

National Early Warning Score 2 (NEWS2) Chart

NEWS Key: 0 | 1 | 2 | 3

Section	Parameter	Reading 1	Score
	Date:	18/9	
	Time:	15²⁵	
A+B Respirations Breaths/min	≥25		3
	21-24		2
	18-20	20	
	15-17		
	12-14		
	9-11		1
	≤8		3
A+B SpO$_2$ Scale 1 Oxygen saturation (%) Use Scale 1 if target range is 96-100%	≥96	97	
	94-95		1
	92-93		2
	≤91		3
SpO$_2$ Scale 2* Oxygen saturation (%) Use Scale 2 if target range is 88-92% eg in hypercapnic respiratory failure	≥97 on O$_2$		3
	95-96 on O$_2$		2
	93-94 on O$_2$		1
	≥93 on air		
* ONLY use Scale 2 under the direction of a qualified clinician	88-92		
	86-87		1
Tick box if using SpO$_2$ Scale 2 ☐	84-85		2
Sign:	≤83		3
Air or Oxygen? Oxygen is a drug and prescribed by target range	A = Air	A	
	O² L/min or %		2
	Device		
C Blood Pressure mmHg Score uses Systolic BP only	≥220		3
	201-219	196	
	181-200	↑	
	161-180		
	141-160	↓	
	121-140	148	
If manual BP mark as M	111-120		
	101-110		1
	91-100		2
	81-90		3
	71-80		3
	61-70		3
	51-60		3
	≤50		3
C Pulse Beats/min	≥131		3
	121-130		2
	111-120		2
	101-110	104	1
	91-100		1
Manual pulse	81-90		
	71-80		
	61-70		
	51-60		
	41-50		1
	31-40		3
	≤30		3
D Consciousness Score for new onset of confusion (no score if chronic)	Alert		
	New Confusion		3
	V		3
	P		3
	U		3
E Temperature °C	≥39.1°		2
	38.1-39.0°		1
	37.1-38.0°	37.2	
	36.1-37.0°		
	35.1-36.0°		1
	≤35.0°		3
	NEWS TOTAL	1	
	Monitoring frequency	1	
	Escalation of care Y/N	N	
	Blood Glucose reading or N/A		
	Pain score (0-10)		
	Initials	[illegible]	

Reproduced from: Royal College of Physicians. National Early Warning Score (NEWS) 2: Standardising the assessment of acute-illness severity in the NHS. Updated report of a working party. London: RCP, 2017.

NEWS of 5 or more?
Think Sepsis!

In a patient with a **NEWS** of **5 or more** and a known infection, signs and symptoms of infection, or at risk of infection, think **'Could this be sepsis?'** and **escalate care immediately.**

Signs of Infection

- Temperature <36°c or >38°c
- Heart rate >90 beats pm
- Respiratory rate >20 breaths pm
- New confusion
- WCC <4 or >12
- Blood sugar >7.7 in non-diabetic

Addressograph

Name:

DOB:

CHI:

NEWS Total	Monitoring Frequency	Clinical Response
Total 0	Commence on 2 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
Total 1 - 4	Commence on 1 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
3 in one parameter *	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to Nurse In Charge (NIC) and Senior Medic
Total 5 - 6	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Total 7 or more	Commence on 15 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Special Instructions		

*or increase in NEWS score of 2

Conscious Level Chart to be completed when clinically indicated

		Date		
		Time		
GLASGOW COMA SCALE	Eyes Open	Spontaneously	4	Eyes closed by swelling = C
		To speech	3	
		To pain	2	
		None	1	
	Best Verbal Response	Orientated	5	Endotracheal tube or tracheostomy = T
		Confused	4	
		Inappropriate words	3	
		Incomprehensible sounds	2	
		None	1	
	Best Motor Response	Obey commands	6	Always record the best arm response
		Localise to pain	5	
		Flexion to pain	4	
		Abnormal flexion	3	
		Extension to pain	2	
		None	1	
		Total GCS Score		
Right Pupil		Size		+ reacts - no reaction c. eye closed
		Reaction		
Left Pupil		Size		
		Reaction		
LIMB MOVEMENT	ARMS	Normal power		Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness		
		Severe weakness		
		Extension		
		No response		
	LEGS	Normal power		
		Mild weakness		
		Severe weakness		
		Extension		
		No response		
		Initials		

Pupil Scale mm 1 2 3 4 5 6 7 8

IV Fluid Prescription

Time Prescribed	Fluid	Volume	Rate	Prescribers Signature	Time Started	Given by (Initials)	Checked by (Initials)	Time Finished

Fluid Balance

INPUT						OUTPUT				
	IV Fluids or SC Fluids IV Medication	**IV Line(s)**	**Oral Input**		**Input**		**Urine**		**Gastric**	
Time	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100ml	Running Total	Time	Volume	Running Total	Volume	Running Total

Drug Infusion

Drug Name:

	Time													
	Rate (ml/hr)													
	Volume in Syringe													
Pump No	Total amount Infused													

Drug Name:

	Time													
	Rate (ml/hr)													
	Volume in Syringe													
Pump No	Total amount Infused													

Home Visit Summary (Send to printer)

Address and Contact Details

Angella Isabella Cross 22/05/1967 Female NHS: KJDCJ/320 CHI: 2205671464
No data recorded.
44 Woodburn Bank Dalkeith Midlothian EH22 2EY
Mobile phone 07940443239
Telephone - home 0131 531 1195
Angella Isabella Cross 22/05/1967 Female NHS: KJDCJ/320 CHI: 2205671464

Special Notes

No data recorded.

Significant PMH

28/02/2017 Gallstones
15/01/2016 Corneal ulcer right
30/09/2013 Essential hypertension
27/08/2013 Anxiety states
13/06/2001 Thyroglossal duct cyst
25/01/2001 Caesarean delivery
17/12/1998 Miscarriage
25/07/1997 Iron deficiency anaemias
30/11/1994 Pneumonia due to unspecified organism
22/03/1994 Acute pyelonephritis
23/07/1993 Caesarean delivery
28/05/1993 Microcytic hypochromic anaemia
20/07/1992 Miscarriage
19/12/1988 Spontaneous vaginal delivery
09/02/1988 Miscarriage
15/11/1987 Miscarriage
11/11/1986 Neurotic depression reactive type -ongoing
14/08/1983 [X]Intentional self poisoning/exposure to noxious substances

Last 6 Surgery , Home or Telephone Consultations

15/09/2021 Emergency Consultation Dr Aldrich Ma - No Data Recorded
15/09/2021 Surgery consultation Ms Jillian Paulin
15/09/2021 Blood sample -> Lab NOS = Attended for bloods and BP
BP very elevated complaining of floaters, headache and heaviness.
Also had a panic attack whilst in surgery
Discussed with Dr Ma as Dr Morrison out on house visit Dr Ma will review
pt sitting in main waiting area Ms Jillian Paulin
15/09/2021 Surgery consultation Ms Jillian Paulin
15/09/2021 11:07.00 BP 204 / 168 taken Sitting from Left Cuff: Standard recall due: O/E - blood pressure reading Ms Jillian Paulin
09/09/2021 Administration Ms Sarah Robertson
09/09/2021 SMS text message sent to patient Dear AC, a prescription was done for you on 8th September and has not been collected. this has therefore been sent to Lloyds Pharmacy, Newbattle and will be ready to collect in the next 24-48 hours. Regards Newbattle Medical Practice Ms Sarah Robertson
08/09/2021 Telephone call to a patient Dr Sonia Keane
08/09/2021 Request for Laboratory test requested
Remote Test request from ICE system: NHS Lothian Ice
Clinical Information:
Priority: non-urgent,
Ordered from: Biochemistry Red, All samples collected
Test: HbA1c, Status: Complete, Updated: 15/09/2021
Ordered from: Biochemistry, All samples collected
Test: Creat & Electolytes, Status: Complete, Updated: 15/09/2021
Test: Cholesterol, Status: Complete, Updated: 15/09/2021
Test: LFTs, Status: Complete, Updated: 15/09/2021
Test: TFT, Status: Complete. Updated: 15/09/2021
Ordered from: Haematology, All samples collected
Test: FBC, Status: Complete, Updated: 15/09/2021 Dr Sonia Keane
08/09/2021 Telephone encounter Very anxious and stressed , not sleeping , longstanding issues with MH but hasnt taken any medication in 2 yrs including BP meds , racing thoughts clearly anxious on phone plans to contact MAP and agreed restart lower dose mirtazapine , will come for bloods and BP check next week and rv thereafter Dr Sonia Keane
08/09/2021 Mirtazapine 15mg tablets Supply: (28) tablet ONE AT NIGHT Dr Sonia Keane
08/09/2021 SMS text message sent to patient 11.10am Jillian nurse Newbattle - 15/9/21 Dr Sonia Keane
08/09/2021 SMS text message sent to patient mep@nhslothian.scot.nhs.uk. Send your name and number to this address Angela Dr Sonia K
08/09/2021 Administration Mrs Kayleigh Withers
08/09/2021 Other Attachment
08/09/2021 Alert received from telehealth monitoring system Mrs Kayleigh Withers

Current Repeat Masters

Repeat Lisinopril 20mg tablets Last issued: 31/12/2018 Issued: 2 maximum 5 allowed Supply: (56) tablet 1 TABLET ONCE A DAY Dr Jim Fulton

Acutes in Last 3 Months

08/09/2021 Mirtazapine 15mg tablets Supply: (28) tablet ONE AT NIGHT Dr Sonia Keane

Allergies and Intolerances

No data recorded.
No data recorded.

Prevention

15/09/2021 11:07.00 BP 204 / 168 taken Sitting from Left Cuff: Standard recall due: O/E - blood pressure reading Ms Jillian Paulin

04/09/2018 11:33.00 BP 155 / 122 taken Sitting Cuff: Standard recall due: O/E - blood pressure reading Dr Jim Fulton
04/09/2018 11:27.00 BP 154 / 122 taken Sitting Cuff: Standard recall due: O/E - BP reading raised n Dr Jim Fulton
No data recorded.
No data recorded.
04/09/2018 Weight: 80 kgs O/E - weight Dr Jim Fulton
No data recorded.

CROSS, ANGELLA ID:2205671464 15-Sep-2021 15:26:24 NHS LOTHIAN-RIE_ED ROUTINE RECORD

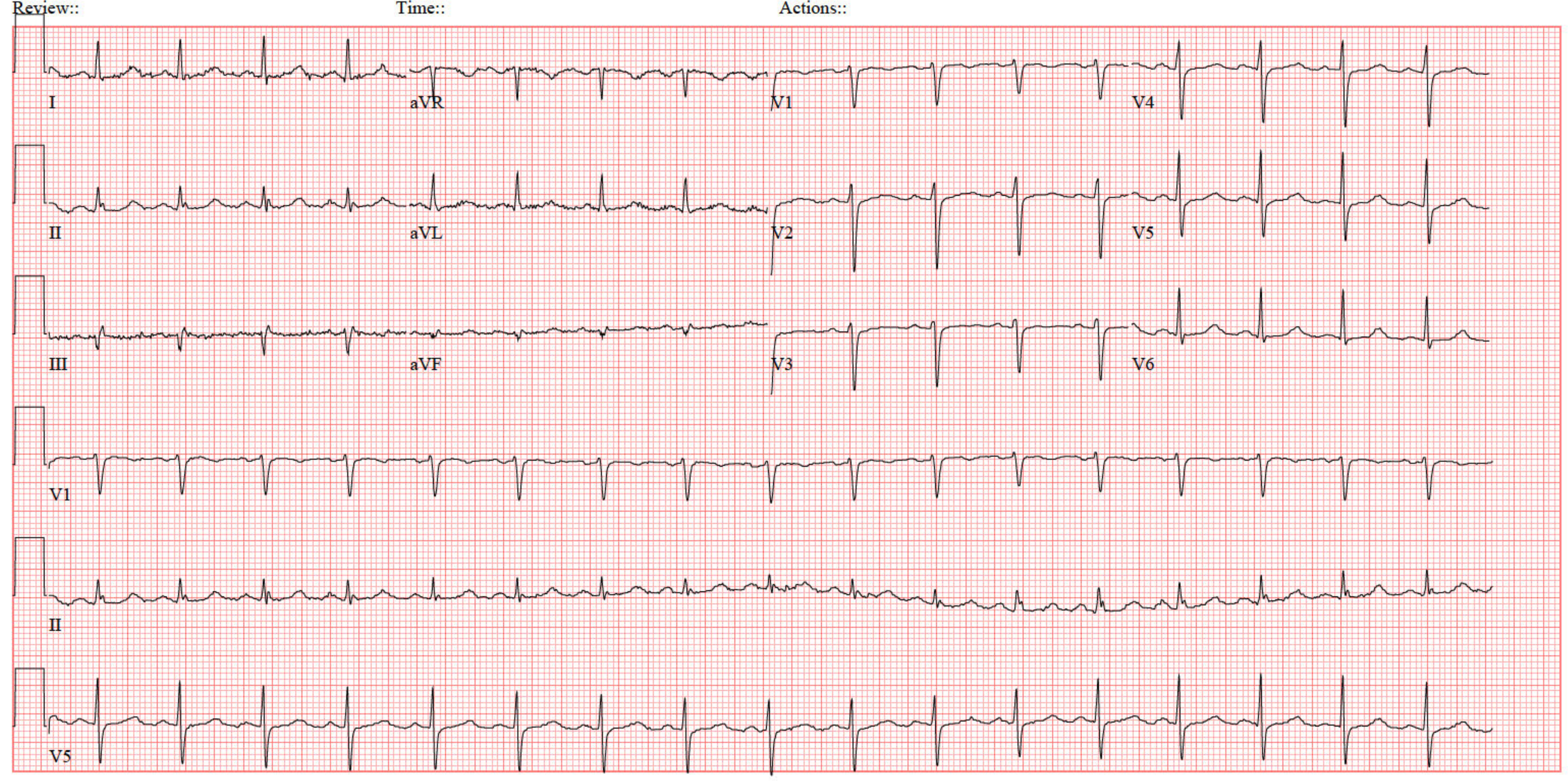
22-May-1967 (54 yr)
Female

Room:
Loc:40

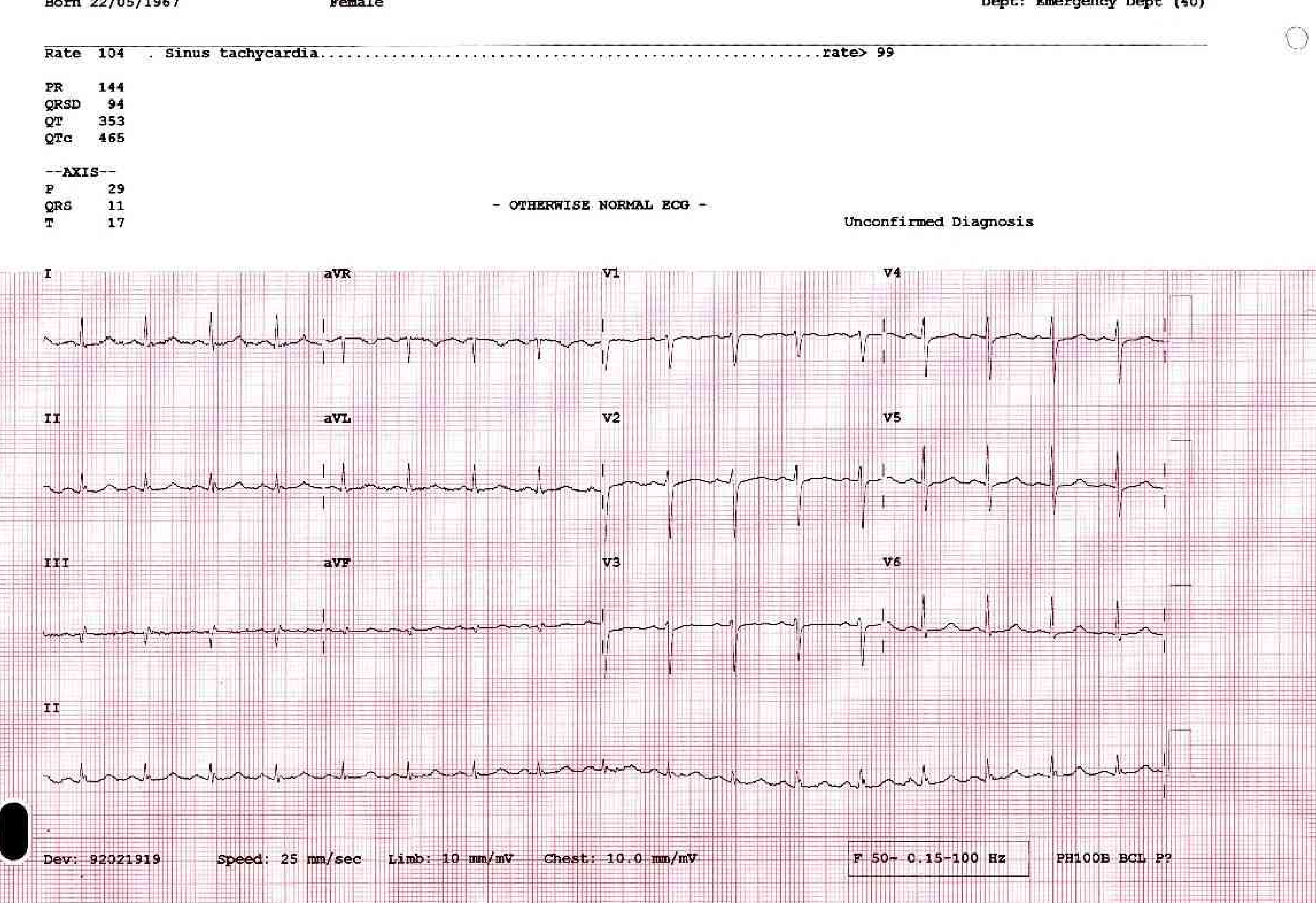
Vent. rate	104	BPM
PR interval	144	ms
QRS duration	94	ms
QT/QTcB	353/465	ms
P-R-T axes	29 11	17

Technician:
Test ind:

Review:: Time:: Actions::



25mm/s 10mm/mV 150Hz 10.1.3 12SL NO SERIAL CID: SID: 1505946 EID: EDT: ORDER:


2205671464
15/09/2021
15:26:24
CROSS, ANGELA
Born 22/05/1967
Female
Royal Infirmary of Edinburgh (1)
Dept: Emergency Dept (40)
Rate 104 . Sinus tachycardia..rate> 99
PR 144
QRSD 94
QT 353
QTc 465
--AXIS--
P 29
QRS 11
T 17
- OTHERWISE NORMAL ECG -
Unconfirmed Diagnosis
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
II
Dev: 92021919
Speed: 25 mm/sec
Limb: 10 mm/mV
Chest: 10.0 mm/mV
F 50~ 0.15-100 Hz
PH100B BCL P?
MedGRAPHICS LTD

620045326K/E4819058 F 22/05/1967
Cross, Angella
44 Woodburn Bank,
Dalkeith,
Midlothian, EH22 2EY

CHI 2205671464
77106 VE Aspinall

INFORME[...]L MS-0264

Title of Project: ***COLLECTION OF VENOUS AND CAPILLARY BLOOD SAMPLES FOR THE DEVELOPMENT OF NEW DIAGNOSTIC DEVICES FOR CARDIOVASCULAR CONDITIONS (NOVEL STUDY)***

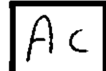
Name of Researcher: Prof A. Gray

Please initial box

Patient Identification Number: N-CKP-1439KIG

1. I confirm that I have read and understand version ...H.....of the information sheet numbered MS-0267 and dated ...11 MAR 2019.for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

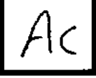
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.



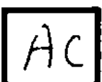
3. I agree that the Sponsor of this research study, others working on the Sponsor's behalf, such as contract research organisations, and regulatory authorities may access relevant sections of my personal and medical data with respect to this study and any further research that may be conducted in direct relation to it.

4. I understand that my identity will not be revealed in any information released to third parties or published. And the data derived from and held in relation to the study will be anonymized and will not be able to personally identify me.

5. I understand that my plasma sample may be retained for up to 5 years by the Sponsor and may be used in further testing and development of this diagnostic test. I understand that my plasma sample will be destroyed securely by the Sponsor after 5 years. I understand that no genetic testing will be done on my sample.



6. I understand that my anonymised data (data that cannot be traced back to me) may be transferred to the Sponsor's other offices outside the EU, to be used in support of a formal submission to sell the device in the future.



7. I agree to take part in the above study.

Ac

White copy- To Study Folder
Yellow copy- To Subject

N-CKD-1639KIG

INFORMED CONSENT FORM FOR PROTOCOL MS-0264

ANGELA A CROSS 15/SEP 2021 A Cross

Name of Patient Date Signature

CAROLINE BLACKSTOCK 15 SEP 2021 [signature]

Name of Person taking consent Date Signature

620045326K/E4819058 F 22/05/1967
Cross, Angella
44 Woodburn Bank,
Dalkeith,
Midlothian, EH22 2EY

CHI 2205671464
77106 VE Aspinall

White copy- To Study Folder
Yellow copy- To Subject

620045326K/E4819058 F 22/05/1967
Cross, Angella
44 Woodburn Bank,
Dalkeith,
Midlothian, EH22 2EY

CHI 2205671464
77106 VE Aspinall

COLLECTION OF VENOUS AND CAPILLARY BLOOD SAMPLES FOR THE DEVELOPMENT OF NEW DIAGNOSTIC DEVICES FOR CARDIOVASCULAR CONDITIONS. (NOVEL STUDY)

We would like to invite you to take part in a research study.
Before you decide to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends and relatives if you wish. Please ask if there is anything that is not clear to you or if you would like more information. Take time to decide whether or not you wish to take part. You can also discuss the study with Dr Edward James who is the independent contact for the study on 0131 242 2316.

What is the Purpose of the research?
LumiraDx UK is developing new point-of-care diagnostic devices for people who have symptoms that may or may not be due to one of the following conditions: heart failure, heart attack, kidney failure, blood clots or inflammation

What will happen if I agree to take part?
The research involves taking a sample of blood from your arm (up to 24ml, which is a bit more than a tablespoonful) which will be tested on device(s) which are being developed by LumiraDx. You may also be asked to provide up to 6 fingerstick samples of blood. We will collect information from you and your medical notes regarding your participation, this includes your age, sex, ethnicity and medical information regarding symptoms of why you attended the hospital. This is to make sure you fit the criteria to take part in the study. This will take no longer than 30 minutes and will occur at your planned clinic visit or in a private cubicle if you are presenting at the accident & emergency department. Taking part in the research will not affect your normal standard of care. Participation in this research study is restricted to once within any 3 month period over the life span of the study.

Will my taking part in the study be kept private?
The NHS will keep your name, NHS number and contact details confidential and will not pass this information to LumiraDx UK Ltd. Individuals from LumiraDx UK Ltd and regulatory organisations may look at your medical and research records to check the accuracy of the research study. The only people in LumiraDx UK Ltd who will have access to information that identifies you will be limited to the people who need .to audit the data collection process. LumiraDx UK Ltd will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name, NHS number or contact details.

Do I have to take part?
No – your participation is completely voluntary and should you decide during the research that you wish to stop then you are free to do so and that all data gathered up to that point with either be kept with your consent or destroyed if that is what you want.

Will I receive payment or expenses?
A sum of up to £10 will be paid to cover travelling expenses if you are asked to attend out with a scheduled clinic appointment for the purposes of this study.

Are there risks or benefits to taking part?

The only risks to taking part are those associated with taking blood draw (e.g. bruising / infection). Blood will be taken by a trained member of staff. As the data will be anonymised you will not receive any feedback from your participation in this study. There are no immediate benefits to taking part. However, this could change if the device proves to be successful.

What will happen to the Blood Sample and Information?

Your data is kept confidential by the hospital and LumiraDx UK Ltd in accordance with Data Protection Legislation. LumiraDx is the sponsor for this study based in the United Kingdom. We will be using information from you and your medical records in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. LumiraDx UK Ltd will keep identifiable information about you for 5 years after the study has finished.

Your blood sample will be retained by LumiraDx UK Ltd for up to 5 years and may be used in further testing designed to improve this test device or develop further tests. It will be securely destroyed after 5 years. No genetic testing will be done on your blood sample. We use personally-identifiable information to conduct research to improve health and care. As an In Vitro Medical Device company we have a legitimate interest in using information relating to your health and care for research studies, when you agree to take part in a research study. This means that we will use your data, collected in the course of a research study, in the ways needed to conduct and analyse the research study. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information at DPO@LumiraDx.com

How do I complain?

If you have a concern about any aspect of this study, you should ask to speak with the Study Staff who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure. Details can be obtained from the hospital.

If you wish to raise a complaint on how we have handled your personal data, you can contact our Data Protection Officer who will investigate the matter. If you are not satisfied with our response or believe we are processing your personal data in a way that is not lawful you can complain to the Information Commissioner's Office (ICO).

You can contact our Data Protection Officer at DPO@lumiraDx.com.

What will happen to the results of the study?

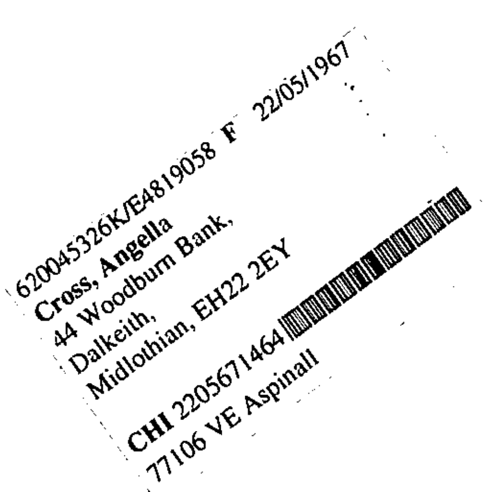
The results of the blood tests are analysed on an ongoing basis to enable the development of the product(s).

Who is funding the Research?
LumiraDx UK Limited, is funding the research.

Who has reviewed the study?
West of Scotland Research Ethics Committee have reviewed the study and given favourable opinion.

What do I do now?
Please contact the Research Nurse or speak to them at your next clinic visit for more information or to consent to the study.

Thank you for taking the time to read this – please ask any questions if you need to.



Patient & GP Information

UHPI Number	620045326K
CHI Number	2205671464
Episode Number	E3497207
Surname/Forename	Cross, Angella
Date of Birth	5/22/67
Sex	Female
Patient Address.	44 Woodburn Bank Dalkeith EH22 2EY
Registered GP	VE Aspinall
GP Address.	Newbattle Medical Practice,Blackcot,Mayfield,Midlothian EH22 4AA

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	E3497207

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
A&E Notes Episode/Ref: E3497207 Margaret Rose Singh 2/27/17 23:24 Meena Parameswaran	CLINICAL NOTES: ,Clinical note: CHI: 2205671464,,History from patient and EPR.,,PC: Epigastric pain,,HPC: 3/52 of intermittent epigastric pain. Has been taking paracetamol, ibuprofen, partners co-codamol and son's omeprazole. Awoken from sleep at 0400 hrs this morning with worse epigastric pain radiating round to upper back. Throbbing in nature and constant. Also sharp right arm pain. No vomiting but nauseated. No relieving factors. Worse after drinking a cup of tea today. States she has been sweating over the past few days. No bowel or bladder symptoms. Pain score at worst 10/10, currently 7/10.,,PMH: HTN, depression,,Meds: Lisinopril, bendroflumethiazide, mirtazapine,,NKDA,,FH: diabetes,,SH: Lives with partner and 16 yr old daughter (Down's Syndrome). Works as a peer support worker. Non smoker, rarely drinks alcohol. No recreational drug use.,,OE: alert, WWP, states 7/10 pain score,,Obs: T 36.7, HR 98, BP 180/122, SPO2 98% RA, BM 5.7,,CVS: HS I+II+0, calves SNT,ECG: SR, nil acute,,RS: Bilateral AE. No cough/cold/wheeze,,Abdo: Soft. Tender epigastrium. No guarding. No JACCOL. No bloating. No bowel/urinary symptoms.,,CNS: Orientated x3. Moving all 4 limbs,,MSk: nil acute,,Imp: ? gastritis,,Plan: Bloods,Given Peptac. If bloods normal then for discharge home with omeprazole 40mgs OD for 7 days and GP review.,,,2340 - Dr Parameswaran, FY2 - Night team,,Bloods chased - FBC, U&Es unremarkable, normal amylase,Newly deranged LFTs - Bili 26, ALT 175, ALP 126,,O/E :,Abdomen soft, tender RUQ ++, epigastrium ++, No guarding, no rebound tenderness. Bowel sounds present.,,Plan :,1. Discussed with surgical SHO who will kindly review patient, many thanks.,,,Patient has been kindly reviewed by the surgical reg who is happy for her to be discharged home with co-codamol and to attend the HOT clinic tomorrow.,,Reviewed by ST8 general surgery P Nesangikar:,History as above. Intermittent upper abdo pain for few weeks. Normal bowel movements. No urinary symptoms,Bloods noted,O/e soft abdomen. Tender RUQ pain and epigastrium. Murphy's -ve,,Imp: Biliary colic,,P,Pt offered admission or HOT clinic USS- would prefer to return tomo,For HOT AUSS,,Dr Parameswaran, FY2,

NHS Lothian

Royal Infirmary of Edinburgh
51 Little France Crescent
Old Dalkeith Road
Edinburgh EH16 4SA

Date: 28/02/2017

Dr JA Scott
Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA

Emergency Discharge Summary

Patient	Angella Cross 44 Woodburn Bank Dalkeith Midlothian EH22 2EY	**CHI**	**2205671464**
		Date of Birth / Age	22/05/1967 (49 years)
		UHPI	620045326K
		A&E Attendance Number	E3497207
Attendance Date	27/02/2017	**Contact**	
Attendance Time	19:09		
Mode of Arrival	Private Transport		
Source of Referral	NHS 24		
Discharge Date	27/02/2017		
Discharge To			

Dear Dr JA Scott

Presentation: abdo pain

CLINICAL NOTES:
Clinical note: CHI: 2205671464

History from patient and EPR.

PC: Epigastric pain

HPC: 3/52 of intermittent epigastric pain. Has been taking paracetamol, ibuprofen, partners co-codamol and son's omeprazole. Awoken from sleep at 0400 hrs this morning with worse epigastric pain radiating round to upper back. "Throbbing" in nature and constant. Also "sharp" right arm pain. No vomiting but nauseated. No relieving factors. Worse after drinking a cup of tea today. States she has been sweating over the past few days. No bowel or bladder symptoms. Pain score at worst 10/10, currently 7/10.

PMH: HTN, depression

Meds: Lisinopril, bendroflumethiazide, mirtazapine

NKDA

FH: diabetes

SH: Lives with partner and 16 yr old daughter (Down's Syndrome). Works as a peer support worker. Non smoker, rarely drinks alcohol. No recreational drug use.

OE: alert, WWP, states 7/10 pain score

Obs: T 36.7, HR 98, BP 180/122, SPO2 98% RA, BM 5.7

CVS: HS I+II+0, calves SNT

ECG: SR, nil acute

RS: Bilateral AE. No cough/cold/wheeze

Abdo: Soft. Tender epigastrium. No guarding. No JACCOL. No bloating. No bowel/urinary symptoms.

CNS: Orientated x3. Moving all 4 limbs

MSk: nil acute

Imp: ? gastritis

Plan: Bloods
Given Peptac. If bloods normal then for discharge home with omeprazole 40mgs OD for 7 days and GP review.

2340 - Dr Parameswaran, FY2 - Night team

Bloods chased - FBC, U&Es unremarkable, normal amylase
Newly deranged LFTs - Bili 26, ALT 175, ALP 126

O/E :
Abdomen soft, tender RUQ ++, epigastrium ++, No guarding, no rebound tenderness. Bowel sounds present.

Plan :
1. Discussed with surgical SHO who will kindly review patient, many thanks.

Patient has been kindly reviewed by the surgical reg who is happy for her to be discharged home with co-codamol and to attend the HOT clinic tomorrow.

Reviewed by ST8 general surgery P Nesangikar:
History as above. Intermittent upper abdo pain for few weeks. Normal bowel movements. No urinary symptoms
Bloods noted
O/e soft abdomen. Tender RUQ pain and epigastrium. Murphy's -ve

Imp: Biliary colic

P
Pt offered admission or HOT clinic USS- would prefer to return tomo
For HOT AUSS

Dr Parameswaran, FY2

Yours Sincerely,

Margaret Rose Singh, Nurse Practitioner

Patient & GP Information

UHPI Number	620045326K
CHI Number	2205671464
Episode Number	E3226446
Surname/Forename	Cross, Angella
Date of Birth	5/22/67
Sex	Female
Patient Address.	44 Woodburn Bank Dalkeith EH22 2EY
Registered GP	VE Aspinall
GP Address.	Newbattle Medical Practice,Blackcot,Mayfield,Midlothian EH22 4AA

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	E3226446

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
A&E Notes Episode/Ref: E3226446 Dr Christopher W L Armstrong 3/19/16 20:02 Dr Christopher W L Armstrong	, ,Clinical note: ED Reg - Armstrong,,48 year old female - cat bites to arm,,Bitten and scratched by cat whilst separating cat and dog today. ,,PMH: HTN. Deression,,DH: Mirtazepine, BFZ, Lisinopril,NKDA,,O/E Well,,Left arm - multiple superficial wunds to upper arm. Nil full thickness. ,,Imp: Minor cat bite wounds. ,,Plan: Clean, dress, home with Coamoxiclav. Watch for signs of infection - GP/ED if any worsening or concerns. ,,

NHS Lothian

Royal Infirmary of Edinburgh
51 Little France Crescent
Old Dalkeith Road
Edinburgh EH16 4SA

Date: 24/03/2016

Dr JA Scott
Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA

Emergency Discharge Summary

Patient	Angella Cross 44 Woodburn Bank Dalkeith Midlothian EH22 2EY	**CHI**	**2205671464**
		Date of Birth / Age	22/05/1967 (48 years)
		UHPI	620045326K
		A&E Attendance Number	E3226446
Attendance Date	19/03/2016	**Contact**	
Attendance Time	18:27		
Mode of Arrival	Private Transport		
Source of Referral	Self Referral to A&E		
Discharge Date	19/03/2016		
Discharge To			

Dear Dr JA Scott

Presentation: dog bite

Clinical note: ED Reg - Armstrong

48 year old female - cat bites to arm

Bitten and scratched by cat whilst separating cat and dog today.

PMH: HTN. Deression

DH: Mirtazepine, BFZ, Lisinopril
NKDA

O/E Well

Left arm - multiple superficial wunds to upper arm. Nil full thickness.

Imp: Minor cat bite wounds.

Plan: Clean, dress, home with Coamoxiclav. Watch for signs of infection - GP/ED if any worsening or concerns.

Yours Sincerely,

Dr Christopher W L Armstrong, Doctor

LHB 925

NHS Lothian
University Hospital Services
Department of Emergency Medicine

Clinical Director Dr. D.Caesar
Clinical Nurse Manager Mr. Chris Connolly
THE ROYAL INFIRMARY OF EDINBURGH
51 Little France Crescent, Edinburgh EH16 4SA
Tel: 0131 242 1300 • Fax: 0131 242 1344

A/E no. E3226446
Previous no. E3092848
UHPI no. 620045326K
CHI no. 2205671464

PATIENT INFORMATION

Surname Cross
Forename Angella
Date of Birth 22/05/1967
Age 48 Yrs Sex F

Address 44 Woodburn Bank
Dalkeith
Midlothian
Postcode EH22 2EY
Telephone 283 8775

Contact [redacted]
Address [redacted]
Telephone [redacted]
W

Complaint dog bite
Allergies

Attendances in last 12 months: 1
School:

General Practitioner

JA Scott
Address
Newbattle Medical Practice
Blackcot
Mi EH22 4AA
Telephone 0131 663 1051

Date and Time of Attendance
19/03/2016 18:27
Incident Date & Time: 19/03/2016
Mode of Arrival
Private Transport
Source of Referral
Self Referral to A&E

TRIAGE

Presenting Complaint: Cat bite

History of Presenting Complaint: Split up a fight between a cat and dog. Cat bit (L) arm.

Assessment: Bites very superficial, small puncture wounds

OBSERVATIONS

Temp	Pulse Rate	BP	RR	Sats	O2/air	BM	PF best	Alcometer	GCS	SEWS
		/		%					/15 e__v__m__	

? SEPSIS temp >383 or <36 ☐ HR > 90 ☐ RR > 20 ☐ BM > 7 (+ not diabetic) ☐ age > 70 ☐ signs of infection ☐

> 2 THINK SEPSIS AND TRIAGE UP Y / N

PAIN SCORE ___/10 Analgesia ☐ Time ______

FAST Stroke Test + / − (circle) Onset Time: ______

Triaged no.: 1 2 3 4 7 (circle) Triaged to: HD / IC / exam / WR / GP (circle) Senior Doctor Informed? Y / N time______

INTERVENTIONS & INVESTIGATIONS

Peripheral Venous Cannula Insertion *Complete all sections*

Date: .... Time:....................

Size		Position		Standard technique	
Blue	☐	LEFT	☐	Handwash	☐
Pink	☐	RIGHT	☐	Gloves	☐
Green	☐	Hand	☐	CHD skin prep	☐
Orange	☐	Forearm	☐	Aseptic Insertion	☐
Brown	☐	ACF	☐	Needle free port	☐
Grey	☐	Foot	☐	Dressing labelled	☐

Operator Signature: ....

BLOODS Routine ☐ Troponin ☐ Amylase ☐

(Trop due________)

TOX ☐ Other ☐ ________

(time of OD________)

BTS ☐ SENT ☐

ECG Required ☐ Done ☐ Time__________

X-RAYS CXR ☐ Other ☐ __________

URINALYSIS Required ☐ Done ☐ HCG: + / − (circle) MSU Sent: Y / N

BED REQUIRED YES / NO (circle)

Speciality Informed ☐ Time__________

Time of Triage:..

Triaged by: (sign) T Russell

(print) T Russell

Care Provider: (print) ....

"WHAT MATTERS TO THE PATIENT?"

THINK:- OTHER SOURCES OF INFORMATION:

FAMILY ☐ CARERS ☐ SAS PRF ☐ EPR ☐ ECS ☐ KIS ☐ GP ☐ PATIENT ALERTS ☐

Care Providers Name:.. Signature:..

ROYAL INFIRMARY OF EDINBURGH
EMERGENCY DEPARTMENT

620045326K/E3226446 F 22/05/1967
Cross, Angella
44 Woodburn Bank,
Dalkeith,
Midlothian,
EH22 2EY
CHI 2205671464
77106 JA Scott

PREVIOUS ADVERSE REACTIONS	

DRUG AND PRESCRIPTION RECORD

Date 19.3.16

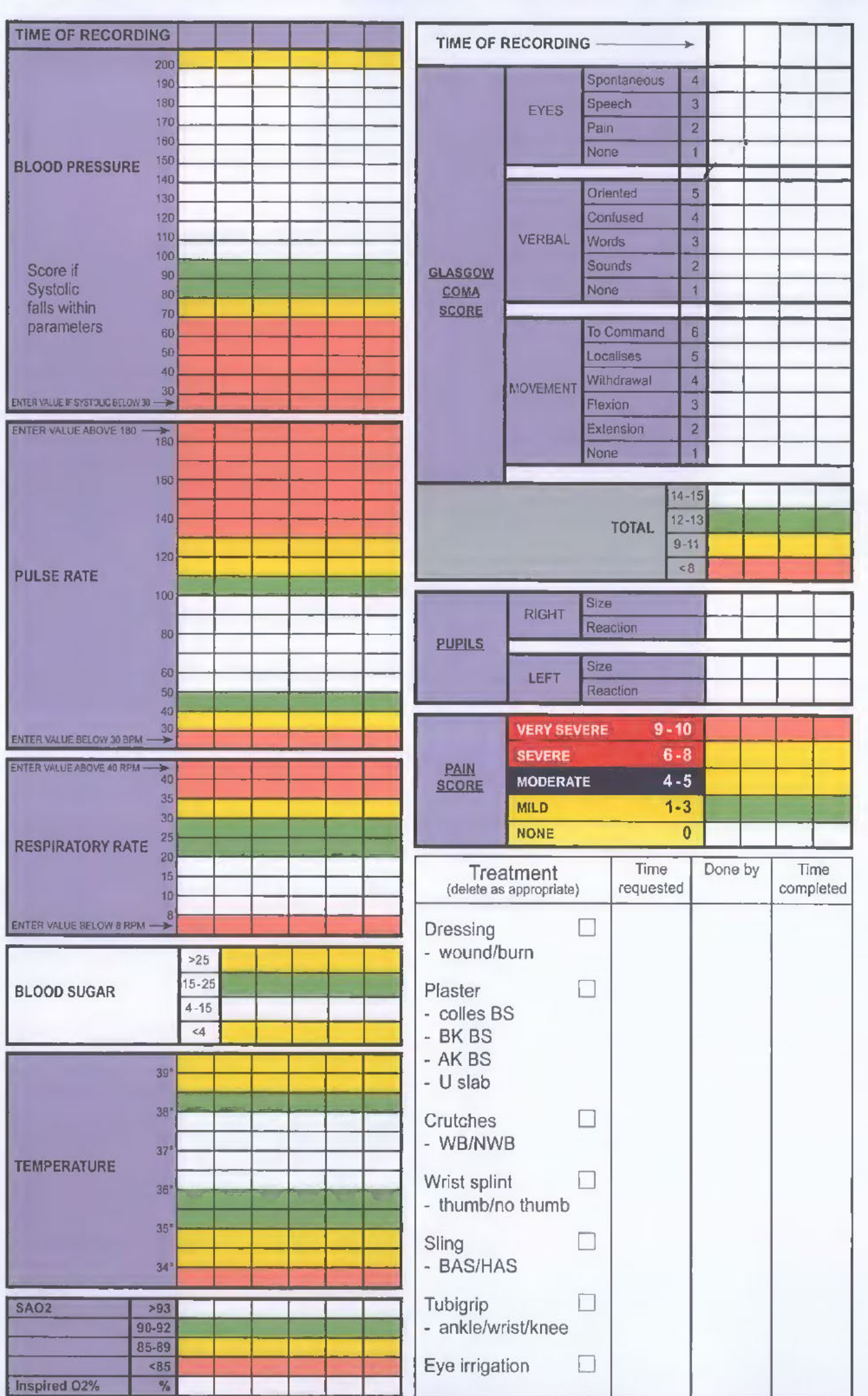
ONCE ONLY PRESCRIPTION

Date	Time	Drug (Approved Name)	Dose	Route	Prescriber's Signature	Time Given	Given by (Initials)	Checked by (Initials)
		Paracetamol		Oral				
		Ibuprofen	400mg	Oral				
		Co-Codamol $^{30}/_{500}$		Oral				
		Tetanus						

DISCHARGE MEDICATION

Date	Time	Drug (Approved Name)	Dose	Frequency	Route	Prescriber's Signature	Given by (Initials)	Checked by (Initials)
		Paracetamol	1g	QDS	Oral			
		Ibuprofen	400mg	TID	Oral			
		Co-Codamol $^{30}/_{500}$	1 - 2	QDS	Oral			
		Chloramphenicol		QDS	Top			
19/3/16	2000	Co-Amoxiclav	500/125	TID	Oral	[signature]	CA.	[initials]
		Flucloxacillin	500mg	QDS	Oral			

LOT 112



TIME OF RECORDING							
BLOOD PRESSURE	200						
	190						
	180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100						
Score if Systolic falls within parameters	90						
	80						
	70						
	60						
	50						
	40						
	30						
ENTER VALUE IF SYSTOLIC BELOW 30 →							

ENTER VALUE ABOVE 180 →							
PULSE RATE	180						
	160						
	140						
	120						
	100						
	80						
	60						
	50						
	40						
	30						
ENTER VALUE BELOW 30 BPM →							

ENTER VALUE ABOVE 40 RPM →							
RESPIRATORY RATE	40						
	35						
	30						
	25						
	20						
	15						
	10						
	8						
ENTER VALUE BELOW 8 RPM →							

BLOOD SUGAR						
	>25					
	15-25					
	4-15					
	<4					

TEMPERATURE							
	39°						
	38°						
	37°						
	36°						
	35°						
	34°						

SAO2	>93						
	90-92						
	85-89						
	<85						
Inspired O2%	%						

TIME OF RECORDING →							
GLASGOW COMA SCORE	EYES	Spontaneous	4				
		Speech	3				
		Pain	2				
		None	1				
	VERBAL	Oriented	5				
		Confused	4				
		Words	3				
		Sounds	2				
		None	1				
	MOVEMENT	To Command	6				
		Localises	5				
		Withdrawal	4				
		Flexion	3				
		Extension	2				
		None	1				
TOTAL			14-15				
			12-13				
			9-11				
			<8				

PUPILS	RIGHT	Size				
		Reaction				
	LEFT	Size				
		Reaction				

PAIN SCORE						
	VERY SEVERE	9-10				
	SEVERE	6-8				
	MODERATE	4-5				
	MILD	1-3				
	NONE	0				

Treatment (delete as appropriate)	Time requested	Done by	Time completed
Dressing ☐ - wound/burn			
Plaster ☐ - colles BS - BK BS - AK BS - U slab			
Crutches ☐ - WB/NWB			
Wrist splint ☐ - thumb/no thumb			
Sling ☐ - BAS/HAS			
Tubigrip ☐ - ankle/wrist/knee			
Eye irrigation ☐			

Patient & GP Information

UHPI Number	620045326K
CHI Number	2205671464
Episode Number	E3092848
Surname/Forename	Cross, Angella
Date of Birth	5/22/67
Sex	Female
Patient Address.	44 Woodburn Bank Dalkeith EH22 2EY
Registered GP	VE Aspinall
GP Address.	Newbattle Medical Practice,Blackcot,Mayfield,Midlothian EH22 4AA

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	E3092848

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
A&E Notes Episode/Ref: E3092848 Andrew W Brown 9/27/15 21:25 Andrew W Brown	, ,Clinical note: CHI: 2205671464,,48y/o female.,,P/C: Right foot pain over past week, unsure of any trauma.,,PMH: Depression, HTN,Meds: Bendroflumethiazide, lisinopril, mirtazapine, propranolol,NKDA,,GCS 15, WWP,Temp 36.7,,O/E R foot: Slight swelling to foot. No bruising or deformity, no signs of infection, skin intact.,Tender over plantar aspect foot, no heat, DNVI.,GROM foot, walking with a slight limp.,,Xray R foot: NBI,,Imp: Soft tissue inj? Plantar fascitis?,,Plan,- See GP in week if does not settle,- Take simple analgesia,- Verbal advice given,- Worsening statement given, return if concerned,

NHS Lothian

Royal Infirmary of Edinburgh
51 Little France Crescent
Old Dalkeith Road
Edinburgh EH16 4SA

Date: 28/09/2015

Dr JA Scott
Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA

Emergency Discharge Summary

Patient	Angella Cross 31A ALLAN TERRACE Dalkeith EH22 1EL	**CHI**	**2205671464**
		Date of Birth / Age	22/05/1967 (48 years)
		UHPI	620045326K
		A&E Attendance Number	E3092848
Attendance Date	27/09/2015	**Contact**	
Attendance Time	19:35		
Mode of Arrival	Private Transport		
Source of Referral	Lothian Unscheduled Care Servi		
Discharge Date	27/09/2015		
Discharge To			

Dear Dr JA Scott

Presentation: ?plantars fascitis ?#

Clinical note: CHI: 2205671464

48y/o female.

P/C: Right foot pain over past week, unsure of any trauma.

PMH: Depression, HTN
Meds: Bendroflumethiazide, lisinopril, mirtazapine, propranolol
NKDA

GCS 15, WWP
Temp 36.7

O/E R foot: Slight swelling to foot. No bruising or deformity, no signs of infection, skin intact.
Tender over plantar aspect foot, no heat, DNVI.
GROM foot, walking with a slight limp.

Xray R foot: NBI

Imp: Soft tissue inj? Plantar fascitis?

Plan
- See GP in week if does not settle
- Take simple analgesia
- Verbal advice given
- Worsening statement given, return if concerned

Yours Sincerely,

Andrew W Brown, Nurse Practitioner

LHB 925

NHS Lothian
University Hospital Services
Department of Emergency Medicine

Clinical Director Dr. D.Caesar
Clinical Nurse Manager Mr. Chris Connolly
THE ROYAL INFIRMARY OF EDINBURGH
51 Little France Crescent, Edinburgh EH16 4SA
Tel: 0131 242 1300 • Fax: 0131 242 1344

A/E no. E3092848
Previous no. E2155289
UHPI no. 620045326K
CHI no. 2205671464

PATIENT INFORMATION

Surname Cross
Forename Angella
Date of Birth 22/05/1967
Age 48 Yrs
Sex F

Address 31A ALLAN TERRACE
Dalkeith

Postcode EH22 1EL
Telephone 6211195

Contact [redacted]
Address [redacted]
W

Complaint ?plantars fascitis ?#
Allergies

Attendances in last 12 months: 0
School:

General Practitioner

JA Scott
Address
Newbattle Medical Practice
Blackcot
Mi EH22 4AA
Telephone 0131 663 1051

Date and Time of Attendance
27/09/2015 19:35
Incident Date & Time:
Mode of Arrival
Private Transport
Source of Referral
Lothian Unscheduled Care Services

TRIAGE

Presenting Complaint: See letter. 6/7 twisted (R) foot. BT over 1-3 MT+

History of Presenting Complaint: cuneifors. Gait + worsening pain ? #

Assessment:

OBSERVATIONS

Temp	Pulse Rate	BP	RR	Sats	O2/air	BM	PF best	Alcometer	GCS	SEWS
		/		%					/15 e__v__m__	

? SEPSIS temp >383 or <36 ☐ HR > 90 ☐ RR > 20 ☐ BM > 7 (+ not diabetic) ☐ age > 70 ☐ signs of infection ☐

> 2 THINK SEPSIS AND TRIAGE UP: Y / N

PAIN SCORE ___/10 Analgesia ☐ Time ______

FAST Stroke Test + / − (circle) Onset Time: ______

Triaged no.: 1 2 3 4 (5) (circle) Triaged to: HD / IC / (exam) / WR / GP (circle) Senior Doctor Informed? Y / N time______

INTERVENTIONS & INVESTIGATIONS

Peripheral Venous Cannula Insertion *Complete all sections*
Date: .... Time:....................

Size		Position		Standard technique	
Blue	☐	LEFT	☐	Handwash	☐
Pink	☐	RIGHT	☐	Gloves	☐
Green	☐	Hand	☐	CHD skin prep	☐
Orange	☐	Forearm	☐	Aseptic Insertion	☐
Brown	☐	ACF	☐	Needle free port	☐
Grey	☐	Foot	☐	Dressing labelled	☐

Operator Signature: ....

BLOODS Routine ☐ Troponin ☐ Amylase ☐
(Trop due________)
TOX ☐ Other ☐ ________
(time of OD________)
BTS ☐ SENT ☐

ECG Required ☐ Done ☐ Time________

X-RAYS CXR ☐ Other ☐ ________

URINALYSIS Required ☐ Done ☐ HCG: + / − (circle) MSU Sent: Y / N

BED REQUIRED YES / NO (circle)

Speciality Informed ☐ Time________

Time of Triage: 1850

Triaged by: (sign) N Le
(print) N. LEHER

Care Provider: (print) ....

"WHAT MATTERS TO THE PATIENT?"

THINK:- OTHER SOURCES OF INFORMATION:

FAMILY ☐ CARERS ☐ SAS PRF ☐ EPR ☐ ECS ☐ KIS ☐ GP ☐ PATIENT ALERTS ☐

Care Providers Name:.. Signature:..

Directorate of
Accident and Emergency Medicine
LOTHIAN UNIVERSITY HOSPITALS NHS TRUST

Clinical Lead Dr. A. Gray
Clinical Nurse Manager Mr. Neil Boyle
THE ROYAL INFIRMARY OF EDINBURGH
51 Little France Crescent, Edinburgh EH16 4SU
Tel: 0131 242 1300 • Fax: 0131 242 1344

A/E no. E2155289
Previous no. E2154519
UHPI no. 620045326K
CHI no. 2205671464

PATIENT INFORMATION

Surname Cross
Forename Angela
Date of Birth 22/05/1967
Age 44 Yrs
Sex F

Address 9 Fairford Gardens
Edinburgh
Midlothian
Postcode EH16 5RW
Telephone 621 0071

Contact [redacted]
Address [redacted]

Complaint Examination
Allergies

Attendances in last 12 months: 1
School:

General Practitioner

Name
E Alexander

Address
Inchpark Surgery
10 Marmion Crescent
EH16 6QU

Telephone 0131 666 2121

Date and Time of Attendance
18/02/2012 16:52
Incident Date & Time:
Mode of Arrival
Police
Source of Referral
Police

T	P	RR	BP	BM	SpO2	Peakflow	Urinalysis	Alcometer
36.1	90	14	110/85		98%			

Nursing Assessment Police -> A/E.
P.C. for internal search.
Hx. for FME examination of retained packages of ? drugs.
O/A alert + orientated.

Pain Assessment Score Plan obs / await FME.
Waterlow Score
Pain Score Review
Time
Triage Score
Signature [signature]
Time 1657
Print Name [handwritten] SCN.

Clinical Notes

Diagnosis

Doctor's Name (print)
Signature

Directorate of
Accident and Emergency Medicine
LOTHIAN UNIVERSITY HOSPITALS NHS TRUST

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Clinical Nurse Manager Mr. Neil Boyle
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A/E no. E2154519
Previous no. E1861047
UHPI no. 620045326K
CHI no. 2205671464

PATIENT INFORMATION

Surname Cross
Forename Angela
Date of Birth 22/05/1967
Age 44 Yrs Sex F

Address 9 Fairford Gardens
Edinburgh
Midlothian
Postcode EH16 5RW
Telephone 621 0071

Contact Address [redacted]

Complaint xray
Allergies

Attendances in last 12 months: 0 School:

General Practitioner

Name
E Alexander
Address
Inchpark Surgery
10 Marmion Crescent
EH16 6QU
Telephone 0131 666 2121

Date and Time of Attendance
17/02/2012 14:28
Incident Date & Time:
Mode of Arrival
Police
Source of Referral
Police

T	P	RR	BP	BM	SpO2	Peakflow	Urinalysis	Alcometer

Nursing Assessment detained under drugs misuse act
– dos refused OA

Pain Assessment Score
Waterlow Score
Pain Score Review Time Triage Score
Signature Time Print Name [signature]

Clinical Notes

Diagnosis

Doctor's Name (print) Signature

Patient & GP Information

UHPI Number	620045326K
CHI Number	2205671464
Episode Number	E1861047
Surname/Forename	Cross, Angella
Date of Birth	5/22/67
Sex	Female
Patient Address.	44 Woodburn Bank Dalkeith EH22 2EY
Registered GP	VE Aspinall
GP Address.	Newbattle Medical Practice,Blackcot,Mayfield,Midlothian EH22 4AA

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	E1861047

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
A&E Notes Episode/Ref: E1861047 Annette Cosgrove 12/14/10 19:41 Mark Taylor (NMR)	CHI: 2205671464,,43 Y/O F,,Slipped on ice, inverting her L ankle. Difficulty weight-bearing since. States is main carer for her disabled daughter.,,OE L lower leg: No swelling, bruising, wounds, deformity. Tender over LM, 3rd, 4th & 5th MTs. No BT MM, calcaneum, navicular, fibula head. AT intact. Pt states that she has had a previous evulsion fracture of the navicular.,,XR L ankle/foot: Shows fracture base of 3rd MT.,,Pt not keen for plastercast. Placed in double tubi-grip. Crutches given. Advised rest, elevation. Regular analgesia. Fracture clinic.,,Any queries please contact A&E Reception on 0131 242 1300

NHS Lothian

Royal Infirmary of Edinburgh
51 Little France Crescent
Old Dalkeith Road
Edinburgh EH16 4SA

Date: 14/12/2010

Dr DR Fraser
Inchpark Surgery
10 Marmion Crescent
Edinburgh
EH16 6QU

Emergency Discharge Summary

Patient	Angela Cross 9 Fairford Gardens Edinburgh Midlothian EH16 5RW	**CHI**	**2205671464**
		Date of Birth / Age	22/05/1967 (43 years)
		UHPI	620045326K
		A&E Attendance Number	E1861047
Attendance Date	14/12/2010	**Contact**	[redacted]
Attendance Time	11:29		
Mode of Arrival	Private Transport		
Source of Referral	Self Referral to A&E		
Discharge Date	14/12/2010		
Discharge To			

Dear Dr DR Fraser

Presentation: inj l foot

CHI: 2205671464

43 Y/O F

Slipped on ice, inverting her L ankle. Difficulty weight-bearing since. States is main carer for her disabled daughter.

OE L lower leg: No swelling, bruising, wounds, deformity. Tender over LM, 3rd, 4th & 5th MTs. No BT MM, calcaneum, navicular, fibula head. AT intact. Pt states that she has had a previous evulsion fracture of the navicular.

XR L ankle/foot: Shows fracture base of 3rd MT.

Pt not keen for plastercast. Placed in double tubi-grip. Crutches given. Advised rest, elevation. Regular analgesia. Fracture clinic.

Any queries please contact A&E Reception on 0131 242 1300

Yours Sincerely,

Annette Cosgrove, Nurse Practitioner

Directorate of
Accident and Emergency Medicine
LOTHIAN UNIVERSITY HOSPITALS NHS TRUST

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Clinical Nurse Manager Mr. Neil Boyle
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51 Little France Crescent, Edinburgh EH16 4SU
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Lothian

A/E no. E1861047

Previous no. E1611180

UHPI no. 620045326K
CHI no. 2205671464

PATIENT INFORMATION

Surname: Cross
Forenames: Angela
Date of Birth: 22/05/1967
Age: 43 Yrs Sex: F

Address: 9 Fairford Gardens
Edinburgh
Midlothian
Postcode: EH16 5RW
Telephone: 621 0071

Contact Address: [redacted]

Complaint: inj l foot
Allergies:

Attendances in last 12 months: 0 School:

General Practitioner

Name: DR Fraser
Address: Inchpark Surgery
10 Marmion Crescent
EH16 6QU
Telephone: 0131 666 2121

Date and Time of Attendance: 14/12/2010 11:29
Incident Date & Time:
Mode of Arrival: Private Transport
Source of Referral: Self Referral to A&E

T	P	RR	BP	BM	SpO2	Peakflow	Urinalysis	Alcometer

Nursing Assessment

Pain Assessment Score Waterlow Score
Pain Score Review Time Triage Score
Signature Time Print Name

Clinical Notes: No answer @ 1150. [signature]
Slipped [illegible] injury (L) ankle [illegible]
[illegible]

ANKLE INVERSION INJURY SIDE: (L) / R
Other relevant history: No / Yes -
Relevant PMH?: No / Yes - Previous avulsion # navicular
Relevant DH?: No / Yes -
Can walk 4 steps immediately and in ED? Y / (N) (xray)
Tender 6cm Post. Lat. Malleolus? (Y) (xray ankle) / N
Tender 6cm Post. Med. Malleolus? Y (xray ankle) / (N)
Gross swelling of Med. Malleolus? Y (xray ankle) / (N)
Tender Base of 5th Metatarsal? (Y) (xray foot) / N — BT 3rd [illegible] MT.
Tender Calcaneum? Y (xray foot) / (N)
Tender Navicular? Y (xray foot) / N
Achilles tendon intact? (Y) / N
Tenderness to knee/head of fibula? Y (xray knee) / (N)
Soft tissue/skin changes Y / (N)
OTTAWA RULE? (Positive) / Negative
X-RAY ANKLE? (YES) / NO X-RAY FOOT? (YES) / NO
X-ray findings: # base 3rd MT
Treatment: POP / (DTG) / (Crutches) / Analgesia / Ankle Advice
Discharged to GP / Admit Ortho / (#Clinic) / Referred to Physio

Diagnosis

Doctor's Name (print): [illegible] Signature: [signature]

Patient & GP Information

UHPI Number	620045326K
CHI Number	2205671464
Episode Number	E1611180
Surname/Forename	Cross, Angella
Date of Birth	5/22/67
Sex	Female
Patient Address.	44 Woodburn Bank Dalkeith EH22 2EY
Registered GP	VE Aspinall
GP Address.	Newbattle Medical Practice,Blackcot,Mayfield,Midlothian EH22 4AA

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	E1611180

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
A&E Notes Episode/Ref: E1611180 Dr Craig A Walker 1/17/10 12:54 Valerie Hardie	CHI: 2205671464,,Diagnosis: Healing burn left lower leg.,This 42 year old lady attended 3 days ago with a partial thickness burn over left lower leg from sunbed. The area was dressed and the patient was discharged. She reattends in police custody today. She was sent by the Police Medical Officer with a possible infection at her dressed site, although the dressing was not removed or inspected by that Police Officer. The patient is systemically well.,,O/E: GCS 15.,Left lower leg - dressing removed. 5 x 4 cm patch of superficial skin loss which has the appearance of a deroofed blister with granulation tissue over the anterior aspect of the middle third of the lower leg. No surrounding erythema. No pus. The area is diffusely tender with normal sensation. NV intact.,,Management: Wound cleaned and redressed with mepitel dressing.,For further dressing at Practice Nurse in 3 days. To return earlier if signs of spreading erythema or systemically unwell.,

Directorate of
Accident and Emergency Medicine
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Edinburgh EH16 4SU
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Fax: 0131 242 1344

NHS Lothian

3

A/E no. E1611180
Previous no. E1609076
UHPI no 620045326K
CHI no. 2205671464

PATIENT INFORMATION

Surname Cross
Forenames Angela
Date of Birth 22/05/1967
Age 42 Yrs Sex F
Address 9 Fairford Gardens
Edinburgh
Midlothian
Postcode EH16 5RW
Telephone 621 0071
Contact Address [redacted]
Complaint dressing change
Allergies
Attendances in last 12 months: 1
School: --

General Practitioner

Name
SD Murray
Address
Inchpark Surgery
10 Marmion Crescent
EH16 6QU
Telephone 0131 666 2121

Date and Time of Attendance
27/11/2009 17:58
Incident Date & Time:
Mode of Arrival
Police
Source of Referral
Reattend

T	P	RR	BP	BM	SpO2	Peakflow	Urinalysis	Alcometer

Nursing Assessment sent up by police medical officer for e/v of burn ? infected - just needs dressing change

Pain Assessment Score
Waterlow Score
Pain Score Review
Time
Triage Score
Signature [signature]
Time 1800
Print Name [illegible]

Clinical Notes

42 ♀ attended 3/7 ago c̄ partial thickness burn left lower leg from sunbed.
Dressed & pt discharged.
Reattends in police custody today; sent by police medical officer c̄ possible infection @ site (not redressed) or inspected by medical officer.
Pt systemically well.
O/E
GCS 15.

Left Lower Leg → Dressing removed:-

5×4cm patch of superficial skin loss (appearance of deroofed blister c̄ granulation tissue). No surrounding erythema. Diffusely tender & sensate. NV intact. No pus.

Mx - Wound cleaned & redressed (Mepitel dressing). For further dressing @ Practice Nurse ≈ 3/7.

Diagnosis (Healing Burn Left Lower Leg)
Doctor's Name (print) Dr. C. WALKER SHO4
Signature [signature]

ROYAL INFIRMARY OF EDINBURGH
EMERGENCY DEPARTMENT

620045326K/E1611180 F 22/05/1967
Cross, Angela
9 Fairford Gardens,
Edinburgh,
Midlothian,
EH16 5RW
CHI 2205671464
70291 SD Murray

ALLERGIES	

DRUG AND PRESCRIPTION RECORD
ONCE ONLY PRESCRIPTION

Date 27/11

Date	Time	Drug (Approved Name)	Dose	Route	Prescriber's Signature	Time Given	Given By (Initials)	Checked By (Initials)
27/11		COCODAMOL 30/500	2 TAB	ORAL QDS TTO 1/52	[signature]	14 45	[initials]	[initials]
27/11								

Insulin Sliding Scale Prescription Chart

BM	Insulin u/hr	Dextrose 10% ml/hr	Other Action	BM	Insulin u/hr	Dextrose 10% ml/hr	Other Action
				INSULIN		SIGNATURE	

STOP

CHECK: Does this patient have a Drug Kardex?
If YES, discontinue this prescription record

INFUSION	DRUG NAME	STARTING AMOUNT	TIME / MLS	TIME / MLS	TIME / MLS	TIME / MLS	TIME / MLS	TIME / MLS	TIME / MLS	TIME / MLS	TIME / MLS	TIME / MLS

Patient & GP Information

UHPI Number	620045326K
CHI Number	2205671464
Episode Number	E1609076
Surname/Forename	Cross, Angella
Date of Birth	5/22/67
Sex	Female
Patient Address.	44 Woodburn Bank Dalkeith EH22 2EY
Registered GP	VE Aspinall
GP Address.	Newbattle Medical Practice,Blackcot,Mayfield,Midlothian EH22 4AA

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	E1609076

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
A&E Notes Episode/Ref: E1609076 Dr Krishna Murthy 1/22/10 12:16 Lynne Whitted	CHI: 2205671464,,42 yo female.,,On sunbed yesterday for 10 mins. Now generalised erythema and very painful blistering to L leg also.,,PMH: NIL,DH: NIL,NKDA,,OE: T 36.4.,Generalise erythema over body. Sun burn type appearance.,L shin - 3x3cm blister noted. Partial thickness.,,Dressed with mepitel.,Kapake and ibuprofen for home.,,lw

Directorate of
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Edinburgh EH16 4SU
Telephone: 0131 242 1300
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620045326K/E1611180 F 22/05/1967
Cross, Angela
9 Fairford Gardens,
Edinburgh,
Midlothian,
EH16 5RW
CHI 2205671464
70291 — SD Murray

A/E no. E1609076
Previous no. E1246063
UHPI no. 620045326K
CHI no. 2205671464

PATIENT INFORMATION

Surname Cross
Forenames Angela
Date of Birth 22/05/1967
Age 42 Yrs Sex F
Address 9 Fairford Gardens
Edinburgh
Midlothian
Postcode EH16 5RW
Telephone 28-3118
Contact Address [redacted]
Edinburgh
Complaint burns
Allergies
Attendances in last 12 months: 0
School:

General Practitioner

Name
SD Murray
Address
Inchpark Surgery
10 Marmion Crescent
EH16 6QU
Telephone 0131 666 2121

Date and Time of Attendance
24/11/2009 11:56
Incident Date & Time:
Mode of Arrival
Private Transport
Source of Referral
Self Referral to A&E

T	P	RR	BP	BM	SpO2	Peakflow	Urinalysis	Alcometer
36.4								

Nursing Assessment S: On sunbed yesterday & burnt skin
PMH: Nil
Pain Assessment Score
Waterlow Score
Pain Score Review
Time
Triage Score
Signature [signature]
Time 11.58
Print Name R. Jones

Clinical Notes

On sunbed yesterday for 10 minutes. Now generalised erythema and very painful. Blistering to (L) leg also.

PMH none
DH none
NKDA

OE, Generalised erythema over body - sunburn appearance. (L) shin 3x3cm blisters noted - partial thickness. Dressed w/ mepitel.

KAPAKE Burfen
(H)

Diagnosis
Doctor's Name (print) K. Murray
Signature [signature]

Patient & GP Information

UHPI Number	620045326K
CHI Number	2205671464
Episode Number	E1246063
Surname/Forename	Cross, Angella
Date of Birth	5/22/67
Sex	Female
Patient Address.	44 Woodburn Bank Dalkeith EH22 2EY
Registered GP	VE Aspinall
GP Address.	Newbattle Medical Practice,Blackcot,Mayfield,Midlothian EH22 4AA

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	E1246063

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
A&E Notes Episode/Ref: E1246063 Dr H Harris 5/11/08 Donna Partridge	CHI: 2205671464 ,,40 year old lady, alleged assault. Right thumb bitten by neighbour baseball bat to head, no LOC, diplopia, vomiting, headache, no c spine tenderness. Complaining of right thumb ripped off and bed exposed, also bite to palmar surface of thumb in distal fat pad. Facial swelling underneath right eye and laceration to right ear lobe. ,,SH: Right handed, cares for Down Syndrome daughter.,,OE: Right thumb evulsed nail, nail bed exposed and almost circumfencial bite in distal third fat pad palmar surface. Sensation in tact proximally but reduced sensation at tip, good capillary refill, good opposition, adduction, abduction and extension but reduced flexion secondary to pain. Good radial pulse. Cool but not cold peripherally. ,,Facial injuries PERLA FROEM, no haemotymapnum or battle sign. Tender over right zygoma. Infra orbital sensation in tact. TMJ located. No malocclusion or loose teeth. Small swelling over right zygoma. ,right ear - small posterior laceration intragous, not obviously involving cartilege. ,X-ray right thumb - communiated distal phalanx fracture open.,X-ray facial views - no obvious fracture seen. ,,Plan:,Oral analgesia,Antibiotics Co-amoxiclav 625mg ,Tetanus,Hep B vaccine,Serology for storage,Ring block and wash of thumb,Betadine dressing,Discussed with Plastics at SJH, nil by mouth to ward 18 SJH.,GP to follow up Hep B vaccination.,Obs awaited/,,09.18 Dr Clark,Patient h/o to me by night staff,Thumb wound irrigated thoroughly with sterile saline under lignocaine ring block,Betadine dressing placed,Xray of R index finger obtained as patient also c/o tenderness over index finger with some basal bruising - no # seen and no open wound.,R ear washed and small infero-posterior wound seen where earring cut ear (not a through-and-through wound) - also irrigated and glued with satisfactory wound closure.,Serology obtained for storage (and reason explained to patient); alleged attacker questioned by colleague and low risk for transimission of infection so Hep B vaccine given only with acclerated course to be f/u by GP please.,Obs stable.,Patient to go to SJH as above for further thumb r/v - copy of Xrays requested.

Patient & GP Information

UHPI Number	620045326K
CHI Number	2205671464
Episode Number	E039046
Surname/Forename	Cross, Angella
Date of Birth	5/22/67
Sex	Female
Patient Address.	44 Woodburn Bank Dalkeith EH22 2EY
Registered GP	VE Aspinall
GP Address.	Newbattle Medical Practice,Blackcot,Mayfield,Midlothian EH22 4AA

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	E039046

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
A&E Notes Episode/Ref: E039046 Dr Eleanor Wicks 5/29/06	39 y/o woman attends today c/o R eye infection. Normally wears contact lenses. She c/o sharp pain in her R eye and the R eye is constantly watering. She is having difficulty with it. It feels like it's worsening . She denies any facial swelling. No foreign body; no trauma. No change to visual acuity but she normally has poor eyesight. She does state that she was wearing contact lenses yesterday and she could feel it wiggling. When she took them out last night she could feel it was worse. This am it was much worse as well.,,PMH: nil,DH: nil, nkda,,OE: P 80 T36.2 Her R eye was injected and the upper and lower lid had blasitis. No uvitis or iritis. No photophobia seen,,IMP: conjunctivitis with some lid involvement. She's been prescribed promoxiclav ABX and eyedrops chloenfenical and has been referred to the eye pavillion should the need arise.

Patient & GP Information

UHPI Number	620045326K
CHI Number	2205671464
Episode Number	04186942
Surname/Forename	Cross, Angella
Date of Birth	5/22/67
Sex	Female
Patient Address.	44 Woodburn Bank Dalkeith EH22 2EY
Registered GP	VE Aspinall
GP Address.	Newbattle Medical Practice,Blackcot,Mayfield,Midlothian EH22 4AA

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	04186942

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
A&E Notes Episode/Ref: 04186942 Dr Claire Turnbull 5/2/05	PC: Sore throat.,HPC: Viral illness last night and seen by GP. Sore throat for last few days. Has had previous tonsillitis but says this feels worse. Painful++ to swallow. Only managing soft diet but managing fluids. No fevers or rigors. Coughing up small flecks of red blood. Has been taking Paracetamol & Ibuprofen.,,PMH: Recurrent tonsillitis, nil else. Adenoids removed as a child.,DH: Nil. NKDA.,SH: Lives with family.,,OE: Uncomfortable, apyrexial.,Palpable lymphadenopathy mainly on L submandibular region, tender. Oropharynx inflammed. Enlarged tonsils with small amount of exudate seen bilaterally. Uvula deviated to R. L tonsil appears larger. No bleeding point seen. No inflammation in ear canal L or R.,P 93, BP 125/77, Temp 36.2, sats 98% on air.,,Bloods - Ur 2.6, Cr 81, Sod 137, Pot 2.9, Tc02 25, Hb 112, MCV 82, WCC 5.7, Plt 283.,,IMP: Tonsillitis ?quinsy due to asymmetry, although apyrexial.,,D/w ENT, exudated tonsillitis, no trismus or pain in jaw so quinsy unlikely. Some degree of tonsillar asymmetry acceptable.,,PLAN: Penicillin V 500mg qds for 5 days as recommended by ENT. To return to Dept or see GP if symptoms worsen.,,DN

Patient & GP Information

UHPI Number	620045326K
CHI Number	2205671464
Episode Number	03065926
Surname/Forename	Cross, Angella
Date of Birth	5/22/67
Sex	Female
Patient Address.	44 Woodburn Bank Dalkeith EH22 2EY
Registered GP	VE Aspinall
GP Address.	Newbattle Medical Practice,Blackcot,Mayfield,Midlothian EH22 4AA

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	03065926

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
A&E Notes Episode/Ref: 03065926 Dr R Kemp 10/6/03	HIST - fell down stairs twisting L ankle.,,OE - swollen L foot.,BT MM and tarsal bone.,,XR - avulsion fracture of navicular.,BKS, Fracture Clinic, crutches.

In Patient Records

NHS Lothian

Royal Infirmary of Edinburgh
51 Little France Crescent
Old Dalkeith Road
Edinburgh EH16 4SA

General Medicine

Dr Aspinall
Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA

Date: 24/10/2022

Inpatient Discharge Summary

Patient	Angella Cross 44 Woodburn Bank Dalkeith EH22 2EY	**CHI** **Date of Birth / Age** **UHPI**	**2205671464** 22/05/1967 (55 years) 620045326K
Ward	Ward 207 RIE	**Admission Date**	18/10/2022
Consultant	Dr Pauline J Jones	**Discharge Date**	21/10/2022

Dear Dr Aspinall

Allergen (Group to which Allergen belongs)	**Reaction**
***No Known Drug Allergies	

Discharge Drugs:

Amlodipine 5mg tablets			
Dose	Route	Frequency	To Continue
5 mg	Oral	Once daily at 0700	Yes
Notes:			
Bisoprolol 2.5mg tablets			
Dose	Route	Frequency	To Continue
2.5 mg	Oral	Once daily at 1400	Yes
Notes:			
Mirtazapine 30mg tablets			
Dose	Route	Frequency	To Continue
30 mg	Oral	Once daily at 2200	Yes
Notes:			
Omeprazole 20mg gastro-resistant capsules			
Dose	Route	Frequency	To Continue
20 mg	Oral	Twice daily at 0700 & 1800	Yes
Notes:			
Peptac liquid			
Dose	Route	Frequency	To Continue
15 mL	Oral	PRN For acid reflux	Yes

Notes:

CHANGES TO DRUGS SINCE ADMISSION (relative to ECS)

Stopped:
Ramipril (difficulty swallowing tablets)
Propranolol - started on Bisoprolol for hypertension

Started:
Amlodipine 5mg OD - high BP
Omeprazole 20mg OD chronic cough ?reflux
Peptac 15ml PRN chronic cough ?reflux
Bisoprolol 2.5mg OD - high BP

Changed: Nil

Withheld: Nil

ALLERGIES / ADVERSE DRUG REACTIONS: Nil

Discharge prescription checked against ECS meds rec: Yes

Pharmacy Check by (enter on Trak): Name: Date: Time:

PRINCIPAL DIAGNOSES:
1. Worsening SOB of unclear origin
2. Chronic cough of unclear origin

ACTION REQUIRED FROM GP (do not ask GP to chase blood results):
Please re-check blood pressure and U&Es in 2 weeks

FOLLOW UP BEING ARRANGED BY HOSPITAL:
Lung function tests (these have been ordered)

LIST OF OUTSTANDING RESULTS / OP INVESTIGATIONS:
Lung function tests

PLEASE CC THIS LETTER TO:
Respiratory Outpatient Clinic, OPD 3, RIE Sent 24/10/22

ADMISSION SUMMARY AND TREATMENT:
Angela Cross is a 55 year old female patient admitted to the RIE on 18/10/22 with a 3 month history of worsening SOB on exertion and cough after recently being treated for a chest infection in the community. She was pyrexial with a BP of 190/145 at her GP appointment prior to admission and subsequently disclosed poor compliance with her anti-hypertensive. A CT head was performed due to concerns about malignant hypertension which was clear. A chest x-ray was also clear and she was seen by the Respiratory team who started her on treatment for GORD and

recommended a CTPA which showed no embolism and normal lung parenchyma. Her antihypertensive medication was increased and she was discharged at her baseline with follow up lung function tests to be arranged by the Respiratory Clinic as an outpatient.

RELEVANT INVESTIGATION RESULTS:
CXR: no focal consolidation
CT-head: nil acute findings
CTPA: no embolism, normal parenchyma
E&S bp: 161/95, 168/98

SIGNIFICANT OBSERVATIONS AT DISCHARGE:
BP: 153/98

CHANGES MADE TO CARE ARRANGEMENTS/ DNACPR STATUS/ ANTICIPATORY CARE PLANNING: Nil

Thank you for your ongoing care of this patient.

Yours Sincerely,

Michael Jenks
FY1
Acute / General Medicine, RIE

CHECKED by (enter on Trak): Name/Designation:

Should you need further information please email: RIEacutemedicine@nhslothian.scot.nhs.uk or phone Acute and General Medicine Secretaries on: 0131 242 1440

NHS Lothian

Royal Infirmary of Edinburgh
51 Little France Crescent
Old Dalkeith Road
Edinburgh EH16 4SA

Dr Scott
Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA

Date: 13/04/2017

Inpatient Discharge Summary

Patient	Angella Cross 44 Woodburn Bank Dalkeith EH22 2EY	**CHI**	**2205671464**
		Date of Birth / Age	22/05/1967 (49 years)
		UHPI	620045326K
Specialty	General Surgery	**Admission Date**	28/02/2017
Ward	Ward 106 RIE		
Consultant	Ms Ijeoma A Azodo (Locum RR)	**Discharge Date**	03/03/2017

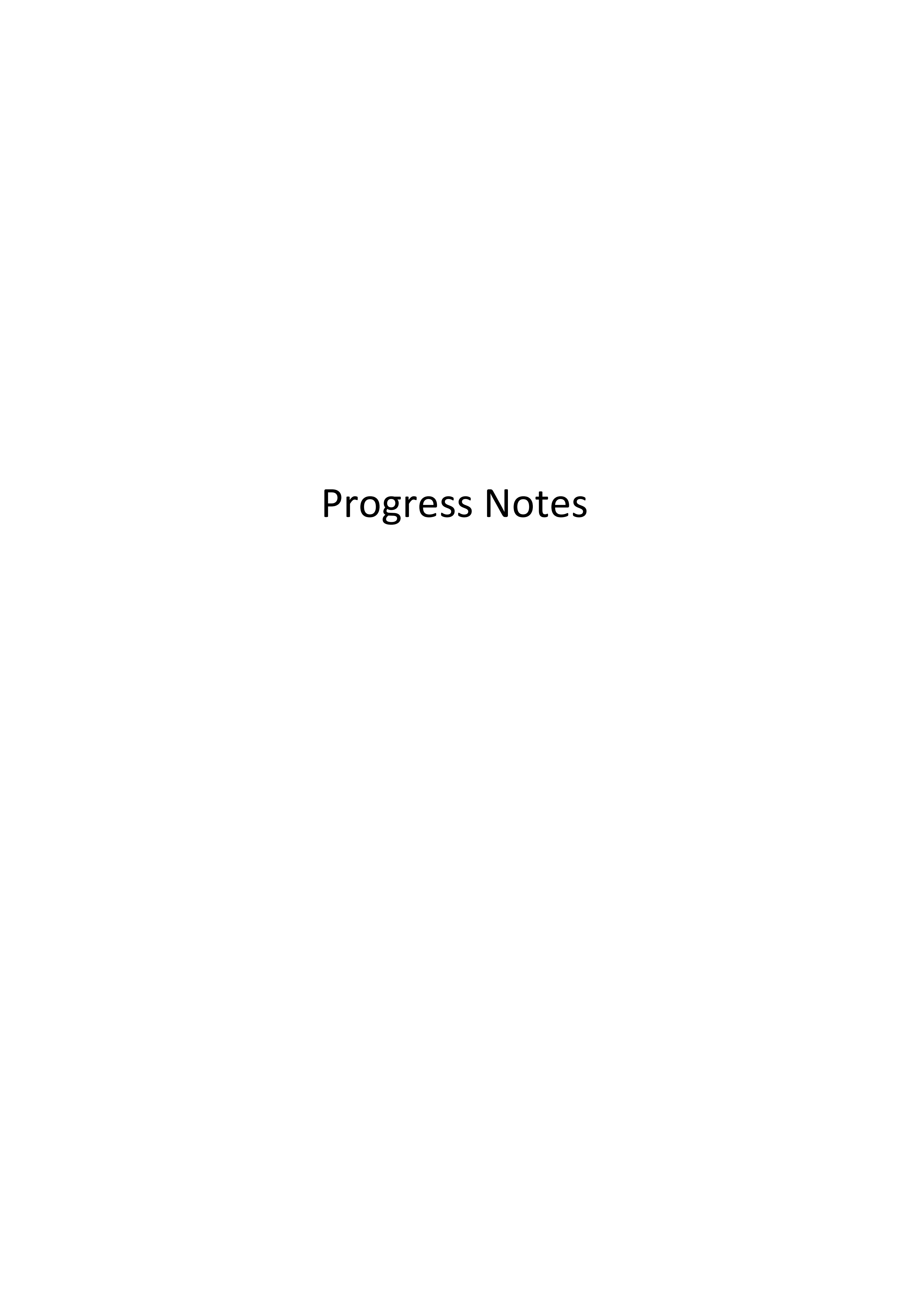
Dear Dr Scott

Discharge Drugs

Discharge Medication	Dose	Frequency	Duration	Additional Info
Bendroflumethiazide Tablets	2.5 MG	ONCE DAILY	Long Term	patients own supply
Cyclizine Tablets	50 MG	THREE times DAILY	Short Term	20 tablets given
Dihydrocodeine Tablets	30 MG	FOUR times daily	Short Term	30 tablets given
Lisinopril Tablets	5 MG	In the MORNING	Long Term	patients own
Paracetamol Tablets	1000 MG	Every FOUR to SIX hours PRN. Max 4	Short Term	32 tablets given

Clinical Summary:
You will have already received the immediate discharge summary regarding this patients admission under our care. I confirm that she underwent a straightforward acute laparoscopic cholecystectomy and she made a good recovery post operatively and has been discharged with no further plans for follow up. Her pathology of her gallbladder has shown cholelithiasis but no other suspicious features. If she has any problems we would be more than happy to see her at short notice.
Yours sincerely

Mr PRABHU NESARGIKARST7 to Miss IJEOMA AZODO


Progress Notes

Patient & GP Information

UHPI Number	620045326K
CHI Number	2205671464
Episode Number	I0005929900
Surname/Forename	Cross, Angella
Date of Birth	5/22/67
Sex	Female
Patient Address.	44 Woodburn Bank Dalkeith EH22 2EY
Registered GP	VE Aspinall
GP Address.	Newbattle Medical Practice,Blackcot,Mayfield,Midlothian EH22 4AA

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	I0005929900

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0005929900 Dr David R McKean 5/21/24 15:55 Angela Simm	THE INFORMATION BELOW RELATES TO PATIENT PRESENTATION ON 20.05.24 CLINICAL NOTES: Clinical note: ED Review (Pod E) - Foytl (ACCS1) 20/05/24 - 22:56 F56 presents with abdominal & back pain following lifting heavy object *** abbreviated summery with full documentation to follow *** PC: abdo + back pain HPC: - lifting heavy object (concrete) stood up and sudden pain in upper abdomen + back - sharp, cramping, debilitating - initially 6/10 now 8/10 - able to walk and mobilise - denies any neurological symtpoms - no numbness, weakness, parasthesia or loss of sesnation - denies bladder or bwel symptoms: able to feel bladder fill / building urge - able to hold off and control - aware of passing and cessation of urine passage and intact sensation on wiping - no head injury - no fall - no other trauma - has had Co-codamol 30/500 x 3 today but nil else. minimmal relief. does not like taking tablets. Concerned about hernia. PMHx: - HTN - T2DM - anxiety DHX: - Metformin - Ramipril - Mirtazapine - Omeprazole NKDA SHx: - carer (currently not working) - alcohol minimal - smoking no - lives with partner On examination - NEWS = 4 tachycardic 104 223/168 Walking in independently. Clearly in pain. Slower movements. On inspection, no obvious bruising, swelling or deformity. No midline tenderness at any level of spine. Abdomen soft, no masses or lumps, no obvious herniation. No brusing. Pain aggrevated by palaption in upper and lower abdomne. Bilaterally painful, swollen and tender erector spinae muscles. Limited thoracic extension and flexion. Limited thoracic rotation. Sensation intact throughout thoracic dermatomes. Sensation intact throughout upper limb dermatomes, bilaterally. Normal tone and power throughout UL bilaterally. ECG - sinus tachy, nil ischemic, long QTc and RsR in II (all seen previously). BLOODS - not indicated Impression: most likely MSK pain due to strain injury - no red flags on Hx or exam so far - needs re-

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	I0005929900

Note Details	Clinical Notes
	examined ? hearnia PLAN: 1. Analgesia (given) 2. Re-examine once able - currently too sore a. need to clincally check for hernia 3. Pending D/W senior provisional plan would be D/C with analgesia, PT self-referral and worsening advice. Foytl (ACCS1) Update - D/W Dr B Earle-Wright (EM ST5): in agreement with all above. suggested addition of CXR (requested). Patient settled with Oramorph, Paracetamol and Ibuprofen. Await CXR and aim for DC. Foytl (ACCS1) CXR reviewed - no obvious Pneumothorax, fracture or injury. No consolidation. Impression of MSK type back pain most likely. Given advice leaflet and advice on self-referral to PT. Analgesia improved and given Oromorph as TTO. Discharged from ED. Foytl (ACCS1)

Patient & GP Information

UHPI Number	620045326K
CHI Number	2205671464
Episode Number	I0005535571
Surname/Forename	Cross, Angella
Date of Birth	5/22/67
Sex	Female
Patient Address.	44 Woodburn Bank Dalkeith EH22 2EY
Registered GP	VE Aspinall
GP Address.	Newbattle Medical Practice,Blackcot,Mayfield,Midlothian EH22 4AA

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	I0005535571

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005535571 Nurse 10/19/22 13:00 Dean Amos	Nursing Pt IND with personal care this am. NEWS as charted Medications as per HEPMA. No complaints voiced by pt. NOTE - SPO2 performed while mobilising. 95% when static. 91-95% when mobile. No SOB. Only short distance covered though. Approx 100 yds. S/N D.Amos

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	I0005535571

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005535571 Dr Suad ME Elawad 10/19/22 23:19 Yasmin Carter (Nursing Student)	Received patient per bed, awake, conscious and coherent. Patient is comfortable, not in pain not in distress. 2030h E & S BP taken. 2230H Patient is in pain. Observations taken .Informed HAN Team regarding patient's pain. Patient stated that she just wants her Propanolol medication. HAN said that there is a medication in another ward that we can get for propanolol. Sent Yasmin to pick it up. Patient is comfortable Maria Sakura Agency RN

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	I0005535571

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0005535571 Dr Pauline J Jones 10/20/22 09:58 Dr Zmarak Ahmad Khan	CHANGES TO DRUGS SINCE ADMISSION (relative to ECS) Stopped: Ramipril (difficulty swallowing tablets) Propranolol - started on Bisoprolol for hypertension Started: Amlodipine 5mg OD - high BP Omeprazole 20mg OD – chronic cough ?reflux Peptac 15ml PRN – chronic cough ?reflux Bisoprolol 2.5mg OD - high BP Changed: Nil Withheld: Nil ALLERGIES / ADVERSE DRUG REACTIONS: Nil Discharge prescription checked against ECS meds rec: Yes Pharmacy Check by (enter on Trak): Name: Date: Time: --- PRINCIPAL DIAGNOSES: 1. Worsening SOB of unclear origin 2. Chronic cough of unclear origin ACTION REQUIRED FROM GP (do not ask GP to chase blood results): Please re-check blood pressure and U&Es in 2 weeks FOLLOW UP BEING ARRANGED BY HOSPITAL: Lung function tests (these have been ordered) --- LIST OF OUTSTANDING RESULTS / OP INVESTIGATIONS: Lung function tests PLEASE CC THIS LETTER TO: Respiratory Outpatient Clinic, OPD 3, RIE – Sent 24/10/22 --- ADMISSION SUMMARY AND TREATMENT: Angela Cross is a 55 year old female patient admitted to the RIE on 18/10/22 with a 3 month history of worsening SOB on exertion and cough after recently being treated for a chest infection in the community. She was pyrexial with a BP of 190/145 at her GP appointment prior to admission and subsequently disclosed poor compliance with her anti-hypertensive. A CT head was performed due to concerns about malignant hypertension which was clear. A chest x-ray was also clear and she was seen by the Respiratory team who started her on treatment for GORD and recommended a CTPA which showed no embolism and normal lung parenchyma. Her antihypertensive medication was increased and she was discharged at her baseline with follow up lung function tests to be arranged by the Respiratory Clinic as an outpatient. RELEVANT INVESTIGATION RESULTS: CXR: no focal consolidation CT-head: nil acute findings CTPA: no embolism, normal parenchyma E&S bp: 161/95, 168/98 SIGNIFICANT OBSERVATIONS AT DISCHARGE: BP: 153/98 CHANGES MADE TO CARE ARRANGEMENTS/ DNACPR STATUS/ ANTICIPATORY CARE PLANNING: Nil Thank you for your ongoing care of this patient. Yours Sincerely,

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	I0005535571

Note Details	Clinical Notes
	Michael Jenks FY1 Acute / General Medicine, RIE CHECKED by Dr Pauline Jones, Consultant Physician 01/11/22 Should you need further information please email: RIEacutemedicine@nhslothian.scot.nhs.uk or phone Acute and General Medicine Secretaries on: 0131 242 1440

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	I0005535571

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005535571 Dr Pauline J Jones 10/20/22 11:34 Dr David Kawecki	WR Dr Miya 55F adm 19/10 with worsening SOBOE (3/52) and cough Issues. 1. SOBOE - a/w CTPA ?PE ?supradded chest infection - ?residual post viral cough BG: HTN, T2DM (diet controlled), anxiety, prev gallstones, prtial thyroidectomy SHx: Cares for Down syndrome daughter 29 Today. - sitting upright in bed at present - Reports palpitations on mobilising - Reports headaches but not at present - discussed longstanding HTN - ongoing cough with associated back pain along that radiates down the front of her right chest - Pain associated with breathing - Had fever when seen GP - main symptom has been SOB on mobilising - notes desaturates to 91-95 when mobile Mild derranged LFT On prophylactic dalteparin at present Covid ve- 15/10 and 18/10 NEWs - Sats 96 on RA highest systolic 177 E&S: 161/95 168/98 No significant postural drop HS pure Chest: few creps on left base Plan. 1. Chase CTPA (phoned radiology to convert CTchest to CTPA) 2. not for treatment dose dalteparin at present - pending CTPA result Kawecki SHO

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	I0005535571

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005535571 Dr Pauline J Jones 10/21/22 00:19 Lee Skinner	Received patient per bed, awake, conscious and coherent with no complaints of pain. Patient is comfortable, E& S Blood pressure taken and recorded. Needs attended. Reinforced the use of call light. Maria Sakura Agency RN

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	I0005535571

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005535571 Dr Pauline J Jones 10/21/22 09:19 Dr Michael Jenks	WR Dr Jones 55F adm 19/10 with worsening SOBOE (3/52) and cough Issues 1. SOBOE - a/w CTPA ?PE ?supradded chest infection - ?residual post viral cough 2. PMHx: HTN, T2DM (diet controlled), anxiety, prev gallstones, prtial thyroidectomy 3. SHx: Cares for Down syndrome daughter 29 Today. -standing upright bedside and doesn't appear breathless - ramipril previously for 3 years - fits of cough recently - no asthma - non-smoker - History for palpitations/anxiety attacks NEWs 1 systolic 171 Plan. 1. For CTPA today - radiology asked to phone them when cannula is in 2. trial bisoprolol 2.5mg OD -IDL: if not tolerated or insufficient then consider losartan 3. bloods incl Anti-TPO 4. lung function test 5. stop propranalol for anxiety as starting bisoprolol (which can be uptitrated if palpitations persist) Kawecki SHO

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	I0005535571

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005535571 Nurse 10/21/22 15:53 Jennifer Clunas	Angella has been discharged home with family, No cannula in situ, Medications and letters given

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	I0005535571

Note Details	Clinical Notes
Outpatient Clinic Letter Episode/Ref: I0005535571 Dr Pauline J Jones 11/4/22 10:31 Paula De Jongh	Following this lady's admission to the Royal Infirmary under my care I have received the results of her anti-TPO antibody. Her anti-TPO was greater than 1,000 IU/mL, I note that she has had a persistently elevated TSH for a number of years, during her admission to hospital she had a TSH of 6.1 mU/L and a free T4 of 15 pmol/L. Although her free T4 is within the normal range, her high anti-TPO suggests that she has a significant probability of becoming increasingly hypothyroid in the future. If she has any symptoms consistent with hypothyroidism it may be worth starting Levothyroxine with the goal of keeping her TSH in the lower half of the normal range. The alternative would be ongoing monitoring of her TSH on a 6-12 monthly basis with initiation of Levothyroxine if her TSH rises above 10 mU/L or her free T4 is below the normal range. Yours sincerely, Checked Electronically Dr Pauline Jones Consultant Physician Acute & General Medicine Cc: Miss Angella Cross, 44 Woodburn Bank, Dalkeith, Midlothian, EH22 2EY Sent 04/11/22

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	I0005535571

Note Details	Clinical Notes
Outpatient Clinic Letter Episode/Ref: I0005535571 Dr Pauline J Jones 1/25/23 13:05 Paula De Jongh	This lady was admitted under my care back in October 2022. Her main concerns were worsening shortness of breath and chronic cough, CTPA was unremarkable and she was empirically treated for gastro-oesophageal reflux disease following advice from the Respiratory team. An outpatient lung function test was requested, she has been offered two appointments for this and has not attended. I am not planning to rebook this test. Yours sincerely, e-checked by: Dr Pauline Jones Consultant Physician Acute & General Medicine

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	I0005535571

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005535571 Nurse 10/19/22 00:15 Gemma Brown	Angella has been settled since arrival on the ward NEWS 0 BM 10.5 Eating and drinking well Awaiting to be seen by medical team No other concerns Staff Nurse Rachel

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	I0005535571

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005535571 Oliver P Llewellyn 10/19/22 00:49 Dr Oliver P Llewellyn	6861276 18/10/2022 CT Head Technique: Unenhanced Comparison: None available Findings: Normal brain appearances and CSF configuration. No intracranial haemorrhage, collection or mass. Normal bones and air spaces. Normal extracranial soft tissue. Opinion: No acute intracranial haemorrhage. No significant finding. Reported by Dr O Llewellyn FRCR, ST4 Clinical Radiology, GMC 7496698, oliver.llewellyn@nhslothian.scot.nhs.uk ****This is a PROVISIONAL report. **** The verified report will be issued by the consultant within 24 hours and that report will be available in the Trak Radiology record.

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	I0005535571

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005535571 Dr Suad ME Elawad 10/19/22 04:38 Dr Eilidh Duthie	AMU ADMISSION REVIEW Summary of ED/Interface presentation: - 3-week history of worsening SOBOE and cough - completed full course of amoxicillin in the community but reported chest symptoms 2 days after finishing. - BP = 190/145 and T = 39.4 at GP - concerns re. malignant hypertension. CT head was unremarkable. Treatment given in ED: • Medication: Amlopidine. • Fluids: Nil. Additional history available? Progress since ED: SOB is main concern - worse when lying down and bending forward. Now SOB when walking 10m on the flat to the bathroom. Far from baseline 3 months ago. Needs 3 pillows to sleep - disturbing sleep. Also has non-productive cough which is worse when lying down. Denies chest pain. Has some palpitations when walking which are associated with lightheadedness - almost every day. Frequently has panic attacks when leaving the house. Also excessively sweats on exertion. Has had Covid twice, most recently in summer 2022. Feels breathing has deteriorated since then. Struggling to do simple tasks like changing the bed and looking after her daughter. Feeling well in herself otherwise. Admits to being variably compliant with anti-hypertensives. Has had hypertension for years. Measures BP at home and SBP usually sits around 175. Gets occasional headaches and thumping in her ear - cannot be more specific with frequency. No visual changes. Also gets a sharp pain in her head when bending down. Recently has noticed tingling in both her lower legs and feet which she attributes to the change in temperature. PMHx: Hypertension (not compliant with medication), type II diabetes mellitus (diet-controlled), anxiety, previous gallstones, partial thyroidectomy for goitre. SHx (driving if relevant): Lives at home with daughter (29) for whom she is the main carer. Previously worked as a peer support worker. Never smoked. No alcohol. NEWS: 0 (RR = 20, SpO2 = 98% RA, BP = 122/70, HR = 62, T = 36.2) Focused examination: A - Patent. B - No increased WOB, chest clear. C - Pulse regular, warm peripherally, HS I+II+0, calves SNT, nil peripheral oedema. D - Grossly intact, moving all 4 limbs appropriately, PERL - note normal neurological examination in Interface. E - Obese abdomen, abdomen SNT, BS +ve. Bloods: CRP = 11, WCC normal, renal function stable, TSH = 6.1, FT4 = 15. ECG: Sinus tachycardia. Radiology: CXR - Awaiting formal report, no focal consolidation, well-demarcated costophrenic angles, raised right hemidiaphragm, ? left heart border irregularity. Medicine: • Is medicine reconciliation complete: Y • ALLERGY: NKDA • Is VTE risk assessed and prescribed: Y Problem lists: 1) Hypertension due to intermittent compliance with medications 2) SOB and dry cough - on ACEi (although this is longstanding) and post-Covid 3) Palpitations post-Covid 4) Headaches - in context of high BP Plan: 1) Start amlodipine 2) CT chest and PFTs - requested 3) E+S BP 4) Respiratory review

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	I0005535571

Note Details	Clinical Notes
	Is DNACPR/AWI completed if appropriate? (if capacity assessment is required use \capacity) Destination: Hospital@Home/Resp/Cardio/GI/GM/Neuro/Stroke/Frailty + CFScoring Name and designation: Eilidh Duthie FY1 AMU Bays 1, 2, 3, 7 - Bleep 2241 AMU Bays 4, 5, 6, 8 - Bleep 2112

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	I0005535571

Note Details	Clinical Notes
Specialty Review Episode/Ref: I0005535571 Dr Suad ME Elawad 10/19/22 07:25 Elspeth Christie	Respiratory RIE On-call Review Team: Lithgow/ Bain/ Christie Infection Status: NEGATIVE COVID-19 vaccination status 0 / 1 / 2 / 3 Respiratory Background: Comorbidities: HTN Type 2 DM - diet controlled anxiety never smoked Functional Status: Escalation/Resuscitation: TEP needed?: Acute Symptoms: COVID Summer 2022 around July Worsening of respiratory symptoms Increasing shortness of breath Dry cough develped post COVID. No precipitating factors to cough Palpatations No issues with swallowing, feels food gets stuck No weight loss, some weight gain recent course of amox Reduced ET Sleeps with 3 pillows Temp 39.7 o/a Examination: Sa02 98% on RA RR 18 NEWS:0 chest - clear, crackles, but disappeared on coughing abdo SNT Investigations: CRP 11 ALT 104 Alk Phos 141 GGT 81 CXR - no focal consolidation Impression: reflux caunibg cough Plan: - aim Sa02 > 94%, NEWS 1 - remain under GM - regular omeprazole - prn gaviscon - would be beneficial to walk patient while monitoring oxygen levels, if desaturates on mobilisation consider CTPA Is patient accepted to Respiratory?: Target SpO2: VTE Prophylaxis: Cubicle Y/N Boardable Y/N Oncall Reg Page 2832 RNS Mobile: 07977282716

Patient & GP Information

UHPI Number	620045326K
CHI Number	2205671464
Episode Number	I0004170853
Surname/Forename	Cross, Angella
Date of Birth	5/22/67
Sex	Female
Patient Address.	44 Woodburn Bank Dalkeith EH22 2EY
Registered GP	VE Aspinall
GP Address.	Newbattle Medical Practice,Blackcot,Mayfield,Midlothian EH22 4AA

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	I0004170853

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0004170853 Ms Ijeoma A Azodo (Locum to RR) 4/12/17 15:43 Karen Ann Bell	Clinical Summary:,You will have already received the immediate discharge summary regarding this patients admission under our care. I confirm that she underwent a straightforward acute laparoscopic cholecystectomy and she made a good recovery post operatively and has been discharged with no further plans for follow up. Her pathology of her gallbladder has shown cholelithiasis but no other suspicious features. If she has any problems we would be more than happy to see her at short notice. ,Yours sincerely,,,,,Mr PRABHU NESARGIKARST7 to Miss IJEOMA AZODO,

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	I0004170853

Note Details	Clinical Notes
Operation Note Episode/Ref: I0004170853 Ms Ijeoma A Azodo (Locum to RR) 3/3/17 07:30 Joyce Brunton	02/03/17,Indication : Right upper quadrant pain with ultrasound demonstrating gallstones and moderately deranged LFT's. The patient underwent a pre-operative MRCP which confirmed no intra-ductal calculi.,Procedure : GA, supine position with table restraints, TEDs, flowtrons, Dalteparin and IV antibiotics. Infraumbilical skin incision and insertion of a 10mm port using modified Hassan technique. A further 10mm and two 5mm ports were placed in the epigastrium and right upper quadrant under vision, after infiltration of .5% Levobupivocaine. Minimal adhesions to a thin walled gallbladder. This was retracted cephalad and on grasping with the blunt snubnose grasper, there was a perforation on the fundus of the gallbladder. There was spillage of bile but no gallstones. The gallbladder was re-grasped using a Debakey grasper and retracted cephalad before anterior and posterior incisions were made. The hepaticocystic triangle was dissected with large posterior window created and the cystic artery and adjacent lymph node were skeletonised. The artery was then triple clipped and divided lateral to the lymph node, leaving two clips on the patient side. Cystic duct was then milked and skeletonised before being triple clipped and divided, again leaving two clips on the patient side. The gallbladder was then dissected from the gallbladder fossa of the liver and retrieved intact in a parachute bag, via the umbilical port site. Washout until the effluent was clear and haemostasis ensured. Ports out under vision and closure with 1 PDS and subcuticular 4/0 biocin to skin after infiltration of the residual .5% Levobupivocaine.,Post operative instructions : To the ward. No further antibiotics. Eat and drink. Mobilise. Dalteparin as prescribed. Home when well.,,,,,Mr ROBERT O'NEILL,Specialist Registrar to Miss IJEOMA AZODO,

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	I0004170853

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0004170853 Ms Ijeoma A Azodo (Locum to RR) 3/3/17 14:25 Lynsey Faichney	PRINCIPAL DIAGNOSIS/PROCEDURE- acute cholecystitis,Dear Dr,,,Your patient was admitted to RIE under surgeons for weeks of intermittent upper, RUQ pain, worst in the last 24 hours with nausea and vomiting. Blds showed elevated WBC and CRP with deranged LFTs, she was started on triple therapy IVABs. An USS and MRCP showed gallstones in a distended gallbladder with no CBD involvement. A laproscopic cholesystectomy was successfully carried out. The patient recovered well and can be discharged.,, ,TREATMENT- Lap chole, ,FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL- Nil, ,CHANGES TO DRUGS SINCE ADMISSION- analgesia, ,ALLERGIES / ADVERSE DRUG REACTIONS- nil, ,SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS,,CHANGES TO DNACPR STATUS OR ANTICIPATORY CARE PLANNING ,,GP to please consider the following check LFTs 2 weeks time, ,Should you need further information please contact..., ,Information contained in this letter has been discussed with the patient/ carer.,,Yours sincerely.........................., ,Staff Signature.......................... PrintName.....LYNSEY HALL.............................,,Designation................ANP............ Date........03/03/17......... Time..................,,Patient/Carer Signature.., ,This is an immediate discharge letter and a further letter may follow.

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	I0004170853

Note Details	Clinical Notes
Pharmaceutical Care Issues Episode/Ref: I0004170853 3/3/17 14:32 Joycelyn Wan	Phar:4 for discharge today. JW 3/3

Patient & GP Information

UHPI Number	620045326K
CHI Number	2205671464
Episode Number	I0003850357
Surname/Forename	Cross, Angella
Date of Birth	5/22/67
Sex	Female
Patient Address.	44 Woodburn Bank Dalkeith EH22 2EY
Registered GP	VE Aspinall
GP Address.	Newbattle Medical Practice,Blackcot,Mayfield,Midlothian EH22 4AA

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	I0003850357

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0003850357 Dr Harry GB Bennett 1/17/16 12:01 Rhys Davies	PRINCIPAL DIAGNOSIS/PROCEDURE,Right contact lens related corneal ulcer, ,TREATMENT,Admitted for intensive topical antibiotics.,Also started on Aciclovir 400mg 5 x day., ,FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL, Wednesday 20th January: 09.30 OPD E4 Dr Bennett clinic,,CHANGES TO DRUGS SINCE ADMISSION, ,PREVIOUS ADVERSE DRUG REACTIONS, ,SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS,,CHANGES TO DNACPR STATUS OR ANTICIPATORY CARE PLANNING ,GP to please consider the following..., ,Should you need further information please contact..., ,Information contained in this letter has been discussed with the patient/carer.,,Yours sincerely........................., ,Staff Signature......................... PrintName..................................,,Designation............................. Date................ Time..................,,Patient/Carer Signature..., ,This is an immediate discharge letter and a further letter may follow.

Patient & GP Information

UHPI Number	620045326K
CHI Number	2205671464
Episode Number	I0000407963
Surname/Forename	Cross, Angella
Date of Birth	5/22/67
Sex	Female
Patient Address.	44 Woodburn Bank Dalkeith EH22 2EY
Registered GP	VE Aspinall
GP Address.	Newbattle Medical Practice,Blackcot,Mayfield,Midlothian EH22 4AA

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	I0000407963

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0000407963 Dr JAA Milne 12/10/01	DIAGNOSIS: UNWANTED FERTILITY,PROCEDURE: LAPAROSCOPIC STERILIZATION,DATE OF PROCEDURE: 10/12/01,,Your patient was admitted today for the above procedure. This was carried out uneventfully with the application of one Filshie clip to each tube. The pelvis was noted to be normal.,,Yours sincerely,,,,,,Richard A Anderson,Consultant Gynaecologist,,,

Patient & GP Information

UHPI Number	620045326K
CHI Number	2205671464
Episode Number	I0000407961
Surname/Forename	Cross, Angella
Date of Birth	5/22/67
Sex	Female
Patient Address.	44 Woodburn Bank Dalkeith EH22 2EY
Registered GP	VE Aspinall
GP Address.	Newbattle Medical Practice,Blackcot,Mayfield,Midlothian EH22 4AA

Report Contents

The report bundle provides information on the following:

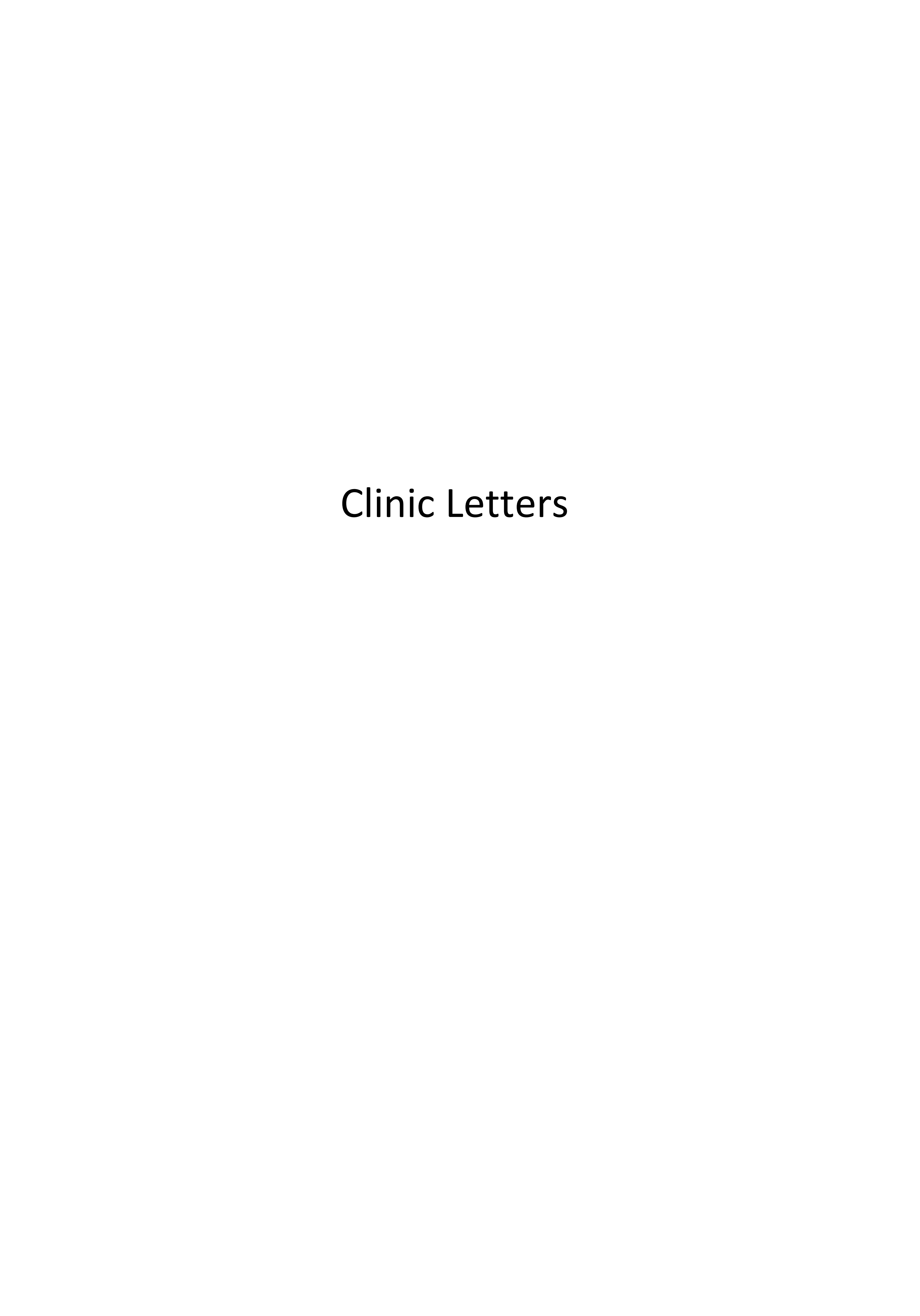
* IP/OP Clinical Notes

Surname/Forename	Cross, Angella
UHPI Number	620045326K

Episode Number	I0000407961

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0000407961 Dr MM Lees 12/17/98	Diagnosis: Missed abortion,Procedure: Evacuation of Uterus,Date of Discharge: 17.12.98,,This woman attended for her amino centesis on 15 December she was unfortunately found to have a missed abortion at approximately 9 weeks gestation. She underwent an Evacuation of the uterus under general anaesthesia as a day case procedure on 17 December 1998. Blood group was O positive and anti-D was not required.,,Yours sincerely,,,,,,Dr J MacNab,Senior Registrar,,JMcN/VSJ/ 21.12.98,,



Clinic Letters

NHS Lothian

Royal Infirmary of Edinburgh
51 Little France Crescent
Old Dalkeith Road
Edinburgh EH16 4SA

General Medicine

Dr Aspinall
Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA

Date: 06/02/2023

Outpatient Clinic Letter

Patient	Angella Cross 44 Woodburn Bank Dalkeith EH22 2EY	**CHI** **Date of Birth / Age** **UHPI**	**2205671464** 22/05/1967 (55 years) 620045326K
Attendance Date			
Consultant	Dr Pauline J Jones		

Dear Dr Aspinall

Discharge Drugs:

Amlodipine 5mg tablets			
Dose	Route	Frequency	To Continue
5 mg	Oral	Once daily at 0700	Yes
Notes:			
Bisoprolol 2.5mg tablets			
Dose	Route	Frequency	To Continue
2.5 mg	Oral	Once daily at 1400	Yes
Notes:			
Mirtazapine 30mg tablets			
Dose	Route	Frequency	To Continue
30 mg	Oral	Once daily at 2200	Yes
Notes:			
Omeprazole 20mg gastro-resistant capsules			
Dose	Route	Frequency	To Continue
20 mg	Oral	Twice daily at 0700 & 1800	Yes
Notes:			
Peptac liquid			
Dose	Route	Frequency	To Continue
15 mL	Oral	PRN For acid reflux	Yes
Notes:			

This lady was admitted under my care back in October 2022. Her main concerns were worsening shortness of

breath and chronic cough, CTPA was unremarkable and she was empirically treated for gastro-oesophageal reflux disease following advice from the Respiratory team.

An outpatient lung function test was requested, she has been offered two appointments for this and has not attended. I am not planning to rebook this test.

Yours sincerely,

e-checked by:

Dr Pauline Jones
Consultant Physician
Acute & General Medicine

University Hospitals Division

Royal Infirmary of Edinburgh
51 Little France Crescent
Old Dalkeith Road
Edinburgh
EH16 4SA

Surgical Ambulatory Care

Dr Aspinall
Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA

Date First Created:	28/02/2017
Date/Time Printed:	07/05/2026 14:51
Our Ref:	620045326K
CHI:	2205671464

Patient:	Miss Angella Cross 44 Woodburn Bank Midlothian Dalkeith EH22 2EY	**UHPI:** **Date of Birth:**	620045326K 22/05/1967
Specialty:	Surgical Ambulatory Care	**Consultant:**	Ms Ijeoma A Azodo (Locum to RR)

HOT clinic 28/2/17

PC: Upper abdominal pain
HPC: 49 year old lady who presented to the surgeons with a few week history of intermittent upper abdominal pain. Worsened sigificantly over the last 24 hours. No urinary or bowel upset.
PMH: Hypertension, partial thyroidectomy, breast reduction
O/E: Abdomen soft, non tender, Murphys negative
Invsetiagtions:
Obseravtios -
Bloods - Bil 26, ALT 178, Alk Phos 128, GGT 128
AUSS -

Impression:

Plan:

NHS Lothian

Royal Infirmary of Edinburgh
51 Little France Crescent
Old Dalkeith Road
Edinburgh EH16 4SA

General Medicine

Dr Aspinall
Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA

Date: 04/11/2022

Outpatient Clinic Letter

Patient	Angella Cross 44 Woodburn Bank Dalkeith EH22 2EY	**CHI** **Date of Birth / Age** **UHPI**	**2205671464** 22/05/1967 (55 years) 620045326K
Attendance Date			
Consultant	Dr Pauline J Jones		

Dear Dr Aspinall

Discharge Drugs:

Amlodipine 5mg tablets			
Dose	Route	Frequency	To Continue
5 mg	Oral	Once daily at 0700	Yes
Notes:			
Bisoprolol 2.5mg tablets			
Dose	Route	Frequency	To Continue
2.5 mg	Oral	Once daily at 1400	Yes
Notes:			
Mirtazapine 30mg tablets			
Dose	Route	Frequency	To Continue
30 mg	Oral	Once daily at 2200	Yes
Notes:			
Omeprazole 20mg gastro-resistant capsules			
Dose	Route	Frequency	To Continue
20 mg	Oral	Twice daily at 0700 & 1800	Yes
Notes:			
Peptac liquid			
Dose	Route	Frequency	To Continue
15 mL	Oral	PRN For acid reflux	Yes
Notes:			

Following this lady's admission to the Royal Infirmary under my care I have received the results of her anti-TPO

antibody.

Her anti-TPO was greater than 1,000 IU/mL, I note that she has had a persistently elevated TSH for a number of years, during her admission to hospital she had a TSH of 6.1 mU/L and a free T4 of 15 pmol/L.

Although her free T4 is within the normal range, her high anti-TPO suggests that she has a significant probability of becoming increasingly hypothyroid in the future. If she has any symptoms consistent with hypothyroidism it may be worth starting Levothyroxine with the goal of keeping her TSH in the lower half of the normal range. The alternative would be ongoing monitoring of her TSH on a 6-12 monthly basis with initiation of Levothyroxine if her TSH rises above 10 mU/L or her free T4 is below the normal range.

Yours sincerely,

Checked Electronically

Dr Pauline Jones
Consultant Physician
Acute & General Medicine

Cc: Miss Angella Cross, 44 Woodburn Bank, Dalkeith, Midlothian, EH22 2EY

Sent 04/11/22

University Hospitals Division **Address Not Specified**

Plastic Surgery

Dr Aspinall	**Date First Created:**	21/05/2008
Newbattle Medical Practice	**Date/Time Printed:**	07/05/2026 14:52
Blackcot	**Our Ref:**	620045326K
Mayfield	**CHI:**	2205671464
Midlothian		
EH22 4AA		

Patient:	Miss Angella Cross 44 Woodburn Bank Midlothian Dalkeith EH22 2EY	**UHPI:** **Date of Birth:**	620045326K 22/05/1967
Specialty:	Plastic Surgery	**Consultant:**	Mr Cameron Raine

I reviewed this lady in the physio led hand clinic this morning. She is now 5 days following washout and nail-bed repair of her right thumb.

On examination today her thumb is oedematous however her wound is healthy and she states she is continuing with her oral antibiotics at home. She shows a good range of movement of the metacarpal and carpal metacarpal pharyngeal joints. I have encouraged her to move very gently around this area and we will review her again in clinic in two weeks time.

Yours sincerely

Grace Meek MSCP, SRP
Chartered Physiotherapist
Advanced Hand Practitioner

NHS Lothian

Midlothian Community Hospital
Psychological Therapies
70 Eskbank Road
Bonnyrigg
Dalkeith
EH22 3ND

Date: 20/03/2019

Dr Aspinall
Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA

Outpatient Clinic Letter

Patient	Angella Cross 44 Woodburn Bank Dalkeith EH22 2EY	**CHI** **Date of Birth / Age** **UHPI**	**2205671464** 22/05/1967 (51 years) 620045326K
Specialty **Consultant**	AMH ML - Psych Therapy Michael Jones	**Attendance Date**	19/02/2019

Dear Dr Aspinall

Dear Dr Scott

Angela Cross 22.05.67 (1464) 44 Woodburn Bank Dalkeith EH22 2EY

Further to my last letter to you in October 2018 Ms Cross decided not to pursue the Survive & Thrive course. As a result we met for a review on 19th February 2019.

Her situation remains the same as outlined in my assessment letter to you and we agreed to place her on the waiting list for one to one therapy. Given her persistent low mood, history of trauma from past abuse and interpersonal difficulties we have considered that CBASP could be a helpful model of therapy for her.

I have provided her with some online resources compassion exercises meantime while she is waiting for individual treatment.

Should you require any further information please contact me on the address or telephone number above.

Yours sincerely

Mike Jones
Psychological Therapies Series

University Hospitals Division

Royal Infirmary of Edinburgh
51 Little France Crescent
Old Dalkeith Road
Edinburgh
EH16 4SA

Orthopaedics

Dr Aspinall
Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA

Date First Created: 10/01/2011
Date/Time Printed: 07/05/2026 14:52
Our Ref: 620045326K
CHI: 2205671464

Patient:	Miss Angella Cross 44 Woodburn Bank Midlothian Dalkeith EH22 2EY	**UHPI:** **Date of Birth:**	620045326K 22/05/1967
Specialty:	Orthopaedics	**Consultant:**	Miss Leela C Biant

No notes.

Diagnosis: Third metatarsal fracture.

This lady is now 3 weeks post injury. Unfortunately there is no dictation from her previous attendance. She has been weight bearing in a below knee cast for the past three weeks.

On examination today there is no tenderness over the fracture site and she has a good range of movement of her foot. No evidence of any bruising.

I have advised her that she should weight bear in normal shoes and that we will review her again in clinic in 2 weeks time for further clinical assessment with the aim to discharge her at this stage.

Yours sincerely

K BUGLER, ST2 to
Leela C Biant FRCSEd (Tr&Orth) MS

East Lothian
Health & Social Care Partnership

Clinical Psychology
East Lothian Health and Social Care Partnership
2nd Floor, Musselburgh Primary Care Centre
Inveresk Road, Musselburgh, EH21 7BP
T: 0131 446 4208

www.eastlothian.gov.uk

Angella Cross
14 Woodburn Bank
Dalkeith
Midlothian
EH22 2EY

Date	13/11/2018
Chi	2205671464
Our Ref	PB/DH/CF/S&T
Enquiries to:	Carrie Findlay Secretary
Extension	523920
Direct Line	01506 523920

Dear Angella

We recently wrote to you offering you a place on our upcoming Survive and Thrive Course. As part of this invitation we asked that you would contact the Department to arrange a pre-group assessment. As we have not heard from you to date, we ask that you contact us on **01506 523920** within **7** days of this letter to let us know if you still require input from the Psychological Therapies Service.

If we have not heard from you during this time we will assume that you no longer require support and will discharge you from the service.

Yours sincerely,

Penny Balfour, Dorothy Hansen & Louise Mason
On Behalf of the Survive And Thrive Group

Gastroenterology

Dr Aspinall		**Date First Created:**	07/06/2001
Newbattle Medical Practice		**Date/Time Printed:**	07/05/2026 14:53
Blackcot		**Our Ref:**	620045326K
Mayfield		**CHI:**	2205671464
Midlothian			
EH22 4AA			

Patient:	Miss Angella Cross 44 Woodburn Bank Midlothian Dalkeith EH22 2EY	**UHPI:** **Date of Birth:**	620045326K 22/05/1967
Specialty:	Gastroenterology	**Consultant:**	Dr Kenneth J Simpson

Dear Dr Murray,

Thank you for referring this 34 year old lady with constipation. Up until seven yeas ago she was passing a motion every two days. Seven years ago she underwent a Cesarean section and also had pylonephritis. At that time she started taking some Dihydrocodeine 2 or 3 a day. She is not very forthcoming as to how long this was a problem for. Now her bowel habit is passing a motion once every seven days. After two or three days she gets generalised abdominal bloating and discomfort. On the seventh day she tries to pass a motion and can spend most of the day on and off the loo sitting for up to an hour. She then passes pellety motions and gets the feeling of incomplete evacuation. Usually this relieves the discomfort then she is okay for another 3 or 4 days. Her weight recently has been increasing. She is undergoing investigation for a nodule in her neck. As she has identified that her weight is increasing she is therefore on a diet. She says that she will have fruit and veg maybe three times a week. She is currently having wholemeal bread in the morning, a sandwich at lunchtime and a low calorie meal in the evening. She said she drinks plenty of water and diluted juice. As you say in your letter she has had a good result with stimulant laxatives such as Senna which would normally produce a result within 24 hours. You have limited this over the past year due to concerns about the use and she is currently maintained on Methyl Cellulose once a day. She is currently taking no other painkillers. There is no family history. She herself has two children and the reason for her DNAing her appointments was the recent birth of her child four months ago. Her first child born seven years ago has Downs syndrome. She has clearly had a troubled life since the mid 80's. She has had problems with depression, suicides and anxiety.

On examination she is mildly obese. There was no abnormality of the cardiovascular, respiratory systems. Examination of the abdomen was unremarkable. PR examination was normal, with no faeces in the rectum and normal anal tone.

I suspect this lady has constipation predominant IBS. It is difficult to say whether her period of opiate abuse has influenced the bowels in some way. She however appears to free of this at the

Gastroenterology

Dr Aspinall
Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA

Date First Created: 07/06/2001
Date/Time Printed: 07/05/2026 14:53
Our Ref: 620045326K
CHI: 2205671464

moment and still has the problem. Today in the clinic I have repeated her thyroid function tests, and liver function tests and full blood count. We will perform a large bowel transit study to ensure there is no dismotility. If all these tests are negative then I will refer her to our clinical nurse practitioner who has a special interest in this area. We will review her in three months time.

Yours sincerely,

DR TOBY DELAHOOKE
Lecturer to Dr Simpson

East Lothian
Health & Social Care Partnership

Clinical Psychology
East Lothian Health and Social Care Partnership
2nd Floor, Musselburgh Primary Care Centre
Inveresk Road, Musselburgh, EH21 7BP
T: 0131 446 4208

www.eastlothian.gov.uk

Angella Cross
14 Woodburn Bank
Dalkeith
Midlothian
EH22 2EY

Date 01/11/2018
Chi 2205671464
Our Ref PB/DH/CF/S&T

Enquiries to: Carrie Findlay
Secretary
Extension 523920
Direct Line 01506 523920

Dear Angella

As you will be aware, following your assessment appointment with a practitioner from the Psychological Therapies Service, your name was placed on the waiting list for the Survive and Thrive course.

I am pleased to inform you that the next course will begin on Wednesday 09 January 2019 and will run weekly for 10 weeks and finish on Wednesday 13 March 2018. We will confirm the time of the course at the pre-course appointment.

If you would like to attend the Survive and Thrive course please call our group administrator on 01506 523920 within the next 2 weeks to book your individual pre-course appointment.

This will last approximately 30 minutes and will be at Musselburgh Primary Care Centre outpatients department where the course is held. It often helps people feel less anxious when they have had the opportunity to visit the venue and meet with one of the course facilitators before the course begins.

If we have not heard from you within the next 2 weeks, we will assume that you do not wish to be seen and will close this referral.

I have enclosed a map, with directions to the department and a Survive and Thrive information sheet.

Yours sincerely

Penny Balfour, Dorothy Hansen & Louise Mason
On Behalf of the Survive And Thrive Group

Cc Dr Scott - Newbattle Medical Practice, Blackcot, Mayfield, Midlothian,Dalkeith,EH22 4AA
Michael Jones

University Hospitals Division **Address Not Specified**

Gynaecology

Dr Aspinall	**Date First Created:**	23/12/99
Newbattle Medical Practice	**Date/Time Printed:**	07/05/2026 14:53
Blackcot	**Our Ref:**	620045326K
Mayfield	**CHI:**	2205671464
Midlothian		
EH22 4AA		

Patient:	Miss Angella Cross 44 Woodburn Bank Midlothian Dalkeith EH22 2EY	**UHPI:** **Date of Birth:**	620045326K 22/05/1967
Specialty:	Gynaecology	**Consultant:**	Prof D Baird

I saw this 32 year old para 3+3 in the Endocrine clinic.

She has had secondary amenorrhoea for approximately one year following an evacuation of uterus for a missed abortion in December 1998. In fact she tells me that she had PV bleeding starting on 22.12.99.

She does have a monthly cycle of mood swings and breast tenderness over the past few years. Her periods were previously regular. In her past obstetric history she has two sons aged 14 and 11 and a daughter aged 6 who has Down's Syndrome. She was delivered by Caesarian section for breech presentation. She has also had one stillbirth at 22 weeks and two missed abortions, for which she has had evacuation of the uterus.

Also of note in her history, is that she had a diagnostic laparoscopy for ? ectopic pregnancy in 1987. She has also had severe constipation since her Caesarian section six years ago.

Drug history laxatives, many different types.

On systemic enquiry she tells me that she has put on three stone in weight in the last one year, though her BMI is still 25. She is trying to lose weight without success.

She has also suffered from severe depression in the past with treatment with Amitriptylline, which has not helped.

Her blood results are indeed consistent with stress induced menstrual disturbance and on questioning her in detail she really has a lot of stress looking after her six year old daughter with Down's syndrome. She has also been significantly depressed in the recent past.

I have reassured her that her bleeding starting yesterday may be the start of regular periods once again, but I have checked her hormone profile today and we will see her back for review in two months' time.

Gynaecology

Dr Aspinall
Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA

Date First Created: 23/12/99
Date/Time Printed: 07/05/2026 14:53
Our Ref: 620045326K
CHI: 2205671464

Yours sincerely

Dr Catherine Calderwood
Registrar to Professor Baird

NHS Lothian

Midlothian Community Hospital
Psychological Therapies
70 Eskbank Road
Bonnyrigg
Dalkeith
EH22 3ND

Dr Scott
Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA

Date: 01/10/2018

Outpatient Clinic Letter

Patient	Angella Cross 44 Woodburn Bank Dalkeith EH22 2EY	**CHI** **Date of Birth / Age** **UHPI**	**2205671464** 22/05/1967 (51 years) 620045326K
Specialty **Consultant**	AMH ML - Psych Therapy Michael Jones	**Attendance Date**	18/09/2018

Dear Dr Scott

SUITABILITY FOR THERAPY ASSESSEMENT

PRESENTING DIFFICULTIES
Described experiencing difficulties with her mood and anxiety, finding it difficult to go out the house and to visit family. She feels worthless and abandoned by others with a sense of never having been loved. She experienced childhood abuse, physical and emotional abuse from her mother. She also describes three past partners dying of drug related issues and the impact these bereavements have had on her.

BaCKGROUND
She grew up in Inverness. Her parents separated and she was cared for by her adopted stepfather whom she describes she has a difficult relationship with him. She has two step brothers from this relationship. She reports that her mother misused alcohol and substances and died ten years ago. Angella spent a significant proportion of her childhood in care leaving at the age of sixteen and a half to move into temporary accommodation system. She describes a number of difficult relationships that were abusive and her partner's misuse of substances. She has sustained significant assaults herself from her ex partners. She has four children aged thirty two, thirty, twenty five and seventeen.

She feels particulary guilty about the death of her third partner who died related to substance misuse. She describes refusing to answer the phone to him on the night that he died.

CURrENT CIRCUMSTANCES
Lives with her daughter [redacted] three to four days a week and she shares the care of her with other carers. I am unsure of the details of this arrangement. Her daughter has Down's syndrome. Her daughter had been previously been moved from her care following Angella's decision to take the rap from my ex partners drug use. She ended up receiving a custodial sentence. She is currently not working. She is in receipt of benefits but possibly needs a review and I have pointed her in the direction of the Citizens Advice Bureau regarding this. She has friends and family in Glasgow but limited contact with them. Physical health is poor with pain in her right leg which her GP is involved in investigating. She is also on blood pressure tablets. She has previously been involved with the Willow project but is uncertain about how much she has retained from involvement in past attendance at Survive & Thrive through Willow.

RISK ASSESSMENT
She has thoughts of not being here but she has never acted upon these thoughts since her teenage years when she took tablets in response to her step father preventing her from seeing her step brothers. She currently received Mirtazapine 45mgs and Propranolol - query dose.

SUITABILITY FOR PSYCHOLOGICAL THERAPY

As noted above she has previously attended Willow for Survive & Thrive but her engagement with Willow was influenced by their connection to social work at the time of her daughter being removed from her care. We discussed a phased based approach to managing the impact of trauma from past abuse and she thought that Survive & Thrive might be helpful for her to revisit however I would take advice from my colleagues who deliver Survive & Thrive on this matter and I have emailed them regarding this.

Provisional formulation
Past history of childhood abuse as well as domestic abuse within relationships, a sense of abandonment and rejection by family and ex partners led to her being anxious, avoidant and critical of herself. She avoids making contact with others to minimise her fear of being hurt by others, making it hard for her to leave the house and increasing anxiety.

Agreed PLAN
As noted above we discussed Survive & Thrive with Angella and she was agreeable to be placed on the waiting list for this and I have emailed my colleagues who deliver this with regard to the appropriateness of it.

NHS Lothian

Royal Edinburgh Hospital
Morningside Place
Edinburgh
EH10 5HF

Dr Scott
Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA

Date: 08/08/2018

Outpatient Clinic Letter

Patient	Angella Cross 44 Woodburn Bank Dalkeith EH22 2EY	**CHI**	**2205671464**
		Date of Birth / Age	22/05/1967 (51 years)
		UHPI	620045326K
Specialty	AMH ML - Psych Therapy	**Attendance Date**	
Consultant	Mary Begg		

Dear Dr Scott

Your patient attended Midlothian Access Point - this is a brief summary of the triage and is not a full psychological assessment.

REFFERAL TO PSYCHOLOGICAL THERAPIES:YES/

GP TO SEND INFORMATION ONLY REFERRAL TO PSYCHOLOGICAL THERAPIES SERVICE VIA SCIGATEWAY:
YES/

Clinicians email address (if further information required):mary.begg@nhslothian.scot.nhs.uk

Summary of presenting problems and strengths identified: This lady was tearful and described her life as a mess She finds it very diffcult to go out alone.Severe physical and emotional abuse from mother resulting in her being in and out of the care system between age 2 and 16.Mother was also alcoholic and a drug user. Blamed Angella when her new husband who also adopted Angella and went on to have 2 further children with her mother, left. He took her with him and the boys but 2 weeks later returned her to the care system.She has had 3 partners who have all died, 1 from HIV and 2 due to drug overdoses. She has 4 children , sons aged 32 30 and 17 and a daughter with downs syndrome aged 25. She lost her home and children when she "Took the rap" for a drug offense of a partner and served 18 months in jail. When she got out of jail, this partner died. She has her daughter 3 days a week.She expresses a strong sense of guilt and shame.Depressed with anxiety and avoidant of social situatons, In triage she hid behind a curtain of hair.Previous attendance at Willow. She wants to be a better person but issues from her past wont go away and stop her from moving on.

Risk Factors: No sense of belonging or family. Multiple losses, low self esteem, thinks she is better away from people to keep them safe. Memories sparked off by smells, images etc.Poor sleep making it more difficult for her on a daily basis.

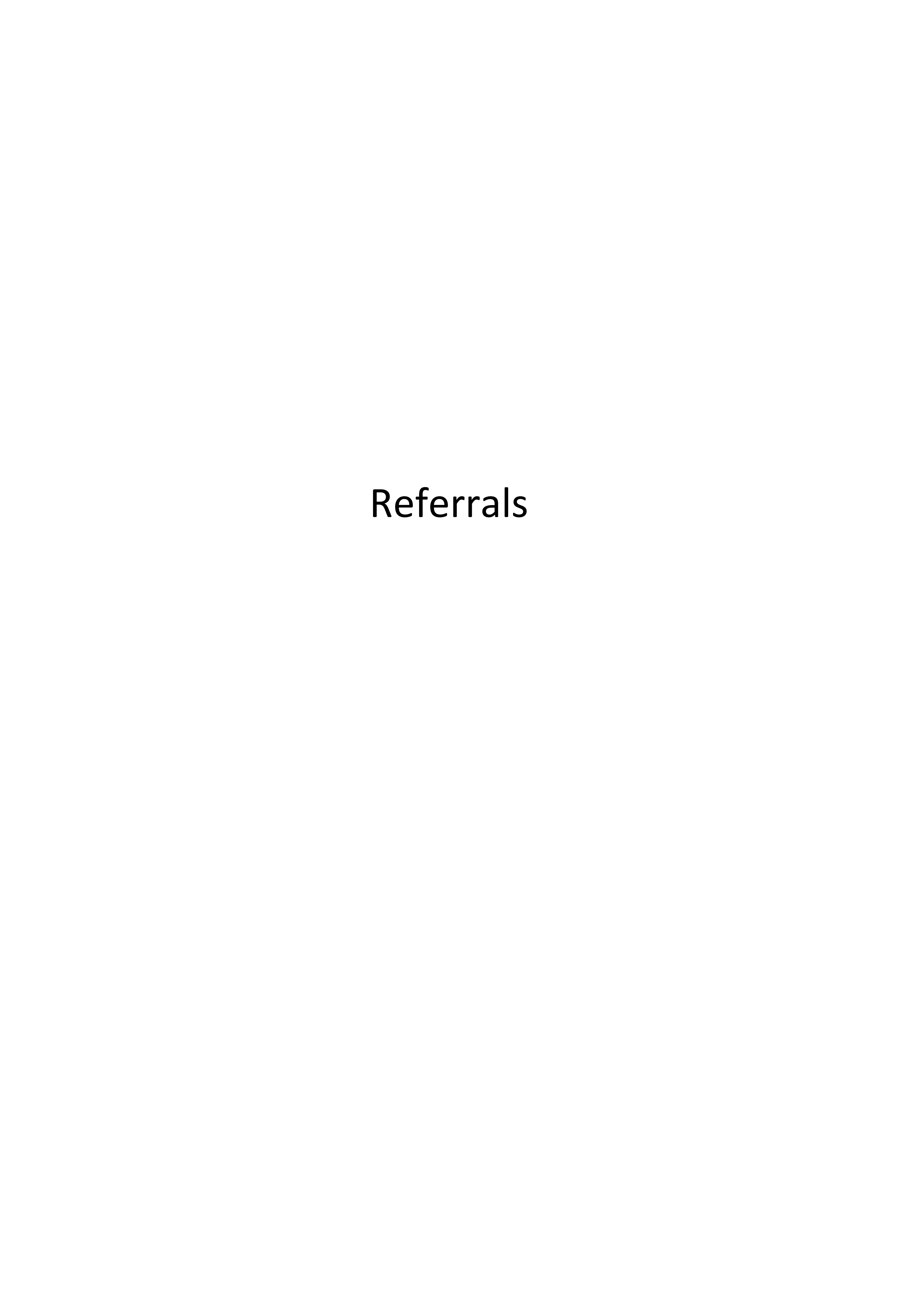
Medication: mirtazipine and propanolol

CORE 10:34

Trauma History (Inc. GBV) as above

Advice and Information: /NO (please list)

Signposted to other local service: /NO (please list)



Referrals

NHS Lothian - Imaging Request

Please note that this request will become invalid if the patient does not attend within 30 days of this request

Referral To	Midlothian Community Hospital Clinical Radiology L Radiology Walk in
Urgency of referral	Routine
Date of referral	31/03/2023
Date submitted	31/03/2023
UCPN	101029197559R

PATIENT DETAILS

CHI number:	2205671464
Name:	MS ANGELLA CROSS
Date of birth:	22/05/1967
Sex:	Female

Contact Details

44 WOODBURN BANK
DALKEITH
MIDLOTHIAN
EH22 2EY

Voice (Home) : 0131 531 1195
Voice (Mobile) : 07940443239

REFERRING PRACTITIONER DETAILS

Name:	Fionna Mackinnon Advanced Physiotherapy Practitioner (GMC: Ph46969)
Practice:	Newbattle Medical Practice (77106)
Phone:	Voice : 0131 663 1051

Practice address

Blackcot
Mayfield
Midlothian
EH22 4AA

INVESTIGATION REQUESTED

Test Requested:	**Shoulder right**
Reason for Request:	right shoulder pain 3-4 months without injury. some limitation of ROM but not true capsular pattern no muscle weakness. any bony pathology or calcification Kind regards Fionna MacKinnon GP APP

CLINICAL INFORMATION

Examinations and Investigations

Description	Result	Date
Middle name : ISABELLA		

Investigations

Description	Result	Date
Please provide smoking status :	Non-Smoker	
Suspected :	Pain	
Could the patient be pregnant? :	Blank	

Signature of requesting doctor **Designation** **Date**

Radiology Walk In is available Monday to Friday as follows:

Lauriston Building	8:30am - 4:00pm
Leith Community Treatment Centre	8:30am - 4:00pm
Midlothian Community Hospital	9:15am - 12:30pm
East Lothian Community Hospital (Roodlands)	8:30am - 4:00pm
Royal Hospital for Sick Children - **Children Only**	9:00am - 4:30pm (Except public holidays)
Royal Infirmary of Edinburgh	9:00am - 4:30pm
St John's Hospital	8:30am - 5:00pm
Western General Hospital	8:00am - 5:00pm (Main xray Department)

NHS Lothian - Imaging Request

Please note that this request will become invalid if the patient does not attend within 30 days of this request

Referral To	Midlothian Community Hospital Clinical Radiology L Radiology Walk in
Urgency of referral	Routine
Date of referral	21/06/2022
Date submitted	21/06/2022
UCPN	101026663256E

PATIENT DETAILS

		Contact Details	
CHI number:	2205671464	44 WOODBURN BANK	Voice (Home) : 0131 531 1195
Name:	MS ANGELLA CROSS	DALKEITH	Voice (Mobile) : 07940443239
Date of birth:	22/05/1967	MIDLOTHIAN	
Sex:	Female	EH22 2EY	

REFERRING PRACTITIONER DETAILS

		Practice address
Name:	Dr. Abigail Paul (GMC: 7474584)	Blackcot
Practice:	Newbattle Medical Practice (77106)	Mayfield Midlothian
Phone:	Voice : 0131 663 1051	EH22 4AA

INVESTIGATION REQUESTED

Test Requested: Abdominal Plain Film

Reason for Request: Persistent SOB on minimal exertion ?any underlying pathology

CLINICAL INFORMATION

Examinations and Investigations

Description	Result	Date
Middle name : ISABELLA		

Investigations

Description	Result	Date
Dyspnoea :	true	
Please provide smoking status :	Non-Smoker	
Could the patient be pregnant? :	Blank	

Signature of requesting doctor **Designation** **Date**

Radiology Walk In is available Monday to Friday as follows:

Lauriston Building	8:30am - 4:00pm
Leith Community Treatment Centre	8:30am - 4:00pm
Midlothian Community Hospital	9:15am - 12:30pm
East Lothian Community Hospital (Roodlands)	8:30am - 4:00pm
Royal Hospital for Sick Children - **Children Only**	9:00am - 4:30pm (Except public holidays)
Royal Infirmary of Edinburgh	9:00am - 4:30pm
St John's Hospital	8:30am - 5:00pm
Western General Hospital	8:00am - 5:00pm (Main xray Department)

NHS Lothian - Imaging Request

Referral To	Midlothian Community Hospital Clinical Radiology L Radiology Walk In
Urgency of referral	Routine
Date of referral	05/09/2018
Date submitted	05/09/2018

PATIENT DETAILS

		Contact Details	
CHI number:	2205671464	31A ALLAN TERRACE DALKEITH EH22 1EL	Voice (Home) : 0131 531 1195
Name:	MS ANGELLA CROSS		
Date of birth:	22/05/1967		
Sex:	Female		

REFERRING PRACTITIONER DETAILS

		Practice address
Name:	Dr. Avril Glencross (GMC: 2547820)	Blackcot
Practice:	Newbattle Medical Practice (77106)	Mayfield Midlothian
Phone:	Voice : 0131 663 1051	EH22 4AA

INVESTIGATION REQUESTED

Test Requested:	**Pelvis/Hips**
Reason for Request:	This lady had very poor movement, poor flexion and external rotation. I think it is likely to be OA and I would welcome an x-ray of this. Many thanks. Dr Jim Fulton.

CLINICAL INFORMATION

Investigations

Description	Result	Date
Could the patient be pregnant? :	Blank	

NHS Lothian - Referral Letter - PMH and Medication Information only from GP

Referral To	Mental Health Midlothian - Adult Psychiatry (Non Urgent Only) L Psychological Therapy Serv
Urgency of referral	Routine
Date of referral	10/08/2018
Date submitted	10/08/2018
UCPN	101016733844D

PATIENT DETAILS

CHI number:	2205671464	**Contact Details**	
Name:	MS ANGELLA CROSS	31A ALLAN TERRACE DALKEITH EH22 1EL	Voice (Home) : 0131 531 1195
Date of birth:	22/05/1967		
Sex:	Female		

REFERRING PRACTITIONER DETAILS

		Practice address
Name:	Dr. Anna Gaskell (GMC: 6151087)	Blackcot
Practice:	Newbattle Medical Practice (77106)	Mayfield Midlothian
Phone:	Voice : 0131 663 1051	EH22 4AA

CLINICAL INFORMATION

Reason for Referral: psychological therapy services

Investigations

Description	Result	Date
Referral Source :	PMH and Medication Information only from GP	
Referral to specific professional/intervention :	No Preference	

Pre-existing conditions (High & Medium Priority)

Description	Modifier	Extension	Start Date	Date Recorded
Gallstones	New event		28/02/2017	28/02/2017
Corneal ulcer	New event	right	15/01/2016	15/01/2016
Essential hypertension			30/09/2013	30/09/2013
Anxiety states			27/08/2013	27/08/2013
Thyroglossal duct cyst			13/06/2001	13/06/2001
Caesarean delivery			25/01/2001	25/01/2001
Miscarriage			17/12/1998	17/12/1998
Iron deficiency anaemias			25/07/1997	25/07/1997
Pneumonia due to unspecified organism			30/11/1994	30/11/1994
Acute pyelonephritis			22/03/1994	22/03/1994
Caesarean delivery			23/07/1993	23/07/1993
Microcytic hypochromic anaemia			28/05/1993	28/05/1993
Miscarriage			20/07/1992	20/07/1992
Spontaneous vaginal delivery			19/12/1988	19/12/1988
Miscarriage			09/02/1988	09/02/1988
Miscarriage			15/11/1987	15/11/1987
Neurotic depression reactive type		-ongoing	11/11/1986	11/11/1986
[X]Intentional self poisoning/exposure to noxious substances			14/08/1983	14/08/1983

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

Drug name	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Propranolol 40mg tablets	tablet	1 TABLET TWO-THREE TIMES DAIL[more]		30/07/2018		30/07/2018
Mirtazapine 30mg tablets	tablet	1 TABLET ONCE A DAY AT NIGHT		30/07/2018		30/07/2018
Lisinopril 10mg tablets	tablet	1 TABLET ONCE A DAY		30/07/2018		30/07/2018

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

Gynaecology F2
L Menstrual Dysfunction

Royal Infirmary of Edinburgh at Little France (S314H)
51 Little France Crescent
Old Dalkeith Road
Edinburgh
EH16 4SA

Urgency of referral	Routine
Date of referral	14/03/2011
Date submitted	14/03/2011
UCPN	101001724844P

PATIENT DETAILS

Surname	CROSS
Forename(s)	Angela
Title	Miss
Sex	Female
Date of birth	22/05/1967
CHI no.	2205671464
Previous Surname	

Address

9 Fairford Gardens
INCH
EDINBURGH
EH16 5RW

Contact number(s)

REFERRING PRACTITIONER DETAILS

Name	Dr. Euan Alexander
GMC code	6096980
GP code	46868
Practice name	INCHPARK SURGERY (70291)
Practice code	70291

Practice address

10 MARMION CRESCENT
EDINBURGH
EH16 6QU

Contact number(s)

Voice : 0131 666 2121

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: dysfunctional uterine bleeding

Comment: Dear colleague, I would be grateful for your review of this 43 yo multiparous lady who has attended our surgery and OOH a number of times in the last year with heavy PV bleeding. Entry today as follows: A: dysfunctional uterine bleeding S: 4 children, sterilised 9yrs ago. prev periods reg. in last year periods monthly but last ~2/52 heavy with clots. no intramentrual bleeding. currently bleeding for last 2/52 PV exam for same July10 unremarkable P: norethisterone to arrest current episode FBC/TFTs refer gynae smear when able ea Please note USS last autumn was as follows: Report TA/TV Exam Slightly bulky uterus in keeping with parity, the myometrium is coarse in echotexture however no focal lesions identified. Clear midline echo identified. Both ovaries appear normal. No free fluid or adnexal masses seen. I have advised Mrs Cross that there may be nil of concern underlying her menorrhagia and that a mirena may be a good option but I would be grateful for your further assessment. Many thanks. Yours faithfully, Dr Euan Alexander

Investigations

Description	Result	Date
Menorrhagia (Regular, heavy bleeding) :	true	
Prolonged and/or irregular bleeding :	true	
Duration of symptoms :	6-12 months	
Smear Result :	normal	
Smear Date (dd/mm/yyyy) :	2004-01-01	
Hb result :	Result awaited	
Thyroid Function :	Result awaited	
Chlamydia result :	Not Done	
Ultrasound (USS) :	Result normal	
USS Location :	RIE	

Reason for referral

Care type requested: Out Patient - New

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & Medium Priority)

Description	Modifier	Extension	Start Date	Date Recorded
Metatarsal bone fracture	3rd		07/01/2011	07/01/2011
Open fracture thumb distal phalanx, shaft		Human bite	11/05/2008	11/05/2008
[V]Breast reduction	Bilateral		18/08/2006	18/08/2006
Neurotic depression reactive type				18/02/2004
Closed fracture navicular				27/09/2003
[V]Sterilisation			10/12/2001	10/12/2001
Constipation				20/07/2001
Spontaneous abortion				29/12/1998
Anxiety states				17/08/1995
Orthostatic hypotension				21/05/1995
Acute pyelonephritis				22/03/1994

Assault by means NOS		24/01/1994
Caesarean delivery		23/07/1993
Iron deficiency anaemias		28/05/1993
Constipation		01/01/1993
H/O: deliberate self harm		03/11/1992
[D]Abdominal pain		28/08/1992
Spontaneous abortion		30/07/1992
Drug dependence	Until 1998	26/02/1992
Assault by means NOS		17/06/1989
Assault by means NOS		13/07/1988
Threatened abortion		09/02/1988
Assault by means NOS		26/09/1987
Homicide and injury purposely inflicted by other persons		26/09/1987
Fostered		15/08/1983
Suicide + selfinflicted poisoning by solid/liquid substances		14/08/1983
Pneumonia or influenza NOS		09/02/1970

Past procedures (High priority - carried out within the last 12 months)

Procedure	Comment	Modifier	Date Performed	Date Recorded
1st hepatitis B vaccination			11/05/2008	11/05/2008
[SO]Thyroglossal cyst				04/07/2001
Single live birth				25/01/2001
Leucopenia - low white count				02/11/1992
Termination of pregnancy NEC				18/02/1991
Single live birth				19/12/1988
Diagnostic endoscopic examination of peritoneum				15/11/1987
Termination of pregnancy NEC				10/07/1986
Single live birth				01/10/1985

Family conditions (High and Medium priority)

Condition Name	Modifier	Extension	Date Recorded
FH: Ischaemic heart dis. <60			23/04/1997

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Norethisterone	06.04.01.2	TABS 5MG	1 Tab	3 times daily	14/03/2011		14/03/2011
Norethisterone	06.04.01.2	TABS 5MG	1 Tab	3 times daily	14/03/2011		14/03/2011

Additional relevant information

Smoking history (Screening): Never smoked tobacco , Date recorded: 22-Jun-2000

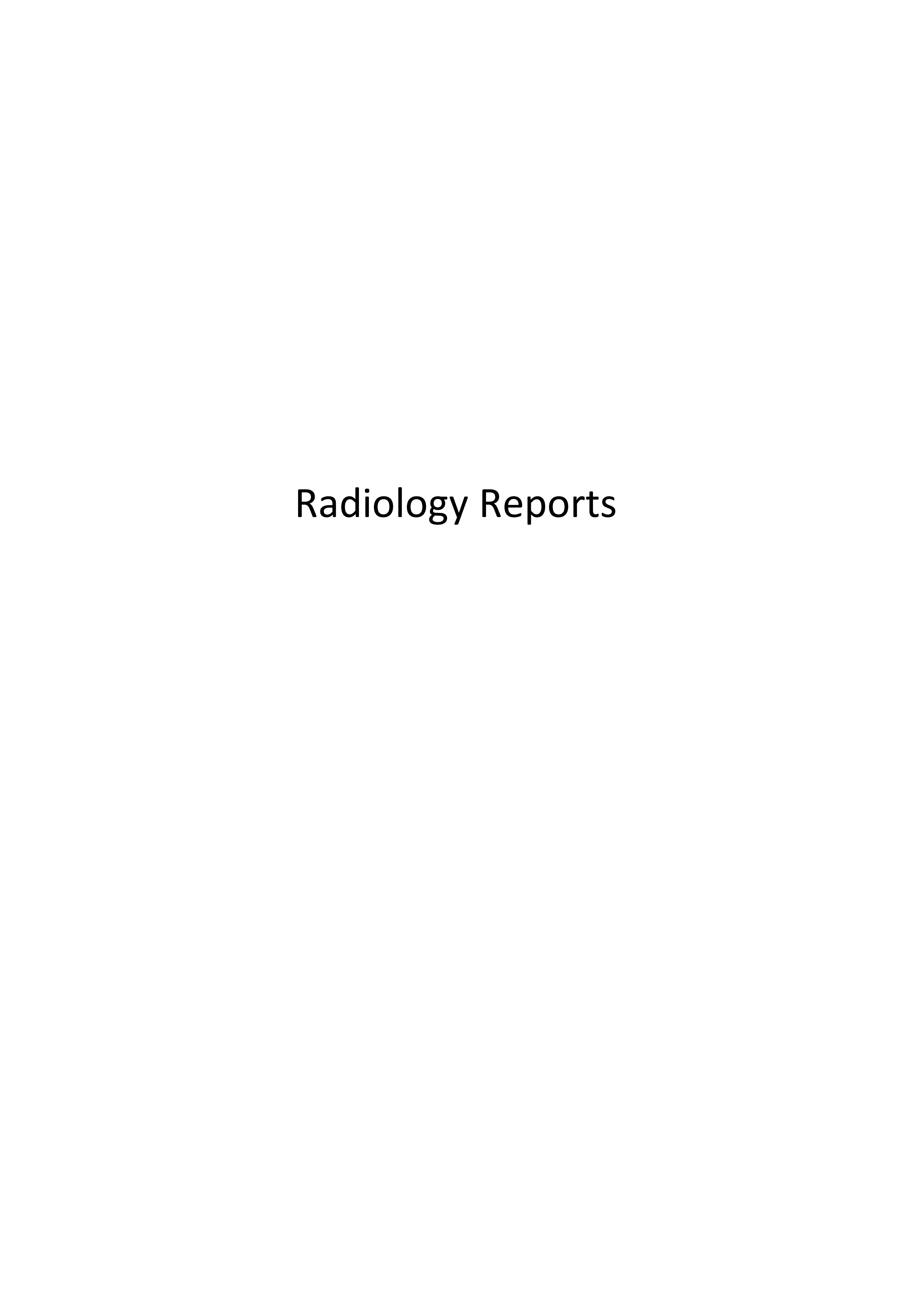
Alcohol history (Screening): Teetotaller , Date recorded: 22-Jun-2000

Patient Weight in Kilograms:70

Patient Height in Metres:1.53

Patient BMI:29.90
Patient Blood Pressure (Systolic):106
Patient Blood Pressure (Diastolic):62

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


Radiology Reports

XR Chest

XR Chest

Clinical History
PC - cough ?haemetmesis NEWS - 1 HR 109 BMI +++ WCC normal CRP 28 ?LRTI vs ?PE

9820372 18/01/2026 XR Chest

Normal heart and mediastinal contours. The lungs are clear.

_
Dr Gillian Ritchie. GMC: 4641812
Consultant Radiologist. Royal Infirmary of Edinburgh

Reporting Radiologist: Dr Gillian Ritchie

Report Information

Requestor	Ingleston, Dr Mike
Requesting Location	(RIEAE7) RIE ED Pod E, A&E
Report Identifier	54423857
Sample Date	18/01/2026 13:37:00

XR Chest

XR Chest

Clinical History
F56 - pain on lifting heavy object with some pleuritic featuers - ? PTx ? ribcage injury

8286776 20/05/2024 XR Chest
The heart is not enlarged
Normal mediastinal contours
No focal collapse or consolidation
Visualised bony skeleton intact.
No free air beneath the diaphragm.
No pneumothorax

—
Dr S McLaughlin GMC 4612331
Consultant Radiologist

Report manually copied from Soliton by PACS team

Reporting Radiologist: Dr Siobhan McLaughlin

Report Information

Requestor	Foytl, Dr Jakub
Requesting Location	(RIEAE7) RIE ED Pod E, A&E
Report Identifier	
Sample Date	20/05/2024 23:30:00

XR Shoulder Rt

XR Shoulder Rt

Clinical History
pain/stiffness/limited movt in right shoulder ?frozen shoulder / Shoulder Right

7714815 06/10/2023 XR Shoulder Rt

No prior for comparison.

Congruent glenohumeral and acromioclavicular joint. No significant glenohumeral degeneration.
Preserved subacromial space. Minor sclerosis of the humeral greater tuberosity, suggestive of a degree of rotator cuff degeneration. No calcific tendinopathy evident. Visualised right hemithorax clear.
—
Dr Tom Blankenstein. GMC: 6156962
Consultant Radiologist.

Reporting Radiologist: Dr Tom N Blankenstein

Report Information

Requestor	ISAAC, OYENWEN
Requesting Location	Newbattle Medical Practice
Report Identifier	46635369
Sample Date	06/10/2023 15:10:00

CT Angiogram Pulmonary

CT Angiogram Pulmonary

Clinical History
55F post covid worsening SOBOE with associated chest pain BG diabetic, overweight, HTN ?PE

6865444 21/10/2022 CT Angiogram Pulmonary

Comparison: MRI 01/03/2017.

Satisfactory opacification of the pulmonary arteries.
No central, lobar or segmental pulmonary thromboembolism.
No evidence right heart strain.
Normal appearance of the lung parenchyma. No focal lesion or size-significant nodularity.
No pleural effusion.
No enlarged thoracic lymph nodes.

Allowing for differences in modality, unchanged appearances of the right sided liver lesion measuring 23 mm. This has the appearance of a haemangioma.
Previous cholecystectomy.
Unremarkable remaining partially visualised upper abdominal organs.
No destructive bone lesion.

Opinion:
No pulmonary thromboembolism.

—
Dr Liam Roebuck. GMC 7561788
Radiology Registrar.

Checked by Dr K Muir Consultant Radiologist.

Reporting Radiologist: Dr Liam Roebuck

Report Information

Requestor	Kawecki, David
Requesting Location	(RIE207) RIE Ward 207
Report Identifier	43530467
Sample Date	21/10/2022 13:03:00

CT Head

CT Head

Clinical History
dry cough for 1 year and shortness of breath with worsening ET to 5 minutes on a flat ground. CT to investigate please. onsetted post covid and has had covid 2x. for CTB: Headaches with BP 180/130 and right sided tinglinig upper and lower limbs - exclude CVA please thanks

6861276 18/10/2022 CT Head

Technique: Unenhanced

Comparison: None available

Findings:
Normal brain appearances and CSF configuration.

No intracranial haemorrhage, collection or mass.

Normal bones and air spaces. Normal extracranial soft tissue.

Opinion:
No acute intracranial haemorrhage.
No significant finding.

Reported by Dr O Llewellyn (ST4 Clinical Radiology)

Checked by Dr Ritchie Consultant Radiologist

Reporting Radiologist: Oliver P Llewellyn

Report Information

Requestor	Thethy, Dr Ishwinder K
Requesting Location	(RIECAA2) AMU Bay 2
Report Identifier	43516743
Sample Date	18/10/2022 22:10:00

XR Chest

XR Chest

Clinical History
Fever, SOB ?CAP

6859872 18/10/2022 XR Chest

Examination superseded by CTPA. Please see separate report.

—
Dr Kenneth Muir. GMC: 6115357
Consultant Radiologist.

Reporting Radiologist: Dr Kenneth C Muir

Report Information

Requestor	Krupej, Dr Sean
Requesting Location	(RIEAE3) 3 Exam, A&E
Report Identifier	43512132
Sample Date	18/10/2022 12:50:00

XR Pelvis

XR Pelvis

Clinical details

XR Pelvis
This lady had very poor movement, poor flexion and external rotation. I think it is likely to be OA and I would welcome an x-ray of this.Many thanks.Dr Jim Fulton. / Pelvis/Hips

Report

No bone or joint abnormality.

Reported by Dr F Perks, Consultant Radiologist, RIE
fperks@nhs.net
01312423800

Reporting Radiologist: Dr Fergus J Perks

Report Information

Requestor	GLENCROSS, AVRIL
Requesting Location	Newbattle Medical Practice
Report Identifier	30762584
Sample Date	05/09/2018 10:42:00

US Abdomen

US Abdomen

Clinical details

US Abdomen
49 y/o upper abdo pain. HOT AUSS 28/2 please. Deranged LFTs. ?gallstones

Report

Abdominal ultrasound
The liver was of normal size. The hepatic echo pattern was increased but no focal hepatic lesions were identified. Calculi were noted within a slightly thickened gallbladder. Pericholecystic fluid was noted adjacent to the gallbladder. Biliary system was not dilated. Portal vein was patent. The pancreas was not visualised due to overlying bowel gas. Both kidneys were normal. Minor splenomegaly was noted.

Opinion:
1/ There is evidence of cholelithiasis. I note a normal white cell count and CRP level. The appearances adjacent to the gallbladder probably represent resolving acute cholecystitis.
2/ The appearances within the liver in conjunction with the minor splenomegaly raise the possibility of chronic parenchymal liver disease.

Dr. James Walsh.
Consultant Radiologist
GMC number: 2620695

Reporting Radiologist: Dr James Walsh

Report Information

Requestor	Penswick, Dr Stephanie
Requesting Location	(RIEAE2) 2 IC, A&E
Report Identifier	26278401
Sample Date	28/02/2017 03:12:00

XR Foot Rt

XR Foot Rt

Clinical details

XR Foot Rt
Twisted R foot 6/7. since the gait and worsening pain not reliefed with analgesia. Initial bruising. BT over 1-3 MT and cunifers. ?#

Report

No fracture or dislocation.

Dr Alberto Nania, radiology registrar (AN66)
Checked by Dr Walsh, Consultant

Reporting Radiologist: Dr Alberto Nania

Report Information

Requestor	( )
Requesting Location	(RIEAE3) 3 Exam, A&E
Report Identifier	22016889
Sample Date	27/09/2015 19:55:00

XR Ankle Lt

XR Ankle Lt

Clinical details

Inversion injury. Tender lateral malleolus 3rd, 4th and 5th MTs. Previous ankle fracture.

Report
LEFT ANKLE
No acute fracture seen.

LEFT FOOT
Undisplaced fracture of the proximal 3rd metatarsal and probable undisplaced fracture proximal 2nd metatarsal.

IMP/LO

#

Reporting Radiologist: Dr I M Prossor

XR Foot Lt

XR Foot Lt

Clinical details

Inversion. Tender lateral malleolus 3rd, 4th and 5th MTs. Previous ankle fracture.

Report

See previous report.

IMP/LO

Reporting Radiologist: Dr I M Prossor

Report Information

Requestor	
Requesting Location	(RIEAE3) 3 - Exam, A&E
Report Identifier	8856464
Sample Date	14/12/2010 12:01:00

US Gynaecology Pelvis ,US Gynaecology Pelvis (TV)

US Gynaecology Pelvis ,US Gynaecology Pelvis (TV)

Clinical details

43 year old, intermenstrual bleeding and suprapubic pain.

Report
TA/TV Exam
Slightly bulky uterus in keeping with parity, the myometrium is coarse in echotexture however no focal lesions identified. Clear midline echo identified.
Both ovaries appear normal.
No free fluid or adnexal masses seen.

CI

Reporting Radiologist: Carolyn Innes

Report Information

Requestor	
Requesting Location	Inchpark Surgery
Report Identifier	7928972
Sample Date	14/09/2010 11:05:00

Lab Reports

Full blood count - FBC				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Haemoglobin	136	115 165	g/L	
Red cell count	5.27	3.8 5.8	10^12/L	
Haematocrit	0.409	0.36 0.47	ratio	
Mean cell volume	78	78 98	fL	
Mean Cell Hb	**25.8**	**27.0 - 32.0**	**pg**	**A**
White cell count	5.5	4.0 11.0	10^9/L	
Neutrophil Count	3.07	2.0 7.5	10^9/L	
Lymphocyte Count	**1.41**	**1.5 - 4.5**	**10^9/L**	**R**
Monocyte Count	0.70	0.2 0.8	10^9/L	
Eosinophil Count	0.22	0.04 0.4	10^9/L	
Basophil Count	0.07	0.01 0.1	10^9/L	
Platelet count	330	150 400	10^9/L	
Mean cell Hb conc.	333	310 360	g/L	

Requestor Comments

Annual diabetic review.

Report Information

Requestor	Hernandez, Dr Marc AS
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	HR235110X
Sample Date	10/04/2026 08:33:00

Liver function tests

Description	Value	Range	Unit	Normalcy Notes
Bilirubin	11	3 21	umol/L	
ALT	32	10 50	U/L	
Alk.Phos	**140**	**40 - 125**	**U/L**	**R**
GGT	32	5 35	U/L	

Requestor Comments

Annual diabetic review.

Serum lipids

Description	Value	Range	Unit	Normalcy Notes
Cholesterol	**7.3**		**mmol/L**	**A**
HDL Chol.	1.2	1.1 - 1.7	mmol/L	
Chol:HDLC Ratio	6.2			
LDL Chol.	**5.1**		**mmol/L**	**A**
Triglyceride	**2.2**	**0.8 - 2.1**	**mmol/L**	**R**

Requestor Comments

Annual diabetic review.

Urea and electrolytes

Description	Value	Range	Unit	Normalcy Notes
Creatinine	75	50 98	umol/L	
Sodium	137	135 145	mmol/L	
Potassium	**5.3**	**3.6 - 5**	**mmol/L**	**R**
eGFR (/1.73m2)	>60		ml/min	

Requestor Comments

Annual diabetic review.

Report Information

Requestor	Hernandez, Dr Marc AS
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	HB907119J
Sample Date	10/04/2026 08:33:00

Urine Albumin:Creatinine Ratio					
Description	**Value**	**Range**	**Unit**	**Normalcy**	**Notes**
MicroalbuminACR	2.4	0 3.0	mg/mmol		
Urine Albumin	42		mg/L		
U. Creatinine	17.8		mmol/L		

Requestor Comments

`Annual diabetic review.`

Report Information

Requestor	Hernandez, Dr Marc AS
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	HB907387Q
Sample Date	10/04/2026 08:33:00

HbA1c level					
Description	**Value**	**Range**	**Unit**	**Normalcy**	**Notes**
HbA1c (IFCC)	**62**	**20 - 41**	**mmol/mol**	**R**	

Requestor Comments

HbA1c for monitoring

Annual diabetic review.

Report Information

Requestor	Hernandez, Dr Marc AS
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	HB907301W
Sample Date	10/04/2026 08:33:00

Coagulation/bleeding test					
Description	**Value**	**Range**	**Unit**	**Normalcy**	**Notes**
VTE Exclusion	224	0 250	ng/ml		

Sample Comments

MI40 21834

Requestor Comments

2/52 cough 3/7 haemoptisis

Report Information

Requestor	given, Not
Requesting Location	(RIEAE7) RIE ED Pod E, A&E
Report Identifier	HR151409J
Sample Date	18/01/2026 14:06:00

Bone Group				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Calcium	2.46	2.2 2.6	mmol/L	
Adjustd Calcium	2.52	2.2 2.6	mmol/L	
Albumin	37	36 47	g/L	
Alk.Phos	**145**	**40 - 125**	**U/L**	**R**

Sample Comments

21424..

Requestor Comments

abdo pain

Liver function tests				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Bilirubin	8	3 - 21	umol/L	
ALT	28	10 - 50	U/L	

Sample Comments

21424..

Requestor Comments

abdo pain

Serum amylase level				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Amylase	30	3 100	U/L	

Sample Comments

21424..

Requestor Comments

abdo pain

Urea and electrolytes				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Urea	4.5	2.5 - 6.6	mmol/L	
Creatinine	79	50 - 98	umol/L	
Sodium	135	135 - 145	mmol/L	
Potassium	4.1	3.6 - 5	mmol/L	
TCO2	26	22 - 30	mmol/L	
eGFR (/1.73m2)	>60		ml/min	

Sample Comments

21424..

Requestor Comments

abdo pain

Serum C reactive protein level				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
C Reactive Prot	**28**	**0 - 5**	**mg/L**	**R**

Sample Comments

21424..

Requestor Comments

abdo pain

Report Information

Requestor	given, Not
Requesting Location	(RIEAE7) RIE ED Pod E, A&E
Report Identifier	HB075714E
Sample Date	18/01/2026 10:52:00

Full blood count - FBC				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Haemoglobin	135	115 165	g/L	
Red cell count	5.23	3.8 5.8	10^12/L	
Haematocrit	0.403	0.36 0.47	ratio	
Mean cell volume	**77**	**78 - 98**	**fL**	**R**
Mean Cell Hb	**25.8**	**27.0 - 32.0**	**pg**	**A**
White cell count	5.0	4.0 11.0	10^9/L	
Neutrophil Count	2.07	2.0 7.5	10^9/L	
Lymphocyte Count	1.59	1.5 4.5	10^9/L	
Monocyte Count	**1.02**	**0.2 - 0.8**	**10^9/L**	**R**
Eosinophil Count	0.30	0.04 0.4	10^9/L	
Basophil Count	0.05	0.01 0.1	10^9/L	
Platelet count	277	150 400	10^9/L	
Mean cell Hb conc.	335	310 360	g/L	

Sample Comments

21424..

Requestor Comments

abdo pain

Report Information

Requestor	given, Not
Requesting Location	(RIEAE7) RIE ED Pod E, A&E
Report Identifier	HR151278J
Sample Date	18/01/2026 10:52:00

Full blood count - FBC				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Haemoglobin	138	115 165	g/L	
Red cell count	5.15	3.8 5.8	10^12/L	
Haematocrit	0.410	0.36 0.47	ratio	
Mean cell volume	80	78 98	fL	
Mean Cell Hb	**26.8**	**27.0 - 32.0**	**pg**	**R**
White cell count	6.4	4.0 11.0	10^9/L	
Neutrophil Count	3.60	2.0 7.5	10^9/L	
Lymphocyte Count	1.77	1.5 4.5	10^9/L	
Monocyte Count	0.61	0.2 0.8	10^9/L	
Eosinophil Count	0.29	0.04 0.4	10^9/L	
Basophil Count	0.08	0.01 0.1	10^9/L	
Platelet count	324	150 400	10^9/L	
Mean cell Hb conc.	337	310 360	g/L	

Sample Comments

Alix Wrighton

Requestor Comments

ear ache?mastoiditis

Report Information

Requestor	given, Not
Requesting Location	(RIEAE3) 3 Exam, A&E
Report Identifier	HR117299E
Sample Date	01/04/2025 10:36:00

Coagulation/bleeding test				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Prothrombin Time	9.9	9.0 12.0	sec	
INR (Warfarin)	0.9		ratio	
APTT	22	21.0 28.0	sec	
APTT Ratio	0.9		ratio	
Fibrinogen (Clauss)	**4.3**	**1.5 - 4.0**	**g/L**	**R**

Sample Comments

Alix Wrighton

Requestor Comments

ear ache?mastoiditis

Report Information

Requestor	given, Not
Requesting Location	(RIEAE3) 3 Exam, A&E
Report Identifier	HR117302H
Sample Date	01/04/2025 10:36:00

Liver function tests				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Bilirubin	8	3 21	umol/L	
ALT	24	10 50	U/L	
Alk.Phos	**134**	**40 - 125**	**U/L**	**R**

Sample Comments

Alix Wrighton

Requestor Comments

ear ache?mastoiditis

Urea and electrolytes				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Urea	3.8	2.5 - 6.6	mmol/L	
Creatinine	77	50 - 98	umol/L	
Sodium	138	135 - 145	mmol/L	
Potassium	4.2	3.6 - 5	mmol/L	
eGFR (/1.73m2)	>60		ml/min	

Sample Comments

Alix Wrighton

Requestor Comments

ear ache?mastoiditis

Serum C reactive protein level				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
C Reactive Prot	**26**	**0 - 5**	**mg/L**	**R**

Sample Comments

Alix Wrighton

Requestor Comments

ear ache?mastoiditis

Report Information

Requestor	given, Not
Requesting Location	(RIEAE3) 3 Exam, A&E
Report Identifier	HB178544L
Sample Date	01/04/2025 10:36:00

Urine Albumin:Creatinine Ratio

Description	Value	Range	Unit	Normalcy	Notes
MicroalbuminACR	1.2	0 3.0	mg/mmol		
Urine Albumin	7		mg/L		
U. Creatinine	6.1		mmol/L		

Report Information

Requestor	Hernandez, Dr Marc AS
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	HB868534Q
Sample Date	29/11/2024 12:27:00

Full blood count - FBC

Description	Value	Range	Unit	Normalcy	Notes
Haemoglobin	139	115 165	g/L		
Red cell count	5.15	3.8 5.8	10^12/L		
Haematocrit	0.408	0.36 0.47	ratio		
Mean cell volume	79	78 98	fL		
Mean Cell Hb	27.0	27.0 32.0	pg		
White cell count	7.1	4.0 11.0	10^9/L		
Neutrophil Count	4.16	2.0 7.5	10^9/L		
Lymphocyte Count	1.93	1.5 4.5	10^9/L		
Monocyte Count	**0.83**	**0.2 - 0.8**	**10^9/L**	**R**	
Eosinophil Count	0.12	0.04 0.4	10^9/L		
Basophil Count	0.06	0.01 0.1	10^9/L		
Platelet count	374	150 400	10^9/L		
Mean cell Hb conc.	341	310 360	g/L		

Report Information

Requestor	Hernandez, Dr Marc AS
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	HR332390B
Sample Date	25/10/2024 12:06:00

Liver function tests

Description	Value	Range	Unit	Normalcy	Notes
Bilirubin	11	3 21	umol/L		
ALT	35	10 50	U/L		
Alk.Phos	**131**	**40 - 125**	**U/L**	**R**	
GGT	**59**	**5 - 35**	**U/L**	**R**	(BGGT)

Test Comments

(BGGT)	Mildly raised GGT is most often due to fatty liver
(BGGT)	or alcohol intake. Please consider lifestyle advice.
(BGGT)	Further investigation may not be appropriate if all
(BGGT)	other liver results are within reference limits. Please
(BGGT)	see Refhelp 'Abnormal LFTs' guideline for advice on
(BGGT)	on when to investigate.'

Serum lipids

Description	Value	Range	Unit	Normalcy	Notes
Cholesterol	**7.3**		**mmol/L**	**A**	
HDL Chol.	1.1	1.1 - 1.7	mmol/L		
Chol:HDLC Ratio	6.4				
LDL Chol.	**5.1**		**mmol/L**	**A**	
Triglyceride	**2.2**	**0.8 - 2.1**	**mmol/L**	**R**	

Urea and electrolytes

Description	Value	Range	Unit	Normalcy	Notes
Creatinine	78	50 98	umol/L		
Sodium	139	135 145	mmol/L		
Potassium	4.3	3.6 5	mmol/L		
eGFR (/1.73m2)	>60		ml/min		

Report Information

Requestor	Hernandez, Dr Marc AS
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	SB090243N
Sample Date	25/10/2024 12:06:00

HbA1c level				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
HbA1c (IFCC)	**52**	**20 - 41**	**mmol/mol**	**R**

Requestor Comments

HbA1c for monitoring

Report Information

Requestor	Hernandez, Dr Marc AS
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	HB840661J
Sample Date	25/10/2024 12:06:00

Full blood count - FBC				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Haemoglobin	139	115 165	g/L	
Red cell count	5.30	3.8 5.8	10^12/L	
Haematocrit	0.431	0.36 0.47	ratio	
Mean cell volume	81	78 98	fL	
Mean Cell Hb	**26.2**	**27.0 - 32.0**	**pg**	**R**
White cell count	8.3	4.0 11.0	10^9/L	
Neutrophil Count	4.32	2.0 7.5	10^9/L	
Lymphocyte Count	2.51	1.5 4.5	10^9/L	
Monocyte Count	**1.02**	**0.2 - 0.8**	**10^9/L**	**R**
Eosinophil Count	0.30	0.04 0.4	10^9/L	
Basophil Count	**0.11**	**0.01 - 0.1**	**10^9/L**	**R**
Platelet count	323	150 400	10^9/L	
Mean cell Hb conc.	323	310 360	g/L	

Sample Comments

21424..

Requestor Comments

abdo pain

Report Information

Requestor	given, Not
Requesting Location	(RIEAE7) RIE ED Pod E, A&E
Report Identifier	HR171903P
Sample Date	20/05/2024 21:09:00

Bone Group				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Calcium	2.40	2.2 2.6	mmol/L	
Adjustd Calcium	2.43	2.2 2.6	mmol/L	
Albumin	37	36 47	g/L	

Sample Comments

21424..

Requestor Comments

abdo pain

Liver function tests				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Bilirubin	7	3 - 21	umol/L	
ALT	20	10 - 50	U/L	
Alk.Phos	107	40 - 125	U/L	

Sample Comments

21424..

Requestor Comments

abdo pain

Serum amylase level				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Amylase	28	3 100	U/L	

Sample Comments

21424..

Requestor Comments

abdo pain

Urea and electrolytes				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Urea	5.0	2.5 - 6.6	mmol/L	
Creatinine	**106**	**50 - 98**	**umol/L**	**R**
Sodium	138	135 - 145	mmol/L	
Potassium	**3.4**	**3.6 - 5**	**mmol/L**	**R**
TCO2	28	22 - 30	mmol/L	
eGFR (/1.73m2)	**47**		**ml/min**	**A**

Sample Comments

21424..

Requestor Comments

abdo pain

Serum C reactive protein level				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
C Reactive Prot	**7**	**0 - 5**	**mg/L**	**R**

Sample Comments

21424..

Requestor Comments

abdo pain

Report Information

Requestor	given, Not
Requesting Location	(RIEAE7) RIE ED Pod E, A&E
Report Identifier	HB110265R
Sample Date	20/05/2024 21:09:00

Liver function tests

Description	Value	Range	Unit	Normalcy	Notes
Bilirubin	13	3 21	umol/L		
ALT	35	10 50	U/L		
Alk.Phos	**126**	**40 - 125**	**U/L**	**R**	
GGT	**36**	**5 - 35**	**U/L**	**R**	

Serum lipids

Description	Value	Range	Unit	Normalcy	Notes
Cholesterol	**6.5**		**mmol/L**	**A**	
HDL Chol.	1.4	1.1 - 1.7	mmol/L		
Chol:HDLC Ratio	4.8				
LDL Chol.	**4.4**		**mmol/L**	**A**	
Triglyceride	1.6	0.8 - 2.1	mmol/L		

Urea and electrolytes

Description	Value	Range	Unit	Normalcy	Notes
Creatinine	84	50 98	umol/L		
Sodium	139	135 145	mmol/L		
Potassium	4.1	3.6 5	mmol/L		
eGFR (/1.73m2)	>60		ml/min		

Report Information

Requestor	1), Dr Katherine H Paul (GPST
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	HB946813F
Sample Date	06/09/2023 12:52:00

HbA1c level				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
HbA1c (IFCC)	**53**	**20 - 41**	**mmol/mol**	**R**

Requestor Comments

HbA1c for monitoring

Report Information

Requestor	1), Dr Katherine H Paul (GPST
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	HB946710C
Sample Date	06/09/2023 12:52:00

Urine Albumin:Creatinine Ratio					
Description	**Value**	**Range**	**Unit**	**Normalcy**	**Notes**
MicroalbuminACR	1.6	0 3.0	mg/mmol		(BUACR)
Urine Albumin	7		mg/L		
U. Creatinine	4.3		mmol/L		

Test Comments

(BUACR) Please note change in ACR reference range since May '23

Report Information

Requestor	1), Dr Katherine H Paul (GPST
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	HB952384N
Sample Date	06/09/2023 12:52:00

HbA1c level					
Description	**Value**	**Range**	**Unit**	**Normalcy**	**Notes**
HbA1c (IFCC)	**64**	**20 - 41**	**mmol/mol**	**R**	(BHBAIF)

Test Comments

(BHBAIF) HbA1c result is in the Diabetes range.

Requestor Comments

`HbA1c for diagnosis`

Report Information

Requestor	Aspinall, Dr Elika
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	HB929252C
Sample Date	27/10/2022 12:55:00

Plasma glucose level				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Glucose (Random)	**8.2**	**3.8 - 7.7**	**mmol/L**	**A**

Report Information

Requestor	Aspinall, Dr Elika
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	HB929202V
Sample Date	27/10/2022 12:48:00

Liver function tests				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Bilirubin	10	3 21	umol/L	
ALT	**119**	**10 - 50**	**U/L**	**R**
Alk.Phos	**144**	**40 - 125**	**U/L**	**R**
GGT	**102**	**5 - 35**	**U/L**	**R**

Serum lipids				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Cholesterol	**7.5**		**mmol/L**	**A**

Urea and electrolytes				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Creatinine	69	50 98	umol/L	
Sodium	135	135 145	mmol/L	
Potassium	4.1	3.6 5	mmol/L	
eGFR (/1.73m2)	>60		ml/min	

Report Information

Requestor	Aspinall, Dr Elika
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	QB550727D
Sample Date	27/10/2022 12:48:00

Full blood count - FBC

Description	Value	Range	Unit	Normalcy	Notes
Haemoglobin	142	115 165	g/L		
Red cell count	5.02	3.8 5.8	10^12/L		
Haematocrit	0.415	0.36 0.47	ratio		
Mean cell volume	83	78 98	fL		
Mean Cell Hb	28.3	27.0 32.0	pg		
White cell count	6.0	4.0 11.0	10^9/L		
Neutrophil Count	2.95	2.0 7.5	10^9/L		
Lymphocyte Count	1.93	1.5 4.5	10^9/L		
Monocyte Count	0.78	0.2 0.8	10^9/L		
Eosinophil Count	0.31	0.04 0.4	10^9/L		
Basophil Count	0.07	0.01 0.1	10^9/L		
Platelet count	306	150 400	10^9/L		
Mean cell Hb conc.	342	310 360	g/L		
Nucleated RBC count			10^9/L		

Sample Comments

kawecki sho 23675

Requestor Comments

....

Report Information

Requestor	Jones, Dr Pauline J
Requesting Location	(RIE207) RIE Ward 207
Report Identifier	HR312683K
Sample Date	21/10/2022 13:32:00

Urea and electrolytes					
Description	**Value**	**Range**	**Unit**	**Normalcy**	**Notes**
Urea	4.0	2.5 6.6	mmol/L		
Creatinine	68	50 98	umol/L		
Sodium	**134**	**135 - 145**	**mmol/L**	**R**	
Potassium	4.6	3.6 5	mmol/L		
eGFR (/1.73m2)	>60.0		ml/min		

Sample Comments

kawecki sho 23675

Requestor Comments

....

Report Information

Requestor	Jones, Dr Pauline J
Requesting Location	(RIE207) RIE Ward 207
Report Identifier	HB353488P
Sample Date	21/10/2022 13:32:00

Thyroid peroxidase antibod lev					
Description	**Value**	**Range**	**Unit**	**Normalcy**	**Notes**
Anti Thyroid Peroxidase	**>1000.**	**0 - 100**	**IU/ml**	**R**	(ITPO)

Test Comments

(ITPO)	Thyroid peroxidase antibody is consistent with
(ITPO)	autoimmune thyroid disease. Autoantibody levels do not
(ITPO)	correlate with disease activity, therefore serial
(ITPO)	measurement is not clinically indicated.

Sample Comments

kawecki sho 23675

Requestor Comments

....

Report Information

Requestor	Jones, Dr Pauline J
Requesting Location	(RIE207) RIE Ward 207
Report Identifier	HI289020S
Sample Date	21/10/2022 13:32:00

Bone Group

Description	Value	Range	Unit	Normalcy	Notes
Calcium	2.43	2.2 2.6	mmol/L		
Adjustd Calcium	2.45	2.2 2.6	mmol/L		
Albumin	38	36 47	g/L		
Magnesium	0.82	0.7 1	mmol/L		

Sample Comments

KRUPEJ 21130

Requestor Comments

Unwell..

Liver function tests

Description	Value	Range	Unit	Normalcy	Notes
Bilirubin	14	3 - 21	umol/L		
ALT	**104**	**10 - 50**	**U/L**	**R**	
Alk.Phos	**141**	**40 - 125**	**U/L**	**R**	
GGT	**81**	**5 - 35**	**U/L**	**R**	

Sample Comments

KRUPEJ 21130

Requestor Comments

Unwell..

Urea and electrolytes

Description	Value	Range	Unit	Normalcy	Notes
Urea	2.9	2.5 6.6	mmol/L		
Creatinine	73	50 98	umol/L		
Sodium	137	135 145	mmol/L		
Potassium	3.7	3.6 5	mmol/L		
eGFR (/1.73m2)	>60.0		ml/min		

Sample Comments

KRUPEJ 21130

Requestor Comments

Unwell..

Serum C reactive protein level

Description	Value	Range	Unit	Normalcy	Notes
C-Reactive Prot	**11**	**0 - 5**	**mg/L**	**R**	

Sample Comments

KRUPEJ 21130

Requestor Comments

Unwell..

Thyroid function tests

Description	Value	Range	Unit	Normalcy	Notes
TSH	**6.1**	**0.23 - 5.6**	**mU/L**	**A**	
Free T4	15	9 28	pmol/L		

Sample Comments

KRUPEJ 21130

Requestor Comments

Unwell..

Blood haematinic levels

Description	Value	Range	Unit	Normalcy	Notes
Vitamin B12	415	180 - 2000	ng/L		

Serum Folate	5.0	2.8 - 20	ug/L

Sample Comments

KRUPEJ 21130

Requestor Comments

Unwell..

Report Information

Requestor	given, Not
Requesting Location	(RIEAE3) 3 - Exam, A&E
Report Identifier	HB175701C
Sample Date	18/10/2022 12:48:00

Plasma glucose level				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Glucose	**7.6**		**mmol/L**	**A**

Sample Comments

KRUPEJ 21130

Requestor Comments

Unwell..

Plasma lactate level				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Lactate	1.1	0.6 - 2.4	mmol/L	

Sample Comments

KRUPEJ 21130

Requestor Comments

Unwell..

Report Information

Requestor	given, Not
Requesting Location	(RIEAE3) 3 - Exam, A&E
Report Identifier	HB175702K
Sample Date	18/10/2022 12:48:00

Coagulation/bleeding test					
Description	**Value**	**Range**	**Unit**	**Normalcy**	**Notes**
Prothrombin Time	10.3	9.0 12.0	sec		
INR (Warfarin)	1.0		ratio		
APTT	21	21.0 28.0	sec		
APTT Ratio	0.9		ratio		
Fibrinogen (Clauss)	3.2	1.5 4.0	g/L		
VTE Exclusion	152	0 250	ng/ml		

Sample Comments

KRUPEJ 21130

Requestor Comments

Unwell..

Report Information

Requestor	given, Not
Requesting Location	(RIEAE3) 3 Exam, A&E
Report Identifier	HR115848S
Sample Date	18/10/2022 12:48:00

Full blood count - FBC				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Haemoglobin	153	115 165	g/L	
Red cell count	5.55	3.8 5.8	10^12/L	
Haematocrit	0.457	0.36 0.47	ratio	
Mean cell volume	82	78 98	fL	
Mean Cell Hb	27.6	27.0 32.0	pg	
White cell count	5.5	4.0 11.0	10^9/L	
Neutrophil Count	2.74	2.0 7.5	10^9/L	
Lymphocyte Count	1.56	1.5 4.5	10^9/L	
Monocyte Count	**0.87**	**0.2 - 0.8**	**10^9/L**	**R**
Eosinophil Count	0.21	0.04 0.4	10^9/L	
Basophil Count	0.09	0.01 0.1	10^9/L	
Platelet count	301	150 400	10^9/L	
Mean cell Hb conc.	335	310 360	g/L	
Nucleated RBC count			10^9/L	

Sample Comments

KRUPEJ 21130

Requestor Comments

Unwell..

Report Information

Requestor	given, Not
Requesting Location	(RIEAE3) 3 Exam, A&E
Report Identifier	HR115849G
Sample Date	18/10/2022 12:48:00

HbA1c level				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
HbA1c (IFCC)	**62**	**20 - 41**	**mmol/mol**	**R**

Sample Comments

HR115849G

Report Information

Requestor	Consultant, Dummy
Requesting Location	(RIEAE) RIE Accident & Emergency
Report Identifier	HB809489L
Sample Date	18/10/2022 12:48:00

Blood culture

Set Comments

Blood Culture

Blood culture NEGATIVE after 2 days incubation
A further report will follow if growth occurs

Sample Comments

KRUPEJ 21130

Requestor Comments

Unwell..

Report Information

Requestor	given, Not
Requesting Location	(RIEAE3) 3 Exam, A&E
Report Identifier	MB731173R
Sample Date	18/10/2022 12:48:00

ESC Sendaway Tests		
Coeliac screen	Send away test	WGH Biochemistry

Requestor Comments

```
Suspected Coeliac Patient
Patient is not known to have a thyroid condition.
Tingling burning limbs.
```

Blood haematinic levels

Description	Value	Range	Unit	Normalcy	Notes
Iron	14	10 - 28	umol/L		
Transferrin	3.09	2 - 4	g/L		(BTR)
Ferritin	50	20 - 300	ug/L		
Vitamin B12	357	180 - 2000	ng/L		
Serum Folate	3.3	2.8 - 20	ug/L		
Transferrin Sat	17		%		

Test Comments

(BTR)	For interpretation of iron studies used in the
(BTR)	investigation of anaemia please consult GP referral
(BTR)	guidelines for anaemias available on: NHSL Intranet -
(BTR)	Healthcare - A-Z - Haematology - GP referral guidelines

Requestor Comments

```
Suspected Coeliac Patient
Patient is not known to have a thyroid condition.
Tingling burning limbs.
```

Bone Group

Description	Value	Range	Unit	Normalcy	Notes
Calcium	2.44	2.2 2.6	mmol/L		
Adjustd Calcium	2.42	2.2 2.6	mmol/L		
Phosphate	1.20	0.8 1.4	mmol/L		
Magnesium	0.88	0.7 1	mmol/L		
Albumin	40	36 47	g/L		

Requestor Comments

```
Suspected Coeliac Patient
Patient is not known to have a thyroid condition.
Tingling burning limbs.
```

Liver function tests

Description	Value	Range	Unit	Normalcy	Notes
Bilirubin	11	3 - 21	umol/L		
ALT	**68**	**10 - 50**	**U/L**	**R**	
Alk.Phos	**143**	**40 - 125**	**U/L**	**R**	
GGT	**44**	**5 - 35**	**U/L**	**R**	

Requestor Comments

```
Suspected Coeliac Patient
Patient is not known to have a thyroid condition.
Tingling burning limbs.
```

Urea and electrolytes

Description	Value	Range	Unit	Normalcy	Notes
Creatinine	66	50 98	umol/L		
Sodium	137	135 145	mmol/L		
Potassium	4.4	3.6 5	mmol/L		
eGFR (/1.73m2)	>60		ml/min		

Requestor Comments

Suspected Coeliac Patient
Patient is not known to have a thyroid condition.
Tingling burning limbs.

Serum C reactive protein level

Description	Value	Range	Unit	Normalcy	Notes
C-Reactive Prot	**10**	**0 - 5**	**mg/L**	**R**	

Requestor Comments

Suspected Coeliac Patient
Patient is not known to have a thyroid condition.
Tingling burning limbs.

Thyroid function tests

Description	Value	Range	Unit	Normalcy	Notes
TSH	**9.8**	**0.23 - 5.6**	**mU/L**	**A**	
Free T4	13	9 - 28	pmol/L		

Requestor Comments

Suspected Coeliac Patient
Patient is not known to have a thyroid condition.
Tingling burning limbs.

Report Information

Requestor	1), Dr Abigail Paul (GPST
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	HB900509Q
Sample Date	09/06/2022 12:24:00

Full blood count - FBC				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Haemoglobin	149	115 165	g/L	
Red cell count	5.51	3.8 5.8	10^12/L	
Haematocrit	0.444	0.36 0.47	ratio	
Mean cell volume	81	78 98	fL	
Mean Cell Hb	27.0	27.0 32.0	pg	
White cell count	6.7	4.0 11.0	10^9/L	
Neutrophil Count	3.61	2.0 7.5	10^9/L	
Lymphocyte Count	1.97	1.5 4.5	10^9/L	
Monocyte Count	0.80	0.2 0.8	10^9/L	
Eosinophil Count	0.21	0.04 0.4	10^9/L	
Basophil Count	0.07	0.01 0.1	10^9/L	
Platelet count	336	150 400	10^9/L	
Mean cell Hb conc.	336	310 360	g/L	
Nucleated RBC count			10^9/L	

Requestor Comments

`Tingling burning limbs.`

Report Information

Requestor	1), Dr Abigail Paul (GPST
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	HR390725G
Sample Date	09/06/2022 12:24:00

HbA1c level				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
HbA1c (IFCC)	**51**	**20 - 41**	**mmol/mol**	**R**

Requestor Comments

HbA1c for monitoring

Tingling burning limbs.

Report Information

Requestor	1), Dr Abigail Paul (GPST
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	HB900531V
Sample Date	09/06/2022 12:24:00

WGH GI Lab LTG

Description	Value	Range	Unit	Normalcy	Notes
Anti tTG IgA (DS2)	1.4	0.1 5.0	U/mL		(QGTTGA)

Test Comments

(QGTTGA) Coeliac testing NOTES:
(QGTTGA) 1. If patient is on gluten free diet, negative serology
(QGTTGA) does NOT exclude coeliac disease. For details of
(QGTTGA) required gluten intake to ensure an adequate 'gluten
(QGTTGA) challenge' see RefHelp.
(QGTTGA) 2. Positive serology(tTG IgA >5U/ml or tTG IgG >10U/ml)
(QGTTGA) is associated with Coeliac Disease but is NOT
(QGTTGA) diagnostic on its own and for all adult patients endo
(QGTTGA) scopic biopsy is required. As such, where serology is
(QGTTGA) positive at any level, please refer to GI and advise
(QGTTGA) NOT to exclude gluten until diagnosis is confirmed or
(QGTTGA) excluded by a Gastroenterologist.
(QGTTGA) 3. Low level positives (tTG IgA 5 to 10 U/ml) may be
(QGTTGA) false positives and are relatively common.
(QGTTGA) 4. See GI and Paediatric GI pages on RefHelp for
(QGTTGA) further information and advice.

Report Information

Requestor	1), Dr Abigail Paul (GPST
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	QB105985X
Sample Date	09/06/2022 12:24:00

SARS-CoV-2

Status: Final - Results stored and verified

SARS CoV 2 Negative	Negative by PCR	(4J3R200)

Test Comments

(4J3R200) Sample taken at Gilmerton Faith Mission Car Park. Sample analysed in the National Lighthouse Laboratory (Glasgow)

Report Information

Requestor	Unknown
Requesting Location	Newbattle Medical Practice
Report Identifier	AAO54675255
Sample Date	30/01/2022 13:59:00

Liver function tests

Description	Value	Range	Unit	Normalcy	Notes
Bilirubin	13	3 21	umol/L		
ALT	34	10 50	U/L		
Alk.Phos	**133**	**40 - 125**	**U/L**	**R**	
GGT	33	5 35	U/L		

Urea and electrolytes

Description	Value	Range	Unit	Normalcy	Notes
Creatinine	72	50 - 98	umol/L		
Sodium	137	135 - 145	mmol/L		
Potassium	4.1	3.6 - 5	mmol/L		
eGFR (/1.73m2)	>60		ml/min		

Report Information

Requestor	1), Dr Carbarns (GPST
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	HB965470H
Sample Date	25/01/2022 09:40:00

HbA1c level				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
HbA1c (IFCC)	**49**	**20 - 41**	**mmol/mol**	**R**

Requestor Comments

`HbA1c for monitoring`

Report Information

Requestor	1), Dr Carbarns (GPST
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	HB965584Q
Sample Date	25/01/2022 09:40:00

Urea and electrolytes					
Description	**Value**	**Range**	**Unit**	**Normalcy**	**Notes**
Creatinine	80	50 98	umol/L		
Sodium	139	135 145	mmol/L		
Potassium	4.5	3.6 5	mmol/L		
eGFR (/1.73m2)	>60		ml/min		

Requestor Comments

increasing htn meds.

Report Information

Requestor	Aspinall, Dr Elika
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	HB924062E
Sample Date	23/11/2021 10:00:00

Urea and electrolytes					
Description	**Value**	**Range**	**Unit**	**Normalcy**	**Notes**
Creatinine	87	50 98	umol/L		
Sodium	139	135 145	mmol/L		
Potassium	4.2	3.6 5	mmol/L		
eGFR (/1.73m2)	**59**		**ml/min**	**A**	

Report Information

Requestor	Aspinall, Dr Elika
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	HB911198E
Sample Date	08/11/2021 11:04:00

Liver function tests				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Bilirubin	12	3 21	umol/L	
ALT	**67**	**10 - 50**	**U/L**	**R**
Alk.Phos	**135**	**40 - 125**	**U/L**	**R**
GGT	**47**	**5 - 35**	**U/L**	**R**

Requestor Comments

Requested by Dr H Carbarn.

Urea and electrolytes				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Creatinine	71	50 - 98	umol/L	
Sodium	138	135 - 145	mmol/L	
Potassium	4.3	3.6 - 5	mmol/L	
eGFR (/1.73m2)	>60.0		ml/min	

Requestor Comments

Requested by Dr H Carbarn.

Report Information

Requestor	Wooff, Dr Fione J
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	HB969519P
Sample Date	01/10/2021 09:40:00

HbA1c level				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
HbA1c (IFCC)	**50**	**20 - 41**	**mmol/mol**	**R**

Report Information

Requestor	Given, Cons Not
Requesting Location	(MDSLX) MDS Failure No Location
Report Identifier	HB729264V
Sample Date	15/09/2021 15:14:00

SARS-CoV-2 secondary assay		
SARS CoV 2 virus PCR	Negative	(ZWUPC2)

Set Comments

For specific Infection Prevention and Control advice for SARS-CoV-2
('COVID-19 virus') infection, please refer to the following NHSL
intranet web link:

http://intranet.lothian.scot.nhs.uk/COVID-19/PatientManagement/Pages/default.aspx

Test Comments

(ZWUPC2) This test is currently unaccredited to ISO 15189
(ZWUPC2)

Sample Comments

x.21325

Requestor Comments

for storage

Report Information

Requestor	given, Not
Requesting Location	(RIEAE3) 3 Exam, A&E
Report Identifier	MI085900V
Sample Date	15/09/2021 13:49:00

Thyroid function tests					
Description	**Value**	**Range**	**Unit**	**Normalcy**	**Notes**
TSH	**6.3**	**0.2 - 4.5**	**mU/L**	**A**	
Free T4	13	9 21	pmol/L		

Sample Comments

KRUPEJ 21130

Requestor Comments

HTN.....

Liver function tests					
Description	**Value**	**Range**	**Unit**	**Normalcy**	**Notes**
Bilirubin	15	3 - 21	umol/L		
ALT	**78**	**10 - 50**	**U/L**	**R**	
Alk.Phos	**141**	**40 - 125**	**U/L**	**R**	
GGT	**51**	**5 - 35**	**U/L**	**R**	

Sample Comments

KRUPEJ 21130

Requestor Comments

HTN.....

Urea and electrolytes					
Description	**Value**	**Range**	**Unit**	**Normalcy**	**Notes**
Urea	2.6	2.5 6.6	mmol/L		
Creatinine	74	50 98	umol/L		
Sodium	140	135 145	mmol/L		
Potassium	3.7	3.6 5.0	mmol/L		
TCO2	27	22 30	mmol/L		
eGFR (/1.73m2)	>60.0		ml/min		

Sample Comments

KRUPEJ 21130

Requestor Comments

HTN.....

Serum C reactive protein level					
Description	**Value**	**Range**	**Unit**	**Normalcy**	**Notes**
C-Reactive Prot	**10**	**0 - 5**	**mg/L**	**R**	

Sample Comments

KRUPEJ 21130

Requestor Comments

HTN.....

Blood haematinic levels					
Description	**Value**	**Range**	**Unit**	**Normalcy**	**Notes**
Ferritin	66	15 200	ug/L		

Sample Comments

KRUPEJ 21130

Requestor Comments

HTN.....

Serum lipids					
Description	**Value**	**Range**	**Unit**	**Normalcy**	**Notes**
Cholesterol	**7.7**		**mmol/L**	**A**	
HDL Chol.	1.1	1.1 - 1.7	mmol/L		
Chol:HDLC Ratio	**7.2**			**A**	
LDL Chol.	**5.8**		**mmol/L**	**A**	

Triglyceride	1.8	0.8 - 2.1	mmol/L

Sample Comments

KRUPEJ 21130

Requestor Comments

HTN.....

Report Information

Requestor	given, Not
Requesting Location	(RIEAE3) 3 - Exam, A&E
Report Identifier	HB096790E
Sample Date	15/09/2021 12:14:00

Serum Protein EPH / IGs					
Description	**Value**	**Range**	**Unit**	**Normalcy**	**Notes**
Prot E'phoresis	COMMENT				(BPEPH)
IgA	2.17	0.8 4.5	g/L		
IgG	11.42	6 15	g/L		
IgM	1.59	0.35 2.9	g/L		

Test Comments

(BPEPH)	Lithium heparin sample is unsuitable for serum protein
(BPEPH)	electrophoresis. Send serum gel tube if electrophoresis
(BPEPH)	is required to exclude the presence of a paraprotein.

Requestor Comments

Hypertension

Serum total protein					
Description	**Value**	**Range**	**Unit**	**Normalcy**	**Notes**
Total Protein	79	60 - 80	g/L		

Requestor Comments

Hypertension

Report Information

Requestor	given, Not
Requesting Location	(RIEAE3) 3 - Exam, A&E
Report Identifier	QB172316G
Sample Date	15/09/2021 12:14:00

Full blood count - FBC				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Haemoglobin	153	115 165	g/L	
Red cell count	5.49	3.8 5.8	10^12/L	
Haematocrit	0.432	0.36 0.47	ratio	
Mean cell volume	79	78 98	fL	
Mean Cell Hb	27.9	27.0 32.0	pg	
White cell count	7.0	4.0 11.0	10^9/L	
Neutrophil Count	4.44	2.0 7.5	10^9/L	
Lymphocyte Count	1.65	1.5 4.5	10^9/L	
Monocyte Count	0.68	0.2 0.8	10^9/L	
Eosinophil Count	0.20	0.04 0.4	10^9/L	
Basophil Count	0.06	0.01 0.1	10^9/L	
Platelet count	340	150 400	10^9/L	
Mean cell Hb conc.	354	310 360	g/L	

Sample Comments

KRUPEJ 1731

Requestor Comments

HTN.....

Report Information

Requestor	given, Not
Requesting Location	(RIEAE3) 3 Exam, A&E
Report Identifier	HR197224C
Sample Date	15/09/2021 12:13:00

Plasma glucose level				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Glucose	**7.7**		**mmol/L**	**A**

Sample Comments

KRUPEJ 1731

Requestor Comments

HTN.....

Plasma lactate level				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Lactate	1.2	0.6 - 2.4	mmol/L	

Sample Comments

KRUPEJ 1731

Requestor Comments

HTN.....

Report Information

Requestor	given, Not
Requesting Location	(RIEAE3) 3 - Exam, A&E
Report Identifier	HB096794A
Sample Date	15/09/2021 12:13:00

Coagulation/bleeding test					
Description	**Value**	**Range**	**Unit**	**Normalcy**	**Notes**
Prothrombin Time	11.0	10.5 13.5	sec		
INR (Warfarin)	1.0		ratio		
APTT	26	26 36	sec		
APTT Ratio	0.9		ratio		
Fibrinogen (Clauss)	4.0	1.5 4.0	g/L		

Sample Comments

KRUPEJ 1731

Requestor Comments

HTN.....

Report Information

Requestor	given, Not
Requesting Location	(RIEAE3) 3 Exam, A&E
Report Identifier	HR197222A
Sample Date	15/09/2021 12:13:00

Full blood count - FBC

Description	Value	Range	Unit	Normalcy	Notes
Haemoglobin	149	115 165	g/L		
Red cell count	5.29	3.8 5.8	10^12/L		
Haematocrit	0.419	0.36 0.47	ratio		
Mean cell volume	79	78 98	fL		
Mean Cell Hb	28.2	27.0 32.0	pg		
White cell count	5.7	4.0 11.0	10^9/L		
Neutrophil Count	3.11	2.0 7.5	10^9/L		
Lymphocyte Count	1.68	1.5 4.5	10^9/L		
Monocyte Count	0.63	0.2 0.8	10^9/L		
Eosinophil Count	0.24	0.04 0.4	10^9/L		
Basophil Count	0.05	0.01 0.1	10^9/L		
Platelet count	313	150 400	10^9/L		
Mean cell Hb conc.	356	310 360	g/L		

Report Information

Requestor	Keane, Dr Sonia
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	HR340193M
Sample Date	15/09/2021 11:14:00

Thyroid function tests

Description	Value	Range	Unit	Normalcy	Notes
TSH	**7.6**	**0.2 - 4.5**	**mU/L**	**A**	
Free T4	12	9 21	pmol/L		

Requestor Comments

`Query Hypothyroid`

Liver function tests

Description	Value	Range	Unit	Normalcy	Notes
Bilirubin	16	3 - 21	umol/L		
ALT	**78**	**10 - 50**	**U/L**	**R**	
Alk.Phos	**138**	**40 - 125**	**U/L**	**R**	
GGT	**52**	**5 - 35**	**U/L**	**R**	

Requestor Comments

`Query Hypothyroid`

Serum lipids

Description	Value	Range	Unit	Normalcy	Notes
Cholesterol	**7.8**		**mmol/L**	**A**	

Requestor Comments

`Query Hypothyroid`

Urea and electrolytes

Description	Value	Range	Unit	Normalcy	Notes
Creatinine	72	50 - 98	umol/L		
Sodium	141	135 - 145	mmol/L		
Potassium	4.0	3.6 - 5.0	mmol/L		
eGFR (/1.73m2)	>60.0		ml/min		

Requestor Comments

`Query Hypothyroid`

Report Information

Requestor	Keane, Dr Sonia
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	HB957333B
Sample Date	15/09/2021 11:14:00

HbA1c level

Description	Value	Range	Unit	Normalcy	Notes
HbA1c (IFCC)	**51**	**20 - 41**	**mmol/mol**	**R**	(BHBAIF)

Test Comments

(BHBAIF) HbA1c result is in the Diabetes range.

Requestor Comments

HbA1c for diagnosis

Report Information

Requestor	Keane, Dr Sonia
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	HB957460N
Sample Date	15/09/2021 11:14:00

SARS-CoV-2

Status: Final - Results stored and verified

SARS CoV 2 Positive	Positive by PCR	(4J3R100)

Test Comments

(4J3R100) Sample taken at RTS Edinburgh Airport. Sample analysed in the National Lighthouse Laboratory (Glasgow)

Report Information

Requestor	Unknown
Requesting Location	Newbattle Medical Practice
Report Identifier	AAH07996519
Sample Date	26/06/2021 09:09:00

SARS-CoV-2

Status: Final - Results stored and verified

SARS CoV 2 Negative	Negative by PCR	(4J3R200)

Test Comments

(4J3R200) Sample taken at RTS Edinburgh Airport. Sample analysed in the National Lighthouse Laboratory (Glasgow)

Report Information

Requestor	Unknown
Requesting Location	Newbattle Medical Practice
Report Identifier	AAD48621054
Sample Date	07/12/2020 14:30:00

Urine culture RIE

Set Comments

```
Urine culture
  No growth
Urine samples for culture and sensitivity testing
should be sent using red topped boric acid universal
containers filled to the fill line.  The use of boric
acid improves the quality of test results and reduces
the number of false positives.  If the sample is less
than 15ml continue to use a white topped universal.
Samples should be refrigerated if there is an
anticipated delay in transport.
```

Requestor Comments

uti.....

Report Information

Requestor	Fulton, Dr JF
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	MU293617B
Sample Date	28/11/2019 16:35:00

Urea and electrolytes

Description	Value	Range	Unit	Normalcy	Notes
Creatinine	79	50 98	umol/L		
Sodium	138	135 145	mmol/L		
Potassium	4.3	3.6 5	mmol/L		
eGFR (/1.73m2)	>60.0		ml/min		

Requestor Comments

repeat bloods.

Report Information

Requestor	Glencross, Dr AH
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	HB955187H
Sample Date	24/08/2018 11:08:00

Thyroid function tests				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
TSH	**7.9**	**0.2 - 4.5**	**mU/L**	**A**
Free T4	10	9 21	pmol/L	

Requestor Comments

Patient is not known to have a thyroid condition.
Hypertension, low mood, weight gain.

Liver function tests				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Bilirubin	10	3 - 21	umol/L	
ALT	27	10 - 50	U/L	
Alk.Phos	104	40 - 125	U/L	
GGT	15	5 - 35	U/L	

Requestor Comments

Patient is not known to have a thyroid condition.
Hypertension, low mood, weight gain.

Serum lipids				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Cholesterol	**7.1**		**mmol/L**	**A**

Requestor Comments

Patient is not known to have a thyroid condition.
Hypertension, low mood, weight gain.

Urea and electrolytes				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Creatinine	72	50 - 98	umol/L	
Sodium	137	135 - 145	mmol/L	
Potassium	4.0	3.6 - 5	mmol/L	
eGFR (/1.73m2)	>60			

Requestor Comments

Patient is not known to have a thyroid condition.
Hypertension, low mood, weight gain.

Report Information

Requestor	2), Dr Alexander Fullbrook (FY
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	HB932897G
Sample Date	30/07/2018 14:38:00

Plasma glucose level					
Description	**Value**	**Range**	**Unit**	**Normalcy**	**Notes**
Glucose (Random)	7.1	3.8 7.7	mmol/L		

Requestor Comments

Hypertension.

Report Information

Requestor	2), Dr Alexander Fullbrook (FY
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	HB932911S
Sample Date	30/07/2018 14:21:00

Full blood count - FBC				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Haemoglobin	153	115 160	g/L	
Red cell count	5.32	3.8 5.8	10^12/L	
Haematocrit	0.419	0.37 0.47	ratio	
Mean cell volume	79	78 98	fL	
Mean Cell Hb	28.8	27.0 32.0	pg	
White cell count	5.8	4.0 11.0	10^9/L	
Neutrophil Count	3.20	2.0 7.5	10^9/L	
Lymphocyte Count	1.65	1.5 4.0	10^9/L	
Monocyte Count	0.67	0.2 0.8	10^9/L	
Eosinophil Count	0.19	0.04 0.4	10^9/L	
Basophil Count	0.04	0.01 0.1	10^9/L	
Platelet count	273	150 400	10^9/L	
Mean cell Hb conc.	**365**	**310 - 360**	**g/L**	**R**

Requestor Comments

Hypertension.

Report Information

Requestor	2), Dr Alexander Fullbrook (FY
Requesting Location	(GSNEWBA) Newbattle Medical Group
Report Identifier	HR212224M
Sample Date	30/07/2018 14:21:00

Report

Clinical Summary

Biliary colic.
Provisional diagnosis: gallstones.

Specimen

Gallbladder.

Macroscopy

This is an open gallbladder measuring 70 x 15 x 30 mm. A 8 mm defect overlies the body. The serosal surface is smooth and shiny. Gallstones are present within the lumen. The mucosal surface is brown and velvety and wall measures 2 mm thick.

Blocks taken: (A) resection margin, body and fundus.

Specimen trimmed by: Dr C Dhaliwal.

Microscopy

Sections of the gallbladder wall show mild smooth muscle hypertrophy and fibrosis with a patchy chronic inflammatory infiltrate mainly in the lamina propria. The histological features are of cholelithiasis.

Gallbladder - Cholelithiasis

Test Comments

(RPT)	Pathologists :
(RPT)	GI Pathology Team
(RPT)	Dr Catharine A Dhaliwal

Sample Comments

Suffix Gall Bladder

Report Information

Requestor	Known, Cons Not
Requesting Location	(RIE106) Ward 106 RIE
Report Identifier	UB004856P/17
Sample Date	03/03/2017 09:07:00

Serum gentamicin level

Description	Value	Range	Unit	Normalcy	Notes
Gentamicin	2.7		mg/L		(BGEN)

Test Comments

(BGEN) For once daily dosing use the GGC NOMOGRAM
(BGEN) (sample 6 14 hours after dose). Adjust interval as
(BGEN) indicated on the nomogram.
(BGEN) Patients with a creatinine clearance of <21ml/minute
(BGEN) consider using an alternative drug, however, if
(BGEN) gentamicin is used NO further gentamicin can be given
(BGEN) until a trough of <1mg/L is obtained.
(BGEN) Using for synergy with a beta lactam (i.e. treatment of
(BGEN) streptococcal/enterococcal endocarditis with penicillin
(BGEN) and gentamicin) aim for a trough of < 1 mg/L and a
(BGEN) peak of between 3 and 5 mg/L.
(BGEN) Patients on other regimens refer to local protocols
(BGEN) for levels.

Sample Comments

21068..

Requestor Comments

Level...

Report Information

Requestor	Ravindran, Mr Rajan
Requesting Location	(RIE106) Ward 106 RIE
Report Identifier	HB337561T
Sample Date	02/03/2017 07:04:00

MRCP

MRCP

Clinical details

MRCP
3 weeks on and off RUQ pain, worsened last 24 hours, tender epigastric and RUQ, deranged lfts, US showed cholelithiasis and possible acute cholecystitis, possible parenchymal liver disease, Ms Azodo would like an MRCP to assess her please prior to considering lap cholecystectomy, ? CBD stones

Report

Several gallstones are seen within a thin-walled gallbladder. There is mild intra and extrahepatic biliary dilatation, the CBD measures up to 10 mm but appears to taper smoothly down to the ampullary level with no evidence of obstructing calculus. Conventional biliary tree anatomy. No pancreatic duct dilatation.

Well-defined high signal lesion within the right lobe of lesion liver measuring 2.3 cm which most likely represents a benign haemangioma, but should be confirmed on a targeted liver ultrasound as I note this was not identified previously. Normal spleen, pancreas, both adrenals and visualised kidneys. No upper abdominal free fluid.

Conclusion:

Gallbladder calculi and mild biliary dilatation but no evidence of obstructing calculus. A right lobe of liver lesion most likely represents a benign haemangioma, but a repeat targeted ultrasound is suggested for confirmation.

Reported by Dr Gillian Ritchie
Consultant Radiologist
Tel. 0131 2423764

Reporting Radiologist: Dr Gillian Ritchie

Report Information

Requestor	Shahim, Owen
Requesting Location	(RIE106) Ward 106 RIE
Report Identifier	26286983
Sample Date	01/03/2017 17:31:00

Liver function tests				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Bilirubin	10	3 21	umol/L	
ALT	**120**	**10 - 50**	**U/L**	**R**
Alk.Phos	112	40 125	U/L	
GGT	**104**	**5 - 35**	**U/L**	**R**

Sample Comments

. . . .

Requestor Comments

. . . .

Urea and electrolytes				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Urea	**2.3**	**2.5 - 6.6**	**mmol/L**	**R**
Creatinine	66	50 - 98	umol/L	
Sodium	140	135 - 145	mmol/L	
Potassium	4.0	3.6 - 5.0	mmol/L	
TCO2	30	22 - 30	mmol/L	
eGFR (/1.73m2)	>60			

Sample Comments

. . . .

Requestor Comments

. . . .

Serum C reactive protein level				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
C Reactive Prot	**7**	**0 - 5**	**mg/L**	**R**

Sample Comments

. . . .

Requestor Comments

. . . .

Report Information

Requestor	Ravindran, Mr Rajan
Requesting Location	(RIESOIP) Surgical Obs Inpatients
Report Identifier	HB336582R
Sample Date	01/03/2017 12:14:00

Full blood count - FBC

Description	Value	Range	Unit	Normalcy	Notes
Haemoglobin	133	115 160	g/L		
Red cell count	4.74	3.8 5.8	10^12/L		
Haematocrit	0.379	0.37 0.47	ratio		
Mean cell volume	80	78 98	fL		
Mean Cell Hb	28.1	27.0 32.0	pg		
White cell count	**3.7**	**4.0 - 11.0**	**10^9/L**	**R**	
Neutrophil Count	**1.63**	**2.0 - 7.5**	**10^9/L**	**R**	
Lymphocyte Count	**1.39**	**1.5 - 4.0**	**10^9/L**	**A**	
Monocyte Count	0.53	0.2 0.8	10^9/L		
Eosinophil Count	0.12	0.04 0.4	10^9/L		
Basophil Count	0.03	0.01 0.1	10^9/L		
Platelet count	249	150 400	10^9/L		
Mean cell Hb conc.	351	310 360	g/L		

Sample Comments

. . . .

Requestor Comments

. . . .

Report Information

Requestor	Ravindran, Mr Rajan
Requesting Location	(RIESOIP) Surgical Obs Inpatients
Report Identifier	HR284735E
Sample Date	01/03/2017 12:14:00

Serum amylase level				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Amylase	27	0 100	U/L	

Sample Comments

21327..

Requestor Comments

abdo pain

Liver function tests				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Bilirubin	**26**	**3 - 21**	**umol/L**	**R**
ALT	**178**	**10 - 50**	**U/L**	**R**
Alk.Phos	**128**	**40 - 125**	**U/L**	**R**
GGT	**128**	**5 - 35**	**U/L**	**R**

Sample Comments

21327..

Requestor Comments

abdo pain

Urea and electrolytes				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Urea	3.3	2.5 6.6	mmol/L	
Creatinine	69	50 98	umol/L	
Sodium	138	135 145	mmol/L	
Potassium	3.8	3.6 5.0	mmol/L	
TCO2	22	22 30	mmol/L	
eGFR (/1.73m2)	>60			

Sample Comments

21327..

Requestor Comments

abdo pain

Serum C reactive protein level				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
C-Reactive Prot	2	0 - 5	mg/L	

Sample Comments

21327..

Requestor Comments

abdo pain

Report Information

Requestor	Devlin, Dr Hilary
Requesting Location	(RIEAE3) 3 - Exam, A&E
Report Identifier	HB170731M
Sample Date	27/02/2017 19:47:00

Full blood count - FBC

Description	Value	Range	Unit	Normalcy	Notes
Haemoglobin	147	115 160	g/L		
Red cell count	5.28	3.8 5.8	10^12/L		
Haematocrit	0.407	0.37 0.47	ratio		
Mean cell volume	**77**	**78 - 98**	**fL**	**R**	
Mean Cell Hb	27.8	27.0 32.0	pg		
White cell count	5.4	4.0 11.0	10^9/L		
Neutrophil Count	3.19	2.0 7.5	10^9/L		
Lymphocyte Count	**1.40**	**1.5 - 4.0**	**10^9/L**	**A**	
Monocyte Count	0.72	0.2 0.8	10^9/L		
Eosinophil Count	0.06	0.04 0.4	10^9/L		
Basophil Count	0.06	0.01 0.1	10^9/L		
Platelet count	280	150 400	10^9/L		
Mean cell Hb conc.	**361**	**310 - 360**	**g/L**	**R**	

Sample Comments

21327..

Requestor Comments

abdo pain

Report Information

Requestor	Devlin, Dr Hilary
Requesting Location	(RIEAE3) 3 Exam, A&E
Report Identifier	HR124605G
Sample Date	27/02/2017 19:47:00

Microbiology test

Set Comments

```
Reference lab report


   PCR    :    Acanthamoeba spp.  DNA NOT detected by PCR
   ----------------
   Reported by:
   SPDRL, Scottish Microbiology Reference Laboratory, Glasgow.
```

Sample Comments

hall paep 61772

Requestor Comments

RIGHT CORNEAL SCRAPE ?Acanthamoeba keratitis

Report Information

Requestor	Devlin, Dr Hilary
Requesting Location	(PAEEOPD) Eye Outpatients Dept, PAEP
Report Identifier	MG367694X
Sample Date	15/01/2016 18:21:00

Culture and Sensitivities

Set Comments

Culture and Sensitivities
  Enterococcus faecalis 1 cfu
   Sensitive : Amoxicillin,Chloramphenicol,High level Gentamicin,Vancomycin.
  No Yeasts isolated
Please note that enterococci respond poorly to quinolones.
Result given to S/N Douglas.

Sample Comments

hall 61772

Requestor Comments

RIGHT CORNEAL SCRAPE: keratitis in contact lens wearer

Microscopy LTG

Set Comments

Microscopy
  No Organisms seen

Sample Comments

hall 61772

Requestor Comments

RIGHT CORNEAL SCRAPE: keratitis in contact lens wearer

Report Information

Requestor	Devlin, Dr Hilary
Requesting Location	(PAEEOPD) Eye Outpatients Dept, PAEP
Report Identifier	MG367644Y
Sample Date	15/01/2016 17:58:00

HSV ADE VZV ENT REAL TIME PCR	
HSV1 PCR:	Negative
HSV2 PCR:	Negative
Varicella Zoster virus PCR:	Negative
Adenovirus PCR:	Negative

Sample Comments

R Peden via switch

Requestor Comments

Red RE with central keratopathy ?disciform but CL wearer

Report Information

Requestor	Devlin, Dr Hilary
Requesting Location	(PAEEOPD) Eye Outpatients Dept, PAEP
Report Identifier	MI315802B
Sample Date	15/01/2016 16:56:00

Culture and Sensitivities

Set Comments

```
Culture and Sensitivities
  Please note delay in receipt of this sample

  No significant growth
```

Sample Comments

R Peden via switch

Requestor Comments

Red RE with central keratopathy ?disciform but CL wearer

Report Information

Requestor	Devlin, Dr Hilary
Requesting Location	(PAEEOPD) Eye Outpatients Dept, PAEP
Report Identifier	MG367917R
Sample Date	15/01/2016 16:56:00

Urea and electrolytes

Description	Value	Range	Unit	Normalcy	Notes
Urea	4.3	2.5 6.6	mmol/L		
Creatinine	69	60 120	umol/L		
Sodium	138	135 145	mmol/L		
Potassium	4.1	3.6 5	mmol/L		
eGFR (/1.73m2)	>60				

Report Information

Requestor	Currie, Dr Julie RM
Requesting Location	(GSSTRA) Strathesk Medical Practice
Report Identifier	HB964844E
Sample Date	27/09/2013 14:51:00

Liver function tests				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Bilirubin	8	3 21	umol/L	
ALT	16	10 50	U/L	
Alk.Phos	67	40 125	U/L	
GGT	23	5 35	U/L	

Requestor Comments

High blood pressure

Serum lipids				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Cholesterol	**5.9**		**mmol/L**	**A**
HDL Chol.	**1.0**	**1.1 - 1.7**	**mmol/L**	**R**
Chol:HDLC Ratio	5.8			
LDL Chol.	4.3		mmol/l	
Triglyceride	1.4	0.8 - 2.1	mmol/L	

Requestor Comments

High blood pressure

Urea and electrolytes				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Urea	4.4	2.5 6.6	mmol/L	
Creatinine	70	60 120	umol/L	
Sodium	137	135 145	mmol/L	
Potassium	4.3	3.6 5	mmol/L	
eGFR (/1.73m2)	>60			

Requestor Comments

High blood pressure

Report Information

Requestor	Dickson, Dr GC
Requesting Location	(GSSTRA) Strathesk Medical Practice
Report Identifier	HB701968R
Sample Date	30/07/2013 09:30:00

Plasma glucose level					
Description	**Value**	**Range**	**Unit**	**Normalcy**	**Notes**
Glucose spec.	Random sample (<11 mmol/L)				
Glucose	5.7		mmol/L		

Requestor Comments

High blood pressure

Report Information

Requestor	Dickson, Dr GC
Requesting Location	(GSSTRA) Strathesk Medical Practice
Report Identifier	HB701969X
Sample Date	30/07/2013 09:30:00

Full blood count - FBC

Description	Value	Range	Unit	Normalcy Notes
Haemoglobin	**111**	**115 - 160**	**g/l**	**R**
Red cell count	4.84	3.8 5.8	x10^12/l	
Haematocrit	**0.345**	**0.37 - 0.47**	**ratio**	**R**
Mean cell volume	**71**	**78 - 98**	**fl**	**R**
Mean cell Hb.	**22.9**	**27.0 - 32.0**	**pg**	**R**
Mean cell Hb conc.	32.2	31.0 36.0	g/dl	
White cell count	**3.5**	**4.0 - 11.0**	**x10^9/l**	**R**
Neutrophil Count	**1.81**	**2.0 - 7.5**	**x10^9/l**	**R**
Lymphocyte Count	**1.03**	**1.5 - 4.0**	**x10^9/l**	**R**
Monocyte Count	0.47	0.2 0.8	x10^9/l	
Eosinophil Count	0.11	0.04 0.4	x10^9/l	
Basophil Count	0.04	0.01 0.1	x10^9/l	
Platelet count	306	150 400	x10^9/l	

Set Comments

```
Rbc microcytic hypochromic+
Elliptocytes+
Neutropenia
```

Requestor Comments

```
High blood pressure
```

Report Information

Requestor	Dickson, Dr GC
Requesting Location	(GSSTRA) Strathesk Medical Practice
Report Identifier	HR920509Y
Sample Date	30/07/2013 09:30:00

Plasma glucose level					
Description	**Value**	**Range**	**Unit**	**Normalcy**	**Notes**
Glucose	4.9		mmol/L		
Glucose spec.	Random sample (<11 mmol/L)				

Requestor Comments

`keep well  pcvd`

Report Information

Requestor	Charge, Doctor In
Requesting Location	(HMPS) HMP Saughton
Report Identifier	HB627922B
Sample Date	16/04/2013 13:00:00

Serum lipids				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Cholesterol	**6.2**		**mmol/L**	**A**
HDL Chol.	1.2	1.1 1.7	mmol/L	
Chol:HDLC Ratio	5.1			
LDL Chol.	4.3		mmol/l	
Triglyceride	1.4	0.8 2.1	mmol/L	

Requestor Comments

```
keep well  pcvd
```

Report Information

Requestor	Charge, Doctor In
Requesting Location	(HMPS) HMP Saughton
Report Identifier	HB627921J
Sample Date	16/04/2013 13:00:00

Hel pylori IgG antibody level

Description	Value	Range	Unit	Normalcy	Notes
Helicobacter pylori E Value:	3.66				(ZHEG1E)

Test Comments

(ZHEG1E)	Helicobacter pylori IgG antibody :POSITIVE (EV >2.2)
(ZHEG1E)	
(ZHEG1E)	Positive serology results indicate past and/or current
(ZHEG1E)	Helicobacter infection. If patients have persistent
(ZHEG1E)	symptoms after eradication therapy consider need for a
(ZHEG1E)	breath test.
(ZHEG1E)	Further advice on management of patients can be found
(ZHEG1E)	in the Lothian Referral Guidelines for Dyspepsia.
(ZHEG1E)	

Report Information

Requestor	Best, Dr Steven R
Requesting Location	(GSINC) Inchpark Surgery
Report Identifier	MS040116Z
Sample Date	23/03/2011 16:34:00

Full blood count - FBC

Description	Value	Range	Unit	Normalcy	Notes
Haemoglobin	**100**	**115 - 165**	**g/l**	**R**	
Red cell count	4.20	3.8 5.8	x10^12/l		
Haematocrit	**0.328**	**0.370 - 0.470**	**ratio**	**R**	
Mean cell volume	78	78 98	fl		
Mean cell Hb.	**23.8**	**27.0 - 32.0**	**pg**	**R**	
Mean cell Hb conc.	**30.5**	**31.0 - 35.0**	**g/dl**	**R**	
White cell count	4.4	4.0 11.0	x10^9/l		
Neutrophil Count	2.46	2.0 7.5	x10^9/l		
Lymphocyte Count	**1.19**	**1.5 - 4.0**	**x10^9/l**	**R**	
Monocyte Count	0.58	0.2 0.8	x10^9/l		
Eosinophil Count	0.14	0.04 0.4	x10^9/l		
Basophil Count	0.03	0.01 0.1	x10^9/l		
Platelet count	**355**	**150 - 350**	**x10^9/l**	**R**	

Set Comments

Rbc hypochromic+

Elliptocytes+

Report Information

Requestor	Best, Dr Steven R
Requesting Location	(GSINC) Inchpark Surgery
Report Identifier	HR654651G
Sample Date	23/03/2011 10:50:00

Liver function tests

Description	Value	Range	Unit	Normalcy	Notes
Bilirubin	6	3 16	umol/L		
ALT	**133**	**10 - 50**	**U/L**	**R**	
Alk.Phos	72	40 125	U/L		
GGT	33	5 35	U/L		

Urea and electrolytes

Description	Value	Range	Unit	Normalcy	Notes
Urea	4.9	2.5 - 6.6	mmol/L		
Creatinine	70	60 - 120	umol/L		
eGFR (/1.73m2)	>60				
Sodium	140	135 - 145	mmol/L		
Potassium	4.5	3.6 - 5.0	mmol/L		

Blood haematinic levels

Description	Value	Range	Unit	Normalcy	Notes
Ferritin	**5**	**14 - 150**	**ug/L**	**R**	

Report Information

Requestor	Best, Dr Steven R
Requesting Location	(GSINC) Inchpark Surgery
Report Identifier	HB935250Y
Sample Date	23/03/2011 10:50:00

ESC Sendaway Tests		
Coeliac screen	Send away test	WGH Biochemistry

Requestor Comments

None given

Liver function tests

Description	Value	Range	Unit	Normalcy	Notes
Bilirubin	4	3 - 16	umol/L		
ALT	15	10 - 50	U/L		
Alk.Phos	63	40 - 125	U/L		
GGT	9	5 - 35	U/L		
Albumin	40	35 - 50	g/L		

Requestor Comments

None given

Urea and electrolytes

Description	Value	Range	Unit	Normalcy	Notes
Urea	3.2	2.5 6.6	mmol/L		
Creatinine	64	60 120	umol/L		
eGFR (/1.73m2)	>60				
Sodium	137	135 145	mmol/L		
Potassium	4.3	3.6 5.0	mmol/L		

Requestor Comments

None given

Report Information

Requestor	Cogliano, Dr Young mi Sofia
Requesting Location	(GSINC) Inchpark Surgery
Report Identifier	HB716651T
Sample Date	21/06/2010 13:40:00

Plasma glucose level					
Description	**Value**	**Range**	**Unit**	**Normalcy**	**Notes**
Glucose	5.8		mmol/L		
Glucose spec.	Random sample (<11 mmol/L)				

Requestor Comments

None given

Report Information

Requestor	Cogliano, Dr Young mi Sofia
Requesting Location	(GSINC) Inchpark Surgery
Report Identifier	HB716652M
Sample Date	21/06/2010 13:40:00

WGH GI Lab LTG				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Anti tTG IgA	1.2	0.1 7.9	AU	

Report Information

Requestor	Cogliano, Dr Young mi Sofia
Requesting Location	(GSINC) Inchpark Surgery
Report Identifier	QC154812Y
Sample Date	21/06/2010 13:40:00

U. HCG / Pregnancy test	
U. Pregnancy Test	Negative

Requestor Comments

No clinical details on request form

Report Information

Requestor	Cogliano, Dr Young mi Sofia
Requesting Location	(GSINC) Inchpark Surgery
Report Identifier	RM424051B
Sample Date	17/06/2010 09:37:00

Full blood count - FBC

Description	Value	Range	Unit	Normalcy	Notes
Haemoglobin	139	115 160	g/L		
Red cell count	4.96	3.8 5.8	10^12/L		
Haematocrit	0.406	0.36 0.46	Ratio		
Mean cell volume	81.9	78 96	fl		
Mean cell Hb.	28.0	27.0 32.0	pg		
Mean cell Hb conc.	34.2	28.0 35.0	g/dl		
White cell count	8.4	4.0 11.0	x10^9/l		
Neutrophil Count	6.80	1.8 7.5	x10 ^9/L		
Lymphocyte Count	**1.00**	**1.2 - 4.0**	**x10 ^9/L**	**R**	
Monocyte Count	0.60	0 0.8	x10 ^9/L		
Eosinophil Count	0.00	0 0.5	x10 ^9/L		
Basophil Count	0.00	0 0.1	x10 ^9/L		
Platelet count	303	150 400	x10^9/l		

Sample Comments

whitaker 548

Report Information

Requestor	Bahia, Mr Hilal Isam
Requesting Location	(SJH18) Ward 18, St John's Hospital
Report Identifier	SH016510T
Sample Date	11/05/2008 13:07:00

Urea and electrolytes					
Description	**Value**	**Range**	**Unit**	**Normalcy**	**Notes**
Urea	3.0	2.5 6.6	mmol/L		
Creatinine	78	60 120	umol/L		
Sodium	137	135 145	mmol/L		
Potassium	3.8	3.6 5.0	mmol/L		
TCO2	23	22 30	mmol/L		
Chloride	104	95 107	mmol/L		
eGFR (/1.73m2)	>60				

Sample Comments

whitaker 548

Report Information

Requestor	Bahia, Mr Hilal Isam
Requesting Location	(SJH18) Ward 18, St John's Hospital
Report Identifier	SB255405W
Sample Date	11/05/2008 13:07:00

Viral studies		
Specimen stored.	Specimen stored	(ZSTO)

Test Comments

(ZSTO) Stored as requested

(ZSTO)

Sample Comments

DR SKINNER

Report Information

Requestor	Known, Cons Not
Requesting Location	(RIEAE) RIE Accident & Emergency
Report Identifier	MS678845F
Sample Date	11/05/2008 09:15:00

Plasma glucose level					
Description	**Value**	**Range**	**Unit**	**Normalcy**	**Notes**
Glucose	4.9		mmol/L		
Glucose spec.	Fasting sample (<7 mmol/L)				

Report Information

Requestor	Murray, Dr SD
Requesting Location	(GSINC) Inchpark Surgery
Report Identifier	HB611266P
Sample Date	02/03/2007 09:00:00

Micro, culture & sensitivities

Set Comments

Micro Culture & Sensitivities
Large numbers of Pseudomonas aeruginosa isolated
This may be colonisation rather than infection
Isolate(s) will be held for 7 days
Please consult microbiologist if advice is required

Large numbers of Staphylococcus aureus isolated
Resistant : Erythromycin,Penicillin.
Sensitive : Flucloxacillin.

Report Information

Requestor	Murray, Dr SD
Requesting Location	(GSINC) Inchpark Surgery
Report Identifier	MG733478G
Sample Date	27/02/2007 09:30:00

Micro, culture & sensitivities

Set Comments

Micro Culture & Sensitivities
Large numbers of Coliform organism isolated
This may be colonisation rather than infection
Isolate(s) will be held for 7 days

Large numbers of Staphylococcus aureus isolated
(NOTE: Repeat isolate)
See previous report for antibiotic sensitivity results
Sensitive : Flucloxacillin.

Report Information

Requestor	Murray, Dr SD
Requesting Location	(GSINC) Inchpark Surgery
Report Identifier	MG706343L
Sample Date	21/09/2006 12:00:00

Micro, culture & sensitivities

Set Comments

Micro Culture & Sensitivities
Large numbers of Staphylococcus aureus isolated
Resistant : Erythromycin,Penicillin.
Sensitive : Flucloxacillin.

Sample Comments

FOLLOWING BREAST RED.

Report Information

Requestor	Murray, Dr SD
Requesting Location	(GSINC) Inchpark Surgery
Report Identifier	MG703496F
Sample Date	06/09/2006 12:30:00

Swab/pus/fluid culture	
Swab/pus/fluid culture	1) A growth of Anaerobic cocci

Requestor Comments

POST BBR

Swab/pus/fluid sens

	1
Metronidazole	S
Co-amoxyclav	S

Requestor Comments

POST BBR

Report Information

Requestor	MCGREGOR, J.C.
Requesting Location	(PDC) Sister McPhee OPD 2
Report Identifier	M059491/06
Sample Date	25/08/2006 00:00:00

Blood Count				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
$$Hb	**113**	**115 - 165**	**g/l**	**LO**
$$RBC	3.97	3.80 5.80	x 1012/l	
Hct	**0.333**	**0.370 - 0.470**		**LO**
$$MCV	84	80 99	fl	
$$MCH	28.3	27.0 32.0	pg	
$$WBC	6.2	4.0 11.0	x 109/l	
$$Neutrophils	4.0	2.0 7.5	x 109/l	
Lymphocytes	**1.4**	**1.5 - 4.0**	**x 109/l**	**LO**
Monocytes	0.7	0.2 0.8	x 109/l	
Eosinophils	0.0	0.0 0.4	x 109/l	
Basophils	0.0	0.0 0.1	x 109/l	
$$Platelets	251	150 450	x 109/l	
BLNK				
$$HM				

Requestor Comments

POST OP - BILATERAL BREAST REDUCTION

Report Information

Requestor	MCGREGOR, J.C.
Requesting Location	(18) Ward 18 St John's
Report Identifier	H0926742
Sample Date	20/08/2006 08:30:00

Report

Macro Report

1. R breast tissue. Skin and fibro-fatty tissue weight 673g. No suspicious areas are seen on cut surface.

2. L breast tissue. Skin and fibro-fatty tissue weight 551g. No suspicious areas are seen on cut surface.

Micro Report

1 & 2. Representative histology of breast tissue shows no remarkable features.

Summary

Reduction Mammoplasty

Dr R Davie/JY

Sample Comments

With Sample Type : BREAST REDUCTION

Requestor Comments

L BREAST REDUCTION

R BREAST REDUCTION

Report Information

Requestor	Robertson, Dr C E
Requesting Location	(18) Ward 18 St John's
Report Identifier	JB05991/06
Sample Date	18/08/2006 00:00:00

Micro, culture & sensitivities

Set Comments

Micro Culture & Sensitivities

B-haemolytic streptococci of groups A,C and G NOT isolated

Report Information

Requestor	Cogliano, Dr Young mi Sofia
Requesting Location	(GSINC) Inchpark Surgery
Report Identifier	MG635860B
Sample Date	29/08/2005 16:29:00

Full blood count - FBC				
Description	**Value**	**Range**	**Unit**	**Normalcy Notes**
Basophil Count	0.02	0.01 0.1	x10^9/l	
Eosinophil Count	0.13	0.04 0.4	x10^9/l	
Haemoglobin	**112**	**115 - 165**	**g/l**	**R**
Haematocrit	**0.340**	**0.370 - 0.470**	**ratio**	**R**
Lymphocyte Count	**0.97**	**1.5 - 4.0**	**x10^9/l**	**R**
Mean cell Hb.	**26.9**	**27.0 - 32.0**	**pg**	**R**
Mean cell Hb conc.	32.9	31.0 35.0	g/dl	
Mean cell volume	82	78 98	fl	
Monocyte Count	0.71	0.2 0.8	x10^9/l	
Neutrophil Count	3.82	2.0 7.5	x10^9/l	
Platelet count	283	150 350	x10^9/l	
Red cell count	4.17	3.8 5.8	x10^12/l	
White cell count	5.7	4.0 11.0	x10^9/l	

Requestor Comments

`No clinical details on request form`

Report Information

Requestor	Mitchell, Dr Roy
Requesting Location	(RIEAE) RIE Accident & Emergency
Report Identifier	HR009514E
Sample Date	02/05/2005 04:50:00

Urea and electrolytes					
Description	**Value**	**Range**	**Unit**	**Normalcy**	**Notes**
TCO2	25	22 30	mmol/L		
Creatinine	81	60 120	umol/L		
Potassium	3.9	3.6 5.0	mmol/L		
Sodium	137	135 145	mmol/L		
Urea	2.6	2.5 6.6	mmol/L		

Report Information

Requestor	Mitchell, Dr Roy
Requesting Location	(RIEAE) RIE Accident & Emergency
Report Identifier	HB124715P
Sample Date	02/05/2005 04:50:00

Unspecified					
Description	**Value**	**Range**	**Unit**	**Normalcy**	**Notes**
TSH	2.66	0.15 3.5	mU/L	N	
Free T4	11	8 27	pmol/L	N	

Report Information

Requestor	Murray, Dr SD
Requesting Location	(GSINC) Inchpark Surgery
Report Identifier	HB348949A
Sample Date	14/06/2004 13:15:00

Unspecified

Description	Value	Range	Unit	Normalcy	Notes
Haemoglobin	122	115 165	g/l	N	
Red cell count	4.65	3.8 5.8	x10^12/l	N	
Haematocrit	0.369		ratio		
Mean cell volume	79	78 98	fl	N	
Mean cell Hb.	**26.2**	**27.0 - 32.0**	**pg**	**A**	(HMCH)
Mean cell Hb conc.	33.1	31.0 35.0	g/dl	N	
White cell count	4.2	4.0 11.0	x10^9/l	N	
Neutrophil Count	2.16	2 7.5	x10^9/l	N	
Lymphocyte Count	**1.23**	**1.5 - 4.0**	**x10^9/l**	**A**	(HLYMP)
Monocyte Count	0.60	0.2 0.8	x10^9/l	N	
Eosinophil Count	0.14	0.04 0.4	x10^9/l	N	
Basophil Count	0.04	0.01 0.1	x10^9/l	N	
Platelet count	279	150 350	x10^9/l	N	

Test Comments

(HMCH)	Failed Reference Ranges
(HLYMP)	Failed Reference Ranges

Report Information

Requestor	Fraser, Dr DRK
Requesting Location	(GSINC) Inchpark Surgery
Report Identifier	HR295397R
Sample Date	25/05/2004 13:40:00

Unspecified

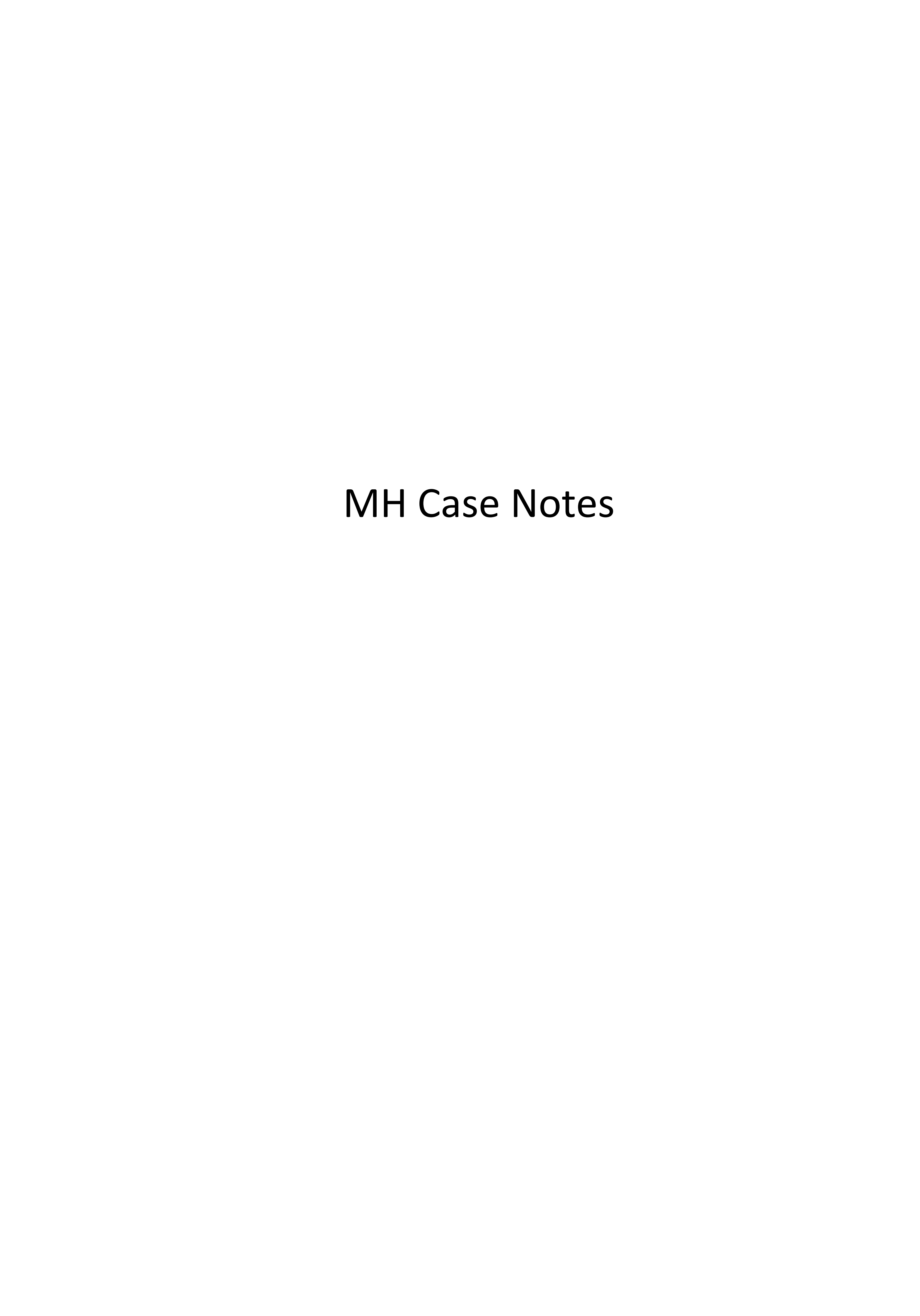
Description	Value	Range	Unit	Normalcy	Notes
Urea	5.7	2.5 6.6	mmol/L	N	
Creatinine	90	60 120	umol/L	N	
Sodium	138	135 145	mmol/L	N	
Potassium	4.3	3.6 5.0	mmol/L	N	
TCO2	23	22 30	mmol/L	N	
Bilirubin	6	3 16	umol/L	N	
ALT	19	10 50	U/L	N	
Alk.Phos	55	40 125	U/L	N	
GGT	13	5 35	U/L	N	
Albumin	40	35 50	g/L	N	
TSH	**4.16**	**0.15 - 3.5**	**mU/L**	**A**	(BTSH)
Free T4	13	8 27	pmol/L	N	

Test Comments

(BTSH) Failed Reference Ranges

Report Information

Requestor	Fraser, Dr DRK
Requesting Location	(GSINC) Inchpark Surgery
Report Identifier	HB334875Z
Sample Date	25/05/2004 13:40:00


MH Case Notes

SG/syt

6 January 199[illegible]

Dr. S.D. Murray
Inchpark Surgery
10 Marmion Crescent
Edinburgh EH16

Dear Dr. Murray

re: Angela Cross - d.o.b. 22.5.67 - 9 Fairford Gardens, Edinburgh

Miss Cross has been referred to our services for assessment by Heather Duff, Community Charge Nurse. If you have any objections to my involvement, please let me know. If I do not hear from you within 14 days, I will offer Miss Cross an appointment and forward a copy of my report in due course.

Yours sincerely

Sandra Guinea
Consultant Clinical Psychologist

SG/syt
Ref: 95183

27 January 1998

Miss A Cross
9 Fairford Gardens
Edinburgh

Dear Angela

Your community nurse, Heather Duff, has asked me to carry out an assessment with you. I would like to meet you to talk about this, and I will visit you at home on Monday 2nd February at 2.30 p.m. If this does not suit you, please telephone 0131-537-8019 and I will make a more convenient date and time for you.

Yours sincerely

SG

Sandra Guinea
Consultant Clinical Psychologist

CLINICAL PSYCHOLOGY REPORT SHEET

UNIT No. [redacted]

NAME

ANGELA CROSS

PSYCHOLOGIST IN CHARGE : SANDRA GUINEA . PSYCHOLOGIST:

2nd February '98

H/V

Angela not in - spoke to [redacted] - not sure when his mum would be back - after 3pm? Unable to wait - will send out another appt.

SG.

LHB 1481

CLINICAL PSYCHOLOGY REPORT SHEET

UNIT No.

NAME

PSYCHOLOGIST IN CHARGE :

PSYCHOLOGIST:

26th Feb.

H/V Angie, [redacted]

[redacted] (partner).

Broke down, depressed, don't like antidepressants (Prozac) – makes me tired, can't remember the day, forget what people say to me, mood swings

Hard done by - in care all my life - mum violent - Court Order. adopted

Support - Student SW

Heather for [redacted]

Susan J for [redacted]

Share the Care for [redacted]

No family here - mum in Inverness

Would've liked a mother-daughter relationship

D/k what hospital I was born in, what weight I was

Son doesn't understand why real Grannie doesn't visit

Why was I dumped?

Violent relationships with men -

David's dad broke my jaw - put me in hospital

Move house to get away

Duddingston home - Inverness home - Niddrie

Left all my friends in Niddrie - no-one knows I'm here

Only been here 5 months – D/K anyone.

[redacted] - Liberton primary
- Portobello High

Mornings chaotic – [redacted] won't eat, has to be dressed

Sorry that [redacted] has to take on so much responsibility

Boys had to be put into care. When I was in hospital

[redacted] sees a ψtrist in Sick kids – I get annoyed with her – wants to talk about my past all the time – don't want to – violence all my life – s'times I think it's my fault – SWs have kept things from me.

Own mum had drug problems – dad in the army ([redacted]) – in Saughton when he signed my birth certificate – he came from Leith – that's all I know.

When I had [redacted] - asking Qs about family background – didn't know – blank space. made me feel stupid

S'times I feel I'm going to turn out like my mum – don't want to feel sorry for myself. go on downers – don't want to eat think s'one's had it in for me.

Don't like asking for help.

Only family I've ever had is SW. – sad eh?

Portobello High – wasn't good at school – used to skive off.

Pregnant with [redacted] at 17.

Worked at Craigmillar festival – felt good

Cleaning jobs.

Parenting group at Greendykes – didn't find it helpful

CLINICAL PSYCHOLOGY REPORT SHEET

UNIT No.

NAME

PSYCHOLOGIST IN CHARGE :

PSYCHOLOGIST:

felt good that [redacted] needed me - I was the only one who could help her

- N's dad died 2 months ago - drug abuse - only 25.

LHB 1481

SG/syt
Ref: 95183

3 February 1998

Ms. A. Cross
9 Fairford Gardens
Edinburgh

Dear Angela

I am sorry you were not in when I came to your house on Monday. I would like to visit you on Friday 20th February at 9.30.a.m. If this is not suitable, please telephone my Secretary on 537-8019 and we can arrange a more convenient date and time.

Yours sincerely

SG

Sandra Guinea
Consultant Clinical Psychologist

SG/syt
Ref: 95183

24 February 1998

Ms Heather Duff
Community Charge Nurse
Bonnington Resource Centre
200 Bonnington Road
Edinburgh, EH6 5NL

Dear Heather

re: Angela Cross - d.o.b. 22.5.67 - 9 Fairford Gardens

Thank you for referring Angela, whom I met at home on Friday 20th February.

Angela presented as a very pleasant lady, and appeared happy to talk to me. Her daughter, [redacted], was also at home, and interactions between them were very warm and appropriate.

Angela gave a very full, if somewhat disjointed, account of her background. This was dominated by her very ambivalent feelings towards her mother, and her sadness at having missed out on a mother-daughter relationship. She was quite insightful at times, saying that when she felt 'down' she would blame herself for her past, but knew that she was a victim. She said she was determined to do the best for her family, but was worried that she may turn out like her mother.

Regarding support from our services, I am sure that Angela would benefit from participation in the Parenting Skills Course. My only caveat is that because she has attended parenting classes before, she may lose motivation or, alternatively, take over the class. However, what she would definitely benefit from is individually tailored home support.

As a first step, we need to establish Angela's level of cognitive functioning, and whether she indeed has a learning disability. I have therefore asked Anne Docherty, Assistant Psychologist to arrange an assessment. I have discussed this with Angela, and she knows to expect Anne's call. I will let you know the results in due course.

Best wishes

Yours sincerely

SG

Sandra Guinea
Consultant Clinical Psychologist

cc: Dr. Murray,. Inchpark Surgery, 10 Marmion Crescent, Edinburgh EH16

18 March 1998

Dr Murray
The Inch Medical Practice
Marmion Crescent
Edinburgh

Dear Dr Murray

Re: Angela Cross, 9 Fairford Gardens, Edinburgh

As you are aware, I am currently working with Angie in relation to her son ███ Susan Jackson my colleague gives support to Angie in relation to ███

I am currently involving Angie in a parenting support group run by myself and my colleague Bernie Harling. Angie is very keen to come along and participate, as a result, I have taken Angie on as a client in the short term. I have made a referral to Sandra Guinea, Psychologist for cognitive assessment as well as to ascertain whether she has a learning disability or not.

The parenting group is a specific interest area of mine and I have always kept Angie in mind for the group as long as she was in a positive frame of mind to accept coming along. As a result, although I work in NE Edinburgh, I will continue to offer support to this family rather than transfer them to the South East Community Learning Disability Team, although my long term aim will be to transfer them over which Angie is aware of.

I hope this meets with your approval. I enclose a copy of my assessment should you wish to discuss any aspect of Angie or the families care, please feel free to contact me at the address/telephone number above. If you have any concerns about Angie's health needs that you feel would be appropriate for me to work on, I would welcome your thoughts.

With kind regards.

Yours sincerely

Heather Duff
Community Charge Nurse
North East Edinburgh

Private & Confidential

FIRST VISIT ASSESSMENT

Angela Cross
9 Fairford Gardens
Edinburgh

GP: Dr Murray
The Inch Medical Practice
Marmion Crescent
Edinburgh

D.O.B: -
UNIT NO: -

Other Professionals Involved
GP - Dr Murray
SW - Gillian Finlay

Angie is a very pleasant woman who has self referred to me. I have agreed to take her on as a client as a short term measure that will allow her to attend the parenting support group run by myself and my colleague. As part of the group, Angie is undergoing psychological assessment for cognitive ability as well as to ascertain whether in fact she has a learning disability or not.

Background
Angie was born in Inverness to [redacted] her mother. [redacted] has a long history of child abuse and neglect. Angie stayed with her maternal grandparents but due to being at risk and her grandparents ill health Angie was adopted at 2 years old. [redacted] Angie lived in homes in Inverness. Angie has 2 brothers, [redacted] and [redacted] They all went to live in Glasgow with adoptive parents [redacted] and [redacted]. This was not a positive experience for Angie. The boys remained in Glasgow but step parents could not cope with Angie. She was placed in Canaan Lodge Home assessment centre in Edinburgh before being placed in Hawthorn Brae, Duddingston until she was 17 years old. She was "kicked out" of Hawthorn Brae and fell pregnant soon after and she moved back to Glasgow. Step parents again unable to deal with and accept Angie and she moved back to Edinburgh.

[redacted] is now 28 years, he lives in Germany and is married.
[redacted] is now 26 years, he lives in Glasgow.
Angie has 2 step sisters, [redacted] - 13 years) live in Glasgow
[redacted] - 10 years)

Angie has occasional contact with her brothers and sisters. She has contact with step parents although they continue to have a difficult relationship.

Angie has no contact with her natural mother - she did see her mum 2 years ago but she was abusive towards [redacted]. Angie ceased contact.

Angie currently has 3 children.
[redacted] - 13 years old goes to Liberton High School. Father [redacted]

[redacted] - 9 years old. Father [redacted] Violent relationship resulting in numerous assaults on Angie and [redacted]. [redacted]

[redacted] I give Angie support with David.

[redacted] - 4 years old with Downs syndrome. Father [redacted], who died recently of a drugs overdose. This was a volatile relationship. [redacted] as numerous health related problems. Angie gets support from Susan Jackson, Community Staff nurse for [redacted].

Angie has had a succession of unreliable relationships. Her current partner [redacted] does not live with Angie and the kids and he is receiving psychological support for his own needs.

Finances
Angie is in receipt of all appropriate benefits. [redacted] from the Action group oversees this.

Schooling
Angie went to numerous primary schools in Inverness and Edinburgh. She attended Portobello High School - but has a history of non attendance.

Angie has never had paid employment due to her circumstances.

Leisure Interests
Interested in art, sports, music, going out and meeting new people.

Medical History
Significant family history.
Step father - heart problems, diabetic, increased BP, obese.
Step mother - depressive and anorexic.

Childhood Illness
Angie had chickenpox at age 18.

Vaccinations
She had all vaccinations.

Acute Illness/Operations
Knocked down by a bus when 7 years old in Singapore. Vision and hearing problems at that time.
Angie had a caesarian section with [redacted].
Angie has had 7 miscarriages due to violent relationships.
Angie has kidney problems - discharged herself from hospital in past when being investigated in the RIE for kidney infection.
? seizure at this time also. Feels she has a constant pain in her side. Assess further.

Allergies
Nil of note.

Epilepsy
Angie is non epileptic but states she thinks she had a seizure related to kidney infection several years ago.

Current Medication
Depra prevara injection 6 monthly.
Lactulose daily.
She was prescribed prozac but has not been taking them.

Mobility
No difficulties identified.

Perception
Vision - poor. Has had glasses refused to wear them. Need to go to the opticians.
Hearing - problems at 7 years. Meant to wear hearing aid but refused. States this is not problematic currently.

Sleep & Rest
Angie hardly sleeps - due to stress and demands of the children. To be assessed further.

Eating & Drinking
No difficulties identified, but is a poor eater, when mood low she does not eat.

Self Help Skills
Fully independent.

Communication
Good - no difficulties.
Angie when dealing with other professionals can be very angry and volatile resulting at times in negative responses. Angie is more aware of this and is working on this.

Psychological
Violent destructive behaviour - aggressive towards professionals on occasions
- quick tempered, volatile.

Withdrawn - into self. Angie retreats and hibernates at times of great stress and anxiety.

Self Abusive Behaviour - history of self harm in the form of overdosing on tablets and cutting her wrists when she was 14/15 years old. Had 1:1 input in children's home. Attempted self harm due to distress and [redacted]'s father and the nature of their relationship. According to Angie she has never been seen by psychiatrist or psychologist re emotional difficulties. She has had brief counselling from Womenzone of end of relationship with [redacted]

Other Disturbances
Angie has a very negative self concept. She has no confidence and self esteem and self worth due to her upbringing and personal relationships.

Social Skills
Angie is a very friendly and likeable attractive young women.

Private & Confidential

Problems as Identified by Angie

Emotional support - for her needs, as well as on coping with the children and help with relationships.

Plan

1) Angie to attend parenting support group for 10 weeks.
2) Await psychological assessment results to see whether in fact she is appropriate for our service.
3) Discuss with Sandra Guinea, Psychologist, possibility of cognitive behaviour therapy.
4) Continue to support Angie in the needs of the children.

Heather Duff
Community Charge Nurse
NE Edinburgh

cc Sandra Guinea, Psychologist
Dr Murray, GP

WAIS-R Microcomputer-Assisted Interpretive Report

Client: Ms Angie Cross
Sex: Female
Occupation:
Education:

Date of Test: 02-26-98
Date of Birth: 05-22-67
Age: 30 yrs 9 mos 4 days
Examiner: AK Docherty

DESCRIPTIVE INFORMATION

Scale	Sum of Scaled Scores	IQ	Percentile Rank
Verbal	35	76	5
Performance	28	73	4
Full Scale	63	73	4

Subtest	Raw Score	Scaled Score	Age Scaled Score	Percentile Rank
Information	4	3	3	1
Digit Span	11	7	7	16
Vocabulary	16	5	5	5
Arithmetic	7	6	6	9
Comprehension	21	10	10	50
Similarities	5	4	4	2
Picture Completion	8	5	5	5
Picture Arrangement	6	6	6	9
Block Design	14	6	6	9
Object Assembly	19	5	5	5
Digit Symbol	42	6	6	9

NOTE: Age Scaled Scores are based on the test performance of individuals of the subject's own age group.

Subtest (Percentiles)			1	2	5	9	16	25	37	50	63	75	84	91	95	98	99		
Information	.	.	X	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Digit Span	.	.	.	.	.	.	X	.	.	.	.	.	.	.	.	.	.	.	.
Vocabulary	.	.	.	.	X	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Arithmetic	.	.	.	.	.	X	.	.	.	.	.	.	.	.	.	.	.	.	.
Comprehension	.	.	.	.	.	.	.	.	.	X	.	.	.	.	.	.	.	.	.
Similarities	.	.	.	X	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Picture Completion	.	.	.	.	X	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Picture Arrangement	.	.	.	.	.	X	.	.	.	.	.	.	.	.	.	.	.	.	.
Block Design	.	.	.	.	.	X	.	.	.	.	.	.	.	.	.	.	.	.	.
Object Assembly	.	.	.	.	X	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Digit Symbol	.	.	.	.	.	X	.	.	.	.	.	.	.	.	.	.	.	.	.
Age Scaled Scores	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19

STATISTICAL INFORMATION

CONFIDENCE INTERVALS

The 95% confidence interval for the Full Scale IQ is 69 to 79. These are reasonable limits of the range within which the examinee's 'true' Full Scale IQ lies.

The 95% confidence interval for the Verbal IQ is 72 to 82, and for the Performance IQ it is 67 to 82.

DIFFERENCE BETWEEN VERBAL AND PERFORMANCE IQs

The Verbal IQ exceeds the Performance IQ by 3 point(s), a difference that is not statistically significant at the .05 level.

DEVIATION OF SUBTEST SCORES FROM THE SUBJECT'S OWN MEAN SCORE

SUBTEST	AGE SCALED SCORE	DEVIATION FROM MEAN SCALED SCORE	SIGNIFICANCE AT .05 LEVEL
Information	3	-2.83	yes
Digit Span	7	1.17	no
Vocabulary	5	-0.83	no
Arithmetic	6	0.17	no
Comprehension	10	4.17	yes
Similarities	4	-1.83	no

MEAN VERBAL SCALED SCORE = 5.83

SUBTEST	AGE SCALED SCORE	DEVIATION FROM MEAN SCALED SCORE	SIGNIFICANCE AT .05 LEVEL
Picture Completion	5	-0.60	no
Picture Arrangement	6	0.40	no
Block Design	6	0.40	no
Object Assembly	5	-0.60	no
Digit Symbol	6	0.40	no

MEAN PERFORMANCE SCALED SCORE = 5.60

NOTE: A positive deviation from the mean indicates that the subtest score is higher than the mean. A negative deviation from the mean indicates that the subtest score is lower than the mean.

SPECIAL CONSIDERATIONS

The examiner observed no special conditions of a visual, auditory, or motoric nature, and no aspects of language background or of medication that might influence test performance. Although the examiner believes that no such factors affected the test scores, interpretation of results should reflect the context of the testing situation.

INTERPRETIVE INFORMATION

Ms Cross's Full Scale IQ of 73 falls at the 4th percentile in comparison with others of her age, and places her in the Borderline classification. This IQ provides an assessment of general intelligence and of general occupational and scholastic aptitude.

Ms Cross obtained a Verbal IQ of 76, which falls at the 5th percentile. This IQ provides an indication of her verbal abilities, which include language comprehension and expression, recall of information, and the ability to reason with words.

However, 2 of the scores contributing to Ms Cross's Verbal IQ differed significantly from her average verbal score. Therefore Ms Cross's Verbal IQ is an average of diverse abilities and may need to be so interpreted.

Ms Cross's Performance IQ of 73 falls at the 4th percentile. This IQ contributes an understanding of her perceptual organization, which reflects certain perceptual-motor skills as well as the ability to employ visual images in thinking and to process visual material efficiently.

None of the scores contributing to the Performance IQ differed significantly from Ms Cross's average performance score. Therefore the Performance IQ appears to be a good summary of her abilities in this area.

The score on Information reflects a relative weakness in Ms Cross's fund of general knowledge. Such scores sometimes indicate a background in a different language or culture.

Ms Cross's Comprehension score is significantly higher than her average verbal subtest score. This suggests relatively good ability to size up practical or social situations that require common-sense reasoning. Such scores imply the effective use of one's knowledge. It is important to keep in mind, though, that this score is only about

average in comparison with the WAIS-R norms.

```
**************************************************************************
*                                                                        *
*  This report is based only on the individual's WAIS-R scores and age,  *
*  and should be reviewed in the light of occupational history,          *
*  educational and cultural background, and medical status.  It is      *
*  assumed that such information about the individual is available      *
*  and will be considered when interpreting results.                     *
*                                                                        *
**************************************************************************
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WAIS-R UK

WECHSLER ADULT INTELLIGENCE SCALE—REVISED

BRITISH ADAPTATION

RECORD FORM

NAME Angie Cross

ADDRESS 9 Fairford Gdns.

SEX ______ AGE ______ MARITAL STATUS ______

OCCUPATION ______ EDUCATION Portobello

COUNTRY OF BIRTH ______ FIRST LANGUAGE ______

PLACE OF TESTING ______ TESTED BY ______

OTHER INFORMATION ______

TABLE OF SCALED SCORE EQUIVALENTS*

Scaled Score	RAW SCORE: VERBAL TESTS: Information	Digit Span	Vocabulary	Arithmetic	Comprehension	Similarities	PERFORMANCE TESTS: Picture Completion	Picture Arrangement	Block Design	Object Assembly	Digit Symbol	Scaled Score
19	—	28	70	—	32	—	—	—	51	—	93	19
18	29	27	69	—	31	28	—	—	—	41	91-92	18
17	—	26	68	19	—	—	20	20	50	—	89-90	17
16	28	25	66-67	—	30	27	—	—	49	40	84-88	16
15	27	24	65	18	29	26	—	19	47-48	39	79-83	15
14	26	22-23	63-64	17	27-28	25	19	—	44-46	38	75-78	14
13	25	20-21	60-62	16	26	24	—	18	42-43	37	70-74	13
12	23-24	18-19	55-59	15	25	23	18	17	38-41	35-36	66-69	12
11	22	17	52-54	13-14	23-24	22	17	15-16	35-37	34	62-65	11
10	19-21	15-16	47-51	12	21-22	20-21	16	14	31-34	32-33	57-61	10
9	17-18	14	43-46	11	19-20	18-19	15	13	27-30	30-31	53-56	9
8	15-16	12-13	37-42	10	17-18	16-17	14	11-12	23-26	28-29	48-52	8
7	13-14	11	29-36	8-9	14-16	14-15	13	8-10	20-22	24-27	44-47	7
6	9-12	9-10	20-28	6-7	11-13	11-13	11-12	5-7	14-19	21-23	37-43	6
5	6-8	8	14-19	5	8-10	7-10	8-10	3-4	8-13	16-20	30-36	5
4	5	7	11-13	4	6-7	5-6	5-7	2	3-7	13-15	23-29	4
3	4	6	9-10	3	4-5	2-4	3-4	—	2	9-12	16-22	3
2	3	3-5	6-8	1-2	2-3	1	2	1	1	6-8	8-15	2
1	0-2	0-2	0-5	0	0-1	0	0-1	0	0	0-5	0-7	1

* Clinicians who wish to draw a profile may do so by locating the subject's raw scores on the table above and drawing a line to connect them. See Chapter 4 in the Manual for a discussion of the significance of differences between scores on the tests.

	Year	Month	Day
Date Tested	96	02	26
Date of Birth			
Age			

SUMMARY

	Raw Score	Scaled Score
VERBAL TESTS		
Information	4	3
Digit Span	11	7
Vocabulary	16	5
Arithmetic	7	6
Comprehension	21	10
Similarities	5	4
Verbal Score		35
PERFORMANCE TESTS		
Picture Completion	8	5
Picture Arrangement	6	6
Block Design	14	6
Object Assembly	19	5
Digit Symbol	42	6
Performance Score		28

	Sum of Scaled Scores	IQ
VERBAL	35	76
PERFORMANCE	28	73
FULL SCALE	63	73

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7 8 9 0
J

5 **VOCABULARY** Discontinue after 5 consecutive failures.		Score 2,1, or 0
1 Bed		2
2 Ship		2
3 Penny		2
START → 4 Winter	When its cold & wet, leaves fallen.	1
5 Breakfast	1st thing in the morning, cereal or full breakfast or toast	2
6 Repair	repair s'thing thats broken Mending it.	2
7 Fabric	material - all diff kinds of fabrics	2
8 Assemble	putting things together	2
9 Enormous	big, large.	1
10 Conceal	sellotaping s'thing up.	0
11 Sentence	long phrase	0
12 Consume	dk.	0
13 Regulate	dk	0
14 Terminate	terminate an agreement eg application form	0
15 Commence	dk.	
16 Domestic	cleaning	
17 Tranquil	to do with tablets	
18 Ponder	dk	
19 Designate	agreement - to designate an agreement	
20 Reluctant	not sure if your going to do s'thing	
21 Obstruct		
22 Sanctuary		
23 Compassion		
24 Evasive		
25 Remorse		
26 Perimeter		
27 Generate		
28 Matchless		
29 Fortitude		
30 Tangible		
31 Plagiarize		
32 Ominous		
33 Encumber		
34 Audacious		
35 Tirade		
	Total	Max=70 16

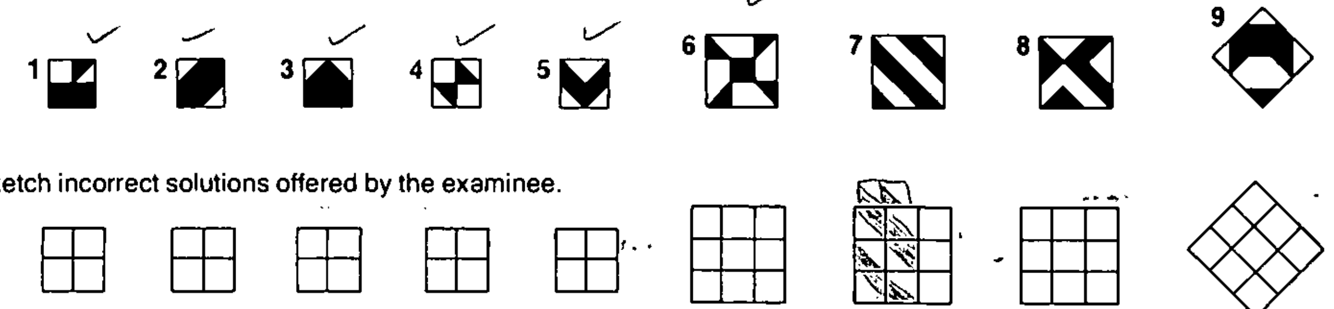
Note: Be sure to include scores for items 1–3 in Total.

6 BLOCK DESIGN **Discontinue after 3 consecutive failures.**

Design		Time	Pass-Fail	Score (Circle the appropriate score for each design.)						
1	60″	1	P			(2)				
		2		0	1					
2	60″	1	P			(2)				
		2		0	1					
3	60″		✓ wrong Angle	(0)			(16-60) 4	11-15 5	1-10 6	
4	60″		✓ wrong Angle	(0)			(16-60) 4	11-15 5	1-10 6	
5	60″		P	0			21-60 (4)	16-20 5	11-15 6	1-10 7
6	120″		✓ P	0			36-120 4	26-35 5	21-25 (6)	1-20 7
7	120″		✓	(0)			61-120 4	46-60 5	31-45 6	1-30 7
8	120″		✓	(0)			76-120 4	56-75 5	41-55 6	1-40 7
9	120″			0			76-120 4	56-75 5	41-55 6	1-40 7

Total Max = 51: 14

Correct solutions



Sketch incorrect solutions offered by the examinee.

Notes:

7 ARITHMETIC **Discontinue after 4 consecutive failures.**

Problem		Response	Score 1 or 0
1	15″		1
2	15″		1
START → 3	15″	9	1
4	15″	4	1
5	30″	£1.50	1
6	30″	6	1
7	30″	dk.	0
8	30″	36p	1
9	30″	£11.50.	0

Problem		Response	Time	Score (Circle)		
10	60″	180	0	0	11-60 1	1-10 2
11	60″	£1.84 ~~16p~~	0	0	11-60 1	1-10 2
12	60″	—	0	0	11-60 1	1-10 2
13	60″	£6 off.		0	16-60 1	1-15 2
14	120″	12		0	16-120 1	1-15 2

Total Max = 19: 7

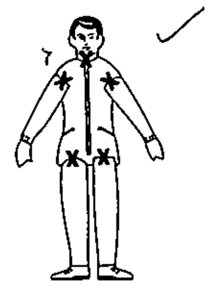
Note: Be sure to include scores for items 1-9 in Total.

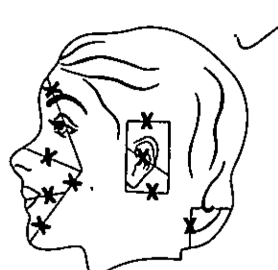
8 OBJECT ASSEMBLY Give entire test to all subjects.

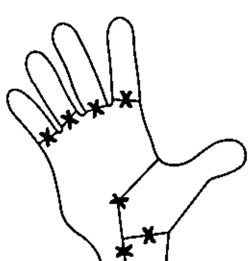
Object		Time	Score (Circle appropriate score for each object.)
1 Manikin	120″		0 1 2 3 4 5 (21-120) 6 (16-20) 7 (11-15) 8 (1-10) — 5–8: perfect assembly
2 Profile	120″		0 1 2 3 4 5 6 7 8 9 (36-120) 10 (26-35) 11 (21-25) 12 (1-20) — 9–12: perfect assembly
3 Hand	180″		0 1 2 3 4 5 6 7 (51-180) 8 (36-50) 9 (26-35) 10 (1-25) — 7–10: perfect assembly
4 Elephant	180″		0 1 2 3 4 5 6 7 8 (51-180) 9 (31-50) 10 (21-30) 11 (1-20) — 8–11: perfect assembly

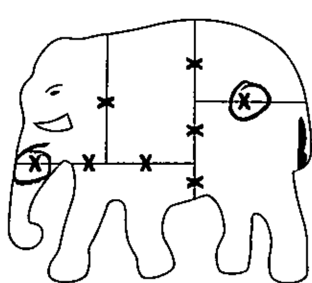
Total 19 (Max = 41)

Object Assembly: For incomplete solutions, circle each X representing a connection for which the examinee receives credit.









Notes:

Notes on the subject's performance of particular test items, unusual behaviour, or special conditions which may have influenced the results can be recorded below.

Test	Item No.	Notes

9 **COMPREHENSION** **Discontinue after 4 consecutive failures.**	**Score 2, 1, or 0**
1 Clothes To get them clean.	2
2 Envelope Post it	2
*3 Foods could be frozen, stops poison, to be eatable, not hard/soft.	1
*4 Child employment to keep children safe.	1
5 Deaf bc. can't balance, can't hear their speech, what they're pronouncing.	1
6 Borrow friend if you can't pay back, you'd be embarrassed.	2
7 Cinema raise the alarm, tell somebody, get s'body whose in charge	2
8 Marriage law, so they know how many people are married,	2
9 Tax To help the roads, police, keep the govt, people safe in order	2
10 Forest try every direction till I got out – climb a tree to look.	1
11 Prescription some could be highly dangerous, could take OD. need doctors advice	2
12 Iron Go for it, nothing to lose,	2
13 Land town has electricity, country no energy needed to keep it goin	0
14 Waters dk.	0
15 Swallow dk.	0
16 Press to let the world know whats happening, the right to find out.	?1
*If the subject replies with only one idea, ask for a second response. Rephrase the test item appropriately, saying, **'Tell me another reason why...'** *Total*	**Max=32** 21

Notes on the subject's performance of particular test items, unusual behaviour, or special conditions which may have influenced the results can be recorded below.

Test	Item No.	Notes

10 DIGIT SYMBOL

1	2	3	4	5	6	7	8	9
—	⊥	⊏	L	⊔	O	∧	X	=

SCORE 42

SAMPLES

2 1 3 7 2 4 8 | 2 1 3 2 1 4 2 3 5 2 3 1 4 5 6 3 1 4

1 5 4 2 7 6 3 5 7 2 8 5 4 6 3 7 2 8 1 9 5 8 4 7 3

6 2 5 1 9 2 8 3 7 4 6 5 9 4 8 3 7 2 6 1 5 4 6 3 7

9 2 8 1 7 9 4 6 8 5 9 7 1 8 5 2 9 4 8 6 3 7 9 8 6

11 SIMILARITIES Discontinue after 4 consecutive failures.		Score 2, 1, or 0
1 Orange–banana	round.	0
2 Dog–lion	4 legs & tail	1
3 Coat–suit	could be same material, colour	0
4 Boat–car	get you place to place.	1
5 Eye–ear	eye you can see, ear you can hear · need both.	0
6 Button–zip	keeps things together	1
7 North–west	two different directions.	0
8 Egg–seed	dk,	0
9 Table–chair	eat at table, need chair 4 legs,	1
10 Air–water	need air & you need water to survive	1
11 Poem–statue	statue meaning of s'thing, poem express how feel	0
12 Work–play	work - hard, play - having fun: opposites.	0
13 Fly–tree	tree big object fly & small object.	0
14 Praise–punishment	p	0
	Total	Max=28 5

ISBN 0 15 899239 3

Scale

Participant Angie Cross **Date.** ______

Person 1 Step Mum - [redacted] *(name/relationship)*

1 a) Can you be honest with ________, trust ________, tell ________ how you feel.

No	A wee bit	A big bit	Lots
✓			

1 b) What would your ideal be ?
How much would you like to be able to be honest with ________, trust ______, tell ________ how you feel.

No	A wee bit	A big bit	Lots
		✓	

2 a) If you're having problems/worries, can you ask ________ for help?

No	A wee bit	A big bit	Lots
✓			

2 b) What would your ideal be ?
How much would you like to be able to ask ________ for help?

No	A wee bit	A big bit	Lots
	✓		

3 a) Does ________ help you in particular ways, with things like running the house, or coping with the children ? helps with [redacted]

No	A wee bit	A big bit	Lots
	✓		

3 b) What would your ideal be ?
If you could have all the practical help you wanted from ________ how much would this be?
To understand [redacted] & his difficulties

No	A wee bit	A big bit	Lots
			✓

4 a) Do you spend a lot of time with ______?

No	A wee bit	A big bit	Lots
✓			

4 b) What would your ideal be ?
If you could, how much time would like to spend with ________ ?

No	A wee bit	A big bit	Lots
✓			

Person 2 Step-Dad : [redacted] *(name/relationship)*

1 a) Can you be honest with ________, trust ________, tell ________ how you feel.

No	A wee bit	A big bit	Lots
✓			

1 b) What would your ideal be ?
How much would you like to be able to be honest with ________, trust ______, tell ________ how you feel.

No	A wee bit	A big bit	Lots
			✓

2 a) If you're having problems/worries, can you ask ________ for help?

No	A wee bit	A big bit	Lots
✓			

2 b) What would your ideal be ?
How much would you like to be able to ask ________ for help?

No	A wee bit	A big bit	Lots
			✓

3 a) Does ________ help you in particular ways, with things like running the house, or coping with the children ?

No	A wee bit	A big bit	Lots
✓			

3 b) What would your ideal be ?
If you could have all the practical help you wanted from ________ how much would this be?

No	A wee bit	A big bit	Lots
			✓

4 a) Do you spend a lot of time with ______?

No	A wee bit	A big bit	Lots
✓			

4 b) What would your ideal be ?
If you could, how much time would like to spend with ________ ?

No	A wee bit	A big bit	Lots
		✓	

Person 3 Brother: [redacted] *(name/relationship)*

1 a) Can you be honest with ___________, trust _______, tell _______ how you feel.

No	A wee bit	A big bit	Lots
☐	☐	☑	☐

1 b) What would your ideal be ?
How much would you like to be able to be honest with _________, trust _____, tell _______ how you feel.

No	A wee bit	A big bit	Lots
☐	☐	☑	☐

2 a) If you're having problems/worries, can you ask _______ for help?

No	A wee bit	A big bit	Lots
☐	☐	☑	☐

2 b) What would your ideal be ?
How much would you like to be able to ask _______ for help?

No	A wee bit	A big bit	Lots
☐	☐	☑	☐

3 a) Does ________ help you in particular ways, with things like running the house, or coping with the children ?

No	A wee bit	A big bit	Lots
☐	☐	☐	☑

3 b) What would your ideal be ?
If you could have all the practical help you wanted from ________ how much would this be?

No	A wee bit	A big bit	Lots
☐	☐	☐	☑

4 a) Do you spend a lot of time with _____?

Varies – he is in army.

No	A wee bit	A big bit	Lots
☐	☑	☐	☐

4 b) What would your ideal be ?
If you could, how much time would like to spend with _________ ?

No	A wee bit	A big bit	Lots
☐	☐	☐	☑

Lives in Glasgow

Person 4 Brother: [redacted] *(name/relationship)*

1 a) Can you be honest with ___________, trust _______, tell _______ how you feel.

No	A wee bit	A big bit	Lots
			✓

1 b) What would your ideal be ?
How much would you like to be able to be honest with _________, trust _____, tell _______ how you feel.

No	A wee bit	A big bit	Lots
			✓

2 a) If you're having problems/worries, can you ask _________ for help?

No	A wee bit	A big bit	Lots
			✓

2 b) What would your ideal be ?
How much would you like to be able to ask _______ for help?

No	A wee bit	A big bit	Lots
			✓

3 a) Does ________ help you in particular ways, with things like running the house, or coping with the children ? Helps with decorating

No	A wee bit	A big bit	Lots
			✓

3 b) What would your ideal be ?
If you could have all the practical help you wanted from ________ how much would this be?

No	A wee bit	A big bit	Lots
			✓

4 a) Do you spend a lot of time with _____?

No	A wee bit	A big bit	Lots
	✓		

4 b) What would your ideal be ?
If you could, how much time would like to spend with _________ ?

No	A wee bit	A big bit	Lots
		✓	

Person 5 Real Mum ; [redacted] *(name/relationship)*

lives in Inverness.

1 a) Can you be honest with ____________, trust ________, tell ________ how you feel.

No	A wee bit	A big bit	Lots
✓			

1 b) What would your ideal be ?
How much would you like to be able to be honest with __________, trust ______, tell ________ how you feel.

No	A wee bit	A big bit	Lots
		✓	

2 a) If you're having problems/worries, can you ask __________ for help?

No	A wee bit	A big bit	Lots
✓			

2 b) What would your ideal be ?
How much would you like to be able to ask ________ for help?

No	A wee bit	A big bit	Lots
		✓	

3 a) Does _________ help you in particular ways, with things like running the house, or coping with the children ?

No	A wee bit	A big bit	Lots
✓			

3 b) What would your ideal be ?
If you could have all the practical help you wanted from _________ how much would this be?

No	A wee bit	A big bit	Lots
		✓	

4 a) Do you spend a lot of time with ______?

No	A wee bit	A big bit	Lots
✓			

4 b) What would your ideal be ?
If you could, how much time would like to spend with _________ ?

No	A wee bit	A big bit	Lots
		✓	

Person 6 ______________________________ *(name/relationship)*

1 a) Can you be honest with ____________, trust ________, tell ________ how you feel.

☐ No ☐ A wee bit ☐ A big bit ☐ Lots

1 b) What would your ideal be ?
How much would you like to be able to be honest with __________, trust ______, tell ________ how you feel.

☐ No ☐ A wee bit ☐ A big bit ☐ Lots

2 a) If you're having problems/worries, can you ask __________ for help?

☐ No ☐ A wee bit ☐ A big bit ☐ Lots

2 b) What would your ideal be ?
How much would you like to be able to ask ________ for help?

☐ No ☐ A wee bit ☐ A big bit ☐ Lots

3 a) Does _________ help you in particular ways, with things like running the house, or coping with the children ?

☐ No ☐ A wee bit ☐ A big bit ☐ Lots

3 b) What would your ideal be ?
If you could have all the practical help you wanted from _________ how much would this be?

☐ No ☐ A wee bit ☐ A big bit ☐ Lots

4 a) Do you spend a lot of time with ______?

☐ No ☐ A wee bit ☐ A big bit ☐ Lots

4 b) What would your ideal be ?
If you could, how much time would like to spend with __________ ?

☐ No ☐ A wee bit ☐ A big bit ☐ Lots

Ange

Assessing emergency responses of people with mental handicaps:

AN ASSESSMENT INSTRUMENT

Alexander J. Tymchuk

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CHECKLIST FOR ASSESSING EMERGENCY KNOWLEDGE AND SKILLS

This Checklist originally formed part of the article detailed above wich was published in Mental Handicap, 1990; 18:4, 136-142.

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UK

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CHECKLIST FOR ASSESSING EMERGENCY KNOWLEDGE AND SKILLS

Name .... Date of birth: .... Age: ....Sex: .... Date: / / Week: ....

Address:.. Children, if any: ....

Observer: 1 .... Group training .... At home:...

2 .... Individual training:........................ At clinic/agency: ....

This checklist provides a means of assessing a person's knowledge and skills for coping with seven emergencies. Assess each emergency one at a time, working through the list from 1 to 7. Assess knowledge and skills separately for each item.

1. GREASE FIRE

	Yes	No
Do you know what a grease fire is?	☑	☐
Do you know where it can occur?	☐	☐
Has it happened to you?	☐	☐
If yes, how often? Put number of times	☐	
Has it happened to your child?	☐	☐
If yes, how often? Put number of times	☐	
If more than one child: Number of children	☐	
Number of times	☐	

What would you do if a grease fire happened?	Knowledge Yes	Knowledge No	Skill Yes	Skill No
Stay calm	☑	☐	☐	☐
Think	☐	☐	☐	☐
Call for help	☐	☐	☐	☐
Put on glove or fetch cloth	☐	☐	☐	☐
Turn oven/hob off	☐	☐	☐	☐
Cover pan/close oven door	☐	☐	☐	☐
Throw baking soda on blaze	☐	☐	☐	☐
Use a dry chemical fire extinguisher	☐	☐	☐	☐
Call 999 for fire brigade	☐	☐	☐	☐

Other: ....

....

Check if the person mentions doing any of these:	Yes	No
Carry pot to sink	☐	☐
Throw water on pot	☐	☐
Get upset	☐	☐

Other: ....

....

What should you NOT do if a grease fire happened?	Knowledge Yes	Knowledge No	Skill Yes	Skill No
Carry pot to sink	☐ ←	☑	☐	☐
Throw water on pot	☐ ←	☑	☐	☐
Get upset	☐ ←	☑	☐	☐

Other: ....

....

2. CLOTHES FIRE

	Yes	No
Do you know what a clothes fire is?	☑	☐
Do you know where it can occur?	☐	☐
Has it happened to you?	☐	☐
If yes, how often? Put number of times	☐	
Has it happened to your child?	☐	☐
If yes, how often? Put number of times	☐	
If more than one child: Number of children	☐	
Number of times	☐	

What would you do if a clothes fire happened?	Knowledge Yes	Knowledge No	Skill Yes	Skill No
Stay calm	☐	☐	☐	☐
Think	☐	☐	☐	☐
Call for help	☑	☐	☐	☐
Stop moving	☐	☐	☐	☐
Fall to floor or push child to floor	☐	☐	☐	☐
Roll over, or push child over, with arms on chest and hands over face	☐	☐	☐	☐
Smother flames with rug, coat, blanket, or place body around child's	☑	☐	☐	☐
Call doctor or 999 ambulance service	☑	☐	☐	☐

Other: ....

....

Check if the person mentions doing any of these:	Yes	No
Run around or let child run	☐	☐
Run away	☐	☐
Get upset	☐	☐

Other: ....

....

What should you NOT do if a clothes fire happened?	Knowledge Yes	Knowledge No	Skill Yes	Skill No
Run around or let child run	☐	☐	☐	☐
Run away	☐	☐	☐	☐
Get upset	☐	☐	☐	☐

Other: ....

....

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3. HOUSE FIRE *Close doors, lie on floor, raise alarm.*

	Yes	No
Do you know what a house fire is?	☐	☐
Do you know where it can occur?	☐	☐
Has it happened to you?	☐	☐
If yes, how often? Put number of times	☐	
Has it happened to your child?	☐	☐
If yes, how often? Put number of times	☐	
If more than one child: Number of children	☐	
Number of times	☐	

What would you do if there was a house fire?	Knowledge Yes	Knowledge No	Skill Yes	Skill No
Stay calm	☐	☐	☐	☐
Think	☐	☐	☐	☐
Call for help	☐	☐	☐	☐
If you can, put out fire	☐	☐	☐	☐
Walk out of the house	☐	☐	☐	☐
Take everyone with you	☐	☐	☐	☐
Call 999 for fire brigade	☐	☐	☐	☐

Other: ....

....

Check if the person mentions doing any of these:	Yes	No
Leave house with children in it	☐	☐
Go back into house to get valuables	☐	☐
Get upset	☐	☐
Run	☐	☐

Other: ....

....

What should you NOT do if a house fire happened?	Knowledge Yes	Knowledge No	Skill Yes	Skill No
Leave house with children in it	☐	☐	☐	☐
Go back into house to get valuables	☐	☐	☐	☐
Get upset	☐	☐	☐	☐
Run	☐	☐	☐	☐

Other: ....

....

4. POISON

	Yes	No
Do you know what poison is?	☑	☐
Do you know how poisoning can occur?	☐	☐
Has it happened to you?	☐	☑
If yes, how often? Put number of times	☐	
Type of poison		
Has it happened to your child?	☐	☑
If yes, how often? Put number of times	☐	
Type of poison		
If more than one child: Number of children	☐	
Number of times	☐	

What would you do if someone was poisoned?	Knowledge Yes	Knowledge No	Skill Yes	Skill No
Stay calm	☐	☐	☐	☐
Think	☐	☐	☐	☐
Call for help	☑	☐	☐	☐
If help is available, ask helper to call 999 for ambulance or take person to doctor/local hospital casualty department	☐	☐	☐	☐
If person is unconscious, having fits, bleeding, or vomiting, place head to one side	☐	☐	☐	☐
Keep person's airway open	☐	☐	☐	☐
If no helper available, call 999 for ambulance and stay on line until told to get off	☐	☐	☐	☐
Tell poison name if possible	☐	☐	☐	☐
Tell person's age, especially if child	☐	☐	☐	☐
Do what ambulance staff or helper tells you	☐	☐	☐	☐
If person stays unconscious and stops breathing, give CPR or artificial respiration	☐	☐	☐	☐
If conscious, keep person calm and warm	☐	☐	☐	☐
Give person tablespoons of cold milk slowly	☐	☐	☐	☐

Other: ....

....

Check if the person mentions doing any of these:	Yes	No
If corrosive, induce vomiting	☐	☐
Whatever the poison, dilute further or neutralise unless instructed	☐	☐
Get upset	☐	☐
Follow directions on bottle unless instructed by doctor	☐	☐

Other: ....

....

What should you NOT do if someone is poisoned?	Knowledge Yes	Knowledge No	Skill Yes	Skill No
If corrosive, induce vomiting	☐	☐	☐	☐
Whatever the poison, neutralise or dilute further unless instructed	☐	☐	☐	☐
Get upset	☐	☐	☐	☐
Follow directions on bottle unless instructed by doctor	☐	☐	☐	☐

Other: ....

....

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5. SCALD

	Yes	No
Do you know what a scald is?	☐	☐
Do you know how a scald can occur?	☐	☐
Has it happened to you?	☐	☐
If yes, how often? Put number of times	☐	
Has it happened to your child?	☐	☐
If yes, how often? Put number of times	☐	
If more than one child: Number of children	☐	
Number of times	☐	

What would you do if someone was scalded?	Knowledge		Skill	
	Yes	No	Yes	No
Stay calm	☐	☐	☐	☐
Think	☐	☐	☐	☐
Call for help	☐	☐	☐	☐
Put cold water on it	☐	☐	☐	☐
Put compress on it	☐	☐	☐	☐
Take to doctor, especially if blistering	☐	☐	☐	☐

Other: ....

....

Check if person mentions doing any of these:	Yes	No
Break blisters	☐	☐
Put cream on	☐	☐
Get upset	☐	☐

Other: ....

....

What should you NOT do if someone is scalded?	Knowledge		Skill	
	Yes	No	Yes	No
Break blisters	☐	☐	☐	☐
Put creams on	☐	☐	☐	☐
Get upset	☐	☐	☐	☐

Other: ....

....

6. CHOKING

	Yes	No
Do you know what choking is?	☐	☐
If yes, specify: coughing	☐	
can't breathe or speak	☐	
turns red/lips blue	☐	
Do you know how choking can occur?	☐	☐
Has it happened to you?	☐	☐
If yes, how often? Put number of times	☐	
Has it happened to your child?	☐	☐
If yes, how often? Put number of times	☐	
If more than one child: Number of children	☐	
Number of times	☐	

What would you do if someone was choking?	Knowledge		Skill	
	Yes	No	Yes	No
Stay calm	☐	☐	☐	☐
Think	☐	☐	☐	☐
Call for help	☐	☐	☐	☐
If help is available, have helper call 999 for ambulance	☐	☐	☐	☐
IF BABY *(less than one year of age)*				
Place baby on your arm with stomach and head down	☐	☐	☐	☐
Hit baby's back four times rapidly	☐	☐	☐	☐
If no dislodging, turn baby over on back	☐	☐	☐	☐
Place thumb in mouth, pull down	☐	☐	☐	☐
Place small finger in mouth to remove object *only* if it can be seen	☐	☐	☐	☐
If baby is not breathing or object is not coming out, call 999 for ambulance or take to doctor/local hospital	☐	☐	☐	☐
IF CHILD *(over one year of age)*				
If child is down, lift up with arm across chest and give four rapid hard back blows	☐	☐	☐	☐
If child is standing, use *Helmlich Procedure** against your body or against chair	☐	☐	☐	☐
Repeat action if needed	☐	☐	☐	☐
If child is still not breathing, call 999 for ambulance or take to doctor/local hospital	☐	☐	☐	☐

Other: ....

....

Check if person mentions doing any of these:	Yes	No
Hold by neck and crush throat	☐	☐
Hit back hard	☐	☐
Push object further into throat	☐	☐
If coughing, put own mouth over	☐	☐
Give water	☐	☐
Get upset	☐	☐

Other: ....

....

**Helmlich Procedure* – abdominal thrusts

1. Stand behind child with arms around child's waist.
2. Make a fist.
3. Place thumb of fist in middle of child's stomach below rib cage.
4. Grasp fist with other hand.
5. Press fist into child's stomach with a quick upward thrust.
6. Repeat thrust if necessary until object is coughed up or child starts to breathe or cough.

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What should you NOT do if someone is choking?	Knowledge Yes	Knowledge No	Skill Yes	Skill No
Hold by neck and crush throat	☐	☐	☐	☐
Hit back hard	☐	☐	☐	☐
Push object further into throat	☐	☐	☐	☐
Put own mouth over	☐	☐	☐	☐
Give water	☐	☐	☐	☐
Get upset	☐	☐	☐	☐

Other: ....

....

7. CUT HAND

	Yes	No
Do you know what a cut hand is?	☐	☐
Has it happened to you?	☐	☐
If yes, how often? Put number of times	☐	
Has it happened to your child?	☐	☐
If yes, how often? Put number of times	☐	
If more than one child: Number of children	☐	
Number of times	☐	

What would you do if someone's hand was cut?	Knowledge Yes	Knowledge No	Skill Yes	Skill No
Stay calm	☐	☐	☐	☐
Think	☐	☐	☐	☐
Call for help	☐	☐	☐	☐
Lift hand above heart	☐	☐	☐	☐
Place clean cloth on cut and press	☑	☐	☐	☐
Remove cloth, clean, and apply antiseptic and bandage	☑	☐	☐	☐
If alone, or cut continues to bleed very badly, call doctor or 999 ambulance and lie down holding hand up in air	☐	☐	☐	☐

Other: ....

....

Check if person mentions doing any of these:	Yes	No
Get upset	☐	☐
Run for help (if own hand cut)	☐	☐
Put hand in mouth	☐	☐
Wash cut with soap	☐	☐

Other: ....

....

What should you NOT do if someone's hand is cut?	Knowledge Yes	Knowledge No	Skill Yes	Skill No
Get upset	☐	☐	☐	☐
Run for help (if own hand cut)	☐	☐	☐	☐
Put hand in mouth	☐	☐	☐	☐
Wash cut with soap	☐	☐	☐	☐

Other: ....

....

Angie Cross 23/4/98.

FIRST STEPS TO PARENTING

The Middle Years (6-11)

1. What kinds of things do 6-11year olds like?

Plays with his models
Likes football

2. What can a six to eleven year old learn from having a best friend ? / their family / a group of friends ?

Best friend: not sure. He misses Johnny a lot. They had a lot in common Played together / did things together
Family: very important. They get discipline and love; can learn from brothers & sisters, play with them etc.

Peer Group: less impt. David prefers spending time with his older brother.

3. What did you do when (child) started school ?
How did you feel ?
Did you show an interest in her/his work ?
What about a regular bedtime
Do you go to the Parent / Teacher meetings ?

Started school: help with homework - reading cards. David has difficulty learning. Natasha wouldn't be able to learn like other children.

Regular bedtime: Important - they all have a regular bedtime, but don't always go to bed / sleep. Can be a problem.

P/T meetings: Go to David & Natasha's reviews. Very helpful. I like to find out how they are getting on etc.

4. If (child) begins to be naughty or misbehave, what do you do ?
- would you tell her/him to stop, how many times ?
- would you ignore her/him ?
- smack her/him ?
- send her/him to their room
- remove special treats

I would send him to his room, or if its late, to bed. If serious I would ground him. Serious includes losing his temper / lashing out. Also not coming in when told. Would remove treats eg pocket money or going swimming. Wouldn't smack - unless EXTREME circumstances.

5. What would you do if (child) was bullied at school ?
- nothing ?
- tell her/him to fight back ?
- tell her/him to ignore it ?
- tell him/her to speak to the teacher ?

Speak to the teacher, If necessary ~~keep~~ going up to the school to see its getting sorted.

Fight back?: Yes, if he was constantly being picked on.
Would do whatever necessary to get it sorted.
Its sometimes difficult to get anything done.

6. What activities or clubs can help children who are 9or 10yrs old ? Why do you think they help?

- Youth clubs
- Scouts /Guides
- Sports
- Computer games

David likes colouring, outdoor sports cartoons. He doesn't go to any clubs - none suitable in the area.
Loves his computer - nintendo play station.

Observation of Parent Child Interaction

Instructions:

* encourage the parent to behave as (s)he would normally with the child(ren).
* the aim is to record as much natural, spontaneous interaction as possible in the home situation, so do not set up any particular conditions.
* keep a tally of the following interactions over a 15-20 minute period

Child centred:

- parent *attends* to child (i.e. describes what C is doing, e.g. 'that's a lovely picture you're drawing!')
- verbal praise
- smiles and eye contact
- imitation
- asking to play/help (giving control of the game to C)
- positive touches (cuddles, strokes etc)
- ignoring minor naughtiness (redirecting, not making a fuss)

Child directive:

- commands
- teaching
- questions (e.g. 'what did you do that for?', 'why are you doing that?')
- criticisms
- negative touches (smacks, pulling C away from a toy)
- ignoring good behaviour

Please complete the Observation Record Form for each session, noting any other significant interaction/incident on the back of the form.

Parent/Child Interaction: observation record form

Parent : Angie Cross

Behaviours	**Observation 1** Date : Setting : Activity :	**Observation 2** Date : Setting : Activity :	**Observation 3** Date : Setting : Activity :	**Observation 4** Date : Setting : Activity :
Child centred - Attends				
- Praise				
- Smiles				
- Imitation				
- Asked to play				
- Positive touches				
- Ignore minor naughtiness				
Child directive- Commands				
- Teaching				
- Questions				
- Criticisms				
- Negative touches				
- Ignore good settled behaviour				

SG/PSS - 2/98

Maternal Risk Profile	***Maternal Advantage Profile***
Potential Risk Factors relating to:	***Potential Advantage factors relating to:***
Section 1: Maternal Background	
1. Previously institutionalised, e.g. placed in child care, admissions to long stay hospitals	**1. Lived at home**
2. Experience of abuse as a child	**2. No evidence of abuse as child**
3. Younger than 18 on birth of first child	**3. Older than 18 on birth of first child**
4. No teaching/training in parenting skills	**4. Parenting skills training**
5. No personal care/life skills education	**5. Training in personal care/life skills**
6. Parent(s) with history of mental health problems, substance abuse, criminal record.	**6. Parent(s) problem free**
Section 2: Current maternal physical/mental well being	
1. IQ < 60	**1. IQ > 60**
2. Physical health problem	**2. No physical health problems**
3. Mental health problem	**3. No mental health problems**
4. Feelings of low self worth, (e.g. 'useless', no confidence in abilities, shopping around for advice)	**4. Adequate self esteem**
5. Reading comprehension below age 7-8	**5. Reading comprehension above age 8**

Section 3: Current maternal parenting behaviour	
1. Lack of warmth/spontaneous affection towards child	**1. Shows affection to child (cuddles, smiles, baby talk etc.)**
2. Difficulty engaging child in age appropriate activities	**2. Plays with child age appropriately**
3. Focus on negative, controlling interactions with child	**3. Focus on positive, child centred interaction**
4. Inconsistent child behaviour management, (e.g. smacking/punishment and little positive reward)	**4. Attempts positive, consistent behaviour management**
5. Inconsistent coping strategies, (e.g. chaotic household, tendency to panic, unable to prioritise tasks)	**5. Adaptive coping strategies (e.g. keeps routines, knows where to get help, some planning ability)**
6. Limited problem solving skills (e.g. difficulty thinking things through, generating alternatives, working out possible consequences)	**6. Some problem solving skills (e.g. some transfer, generalisation of knowledge, can work things through)**
7. Evidence of abuse of child	**7. No evidence of child abuse**
8. Unwilling to use appropriate supports (both formal, professional and informal)	**8. Uses supports well**

Section 4: Environment	
1. Inadequate housing (e.g. too small, damp, problems with neighbours)	**1. Adequate housing, good relations with neighbours**
2. Financial difficulties	**2. Manages current budget**
3. No/limited social support	**3. Good formal/informal support networks**
4. Support undermines maternal confidence	**4. Support tailored to specific needs of family**

Section 4: Environment - cont'd	
5. Extended family involved but not supportive (e.g. giving unwanted/conflicting advice, borrowing money)	**5. Extended family help out appropriately**

Section 5: Family	
1. More than one child	**1. Only one child**
2. Older child in family	**2. Younger children**
3. Current partner abusive	**3. Current partner supportive**
4. Current partner has mental health problem	**4. Current partner has no mental health problems**
5. Current partner unemployed/has no day activity	**5. Current partner has job/structured day activity**

Section 6: Child	
1. IQ < 70	**1. IQ > 70**
2. Physical health problems	**2. No physical health problems**
3. Behavioural difficulties	**3. No significant behaviour management difficulties**
4. Frequent accidents	**4. Few accidents**
5. Child > age 6	**5. Child > age 6**
6. Male	**6. Male**

Parenting Support Study: Assessment Protocol

Participant: Angie Cross

Measures:	*Method:*	*Date administered:*
A. Parent Profile		
✓ ♦ *family history*	*review of medical notes*	
✓ ♦ *personal history*	*Parent Profile interview*	
✓ ♦ *cognitive functioning*	*WAIS(R)*	
♦ *behavioural memory*	*Rivermeade Behavioural Memory Test*	
♦ *reading ability*	*Neale Analysis of Reading Ability*	
✓ ♦ *physical health screen*	*community nursing assessment*	
✓ ♦ *mental health screen*	*community nursing assessment* *Tennessee Self Concept Scale* *additional measures if mental health problem identified*	
B. Environmental / Life style Profile		
* *maternal advantages/risks*	*Maternal Profile (adapted)*	
✓ * *current supports*	*Significant Others Scale (adapted)*	
* *perception of parental competence*	*Support provider interview*	
C. Parenting Skills Profile		
✓ • *parent child interaction*	*observation sessions*	
✓ • *knowledge of child development/child rearing*	*First Steps to Parenthood*	
✓ • *knowledge of home safety*	*Home Dangers Inventory*	

PARENTING SUPPORT STUDY: PARENT PROFILE

Client Details

Name: Angie Cross	***Date of Birth: 22/5/67***
Address: 9 Fairford Gardens	
GP: Dr Murray, The Inch Medical Practice	
Community Nurse: Heather Duff	
Other services involved: Michael Adair, Special Needs SW, Captains Rd.	
Day Time Occupation/Activity: N/A	

Family Details: ***Client Household***

1. Other Adults Living With Client

	Partner	***Mother/Father***	***Other***
Name:	Stephen		
LD (if known):			
Daytime activity:			
Community Nurse:			

2. Children Living With Client

	Child 1	***Child 2***	***Child 3***	***Child 4***
Name:	[redacted]	[redacted]	[redacted]	
Age:	12	10	4	
LD (if known)	no	no	yes (DS)	
School/Day Activity:	Portobello High	Liberton Primary	Prospect Bank	
Community Nurse:	N/A	Heather Duff	Heather Duff	

Other Significant Adults Not Living With Client
e.g. partner, ex-partner / father of children / mother of children, client's parent / grand-parent.

	Adult 1	***Adult 2***	***Adult 3***	***Adult 4***
Name: N/A				
Relationship to client:				

Other Children Not Living With Client

	Child 1	***Child 2***	***Child 3***	***Child 4***
Name: N/A				
Age:				
LD (if known):				
Placement *(e.g. father / foster care / other):*				

CLIENT PROFILE

A. Personal History

Angie was born in Inverness. Her mother, [redacted] has a long history of committing child abuse and of neglect. Angie stayed with her maternal grandparents for some time, but due to her being at risk and her grandparents ill health, Angie and her brothers were taken into care. [redacted] Initially, Angie lived in children's homes in Inverness, then she and her brothers, [redacted], went to live in Glasgow with adoptive parents, [redacted]
This is reported as not a positive experience for Angie. Whilst the boys remained in Glasgow, [redacted] were unable to cope with Angie. She then attended Canaan Lodge Home Assessment Centre in Edinburgh, before being placed in Hawthorn Brae, Duddingston, where she remained until she was 17. After leaving Hawthorn Brae she became pregnant and moved back to Glasgow. Her adoptive parents were unable to cope and so she moved back to Edinburgh.
Her brother [redacted] (28) lives in Germany, [redacted] (26) lives in Glasgow. She has two step sisters, aged 13 and 10 years, who live in Glasgow.

B. Medical History

Angie has a history of visual and hearing problems in her childhood.
She had a Caesarean section with [redacted], and has had seven miscarriages (?due to violent relationships).
Angie also has kidney problems, which have not been fully investigated as she discharged herself from hospital.
Current medication: depo prevara, injection 6 monthly; lactulose, daily.
She has been on a course of anti depressants, although is not currently.
Recent history of alleged drug misuse. Requires a lot of emotional and psychological support. Referral to Sandra Guinea for cognitive behavioural therapy.
Angie has a very negative self concept requiring a lot of positive support for her, in particular relating to her parenting skills and in terms of confidence with the children. Due to problems of her own needs, she finds it difficult to meet the children's needs on occasion.

C. Psychological Assessment

Angie's intellectual functioning was assessed using the Weschler Adult Intelligence Scales - Revised (WAIS-R). Her overall score places her in the "borderline" category.
Verbal Comprehension - Angie's strengths lay in the comprehension subtest, where she showed good ability for verbal/common sense reasoning and social knowledge. Her score here was significantly higher than her average verbal scores, falling in the 50th percentile.
Attention - She was able to show complex attention skills required for a coding task, do simple mental arithmetic and to manipulate a limited amount of information mentally.
Perceptual organisation - Angie was able to complete some puzzles requiring perceptual organisational and conceptual skills, but struggled as they became more complex.

PARENTING SKILLS PROFILE

A. Parent Child Interaction

Angie's interaction with [redacted] was observed during a routine assessment visit, rather than a specific observation session. Angie was therefore, quite child directive as she was attempting to give her attention to the assessment. However, she did also demonstrate child centred behaviour, giving [redacted] lots of smiles and attention, and listening to her when she was telling a story from her book.

B. Knowledge of Child Development

Angie showed good knowledge of appropriate play and development of 6-11 year olds. She understood the importance of a best friend and of family. She felt that peer groups were not as important as family, particularly with regard to [redacted] who likes to spend time with his older brother. Angie understood the needs of children in terms of starting school, having a regular bedtime and parents showing an interest. She finds bedtime very problematic however.
Angie also indicated that she feels it is important that she attends both [redacted]s and [redacted]'s reviews.

C. Knowledge of Home Safety

Angie's knowledge of Home Safety was good. She understood what a "fat fire" was and the dangers of a house fire and clothes fire. She understood the need to stay calm, although felt that in fact she may panic if the children were there. She knew to call for help / raise the alarm / phone for the fire brigade, as well as to lie on the floor. With regard to poisons and scalds, Angie was confident that she would be able to phone for the appropriate help, as her specific knowledge of what to do was limited. She knew how to clean a cut hand and apply a bandage.

ENVIRONMENTAL / LIFE STYLE PROFILE

A. Maternal / Paternal Advantages / Risks

1) Maternal background: Risk factors: Brought up in care
Advantage factors:
2) Current maternal physical / mental well-being: Risk factors: Feelings of low self worth
Advantage factors: IQ>60, good physical health, reading comprehension above age 8
3) Current maternal parenting behaviour: Risk factors: Inconsistent behaviour management & coping strategies, limited problem solving skills.
Advantage factors: Shows affection, plays/ interacts age appropriately, no evidence of child abuse.
4) Environment: Risk factors: Limited social support, inadequate housing.
Advantage factors:
5) Family: Risk factors: More than one child, older child.
Advantage factors:
6) Children: child 1: Risk factors:
Advantage factors: IQ >70, good physical health, >6 yrs old.
child 2: Risk factors: IQ ?<70, physical health problems, behavioural difficulties.
Advantage factors: >6 yrs old.
child 3: Risk factors: IQ <70, physical health problems, Down's Syndrome
Advantage factors: female

B. Summary of Current Supports

Angie named her step mum, [redacted] her step dad, [redacted] her brothers, [redacted], and her birth mother, [redacted], as significant people in her life.
There was little mismatch between actual and ideal support form her brothers [redacted]
Angie would like to be able to be more honest and able to talk over problems more with [redacted] as well as get more practical help. Similarly, she would like to be more honest with and ask for more help from [redacted], as well as to be able to spend more time with him. Angie would also like to be more honest and talk more with [redacted] as well as to be able to spend more time with her.

C. Perception of Parental Competence

From the referral: Lack of boundaries and of consistency. Although Angie has knowledge, she has difficulty with general application.

PARENTING SUPPORT PARTICIPATION

Attendance at group: Did not attend group (partly due to childcare problems, partly due to other family circumstances.)

Participation in group: N/A

Session Objectives: N/A

Homework tasks achieved: N/A

Any other comments: N/A

Individually Tailored Support: Yes / No

I.T.S. Summary

I.T.S. Worker :	
Key Goals	Goals Achieved
1	1
2	2
3	3
4	4
5	5

Summary:
Angie is an able parent who can become overwhelmed at times. She finds it difficult to balance her own needs with those of her children.

Recommendations:

Angie would still benefit from the group, but more specifically requires 1:1 support in the house.

Anne K Docherty.

Parenting Support Study: Bernie Harling, Community Charge Nurse
Heather Duff, Community Charge Nurse
Sandra Guinea, Consultant Clinical Psychologist
Anne Docherty, Assistant Psychologist

PRIVATE AND CONFIDENTIAL
11 August 1998
Unit No: 95183

Learning Disabilities Service
Community Nursing Service
(for People with Learning Disabilities)
Bonnington Resource Centre
200 Bonnington Road
Edinburgh
EH6 5NL

Tel: 0131 554 5404
Fax: 0131 554 2655

Sandra Guinea
Consultant Psychologist
139 Grange Loan
Astley Ainslie Hospital
Edinburgh
EH9 2HL

Dear Sandra

RE: ANGELA CROSS
DOB: 22/5/67
9 FAIRFORD GARDENS, EDINBURGH

I would like to formally refer Angie to you for assessment with regards to her suitability for cognitive behaviour therapy.

You are well aware of Angie's background having already completed a range of psychological testing on her for the parenting group so I will not repeat it.

At present Angie has just broken up her relationship with [redacted]. She is not coping with this. Her self esteem and confidence is rock bottom. Her coping mechanisms have further deteriorated and she is openly stating she cannot cope with herself; as well as the children. As a result [redacted] and [redacted] have been taken into care voluntarily. [redacted] remains at home. Angie has access twice weekly.

Angie due to her own needs has confessed to taking of DF 118 tablets and Valium bought on the street, and drunk down with alcohol. We have attended Dr Hennessy, GP, in regards to this. She was prescribed Librium which Angie has not taken correctly and states it was not beneficial. No further medication was then prescribed. She states she is also using Methadone. Angie has been referred to the CDPS for assessment, although Angie has many anxieties surrounding this as many of her ex partners/friends attend the CDPS (specifically [redacted]'s father who has abused both Angie and [redacted] in the past).

I have discussed this referral with Angie and she is more than happy about this. Welcoming the opportunity to explore many of her emotional difficulties.

I can be contacted at Bonnington to discuss the complexities of Angie further.

With many thanks

Yours sincerely

Heather Duff

Heather Duff
Community Charge Nurse

cc Dr Hennessy, Inchpark Surgery, 10 Marmion Crescent, Edinburgh EH16 5QU

Our Ref: SG/IM/
Date: 26 August 1998

Dr Hennessy
Inchpark Surgery
10 Marmion Crescent
Edinburgh EH16

Clinical Psychology Services
Learning Disabilities
Astley Ainslie Hospital
139 Grange Loan
Edinburgh EH9 2HL
Tel: 0131 537 9472/0

Dear Dr Hennessy

Re: Angela Cross, dob: 22.5.67
9 Fairford Gdns Edinburgh

I have been asked by Heather Duff, Community Charge Nurse to undertake some work with Angie. If I do not hear from you within 10 days, I will assume you have no objections to my involvement and I will arrange to see her in the near future. I will inform you of the outcome of this.

Yours sincerely

Sandra Guinea
Consultant Psychologist
SE Community Team

cc: Medical Notes

Our Ref: SG/IM/95183
Date: 26 August 1998

Heather Duff
Community Charge Nurse
Bonnington RC
200 Bonnington Road
Edinburgh

Clinical Psychology Services
Learning Disabilities
Astley Ainslie Hospital
139 Grange Loan
Edinburgh EH9 2HL
Tel: 0131 537 9472/0

Dear Heather

Re: : Angela Cross, dob: 22.5.67
9 Fairford Gdns Edinburgh

Than you for asking me to see Angie again. I will offer her an appointment in the near future and will keep you informed of my involvement.

Yours sincerely

Sandra Guinea
Consultant Psychologist
SE Community Team

cc: Medical Notes

UNIT No.

CLINICAL PSYCHOLOGY REPORT SHEET

NAME

ANGELA CROSS

PSYCHOLOGIST IN CHARGE : SC

PSYCHOLOGIST :

29th September '98

H/V Angie

Looking well

Boyfriend + 2 mates in ∴ not appropriate to talk.

— left.

A – pregnant (approx 6 wks) – not planned

GP appt tomorrow to confirm

Boyfriend pleased

A worried it may be another handicapped baby

— doesn't think she could cope

Ambivalent – other children now at school ∴ time to herself during the day – but back to looking after a baby.

Seeing Heather tonight

Letter → Heather

cc. GP

7th October

H/V – no-one in

— appt for 13/10

LHB 1481

13th October

H/V

Angie answered the door, but had visitors, + did not invite me in - also said floorboards were up - having heating sorted

Agreed to send out another appt.

3rd November

H/V

Angie looking quite well although c/o depressed mood, very weepy etc

Worried about baby - now 10 wks preg - has had bleeding - scans at SMMP - ok so far but should rest - boyfriend supportive

? not appropriate time to begin any work too preoccupied with preg. worries
∴ will not know if ? low mood due to hormones/ baby concerns / ~~too~~ negative thoughts.

However, A keen to talk.

HADS administered

Will see next week.

SC.

CLINICAL PSYCHOLOGY REPORT SHEET	UNIT No.
	NAME ANGELA CROSS

PSYCHOLOGIST IN CHARGE : SG. PSYCHOLOGIST:

10th November

H/V Angie - no-one in

Appt for 2/52.

SG

24th November

H/V - no-one in

SG.

LHB 1481

Our Ref: SG/IM/95183
Date: 14 September 1998

Ms A Cross
9 Fairford Gardens
Edinburgh

Clinical Psychology Services
Learning Disabilities
Astley Ainslie Hospital
139 Grange Loan
Edinburgh EH9 2HL
Tel: 0131 537 9472/0

Dear Angie

Heather Duff has asked me to visit you to have a ehat about your feelings. I will come to your house on Tuesday 29th September at 1.30 pm.

If this is not suitable, then please call my secretary on telephone number 537 9471.

I look forward to seeing you.

Yours sincerely

Sandra Guinea
Consultant Clinical Psychologist
SE Community Team

cc: Medical Notes

Our Ref: SG/IM/
Date: 7 October 1998

Heather Duff
Community Charge Nurse
NE Community LDS Team
Eastern General Hospital
Scafield Street
Edinburgh EH6 7LN

Clinical Psychology Services
Learning Disabilities
Astley Ainslie Hospital
139 Grange Loan
Edinburgh EH9 2HL
Tel: 0131 537 9472/0

Dear Heather

Re: : Angela Cross, dob: 22.5.67
9 Fairford Gdns Edinburgh

Thank you for referring Angic, whom I visited at home on 29 September. As you know, Angie and I had met previously, regarding assessment for inclusion in our Parenting Support Group. Then, as now, Angie presented as an articulate woman, who gave a full account of her history. Several recurring themes emerged, manly concerning her ambivalence towards her mother, her experiences of abuse, and her worries about the adequacies of her parenting. Her account also suggested a degree of learned helplessness and a very low opinion of herself.

Angie agrccd to see mc again and I plan to carry out some baseline assessments of her mood and her ability to takc on board the main aspects of modified cognitive behaviour therapy. Unfortunately, Angie was not at homc when I arrived for our second appointment so I will re-arrange this.

I will keep you informcd of my involvement.

Best wishes,

Yours sincercly

SG

Sandra Guinea
Consultant Clinical Psychologist
SE Community Team

cc: Medical Notes
Dr Hennessy, Inchpark Surgcry

Our Ref: SG/IM
Date: 28 October 1998

Ms A Cross
9 Fairford Gardens
Edinburgh

Clinical Psychology Services
Learning Disabilities
Astlcy Ainslie Hospital
139 Grange Loan
Edinburgh EH9 2HL
Tel: 0131 537 9472/0

Dear Angie

I will visit you at home on Tuesday 3rd November at 12 mid-day.

If this is not suitable, then please call my secretary on telephone number 537 9471.

Yours sincerely

Sandra Guinea
Consultant Clinical Psychologist
SE Community Team

cc: Medical Notes

Our Ref: SG/IM/95183
Date: 5 November 1998

Heather Duff
Community Charge Nurse
Eastern General Hospital
Seafield Street
Edinburgh

Clinical Psychology Services
Learning Disabilities
Astley Ainslie Hospital
139 Grange Loan
Edinburgh EH9 2HL
Tel: 0131 537 9472/0

Dear Heather

Re: : Angela Cross, dob: 22.5.67
9 Fairford Gdns Edinburgh

To update you on my involvement, Angie has only kept 2 out of 5 appointments so far, so progress has been very slow.

As you know, Angie is currently preoccupied with worries about her pregnancy and is obviously going through a difficult time. This in turn complicates the assessment picture, making it difficult to differentiate between negative, intrusive thoughts, genuine concerns for the baby, and low mood exacerbated by physical and hormonal changes.

What did concern me was Angic's suicidal ideation, although she said she felt better during my last visit, as she had been ablc to get out that morning. I think it would be important to monitor her suicidal thoughts and I would be happy to discuss this further with you. Interestingly, on formal assessment of mood, Angie presented with more symptoms/feelings of anxiety rather than depression, although I will monitor this as well.

Perhaps realistically, Angie is unlikely to be motivated to participate fully in our sessions until she is sufficicntly reassured (if possible) about her pregnancy. However, she has agreed to see me again next week and I will continue the assessment process. I will keep you informed of my involvement.

Yours sincerely

SG

Sandra Guinea
Consultant Clinical Psychologist
SE Community Team

cc: Dr Hcnnessy, Inchpark Surgery
Medical Notes

File

Our Ref: SG/IM/95183
Date: 18 December 1998

Dr Hennessy
Inchpark Surgery
10 Marmion Cres
Edinburgh EH16

Clinical Psychology Services
Learning Disabilities
Astley Ainslie Hospital
139 Grange Loan
Edinburgh EH9 2HL
Tel: 0131 537 9472/0

Dear Dr Hennessy

Re: : Angela Cross, dob: 22.5.67
9 Fairford Gdns Edinburgh

Since I last wrote, Angie was not at home when I called again, and I have not seen her since 3 November.

I have discussed her with Heather Duff, and it was felt that in view of Angie's forthcoming amniocentesis, that it would be better if I arranged to see her after the Christmas holiday.

I will let you know of the outcome of this.

Yours sincerely

Sandra Guinea
Consultant Clinical Psychologist
SE Community Team

cc: Medical Notes

file

Our Ref: SG/IM/
Date: 18 December 1998

Angie Cross
9 Fairford Gardens
Edinburgh

Clinical Psychology Services
Learning Disabilities
Astley Ainslie Hospital
139 Grange Loan
Edinburgh EH9 2HL
Tel: 0131 537 9472/0

Dear Angie

I'm sorry I missed you again. I have spoken to Heather and we felt it would be better if I waited and came to see you after the Christmas holidays. I will write to you again to arrange a time.

Have a happy Christmas.

Yours sincerely

Sandra Guinea
Consultant Clinical Psychologist
SE Community Team

cc: Medical Notes

2 March 1999

Sandra Guinea
Consultant Clinical Psychologist
Learning Disability Team
139 Grange Loan
Astley Ainslie Hospital
Edinburgh
EH9 2HL

Community Nursing Service
(for People with Learning Disabilities)
Eastern General Hospital
Seafield Street
Edinburgh
EH6 7LN

Tel: 0131 536 7160

Dear Sandra

RE: ANGELA CROSS
DOB: 22/5/67
9 FAIRFORD GARDENS, EDINBURGH

I am writing to let you know I will be closing Angie's case to Community Nursing shortly. I have had a full discussion with Angie; she is aware and understanding that I will be transferring the children to Janette Mathieson, Community Learning Disability Nurse in the South East Team. Angie is quite upset about the transfer at the moment, but we have discussed how we can make the transition as easy as possible for all concerned. Angie feels unable to accept Community Nursing support for herself, but is aware she will be able to receive informal carer support once she has established a relationship with Janette.

Angie has requested I write to you, to request you recommence counselling work with her. She feels life has settled down a bit and she is more able to commence individual 1:1 work. She is keen to re-establish contact with you. I would be more than happy to discuss this further with you in more detail.

I look forward to hearing from you.

Kind regards

Yours sincerely

Heather

Heather Duff
Community Charge Nurse
North East Edinburgh

cc Medical Records
Dr Murray, GP

CLINICAL PSYCHOLOGY REPORT SHEET

UNIT No.

NAME

ANGIE CROSS

DC (1)

PSYCHOLOGIST IN CHARGE : SG

PSYCHOLOGIST:

24th March '99

H/V Angie

In good form - bright in mood

Appears to have coped well with loss of baby

On Depo Provera — has put on weight — annoyed by this

Boyfriend still around.

[redacted] - having probs at school

A happy to work with Janette Mathiesen

Been let down by Share-the-Care at last minute

-looks forward to w/end breaks.

Having sister over for Easter holidays

Will contact after that.

SG.

letter → GP.

CLINICAL PSYCHOLOGY REPORT SHEET

UNIT No.

NAME

ANGIE CROSS

DC (2)

PSYCHOLOGIST IN CHARGE : SG

PSYCHOLOGIST:

28th April

H/V Angie

'Stressed out'

[redacted] respite ~~stopped~~ - no-one helping

Tearful ++

'Down - depressed'

Eating to comfort ~~[illegible]~~ myself

No periods for 9 wks since injection stopped

Stomach blown out - ? pregnant

GP checked - NAD - pregnancy test every week
- all negative

Can't move bowels - take tablets

[redacted] tantrums, crying a lot
- feeding probs - won't eat at school
School want A not to feed her - A can't
-spoon feeds.

A - too hard - give in to N

GP won't give anything
-had drug problem last year - DFs + valium
-put children in care cos I knew I had a problem.

On DFs again

LHB 1481

Takes 2 in evening

By 7 - in pain, nose + eyes running

— takes DF - 'like speed' → energy ++

Initially prescribed them for broken finger and

swollen / twisted neck (14 tabs) - now gets them

'on the street' / from mates, although trying to keep

away from mates.

[redacted] - not going to school or Army cadets

now grounded

A - just wants to go away by herself.

- worried that children will end up in care again

- angry at SW for not acting

Janette Mathiesen visiting today

Will see Angie next week.

SG

5th May

H/V

Angie not at home.

SG

UNIT No. ████

CLINICAL PSYCHOLOGY REPORT SHEET

NAME

ANGIE CROSS.

DC (3)

PSYCHOLOGIST IN CHARGE : SCh   PSYCHOLOGIST:

23rd June

H/V

A looking well - had good holiday in Tenerife

Worried about not coping with summer holidays

To mood swings

anger -

feel people are putting me down - I try to do better

- makes me mad

→ challenge

- give example - if school phone accusing me

I get mad

think everyone's gone behind my back

- if ████ says at school that he's not sleeping cos me + ████ are arguing

- Michael phones me to check up

- ~~should~~ School phone me first - not social work

- I'm not a child beater - ████ on supervision cos of partner not me

- feel people don't believe me

- in my head I think people put me down

Janette wants me to go to a GP for ████ but I've been to them all - didn't help - I've been round that block before

CLINICAL PSYCHOLOGY REPORT SHEET

UNIT No.

NAME

ANGIE CROSS

1c (i)

PSYCHOLOGIST IN CHARGE : SG PSYCHOLOGIST:

8th May

Discussed with Janette Matwesai

- Angie similar presentation tho' not crying but obviously upset

- wanting time away to herself.

J T/C to Michael Adair, who agreed to visit that day (28/4) and will hopefully arrange respite so that Angie gets a break.

A did not want J to visit for a couple of weeks - didn't feel the need.

J to contact Michael again for update.

SG.

feedback from Janette

- Angie off to Tenerife for 1 week.

- will arrange appt.

Our Ref: SG/IM/95183
Date: 31 March 1999

Dr Hennessy
Inchpark Surgery
10 Marmion Cresc
Edinburgh

Clinical Psychology Services
Learning Disabilities
Astley Ainslie Hospital
139 Grange Loan
Edinburgh EH9 2HL

Tel: 0131 537 9472

Dear Dr Hennessy

Re: Angela Cross, dob: 22.5.67
9 Fairford Gdns Edinburgh

I have recently resumed contact with Angela, as she has requested 'counselling'. She appears to be coping with the loss of her baby, and reported that she currently felt quite well in herself. My plan will be to assess her for her ability to cope with modified cognitive behaviour therapy and then work on her self esteem and parenting skills. I will also liaise with Janette Mathieson, Community charge Nurse who will be providing support with Angela's daughter ■■■■.

I will keep you informed of my involvement.

Yours sincerely

Sandra Guinea
Consultant Clinical Psychologist
SE Community Team

cc: Medical Notes
Michael Adair, Social Worker

Our Ref: SG/IM/95138
Date: 24 June 1999

Dr Murray
Inchpark Surgery
10 Marmion Crescent
Edinburgh

Clinical Psychology Services
Learning Disabilities
Astley Ainslie Hospital
139 Grange Loan
Edinburgh EH9 2HL

Tel: 0131 537 9472/0

Dear Dr Murray

Re: Angela Cross, dob: 22.5.67
9 Fairford Gdns Edinburgh

Angela has kept a further 2 out of 3 appointments, and on my last visit she looked well following her recent holiday in Tenerife.

My plan is to further explore Angela's feelings about her own upbringing and her perceived inadequacies as a parent. She would also appear to be stuck in a behavioural pattern of interpreting any comments made about her children as criticism of her and responding in a defensive and hostile way. She is also concerned about the school holiday and how she will cope with the children at home.

I am about to go on annual leave and Angela has agreed to see me on my return.

I will keep you informed of my involvement.

Yours sincerely

Sandra Guinea
Consultant Clinical Psychologist
SE Community Team

cc: Medical Notes
Janette Mathieson, CCN
Michael Adair, SWD

Chairman: Mr Garth Morrison CBE
Chief Executive Designate: Mr David Pigott

Our Ref: JM/IM/95183
Date: 21 September 2000

Sandra Guinea
Consultant Clinical Psychologist
139 Grange Loan
Astley Ainslie Hospital

Community Nursing Service for
People with Learning Disabilities
Astley Ainslie Hospital
139 Grange Loan
Edinburgh EH9 2HL

Tel: 0131 537 9470/3/7
Fax: 0131 537 9475

Dear Sandra

Re: Angela Cross, dob: 22.5.67
9 Fairford Gdns Edinburgh

In visiting to review [redacted] Angie has asked me to contact you about the possibility of seeing her again. She is under considerable stress at the moment and struggling to cope.

[redacted] continues to present with problems with behaviour and sleep. Her share the carer has stopped working and there is no respite care in place. Angie hopes this will be addressed very soon. [redacted]s brother [redacted] seems to be having problems settling into high school and is being bullied. Angie is 5 months pregnant and has been having difficulties with bleeding throughout the pregnancy with the threat of losing the baby. Her natural mother made contact with her a few months ago and stayed with her. Aside form bringing up difficult issues from her childhood, Angie's mum seems to have lied to Angie about being terminally ill and abused her trust. She was apparently often under the influence of alcohol and/or drugs and Angie ended up telling her to leave the house.

Because of the pregnancy Angie is unable to take antidepressants, and feels in need of some support to help her deal with the current stress. She would appreciate contact from you again.

Yours sincerely

Janette Mathieson
Community Charge Nurse
South East District

Chairman:* *Mr Garth Morrison CBE
Chief Executive Designate: Mr David Pigott

Our Ref: SG/IM/95183
Date: 9 October 2000

Angela Cross
9 Fairford Gardens
Edinburgh

Clinical Psychology Services
Learning Disabilities
Astley Ainslie Hospital
139 Grange Loan
Edinburgh EH9 2HL

Tel: 0131 537 9472
Fax: 0131 537 9475

Dear Angela

Janette Mathieson has told me that you would like some more support at the moment. I would like to visit you at home on Tuesday 24 October at 1:30 pm. If this appointment is not suitable, then please call my secretary on telephone number 537 9471.

I look forward to seeing you again.

Yours sincerely

SG

<u>*Sandra Guinea*</u>
Consultant Clinical Psychologist
SE Community Team

cc: Medical Notes

CLINICAL PSYCHOLOGY REPORT SHEET

UNIT No.

NAME

ANGELA CROSS

PSYCHOLOGIST IN CHARGE : SG

PSYCHOLOGIST:

24th Oct.

H/V Angie

no-one in - will rearrange

SG

1st November

H/V Angie

no-one in

SG

LHB 1481

CLINICAL PSYCHOLOGY REPORT SHEET

UNIT No.

NAME

ANGIE CROSS

PSYCHOLOGIST IN CHARGE : [illegible] .

PSYCHOLOGIST:

2/11/98 H/V

HADS

A: 2.

1. Tense
- very annoyed - narky
argumentative

Suicidal thoughts - want to end it all

Crying ++ very low
Ok today because I've been out
feel sorry for myself.
Worried about the baby.

D: 2

2. Not going out just now
Effort to go to the shops
Nothing out there for me.

Method - take tablets
have slit my wrists in
the past - not serious

Neglect myself - don't eat for 3/5 days
Punish -

Eating just now - frightened I lose the baby
Try + eat once a day.

LHB 1481

3. Frightened feeling?

s'times think ███ will be taken away

(A:3) very anxious if she gets an illness

- should be able to prevent it

am I neglecting them?

want to make their life better than I had.

get myself so worked up - breathing goes all funny

- used to have panic attacks

- sheet for breathing exercises - helped.

4. Can't

- can't see anything funny on TV

(D:3) - take everything too serious

- take " to heart

paranoid - are people saying bad things about my kids? don't understand

5. Worried about the baby

(A:2) is ███ going to turn out like his father?

Is this my fault?

6. Cheerful?

(D:3) No - feel people are out there picking on me + talking about it

7. ok at night time

(A:1) watch TV

not sleeping - too tense to sleep.

8. Just the same.

(D:0)

9. no

(A:0)

CLINICAL PSYCHOLOGY REPORT SHEET

UNIT No.

NAME

ANGIE CROSS
(HADS cont 2/11/98)

PSYCHOLOGIST IN CHARGE :

PSYCHOLOGIST:

10. aye, still do that
(hair done
make up on
jewellery on
nice clothes).

(D:0)

11. no.

(A:0)

12. aye - children getting on in life
Xmas? - no - money probs
but I like it
too worried to look forward to the baby.

(D:0)

13. aye - out of breath.
happens a lot.
Shout at kids - get flustered.

(A:3)

14. aye - like my telly
a comfort to me.

(D:0)

A: = 11

D: = 8

LHB 1481

ANGIE CROSS 23/6/99

Self Esteem Questionnaire
(adapted from Robson P, Psychological Medicine 1989)

Instructions

This is to help me understand how you feel about yourself most of the time.

I am going to read out a list of different things that people might say about themselves. For each one, I want you to tell me if you agree with it, if you think these things about yourself and your life. Remember this is about how you feel most of the time, not just on a good or bad day.

Example: I am a happy person most of the time

Choose the box that shows how much you agree with this.

first time I've got dressed + make up on but I'm going to a funeral

no don't agree	agree a wee bit	agree a big bit	definitely agree lots
☐	☐	☐	☐

Now do the same for these sayings:

Example

	no don't agree	agree a wee bit	agree a big bit	definitely agree lots
1. I am not embarrassed to tell people what I think about things	☐	☐	☐	☑
2. I seem to be very unlucky	☐	☐	☐	☑
3. I am easy to like	☐	☐	☑	☐
4. If a job is difficult, it just makes me try all the harder to do it	☐	☐	☐	☐
5. I'd like to change lots of things about myself	☐	☐	☑	☐
6. I can never seem to be good at anything important	☐	☑	☐	☐

(Handwritten beside item 2:) Everyone sees me coming

(Handwritten beside item 5/6:) my attitude but I'm not sure

worried about looks
- too fat
- too sluttish

I felt like I failed when I did a college course
Bad tempered when everyone else could do it and I couldn't

	no don't agree	agree a wee bit	agree big bit	definitely agree lots
7. I don't care what happens to me	☐	☐	☐	☑
8. I control my own life I do what I want when I want	☑	☐	☐	☐
9. Most people think I'm quite good looking	☐	☑	☐	☐
10. I am happy that I am me	☑	☐	☐	☐
11. Most people would take advantage of me if they could	☐	☐	☑	☐
12. I am a reliable person	☐	☑	☐	☐
13. People would be bored if I talked about myself	☐	☐	☐	☐
14. When I'm good at something or when something good happens, it is because of luck	☐	☑	☐	☐
15. I have a nice personality	☐	☐	☑	☐
16. I never feel fed up for very long	☑	☐	☐	☐
17. I often feel embarrassed/ashamed	☐	☐	☑	☐
18. I can usually make up my mind and stick to it	☐	☑	☐	☐
19. Everyone else seems more confident and happier than me	☐	☐	☐	☑

Handwritten annotations:

- 7: s'times I want to go away or go to sleep + not wake up.
- 8: I feel people are watching me that I'm not doing things right
- 9: I don't
- 10: I wish my life was different but I've achieved having children
- 12: but others will say no! I forget appointments but I forget when I'm under pressure
- 15: aye but mood swings
- 17: I think people think I'm no good.
- 19: I feel hard done by – lost everything but I won't let my children suffer

self blame 'should' statements.

	no don't agree	agree a wee bit	agree big bit	definitely agree lots
20. Even when I have good fun there doesn't seem much point to it	☐	☐	☐	☐
21. I often worry about what other people think about me	☐	☐	☐	✓
22. I believe in 'what will be will be' - you can't make things happen in your life	✓	☐	☐	☐
23. I look terrible just now	✓	☐	☐	☐
24. If I try hard I can sort out my problems	☐	✓	☐	☐
25. It is hard going being me	☐	✓	☐	☐
26. I feel I have adult feelings	☐	☐	☐	✓
27. When people tell me off/ point out mistakes, I feel helpless and not as good as them	☐	☐	☐	✓
28. If I'm going through a hard time, I often think 'why bother?'	☐	☐	☐	✓
29. I like myself even if others don't	☐	✓	☐	☐
30. People who know me well are fond of me	☐	☐	✓	☐

(22) up to you not fate.

(23) overweight
used to feel guilty about eating

(24) depends on my mood - if I'm emotional - I'll try but if s'one puts me down, that's me.

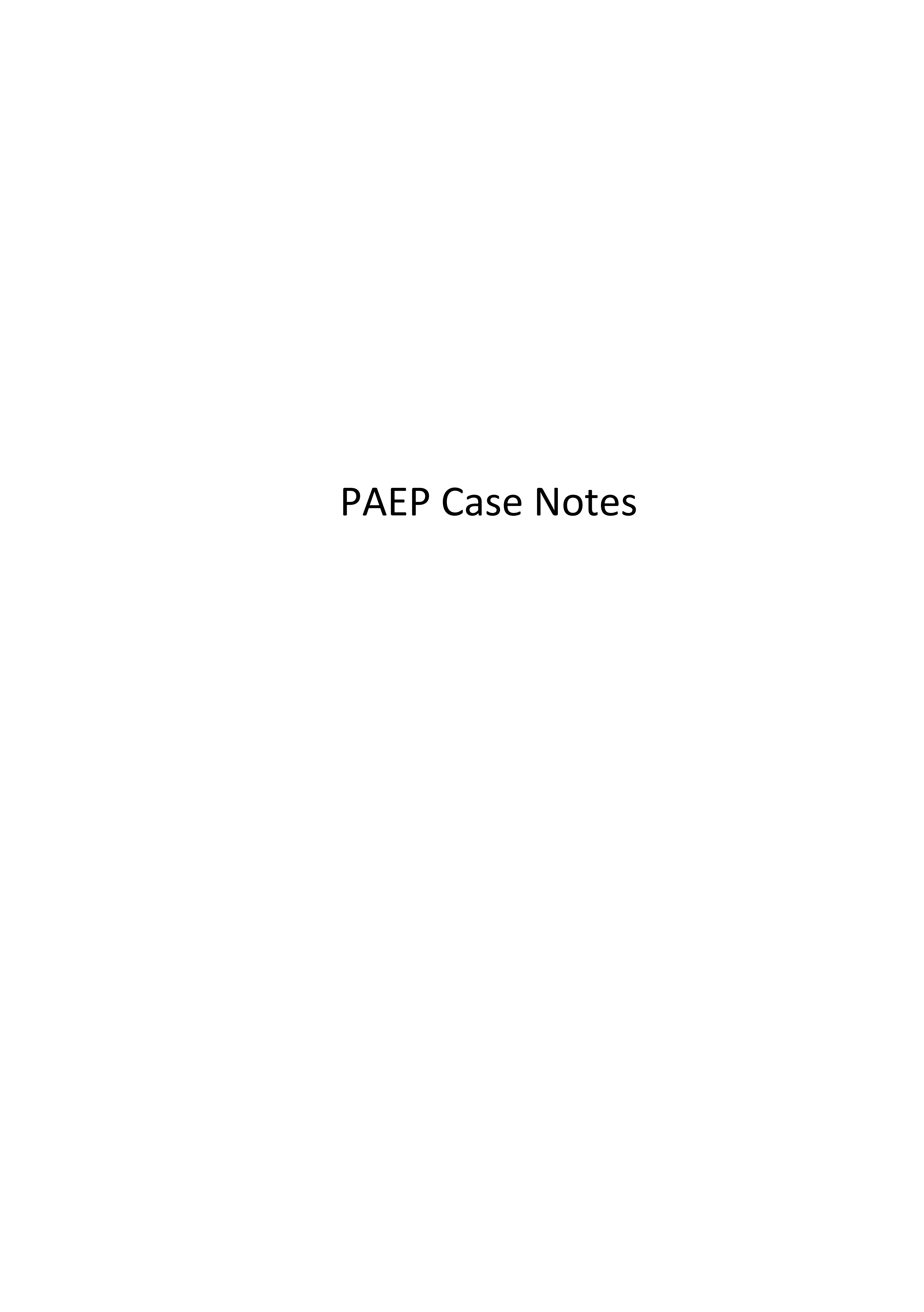
(25) s'times
I try to do things right but if it goes wrong I'm hard on myself.

(26) never a child

(29) s'times

(30) don't like people knowing my past
- in care etc - I'm ashamed that I was neglected
I get jealous of people who have nice families

sg/boxes/210499



PAEP Case Notes

LOTHIAN UNIVERSITY HOSPITAL NHS TRUST
ROYAL INFIRMARY OF EDINBURGH
PRINCESS ALEXANDRA EYE PAVILION

NAME A77100 JA Scott 620045326K F 22/05/1967 Cross, Angella 44 Woodburn Bank, Dalkeith, Midlothian, EH22 2EY CHI 2205671464 POSTCODE TEL NO.	UNIT NO	DATE OF BIRTH AGE
	MAIDEN SURNAME	
	MARITAL STATUS / SEX	RELIGION
CHANGE OF ADDRESS POSTCODE TEL NO.	OCCUPATION/INDUSTRY IF HOUSEWIFE – HUSBAND'S OCCUPATION IF CHILD – FATHER'S OCCUPATION	
FAMILY DOCTOR Dr Scott. Newbattle M/P. TEL NO	IF RETIRED – LAST OCCUPATION PRECEDED BY RETIREMENT NAME AND ADDRESS OF NEXT OF KIN RELATIONSHIP TO PATIENT TEL NO.	
CHANGE OF FAMILY DOCTOR TEL NO	HAZARDS CONSULTANT H Bennett. ADMISSIONS	

DATE OF ATTENDANCE	DIAGNOSIS / VISUAL ACUITY R/L	SEEN BY	CODING	DATE OF ADMISSION	DATE OF DISCHARGE	DIAGNOSIS AND/OR OPERATION	CODING
180516							
CJD	HIGH / LOW						
	RISK / RISK						
SIGNATURE							

OVERSEAS VISITORS – STAGE 1 QUESTIONNAIRE

	yes	no
Q1. HAVE YOU (YOUR HUSBAND/WIFE/MOTHER/FATHER) BEEN LIVING IN THE U.K. FOR 12 MONTHS?	☐	☐
Q2. ARE YOU (YOUR HUSBAND.WIFE/MOTHER/FATHER) GOING TO LIVE IN THE U.K PERMANENTLY?	☐	☐

NOT LIABLE DATE			
LIABLE			
FOR STAGE 2			
DATE OF INTERVIEW			

On call 17.00 15/1/16 pt will have referral

NHS LOTHIAN

S.N 086272

Princess Alexandra Eye Pavilion — Acute Referral Clinic

In Confidence

Consultant HB

White Copy (top) - File | White Copy (middle) - Pharmacy | Pink Copy - G.P.

Surname / First Name / DOB / Address	620045326K F 22/05/1967 Cross, Angella 44 Woodburn Bank, Dalkeith, Midlothian, EH22 2EY CHI 2205671464 77106. JA Scott	Date 15-1-15 Time 1645	Occupation Driving YES or NO
		GP	
		Address	
Home Tel	Work Tel	GP Tel	

History: GP referral - suspected iritis. Pt c/o throbbing pain + sticky discharge.
POH - infections, squint ops
FOH - squints
Allergies - NKDA
Medication - Bendroflumethiazide, Lisinopril, Mirtazapine
PMH - see GP letter

Visual Acuity: Right Eye 2/36 — Left Eye 6/36-1 +PH 6/24

Jess Nelson

LA already instilled + No sens. 18 - AT -

2-3 days Red, sore RE.
Sticky ++ - Mild photophobia - dryness.
Better today. Vision 'misty' 24°
Painful - was crying with pain at one point
No S+L(C).
Ongoing URTI
CL wearer - monthly disposable (*)
last worn 3/7 ago - No swimming fresh water
Cold sore on lip ~3/52 ago

Right: Dilated Pupil, hyperaemia. patchy PEEs + ?precipitates / stromal oedema — agree. Deep ? few cells — agree. No hypopyon. lens

Left: ?v. faint small infiltrate L lids + Quiet. Stromal oedema. Amblyopia (strabismus) NAD. Clear cornea. AC deep. White eye.

DIAGNOSIS
(R) Keratitis in only eye c stromal oedema, epithelial disease in CL wearer c h/o cold sores

Recommendations/Comments
? Acanthamoeba ?? disciform

Medicine	Dose	Administration Times	Additional Instructions	Quantity	LJF*	Dispensed By
Rapid ↓ vision						
Plan Admit.		1° Chlorhexidine + Brolene	Cyclo tds.			Moxifloxacin 2°.
		Aciclovir 400mg x5.				
HSV swab.		Scrapes in acanthamoeba ✓	Send	CL when family bring it in.		

(*) Has showered in CLs and wore last CLs for >1 month

Discharge: GP Optician Clinic		Acute Returns Clinic	Discharge
Signatures: NURSE		DOCTOR: [signature]	Pager No
Print Name		Print Name Hall	LS form in notes
Time Seen		Time Seen	

* Tick box if drugs not on the 'Lothian Joint Formulary' and give explanatory note for non-formulary medicines under recommendations/comments

LU 072

Small ED post scrape. d/w HB

On call 17.00 15/1/16

Pt will have [illegible]

NHS LOTHIAN

S.N 086272

Princess Alexandra Eye Pavilion / Acute Referral Clinic

Consultant HB

In Confidence

White Copy (top) - File | White Copy (middle) - Pharmacy | Pink Copy - G.P.

Surname CROSS	M/F	Date 15.1.15	Occupation
First Name ANGELA		Time 1645	Driving YES or NO
DOB 22/05/1967	Age	GP	
Address		Address	
Home Tel	Work Tel	GP Tel	

History GP referral - suspected iritis. Pt c/o throbbing pain + sticky discharge

POH - infections. Medication - Bendroflumethiazide, Lisinopril, Mirtazapine

FOH - squints. PMH - see GP letter

Allergies - NKDA

Right Eye 2/36 — Visual Acuity — Left Eye 6/36 + PH 6/24

18 - AT -

2-3 days Red, sore RE. Sticky ++. Mild photophobia. Better today. Vision ... 24. Painful ... crying with pain at one point. Dilated ... No Sx LE. ... CL wearer - monthly disposable (*). Last worn 3/7 ago - washing ... tap water.

LA already notified, ... Nurses.

? v. faint small infiltrate. Lids + ... Stromal oedema. ... agree. ... Amblyopia (...) N/SQ. Clear cornea. AC deep. White eye.

DIAGNOSIS (R) Keratitis in amblyopic eye: stromal oedema, epithelial disease in CL wearer c h/o cold sores

Recommendations/Comments ? Acanthamoeba ?? disciform

Medicine	Dose	Administration Times	Additional Instructions	Quantity	LJF*	Dispensed By
Rapid ↓ vision						
Na Adult. 1° Chlorhexidine + ...				Cycle ...		Moxifloxacin 2
Aciclovir 4...						
HSV ... Ferrous in acanthamoeba ✓ ...						Send CL when ... bring it in.

Discharge: GP Optician Clinic	Acute Returns Clinic	Discharge
Signatures: NURSE	DOCTOR:	Pager No
Print Name	Print Name Hall	
Time Seen	Time Seen	

(*) Has showered in CLs and wore last CLs for >1 month

Cold sore on lip ~3/52 ago

Jane Wilson

LS form in notes

Small ... part scrape

* Tick box if drug is not on the 'Lothian Joint Formulary' and give explanatory note for non-formulary medicines under recommendations/comments

LU 072

... HB ✓

17.10 15/11/16

NHS LOTHIAN

S.N 086272

Princess Alexandra Eye Pavilion / Acute Referral Clinic

In Confidence

Consultant [illegible]

White Copy (top) - File | White Copy (middle) - Pharmacy | Pink Copy - G.P.

Surname [illegible]	M/F	Date 15/[illegible]	Occupation
First Name [illegible]		Time 1645	Driving YES or NO
DOB 22/05/1967	Age	GP	
Address		Address	
Home Tel	Work Tel	GP Tel	

History GP [illegible] ? suspected iritis. Pt c/o [illegible] pain [illegible]

POH – [illegible] Medication – [illegible] bendroflumethiazide

[illegible] squints

FOH – squints [illegible]

Allergies – NKDA

Visual Acuity Right Eye 2/36 | Left Eye 6/36 [illegible] +PH 6/24

[illegible] 18 – A T – [illegible] Amblyopic

2-3 days [illegible]

[illegible] LUSC [illegible] oedema [illegible] NSd

Better [illegible]

[illegible] agree [illegible] Clear cornea [illegible]

CL wearer – monthly [illegible] (*) – agree [illegible] White eye

[illegible] 3/52 ago [illegible]

DIAGNOSIS– (R) Keratitis [illegible] stromal oedema, epithelial [illegible] CL wearer [illegible]

Recommendations/Comments

? Acanthamoeba ?? [illegible]

Medicine	Dose	Administration Times	Additional Instructions	Quantity	LJF*	Dispensed By
[illegible]						
[illegible]		1° Chlor [illegible]	[illegible]	Cyclo [illegible]		[illegible]
		[illegible]				
[illegible]		[illegible]	[illegible]	[illegible]		CL [illegible]

(*) Has [illegible] CLs and [illegible]

Discharge: GP Optician Clinic		Acute Returns Clinic	Discharge [illegible]
Signatures: NURSE		DOCTOR: [signature]	Pager No
Print Name		Print Name [illegible]	
Time Seen		Time Seen [illegible]	[illegible] notes

* Tick box if drug is not on the 'Lothian Joint Formulary' and give explanatory note for non-formulary medicines under recommendations/comments

LU 072

[illegible] #1 HA ✓

NEWBATTLE MEDICAL PRACTICE

Dr. H.M. Ansell
Dr. P. Bailey
Dr. A.H. Glencross
Dr. A. Ma
Dr. I. Morrisoo
Dr. R.A.B. Morrison
Dr. A. McClelland x
Dr. E. Read
Dr. L. Smart

BLACKCOT
MAYFIELD
DALKEITH
MIDLOTHIAN
EH22 4AA

TEL: 0131-663 1051
FAX: 0131-654 0665

2205671464 F
CROSS
Angella
31a Allan Terrace
Dalkeith
EH22 1EL 22/05/1967

15 JAN 2016
3pm

Dear Dr,

painful red rt eye since yesterday with loss of vision.

Eye is red, tender + photophobic. Unable to see the light. — Not unable to read chart.

c/o clear discharge since yesterday.

new patient - says ph of infections.

Cornea appears hazy

? uveitis

Like a line over the eye.

ph enc.

Thank you

[signature]

Encounter Report

Address and Telephone numbers

31a Allan Terrace Dalkeith EH22 1EL
Telephone - home 07907228916
Telephone - home 0131 531 1195

Significant Medical History

30/09/2013 Essential hypertension
27/08/2013 Anxiety states
28/08/2006 Reduction mammoplasty -bilateral
29/09/2003 Closed fracture navicular
10/12/2001 Endoscopic bilateral female sterilisation
19/10/2001 Thyroid gland operations -removal of cyst
13/06/2001 Thyroglossal duct cyst
25/01/2001 Caesarean delivery
17/12/1998 Miscarriage
25/07/1997 Iron deficiency anaemias
30/11/1994 Pneumonia due to unspecified organism
22/03/1994 Acute pyelonephritis
23/07/1993 Caesarean delivery
28/05/1993 Microcytic hypochromic anaemia
22/09/1992 Self-harm -cut wrists
20/07/1992 Miscarriage
18/04/1991 Termination of pregnancy NEC
23/10/1989 Termination of pregnancy NEC
19/12/1988 Spontaneous vaginal delivery
09/02/1988 Miscarriage
15/11/1987 Miscarriage
11/11/1986 Neurotic depression reactive type -ongoing
10/07/1986 Termination of pregnancy NEC
14/08/1983 [X]Intentional self poisoning/exposure to noxious substances

Chronic Disease Register

Essential hypertension Placed on register: 30/09/2013
No data recorded.
No data recorded.
No data recorded.
No data recorded.
No data recorded.
No data recorded.

Current Repeat Medication

No data recorded.

Acute and Repeat issues in last 3 months

No data recorded.

Allergies and Intolerances

No data recorded.
No data recorded.

Recalls - 3 months back to 1 month in future

No data recorded.

Referrals and Requests in last 3 months

No data recorded.

Tests in last 3 months

No data recorded.

Last Consultation

03/09/2015 Administration Mrs Lisa Forbes
03/09/2015 Suspected diabetes mellitus Mrs Lisa Forbes

Prevention

No data recorded.
No data recorded.
No data recorded.
No data recorded.
No data recorded.
No data recorded.
05/04/2011 Cervical smear: negative
No data recorded.

New Consultation Details

Date: Clinician:

PAEP EYE DEPARTMENT

CONTINUATION SHEET

EP30

NAME

UNIT NO:

620045326K F
CROSS Angella
22-May-67 CHI: 220 567 1464
77106 JA Scott
31A ALLAN TERRACE
EH22 1EL

Date	RIGHT EYE	LEFT EYE	Signature + time
15.1.16 2020	C2 medical admission		
	PMH: HTN	Thyroglossal cyst	
	Anxiety (previous	depression)	
	Meds: Lisinopril, BR2, Mirtazapine		
	NKDA		
	OE Well at rest. Obese	WWP	
	HS I+II+0	Chest clear	
	No pedal oedema	Calves SNT	
	Abdo SNT	GCS 15	
	→ Admit		
	Lung clinic ✓		[signature] STq
15/1/16	Gram stain → No organisms seen.		[signature] Hall Snr

PAEP EYE DEPARTMENT

CONTINUATION SHEET

EP30

NAME

UNIT NO:

Date	RIGHT EYE	LEFT EYE	Signature + time
16/1/16	6/24 gl		
	6/12 PH		
	faint subepithelial [illegible] patch		
	better		
	moxifloxacin 1° day		
	x2 doses d/w		
	stop [illegible] Rx		
	[illegible]		[illegible]
17/1/17	VA ↑ pain ↓ 6/12 gl		
	feels much better 6/9+1 gl + PH		
	central haze; healing epithelium	Imp healing R central lens ulcer	
		Plan D/C drops	
		1° moxiflox 6am → 12 midnight	
		+ start 3am [illegible]	
	no endothelial KPs/dusting	[illegible] next	[illegible]
	no DM folds		
	no cells / flare	No CL wear	

Eye Department Continuation Sheet

NHS Lothian

620045326K F 22/05/1967
Name: Cross, Angella
44 Woodburn Bank,
Dalkeith,
D.o.B: Midlothian,
EH22 2EY
CHI No: CHI 2205671464

have requested notes
appt with HB 20/1/16

DATE	RIGHT EYE	LEFT EYE	SIGNED
19/1/16	Triage - Results of RE corneal scrape.		
	1 CSU ENTEROCOCCUS FAECALIAS	(not the best)	
13.15	sensitivities - Amoxycillin, chloramphenicol, gentamicin, vancomicin		
	(lab contact 52004)		Douglas
20/1/16	6/9 sc	6/36	CSW Spence
	6/6 -1 pH	6/18	[illegible]
	feels better		
	c/e		
	v. faint haze		
	no oedema (EC)		
	(P) ↓ moxiflox 2°		
	chlor ON		
	FML TDS		
	rev 1/52		[illegible]
27.1.16	DNA		
17.5.16	DNA		

LOT 810 - May 2015

DATE	RIGHT EYE	LEFT EYE	SIGNED

PAEP EYE DEPARTMENT CONTINUATION SHEET EP30	*NAME* *UNIT NO:*

Date	RIGHT EYE	LEFT EYE	Signature + time

PAEP EYE DEPARTMENT

CONTINUATION SHEET

EP30

NAME

UNIT NO:

Date	RIGHT EYE	LEFT EYE	Signature + time

Princess Alexandra Eye Pavilion
Chalmers Street
EH3 9HA

Cont'd... **Ref:** 620045326K **Patient Name:** Angella Cross

CHANGES TO DNACPR STATUS OR ANTICIPATORY CARE PLANNING
GP to please consider the following...

Should you need further information please contact...

Information contained in this letter has been discussed with the patient/carer.

Yours sincerely.........................

Staff Signature......................... PrintName.................................

Designation............................ Date................ Time..................

Patient/Carer Signature...

This is an immediate discharge letter and a further letter may follow.

Impatient Discharge Summary

PRINCESS ALEXANDRA EYE PAVILION WARD E2
ADMISSION DOCUMENTS

ADD 620045326K F
CROSS Angella
22-May-67 CHI:220 567 1464
77106 JA Scott
31A ALLAN TERRACE
EH22 1EL

HB BWF HD AT NT BD JXS
JK MW AOM AA SM PK PC
PA MM KM

TEL: 0131 283 8775.

Addressed as:
Age: 48. Sex: M / (F)
Religion: N/A.
Marital status:

DIAGNOSIS:
(L) infection
? acanthamoeba.

1st Admission
Admitted by: [signature]

Date: 15/1/16 time: 1900hrs.

GP: DR MACLENNAN.
Address: NEWBATTLE MEDICAL PRACTICE MAYFIELD.

tel: 0131 663 1051.

2nd Adm:
Admitted by:

Date: time:

NEXT OF KIN:
name: [redacted]
address:

tel: [redacted]
relationship: [redacted]

ALTERNATIVE CONTACT
name:
address:

tel:
relationship:

occupation: CARE SUPPORT MENTAL HEALTH.

type of accomodation :
sheltered / oph / house or flat+level
hospital: where/ ward

social support: family / DN / day hospital / home help / SW etc
N/A.

details

contact no:

money: own care/locked drawer/cashier clothes : own care / listed valuables: own care/locked drawer / cashier / safe RIE policyexplained by: S/N	mental state/attitude: alert learning disabilities rational anxious forgetful disorientated / confused

social interaction: HEARING good/fair/none/ hearing aid
SPEECH good / fair / poor / none
IS English 1st language Yes / No please state
Interpreter req: Yes / No booked:...........

discharge planning/Arrangements 1st admission: estimated date of discharge: can provide own transport Y / N IF Y state type: if amb req : Car / 1 man / 2 man / escort ordered by: date: ref no:	discharge planning/Arrangements 2nd admission: estimated date of discharge: can provide own transport Y / N IF Y state type: if amb req: Car / 1man / 2man / escort ordered by: date: ref no:

education / eye treatment plan: 1st adm: able to do own eye treatment: y / n method ....Self................. requires D/N Y / N arranged by: date:	education / eye treatment plan: 1st adm: able to do own eye treatment: y / n method .... requires D/N Y / N arranged by: date:

date: 15/1/16. sign:	date: sign:

620045326K F
CROSS Angella
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Medical History	NO	YES	If yes, expand	guidance
Hypertension		✓	ON TX.	
Myocardial infarction	✓			date
Angina	✓			Exercise tolerance
Breathlessness		✓	TAKES PANIC ATTACKS.	Distance walked on the flat
Asthma/bronchitis	✓			Exercise tolerance
Wheeze/chronic cough		✓	COUGH AT PRESENT.	
tuberculosis	✓			Date of last CXR
Smoking	✓			No/oz per day
Alcohol	✓			Units per week
Stroke / tia	✓			Side and date
Convulsion/epilepsy	✓			Date of last fit
Diabetes	✓			Type and duration
Hiatus hernia /heartburn	✓			
jaundice	✓			Hep ABC, gallstones
Excessive bleeding	✓			
Previous anaesthetics including any problems				Family history of anaesth problems
Any other problems			NIL.	Muscular weakness, neck stiffness
Hospital admissions Operations Regular GP attendance Past Ophthalmic history			NO OVERNIGHT ADMISSIONS IN 1 YEAR.	

MEDICAL ASSESSMENT WILL BE IN MEDICAL CASE NOTES

MEDICATIONS: TYPE AND DOSE	Breakfast 0800	Lunchtime 1200	1800hrs	2200hrs	OTHER
BENDROFLUMETHIAZIDE 2.5MG	✓				
LISINOPRIL 5MG	✓				
MIRTAZAPINE 45MG				✓	

EYE medication	Right eye	Left eye
NIL		

Allergies:
Include reaction

NONE KNOWN

Other relevant information:

620045326K F 22/05/1967
Cross, Angella
31A ALLAN TERRACE,
Dalkeith,
EH22 1EL
CHI 2205671464

NHS Lothian

Risk Assessment Bundle This core bundle is intended for a **2 week** in-patient stay.		Name DOB Unit no. /
Site: **Ward:**		
Index		Guidance
2	4 AT -	Over 65 years of age, or if clinical concerns On admission and reassessment if clinical condition changes. Nursing staff to complete 4AT if not done so by Medical Staff
3	Infection Prevention Risk Assessment	On admission, please complete TRAK for MRSA information
4	Mobility Assessment	On Admission or if changing clinical condition
5	Falls Prevention	Within 24 hours of admission Patients over 65 admitted with falls or patients history of falls at risk weekly/or change in condition.
6	Malnutrition Assessment	24 hours of admission Weekly assessment or if condition changes
7	Food Profile / Assistance requirements	On admission or if condition changes
8	Waterlow Assessment	6 hours of admission visual skin check/Water low Weekly assessment or if condition changes
9	Bowel Management –	Update daily for all patient's
10	Mouth care	Mouth care assessment on admission Frequency will be based upon scoring system
11	PVC or other Insertion	On insertion / daily maintenance and removal
12	Urinary Catheter	On insertion / daily maintenance and removal
Date Commenced:		**Date Completed** **Volume:**

Print Name	Signature	Initials
F Johnson	[signature]	[initials]
Elspeth McHale	[signature]	[initials]

Addressograph, or

Name

DOB

Unit no. / CHI

Created by NHSLAdmin

[1] ALERTNESS

This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.

Normal (fully alert, but not agitated, throughout assessment)	0
Mild sleepiness for <10 seconds after waking, then normal	0
Clearly abnormal	4

[2] AMT4

Ask the patient 4 questions: their age, date of birth, place (name of the hospital or building), current year.

No mistakes	0
1 mistake	1
2 or more mistakes/untestable	2

[3] ATTENTION

Ask the patient: "Please tell me the months of the year in backwards order, starting at December."
To assist initial understanding one prompt of "what is the month before December?" is permitted.

Months of the year backwards	Achieves 7 months or more correctly	0
	Starts but scores < 7 months / refuses to start	1
	Untestable (cannot start because unwell, drowsy, inattentive)	2

[4] ACUTE CHANGE OR FLUCTUATING COURSE

Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hours

No	0
Yes	4

Score of 4 or above: possible delirium +/- cognitive impairment
1-3: possible cognitive impairment
0: delirium or severe cognitive impairment unlikely (but delirium still possible if [4] information incomplete)

Medical staff should be informed of scores >0 ;NB scores >3 indicate possible medical emergency
Action Plan: to be used with Goal Setting and Care Planning (see example in shaded area in shaded area)

Date	Time	Score	Action Plan	Initial
04/09/2014	10.00	5	Medical staff informed, additional risk assessments undertaken to maintain patient safety, infection screening required, Generic Baseline Risk Assessment and nursing care plan commenced. Continue to monitor Patient, and review 4AT score.	DBC

GUIDANCE NOTES

The 4AT is a screening instrument designed for rapid initial assessment of delirium and cognitive impairment. A score of 4 or more *suggests* delirium but is not diagnostic: more detailed assessment of mental status may be required to reach a diagnosis. A score of 1-3 suggests cognitive impairment and more detailed cognitive testing and informant history-taking are required. A score of 0 does not definitively exclude delirium or cognitive impairment: more detailed testing may be required depending on the clinical context. Items 1-3 are rated *solely on observation of the patient at the time of assessment*. Item 4 requires information from one or more source(s), eg. your own knowledge of the patient, other staff who know the patient (eg. ward nurses), GP letter, case notes, carers. The tester should take account of communication difficulties (hearing impairment, dysphasia, lack of common language) when carrying out the test and interpreting the score.

Alertness: Altered level of alertness is very likely to be delirium in general hospital settings. If the patient shows significant altered alertness during the bedside assessment, score 4 for this item. **AMT4 (Abbreviated Mental Test - 4)**: This score can be extracted from items in the AMT10 if the latter is done immediately before. **Acute Change or Fluctuating Course**: Fluctuation can occur without delirium in some cases of dementia, but marked fluctuation usually indicates delirium. To help elicit any hallucinations and/or paranoid

thoughts ask the patient questions such es, "Are you concemed about any ... y anything or anyone?"; "Heve you been seeing or hearing enything unusual?

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Infection Prevention and Control Assessment

Name
DOB
Unit

If this infection prevention document has been completed (volume 1) during this admission, please score through this record.

Infection Prevention and Control Assessment	Y	N	Action	Date	Initial
⚠TRAK Alert checked for recent Infection prevention and control alerts			Patient has active alert Yes ☐ No ☐ If yes: • isolate if appropriate • contact IPCT	15/1/16	e
MRSA Clinical Risk Assessment (CRA)					
MRSA Clinical Risk Assessment completed within 24 hrs of admission (see 3 questions in TRAK)			If MRSA positive: • isolate • put appropriate signage • apply transmission based precautions • make sure suppression therapy considered/commenced by medical team	15/1/16	e
Loose Stool Risk Assessment for CDI or Norovirus etc					
Patient has presented with loose stool, and or vomiting.		✓	If yes: • isolate patient • complete full loose stool risk assessment with Bristol Stool Chart	15/1/16	
Patient has been transferred from any ward/ nursing home with suspected or confirmed Norovirus.		/	If yes: • isolate patient • call IPCT if patient has been transferred from Norovirus suspected/confirmed area • send stool sample to virology and bacteriology • vomit may be sent to Virology for Norovirus testing (2 or more cases in Ward - Contact IPCT ex 63373)		
Patient presents with diarrhoea, is aged >15 yrs and has been treated with any antibiotic in the last 14 days		/	If yes: • isolate • have medics review and assess for CDI		e
Has the patient had known contact with anyone symptomatic with diarrhoea and/or vomiting in			If yes: • isolate • call IPCT		e
Multi-drug resistant organism or Carbapenemase-producing Enterobacteriaceae (CPE)					
Has the patient either been transferred from a hospital outside Scotland or been hospitalised outside Scotland in the last 12 months?		/	If yes: • Isolate (especially is previously positive for CPE and for all direct hospital transfers) • Call IPCT • Commence CPE document	15/1/16	e.
Has the patient been previously positive for CPE at any body site?		/	If yes: • isolate • contact IPCT • carry out CPE screening.		e
Potential Pandemic Respiratory Virus (ie avian influenze or novel coronavirus)					
Does the patient present with fever and/or respiratory symptoms and recent foreign travel (arrival back from overseas within the last 21 days)?		/	If yes: • check for current Health Protection Scotland (HPS) alert regarding any potential pandemic or novel respiratory virus • follow relevant HPS protocol if symptoms and		

			country of exposure fit definitions

Mobility Assessment / Manual Handling Requirements

Addressograph, or
Name
DOB
Unit no. / CHI

NHS Lothian

This assessment is a legal ~~requirement to assess manual handling requirements this aids staff and patient safety.~~
Assessment requires to be ~~carried out on admission. Further assessments are only required as and when patient~~ condition changes.
Refer to Patients 4 AT score ~~(cognition/delirium) / communication concerns ie hearing / sight~~
Ensure that an accurate BMI ~~is recorded (MUST) Refer to Bariatric policy if applicable~~

Date:	5/1/16													
Activity														
Lying to sitting	IND													
Sit to stand to sit	IND													
Walking	IND													
Moving up the bed	IND													
Turning / proning	IND													
Toileting	IND													
Lateral transfers	IND													
On / Off floor	IND													
Dressing	IND													
Bathing / washing	IND													
Initial / time	[illegible]													

Mobility Codes		
AST 1/2/3: Assistance of 1/ 2/3 etc	**SUP**: Supervision	**IND**: Independent
NWB: Non weight bearing	**PWB**: partial weight bearing	**FWB**: full weight bearing
Equipment Codes / Handling Aids (For all hoists specify hoist type and size of sling)		
H: Full body lifting hoist (specify hoist and sling)	**STA**: Stand aid · (specify hoist and sling)	**BH**: Bathing hoist (specify hoist type)
SC: Shower chair(specify)	**PAT**: Patslide	**HB**: Hand blocks
Pt T: Pt turner (specify e.g. Stedy)	**W**: Wheelchair or pushchair	**C**: Crutches
S: Stick(s)	**Z / R**: Zimmer / Rollator	**GS**: Glidesheets

Key Handling Tasks and Risk Factors	Risk Management	Date / initial

Stratified Falls Risk Assessment	Name DOB Unit no. / CHI	Addi 620045326K F CROSS Angella 22-May-67 CHI:220 567 1464 77106 JA Scott 31A ALLAN TERRACE EH22 1EL

Guidance: assessment should be carried out on admission, if condition changes and / or week
All patients admitted with a fall Has fallen since admission Aged 65 or over
**Clinical judgement regarding completing a falls risk assessment for patients that fall out with this category

Falls Risk Assessment (Stratify)	YES	NO
Admitted with fall or fall since admission/ history of falls.	1	0
Confused or agitated.	1	0
Function impaired by poor vision.	(1)	0
Frequent toileting.	1	0
Help or assistance to transfer / walk (score 0 if bed-bound).	1	0

Date / Time	Score	Action /Comment /Clinical Judgement	Initial
15/1/16	(1)		Q.

Complete first section of care plan for all patients.		Initial / date
Goal / Objective	Reduce the risk of the patient falling to its lowest level. Raise awareness of reduction strategies **Engage multidisciplinary team, patient &/or carers to ensure best outcome**	
All patients	Discuss and ensure safe footwear with patient / family / carers	Q
	Ensure the mobility assessment is completed/ educate patient in safe practice	Q
	Refer to podiatrist if required / available	Q
Part 2 To be completed for all Patients admitted with fall/ fallen since admission and/or if score of 2 or more	Manage communication problems such as eyesight, hearing, language discussion with patient and / or carers as appropriate	
	The outcome of the falls assessment to be fully discussed with the patient and/or (if appropriate) with family/carers, with the patient's consent where possible	
	Falls risk sign displayed and falls leaflet issued to patient, family, carers, relatives	
	Commence MDT Falls Prevention Checklist	
	Consider an Elderly Care Review for the patient who has frequent or unexplained falls	
	Physiotherapy referral	
	Occupational Therapy referral	
	Consider regular observation / intentional rounding as appropriate	
	Lying and standing BP (lying 10 mins, stand for 1, 2 & 3 mins). Report BP deficit (20mm Hg in systolic BP is considered significant)	
	Position patient in easily observable area/position – consider lighting	
	Bed rails risk assessment	
	Consider one-to-one nursing – escalate concerns	
	Consider use of falls sensor, as per guidance (if available)	

- If patient found to be at risk of falls, commence 2 hourly care rounding,
- If a falls occurs please complete relevant documentation (attach supplementary post falls care plan
- If patient is considered a falls risk and / or falls this, requires to be highlighted within the person-centred care plan

Version 11 Adapted with permission from Julie Sadler's seven Simple Steps, Falls Prevention Programme Draft The Ipswich Hospital NHS Trust 10/02/12 review date 10/02/14

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Malnutrition Universal Screening Tool **Refer to full guidance prior to undertaking MUST Screening**	Name DOB Unit no. / CH	NHS Lothian

Full MUST guidance is recommended when carrying out the Malnutrition Screening Tool to ensure accurate results and full guidance following outcome of result. Within the Action Plan, please document plan of care Screening should be carried out weekly or if clinical concerns

Previous refer to Dietitian Yes ☐ No ☐ Please state:	Current Care of Dietitian Yes ☐ No ☐ Community / Other
Usual weight kg (prior to admission)	Height 6'10 -
Guidance	

Step 1	**Step 2**	**Step 3**	**Step 4**	**Step 5**
>20 = 0 18.5-20 = 1 <18.5 = 2 BMI score 0,1 or 2	Unplanned weight loss In past 3-6 months 5% = 0 5-10% =1 >10% = 2 Weight loss 0,1 or 2	If patient is acutely ill and there has been or is likely to be no nutritional intake for >5 days Acute disease 0 or 2	MUST score add steps 1 + 2 + 3	Category Low = 0 Medium = 1 ref to guidance High ≥2 Ref to Dietician

Low Risk 0 **Routine clinical care** Repeat screening weekly	**Medium Risk 1** **Observe** • Document dietary intake for 3days: If improved or adequate intake little clinical concern; if no improvement and clinical concern – follow local policy (snack list available) • Repeat screening weekly	**High Risk 2 or more** • Refer to dietitian • Improve and increase overall nutritional intake (refer to local policy /snack list) • Monitor and review care plan Weekly Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

Date 15/1/16. **Time** 12:10pm.			**Week**	**Repeat assessment due:**		
Weight	BMI	Step 1	Step 2	Step 3	Step 4	Step 5
80kg.	36	0	/	/	0	low
Action Plan						

Date **Time**			**Week**	**Repeat assessment due:**		
Weight	BMI	Step 1	Step 2	Step 3	Step 4	Step 5
Action Plan						

Weight Chart

Daily Weekly Twice Weekly Please state:
Weight Chart only requires to be completed if clinically indicated

Date								
Weight KG								
Date								
Weight KG								

Nutritional Profile	Name DOB Unit no. / CHI	620045326K F CROSS Angella 22-May-67 CHI:220 567 1464 77106 JA Scott 31A ALLAN TERRACE EH22 1EL	

Fasting/ Nil by Mouth : Commenced			Recommenced diet and Fluids		
Date	Time	Initial	Date	Time	Initial

Nutritional Profile	
Patients eating and drinking preferences, including likes and dislikes? N/A TEA	
Patient is able to choose from the menu at each mealtime themselves?	Yes ☑ No ☐
Does the patient have special dietary requirements? i.e. vegetarian, texture, modified diet and fluids:, small portions including cultural, religious and/or ethnic dietary preferences? *If yes please comment* :	Yes ☐ No ☑
Are there any contributing factors that may affect food intake? If yes please state below Such as physical,, oral problems, physiological i.e. nausea Psychological i.e. dementia, social or environmental? If Yes please give details:	Yes ☐ No ☑
Does the patient have any swallowing difficulties Yes ☐ No ☑ If yes please indicate reason	SALT referral Yes ☐ No ☑
Does the Patient have any food allergies? If yes, please give details	Yes ☐ No ☑

Individual Care Requirements with Nutritional and Hydration needs
Assistance with Fluids Yes ☐ No ☑ *If yes please provide details of assistance required.*
Assistance with Eating Yes ☐ No ☑ *If yes please provide details of assistance required*
Is there a need for equipment Yes ☐ No ☑ *If yes please provide details of assistance required*
Nutritional information required on discharge Yes ☐ No ☑

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Adapted Waterlow
Pressure Area Risk Assessment Chart

To be completed within 6 hours of admission

Reassess if there is a change in individual's clinical condition either improvement or deterioration							
	Date		15/1/16				
	Time		1900				
	Initial		[illegible]				
Sex	Male	1					
	Female	2	2				
Age	14 - 49	1	1				
	50 - 64	2					
	65 - 74	3					
	75 - 80	4					
	81+	5					
Build/ Weight for Height (BMI = weight in Kg height in m 2)	Average BMI 20 – 24.9	0	0				
	Above average BMI 25 – 29.9	1					
	Obese BMI > 30	2					
	Below average BMI < 20	3					
Continence	Complete / Catheterised	0					
	Incontinent of urine	1					
	Incontinent of faeces	2					
	Doubly incontinent (urine & faeces)	3					
Skin Type (Visual Risk Area) *	Healthy	0	0				
	Tissue paper (thin/fragile)	1					
	Dry (appears flaky)	1					
	Oedematous (puffy)	1					
	Clammy (moist to touch /pyrexial)	1					
	Discoloured (bruising/mottled)	2					
	Broken (established ulcer)	3					
Mobility	Fully mobile	0	0				
	Restless / fidgety	1					
	Apathetic (sedated/ depressed/ reluctant to move)	2					
	Restricted (restricted by severe pain or disease)	3					
	Bedbound (unconscious/ unable to change position/traction)	4					
	Chair bound (unable to leave chair without assistance)	5					
Nutritional * Element	Unplanned weight loss in past 3 – 6 months						
	< 5 % score	0	0				
	5 – 10 %	1					
	> 10%	2					
	BMI > 20	0					
	BMI 18.5 – 20	1					
	BMI < 18.5	2					
	Patient/ client acutely ill or no nutritional intake to > 5 days	2					
Special Risks * (Tissue Malnutrition)	Smoking	1	0				
	Anaemia = Hb < 8	2					
	Single organ failure ie cardiec, renel, respiratory	5					
	Peripheral Vascular Disease	5					
	Multiple organ failure/ terminal cachexia	8					
Special Risks* (Neurological Deficit)	Diabetes/ MS/ CVA/ Motor/ Sensory paraplegia	4-6	0				
Special Risks (Surgery/Trauma)*	Orthopaedic / below waist (up to 48 hours post	5					
	On table > 2 hours (up to 48 hours post op)	5					
	On table > 6 hours	8					
Special risk (Medication)	Cytotoxic anti inflammatory long term/high dose steroids	4	3				
10+= 'At Risk': 15+ = 'High Risk': 20+ = 'Very High Risk' *More than one score can be used in some categories							

Date	Score	Equipment required	COMMENTS
15/1/16.	3		[illegible]

Adapted from tissueviabilityonline.com. Version 1 (March 2009) NHS Quality Improvement Scotland

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Bowel Management	Add Name DOB Unit no. / CH	

This form is **NOT** a formal Bristol Stool Chart and therefore not to be used when patients present or develop **loose stool**

This form should be utilised as a document to monitor **daily** Bowel movement for **all patients** who do not have diarrhoea within an in-patient setting.

If patient develops or presents with loose stool: please follow the guidance below

Developed loose stool	Commenced Bristol stool chart	Discontinued bowel chart below
Y ☐	Y ☐	Y ☐

Commenced the Management of Diarrhoea: located on *intranet* Y ☐
Healthcare/AZ/InfectionControl/icm/SD_CP0013/CdTKFull.pd

Medical staff informed Y ☐

All necessary measures taken to reduce spread of transmission of infection Y ☐

Date	Time	Initial

Type 1	Separate hard lumps, like nuts (hard to pass)	Type 2	Sausage-shaped but lumpy
Type 3	Like a sausage but with cracks on its surface	Type 4	Like a sausage or snake, smooth and soft
Type 5	Soft blobs with clear-cut edges (passed easily)	Type 6	Fluffy pieces with ragged edges, a mushy stool
Type 7	Watery, no solid pieces. **Entirely Liquid**	Reproduced by kind permission of Dr KW Heaton, Reader in Medicine at the University of Bristol	

If no bowel movement please state: NBO

Date 15/1/16	Date 16/1/16	Date	Date	Date	Date	Date
initial	initial	initial	initial	initial	initial	initial

If no bowel movement please state: NBO

Date	Date	Date	Date	Date	Date	Date
initial	initial	initial	initial	initial	initial	initial

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Mouth Care Assessment Adapted from Eilers Oral Assessment Tool	Address Name DOB Unit no. / CHI

Mouth Care Assessment

Please document date	15/4/16	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
LIPS 1= Smooth and pink 2= Dry and Cracked 3= Ulcerated or bleeding	1													
MUCOUS MEMBRANES/ TONGUE 1= Pink and moist 2= Reddened/Blue-red/ White/Coated 3= Very red or thick/ Ulceration +/- bleeding/Debris	1													
GINGIVAE 1= Pink and firm 2= Oedematous and/or Redness/ White coating 3= Ulcerated or bleeding	1													
SALIVA 1= Watery 2= Viscous 3= Absent	1													
TEETH/ DENTURES 1= Clean 2= Localised plaque or debris 3= Generalised plaque or debris	1													
Total Score	5													
Initial	[illegible]													

Treatment Recommendations

LIPS	2	Vaseline +/- plain moisturiser
	3	Swab, inform medical staff, care as per 2 and analgesia
Tongue	2	Medical staff review, brush tongue to see if coating can be removed, continue mouth care
Mucous Membrane	3	Difflam spray for analgesia
Saliva	2	Treatment depends on cause (medical review)
	3	Inform medical staff for review
Teeth / Dentures	2	Continue mouth care
	3	May require dental treatment upon discharge

ACTION PLAN

Score 6 – 8 Encourage tooth brushing or mouthwashes morning and Night time and after meals to freshen mouth

Score 9 – 14 3 hourly mouth care

Score 15 plus 2 hourly mouth care

15/1/16 N/A.

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NHS Lothian

Device Code	Clinical Indication	
P Peripheral Line SC Subcutaneous C	E Emergency IV access R Routine NBM Nil by Mouth B Blood IV Fluids or Medicines	N D U

Potential Complications of IV Cannulation

1) Redness, pain or inflammation at insertion site due to phlebitis or local infection
2) Local oedema due to infiltration 3) Bloodstream infections 4) Extra vasation

Insertion Bundle

No	Date	Time	Device Code	Site	Colour	Aseptic technique	Clinical Indication	Dressing Dated	Initial
			See code				See code		

Maintenance Bundle: Hand hygiene to be carried out prior to every intervention

Date	Device still Required		Dressing Dated		Dressing Clean/intact		Absence of Inflammation		In situ for < 72 hours		Date removed	Initial
	Y	N	Y	N	Y	N	Y	N	Y	N		
	Y	N	Y	N	Y	N	Y	N	Y	N		
	Y	N	Y	N	Y	N	Y	N	Y	N		
	Y	N	Y	N	Y	N	Y	N	Y	N		
	Y	N	Y	N	Y	N	Y	N	Y	N		

Additional Comments *if PVC is in situ for greater than 72 hours please indicate clinical reason,

Insertion Bundle

No	Date	Time	Device Code	Site	Colour	Aseptic technique	Clinical Indication	Dressing Dated	initial
			See code				See code		

Maintenance Bundle: Hand hygiene to be carried out prior to every intervention

Date	Device still Required		Dressing Dated		Dressing Clean/intact		Absence of Inflammation		In situ for < 72 hours		Date removed	Initial
	Y	N	Y	N	Y	N	Y	N	Y	N		
	Y	N	Y	N	Y	N	Y	N	Y	N		
	Y	N	Y	N	Y	N	Y	N	Y	N		
	Y	N	Y	N	Y	N	Y	N	Y	N		
	Y	N	Y	N	Y	N	Y	N	Y	N		

Additional Comments *if PVC is in situ for greater than 72 hours please indicate clinical reason,

Insertion Bundle

No	Date	Time	Device Code	Site	Colour	Aseptic technique	Clinical Indication	Dressing Dated	initial
			See code				See code		

Maintenance Bundle: Hand hygiene to be carried out prior to every intervention

Date	Device still Required		Dressing Dated		Dressing Clean/intact		Absence of Inflammation		In situ for < 72 hours		Date removed	Initial
	Y	N	Y	N	Y	N	Y	N	Y	N		
	Y	N	Y	N	Y	N	Y	N	Y	N		
	Y	N	Y	N	Y	N	Y	N	Y	N		
	Y	N	Y	N	Y	N	Y	N	Y	N		
	Y	N	Y	N	Y	N	Y	N	Y	N		

Additional Comments *if PVC is in situ for greater than 72 hours please indicate clinical reason,

Device Code	Clinical Indication	Addressograph, or
P Peripheral Line SC Subcutaneous C	E Emergency IV access R Routine NBM Nil by Mouth B Blood IV Fluids or Medicines	Name DOB Unit no. / CHI NHS Lothian

Potential Complications of IV Cannulation

1) Redness, pain or inflammation at insertion site due to phlebitis or local infection
2) Local oedema due to infiltration 3) Bloodstream infections 4) Extra vasation

Insertion Bundle

No	Date	Time	Device Code	Site	Colour	Aseptic technique	Clinical Indication	Dressing Dated	Initial
			See code				See code		

Maintenance Bundle: Hand hygiene to be carried out prior to every intervention

Date	Device still Required		Dressing Dated		Dressing Clean/intact		Absence of Inflammation		In situ for < 72 hours		Date removed	Initial
	Y	N	Y	N	Y	N	Y	N	Y	N		
	Y	N	Y	N	Y	N	Y	N	Y	N		
	Y	N	Y	N	Y	N	Y	N	Y	N		
	Y	N	Y	N	Y	N	Y	N	Y	N		
	Y	N	Y	N	Y	N	Y	N	Y	N		

Additional Comments *if PVC is in situ for greater than 72 hours please indicate clinical reason,

Insertion Bundle

No	Date	Time	Device Code	Site	Colour	Aseptic technique	Clinical Indication	Dressing Dated	Initial
			See code				See code		

Maintenance Bundle: Hand hygiene to be carried out prior to every intervention

Date	Device still Required		Dressing Dated		Dressing Clean/intact		Absence of Inflammation		In situ for < 72 hours		Date removed	Initial
	Y	N	Y	N	Y	N	Y	N	Y	N		
	Y	N	Y	N	Y	N	Y	N	Y	N		
	Y	N	Y	N	Y	N	Y	N	Y	N		
	Y	N	Y	N	Y	N	Y	N	Y	N		
	Y	N	Y	N	Y	N	Y	N	Y	N		

Additional Comments *if PVC is in situ for greater than 72 hours please indicate clinical reason,

Insertion Bundle

No	Date	Time	Device Code	Site	Colour	Aseptic technique	Clinical Indication	Dres Date	Initial
			See code				See code		

Maintenance Bundle: Hand hygiene to be carried out prior to every intervention

Date	Device still Required		Dressing Dated		Dressing Clean/intact		Absence of Inflammatio		In situ for < 72 hours		Date remo	Initial
	Y	N	Y	N	Y	N	Y	N	Y	N		
	Y	N	Y	N	Y	N	Y	N	Y	N		
	Y	N	Y	N	Y	N	Y	N	Y	N		
	Y	N	Y	N	Y	N	Y	N	Y	N		
	Y	N	Y	N	Y	N	Y	N	Y	N		

Additional Comments *if PVC is in situ for greater than 72 hours please indicate clinical reason,

15/1/16 N/A.

CATHETER PROCEDURE RECORD CHART AND CAUTI BUNDLE	Name DOB Unit no. /	620045326K F CROSS Angella 22-May-67 CHI:220 567 1464 77106 JA Scott 31A ALLAN TERRACE EH22 1EL	

Complete at every catheter change and document any additional relevant information in nursing record

☐ Is the catheter still required? (consider other methods of continence management)

Following assessment indicate rationale for ongoing catheter use:

☐ Incomplete bladder emptying ☐ Intractable incontinence /quality of life

☐ Chronic retention ☐ Acute retention ☐ Compromised tissue viability

☐ Pre or post op ☐ Palliative care ☐ Urodynamics investigation

Date of catheter change: ______________ **Reason:** ______________________________

Consent obtained ☐ √ **X**		Tick or cross below √ **X**
Lubricant: batch number: exp date:		
Hand hygiene carried out immediately before commencing insertion		
Personal Protective Equipment used		
Sterile gloves x 2 pairs used separately during procedure		
Urethral meatus/supra pubic cystostomy cleaned prior to insertion with 0.9% saline		
Single use sterile lubricating gel used		
Aseptic technique used for catheter insertion and sterile field placed on patient during procedure		
Smallest appropriate gauge selected and balloon filled to 10mls unless otherwise indicated		
Aseptic technique used for attaching leg bag following catheter insertion		
Patient has passport		

Record any reason for variance from bundle (X) here:	
Date of next planned change:	
Initial	Time

16/1/16. N/A.

CATHETER PROCEDURE RECORD CHART AND CAUTI BUNDLE	Addressograph, or Name DOB Unit no. / CHI	NHS Lothian

Maintenance Bundle:

- Hand hygiene is performed immediately prior to access or manipulation of the indwelling urinary catheter?
- The drainage bag is emptied when clinically indicated using a clean disposable container for each patient - as per care rounding tool

Date	Catheter still required * remove if possible		The clinical need for the catheter has been reviewed and recorded daily Please state below	Drainage bag situated below the level of the bladder The tap is not in contact with any surface e.g. floor?		Daily catheter hygiene performed		Initial
	Y	N		Y	N	Y	N	
	Y	N		Y	N	Y	N	
	Y	N		Y	N	Y	N	
	Y	N		Y	N	Y	N	
	Y	N		Y	N	Y	N	
	Y	N		Y	N	Y	N	
	Y	N		Y	N	Y	N	

Catheter bag requires to be changed every 7 days (as per manufactures instructions) or as clinically indicated
Catheter bag changed: **Date of last change:**

	Y	N		Y	N	Y	N	
	Y	N		Y	N	Y	N	
	Y	N		Y	N	Y	N	
	Y	N		Y	N	Y	N	
	Y	N		Y	N	Y	N	
	Y	N		Y	N	Y	N	
	Y	N		Y	N	Y	N	

Scottish Patient Safety Programme: The above precautions are to aim to reduce Catheter Associated Urinary Tract Infections (CAUTI) by 30% by end December 2015

Definition of CAUTI

Urinary Catheter In situ or removed within previous 48hours	Y	N
plus fever (Temp <36 C or >37.9 C or 1.5 above normal baseline reading on 2 occasions in last 12 hours	Y	N
Plus **one or more** of the following:		
Shaking chills (rigors)	Y	N
New costovertebral (central lower back) tenderness	Y	N
New onset or worsening delirium (confusion)	Y	N
On antibiotics for treatment of UTI.	Y	N
Please state:		

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DVT BUNDLE – da

Date	Teds prescribed			situ			Clexane prescribed		
15/1/16	Y	N	NA	Y	N	NA	Y	N	NA
16.1.16	Y	N	NA	Y	N	NA	Y	N	NA
17/1/16	Y	N	NA	Y	N	NA	Y	N	NA
	Y	N	NA	Y	N	NA	Y	N	NA
	Y	N	NA	Y	N	NA	Y	N	NA
	Y	N	NA	Y	N	NA	Y	N	NA
	Y	N	NA	Y	N	NA	Y	N	NA
	Y	N	NA	Y	N	NA	Y	N	NA
	Y	N	NA	Y	N	NA	Y	N	NA
	Y	N	NA	Y	N	NA	Y	N	NA
	Y	N	NA	Y	N	NA	Y	N	NA
	Y	N	NA	Y	N	NA	Y	N	NA
	Y	N	NA	Y	N	NA	Y	N	NA
	Y	N	NA	Y	N	NA	Y	N	NA

Author: Clinical Policy Advisor
Approved by the clinical documentation group
Date Uploaded to the intranet: May 2012
Version: 2.1
Date of Authorisation: May 2012
Date of Review: May 2015

NHS Lothian discharge checklist: to be completed for all inpatients

Patient Name:
Address:

Date of Birth:
CHI Number:
Addressograph Label may be used

Estimated Date of Discharge: / /
Next of Kin:
Address:

Contact Number:

NHS Lothian

Discharge Summary on admission/pre admission	y	n	n/a	Date	Initial
1.Relevant Care Provider informed of estimated discharge date Name: Contact Number:			—	5/1/16	[illegible]
2. Services in the community contacted Name: Contact Number:			—	5/1/16	[illegible]
3.Does the patient have an unpaid carer Name: Contact Number:			—	5/1/16	[illegible]
Discharge Summary 24/48 hours pre discharge					
1. Has the unpaid carer been involved in the discharge process and offered an assessment/ training Declined ☐					
2. Services in the community contacted					
3. Transport (if clinical need) booked ref no: Transport type: **2 Man 1 Man Stretcher Wheelchair** Number of stairs:					
4. DNACPR form completed					
5. Follow-up appointment booked: Transport Ref No:					
6. Patient education/information commenced and given Please specify education given: Products given to patient: Supply: Days					
7. Does patient need referred to Lothian unscheduled care service?					
Discharge Summary 24 hours pre discharge					
1. Post care information leaflet given:					
2. Discharge letter requested from medical staff/on ward round					
3. Transport confirmed Ref Number:					
4. Is patient applicable for discharge lounge? If yes, inform discharge lounge and complete discharge lounge form ☐					
5. Next of kin informed					
6. Discharge letter/ Discharge prescription obtained					
7. Does the patient require Medication Administration Record(MAR)?					
8. Patient has keys to house? Reason if patient does not have keys:					
9. Medication appliance (Dosette Box) required.					
Day of discharge					
1. Discharge medication given and explained to patient	✓				
2. Patient's own medication returned			✓	17/01/16	[illegible]
3. Copy of immediate discharge letter given to patient	✓				
4. Valuables and patients own belongings returned to patient	✓				
5 Peripheral Vascular Cannula removed			✓		
6. Patient transferred to discharge lounge			✓		
7. Patient Administration System (e.g. TRAK/PIMS) is updated	✓				

Additional Information:

The patient is ready for discharge: Last SEWS prior to discharge: 0
Signed: [illegible] EZ.
Ward: 20
Hospital: PAEP Date: 17 / 1 / 16

Author: Clinical Policy Advisor
Approved by the clinical documentation group
Date Uploaded to the intranet: May 2012

Version: 2.1
Date of Authorisation: May 2012
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MEDICAL care plan Ward E2
Princess Alexandra Eye Pavilion

620045326K F
CROSS Angella
22-May-67 CHI: 220 567 1464
77106 JA Scott
31A ALLAN TERRACE
EH22 1EL

DATE	PROGRESS	SIGNATURE
15/1/16.	Patient admitted from home with	
1910pm.	? acanthamoeba. Drops to be	
	prescribed. BP high on admission	[signature]
	but patient suffers from hypertension	
	and on treatment for this.	[signature]
16/1/16	Nursing	
4.00	eye drops every hourly. Slept on & off	
	No issues	[signature]
16.1.16	S/B Dr Bennett. Treatment	
	Changed to hourly moxifloxacin	[signature]
17.1.16	EYE DROPS CONTINUE AS PER CHART. NO	
	COMPLAINTS FROM PATIENT OR CHANGES TO	[signature]
	CARE. SETTLED & APPEARS TO HAVE SLEPT	(ALLAN)
	WELL.	S/N

Addressograph Label:

DATE	PROGRESS	SIGNATURE

620045326K F
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22-May-67 CHI: 220 567 1464
77106 JA Scott
31A ALLAN TERRACE
EH22 1EL

Sticker

Medical care plan WARD E2 PAEP

Day 1 Date...................	SIGN	Time	Day 2 Date....16.1.16.....	SIGN	Time	Day 3 date.....................	SIGN	Time
Welcome patient to ward			Give assistance as required			Give assistance as required		
Intoduce named nurse			Offer choice from menu			Offer choice from menu		
Assess level of dependance and assist with activities of daily living			Offer wash / shower			Offer wash / shower		
Give assistance as required			Assess level of pain			Assess level of pain		
Commence eye treatment as prescribed			Give analgesia as required			Give analgesia as required		
If infected follow ward Protocol			Monitor effects of above			Monitor effects of above		
Offer choice from menu			If infected follow ward Protocol			If infected follow ward Protocol		
Offer wash / shower								
Assess level of pain								
Give analgesia as required								
Monitor effects of above								
DRS round information on PROGRESS page			DRS round information on PROGRESS page			DRS round information on PROGRESS page		
All recordings on SEWS chart			All recordings on SEWS chart			All recordings on SEWS chart		
Ensure patient has restful night sleep			Ensure patient has restful night sleep	SA		Ensure patient has restful night sleep		

Nurses PRINT & Sign			
	E	E	E
	L	L	L
	ND	ND SA [signature] ALLAN S/N	ND

STICKER

Date....................	SIGN	Time
Welcome patient to ward		
Intoduce named nurse		
Assess level of dependance and assist with activities of daily living		
Give assistance as required		
Commence eye treatment as prescribed	-	
If infected follow ward Protocol		
Offer choice from menu		
Offer wash / shower		
Assess level of pain		
Give analgesia as required		
Monitor effects of above		
DRS round information on PROGRESS page		
All recordings on SEWS chart		
Ensure patient has restful night sleep		

Date.....................	SIGN	Time
Give assistance as required		
Offer choice from menu		
Offer wash / shower		
Assess level of pain		
Give analgesia as required		
Monitor effects of above		
If infected follow ward Protocol		
DRS round information on PROGRESS page		
All recordings on SEWS chart		
Ensure patient has restful night sleep		

Date......................	SIGN	Time
Give assistance as required		
Offer choice from menu		
Offer wash / shower		
Assess level of pain		
Give analgesia as required		
Monitor effects of above		
If infected follow ward Protocol		
DRS round information on PROGRESS page		
All recordings on SEWS chart		
Ensure patient has restful night sleep		

Nurses PRINT & Sign			
	E	E	E
	L	L	L
	ND	ND	ND

PRESCRIPTION AND ADMINISTRATION RECORD

Standard Chart

Hospital/Ward:	Consultant:	620045326K tlen F 22/05/1967 Cross, Angella 31A ALLAN TERRACE, Dalkeith, EH22 1EL
Weight:	Height:	
If re-written, date:		
DISCHARGE PRESCRIPTION		
Date completed:	Completed by:	CHI 2205671464 77106 JA Scott

OTHER MEDICINE CHARTS IN USE		PREVIOUS ADVERSE REACTIONS This section must be completed before any medicine is given		Completed by (sign & print)	Date
Date	Type of Chart	None known ☑		[signature]	
		Medicine / Agent	Description of reaction		

- Write clearly in block capitals, using a black ballpoint pen
- Use approved names for medicines
- Never alter a prescription
- Route of administration
  The only acceptable abbreviations are:
  IV - intravenous SL - sublingual NG - nasogastric
  IM - intramuscular PR - per rectum ID - intradermal
  SC - subcutaneous PV - per vagina TOP - topical
  INHAL - inhaled NEB - nebulised
  Never abbreviate ORAL or INTRATHECAL
  Specify RIGHT or LEFT for eye and ear preparations

- Write the medicine dose clearly
  - The only acceptable abbreviations are:
    g - gram mg - milligram ml - millilitre
    all other doses must be written out in full eg. micrograms
  - Avoid decimal points eg. 100 micrograms (not 0.1mg). If unavoidable, write zero in front of the decimal point
  - Prescribe liquids by writing the dose in mg
  - For 'as required' medicines, state the symptoms to be relieved, the minimum time interval between doses and the maximum daily dose
  - Write units as 'units' not 'iu'

ONCE ONLY

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber - Sign + Print	Time Given	Given By

Name: Angella Cross D.O.B.: .... CHI No: ....

REGULAR THERAPY

CODES FOR NON-ADMINISTRATION OF PRESCRIBED MEDICINE

If a dose is not administered as prescribed, initial and enter a code in the column with a circle drawn round the code according to the reason as shown below. Inform the responsible doctor in the appropriate timescale.

1. Patient refuses
2. Patient not present
3. Medicines not available - CHECK ORDERED
4. Asleep / drowsy
5. Administration route not available - CHECK FOR ALTERNATIVE
6. Vomiting / nausea
7. Time varied on doctor's instructions
8. Once only / as required medicine given
9. Dose withheld on doctor's instructions
10. Possible adverse reaction / side effect

OXYGEN	Start Date	Start Time	Route Mask (%)	Route Prongs (l/min)	Prescriber - Sign + Print	Administered by	Stop Date	Stop Time

PRESCRIPTION	Patient's Own Medicine	Time	15/1/16	16/1/16	17/1/16
Medicine (Approved Name): ACICLOVIR	For use / Date	(6)		[initials]	SA
Dose: 400mg; Route: oral	Quantity	(8)			
		(12)		Ey	
Notes/Indication for antibiotic; Start Date: 15/1/16	Stop Date	(14)		[initials]	
Prescriber - sign + print: Hall	Pharmacy	(18)		Ey	
		(22)	[initials]	AW	
Medicine (Approved Name): BENDROFLUMETHIAZIDE	For use / Date	6			
Dose: 2.5mg; Route: PO	Quantity	(8)		Ey	SA
		12			
Notes/Indication for antibiotic; Start Date: 15.1.16	Stop Date	14			
Prescriber - sign + print	Pharmacy	18			
		22			
Medicine (Approved Name): LISINOPRIL	For use / Date	6			
Dose: 5mg; Route: PO	Quantity	(8)		(3) Ey	SA
		12		Ey	
Notes/Indication for antibiotic; Start Date: 15.1.16	Stop Date	14			
Prescriber - sign + print	Pharmacy	18			
		22			
Medicine (Approved Name): MIRTAZAPINE	For use / Date	6			
Dose: 45mg; Route: PO	Quantity	8			
		12			
Notes/Indication for antibiotic; Start Date: 15.1.16	Stop Date	14			
Prescriber - sign + print	Pharmacy	18			
		(22)	[initials]	AW	

Name: .... D.O.B.: .... CHI No: ....

REGULAR THERAPY

PRESCRIPTION		Patient's Own Medicine	Date → / Time ↓															
Medicine (Approved Name)		For use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															

Name: .... D.O.B.: .... CHI No: ....

AS REQUIRED THERAPY

PRESCRIPTION		Patient's Own Medicine													
Medicine (Approved Name)		For use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												

Name: .... D.O.B.: .... CHI No: ....

REGULAR THERAPY

PRESCRIPTION		Patient's Own Medicine	Date → / Time ↓	
Medicine (Approved Name)		For use / Date	6	
Dose	Route	Quantity	8	
			12	
Notes/Indication for antibiotic	Start Date	Stop Date	14	
Prescriber - sign + print		Pharmacy	18	
			22	
Medicine (Approved Name)		For use / Date	6	
Dose	Route	Quantity	8	
			12	
Notes/Indication for antibiotic	Start Date	Stop Date	14	
Prescriber - sign + print		Pharmacy	18	
			22	
Medicine (Approved Name)		For use / Date	6	
Dose	Route	Quantity	8	
			12	
Notes/Indication for antibiotic	Start Date	Stop Date	14	
Prescriber - sign + print		Pharmacy	18	
			22	
Medicine (Approved Name)		For use / Date	6	
Dose	Route	Quantity	8	
			12	
Notes/Indication for antibiotic	Start Date	Stop Date	14	
Prescriber - sign + print		Pharmacy	18	
			22	
Medicine (Approved Name)		For use / Date	6	
Dose	Route	Quantity	8	
			12	
Notes/Indication for antibiotic	Start Date	Stop Date	14	
Prescriber - sign + print		Pharmacy	18	
			22	
Medicine (Approved Name)		For use / Date	6	
Dose	Route	Quantity	8	
			12	
Notes/Indication for antibiotic	Start Date	Stop Date	14	
Prescriber - sign + print		Pharmacy	18	
			22	

TURN OVER →

Name: .... D.O.B.: .... CHI No: ....

AS REQUIRED THERAPY

PRESCRIPTION		Patient's Own Medicine													
Medicine (Approved Name): PARACETAMOL		For use	Date												
			Time												
Dose + frequency + max: 1g QID	Route: PO	Quantity	Dose												
			Initials												
Indication + notes	Start Date: 15.1.16	Date	Date												
			Time												
Prescriber - sign + print: [signature]		Pharmacy	Dose												
			Initials												
Medicine (Approved Name): DIHYDROCODEINE		For use	Date												
			Time												
Dose + frequency + max: 30mg 4°	Route: PO	Quantity	Dose												
			Initials												
Indication + notes	Start Date: 15.1.16	Date	Date												
			Time												
Prescriber - sign + print: [signature]		Pharmacy	Dose												
			Initials												
Medicine (Approved Name): IBUPROFEN		For use	Date	16.1.16											
			Time	0815											
Dose + frequency + max: 200mg TDS	Route: PO	Quantity	Dose	200mg											
			Initials	[illegible]											
Indication + notes	Start Date: 15.1.16	Date	Date												
			Time												
Prescriber - sign + print: [signature]		Pharmacy	Dose												
			Initials												
Medicine (Approved Name): TRAMADOL		For use	Date												
			Time												
Dose + frequency + max: 50mg 4°	Route: PO	Quantity	Dose												
			Initials												
Indication + notes	Start Date: 15.1.16	Date	Date												
			Time												
Prescriber - sign + print: [signature]		Pharmacy	Dose												
			Initials												
Medicine (Approved Name): CYCLIZINE		For use	Date												
			Time												
Dose + frequency + max: 50mg TDS	Route: IM/IV	Quantity	Dose												
			Initials												
Indication + notes	Start Date: 15.1.16	Date	Date												
			Time												
Prescriber - sign + print: [signature]		Pharmacy	Dose												
			Initials												
Medicine (Approved Name): ONDANSETRON		For use	Date												
			Time												
Dose + frequency + max: 4mg 8°	Route: PO/IV	Quantity	Dose												
			Initials												
Indication + notes	Start Date: 15.1.16	Date	Date												
			Time												
Prescriber - sign + print: [signature]		Pharmacy	Dose												
			Initials												

77100 JA Scott
620045326K F 22/05/1967
Cross, Angella
31A ALLAN TERRACE,
Dalkeith,
EH22 1EL

CHI 2205671464

EYE TREATMENT CHART

EP55A

DATE OF BIRTH	DRUG ALLERGIES	AFFIX CONTINUATION SHEET	PATIENT'S NAME

RIGHT EYE

Pharmacist	DATE	MEDICINE	STRENGTH	2	4	6	8	10	12	14	16	18	20	22	24	SIGNATURE PRESCRIBER	DISCONTINUED DATE	DISCONTINUED INITIALS
	~~15/1/16~~	~~CHLORHEXIDINE~~	~~0.02%~~	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	[signature]	16/1/16	HT
	~~15/1/16~~	~~BROLENE~~	~~0.1%~~	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	[signature]	16/1/16	HT
	~~15/1/16~~	~~CYCLOPENTOLATE~~	~~1%~~				✓			✓				✓		[signature]	16/1/16	HT
	~~15/1/16~~	~~MOXIFLOXACIN~~	~~0.5%~~	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	[signature]	16/1/16	HT
	16/1/16	MOXIFLOXACIN		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	[signature]	[crossed out]	

Administration record: DATE 15.1.16 | DATE 16.1.16 | DATE 17.1.16 | DATE (initials recorded; largely illegible)

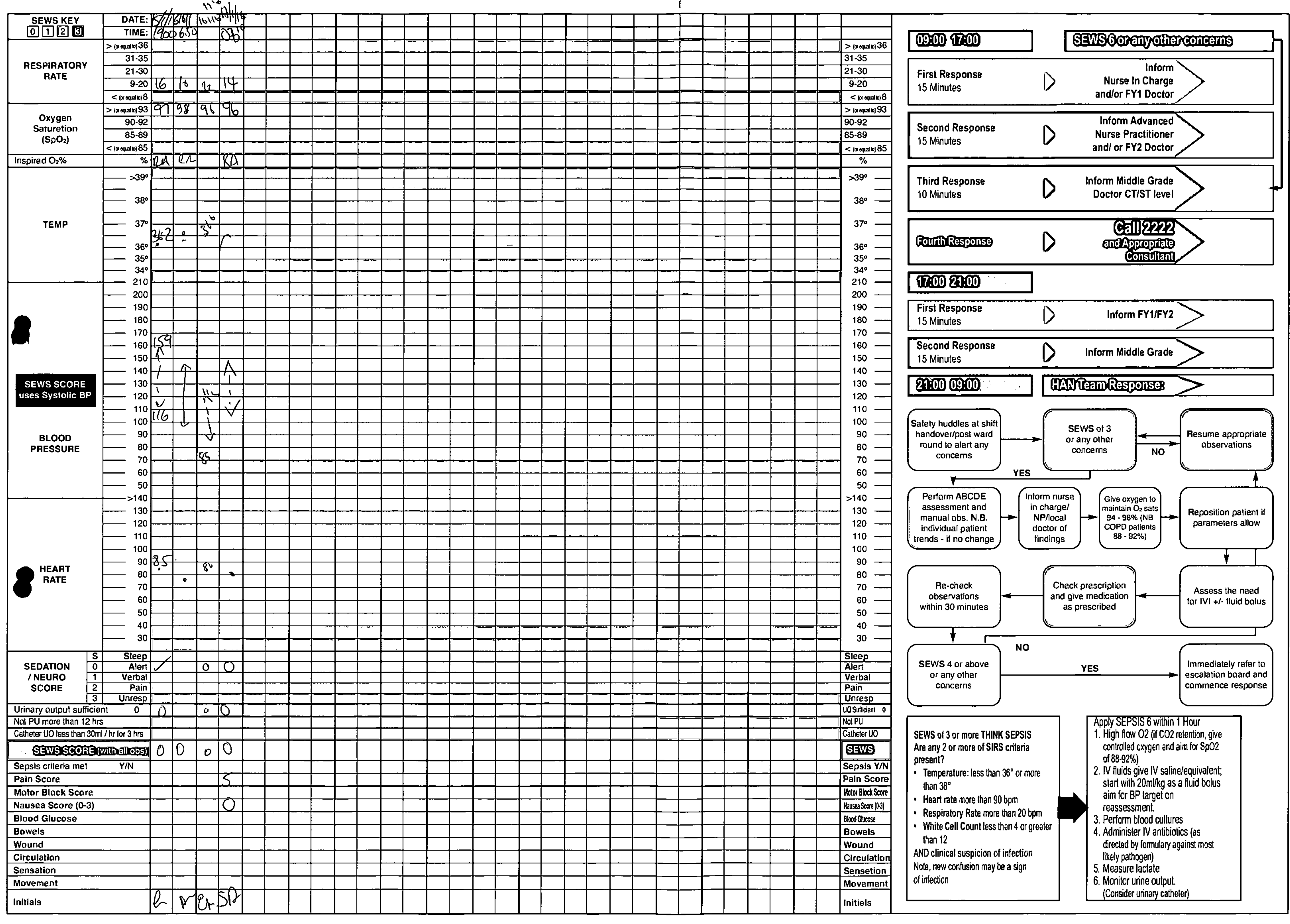
ONCE ONLY & PRE-OP

LEFT EYE

Pharmacist	DATE	MEDICINE	STRENGTH	2	4	6	8	10	12	14	16	18	20	22	24	SIGNATURE PRESCRIBER	DISCONTINUED DATE	DISCONTINUED INITIALS

Administration record: DATE | DATE | DATE | DATE

ONCE ONLY & PRE-OP



SEWS KEY 0 1 2 3	DATE:	8/11	16/11	16/11/16	17/11/16
	TIME:	1900	650	11:00	07:10
RESPIRATORY RATE	> (or equal to) 36				
	31-35				
	21-30				
	9-20	16	18	12	14
	< (or equal to) 8				
Oxygen Saturation (SpO_2)	> (or equal to) 93	97	98	96	96
	90-92				
	85-89				
	< (or equal to) 85				
Inspired O_2%	%	RA	RA		RA
TEMP	>39° / 38° / 37° / 36° / 35° / 34°	36.2		36.6	
SEWS SCORE uses Systolic BP / BLOOD PRESSURE	210 – 50	159/116		85	
HEART RATE	>140 – 30	85		80	
SEDATION / NEURO SCORE	S Sleep				
	0 Alert	✓		0	0
	1 Verbal				
	2 Pain				
	3 Unresp				
Urinary output sufficient	0	0		0	0
Not PU more than 12 hrs					
Catheter UO less than 30ml / hr for 3 hrs					
SEWS SCORE (with all obs)		0	0	0	0
Sepsis criteria met	Y/N				
Pain Score					5
Motor Block Score					
Nausea Score (0-3)					0
Blood Glucose					
Bowels					
Wound					
Circulation					
Sensation					
Movement					
Initials		[illegible]	[illegible]	[illegible]	SP

09:00 17:00 — **SEWS 6 or any other concerns**

- First Response 15 Minutes → Inform Nurse In Charge and/or FY1 Doctor
- Second Response 15 Minutes → Inform Advanced Nurse Practitioner and/ or FY2 Doctor
- Third Response 10 Minutes → Inform Middle Grade Doctor CT/ST level
- Fourth Response → Call 2222 and Appropriate Consultant

17:00 21:00

- First Response 15 Minutes → Inform FY1/FY2
- Second Response 15 Minutes → Inform Middle Grade

21:00 09:00 — **HAN Team Response:**

Safety huddles at shift handover/post ward round to alert any concerns → SEWS of 3 or any other concerns → NO → Resume appropriate observations

YES → Perform ABCDE assessment and manual obs. N.B. individual patient trends - if no change → Inform nurse in charge/ NP/local doctor of findings → Give oxygen to maintain O_2 sats 94 - 98% (NB COPD patients 88 - 92%) → Reposition patient if parameters allow → Assess the need for IVI +/- fluid bolus → Check prescription and give medication as prescribed → Re-check observations within 30 minutes → SEWS 4 or above or any other concerns → YES → Immediately refer to escalation board and commence response; NO → Resume appropriate observations

SEWS of 3 or more THINK SEPSIS
Are any 2 or more of SIRS criteria present?
- Temperature: less than 36° or more than 38°
- Heart rate more than 90 bpm
- Respiratory Rate more than 20 bpm
- White Cell Count less than 4 or greater than 12

AND clinical suspicion of infection
Note, new confusion may be a sign of infection

Apply SEPSIS 6 within 1 Hour
1. High flow O2 (if CO2 retention, give controlled oxygen and aim for SpO2 of 88-92%)
2. IV fluids give IV saline/equivalent; start with 20ml/kg as a fluid bolus aim for BP target on reassessment.
3. Perform blood cultures
4. Administer IV antibiotics (as directed by formulary against most likely pathogen)
5. Measure lactate
6. Monitor urine output. (Consider urinary catheter)

SEWS Chart

Name: 620045326K F CROSS Angella DOB: 22-May-67 CHI: 220 567 1464 CHI: 77106 JA Scott 31A ALLAN TERRACE EH22 1EL	Consultant: ______ Date chart commenced: ______ This is chart number ______ this admission Weight: Actual ______ kgs Estimated ______ kgs ASU: ______

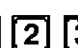
How to calculate a Standardised Early Warning (SEWS) in NHS Lothian

The clinical observations used to calculate a SEWS score are:

- Respiratory rate
- Oxygen saturation
- Temperature
- Systolic blood pressure
- Heart rate
- Sedation/Neurological score (AVPU)
- Urine output

The SEWS chart is colour coded to identify when a clinical observation is outside the normal range. A SEWS of 0-3 is allocated to each parameter using the SEWS key as shown.

SEWS KEY



All the observations have to be recorded and the total score added up and signed for. A **SEWS score of 4 or more** is an alert that a patient is acutely ill or deteriorating and an appropriate response using the escalation procedure is required... SEWS should NOT replace sound clinical judgement. Immediate action and appropriate escalation should take place if there are any concerns regarding a patient's clinical condition. Staff are accountable for seeking further help if not reassured by the response and action taken. Follow the ABCDE guidance on assessment and action and the flowchart for appropriate escalation.

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

Staff should use SBAR in all communications

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

SEWS should guide the frequency of patients monitoring

SEWS SCORE OF 1-3 **MINIMUM 4 HOURLY OBSERVATIONS**	SEWS SCORE OF 3 IN ONE PARAMETER OR SEWS SCORE OF 4-5 **MINIMUM 1 HOURLY OBSERVATIONS**	SEWS SCORE OF 6 OR MORE **CONTINUOUS MONITORING OF VITAL SIGNS**

Respiratory distress: The presence of respiratory distress is an important sign of acute illness. The patient may complain of feeling breathless. Other signs include, looking breathless, using accessory muscles of respiration, pursed lip breathing and audible breathing. If the patient has signs of respiratory distress please record in notes.

Urinary output: If a patients fluid balance is of concern and urine output is measured hourly to 4 hourly they should be on a fluid balance chart where blood loss is also recorded. If urine output is sufficient the score entered on the SEWS chart is 0. If urine output for catheterised patients is less than 30mls per hour for more than 3hrs the score is 3. If a patient has not passed urine within 12 hours the score is 3.

Sepsis criteria met Y/N: If the patient has a SEWS score of 3 or more and two or more of the Systemic Inflammatory Response Syndrome (SIRS) criteria, chart this on the SEWS chart and initiate the sepsis 6 bundle which should be completed **within one hour**. If sepsis is suspected do not hesitate to act before the criteria are breached.

Pain: The pain score must be recorded in the chart. Refer to the pain assessment and management guidelines.

ABCDE: ASSESSMENT AND CLINICAL RESPONSE TO SEWS TRIGGERS

	Assess	Possible Actions
AIRWAY	Is the Airway – • PATENT, • AT RISK, • OBSTRUCTED.	→ Suction if Indicated, → Head tilt, chin lift/jaw thrust → Airway Adjuncts, → Administer Oxygen, → Call 2222 if at Risk.
BREATHING	• Respiratory rate, • SpO2, • Accessory Muscle use • Noises +/- Percussion, Palpation & Auscultation, • Position/posture.	→ Administer prescribed Oxygen to maintain saturations 94%-98 % (NB COPD 88%-92%) → Monitor SpO2/ABGs → Consider Chest X-Ray → Treat underlying cause, → Call 2222 if not breathing.
CIRCULATION	• Pulse, • Blood Pressure, • Capillary refill time • Core Temp/Colour, • Urine Output, • Consider 4 body cavities for fluid/blood loss (4 + on the floor) • Monitor drain losses	→ Obtain IV access → Obtain blood samples → Prepare fluid challenge, → Initiate Fluid balance Chart → Call 2222 if no circulation → Consider initiating Major Haemorrhage Protocol → Monitor Response to actions
DISABILITY A = Alert V = Voice/Verbal P = Pain U = Unresponsive	• AVPU for initial assessment • GCS, on-going neuro assessment • ABC's & treat Hypoxia or Hypovolaemia, • Blood Glucose • Drugs.	→ Re-assess GCS → Check blood glucose if less than 4mmols/litre activate hypoglycaemia protocol → Check drug chart, → Remember Accurate Documentation
EXPOSURE	• Top to Toe examination, • Look for evidence of blood loss / rashes / drains / wounds etc,	→ Control bleeding, → Treat any underlying conditions identified, → Reassess, → Maintain patient's dignity. → Evaluate actions → Escalate if appropriate

Remember: to record all observations on SEWS chart & document any deterioration in the notes.
If at any point during your assessment you are concerned about your patient - **Call for help.**

Pain Assessment & Management Guidelines

How to score pain:

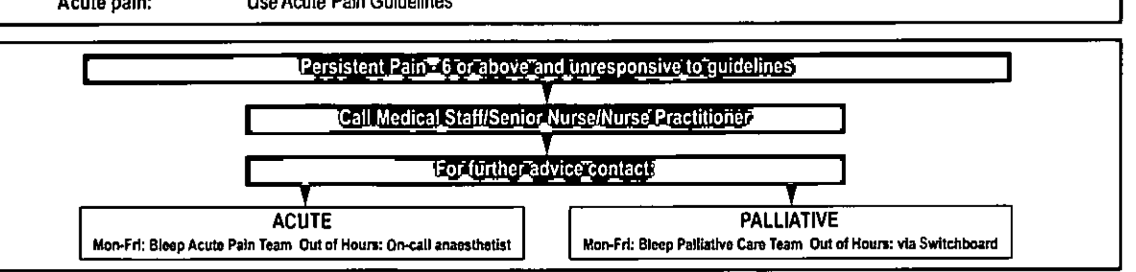
Cancer-related pain:	Always score worst pain in last 24 hours or since last assessment.
Acute pain:	Score current pain on movement e.g. deep breathing

Pain Score:		Action:
0	NONE	Continue to assess pain with every set of observations (must be at least daily)
1-3	MILD	Continue to assess pain with every set of observations (must be at least daily)
4-5	MODERATE	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.
6-10	SEVERE	Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.

PERSISTENT SEVERE PAIN (6 OR ABOVE), WHICH DISTRESSES THE PATIENT: REFER. SEE FLOW CHART BELOW.

Pain Assessment & Management Guidelines

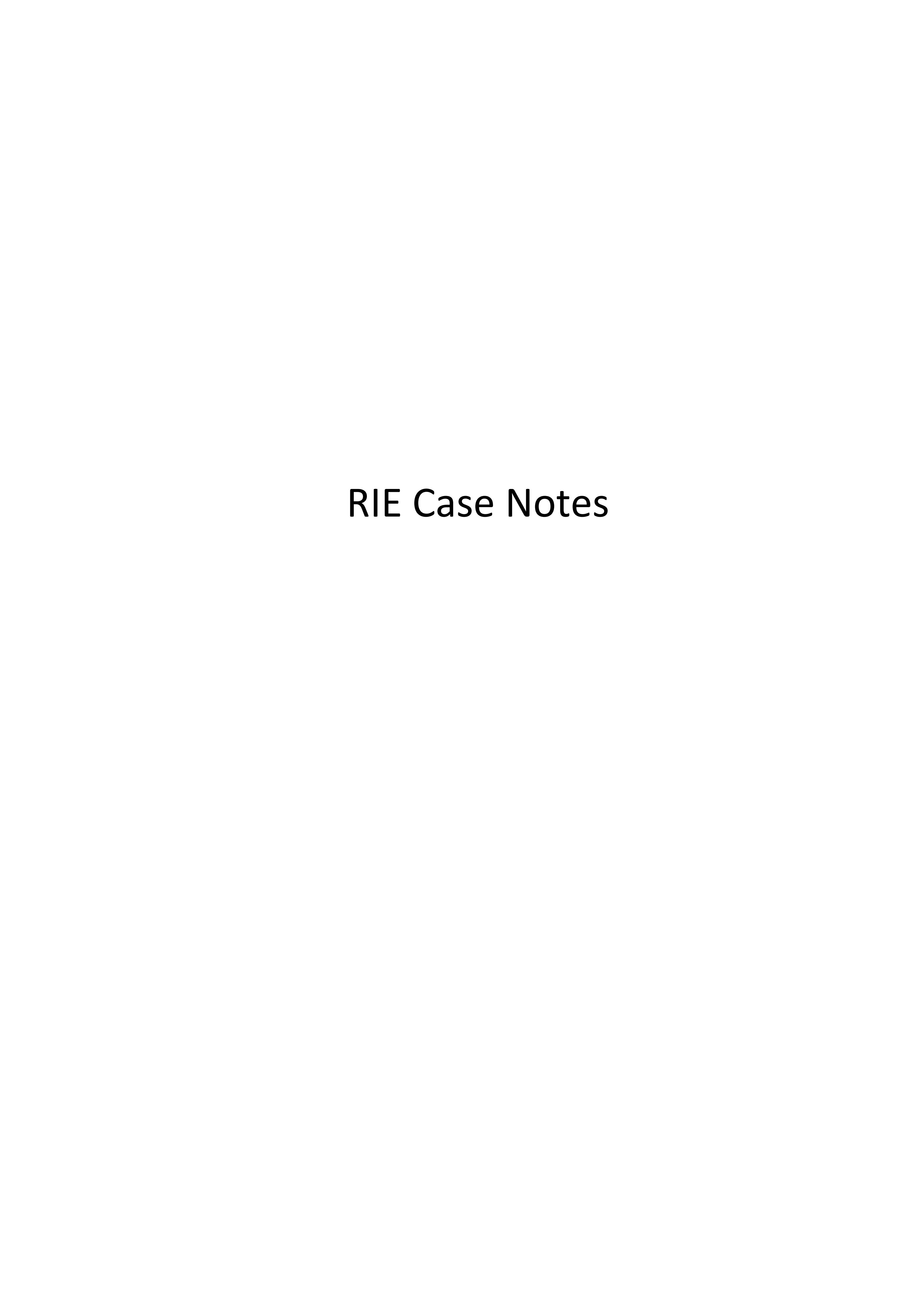
Cancer-related pain:	Initiate Edinburgh Pain Assessment Tool (EPAT®) for pain score of 4 or above. Use Palliative Care Guidelines
Acute pain:	Use Acute Pain Guidelines



Nausea Score (0-3)

0 = No Nausea
1 = Nausea (consider anti-emetic)
2 = Nausea/Vomiting (administer anti-emetic)
3 = Persistent Nausea &/or Vomiting (contact Doctor)

PERSISTENT NAUSEA &/OR VOMITING: USING GUIDELINES PRESCRIBE / GIVE ANTI-EMETICS. REVIEW.



RIE Case Notes

The Royal Infirmary of Edinburgh
Little France, Edinburgh, EH16 4SA

GENERAL SURGERY
Emergency Admissions
Tel: 0131 242 3665

Mr A de Beaux
Mr G Browning
Mr G Couper
Mr C Deans
Miss T Gillies
Mr P Lamb
Mr D Mole
Miss A Paisley
Mr S Paterson-Brown
Mr R Ravindran
Mr B Tulloh

Ward 106/107
Secretary

Billie-Jane Peden
Tel: 0131 242 3665
Email: Billie-Jane.Peden@luht.scot.nhs.uk

Dr Hilary Ansell
Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA

Dear Dr Ansell

Angella Cross, 44 Woodburn Bank, Dalkeith, EH22 2EY
DoB: 22/5/1967, CRN/UHPI: 620045326K, CHI: 2205671464

Admitted:	2B/2/2017	*Discharged:*	3/3/2017
Dictated:	31/3/2017	*Typed:*	12/4/2017
Consultant (s):	IJEOMA AZODO	*Ward:*	106
Speciality:	General Surgery	*Ref:*	PN/KAB

Date: 2/3/2017, Consultant: Ijeoma Azodo

Site	Diagnosis	Operation	Code	Type
BILIARY TREE AND GALL BLADDER	**Gall stones - chronic symptoms**	**Laparoscopic cholecystectomy**	**100324**	

Clinical Summary:

You will have already received the immediate discharge summary regarding this patients admission under our care. I confirm that she underwent a straightforward acute laparoscopic cholecystectomy and she made a good recovery post operatively and has been discharged with no further plans for follow up. Her pathology of her gallbladder has shown cholelithiasis but no other suspicious features. If she has any problems we would be more than happy to see her at short notice.

Yours sincerely

Mr PRABHU NESARGIKAR
ST7 to Miss IJEOMA AZODO

University Hospitals Division

Royal Infirmary of Edinburgh
51 Little France Crescent
Old Dalkeith Road
Edinburgh EH16 4SA

Department of General Surgery

Dr Scott
Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA

Date First Created	03/03/2017
Date Authorised	
Date/Time Printed	03/03/2017 14:45
Our Ref	620045326K
CHI	2205671464

Patient:	Angella Cross 44 Woodburn Bank Dalkeith EH22 2EY	**UHPI:**	620045326K
		Date of Birth:	22/05/1967
Ward:	Ward 106 RIE	**Admission Date:**	28/02/2017
Consultant:	Ms Ijeoma A Azodo (Locum RR)	**Discharge Date:**	03/03/2017

Impatient Discharge Summary

General Surgery

Prof OJ Garden
Ms TE Gillies
Professor SJ Wigmore
Mr S Paterson-Brown
Professor RW Parks
Mr M Akyol
Prof JLR Forsythe
Mr JJC Casey
Mr JJ Powell
Mr GW Couper
Mr GGP Browning
Mr B Tulloh
Mr A De Beaux
Miss LP Marson
Mr C Deans
Mr P Lamb
Mr R Ravindran
Miss A Paisley
Mr E Harrison
Mr O Mole
Mr G Oniscu

Associate Specialist:
Mr S Kumar

For enquiries:
0131 242 1000

Hepatobiliary Team:
0131 242 3661/2

Upper GI:
0131 242 3620
0131 242 3667

Thyroid:
0131 242 3663

Oncology Consultant WGH:
Dr Lucy Wall
0131 537 3916

Discharge Medication	Dose	Frequency	Duration	Additional Info
✓ Bendroflumethiazide Tablets	2.5 MG	ONCE DAILY	Long Term	Box of 20
Dihydrocodeine Tablets	30 MG	FOUR times daily	Short Term	
✓ Lisinopril Tablets	5 MG	In the MORNING	Long Term	Strip of 7
Paracetamol Tablets	1000 MG	Every FOUR to SIX hours PRN. Max 4 doses in 24hrs	Short Term	

Prescribed By [signature] **Date** 03/03 **Print Name** [illegible]
Dispensed By .... **Date** .... **Print Name** ....
Pharmacist Check .... **Date** .... **Print Name** ....
Final Check .... **Date** .... **Print Name** ....

PRINCIPAL DIAGNOSIS/PROCEDURE- acute cholecystitis
Dear Dr,

Your patient was admitted to RIE under surgeons for weeks of intermittent upper, RUQ pain, worst in the last 24 hours with nausea and vomiting. Blds showed elevated WBC and CRP with deranged LFTs, she was started on triple therapy IVABs. An USS and MRCP showed gallstones in a distended gallbladder with no CBD involvement. A laproscopic cholesystectomy was successfully carried out. The patient recovered well and can be discharged.

Royal Infirmary of Edinburgh
51 Little France Crescent
Old Dalkeith Road
Edinburgh EH16 4SA

Cont'd... **Ref:** 620045326K **Patient Name:** Angella Cross

TREATMENT- Lap chole

FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL- Nil

CHANGES TO DRUGS SINCE ADMISSION- analgesia

ALLERGIES / ADVERSE DRUG REACTIONS- nil

SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS

CHANGES TO DNACPR STATUS OR ANTICIPATORY CARE PLANNING

GP to please consider the following check LFTs 2 weeks time

Should you need further information please contact...

Information contained in this letter has been discussed with the patient/carer.

Yours sincerely..........................

Staff Signature.......................... PrintName.....LYNSEY HALL..............................

Designation.................ANP............. Date........03/03/17......... Time...................

Patient/Carer Signature...

This is an immediate discharge letter and a further letter may follow.

University Hospitals Division

Royal Infirmary of Edinburgh
51 Little France Crescent
Old Dalkeith Road
Edinburgh EH16 4SA

Department of General Surgery

Dr Scott
Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA

Date First Created 03/03/2017
Date Authorised
Date/Time Printed 03/03/2017 16:14
Our Ref 620045326K
CHI 2205671464

Patient:	Angella Cross 44 Woodburn Bank Dalkeith EH22 2EY	**UHPI:**	620045326K
		Date of Birth:	22/05/1967
Ward:	Ward 106 RIE	**Admission Date:**	28/02/2017
Consultant:	Ms Ijeoma A Azodo (Locum RR)	**Discharge Date:**	03/03/2017

General Surgery

Prof OJ Garden
Ms TE Gillies
Professor SJ Wigmore
Mr S Paterson-Brown
Professor RW Parks
Mr M Akyol
Prof JLR Forsythe
Mr JJC Casey
Mr JJ Powell
Mr GW Couper
Mr GGP Browning
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Mr A De Beaux
Miss LP Marson
Mr C Deans
Mr P Lamb
Mr R Ravindran
Miss A Paisley
Mr E Harrison
Mr D Mole
Mr G Oniscu

Associate Specialist:
Mr S Kumar

For enquiries:
0131 242 1000

Hepatobiliary Team:
0131 242 3661/2

Upper GI:
0131 242 3620
0131 242 3667

Thyroid:
0131 242 3663

Oncology Consultant WGH:
Dr Lucy Wall
0131 537 3916

Inpatient Discharge Summary

Discharge Medication	Dose	Frequency	Duration	Additional Info
Bendroflumethiazide Tablets	2.5 MG	ONCE DAILY	Long Term	patients own supply
Cyclizine Tablets	50 MG	THREE times DAILY	Short Term	20 tablets given
Dihydrocodeine Tablets	30 MG	FOUR times daily	Short Term	30 tablets given
Lisinopril Tablets	5 MG	In the MORNING	Long Term	patients own
Paracetamol Tablets	1000 MG	Every FOUR to SIX hours PRN. Max 4 doses in 24hrs	Short Term	32 tablets given

Prescribed By .... Date .... **Print Name**............................
Dispensed By .... Date .... **Print Name**............................
Pharmacist Check .... Date .... **Print Name**............................
Final Check .... Date .... **Print Name**............................

PRINCIPAL DIAGNOSIS/PROCEDURE- acute cholecystitis
Dear Dr,

Your patient was admitted to RIE under surgeons for weeks of intermittent upper, RUQ pain, worst in the last 24 hours with nausea and vomiting. Blds showed elevated WBC and CRP with deranged LFTs, she was started on triple therapy IVABs. An USS and MRCP showed gallstones in a distended gallbladder with no CBD involvement. A laproscopic cholesystectomy was successfully carried out.

Royal Infirmary of Edinburgh
51 Little France Crescent
Old Dalkeith Road
Edinburgh EH16 4SA

Impatient Discharge Summary

Cont'd... **Ref:** 620045326K **Patient Name:** Angella Cross

The patient recovered well and can be discharged.

TREATMENT- Lap chole

FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL- Nil

CHANGES TO DRUGS SINCE ADMISSION- analgesia

ALLERGIES / ADVERSE DRUG REACTIONS- nil

SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS

CHANGES TO DNACPR STATUS OR ANTICIPATORY CARE PLANNING

GP to please consider the following check LFTs 2 weeks time

Should you need further information please contact...

Information contained in this letter has been discussed with the patient/carer.

Yours sincerely..........................

Staff Signature.......................... PrintName.....LYNSEY HALL..............................

Designation.................ANP............. Date........03/03/17......... Time...................

Patient/Carer Signature...

This is an immediate discharge letter and a further letter may follow.

E9 B4.

Department of General Surgery, Royal Infirmary of Edinburgh
Operation Record

Name:	**Ms Angella Cross**	DoB:	22/5/1967	UHPI:	620045326K
				CHI:	2205671464
Consultant:	IJEOMA AZODO	Ward:	106	Date of Op:	2/3/2017
Surgeon:	ALAN O'NEILL	Assistant:	MICHAEL NIELSEN		
An esthetist:	Dr Carey	Anaesthetic:	General		
rgency:	Emergency	Case:	Inpatient		

Opera ns

Site	Diagnosis	Operation	Code	Type
BILIARY TREE AND GALL BLADDER	**Gall stones - chronic symptoms**	**Laparoscopic cholecystectomy**	**100324**	

Operative Findings and Techniques

02/03/17

Indication : Right upper quadrant pain with ultrasound demonstrating gallstones and moderately deranged LFT's. The patient underwent a pre-operative MRCP which confirmed no intra-ductal calculi.

Procedure : GA, supine position with table restraints, TEDs, flowtrons, Dalteparin and IV antibiotics. Infraumbilical skin incision and insertion of a 10mm port using modified Hassan technique. A further 10mm and two 5mm ports were placed in the epigastrium and right upper quadrant under vision, after infiltration of .5% Levobupivocaine. Minimal adhesions to a thin walled gallbladder. This was retracted cephalad and on grasping with the blunt snubnose grasper, there was a perforation on the fundus of the gallbladder. There was spillage of bile but no gallstones. The gallbladder was re-grasped using a Debakey grasper and retracted cephalad before anterior and posterior incisions were made. The hepaticocystic triangle was dissected with large posterior window created and the cystic artery and adjacent lymph node were skeletonised. The artery was then triple clipped and divided lateral to the lymph node, leaving two clips on the patient side. Cystic duct was then milked and skeletonised before being triple clipped and divided, again leaving two clips on the patient side. The gallbladder was then dissected from the gallbladder fossa of the liver and retrieved intact in a parachute bag, via the umbilical port site. Washout until the effluent was clear and haemostasis ensured. Ports out under vision and closure with 1 PDS and subcuticular 4/0 biocin to skin after infiltration of the residual .5% Levobupivocaine.

Post operative instructions : To the ward. No further antibiotics. Eat and drink. Mobilise. Dalteparin as prescribed. Home when well.

Mr ROBERT O'NEILL
Specialist Registrar to Miss IJEOMA AZODO

620045326K F
CROSS Angeila
22-May-67 CHI: 220 567 1464
77106 JA Scott
44 Woodburn Bank Midlothian
EH22 2EY

Post code

THEATRE PATIENT CARE PLAN

PRE-OPERATIVE ASSESSMENT: Pre-operative visit performed? Yes ☐ No ☐

Signature: **Name (print):** **Date:**

Identified Problems	Planned Nursing Care

PRE-OPERATIVE CHECKLIST:

Check	Ward Nurse Y	Ward Nurse N	Theatre Nurse Y	Theatre Nurse N	Comments
Correct patient?	✓	☐	✓	☐	
Correct procedure?	✓	☐	✓	☐	
All bracelets in situ with name, date of birth, ward, unit number, gender & CHI number?	✓	☐	✓	☐	
Operation consent form signed?	✓	☐	✓	☐	
Operation site & side marked?	☐	✓	☐	✓	
Prescribed pre-medication given?	✗	✓	☐	✓	
Routine drug therapy taken?	✓	☐	✓	☐	
Make up removed as required?	✓	☐	✓	☐	
Jewellery (incl body piercings) & hairclips removed, rings taped?	✓	☐	✓	☐	Top crowns - secure
Items accompanying patient to theatre? (eg wigs, hearing aids, prosthesis etc)	✓	☐	✓	☐	Hair extensions
Dressed for theatre?	✓	☐	✓	☐	
Does the patient have any allergies?	☐	✓	☐	✓	
Has the patient passed urine?	✓	☐	✓	☐	
Urinalysis results recorded?	✓	☐	☐	☐	HCG neg.
Date of last menstrual period?	1yr ½ - sterilisation				
Last food? Date: 1/3 Time: 2030	✓	☐	✓	☐	
Last drink? Date: 2/3. Time: 0800 SIPS	✓	☐	✓	☐	
Documents accompanying patient? Healthcare record ☐ ICP (if separate) ☐ Xrays ☐ Drug chart ✓ Blood results ✓ Cross matched ☐	✓	☐	✓	☐	

	Signature	Print name	Date
Ward Nurse	[signature]	T [illegible]	2/3/17
Theatre Practitioner	[signature]	D Dandsen	2/3/17.

INTRAOPERATIVE CARE RECORD

Patient name:

CHI number:

Patient address:

Surgical Position Supine Initials: DD		Equipment Used/Protection/Pressure Care Gel pads legstrap side support eyes taped Warming Blanket · SCD Boots
Mobility Initials DD	Special Actions taken Self Pre op	
Diathermy Initials: DD	Position Left Thigh. Problem/action taken	
Skin prep. Initials: DD	Details Videne Antiseptic Solution.	
Skin closure Initials: [illegible]	Details 4-0 Biosyn absorbable.	
Dressings ☐ N/A Initials: [illegible]	Details Mepore's	
Drains ☐ N/A Initials: [illegible]	Details X	
Catheters ☐ N/A Initials: [illegible]	Details Mls in balloon X	
Specimens ☐ N/A Initials: [illegible]	Details Gallbladder → Pathology	
Packs ☐ N/A Initials:	Details X	
Tourniquet ☐ N/A Initials:	Position Protection used X	Pressure X / Time on / Time off X

Comments:

8 Mls of 0.5% levobupivacaine

Signature: [signature] Print name: JADE KILGOUR

INTRAOPERATIVE COUNTS

Patient name:

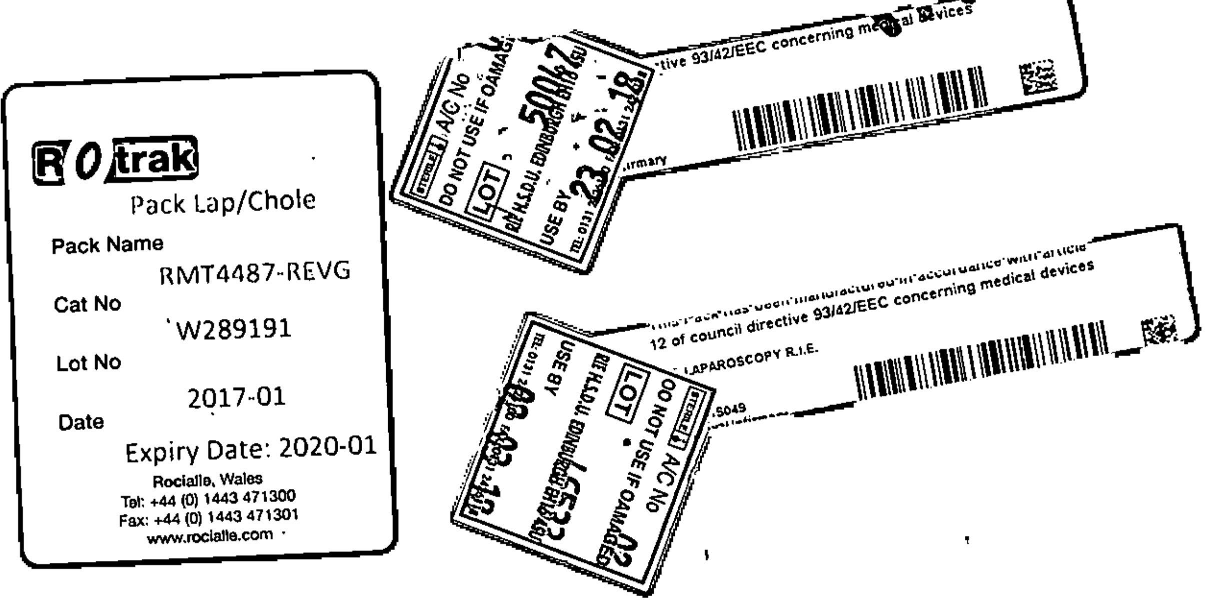
CHI number:

Patient address:

Post code

	Initial Count	Intraoperative	Intraoperative	Intraoperative	Final count
Correct Signature	[signature]	X	Jane Dam	X	Jane Dam
Discrepancy and Action taken	X	X	X	X	X
Scrub nurse	Comments		Total blood loss minimal blood loss		
	1. Print JADE Kilgour S/N		Sign Kilgour S/N		
	2. Print		Sign		

HSDU LABELS – FROM PACKS/INSTRUMENTS USED



INTRAOPERATIVE COUNTS

Patient name:

CHI number:

Patient address:

Post code

IMPLANTS

OPERATION SUMMARY (surgeon or deputy to complete)

Surgeon: O'Neill.	Assistants: M. Neilson
Drugs:	
Operation performed: Laparoscopic cholecystectomy → minimal inflammation.	Diathermy used ☐
Postoperative instructions: E+D, Dalteparin	
Printed: O'Neill.	Signed: [signature]

Name: ANGELA CROSS
Hospital Number: 220567/464
Date of Birth: 22/05/67
Affix Label

ANAESTHETIST(S) GRADE
K. MONTGOMERY ST7
E. NOLAN CT1
SUPERVISING CONSULTANT: K. CAREY.
INFORMED Yes ☑ No ☐

OPERATION PERFORMED: LAP. CHOLECYSTECTOMY
LOCATION: TH 17, RIE
SURGEON:

DATE: 2/3/17
START TIME:
END TIME:
TRAINED ASSISTANT PRESENT ☑ STEVE

CONDUCT OF ANAESTHETIC

Induction anxious ++
Pre O_2 ☑ RSI ☑ Cricoid ☑

Midazolam 2mg - fent.
Al Fentanyl 1mg
Propofol 200mg
Rocuronium 70mg

Maintenance

Sevoflurane

Reversal

AIRWAY

Face Mask ☑
Oral Airway ☐
Nasal Airway ☐
LMA ☐
Type
Size
ETT ☑
Cuff Oral ☑
Type Portex
Size #7
Laryngoscopy grade (1) 2 3 4
Standard MAC blade.

BREATHING SYSTEM

Circuit CIRCLE
Ventilator DATEX OHMEDA
Gas flow 6L → 0.5L/min
Filter /Humidifier ☑
S.V. ☐
I.P.P.V. ☑
Throat Pack In ☐ Out ☑
Easy to hand ventilate Y ☐ N ☐ N/A ☑

VASCULAR ACCESS

Cannula(e)	Site
22G in situ	LACF
16G sited	DLH
18G sited	DRH

A – line ☐
CVP ☐
Ultrasound guidance Y ☐ N ☐

MONITORING

Machine checks
Anaesthetic room ☑
Theatre ☐
Monitor used MINDRAY
ECG ☑ P_{aw} ☑
S_pO_2 ☑ Disconnect ☑
NIBP ☑ NMB ☐
F_iO_2 ☑ Steth ☐
F_ECO_2 ☑ Temp ☐
Agent ☑ Urine ☐
Anaesthetic depth ☐

POSITION

Patient / limb position
SUPINE

PROPHYLAXIS

Eye care ☑
Pressure care ☑
Fluid warmer ☐
Warming blanket ☑

	Y	N	N/A
DVT	☑	☐	☐
Antibiotics	☑	☐	☐
PONV	☑	☐	☐

REGIONAL TECHNIQUE

Type of block
Consent ☐
Awake ☐
Asleep ☐
Stimulator ☐
Ultrasound guidance ☐
Catheter ☐
Entry site
Needle used
Drugs given
Technique

EVENTS

A INDUCTION
B TO THEATRE
C RTS 1457
D
E
F
G
H
I
J
K
L
M
N
O
P
Q
R
S
T
U
V

TIME	1400		30			1500		30			1600	30
S_pO_2	100	100	100	100	99	100	100	100	100	100	100	
F_ECO_2	4.5	4.3	4.4	4.3	4.8	4.6	4.3	4.4	4.4	4.4		
F_iO_2	.90	.64	.64	.66	.60	.55	.54	0.5	0.5	0.5		
F_EAn SEVO	2.15	2.08	2.06	2.33	2.89	2.14	2.2	2.3				
P_{aw} (cmH_2O)	17/5	18/5	18/5									
Age MAC	1.05	1.10	1.28	1.1								

CVP
Urine Output
Blood loss
Temperature

200
150
SBP - v
MAP - x
100
DBP - ^
Pulse - •
50

Events A B C
Fluids (1)

METARAMINOL (0.5mg) ↑ ↑ ↑
MORPHINE (mg) 2 2 2 2
ONDANSETRON 4mg

FLUIDS

1 ALBUMINATE 1000
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18

TOTAL FLUIDS
TOTAL BLOOD LOSS
TOTAL URINE

620045326K F
CROSS Angella
22-May-67 CHI: 220 567 1464
77106 JA Scott
44 Woodburn Bank Midlothian
EH22 2EY

RECOVERY ROOM* (→ WARD on day of surgery)

TIME IN: 1615 TIME OUT:

Discharge criteria met? Y ☐ N ☐

EVENTS

- A ETT Extubated
- B PAC
- C Anaesthetic Review
- D
- E
- F
- G
- H

MONITORING

Machine checks
- Anaesthetic room ☐
- Theatre ☐

Monitor used
- ECG ☐ P_{aw} ☐
- S_pO_2 ☐ Disconnect ☐
- NIBP ☐ NMB ☐
- F_iO_2 ☐ Steth ☐
- F_ECO_2 ☐ Temp ☐
- Agent ☐ Urine ☐
- Anaesthetic depth ☐

POSITION

Patient / limb position

PROPHYLAXIS

- Eye care ☐
- Pressure care ☐
- Fluid warmer ☐
- Warming blanket ☐

	Y	N	N/A
DVT	☐	☐	☐
Antibiotics	☐	☐	☐
PONV	☐	☐	☐

REGIONAL TECHNIQUE

- Type of block
- Consent ☐
- Awake ☐
- Asleep ☐
- Stimulator ☐
- Ultrasound guidance ☐
- Catheter ☐
- Entry site
- Needle used
- Drugs given
- Technique

Recovery

PAIN SCORE
- 0 NONE. Continue to assess pain with every set of observations
- 1-3 MILD Continue to assess pain with every set of observations
- 4-5 MODERATE Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review
- 6-10 SEVERE Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review

NAUSEA SCORE
- 0 No Nausea
- 1 Nausea (consider anti-emetic)
- 2 Nausea/vomiting (administer anti-emetic)
- 3 Persistent nausea &/or vomiting (contact Dr.)

SEDATION SCORE
- 0 None, patient alert
- 1 Mild, occ drowsy, easy to rouse
- 2 Mod frequently drowsy, easy to rouse
- 3 Severe, somnolent, difficult to rouse
- S Normal sleep, stirs to light touch
- U Unconscious

RECOVERY COMMENTS

Laproscopic Cholecystectomy
- minimal blood loss - minimal inflammation
- ET Tube extubated by anaesthetist
- Very drowsy after extubation, Karen to be prompted to take breaths for about 15 minutes. Resp rate low.
- Dressing dry and intact
- Not passed urine in recovery (incontinent x2 ++)
- Obs as charted
- pain well controlled @1720
- Vommited x2 bile - antiemetics given
- * Hourly obs over night *

Name (print) K.KILANOWSKI Signature [signature]

POST-OPERATIVE INSTRUCTIONS

- Intravenous cannulae have been flushed ☑
- Oxygen: for sats ≥95% & fully awake
- Monitoring: routine please
- Fluids: may drink — As charted ☐
- Analgesia — As charted ☑
- Anti-emetics — As charted ☑
- Special Instructions (including expected return of power & sensation after RA):

Destination: Day case ☐ Ward ☑ HDU ☐ ITU ☐

Name (print) K.Mattcomey Signature [signature]
Contact No. 2200

NHS LOTHIAN ANAESTHESIA RECORD

Proposed operation: Laparoscopic cholecystectomy +/- open

Date: 02.03.17 Side:

NCEPOD: Ele ☐ Exp ☐ Urg ☑ Imm ☐

Name: Angella Cross
Hospital Number:
Date of Birth: Age:
CHI Number: 220 5671464
Gender: F
Affix Label

PRE-OP ASSESSMENT

Assessor: TIMONY-NOGO Date: 02.03.17 Location: 107

CDNS ☐ SAS ☐ ST__ ☐ CT 1 ☑ Other ☐

Consent form signed and checked ☑

History / Examination (& see care pathway)
C-sections, ear + eye ops, breast reduction, hypertension

HR
BP
Weight (kg)
Height (m)

Medications (including herbal)
lisinopril (taken)

Allergies & adverse reactions
no

ASA Grade 1 (2) 3 4 5 6 E

Airway Assessment
Mallampati II, flex/ext ✓, thyromental ✓, sublux ✓
Teeth ✓ own, one crown.

Previous Anaesthesia
GA

Uneventful Y ☑ N ☐ N/A ☐

Family History: no

- Alcohol: no (rare)
- Smoking: no
- Drugs
- Reflux / GORD: no
- Fasted: yesterday.

Investigations
- FBC
- U&E's / eGFR
- G+S / e-Release / X-match
- ECG
- CXR

Information Given to Patient

	Y	N	N/A
Intended anaesthetic technique discussed	☐	☐	
Regional / local anaesthetic technique discussed	☐	☐	☐
Risks of regional anaesthesia discussed:			☐
PDPH	☐	☐	☐
Failure	☐	☐	
Temporary nerve damage	☐	☐	
Permanent nerve damage	☐	☐	
Post-operative analgesia discussed	☐	☐	
Consent for PR drug administration	☐	☐	

Pre-op Instructions

	Y	N	N/A
Pre-medication prescribed on drug chart	☐	☐	☐
Give charted medication	☐	☐	☐
Omit anticoagulant	☐	☐	☐
Keep dentures in	☐	☐	☐

Fasting: Solids______hrs Clear fluids______hrs
(or state times)
Other:

Post-operative Remarks

	Y	N
Uneventful anaesthetic	☐	☐

- Significant events
- Critical incident
- Warnings / Hazards

Name (print) Signature
Contact No

RECOVERY ROOM* (→ WARD on day of surgery)

620045326K F
CROSS Angella
22-May-67 CHI: 220 567 1454
77106 JA Scott
44 Woodburn Bank Midlothian
EH22 2EY

TIME IN: 1615 TIME OUT:

Discharge criteria met? Y ☐ N ☐

EVENTS

A ETT Extubated
B PAC
C Anaesthetic Review
D
E
F
G
H

TIME	16 20	25	30	35	40	45	50	55	00	05	10	15	20	25	30	35	40	45
Airway	ET	ET	ET	ET	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV
Oxygen Therapy	6L	6L	6L	6L	6L	6L	6L	6L	6L	6L	6L	6L	6L	6L	6L	6L	6L	6L
S_pO_2	100	99	100	100	98	100	100	100	100	99	99	100	100	100	100	100	100	99
Respiration	0	2	10	0	0	1	7	6	3	12	8	6	7	12	17	11	18	18
PAIN Severe 6 - 10																		
PAIN Moderate 4 - 5																		
PAIN Mild 1 - 3																		
PAIN None 0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Nausea Score	0	0	0	0	3	3	0	0	0	1	1	0	0	1	1	0	3	3
Sedation Score	U	U	U	U	3	3	3	3	3	2	2	1	1	S	S	S	0	0
Urine Volume	NPU									NPU								
Wound Check										✓ dry						✓ dry		
Drains	N/A.																	
Temperature	36.7°C																	
Events				A						B								

SBP - ∨ MAP - x DBP - ∧ Pulse - •

200 150 100 50

Fluids: Plasmalyte running from theatre
Drugs: IV Cyclizine
IV Ondansetron 4mg

TIME	1800	10	20	30	40	50	1700	10	15	20	25	30	35	40	45	50	55	2000
Airway	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV
Oxygen Therapy	4L	4L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L
S_pO_2	?	98	96	99	100	100	100	100	98	99	100	98	99	99	99	100	100	99
Respiration	19	21	12	8	6	6	5	14	8	9	8	6	11	11	10	11	14	13
PAIN Severe 6 - 10																		
PAIN Moderate 4 - 5																		
PAIN Mild 1 - 3																		
PAIN None 0	0	0	0	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nausea Score	2	3	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sedation Score	0	0	0	S	S	S	S	S	S	S	S	S	S	S	S	S	0	0
Urine Volume	Incont +++ x2															Requested Bedpan 100ml		
Wound Check		✓ dry		✓ dry														
Drains	Nil																	
Temperature																		
Events								C										

SBP - ∨ MAP - x DBP - ∧ Pulse - •

200 150 100 50

Fluids: Sips H2O ... Sips H2O
Drugs: IV Cyclizine 50mg
IV Ondansetron

PAIN SCORE
0 NONE. Continue to assess pain with every set of observations
1-3 MILD Continue to assess pain with every set of observations
4-5 MODERATE Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review
6-10 SEVERE Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review

NAUSEA SCORE
0 No Nausea
1 Nausea (consider anti-emetic)
2 Nausea/vomiting (administer anti-emetic)
3 Persistent nausea &/or vomiting (contact Dr.)

SEDATION SCORE
0 None, patient alert
1 Mild, occ drowsy, easy to rouse
2 Mod frequently drowsy, easy to rouse
3 Severe, somnolent, difficult to rouse
S Normal sleep, stirs to light touch
U Unconscious

RECOVERY COMMENTS

Laproscopic Cholecystectomy
- minimal blood loss - minimal inflammation
- ET Tube extubated by anaesthetist
- Very drowsy after extubation, Karen to be prompted to take breaths for about 15 minutes. Resp rate low.
- Dressing dry and intact
- Not passed urine in recovery (incontinent x2 ++)
- Obs as charted
- Pain well controlled @ 1720
- Vommited x2 bile - antiemetics given
* Hourly obs over night *

Name (print) K. KILANOWSKI Signature [signature]

POST-OPERATIVE INSTRUCTIONS

Intravenous cannulae have been flushed ☑
Oxygen for sats ≥ 95% & fully awake
Monitoring routine please
Fluids may drink As charted ☐
Analgesia As charted ☑
Anti-emetics As charted ☑
Special Instructions (including expected return of power & sensation after RA):

Destination Day case ☐ Ward ☑ HDU ☐ ITU ☐

Name (print) K. Mattamey Signature [signature]
Contact No. 2200

NHS LOTHIAN ANAESTHESIA RECORD

Proposed operation: Laparoscopic cholecystectomy +/- open

Name: Angella Cross
Hospital Number:
Date of Birth: Age:
Number: ... 5671464
Affix Label

SAS ☐ ST ☐ CT1 ☑ Other ☐
Consent form signed and checked ☑

... (including herbal) ... (taken)

Allergies & adverse reactions: no

ASA Grade: 1 (2) 3 4 5 6 E

Airway Assessment: Mallampati II, flex/ext ✓, thyromental ✓, subluxation ✓
Teeth: own, one crown.

...ons
...FR
...ease / X-match
CXR
no

Information Given to Patient

	Y	N	N/A
Intended anaesthetic technique discussed	☐	☐	
Regional / local anaesthetic technique discussed	☐	☐	☐
Risks of regional anaesthesia discussed:			☐
PDPH	☐	☐	☐
Failure	☐	☐	
Temporary nerve damage	☐	☐	
Permanent nerve damage	☐	☐	
Post-operative analgesia discussed	☐	☐	
Consent for PR drug administration	☐	☐	

Pre-op Instructions

	Y	N	N/A
Pre-medication prescribed on drug chart	☐	☐	☐
Give charted medication	☐	☐	☐
Omit anticoagulant	☐	☐	☐
Keep dentures in	☐	☐	☐

Fasting: Solids____hrs Clear fluids____hrs
(or state times)
Other:

Post-operative Remarks

	Y	N
Uneventful anaesthetic	☐	☐

* Significant events
* Critical incident
* Warnings / Hazards

Name (print) Signature
Contact No

Name: ANGELA CROSS
Hospital Number: 22056 71464
Date of Birth: 22/05/67
Affix Label

ANAESTHETIST(S) GRADE
K. MONTGOMERY ST7
E. NOLAN CT
SUPERVISING CONSULTANT: K. CAREY
INFORMED Yes [x] No [ ]

OPERATION PERFORMED: LAP. CHOLECYSTECTOMY
LOCATION: Th 17, RIE
SURGEON:

DATE: 2/3/17
START TIME:
END TIME:
TRAINED ASSISTANT PRESENT [x] STEVE

CONDUCT OF ANAESTHETIC
Induction: anxious ++
Pre O_2 [x] RSI [x] Cricoid [ ]
MIDAZOLAM 2mg - for CL
Alfentanil 1mg
PROPOFOL 200mg
ROCURONIUM 70mg
Maintenance
SEVOFLURANE
Reversal

AIRWAY
Face Mask [x]
Oral Airway [ ]
Nasal Airway [ ]
LMA [ ]
Type
Size
ETT [x]
Cuff: orth [x]
Type: ACRTEY
Size: #7
Laryngoscopy grade (1) 2 3 4
Standard MAC blade.

BREATHING SYSTEM
Circuit: CIRCLE
Ventilator: DATEX OHMEDA
Gas flow: 6L → 0.5L/min
Filter /Humidifier [x]
S.V. [ ]
I.P.P.V. [x]
Throat Pack In [ ] Out [x]
Easy to hand ventilate Y [ ] N [ ] N/A [x]

VASCULAR ACCESS
Cannula(e)	Site
22G in situ	LACF
16G sited	DLH
18G sited	DRH

A – line [ ]
CVP [ ]
Ultrasound guidance Y [ ] N [ ]

MONITORING
Machine checks
Anaesthetic room [x]
Theatre [ ]
Monitor used: MINDRAY
ECG [x] P_{aw} [x]
S_pO_2 [x] Disconnect [x]
NIBP [x] NMB [ ]
F_iO_2 [x] Steth [ ]
F_ECO_2 [x] Temp [ ]
Agent [x] Urine [ ]
Anaesthetic depth [ ]

POSITION
Patient / limb position: SUPINE

PROPHYLAXIS
Eye care [x]
Pressure care [x]
Fluid warmer [ ]
Warming blanket [x]

	Y	N	N/A
DVT	[x]	[ ]	[ ]
Antibiotics	[x]	[ ]	[ ]
PONV	[x]	[ ]	[ ]

REGIONAL TECHNIQUE
Type of block
Consent [ ]
Awake [ ]
Asleep [ ]
Stimulator [ ]
Ultrasound guidance [ ]
Catheter [ ]
Entry site
Needle used
Drugs given
Technique

EVENTS
A INDUCTION
B TO THEATRE
C KTS 1451
D
E
F
G
H
I
J
K
L
M
N
O
P
Q
R
S
T
U
V

TIME	1400		30		1500		30		1600		30
S_pO_2	100 100	100	100 99	100	100 100	100 100	100				
F_ECO_2	4.5	4.3 4.4	4.3 4.8	4.6 4.3	4.4 4.4	4.4					
F_iO_2	.90	.64 .64	.66 .60	.55 .54	0.5 0.5	0.5					
F_EAn SEVO	2.15	2.08 2.06	2.33	2.89	2.14 2.2	2.3					
P_{aw} (cmH2O)	17/5		18/5		18/5						
Age MAC	1.05	1.10	1.28		1.1						

CVP
Urine Output
Blood loss
Temperature
200
150
SBP - v
MAP - x
100
DBP - ^
Pulse - •
50

Events: A B C
Fluids: (1)

METARAMINOL (0.5mg) ↑ ↑ ↑
MORPHINE (mg) 4 +2 +2
ONDANSETRON 4mg

FLUIDS
1 PLASMALYTE 1000
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18

TOTAL FLUIDS
TOTAL BLOOD LOSS
TOTAL URINE

CONSENT FORM:

Medical or Dental Investigation, Treatment or Operat

620045326K F
CROSS Angella
22-May-67 CHI: 220 567 1464
77106 JA Scott
44 Woodburn Bank Midlothian
EH22 2EY

Hospital: ...

Patient's Surname: ...

Other Names: ...

Unit Number: ...

CHI Number: ...

22/05/1967

(or affix patient label)

ANGELIA CROSS

Sex (tick box) Male ☐ Female ☐ Date of Birth ...

(To be completed by the medical, dental, nursing or paramedical practitioner. See notes)

Type of operation, investigation or treatment for which written evidence of consent is considered appropriate

laparoscopic cholecystectomy, possible open

I confirm that I have explained to the patient in terms which in my judgement are suited to his/her understanding (and/or to one of his/her parents or guardians), the proposed operation, investigation or treatment, including options available, and if relevant, the need for anaesthesia or sedation.

Relevant Written Information given to the patient: ☐ Yes ☐ No

Signature [signature] Date 01 MAR 2017

Name and Status of Practitioner [illegible] / locum consultant

Re-confirmation of Consent on the day of admission:

Signature ... Date ...

Name and Status of Practitioner ...

To the Patient (or Parent or Guardian if Appropriate)

1. **Please read this form and the notes overleaf very carefully.**
2. **If there is anything that you don't understand about the explanation or if you want more information, you should ask the practitioner before signing.**
3. **Please check that all the information on the form is correct. If it is and you understand the explanation, then sign the form.**

I am the patient/~~parent/guardian (delete as necessary)~~

I agree	✧ to what is proposed, which has been explained to me by the practitioner named above
I understand	✧ that anaesthesia (general/regional/local) or sedation will be needed
	✧ that the procedure may not be done by the practitioner who has been treating me so far
	✧ that any procedure in addition to the investigation or treatment described on this form will only be carried out if it is necessary and in my best interests and can be justified for medical reasons
I have told	✧ the practitioner about the procedures I have noted below* which I would wish not to be carried out without my having the opportunity to consider them first

* risks, benefits, goals, alternatives including but
* not limited to bleeding, infection, bile duct injury ...
* ...

Signature Angella Cross Name A Cross

Address ... Date 1/3/17

LU 055

NOTES TO ALL HEALTH PRACTITIONERS
(DOCTORS, DENTISTS, NURSES, PROFESSIONS ALLIED TO MEDICINE)

A patient has an absolute legal right to grant or withhold consent prior to examination or treatment. Patients should be given sufficient information, in a way that they can understand, about the proposed treatment and the possible alternatives. Patients must be allowed to decide whether they will agree to the treatment and they may refuse or withdraw consent to the treatment at any time. The patient's consent to treatment should be recorded on this consent form (further guidance is given in the Trust Policy Statement).

NOTES TO PATIENTS

The health practitioner is here to help you. He or she will explain the proposed treatment and what the alternatives are. You can ask any questions and seek further information. You can refuse treatment.

You should be provided with sufficient information to allow you to come to a decision as to whether to consent to the treatment proposed. The type of information you should receive should include:

I. Nature of your condition & proposed procedures, including degree of urgency
II. Benefits to be reasonably accepted of the procedure
III. Nature & probability of material (= significant) risks involved, including consideration of ratio of risks and benefits
IV. Inability of the practitioner to predict results
V. Irreversibility of the procedure, if that is the case
VI. The likely result of not having the proposed treatment or procedure
VII. Alternatives available, including their risks and benefits

You may ask for a relative, a friend or a nurse to be present.

Training doctors, dentists, nurses and other health professionals is essential to the continuation of the health service and improving the quality of care. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a senior doctor, dentist, nurse or other health professional.

You may however decline to be involved in the formal training of medical, dental, nursing and other students without this adversely affecting your care and treatment. You must tell a senior doctor or nurse if you do not wish students to be involved in your care and you should write this on the consent form in the space for things that you do not wish to happen without your being given the chance to consider them first.

1342.
1405 ARRIVE

WHO Surgical Safety Checklist

(adapted for General Surgery NHS Lothian)

Patient Details or Addressograph label

Last Name	CROSS
First Name	ANgellA
Date of Birth	22056714 64
CHI Number	

*DATE	020317.
*THEATRE	17.
*SITE	RIE
*OPERATING/SUPERVISING CONSULTANT	AZODO
*PROCEDURE	LAPCHOLE +/- Open

Please complete ALL boxes

SIGN IN (To be read out loud)

Before commencement of anaesthesia

Member verbally confirms with the team:

	Yes	No	N/A
Patient confirmed his/her identity, site, procedure and consent	✓		
Correct operating table?	✓		
Surgical site/side marked			✓
Are prophylactic antibiotics required?	✓		
Does the patient have a:			
Known Allergy?		✓	
Difficult airway/aspiration risk?	✓		
Complete case notes available?	✓		
Estimated blood loss > 500ml?		✓	
If yes, adequate IV access/fluid warming/cell salvage planned?			
Negative pregnancy test documented?	✓		
Blood results available?	✓		
Group & Save available?			✓
Patient temperature (°C)	37.5 °C		
Patient diabetic?		✓	
If yes, BM (millimoles)			
Patient on Beta blockade?		✓	
If yes, Beta blockade given?			
If not given, state reason omitted:			

Name: K. Marcaney
Signature: [signature]

TIME OUT (To be read out loud)

Before start of surgical intervention

Member verbally confirms with the team:

	Yes	No	N/A
Team members introduce themselves by name and role			
Correct patient?	✓		
Correct procedure/consent?	✓		
Correct site/side marked?	✓		✓
Correct positioning?	✓		
Does the patient have a known allergy?		✓	
Essential imaging displayed	✓		
Has DVT prophylaxis been undertaken?			
TEDS	✓		
Calf compression	✓		
Heparin	✓		

	Complete	Started	N/A
Antibiotic prophylaxis administration complete?	✓		

	Yes	No	N/A
Diathermy plate on	✓		
Extra/Specific Equipment required		✓	

Any anticipated difficulties expected by?	Yes	No
Surgeon		✓
Anaesthetist		✓
Theatre Practitioner		✓

Name: O'Neill
Signature:

Please record any Problems Identified overleaf
www.patientsafetyalliance.scot.nhs.uk/programme

SIGN OUT (To be read out loud)

Before patient leaves operating room

Member verbally confirms with the team:

	Yes	No	N/A
Has the operation/procedure summary been completed?	✓		
Have the post operative instructions been documented by:			
Surgeon	✓		
Anaesthetist	✓		
Theatre Practitioner	✓		
Have the specimens been labelled correctly (including patient name)?	✓		
Have blood tags been completed?			✓
Regular DVT prophylaxis prescribed?	✓		
Further antibiotic doses prescribed?			✓
Cardiac medication prescribed?			✓
Discharge medical analgesia prescribed?			✓
Please ensure all *asterix boxes have been completed			

Name: [signature]
Signature: [signature]

RECOVERY AREA (On arrival:)

Patient temperature (°C)	36.7 °C
Patient BM if diabetic (millimoles)	N/A

Name: K. KILANOWSKY
Signature: [signature]

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

GynaecologyF2
L Menstrual Dysfunction

Royal Infirmary of Edinburgh at Little France (S314H)
51 Little France Crescent
Old Dalkeith Road
Edinburgh
EH16 4SA

Urgency of referral	Routine
Date of referral	14-Mar-2011
Date submitted	14-Mar-2011
UCPN	101001724844P

PATIENT DETAILS

Surname	CROSS
Forename(s)	Angela
Title	Miss
Sex	Female
Date of birth	22-May-1967
CHI no.	2205671464
Previous Surname	

Address
9 Fairford Gardens
INCH
EDINBURGH
EH16 5RW

Contact number(s)

REFERRING PRACTITIONER DETAILS

Name	Dr. Euan Alexander
GMC code	6096980
GP code	46868
Practice name	INCHPARK SURGERY (70291)
Practice code	70291

Practice address
10 MARMION CRESCENT
EDINBURGH
EH16 6QU

Contact number(s)
Voice : 0131 666 2121

http ...Referral.cls?ID=226752&TPAGID=2dc8544iY... 15/03/2011

Threatened abortion	09-Feb-1988
Assault by means NOS	26-Sep-1987
Homicide and injury purposely inflicted by other persons	26-Sep-1987
Fostered	15-Aug-1983
Suicide + selfinflicted poisoning by solid/liquid substances	14-Aug-1983
Pneumonia or influenza NOS	09-Feb-1970

Past procedures (High priority - carried out within the last 12 months)

Procedure	Comment	Modifier	Date Performed	Date Recorded
1st hepatitis B vaccination			11-May-2008	11-May-2008
[SO]Thyroglossal cyst				04-Jul-2001
Single live birth				25-Jan-2001
Leucopenia - low white count				02-Nov-1992
Termination of pregnancy NEC				18-Feb-1991
Single live birth				19-Dec-1988
Diagnostic endoscopic examination of peritoneum				15-Nov-1987
Termination of pregnancy NEC				10-Jul-1986
Single live birth				01-Oct-1985

Family conditions (High and Medium priority)

Condition Name	Modifier	Extension	Date Recorded
FH: Ischaemic heart dis. \lt;60			23-Apr-1997

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

Drug name	BNF code	Formulation	Dosage	Frequency	Course started	Duration	Last Prescribed Date
Norethisterone	06.04.01.2	TABS 5MG	1 Tab	3 times daily	14-Mar-2011		14-Mar-2011
Norethisterone	06.04.01.2	TABS 5MG	1 Tab	3 times daily	14-Mar-2011		14-Mar-2011

Additional relevant information

Smoking history (Screening): Never smoked tobacco , Date recorded: 22-Jun-2000
Alcohol history (Screening): Teetotaller , Date recorded: 22-Jun-2000
Patient Weight in Kilograms:70
Patient Height in Metres:1.53
Patient BMI:29.90
Patient Blood Pressure (Systolic):106
Patient Blood Pressure (Diastolic):62

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

O.P. CLINICAL NOTES

(GYNAECOLOGY)

NUMBER

NAME

DATE	ENSURE THAT THE PATIENTS NAME AND NUMBER IS ENTERED ABOYE AND THAT EACH ENTRY BELOW IS LEGIBLE, DATED AND SIGNED WITH THE NAME AND DESIGNATION OF THE SIGNATORY CLEARLY STATED.	SIGNATURE PRINT NAME & DESIGNATION

RIE 267

DATE	PLEASE ENSURE THAT EACH ENTRY BELOW IS LEGIBLE, DATED AND SIGNED WITH THE NAME AND DESIGNATION OF THE SIGNATORY CLEARLY STATED.	SIGNATURE PRINT NAME & DESIGNATION

PATHOLOGY

NHS Lothian, University Hospitals Division, 51 Little France Crescent, Edinburgh EH16 4SA
RIE: 0131 242 7147/8
RHSC: 0131 242 7147/8

CROSS, ANGELLA

CHI Number 2205671464
Patient Number 2205671464
Date of Birth 22/05/1967
Date Received 03/03/2017

Specimen: UB004856P/17

Cons Not Known
RIE Ward 106

Date Reported 29/03/2017
Time Reported 08:27

Clinical Summary

Biliary colic.
Provisional diagnosis: gallstones.

Specimen

Gallbladder.

Macroscopy

This is an open gallbladder measuring 70 x 15 x 30 mm. A 8 mm defect overlies the body. The serosal surface is smooth and shiny. Gallstones are present within the lumen. The mucosal surface is brown and velvety and wall measures 2 mm thick.

Blocks taken: (A) resection margin, body and fundus.

Specimen trimmed by: Dr C Dhaliwal.

Microscopy

Sections of the gallbladder wall show mild smooth muscle hypertrophy and fibrosis with a patchy chronic inflammatory infiltrate mainly in the lamina propria. The histological features are of cholelithiasis.

Gallbladder - Cholelithiasis

Pathologists
GI Pathology Team
Dr Catharine A Dhaliwal

Clinically Approved
Approved for printing by: Dr Catharine Dhaliwal

Surname:	Cross, Angelia	**UHPI:**	620045326K	**CHI:**	2205671464
DOB:	22/05/1967				
Location:	2 - IC, A&E	**Specialty:**	2 - IC, A&E	**Consultant:**	Dr Meena Chow Parameswaran

NHS Lothian

Printed on: 28/02/2017 at 12:41 pm

Order Name	Result Date	Time
US Abdomen	28/02/2017	12:32

Result

Clinical details

US Abdomen
49 y/o upper abdo pain. HOT AUSS 28/2 please. Deranged LFTs. ?gallstones

Report

Abdominal ultrasound
The liver was of normal size. The hepatic echo pattern was increased but no focal hepatic lesions were identified. Calculi were noted within a slightly thickened gallbladder. Pericholecystic fluid was noted adjacent to the gallbladder. Biliary system was not dilated. Portal vein was patent. The pancreas was not visualised due to overlying bowel gas. Both kidneys were normal. Minor splenomegaly was noted.

Opinion:
1/ There is evidence of cholelithiasis. I note a normal white cell count and CRP level. The appearances adjacent to the gallbladder probably represent resolving acute cholecystitis.
2/ The appearances within the liver in conjunction with the minor splenomegaly raise the possibility of chronic parenchymal liver disease.

Dr. James Walsh.
Consultant Radiologist
GMC number: 2620695

27 Feb 2017
Bili 26
ALT 178
GGT 128

This list of patients' details is provided for its agreed purpose only. Please handle in accordance with the Caldicott principles and destroy this report immediately after use.

NUMBER

NAME

X-RAY MOUNT

▲ 14		▲ 14
▲ 13		▲ 13
▲ 12		▲ 12
▲ 11		▲ 11
▲ 10		▲ 10
▲ 9		▲ 9
▲ 8		▲ 8
▲ 7		▲ 7
▲ 6		▲ 6
▲ 5		▲ 5
▲ 4		▲ 4
▲ 3		▲ 3
▲ 2		▲ 2
▲ 1		▲ 1

⇧ ***FIRST REPORT HERE*** ⇧

Please set accurately

Enterprise Stationery Ltd Ref 24349

LHB/2765 12689

PEEL AWAY PROTECTIVE STRIPS SUCCESSIVELY, STARTING WITH No. 1 - PLACE TOP EDGE OF REPORT ALONG PRINTED LINE IMMEDIATELY ABOVE EACH ADHESIVE LAYER. PRESS HARD FOR GOOD ADHESION

Patient's name:- **Date:-** **Time:-**

94

Glucose	Neg ☐ Trace ☐ + ☐ ++ ☐ +++ ☐ ++++ ☐
Bilirubin	Neg ☐ + ☐ ++ ☐ +++ ☐
Ketones	Neg ☐ Trace ☐ + ☐ ++ ☐ +++ ☐ ++++ ☐
Specific Gravity	1.000 ☐ 1.005 ☐ 1.010 ☐ 1.015 ☐ 1.020 ☐ 1.025 ☐ 1.030 ☐
Blood	Neg ☐ trace ☐ ++ ☐ (Non-haemolysed) trace ☐ + ☐ ++ ☐ +++ ☐ (Haemolysed)
pH	5.0 ☐ 6.0 ☐ 6.5 ☐ 7.0 ☐ 7.5 ☐ 8.0 ☐ 8.5 ☐
Protein	Neg ☐ Trace ☐ + ☐ ++ ☐ +++ ☐ ++++ ☐
Urobilinogen	0.2 ☐ 1 ☐ 2 ☐ 4 ☐ ≥8 ☐
Nitrites	Neg ☐ Any degree of pink = postive ☐
Leucocytes	Neg ☐ Trace ☐ + ☐ ++ ☐ +++ ☐

Females - ßhcG result Negative ☐ Positive ☐

NHS Lothian University Hospital Acute Division	Patient's Name:
Surgical Directorate SOU / 106	CHI No:
	Date of Birth:
	Address:
Admission Document	(or affix patient label)

INITIAL ASSESSMENT

PAIN	Please state / expand / more information:
• Location of acute pain and duration?	Central abdo pain lasted 24hrs - never fully went away
• Severity of acute pain?	10/10.
• Any chronic pain issues?	NA.
• Anything that alleviates pain/ makes it worse?	NA.
• Any associated symptoms?	vomiting Shivers + fevers
• Has analgesia been taken? If so please state	

BREATHING	On initial assessment :	Expand / more information:
Oxygen Saturations/ RR	98% RA RR 18.	
Does the patient ever get SOB • Walking on flat • Climbing stairs/hill • Lying flat	NA	
O2 therapy at home? • If yes, how many litres?	NA	
Nebulisers/ Inhalers at home? • Does the patient use CPAP?	NA	

NHS Lothian University Hospital Acute Division	Patient's Name:	
Surgical Directorate SOU / 106	CHI No:	620C45326K F
	Date of Birth:	CROSS Angelia 22-May-67 CHI: 220 567 1464
	Address:	77106 JA Scott 44 Woodburn Bank Midlothian EH22 2EY
Admission Document	(or af	

SOCIAL INFORMATION

Social Support

- **Home care:** Yes ☐ / No ☑
  Provider:______________________ Contact number:______________
  Is provider aware of admission? Yes ☐ / No ☐ Is POC being held? Yes ☐ / No ☐ Date until:________
  Visits: OD ☐ / BD ☐ / TDS ☐ / QDS☐
- **District Nurse:** Yes ☐ / No ☑
  Details of Nurse visits: ______________________
- **CPN:** Yes ☐ / No ☑
  Support provided:______________________
- **Community OT:** Yes ☐ / No ☑
  Support provided:______________________
- **Day hospital / day care:** Yes ☐ / No ☑
  Support provided:______________________ Last attendance date:__________
- **Accommodation:** House / Flat / Bungalow / Nursing Home / Supported accommodation / Sheltered Housing

Please provide contact numbers for all relevant people / facilities / home helps that will be required on discharge.

ACTIVITIES OF DAILY LIVING	MOBILITY & FALLS ASSESSMENT
• Does the patient req assistance with washing and dressing? Yes ☐/ No ☑? Ast x1 ☐ Ast x2☐Ast x4☐	• Recent change in mobility? Yes ☐ / No ☑
• Does the patient require any incontinence aids? Yes ☐/ No ☑?	• Physiotherapy referral required? Yes ☐ / No ☑
• When was the patients last Bowel movement? How often do their BO? Every 2nd day	• Patient a potential falls risk? Yes ☐ / No ☑
• Do they take regular medication? Yes ☑/ No ☐?	• Admitted with a fall 65 +? Yes ☐/ No ☑
If Yes please state See ECS.	**If yes consider the following** ECG ☐ Erect / Supine BP ☐ MSU ☐
	• Falls risk and Mobility assessment / Manual Handling section completed in care bundle ☐

ADDITIONAL EQUIPMENT AT HOME		COGNITIVE ASSESSMENT
• Toilet Aids ☐	Bath Aids ☐	• If patient >65 complete 4AT in care bundle.
• Bed Rails ☐	Wheelchair ☐	• Does the patient have known cognitive impairment/present with confusion?Yes ☐/No☐_____
• Zimmer ☐	Trolley ☐	*If yes to the above please complete "Fraility Screen" +/- "Getting to know me document"Referral to ECAT req?
• Personal Alarm ☐	Commode ☐	Yes ☐ / No☐ Date Referred __________
Other (please state)______________		

NHS Lothian University Hospital Acute Division Surgical Directorate SOU / 106 Admission Document	Patient's Name: CHI No: Date of Birth: Address: (or affix patient label

NUTRITIONAL NEEDS ON ADMISSION

- Any recent unexpected weight loss?
- Yes☐ / No ☑
- If yes please state rough estimate ________
- Nutrition section completed, including must in the care bundle ☑
- Patient diabetic? Yes ☐ / No ☑
- If yes, NIDDM ☐ - diet controlled ☐/ medication ☐ / both / other ☐
- IDDM – regime: (please state below)
- BM on admission ______
- Insulin Regime________

PERSONAL ATTACHMENTS

- Dentures insitu Yes ☐ / No☑
- If yes please state top / bottom / partial / full set:
- ________
- Glasses required? Yes ☑ / No ☐
- If yes please state for reading / full time:
- Fully sighted ☐ Blind ☐ Partially sighted ☑
- ________
- Hearing difficulties? Yes☐ / No☑
- Hearing Aids Yes ☐ / No ☐
- If yes please state left / right / bilateral

SKIN INTEGRITY ON ADMISSION

- Intact and healthy? Yes ☑ / No ☐
- Pressure damage? Yes ☐ / No ☑
- Wound insitu? Yes ☐ / No ☑
- Swabs taken? Yes ☐ / No ☑
- Waterlow Score _____
- Waterlow section completed in care bundle ☑

If grade 2 pressure ulcer > 2 please complete datix form

SLEEP

- Any problems with sleeping? Yes ☑ / No ☐
- If yes please state: Wakes up average x6 nightly
- On any night sedation? Yes ☐ / No ☑
- If yes please state: Used to be on night sedation.

TRANSPORT

- Does the patient require hospital transport home on discharge? Yes ☐ / No ☑
- Could family provide transport?
  Yes ☑ / No ☐

Contact: Partner.

NHS Lothian University Hospital Acute Division	Patient's Name:
Surgical Directorate SOU / 106	CHI No:
	Date of Birth:
	Address:
Admission Document	(or affix patient label)

PATIENT PROPERTY	Admission Ward
• Policy Explained	Yes ☑ / No ☐
• Valuables (mobile phone / lap top / dentures etc)	Please state: 1x mobile. jewellery
• Money	• Send to cashier Yes ☐ / No ☑ Keep on self Yes ☑ / No ☐ Additional Information:
• Patient's own medication	• Locked away in their POD / Locked away in the CD cupboard Yes ☐ / No ☑ Additional Information:
PATIENT'S VALUABLES REGISTER COMPLETED (required if valuables need locked away)	Yes ☐ / No ☑

Additional Information:

Signature / Print of admitting Nurse: OHaney / OHARLEY
Date: 280217. Time: 1840 Designation: S/N

NHS Lothian University Hospital Acute Division	Patient's Name:
Surgical Directorate SOU / 106	CHI No:
	Date of Birth:
	Address:
Admission Document	(or affix patient label)

DOCTORS ADMISSION ASSESSMENT

Scribe for Rathu

HISTORY OF PRESENTING COMPLAINT

49 On + off upper abdo pain - few weeks + worst past 24hr. 10/10 severity works as care support worker
Bowels N. N urine - N odour
~~does~~ post menopausal

Vomiting + Nausea. → watery vomit, no blood.

PAST MEDICAL / SURGICAL HISTORY

Hypertension	Yes ☑ / No ☐	Asthma	Yes ☐ / No ☐	Jaundice	Yes ☐ / No ☐
IHD / MI	Yes ☐ / No ☐	COPD	Yes ☐ / No ☐	Epilepsy	Yes ☐ / No ☐
Stroke	Yes ☐ / No ☐	TB	Yes ☐ / No ☐	Dementia	Yes ☐ / No ☐
Rheumatic Fever	Yes ☐ / No ☐	Diabetes	Yes ☐ / No ☐	Parkinson's	Yes ☐ / No ☐
Previous DVT/PE	Yes ☐ / No ☐				

OTHER CONDITIONS AND PREVIOUS OPERATIONS / PROCEDURES

2 c sections eye + ear operation.
Sterilization.
Prev ectopic → laparoscopy.

SH
thyroglop - Ca
partial thyroidectomy
breast reduction
~~NA~~ LUSCS x 2

FAMILY HISTORY

Diabetes. Both type 1 & 2.

NHS Lothian University Hospital Acute Division

Surgical Directorate SOU / 106

Patient's Name:

CHI No:

Date of Birth:

Address:

Admission Document (or affix patient label)

DRUG / MEDICATION HISTORY

Drug history obtained from: GP letter ☐ Patient ☐ Patient's relative ☐ Previous discharge ☐ ECS ☐ (2sources required). Signed by Designation Date:

Drugs on admission	Route / Form	Dose	Frequency	Patients own drugs	Action *(C/W/S)	Comments
[illegible]						
LISINOPRIL						
Bendroflumethiazide						

Allergies / sensitivities must be noted on the front cover of this booklet. Please document if patient had no known allergies / sensitivities. **(*CWS – continue / withhold / stop)** NKDA

PHARMACY

Drugs prescribed on admission checked and correct Yes ☐ / No ☐

Patients own drugs stored appropriately Yes ☐ / No ☐

Does patient have a dosette box & are pharmacy aware Yes ☐ / No ☐ Pharmacy __________ Tel:______________

Special devices required Yes ☐ / No ☐

Medicine supply problem Yes ☐ / No ☐

Details of counselling required______________________ Date counselled____________________

Signature:__________________ Print Name:________________________

Designation:_________________ Date:_______________________

NHS Lothian University Hospital Acute Division	Patient's Name:
Surgical Directorate SOU / 106	CHI No:
	Date of Birth:
	Address:
Admission Document	(or affix patient label)

SYSTEMATIC ENQUIRY

Cardiovascular System	Central Nervous System
Chest pain → shoulder. Still [illegible]. Feeling SOB with pain.	Pins + needles in hands.

Respiratory	Locomotor
/	/

Gastrointestinal	Genito-urinary
Stools ok, bowels ok.	/

SOCIAL HISTORY

Smoker Yes ☐ / No ☑ Quantity________ Pack Year? ______

Alcohol Yes ☐ / No ☑ Quantity________

NHS Lothian University Hospital Acute Division
Surgical Directorate SOU / 106

Patient's Name:
CHI No:
Date of Birth:
Address:

Admission Document (or affix patient label)

EXAMINATION

OBSERVATIONS ON ADMISSION Time:

Temp:______ Pulse______ > Regular ☐ / Irregular ☐ Blood Pressure____________

RR ______ Sats:_____

GENERAL EXAMINATION

Lympadenopathy ✓ Clubbing ✓ Pallor ✓ Cyanosis ✓

Thyroid ✓ Breasts ✓ Jaundice ✓ Skin ✓

CARDIOVASCULAR SYSTEM

JVP (N)

Apex Beat (N) I + II + 0 No murmur

Heart Sounds / Murmur

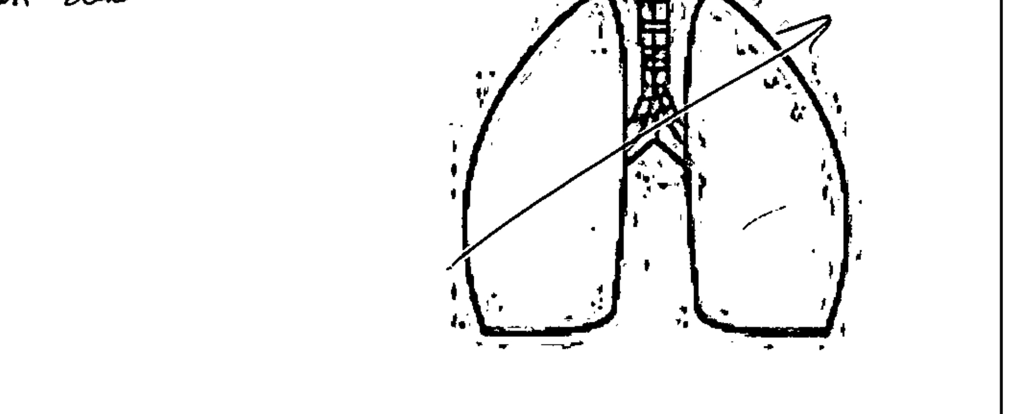
Oedema – sacral / leg / ankle

Pulses	Radial	Carotid	Femoral	Popliteal	Dorsalis Pedis	Posterior Tibial
Right						
Left						

0 – absent 1 – diminished 2 – normal 3- bounding 4- aneurismal (please document presence of bruit)

RESPIRATORY SYSTEM

- Trachea Chest clear
- Expansion
- Percussion
- Auscultation
- Other comments:



NHS Lothian University Hospital Acute Division
Surgical Directorate SOU / 106

Patient's Name:
CHI No:
Date of Birth:
Address:

Admission Document

(or affix patient label)

GASTROINTESTINAL SYSTEM

- Liver
- Spleen
- Kidneys
- Masses
- Hernia
- Rectal Examination

FOB – positive ☐ / negative ☐

Prostate

- Other comments

Tender epigastric, RUQ,

Soft
murphys +ve

GENITO-URINARY SYSTEM

/

CENTRAL NERVOUS SYSTEM

GCS 15

LOCOMOTOR SYSTEM

/

NHS Lothian University Hospital Acute Division

Surgical Directorate SOU / 106

Admission Document

Patient's Name:

CHI No:

Date of Birth:

Address:

(or affix patient label)

As per reg

DIFFERENTIAL DIAGNOSES (must be completed)

?GS

Consider PID

Women less than 30, non-specific lower Abdomen/Pelvic pain

Chlamydia test required- **Yes/No**

TREATMENT / MANAGEMENT PLAN

- USS
  ↳ HO
- pt would prefer to return
  phone no: 07729100241

ADMISSION INVESTIGATIONS

FBC ☐ U+E's ☐ LFT's ☐ GGT ☐ Amylase ☐ Blood Gases ☐ Group + Save ☐

Glucose ☐ Coag ☐ Lactate ☐ CXR ☐ AXR ☐ PUSS / AUSS ☐ ECG ☐ Urine ☐

Other:

DVT PROPHYLAXIS:

Age > 70yrs ☐ Malignancy ☐ Pregnancy / puerperium ☐ Poor mobility ☐ BMI > 30 ☐

Surgery > 1hr ☐ Oestrogen Rx ☐ Emergency admission ☐ Heart failure ☐ Severe COPD ☐

Thrombotic states ☐ Previous DVT / PE ☐ Severe infection ☐

☐ 1 factor = SC Dalteparin 2,500u ☐ > 1 factor = SC Dalteparin 5,000u* + TEDS ☐ = Vasc NO TEDS

(*if weight < 46kgs / BMI < 19, age > 70yrs = 2,500u Dalteparin max + TEDS if appropriate)

(if eGFR < 30 SC Heparin 5,000u BD)

Prophylaxis Required: TED Stockings ☐ Heparin ☐ Dalteparin ☐ Other (specify) Reason for deviation from prot

Signature / Print of admitting Doctor: [signature]

Date: 28/2/17 **Time:** 1730 **Designation:** F21

NHS Lothian University Hospital Acute Division
Surgical Directorate SOU / 106

Patient's Name:
CHI No:
Date of Birth:
Address:

Admission Document (or affix patient label)

INITIAL INVESTIGATIONS AND RESULTS

Previous results	Date	28/2						
	Hb	147						
	MCV	77						
	WBC	5.4						
	Platelets	280						
	APTT							
	PT							
	INR							
	Urea	3.3						
	Na+	138						
	K+	3.8						
	TCO2							
	Creatinine	69						
	eGFR	>60						
	Glucose							
	CK							
	LDH							
8 16	Bilirubin	26						
16 65	ALT	178						
67 23	Alk Phos	128						
23	GGT	128						
	Albumin							
	Amylase	27						
	Calcium							
	Adj CA							
	CRP	2						
	Phosphate							
	Magnesium							
	Lactate							
	Troponin							

CXR		AXR	

ECG / Urinalysis/ βHCG/Other investigations

US → cholelithiasis, minor splenomegaly. - ? chronic parenchymal liver disease.

620045326K F
CROSS Angella
22-May-67 CHI: 220 567 1464
77106 JA Scott
44 Woodburn Bank Midlothian
EH22 2EY

Name:

Date of Bi

CHI No:

NHS Lothian

Ward / Clinical Area

PATIENT PROGRESS / COMMUNICATION SHEET

State Action(s) taken After Exception Reporting
Each entry should be dated and timed

Date & Time	Progress Notes / Problems Action Taken & Investigations Required	Signature (Print name & designation)
	Hx, Ms Azodo r/v	
	Off/on abdo pain last "few weeks" – worst last 24hrs	
	ø fever/chills/shakes – but has been "sweaty"	
	ø acid indigestion but takes "a lot of Gaviscon"	
	O/E	
	2 C sections, sterilization	
	epigastric tenderness + lower abdominal suprapubic + RIF pain	
	– Deranged LFTs	? resolving
	AUSS today: Cholelithiasis	+ acute cholecystitis.
	Ax: biliary colic, possible cbd stone	
	Plan Urinalysis	
	MRCP	
	Admit for fluid resuscitation + nausea/pain mgt	
	Repeat bloods tomorrow	
	Will probably need lap chole → MRCP 1st.	
		[signature] SNP
		A MACNAMARA
	Transferred to ward 106.	
	Verbal handover given	
		[signature] S [illegible]

Author: Clinical Policy Advisor
Approved by: Clinical Policy, Documentation and Information Group

Patient Addressograph
Name:
Date of Birth:
CHI No:

Ward / Clinical Area

PATIENT PROGRESS / COMMUNICATION SHEET

State Action(s) taken After Exception Reporting
Each entry should be dated and timed

Date & Time	Progress Notes / Problems Action Taken & Investigations Required	Signature (Print name & designation)
280217 1930	Admitted to ward 106 from SM. NEWS 0. Orientated to ward. Nursing admission completed. Requires ASVO. For IVF, aware to let us know if analgesia required. form given to get food from canteen.	[illegible] SN
1/3/17 0420	Nursing: Angella had a settled night. No complaints of pain. Independent to the toilet. Awaiting MRCP today.	C. Osborne (OSBORNE) (S)
1/3/17	WR MS AZOOO Unchanged today NEWS 1 HR 74 Note USS: Slightly thickened GB. O/E looks well Abdo soft (P) Clear fluids MRCP ? ductal stone Update bloods inc	[illegible]
1/3/17 1555	Nursing Patient comfortable following anti sickness injection. NEWS (1) continues on free fluids. Awaiting MRCP results	[signature] L McFarlane

Name 620045326K F
CROSS Angella
Date 23-May-07 CHI:220 567 1464
77106 JA Scott
44 Woodburn Bank Midlothian
CHI No EH22 2EY

Ward / Clinical Area

PATIENT PROGRESS / COMMUNICATION SHEET

State Action(s) taken After Exception Reporting
Each entry should be dated and timed

Date & Time	Progress Notes / Problems Action Taken & Investigations Required	Signature (Print name & designation)
01 Mar 2017 17:08	ECI ([illegible])	
	MRCP c̄ no CBD stones.	
	Distended gallbladder ~~and [illegible]~~	
	ongoing abdominal pain & poor oral food tolerance.	
	Dx: biliary colic. Symptomatic cholelithiasis	
	Plan: 1) list for lap chole – informed consent discussed, pt wishes to proceed	
	2) start [illegible]	
	3) fast	
	4) IV fluids	
	5) nil P/O in am	
	[signature] / ward consultant	
2/3/17 03.10	Nursing: Angella required pain relief a few times overnight. Angella is fasting from mid-night for Lap chole tomorrow. IV fluids will be started at 6am. IV Abx given. No other issues overnight.	C.Osborne C OSBORNE (S)
02 Mar 2017 10:33 am	ECI ([illegible])	
	pt awaiting cholecystectomy, feels poorly.	
	Plan: 1) lap cholecystectomy, possible open	
	[signature] / ward consultant	

Patient Addressograph

Name: Angella Cross

Date of Birth:

CHI No:

Ward / Clinical Area Recovery / 106

PATIENT PROGRESS / COMMUNICATION SHEET

State Action(s) taken After Exception Reporting
Each entry should be dated and timed

Date & Time	Progress Notes / Problems Action Taken & Investigations Required	Signature (Print name & designation)
2/3/17	Recovery	
2000	- Patient in recovery after Lap Chole procedure.	
	- Very sleepy post op with low sats.	
	- Patient reviewed by anaethetist to assess drowsyness.	
	- Decided not to give naloxone because it would cause to much discomfort.	
	- Anaethetist was happy for patient to be returned to ward if resp rate was above 10. Resp rate currently fluctuating between 11 & 14.	
	- Anaethetist believes patient has been very sensitive to morphine.	
	- Anaethetist has requested hourly obs overnight.	
	[signature] K. KILANOWSKI	S/N
3/3/17	Nursing:	
0120	Return to the ward post Lap chole around 2015. Post-op obs stable. Patient manage to pass urine. Diet and fluids as able.	[signature]
03/03	WR Azodo	
	Post op, has been walking	
	Has been eating + drinking	
	(H) later.	[signature]

Patient Addressograph
Name:
Date of Birth:
CHI No:

Ward / Clinical Area

PATIENT PROGRESS / COMMUNICATION SHEET

State Action(s) taken After Exception Reporting
Each entry should be dated and timed

Date & Time	Progress Notes / Problems Action Taken & Investigations Required	Signature (Print name & designation)
1620	NURSING:	
3/3	Patient D/C from ward 106, D/C letters	
	and medication given and explained no	
	concerns voiced.	
	Venflon removed prior to D/C.	
	Wound care advice given	[signature]

Patient Addressograph

Name:

Date of Birth:

CHI No:

Ward / Clinical Area

PATIENT PROGRESS / COMMUNICATION SHEET

State Action(s) taken After Exception Reporting
Each entry should be dated and timed

Date & Time	Progress Notes / Problems Action Taken & Investigations Required	Signature (Print name & designation)

PRESCRIPTION AND ADMINISTRATION RECORD
including the Warfarin Chart

Hospital/Ward: Consultant:
Weight: Height:
If re-written, date:
DISCHARGE PRESCRIPTION
Date completed: Completed by:

Name: 620045326K F
CROSS Angella
CHI No: 22-May-67 CHI:220 567 1464
77106 JA Scott
44 Woodburn Bank Midlothian
D.O.B. EH22 2EY

OTHER MEDICINE CHARTS IN USE		PREVIOUS ADVERSE REACTIONS This section must be completed before any medicine is given		Completed by (sign & print)	Date
Date	Type of Chart	None known (tick box) ☑			
		Medicine / Agent / Food / Other	Description of reaction		

Risk assessment for Venous Thromboembolism (VTE) has been completed ☐

Outcome: No action required ☐ TEDS ☐ LMWH/heparin (please prescribe) ☐

- Write clearly in block capitals, using a black ballpoint pen
- Use approved names for medicines
- Never alter a prescription
- Route of administration

  The only acceptable abbreviations are:

  IV - intravenous SL - sublingual NG - nasogastric
  IM - intramuscular PR - per rectum ID - intradermal
  SC - subcutaneous PV - per vagina TOP - topical
  INHAL - inhaled NEB - nebulised

  Never abbreviate ORAL or INTRATHECAL
  Specify RIGHT or LEFT for eye and ear preparations

- Write the medicine dose clearly
  - The only acceptable abbreviations are:
    g - gram mg - milligram ml - millilitre
    all other doses must be written out in full eg. micrograms
  - Avoid decimal points eg. 100 micrograms (not 0.1mg). If unavoidable, write zero in front of the decimal point
  - Prescribe liquids by writing the dose in mg
  - For 'as required' medicines, state the symptoms to be relieved, the minimum time interval between doses and the maximum daily dose
  - Write units as 'units' not 'iu'

ONCE ONLY

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber - Sign + Print	Time Given	Given By
1/3	1800	AMOXICILLIN	1g	IV	[signature]	19:00	[signature]
1/3	1800	METRONIDAZOLE	500mg	IV	[signature]	19:00	[signature]
1/3	1800	GENTAMICIN	320mg	IV	[signature]	19:00	[signature]
~~2/3/14~~	~~DECO~~	~~MORPHINE~~	~~up to 10mg~~	~~IV~~	~~[signature]~~		
2/3/14	2300	DALTEPARIN	5000 units	S/C	[signature]	0020	[initials]

Risk Factors for venous thromboembolism:

Age >70yrs	☐	Malignancy	☐
BMI>30	☐	Pregnancy/puerperium	☐
Poor Mobility	☐	Oestrogen Rx	☐
Surgery >1hr	☐	Heart Failure	☐
Thrombotic states	☐	Severe COPD	☐
Previous DVT/PE	☐	Severe Infection	☐
Emergency admission	☐		

☐ 1 factor: sc dalteparin 2,500u
☐ >1 factor: sc dalteparin 5,000u & TEDS ☐ Vasc NO TEDS
(if weight less than 46kg / BMI less than19, age greater than 70yrs: 2,500 dalteparin maximum. & TEDS if appropriate)
(if eGFR is less than 30: sc heparin 5,000u BD)

Name: Signature:
Date: Prescribed Rx: ☐

Author: Medicines Policies Sub-Committee, August 2013
Version 1.0

Name: Angelica Cross D.O.B.: 22/5/67 CHI Number:

REGULAR THERAPY

CODES FOR NON-ADMINISTRATION OF PRESCRIBED MEDICINE

If a dose is not administered as prescribed, initial and enter a code in the column with a circle drawn round the code according to the reason as shown below. Inform the responsible doctor in the appropriate timescale.

1. Patient refuses
2. Patient not present
3. Medicines not available - CHECK ORDERED
4. Asleep / drowsy
5. Administration route not available - CHECK FOR ALTERNATIVE
6. Vomiting / nausea
7. Time varied on doctor's instructions
8. Once only / as required medicine given
9. Dose withheld on doctor's instructions
10. Possible adverse reaction / side effect

OXYGEN

Start Date	Start Time	Route Mask (%)	Route Prongs (l/min)	Prescriber - Sign + Print	Administered by	Stop Date	Stop Time

PRESCRIPTION

Prescription	Patient's Own Medicine	Time	1/3/17	2/3/17	3/3/17
Medicine (Approved Name): DALTEPARIN	For Use / Date	6			
Dose: 5000 Units; Route: S/C	Quantity	8			
Notes/Indication for antibiotic; Start Date: 28/2	Stop Date	12			
		14			
Prescriber - sign + print: [signature]	Pharmacy	(18)	W	(7)	
		22			
Medicine (Approved Name): TEDS	For Use / Date	(6)			
Dose: 1 pair; Route: TOP	Quantity	(8)		OH	CW
Notes/Indication for antibiotic; Start Date: 28/2	Stop Date	(12)			
		(14)			
Prescriber - sign + print: [signature]	Pharmacy	(18)			
		(22)			
Medicine (Approved Name): LISINOPRIL	For Use / Date	6			
Dose: 5 mg; Route: oral	Quantity	(8)	SL	OH	CW
Notes/Indication for antibiotic; Start Date: 28/2	Stop Date	12			
		14			
Prescriber - sign + print: [signature]	Pharmacy	18			
		22			
Medicine (Approved Name): BENDROFLUMETHIAZIDE	For Use / Date	6			
Dose: 2.5 mg; Route: oral	Quantity	(8)	SL	OH	CW
Notes/Indication for antibiotic; Start Date: 28/2	Stop Date	12			
		14			
Prescriber - sign + print: [signature]	Pharmacy	18			
		22			

Name:.. D.O.B.:.......................... CHI Number:..............................

REGULAR THERAPY

PRESCRIPTION		Patient's Own Medicine	Date → / Time ↓	28/2/17	1/3/17	2/3/17	3/3/17
Medicine (Approved Name): PARACETAMOL		For Use / Date	6				
Dose: 1g	Route: oral	Quantity	8	X			
Notes/Indication for antibiotic	Start Date: 28/2	Stop Date	12	X			
Prescriber - sign + print		Pharmacy	14				
			18	X			
			22	CO	CO		
Medicine (Approved Name): AMOXICILLIN		For Use / Date	6				
Dose: 1g	Route: IV	Quantity	8				
Notes/Indication for antibiotic	Start Date: 1/3	Stop Date	12				
Prescriber - sign + print		Pharmacy	14				
			18				
			22		8		
Medicine (Approved Name): METRONIDAZOLE		For Use / Date	6				
Dose: 500mg	Route: IV	Quantity	8				
Notes/Indication for antibiotic	Start Date: 1/3	Stop Date	12				
Prescriber - sign + print		Pharmacy	14				
			18				
			22		18		
Medicine (Approved Name): GENTAMYCIN		For Use / Date	6				
Dose: AS PER CHART	Route: IV	Quantity	8				
Notes/Indication for antibiotic	Start Date: 1/3	Stop Date	12				
Prescriber - sign + print		Pharmacy	14	X			
			18				
			22				
Medicine (Approved Name): METRONIDAZOLE		For Use / Date	6				
Dose: 400mg	Route: PO	Quantity	8				
Notes/Indication for antibiotic	Start Date: 10	Stop Date	12				
Prescriber - sign + print		Pharmacy	14			TO	
			18				
			22				
Medicine (Approved Name)		For Use / Date	6				
Dose	Route	Quantity	8				
Notes/Indication for antibiotic	Start Date	Stop Date	12				
Prescriber - sign + print		Pharmacy	14				
			18				
			22				

Name:.. D.O.B.:.................................. CHI Number:....................................

WARFARIN CHART

Recommended target INRs and indications:

- INR 2-2.5 for prophylaxis of DVT including surgery on high risk patients.
- INR 2.5 for treatment of DVT and PE (or for recurrence in patients no longer receiving warfarin), AF, cardioversion, dilated cardiomyopathy, mural thrombus following MI, and for rheumatic mitral valve disease.
- INR 3.5 for recurrent DVT and PE (in patients currently receiving warfarin) and mechanical prosthetic heart valves.

Indication	Target INR	Duration of treatment	Signature	Date

Yellow anticoagulant booklet completed and issued:

Signature Date

Date	INR	Warfarin Dose	Prescriber - sign + print	Administered by

Name:........................ D.O.B.:........................ CHI Number:........................

REGULAR THERAPY

PRESCRIPTION		Patient's Own Medicine	Date → Time ↓															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															
Medicine (Approved Name)		For Use / Date	6															
Dose	Route	Quantity	8															
			12															
Notes/Indication for antibiotic	Start Date	Stop Date	14															
Prescriber - sign + print		Pharmacy	18															
			22															

TURN OVER →

Name:... D.O.B.:.............................. CHI Number:...............................

PRESCRIPTION		Patient's Own Medicine	AS REQUIRED THERAPY												
Medicine (Approved Name) ORAMORPH		For Use	Date	28/2	1/3/17	1/3/17	1/3	1/3	1/3/17	2/3/17	2/3/17	2/3	3/3/17	3/3/17	3/3/17
			Time	1900	05.45	1100	1335	1800	20.05	01.20	1015	1240	2205	0340	0620
Dose + frequency + max 10mg 2°, 10	Route oral	Quantity	Dose	10mg/O	10mg/O	10/O	10/O	10/O	10mg/O	10mg/O	10mg/O	10/O	10	10	10
			Initials	DH	CO	[illegible]	LM	LM	CO	CO	DH	O	[illegible]	[illegible]	[illegible]
Indication + notes PAIN	Start Date 28/2	Date	Date												
			Time												
Prescriber - sign + print [signature] K Montgomery		Pharmacy	Dose												
			Initials												
Medicine (Approved Name) CYCLIZINE		For Use	Date	1/3/17	1/3	2/3/17	2/3/17								
			Time	05.50	1525	1015	1820								
Dose + frequency + max 50mg TDS	Route oral/IM/IV	Quantity	Dose	50mg/O	50 IM	50/O	50 IV								
			Initials	CO	SL	[illegible]	CS								
Indication + notes Nausea	Start Date 28/2	Date	Date												
			Time												
Prescriber - sign + print [signature]		Pharmacy	Dose												
			Initials												
Medicine (Approved Name) ONDANSETRON		For Use	Date	1/3/17	2/3										
			Time	0745	1740										
Dose + frequency + max 4mg TDS	Route oral/IM	Quantity	Dose	4mg IM	4mg										
			Initials	SL	[illegible]										
Indication + notes Nausea	Start Date 28/2	Date	Date												
			Time												
Prescriber - sign + print [signature]		Pharmacy	Dose												
			Initials												
Medicine (Approved Name) DIHYDROCODEINE		For Use	Date	3/3											
			Time	0740											
Dose + frequency + max 30mg 4-6°	Route PO	Quantity	Dose	30/PO											
			Initials	BW											
Indication + notes pain	Start Date 2/3/17	Date	Date												
			Time												
Prescriber - sign + print [signature] Montgomery		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												
Medicine (Approved Name)		For Use	Date												
			Time												
Dose + frequency + max	Route	Quantity	Dose												
			Initials												
Indication + notes	Start Date	Date	Date												
			Time												
Prescriber - sign + print		Pharmacy	Dose												
			Initials												

620045326K F
CROSS Angella
22-May-67 CHI:220 567 1464
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EH22 2EY

ADULT FLUID PRESCRIPTION CHART

Date 3/3/17	Sheet no

Ward 106

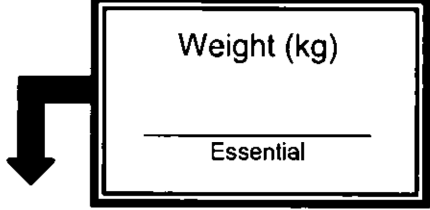
IV fluids for adults: for more details, see pocket guideline or App

Consider volume status: Hypovolaemic / Euvolaemic / Hypervolaemic

Does your patient need IV fluids? If so, are they needed for:

Maintenance, Replacement, or Resuscitation?

Write in Maintenance requirements in next 24 hours:



Volume 30ml/kg	Sodium 1mmol/kg	Potassium 1mmol/kg (unless $K^+ > 5.0$)
ml	mmol	mmol

Estimated oral intake in the next 24 hours ______ml. Oral intake will reduce the intravenous volume required

Never give more than 100 ml/hr of 0.18% NaCl / 4% Glucose: risk of hyponatraemia

If Sodium ≤132 mmol/l, then Plasmalyte 148 should be used for maintenance. Plasmalyte 148 not to be used for maintenance in other circumstances

Weight (kg)	Maintenance Fluid Requirement in 24hr	Rate (ml/hr)	Equivalent to 1000 ml over:
35-44	1200 ml	50	20 hr
45-54	1500 ml	65	16 hr
55-64	1800 ml	75	14 hr
65-74	2100 ml	85	12 hr
≥75	2400 ml	100 (max)	10 hr

Prescribe ***Maintenance fluids and diabetic fluids*** *here.* ***Max rate is 100ml/hr.***

Prescribe subcutaneous fluids using SC guidelines *Use separate prescription chart if more bags are required Mark as 'Sheet 2'*

Type + Additions	*Vol (ml)*	*IV/ SC*	*Rate (ml/hr)*	Start time	Finish time	Prescribed by (Sign and Print)	Set up by (Sign and Print)

Use the box below to prescribe any additional fluids that are required for ***Replacement*** *or* ***Resuscitation***

Resuscitation: *give Fluid Challenge 250 to 500ml Plasmalyte 148 over 5 to 15 min. Stop and assess before repeat. Request senior / ICU opinion if 2000ml insufficient*

See NHS Lothian Guidance for Intravenous Fluid and Electrolyte prescribing (on Intranet)

Date___/___/____

ADULT FLUID BALANCE CHART

Name: ______________________________

CHI/Unit No.

Today's PEG/NG Feed: ________ ml/24hr TPN __________ ml/24hr

Total Input Goal: ________ ml in 24hr

Fluid Restriction: ________ ml in 24hr

	IV FLUIDS or SC FLUIDS IV MEDICATION	Line 1	ORAL INPUT		ENTERAL: NG/ PEG / RIG	TPN/Other Line 2	URINE		GASTRIC	DRAIN 1	DRAIN 2 OTHER
	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100 ml	Volume	Volume	Volume	Running Total	Volume	Volume	Volume
06.00							/				
07.00			water	200ml			/				
08.00			tea	200ml			/				
09.00							/				
10.00							/				
11.00							/				
12.00							/				
Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print											
13.00							/				
14.00							/				
15.00							/				
16.00							/				
Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print											
17.00							/				
18.00							/				
19.00							/				
20.00							/				
21.00							/				
22.00							/				
23.00							/				
24.00							/				
01.00							/				
02.00							/				
03.00							/				
04.00							/				
05.00							/				
Totals		A		B	C	D	E		F	G	H
	Total input and output			A+B+C+D	Total in				E+F+G+H	Total out	
NOTES									24 Hr Balance		

See NHS Lothian Guidance for Intravenous Fluid and Electrolyte prescribing (on Intranet)

620045325K F
CROSS Angella
22-May-67 CHI:220 567 1464
77106 JA Scott
44 Woodburn Bank Midlothian
EH22 2EY

ADULT FLUID PRESCRIPTION CHART

Date	Sheet no
2/3/17	1

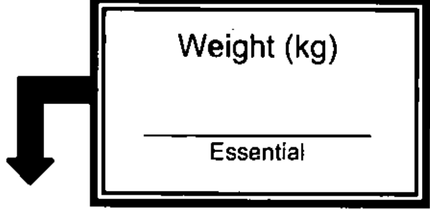
Ward
106

IV fluids for adults: for more details, see pocket guideline or App

Consider volume status: Hypovolaemic / Euvolaemic / Hypervolaemic

Does your patient need IV fluids? If so, are they needed for:

Maintenance, Replacement, or Resuscitation?



Weight (kg)

Essential

Write in Maintenance requirements in next 24 hours:

Volume 30ml/kg	Sodium 1mmol/kg	Potassium 1mmol/kg (unless $K^+ > 5.0$)
ml	mmol	mmol

Estimated oral intake in the next 24 hours ____________ ml. Oral intake will reduce the intravenous volume required

Never give more than 100 ml/hr of 0.18% NaCl / 4% Glucose: risk of hyponatraemia

If Sodium ≤132 mmol/l, then Plasmalyte 148 should be used for maintenance. Plasmalyte 148 not to be used for maintenance in other circumstances

Weight (kg)	Maintenance Fluid Requirement in 24hr	Rate (ml/hr)	Equivalent to 1000 ml over:
35-44	1200 ml	50	20 hr
45-54	1500 ml	65	16 hr
55-64	1800 ml	75	14 hr
65-74	2100 ml	85	12 hr
≥75	2400 ml	100 (max)	10 hr

Prescribe ***Maintenance fluids and diabetic fluids*** *here.* ***Max rate is 100ml/hr.***

Prescribe subcutaneous fluids using SC guidelines *Use separate prescription chart if more bags are required Mark as 'Sheet 2'*

Type + Additions	*Vol (ml)*	*IV/ SC*	*Rate (ml/hr)*	Start time	Finish time	Prescribed by (Sign and Print)	Set up by (Sign and Print)

Use the box below to prescribe any additional fluids that are required for ***Replacement*** *or* ***Resuscitation***

Resuscitation: *give Fluid Challenge 250 to 500ml Plasmalyte 148 over 5 to 15 min. Stop and assess before repeat. Request senior / ICU opinion if 2000ml insufficient*

See NHS Lothian Guidance for Intravenous Fluid and Electrolyte prescribing (on Intranet)

Date 2/3/17
Name: Angella Cross
CHI/Unit No.

ADULT FLUID BALANCE CHART

Today's PEG/NG Feed: ______ ml/24hr TPN ______ ml/24hr

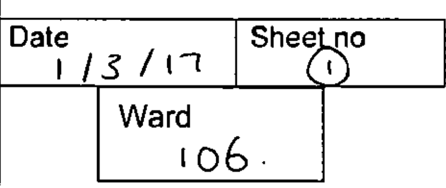
Total Input Goal: ______ ml in 24hr
Fluid Restriction: ______ ml in 24hr

	IV FLUIDS or SC FLUIDS IV MEDICATION	Line 1	ORAL INPUT		ENTERAL: NG/ PEG / RIG	TPN/Other Line 2	URINE		GASTRIC	DRAIN 1	DRAIN 2 OTHER
	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100 ml	Volume	Volume	Volume	Running Total	Volume	Volume	Volume
06.00	Plasmalyte (1000)	100	Fasting								
07.00	metronidazole + flush	150									
08.00		100									
09.00		100									
10.00		100									
11.00		100									
12.00											
Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print											
13.00											
14.00											
15.00											
16.00											
Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print											
17.00											
18.00			RTW from Recovery								
19.00											
20.00	IVI in theatre	1000									
21.00			water	200			100				
22.00											
23.00			water	200			100	200			
24.00											
01.00							80	280			
02.00											
03.00											
04.00											
05.00											
Totals		A 1500		B 400	C	D		E	F	G	H
	Total input and output			A+B+C+D	Total in	1950			E+F+G+H	Total out	
NOTES									24 Hr Balance		

See NHS Lothian Guidance for Intravenous Fluid and Electrolyte prescribing (on Intranet)

620045326K F
CROSS Angelia
22-May-67 CHI: 220 567 1464
77106 JA Scott
44 Woodburn Bank Midlothian
EH22 2EY

ADULT FLUID PRESCRIPTION CHART



Date	Sheet no
1/3/17	1

Ward: 106.

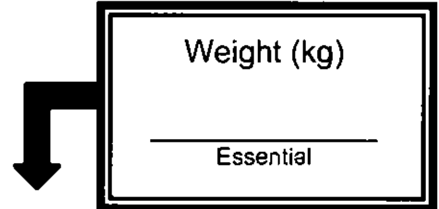
IV fluids for adults: for more details, see pocket guideline or App

Consider volume status: Hypovolaemic / Euvolaemic / Hypervolaemic

Does your patient need IV fluids? If so, are they needed for:

Maintenance, Replacement, or Resuscitation?

Write in Maintenance requirements in next 24 hours:



Volume 30ml/kg	Sodium 1mmol/kg	Potassium 1mmol/kg (unless $K^+ > 5.0$)
ml	mmol	mmol

Estimated oral intake in the next 24 hours ________ml. Oral intake will reduce the intravenous volume required

Never give more than 100 ml/hr of 0.18% NaCl / 4% Glucose: risk of hyponatraemia

If Sodium ≤132 mmol/l, then Plasmalyte 148 should be used for maintenance. Plasmalyte 148 not to be used for maintenance in other circumstances

Weight (kg)	Maintenance Fluid Requirement in 24hr	Rate (ml/hr)	Equivalent to 1000 ml over:
35-44	1200 ml	50	20 hr
45-54	1500 ml	65	16 hr
55-64	1800 ml	75	14 hr
65-74	2100 ml	85	12 hr
≥75	2400 ml	100 (max)	10 hr

Prescribe ***Maintenance fluids and diabetic fluids*** *here.* ***Max rate is 100ml/hr.***

Prescribe subculaneous fluids using SC guidelines *Use seperate prescription chart if more bags are required Mark as 'Sheet 2'*

Type + Additions	***Vol (ml)***	***IV/ SC***	***Rate (ml/hr)***	Start time	Finish time	Prescribed by (Sign and Print)	Set up by (Sign and Print)

Use the box below to prescribe any additional fluids that are required for ***Replacement*** *or* ***Resuscitation***

PLASMALYTE	1000	IV	100	06.00		[signature]	C. Osborne

Resuscitation: *give Fluid Challenge 250 to 500ml Plasmalyte 148 over 5 to 15 min. Stop and assess before repeat. Request senior / ICU opinion if 2000ml insufficient*

Date 1 / 3 / 17

ADULT FLUID BALANCE CHART

Name: Angella Cross

CHI/Unit No.

Today's PEG/NG Feed: ________ ml/24hr TPN ________ ml/24hr

Total Input Goal: ________ ml in 24hr

Fluid Restriction: ________ ml in 24hr

	IV FLUIDS or SC FLUIDS IV MEDICATION	Line 1	ORAL INPUT		ENTERAL: NG/ PEG / RIG	TPN/Other Line 2	URINE		GASTRIC	DRAIN 1	DRAIN 2 OTHER
	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100 ml	Volume	Volume	Volume	Running Total	Volume	Volume	Volume
06.00	IVI continued	100					/				
07.00		100					/				
08.00		100.					/				
09.00		100.					/				
10.00							/				
11.00							/				
12.00							/				
Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print											
13.00							/				
14.00							/				
15.00							/				
16.00							/				
Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print											
17.00							/				
18.00							/				
19.00							/				
20.00							/				
21.00							/				
22.00							/				
23.00	~~[illegible]~~						/				
24.00	Plasmalyte 2(1000)	~~100~~					/				
01.00		~~100~~					/				
02.00							/				
03.00							/				
04.00							/				
05.00							/				
Totals		A		B	C	D	E		F	G	H
	Total input and output			A+B+C+D	Total in				E+F+G+H	Total out	

NOTES

24 Hr Balance

See NHS Lothian Guidance for Intravenous Fluid and Electrolyte prescribing (on Intranet)

620046326K F
CROSS Angella
22-May-67 CHI: 220 567 1464
77106 JA Scott
44 Woodburn Bank Midlothian
EH22 2EY.

ADULT FLUID PRESCRIPTION CHART

Date 28/2/17	Sheet no 1

Ward 106

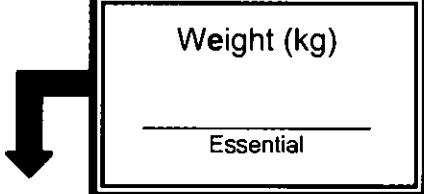
IV fluids for adults: for more details, see pocket guideline or App

Consider volume status: Hypovolaemic / Euvolaemic / Hypervolaemic

Does your patient need IV fluids? If so, are they needed for:

Maintenance, Replacement, or Resuscitation?

Write in Maintenance requirements in next 24 hours:



Weight (kg)

Essential

Volume 30ml/kg	Sodium 1mmol/kg	Potassium 1mmol/kg (unless $K^+ > 5.0$)
ml	mmol	mmol

Estimated oral intake in the next 24 hours ______ ml. Oral intake will reduce the intravenous volume required

Never give more than 100 ml/hr of 0.18% NaCl / 4% Glucose: risk of hyponatraemia

If Sodium ≤132 mmol/l, then Plasmalyte 148 should be used for maintenance. Plasmalyte 148 not to be used for maintenance in other circumstances

Weight (kg)	Maintenance Fluid Requirement in 24hr	Rate (ml/hr)	Equivalent to 1000 ml over:
35-44	1200 ml	50	20 hr
45-54	1500 ml	65	16 hr
55-64	1800 ml	75	14 hr
65-74	2100 ml	85	12 hr
≥75	2400 ml	100 (max)	10 hr

Prescribe ***Maintenance fluids and diabetic fluids*** *here.* ***Max rate is 100ml/hr.***

Prescribe subcutaneous fluids using SC guidelines *Use separate prescription chart if more bags are required Mark as 'Sheet 2'*

Type + Additions	*Vol (ml)*	*IV/ SC*	*Rate (ml/hr)*	Start time	Finish time	Prescribed by (Sign and Print)	Set up by (Sign and Print)
PLASMALYTE	1000	IV	250	19⁰⁰		[signature]	B Haney
PLASMALYTE	1000	IV	100	23-30		[signature]	C. Osborne

Use the box below to prescribe any additional fluids that are required for ***Replacement*** *or* ***Resuscitation***

Resuscitation: *give Fluid Challenge 250 to 500ml Plasmalyte 148 over 5 to 15 min. Stop and assess before repeat. Request senior / ICU opinion if 2000ml insufficient*

Date 28/2/17

ADULT FLUID BALANCE CHART

Name: Angella Cross

CHI/Unit No.

Today's PEG/NG Feed: ______ ml/24hr TPN ______ ml/24hr

Total Input Goal: ______ ml in 24hr

Fluid Restriction: ______ ml in 24hr

	IV FLUIDS or SC FLUIDS IV MEDICATION	Line 1	ORAL INPUT		ENTERAL: NG/ PEG / RIG	TPN/Other Line 2	URINE	GASTRIC	DRAIN 1	DRAIN 2 OTHER
	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100 ml	Volume	Volume	Volume / Running Total	Volume	Volume	Volume
06.00							/			
07.00							/			
08.00							/			
09.00							/			
10.00							/			
11.00							/			
12.00							/			
Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print										
13.00							/			
14.00							/			
15.00							/			
16.00							/			
Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print										
17.00							/			
18.00							/			
19.00	Plasmalyte 1000	250					/			
20.00		250					/			
21.00		250					/			
22.00		250					/			
23.00	Plasmalyte (1000)	100					/			
24.00		100					/			
01.00		100					/			
02.00		100					/			
03.00		100					/			
04.00		100					/			
05.00		100					/			
Totals		A		B	C	D	E	F	G	H
	Total input and output			A+B+C+D	Total in			E+F+G+H	Total out	
NOTES								24 Hr Balance		

See NHS Lothian Guidance for Intravenous Fluid and Electrolyte prescribing (on Intranet)

Ward: 106 Site: RIE Date: 2/3/17

This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency.

1hrly 2 hrly (3 hrly) _____hrly (please circle/complete)

Print name and sign C. Osborne (OSBORNE)

Addressograph, or

C20045326K F
CROSS Angella
22-May-67 CHI:220 567 1464
77106 JA Scott
44 Woodburn Bank Midlothian
EH22 2EY

NHS Lothian

Codes (Y) Yes, (N) No, (N/A) not applicable,(D) Declined (AS) Asleep (I) Independent, (NW) not on ward, (TH) Theatre,

Section	Item												
	Time of Care Rounding Document the exact time care rounding took place e.g. 0830	0740	12:40	15 00	18 00	2000	2200						
		08.00 am ← 24 hour period → 07.00 am											
Pressure Area Care	Waterlow score less than 10 low risk requires only a daily skin review: Use codes for outcome of skin review												
	Waterlow 10+ - Visual Skin Check (tick)												
	Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister	H	H	NW	NW		H						
	Vulnerable areas? (circle areas of damage)	Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other................											
	If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan												
	Have you changed position since last CR?	I	I				Y						
	Positioning (R) or (L) side (B) Back (C) Chair	C	B				B						
	Mattress type / Cushion type	*please state type:* Pentaflex											
Elimination	Do you need the toilet?	I	I				N						
	Is the patient continent of urine? (at time of Care Rounding)	Y	Y				Y						
	Continence product changed/offered?	/	/				NA						
	Catheter care performed?	/	/				NA						
	Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact												
	Is patient continent of faeces? (at time of Care Rounding)	Y	Y				Y						
	Bowel function monitored	Observe bowel function and update daily											
Food, Fluid & Nutrition	Would you like a drink? Ensure fluids are within easy reach	FAST	FAST				W						
	Fluid Balance Chart (if clinically indicated)	Y	Y				Y						
	When did you last eat?	FAST	FAST				?						
	(B) Breakfast (L) Lunch (D) Dinner (S)Snack (NBM) Nil by Mouth (A) Assistance Update Food Chart if required												
	Oral Hygiene Performed (ref to risk assessment)	I	I				I						
Falls	Appropriate Footwear?	Y	Y				Y						
	Walking aid available(and within reach)	/	/				NA						
	Area de-cluttered?	Y	Y				Y						
	Chair and bed height assessed?	Y	Y				N						
	Falls alarm in use and attached?	/					NA						
	Glasses available for use? (if worn) Hearing aid available for use? (if worn)	/	/				/						
	Requires close observation for commode, toilet, bathing or showering Y ☐ N ☒												
Pain	Are you in pain?	Y	Y				Y						
	Analgesia Given?	Y	Y				Y						
General	Peripheral Venous Cannula observed?	Y	Y				N						
	Observe for signs of inflammation/swelling at every CR session. **Bundle/VIP score to be updated daily**												
	Are you comfortable? Y/N	Y	Y				Y						
	Anything else I can do for you?	N	N				N						
	Buzzer within easy reach	Y	Y				Y						
	Personal Care *Type* _______ *(specify)* **Time Given** _______												
	Initials — document at time of care delivery	OJ	[illegible]	OJ	OJ	CG	CG						

Handwritten across columns: IN THEATRE

Ward: 106 Site: RIE Date: 3/3/17

Addressograph, or

Name Angella Cross

DOB 22/5/67

Unit no. / CHI

NHS Lothian

This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency.

1hrly 2 hrly 3 hrly 4° hrly (please circle/complete)

Print name and sign GWaters | RWATERS

Codes (Y) Yes, (N) No, (N/A) not applicable, (D) Declined (AS) Asleep (I) Independent, (NW) not on ward, (TH) Theatre,

Time of Care Rounding Document the exact time care rounding took place e.g. 0830	0800											
	08.00 am ← 24 hour period → 07.00 am											
Pressure Area Care												
Waterlow score less than 10 low risk requires only a daily skin review: Use codes for outcome of skin review												
Waterlow 10+ - Visual Skin Check (tick)												
Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister	SW											
Vulnerable areas? (circle areas of damage)	Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other.................											
If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan												
Have you changed position since last CR?	N											
Positioning (R) or (L) side (B) Back (C) Chair	B											
Mattress type / Cushion type	*please state type:*											
Elimination												
Do you need the toilet?	N											
Is the patient continent of urine? (at time of Care Rounding)	Y											
Continence product changed/offered?	X											
Catheter care performed?												
Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact												
Is patient continent of faeces? (at time of Care Rounding)	Y											
Bowel function monitored	Observe bowel function and update daily											
Food, Fluid & Nutrition												
Would you like a drink? Ensure fluids are within easy reach	W											
Fluid Balance Chart (if clinically indicated)	Y											
When did you last eat?	B											
(B) Breakfast (L) Lunch (D) Dinner (S) Snack (NBM) Nil by Mouth (A) Assistance **Update Food Chart if required**												
Oral Hygiene Performed (ref to risk assessment)	I											
Falls												
Appropriate Footwear?	Y											
Walking aid available (and within reach)	N											
Area de-cluttered?	Y											
Chair and bed height assessed?	✓											
Falls alarm in use and attached?	NA											
Glasses available for use? (if worn) Hearing aid available for use? (if worn)	NS											
Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐												
Pain												
Are you in pain?	Y											
Analgesia Given?	Y											
General												
Peripheral Venous Cannula observed?	✓											
Observe for signs of inflammation/swelling at every CR session. **Bundle/VIP score to be updated daily**												
Are you comfortable? Y/N	Y											
Anything else I can do for you?	N											
Buzzer within easy reach	Y											
Personal Care *Type* ______________ *(specify)* **Time Given** ____________												
Initials – document at time of care delivery	Gw											

Ward: 10b . Site: Ree Date: 28.6.17

This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency.

1hrly 2 hrly (3 hrly) _____hrly (please circle/complete)

Print name and sign C. Osbome (OSBORNE)

620045326K F
CROSS Angella
22-May-67 CHI: 220 567 1464
77106 JA Scott
44 Woodburn Bank Midlothian
EH22 2EY

Unit no. / CHI

NHS Lothian

Codes (Y) Yes, (N) No, (N/A) not applicable,(D) Declined (AS) Asleep (I) Independent, (NW) not on ward, (TH) Theatre,

Section	Time of Care Rounding (Document the exact time care rounding took place e.g. 0830) — 08.00 am ← 24 hour period → 07.00 am	1900	2000	24.00	0400								
Pressure Area Care	Waterlow score less than 10 low risk requires only a daily skin review: Use codes for outcome of skin review												
	Waterlow 10+ - Visual Skin Check (tick)												
	Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister		H	NS	NS								
	Vulnerable areas? (circle areas of damage)	Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other................											
	If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan												
	Have you changed position since last CR?	I	I	I	I								
	Positioning (R) or (L) side (B) Back (C) Chair	B	B	T	B								
	Mattress type / Cushion type	*please state type:*											
Elimination	Do you need the toilet?	I	I	I	I								
	Is the patient continent of urine? (at time of Care Rounding)	Y	Y	Y	Y								
	Continence product changed/offered?	/	NA	NA	NA								
	Catheter care performed?	/	NA	NA	NA								
	Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact												
	Is patient continent of faeces? (at time of Care Rounding)	Y	Y	Y	Y								
	Bowel function monitored	Observe bowel function and update daily											
Food, Fluid & Nutrition	Would you like a drink? Ensure fluids are within easy reach	W	W	W	W								
	Fluid Balance Chart (if clinically indicated)	Y	Y	Y	Y								
	When did you last eat?	D	D	D	D								
	(B) Breakfast (L) Lunch (D) Dinner (S)Snack (NBM) Nil by Mouth (A) Assistance — Update Food Chart if required												
	Oral Hygiene Performed (ref to risk assessment)	I	N	I	N								
Falls	Appropriate Footwear?	Y	Y	Y	Y								
	Walking aid available(and within reach)	/	NA	NA	NA								
	Area de-cluttered?	Y	Y	Y	Y								
	Chair and bed height assessed?	Y	Y	Y	Y								
	Falls alarm in use and attached?	/	NA	NA	NA								
	Glasses available for use? (if worn) Hearing aid available for use? (if worn)	/	NA	N	N								
	Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐												
Pain	Are you in pain?	Y	N	N	N								
	Analgesia Given?	Y	N	N	N								
General	Peripheral Venous Cannula observed?	Y	Y	N	Y								
	Observe for signs of inflammation/swelling at every CR session. **Bundle/VIP score to be updated daily**												
	Are you comfortable? Y/N	Y	Y	Y	Y								
	Anything else I can do for you?	N	N	N	N								
	Buzzer within easy reach	Y	Y	Y	Y								
	Personal Care *Type* _______ *(specify)* Time Given _______												
	Initials – document at time of care delivery	BF	CO	GM	CO								

Ward: 106 Site: RIE Date: 1/3/17

Addressograph or

620045326K F
CROSS Angella
22-May-67 CHI: 220 567 1464
77106 JA Scott
44 Woodburn Bank Midlothian
EH22 2EY

NHS Lothian

This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency.

1hrly 2 hrly (3 hrly) ____hrly (please circle/complete)

Print name and sign C·OSBOMC (OSBORNE)

Codes (Y) Yes, (N) No, (N/A) not applicable,(D) Declined (AS) Asleep (I) Independent, (NW) not on ward, (TH) Theatre,

Time of Care Rounding Document the exact time care rounding took place e.g. 0830	0705	11.15	1545	2000	2400	400						
	08.00 am ← 24 hour period → 07.00 am											
Pressure Area Care — Waterlow score less than 10 low risk requires only a daily skin review: Use codes for outcome of skin review												
Waterlow 10+ - Visual Skin Check (tick)												
Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister	N/S	N/S	N/S	NS	NS	NS						
Vulnerable areas? (circle areas of damage)	Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other................											
If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan												
Have you changed position since last CR?	I	I	I	I	I	I						
Positioning (R) or (L) side (B) Back (C) Chair	B	B	B	B	B	B						
Mattress type / Cushion type	*please state type:*											
Elimination — Do you need the toilet?	I	I	I	I	I	I						
Is the patient continent of urine? (at time of Care Rounding)	Y	Y	Y	Y	Y	Y						
Continence product changed/offered?	NA	N/A	N	NA	NA	NA						
Catheter care performed?	NA	N/A	NA	NA	NA	NA						
Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact												
Is patient continent of faeces? (at time of Care Rounding)	Y	Y	Y	Y	Y	Y						
Bowel function monitored	Observe bowel function and update daily											
Food, Fluid & Nutrition — Would you like a drink? Ensure fluids are within easy reach	W.	W	W	W	AS	AS						
Fluid Balance Chart (if clinically indicated)	Y	Y	N	N	N	N						
When did you last eat?	B	B	L	S	S	S						
(B) Breakfast (L) Lunch (D) Dinner (S)Snack (NBM) Nil by Mouth (A) Assistance Update Food Chart if required												
Oral Hygiene Performed (ref to risk assessment)	I	I	I	N	N	N						
Falls — Appropriate Footwear?	Y	Y	Y	Y	Y	Y						
Walking aid available(and within reach)	NA	N/A	NA	NA	NA	NA						
Area de-cluttered?	Y	Y	Y	Y	Y	Y						
Chair and bed height assessed?	N	N	N	N	N	N						
Falls alarm in use and attached?	N	N	N	NA	N	N						
Glasses available for use? (if worn) Hearing aid available for use? (if worn)	Y	Y	Y	Y	Y	Y						
Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐												
Pain — Are you in pain?	Y	Y	Y	N	N	N						
Analgesia Given?	Y	Y	Y	Y	Y	N						
General — Peripheral Venous Cannula observed?	Y	Y	Y	Y	Y	Y						
Observe for signs of inflammation/swelling at every CR session. **Bundle/VIP score to be updated daily**												
Are you comfortable? Y/N	Y	Y	Y	Y	Y	Y						
Anything else I can do for you?	N	N	N	N	N	N						
Buzzer within easy reach	W	W	Y	Y	Y	Y						
Personal Care *Type* ______ *(specify)* Time Given ______												
Initials – document at time of care delivery	SL	SH	LM	CO	AH	AH						

GENTAMICIN DOSE CALCULATOR AND PRESCRIPTION RECORD FOR ADULT PATIENTS
NOT for synergistic use; prophylaxis. See guidance document for exclusion conditions and contraindications

To ensure the most up-to-date versions of this prescription chart and calculator are used, they should only be used when accessed from the AMT intranet site

NHS Lothian

INSTRUCTIONS

1. Enter patient details into shaded blue cells in the calculator to the right.
2. Gentamicin dosage regimen will automatically be calculated.
3. Print worksheet and place with prescription and administration record.
4. Use the table in the print out to record drug monitoring levels.

IF CREATININE IS NOT KNOWN, SEE BOX B ON PAGE 2 FOR INSTRUCTIONS ON HOW TO GIVE THE FIRST DOSE OF GENTAMICIN

Calculator version: Version 2.3; February 2017

Print date: 01/03/2017 17:48

Patient Name:	Angela Cross
CHI Number:	2205671464
After printing, patient label may be affixed above if available	

Type in the data into shaded blue boxes and press <enter>		Recommended doses and dosage intervals are shown in red	
Creatinine Clearance (ml/min)		INITIAL GENTAMICIN DOSAGE REGIMEN	
Age* (years)	49	Dose (mg) Add to 100ml sodium chloride (NaCl) 0.9% or glucose 5%	320
Height* (cm)			
OR Height* (feet)	5		
(inches)	0	Duration of infusion	30 mins
Actual Body Weight* (kg)	68.0		
Sex* (m/f)	f	Dosing interval is determined by monitoring levels	Take a sample 6-14 hours after start of administration
Creatinine* (µmol/L) (NOT eGFR) *Caution if not stable*	66		
Creatinine Clearance (ml/min)	78	Predicted dosing interval	Based on data entered, calculator expects dosing interval to be 24 hours, but confirm this with levels before prescribing the next dose
Fields marked with * are mandatory (height can be recorded in either cm OR feet & inches)			
Administer within 1 hour of recognising sepsis to reduce mortality			

Calculation must be checked by person administering first dose | Checked by:

Prescribe gentamicin "as charted" on the prescription and administration record; use the table below to prescribe individual doses

Check creatinine EVERY day

Date/time	Creatinine (µmol/L)
28/02/2017	
01/03/2017	
02/03/2017	
03/03/2017	
04/03/2017	
05/03/2017	
06/03/2017	

Gentamicin Prescription Record: Complete a line for each day. If dosing 48 hourly write 'No dose today' against date.
Administration Record: Complete each time gentamicin is administered (in addition to the prescription and administration record).
Monitoring Record: Levels must be taken between 6 and 14 hours after start of each dose.

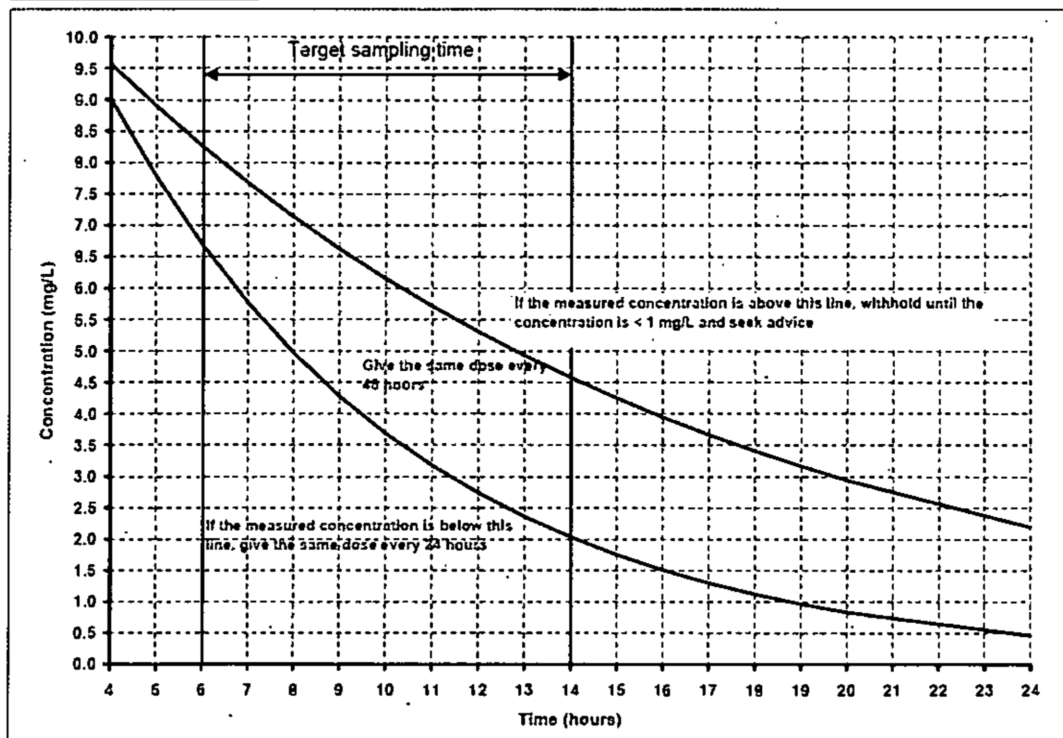
Date to be given	Time to be given (24 hr clock)	Gentamicin Dose (mg)	Prescriber's signature and PRINTED name	*Infuse over 30 mins* Date given	Time started (24 hr clock)	Given by	Date of sample	Time of sample (24 hr clock)	Gentamicin level (mg/L)	Actions / Comments (please initial action to be taken and document in patient notes)
01/03/2017 Gentamicin isn't always given every day; check today is the day	1800	Prescribe first dose here 320mg In NaCl 0.9% ☑ or glucose 5% ☐	[signature] WKE Wilson	1/3/17	19.02	[signature]				24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other: Sign and print name:
02/03/2017 Gentamicin isn't always given every day; check today is the day		In NaCl 0.9% ☐ or glucose 5% ☐								24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other: Sign and print name:
03/03/2017 Gentamicin isn't always given every day; check today is the day		In NaCl 0.9% ☐ or glucose 5% ☐								24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other: Sign and print name:
AFTER 3 DAYS REVIEW NEED FOR CONTINUED GENTAMICIN - SEE GUIDANCE ON MICROGUIDE OR INTRANET; DISCUSS WITH YOUR CONSULTANT AND/OR MICROBIOLOGY OR ID										
04/03/2017 Gentamicin isn't always given every day; check today is the day		In NaCl 0.9% ☐ or glucose 5% ☐								24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other: Sign and print name:
05/03/2017 Gentamicin isn't always given every day; check today is the day		In NaCl 0.9% ☐ or glucose 5% ☐								24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other: Sign and print name:
06/03/2017 Gentamicin isn't always given every day; check today is the day		In NaCl 0.9% ☐ or glucose 5% ☐								24 hourly ☐ 48 hourly ☐ Withhold ☐ Stop ☐ Details/other: Sign and print name:

GENTAMICIN DOSE CALCULATOR AND PRESCRIPTION RECORD FOR ADULT PATIENTS

To ensure the most up-to-date versions of the prescription chart and calculator are used, they should only be used when accessed from the NHS intranet site.

NOT for synergistic use, prophylaxis. See guidance document for exclusion conditions and contraindications.

MONITORING CHART



A: SIGNS OF GENTAMICIN TOXICITY

RENAL:

- Decreased urine output/oliguria

OR

- Increased serum creatinine

OTO/VESTIBULAR : development of NEW:

- tinnitus
- dizziness
- poor balance
- hearing loss
- oscillating vision

B: HOW TO GIVE FIRST DOSE OF GENTAMICIN WHEN CREATININE NOT KNOWN

- Give 5mg/kg (max 400mg) gentamicin
  OR IF CKD 5: give 2.5mg/kg (max 180mg) gentamicin on advice of senior medical staff
- Round doses to the nearest multiple of 20mg
- Check creatinine
- Once creatinine is known, use calculator to determine dose regimen and follow monitoring guidelines
- Check level between 6 -14 hrs after initial dose and follow guidelines

C: MONITORING GUIDELINES

IF CREATININE CLEARANCE IS >= 21ml/min.

- **Make sure all doses are documented with the date and time of administration**
- Take a sample 6 – 14 hours after the start of the first infusion and every infusion thereafter
- Record the exact time of the dose and sample
- Record the serum concentration on the monitoring record (overleaf) and determine appropriate next dose/interval from the chart (left)
- **The plot will indicate one of 3 options:**
  (1) continue present dosage regimen OR
  (2) adjust dosage interval OR
  (3) withhold and resample after 24 hours
- If the concentration falls exactly on the line choose the option above the line and seek advice from Pharmacy
- Seek advice from Pharmacy or Microbiology if help needed to interpret the result or if concentration unexpectedly high or low
- Monitor serum creatinine concentrations daily
- Take a further sample 6 -14 hours after each dose
- Do not continue with treatment for more than 3 days unless recommended by a specialist consultant, ID physician or microbiology. The IVOS policy (*available on the antibiotic app or on the intranet*) gives more guidance.

IF CREATININE CLEARANCE IS ≤21ml/min.

- Make sure all doses are documented with the date and time of administration
- Take a sample 24 hours after the start of the first infusion
- Record the exact time of the dose and sample
- Record the serum concentration on the monitoring record (overleaf). Do not give a further dose until the level is <1mg/L
- Seek advice from Pharmacy or Microbiology if you are unsure how to interpret the result or if concentration very low
- Monitor serum creatinine concentrations daily
- If therapy to continue, take additional samples every 24 hours and give a further dose only when the measured concentration is <1mg/L
- Do not continue with treatment for more than 3 days unless recommended by a specialist consultant, ID physician or microbiology. The IVOS policy (*available on the antibiotic app or on the intranet*) gives more guidance.

National Early Warning Score (NEWS) Chart

620045326K F
CROSS Angella
22-May-67 CHI: 220 567 1464
77106 JA Scott
44 Woodburn Bank Midlothian
EH22 2EY

Consultant: Date chart commenced:

This is chart number this admission

Weight: Actual kgs Estimated kgs

ASU: Ward:

Conscious Level Chart to be completed when clinically indicated

		Date	
		Time	
GLASGOW COMA SCALE	Eyes Open	Spontaneously	4
		To speech	3
		To pain	2
		None	1
	Best Verbal Response	Orientated	5
		Confused	4
		Inappropriate words	3
		Incomprehensible sounds	2
		None	1
	Best Motor Response	Obey commands	6
		Localise to pain	5
		Flexion to pain	4
		Abnormal flexion	3
		Extension to pain	2
		None	1
		Total GCS Score	
Right Pupil		Size	
		Reaction	
Left Pupil		Size	
		Reaction	
LIMB MOVEMENT	ARMS	Normal power	
		Mild weakness	
		Severe weakness	
		Extension	
		No response	
	LEGS	Normal power	
		Mild weakness	
		Severe weakness	
		Extension	
		No response	
		Initials	

Endotracheal tube or tracheostomy = T

Always record the best arm response

+ reacts
- no reaction
c. eye closed

Record right (R) and left (L) separately if there is a difference between the two sides

Pupil Scale mm 1 • 2 • 3 • 4 • 5 • 6 • 7 8

REMEMBER
- **Record all** observations on NEWS chart
- **Document any** deterioration in the notes - remember the Structured Response Tool
- **Escalate** your frequency of observations
- If at any point during your assessment you are concerned about your patient - **CALL FOR HELP**

	Assess	Possible Actions
AIRWAY	Is the airway - • Patent • At Risk • Obstructed	→ Suction if indicated → Head tilt, chin lift/jaw thrust → Airway Adjuncts → Administer Oxygen → Call 2222 if at risk
BREATHING	• Respiratory rate • SpO2 • Accessory muscle use • Noises +/- percussion, palpation & auscultation • Position / posture	→ Administer prescribed Oxygen to maintain saturations 94%-98% (NB COPD 88%-92%) → Monitor SpO2 / ABGs → Consider chest x-ray → Treat underlying cause → Call 2222 if not breathing
CIRCULATION	• Pulse • Blood Pressure • Capillary refill time • Core temperature / colour • Urine output • Consider 4 body cavities for fluid & blood loss (4 + on the floor) • Monitor drain losses	→ Obtain IV access → Obtain blood samples → Prepare fluid challenge → Initiate Fluid Balance Chart → Call 2222 if no circulation → Consider initiating Major Haemorrhage Protocol → Monitor response to actions
DISABILITY A = Alert V = Voice / Verbal P = Pain U = Unresponsive	• AVPU for initial assessment • GCS, on-going neuro assessment • ABC's & treat hypoxia or hypovolaemia • Blood Glucose • Drugs	→ Re-assess GCS → Check blood glucose if less than 4mmols/litre activate hypoglycaemia protocol → Check Drug Chart → Remember accurate documentation
EXPOSURE	• Top to toe examination • Look for evidence of blood loss / rashes / drains / wounds etc	→ Control bleeding → Treat any underlying conditions identified → Reassess → Maintain patient's dignity → Evaluate actions

Pain Assessment and Management Guidelines

Cancer-related pain: Always score worst pain in the last 24 hours or since last assessment: refer to Palliative Care Guidelines

Acute Pain: Score current pain on movement, e.g. deep breathing: refer to Acute Pain Guidelines

Persistent pain - 6 or above which distresses the patient and is unresponsive to guidelines

↓

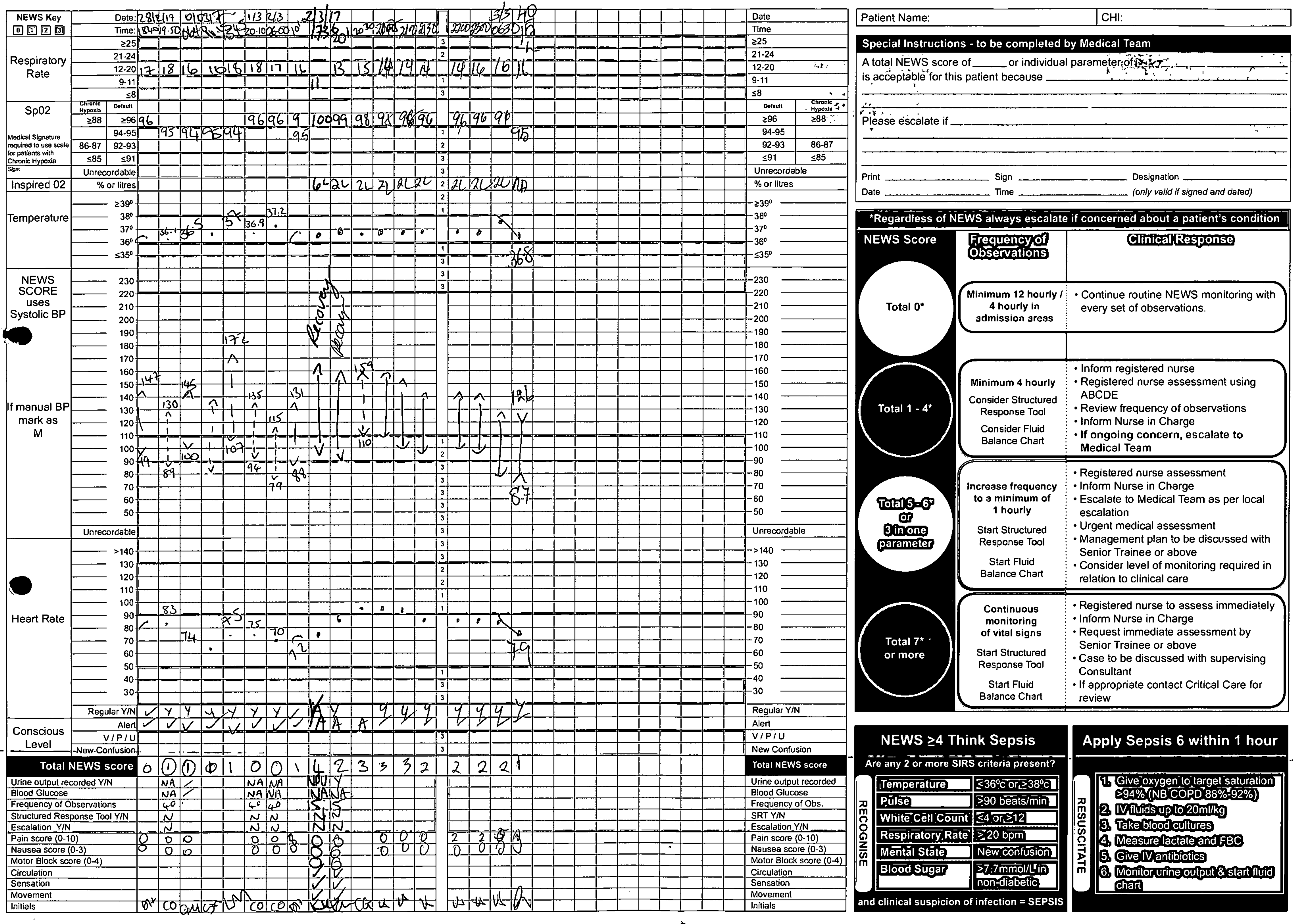
Call Medical staff / Senior Nurse / Nurse Practitioner

↓

For further advice contact:

ACUTE	PALLIATIVE
Mon-Fri: Bleep Acute Pain Team Out of Hours: On-call Anaesthetist	Mon-Fri: Bleep Palliative Care Team Out of Hours: Via Switchboard

Pain Score	Nausea Score 0-3	Epidural Motor Block Score please do not √ motor block column
0 None Continue to assess pain at least daily	**0 - No Nausea**	**0 - Full Power**
1-3 Mild Continue to assess pain with routine observations, must be at least daily	**1 - Nausea** Consider anti-emetic	**1 - Weak but able to raise legs**
4-5 Moderate Assess, administer and review analgesia as appropriate for patient	**2 - Nausea / Vomiting** Administer anti-emetic	**2 - Able to bend knees** **3 - Minimal movement**
6-10 Severe Assess, administer and review analgesia as appropriate for patient	**3 - Persistent Nausea &/or Vomiting** Contact Doctor	**4 - Paralysis**
Using appropriate Lothian Guidelines	**Using guidelines prescribe / give anti-emetics and review**	If score 2 or above please immediately contact the Acute Pain Team or On-Call Anaesthetist if out of hours



NEWS Key 0 1 2 3	Date: / Time:
Respiratory Rate	≥25 (3); 21-24 (2); 12-20; 9-11 (1); ≤8 (3)
Sp02 — Chronic Hypoxia / Default	≥88 / ≥96; 94-95 (1); 86-87 / 92-93 (2); ≤85 / ≤91 (3); Unrecordable (3)
Medical Signature required to use scale for patients with Chronic Hypoxia. Sign:	
Inspired 02	% or litres (2)
Temperature	≥39° (2); 38° (1); 37°; 36°; ≤35° (1, 3)
NEWS SCORE uses Systolic BP. If manual BP mark as M	230 (3); 220 (3); 210; 200; 190; 180; 170; 160; 150; 140; 130; 120; 110; 100 (1); 90 (2); 80 (3); 70 (3); 60 (3); 50 (3); Unrecordable (3)
Heart Rate	>140 (3); 130 (3); 120 (2); 110 (2); 100 (1); 90 (1); 80; 70; 60; 50 (1); 40 (3); 30 (3)
	Regular Y/N
Conscious Level	Alert; V / P / U (3); New Confusion (3)
Total NEWS score	
Urine output recorded Y/N	
Blood Glucose	
Frequency of Observations	
Structured Response Tool Y/N	
Escalation Y/N	
Pain score (0-10)	
Nausea score (0-3)	
Motor Block score (0-4)	
Circulation	
Sensation	
Movement	
Initials	

Patient Name: | CHI:

Special Instructions - to be completed by Medical Team

A total NEWS score of ______ or individual parameter of ______ is acceptable for this patient because ______

Please escalate if ______

Print ______ Sign ______ Designation ______

Date ______ Time ______ *(only valid if signed and dated)*

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

NEWS Score	Frequency of Observations	Clinical Response
Total 0*	Minimum 12 hourly / 4 hourly in admission areas	• Continue routine NEWS monitoring with every set of observations.
Total 1 - 4*	Minimum 4 hourly Consider Structured Response Tool Consider Fluid Balance Chart	• Inform registered nurse • Registered nurse assessment using ABCDE • Review frequency of observations • Inform Nurse in Charge • **If ongoing concern, escalate to Medical Team**
Total 5 - 6* or 3 in one parameter	Increase frequency to a minimum of 1 hourly Start Structured Response Tool Start Fluid Balance Chart	• Registered nurse assessment • Inform Nurse in Charge • Escalate to Medical Team as per local escalation • Urgent medical assessment • Management plan to be discussed with Senior Trainee or above • Consider level of monitoring required in relation to clinical care
Total 7* or more	Continuous monitoring of vital signs Start Structured Response Tool Start Fluid Balance Chart	• Registered nurse to assess immediately • Inform Nurse in Charge • Request immediate assessment by Senior Trainee or above • Case to be discussed with supervising Consultant • If appropriate contact Critical Care for review

NEWS ≥4 Think Sepsis

Are any 2 or more SIRS criteria present?

RECOGNISE

Temperature	<36°c or ≥38°c
Pulse	>90 beats/min
White Cell Count	≤4 or ≥12
Respiratory Rate	≥20 bpm
Mental State	New confusion
Blood Sugar	>7.7mmol/L in non-diabetic

and clinical suspicion of infection = SEPSIS

Apply Sepsis 6 within 1 hour

RESUSCITATE

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

ROYAL INFIRMARY OF EDINBURGH
EMERGENCY DEPARTMENT

620045326K F
CROSS Angella
22-May-67 CHI:220 567 1464
77106 JA Scott
44 Woodburn Bank Midlothian
EH22 2EY

Previous Adverse Reactions	

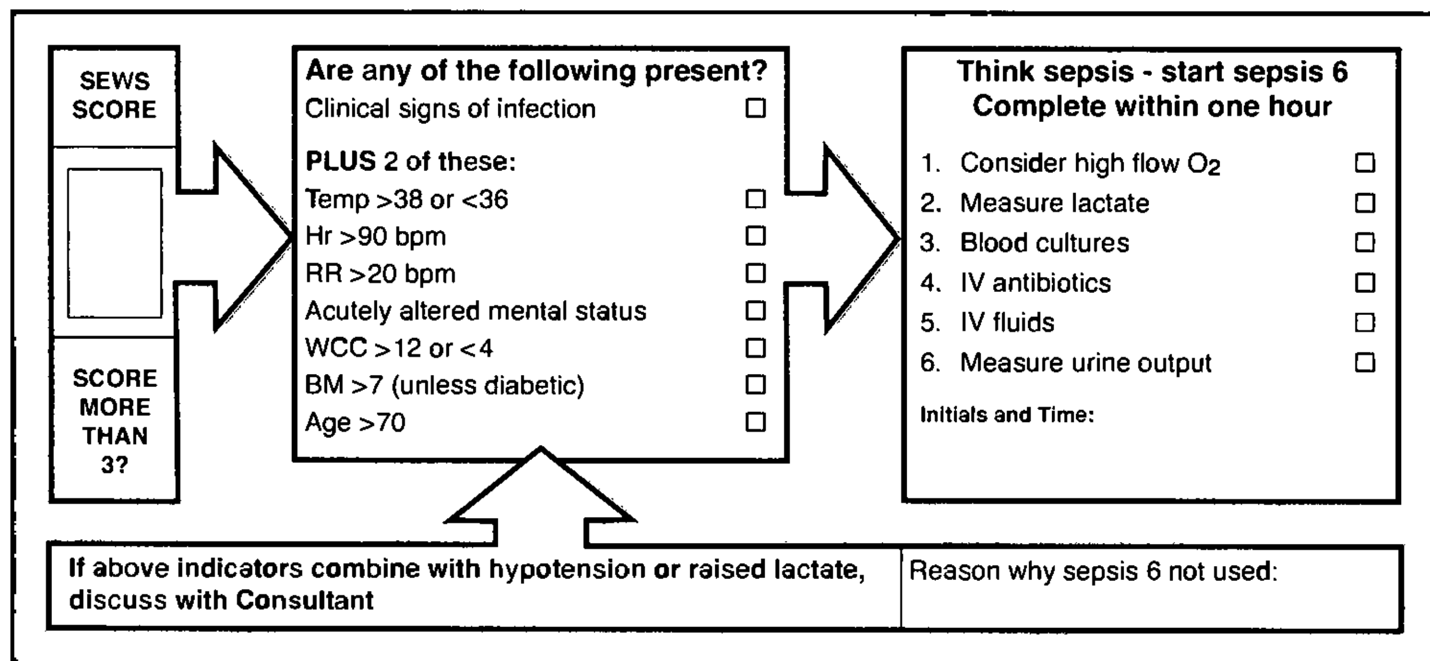
Weight ....

DRUG AND PRESCRIPTION RECORD

ONCE ONLY PRESCRIPTION

Date 28.2.17

Date	Time	Drug (Approved Name)	Dose	Route	Prescriber's Signature	Time Given	Given By (Initials)	Checked By (Initials)
28/2/17	1605	CO-CODAMOL 30/500	2 TABS	ORAL	[signature]	1605	FH	
28/2/17	1605	CYCLIZINE	50mg	ORAL	[signature]	1605	FH	
		Oxygen	%		target sats			
		via np/mask/nrbn						



TIME OF RECORDING →																		
GLASGOW COMA SCORE	EYES	Spontaneous	4															
		Speech	3															
		Pain	2															
		None	1															
	VERBAL	Oriented	5															
		Confused	4															
		Words	3															
		Sounds	2															
		None	1															
	MOVEMENT	To Command	6															
		Localises	5															
		Withdrawal	4															
		Flexion	3															
		Extension	2															
		None	1															

TOTAL																		
	14-15																	
	12-13																	1
	9-11																	2
	<8																	3

PUPILS																		
	RIGHT	Size																
		Reaction																
	LEFT	Size																
		Reaction																

PUPIL SIZE 1mm • 2mm ● 3mm ● 4mm ● 5mm ● 6mm ●

PAIN SCORE																		
	VERY SEVERE	9-10																
	SEVERE	6-8																
	MODERATE	4-5																
	MILD	1-3																
	NONE	0																

BLOOD SUGAR																	
	>25																
	15-25																
	4-15																
	<4																

URINE OUTPUT (mls/hr)																		
	>30																	0
	<30																	3

Key	SEWS SCORE																	
= 0		<3																
1		3-5																
2		6-10																
3		>10																

If Sews > 3 contact senior doctor

TIME OF RECORDING																				
BLOOD PRESSURE	200																		200	
	190																		190	
	180																		180	
	170																		170	
	160																		160	
	150																		150	
	140																		140	
	130																		130	
	120																		120	
	110																		110	
	100																		100	
Score if Systolic falls within parameters	90																		90	
	80																		80	1
	70																		70	2
	60																		60	
	50																		50	
	40																		40	3
	30																		30	
ENTER VALUE IF SYSTOLIC BELOW 30→																			Enter value if Systolic below 30	

ENTER VALUE ABOVE 180 →																			Enter value above 180	
	180																		180	
																				3
	160																		160	
	140																		140	
	120																		120	2
PULSE RATE																				1
	100																		100	
	80																		80	
	60																		60	
	50																		50	1
	40																		40	2
	30																		30	
ENTER VALUE BELOW 30 BPM →																			Enter value below 30 BPM	3

ENTER VALUE ABOVE 40 RPM →																			Enter value above 40 RPM	3
	40																		40	
	35																		35	2
	30																		30	
RESPIRATORY RATE	25																		25	1
	20																		20	
	15																		15	
	10																		10	
	8																		8	
ENTER VALUE BELOW 8 RPM →																			Enter value below 8 RPM	3

	39°																		39°	2
																				1
	38°																		38°	
	37°																		37°	
TEMPERATURE																				
	36°																		36°	
																				1
	35°																		35°	
																				2
	34°																		34°	3

SAO2	>93																		
	90-92																		1
	85-89																		2
	<85																		3
Inspired O2%	%																		

I.V. LINE 1____________________________**location**

Time prescribed	Fluid	volume	start	finish	PRESCRIBER'S SIGNATURE	given by
	Added Drugs	dose	start	finish	PRESCRIBER'S SIGNATURE	added by

I.V. LINE 2____________________________**location**

Time prescribed	Fluid	volume	start	finish	PRESCRIBER'S SIGNATURE	given by
	Added Drugs	dose	start	finish	PRESCRIBER'S SIGNATURE	added by

DISCHARGE DRUGS

Drug name	dose	frequency	duration	instructions	signature

DRUG INFUSION

	Rate *(ml/hr)*															
	Level															
Pump No:	*Amount Infused*															
	Rate *(ml/hr)*															
	Level															
Pump No:	*Amount Infused*															
	Rate *(ml/hr)*															
	Level															
Pump No:	*Amount Infused*															
	Rate *(ml/hr)*															
	Level															
Pump No:	*Amount Infused*															

University Hospitals Division

Royal Infirmary of Edinburgh
51 Little France Crescent
Old Dalkeith Road
Edinburgh EH16 4SA

Department of Acute Medicine

Dr Aspinall
Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA

Date First Created : 20/10/2022
Date Authorised :
Date/Time Printed : 21/10/2022 16:21
Our Ref : 620045326K
CHI : 2205671464

Team 1
Dr M Young
Dr S Hart
Dr H Narayan
Dr L Barr
Dr K Strachan
Dr R Harris
Dr E Ryan
Dr S MacKenzie
Dr E Morrison

PA/Team Secretary
0131 242 1441

Team 2
Dr S Dummer
Dr P Jones
Dr J Renton
Dr J Harrison
Dr J Dear
Dr I Thethy
Dr N Zammitt
Dr S Elawad

PA/Team Secretary
0131 242 1440

Team 3
Dr J Simpson
Dr N Tun
Dr M Lyall
Dr R Murphy
Dr K Linton
Dr E Sandilands
Dr M Adam

PA/Team Secretary
0131 242 2038

Team 4
Dr A Lockman
Dr A Veiraiah
Dr F Gibb
Dr L Nicol
Dr A Dover
Dr A Jaap
Dr J Tieman
Dr I MacIntyre
Dr A Coull
Dr N Hunter

PA/Team Secretary
0131 242 1438

AMU Reception
0131 242 1422

OPD2 Secretaries
0131 242 1383/4
0131 242 1481

Inpatient Discharge Summary

Patient:	Angella Cross 44 Woodburn Bank Dalkeith EH22 2EY	**UHPI:**	620045326K
		Date of Birth:	22/05/1967
Ward:	Ward 207 RIE		
Consultant:	Dr Pauline J Jones	**Admission Date:**	18/10/2022
		Discharge Date:	21/10/2022

Allergen (Group to which Allergen belongs)	Reaction
***No Known Drug Allergies	

Amlodipine 5mg tablets				
Dose	Route	Frequency	Days Supply	To Continue
5 mg	Oral	Once daily at 0700	7	Y
Notes:				
Bisoprolol 2.5mg tablets				
Dose	Route	Frequency	Days Supply	To Continue
2.5 mg	Oral	Once daily at 1400	7	Y
Notes:				
Mirtazapine 30mg tablets				
Dose	Route	Frequency	Days Supply	To Continue
30 mg	Oral	Once daily at 2200	7	Y
Notes:				
Omeprazole 20mg gastro-resistant capsules				
Dose	Route	Frequency	Days Supply	To Continue
20 mg	Oral	Twice daily at 0700 & 1800	7	Y
Notes:				

Prescribed By .... **Date**.................. **Print Name**......................
Dispensed By .... **Date**.................. **Print Name**......................
Final Check .... **Date**.................. **Print Name**......................
Verified By .... **Date**.................. **Print Name**......................

University Hospitals Division

Royal Infirmary of Edinburgh
51 Little France Crescent
Old Dalkeith Road
Edinburgh EH16 4SA

Peptac liquid				
Dose	Route	Frequency	Days Supply	To Continue
15 mL	Oral	PRN For acid reflux	7	Y
Notes:				

OPD2 Reception
0131 242 1368

Dept Team Leader
0131 242 1294

Prescribed By .... **Date**.................. **Print Name**.....................
Dispensed By .... **Date**.................. **Print Name**.....................
Final Check .... **Date**.................. **Print Name**.....................
Verified By .... **Date**.................. **Print Name**.....................

CHANGES TO DRUGS SINCE ADMISSION (relative to ECS)

Stopped:
Ramipril (difficulty swallowing tablets)
Propranolol - started on bisoprolol for hypertension

Started:
Amlodipine 5mg OD - high BP
Omeprazole 20mg OD – chronic cough ?reflux
Peptac 15ml PRN – chronic cough ?reflux
Bisoprolol 2.5mg OD - high BP

Changed: Nil

Withheld: Nil

ALLERGIES / ADVERSE DRUG REACTIONS: nil

Discharge prescription checked against ECS meds rec: Yes

Pharmacy Check by (enter on Trak): Name: Date: Time:

PRINCIPAL DIAGNOSIS:
1. Worsening SOB of unclear origin
2. Chronic cough of unclear origin

ACTION REQUIRED FROM GP (do not ask GP to chase blood results): please re-check blood pressure and U&Es in 2 weeks

FOLLOW UP BEING ARRANGED BY HOSPITAL: lung function tests (these have been ordered)

LIST OF OUTSTANDING RESULTS / OP INVESTIGATIONS

PLEASE CC THIS LETTER TO:
Respiratory outpatient clinic at the Royal Infirmary of Edinburgh

---

Dear Doctor,

ADMISSION SUMMARY AND TREATMENT:

Inpatient Discharge Summary

Royal Infirmary of Edinburgh
51 Little France Crescent
Old Dalkeith Road
Edinburgh EH16 4SA

Cont'd... **Ref:** 620045326K **Patient Name:** Angella Cross

Angela Cross is a 55 year old female patient admitted to the RIE on 18/10/22 with a 3 month history of worsening SOB on exertion and cough after recently being treated for a chest infection in the community. She was pyrexial with a BP of 190/145 at her GP appointment prior to admission and subsequently disclosed poor compliance with her anti-hypertensive. A CT head was performed due to concerns about malignant hypertension which was clear. A chest X ray was also clear and she was seen by the respiratory team who started her on treatment for GORD and recommended a CTPA which showed no embolism and normal lung parenchyma. Her antihypertensive medication was increased and she was discharged at her baseline with follow up lung function tests to be arranged by the respiratory clinic as an outpatient.

RELEVANT INVESTIGATION RESULTS:
CXR: no focal consolidation
CT-head: nil acute fiindings
CTPA: no embolism, normal parenchyma
E&S bp: 161/95, 168/98

SIGNIFICANT OBSERVATIONS AT DISCHARGE:
BP: 153/98

CHANGES MADE TO CARE ARRANGEMENTS/ DNACPR STATUS/ ANTICIPATORY CARE PLANNING: Nil

Thank you for your ongoing care of this patient.

Yours Sincerely,

Michael Jenks
FY1
Acute / General Medicine, RIE

CHECKED by (enter on Trak): Name/Designation:

Should you need further information please email: RIEacutemedicine@nhslothian.scot.nhs.uk or phone Acute and General Medicine Secretaries on: 0131 242 1438/ 40/ 41 or 0131 242 2036.

Inpatient Discharge Summary

Ward: 207 Site: RIE Date: 21/10/22

This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency.

1hrly 2 hrly 3 hrly _____hrly (please circle/complete)

Print name and sign ______

Name: 620045326K F CROSS Angella
DOB: 22-May-67 CHI: 220 567 1464
771D6 VE Aspinall
44 Woodburn Bank Midlothian
EH22 2EY
Unit no.

NHS Lothian

Codes (Y) Yes, (N) No, (N/A) not applicable,(D) Declined (AS) Asleep (I) Independent, (NW) not on ward, (TH) Theatre,

Time of Care Rounding Document the exact time care rounding took place e.g. 0830	0800	1100	1400									
	08.00 am ← 24 hour period → 07.00 am											
Pressure Area Care												
Waterlow score less than 10 low risk requires only a daily skin review: Use codes for outcome of skin review												
Waterlow 10+ - Visual Skin Check (tick)	N	Y	Y									
Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister	NS	H	H									
Vulnerable areas? (circle areas of damage)	Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other................											
If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan												
Have you changed position since last CR?	Y	Y	Y									
Positioning (R) or (L) side (B) Back (C) Chair	C	C	C									
Mattress type / Cushion type	please state type:											
Elimination												
Do you need the toilet?	I	I	I									
Is the patient continent of urine? (at time of Care Rounding)	Y	Y	Y									
Continence product changed/offered?	N/A	N/A	N/A									
Catheter care performed?	N/A	N/A	N/A									
Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact												
Is patient continent of faeces? (at time of Care Rounding)	Y	Y	Y									
Bowel function monitored	Observe bowel function and update daily											
Food, Fluid & Nutrition												
Would you like a drink? Ensure fluids are within easy reach	WR	WR	WR									
Fluid Balance Chart (if clinically indicated)	N	N	N									
When did you last eat?	B	B	L									
(B) Breakfast (L) Lunch (D) Dinner (S)Snack (NBM) Nil by Mouth (A) Assistance Update Food Chart if required												
Oral Hygiene Performed (ref to risk assessment)	N	N	N									
Falls												
Appropriate Footwear?	Y	Y	Y									
Walking aid available(and within reach)	N	N	N									
Area de-cluttered?	Y	Y	Y									
Chair and bed height assessed?	Y	Y	Y									
Falls alarm in use and attached?	N	N	N									
Glasses available for use? (if worn) Hearing aid available for use? (if worn)	Y	Y	Y									
Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐												
Pain												
Are you in pain?	N	N	N									
Analgesia Given?	N	N	N									
General												
Peripheral Venous Cannula observed?	N	N	N									
Observe for signs of inflammation/swelling at every CR session. **Bundle/VIP score to be updated daily**												
Are you comfortable? Y/N	Y	Y	Y									
Anything else I can do for you?	N	N	N									
Buzzer within easy reach	Y	Y	Y									
Personal Care *Type* ______ *(specify)*	Time Given											
Initials – document at time of care delivery	[illegible]	[illegible]	[illegible]									

Ward: Site: Date:	Addressograph, or
This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency. **1hrly 2 hrly 3 hrly _____hrly** (please circle/complete) **Print name and sign** ______________________	Name DOB Unit no. / CHI

NHS Lothian

Codes (Y) Yes, (N) No, (N/A) not applicable,(D) Declined (AS) Asleep (I) Independent, (NW) not on ward, (TH) Theatre,

	Time of Care Rounding Document the exact time care rounding took place e.g. 0830												
		08.00 am		←	24 hour period		→						07.00 am
Pressure Area Care	**Waterlow score less than 10 low risk requires only a daily skin review:** Use codes for outcome of skin review												
	Waterlow 10+ - Visual Skin Check (tick)												
	Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister												
	Vulnerable areas? (circle areas of damage)	Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other................											
	If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan												
	Have you changed position since last CR?												
	Positioning (R) or (L) side (B) Back (C) Chair												
	Mattress type / Cushion type	*please state type:*											
Elimination	Do you need the toilet?												
	Is the patient continent of urine? (at time of Care Rounding)												
	Continence product changed/offered?												
	Catheter care performed?												
	Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact												
	Is patient continent of faeces? (at time of Care Rounding)												
	Bowel function monitored	Observe bowel function and update daily											
Food, Fluid & Nutrition	Would you like a drink? Ensure fluids are within easy reach												
	Fluid Balance Chart (if clinically indicated)												
	When did you last eat?												
	(B) Breakfast (L) Lunch (D) Dinner (S)Snack (NBM) Nil by Mouth (A) Assistance Update Food Chart if required												
	Oral Hygiene Performed (ref to risk assessment)												
Falls	Appropriate Footwear?												
	Walking aid available(and within reach)												
	Area de-cluttered?												
	Chair and bed height assessed?												
	Falls alarm in use and attached?												
	Glasses available for use? (if worn) Hearing aid available for use? (if worn)												
	Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐												
Pain	Are you in pain?												
	Analgesia Given?												
General	Peripheral Venous Cannula observed?												
	Observe for signs of inflammation/swelling at every CR session. **Bundle/VIP score to be updated daily**												
	Are you comfortable? Y/N												
	Anything else I can do for you?												
	Buzzer within easy reach												
Personal Care *Type* ______________ *(specify)* **Time Given** ____________													
Initials – document at time of care delivery													

Ward: 207 Site: RIC Date: 20/10/22

This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency.

1hrly 2 hrly 3 hrly 4 hrly (please circle/complete)

Print name and sign 4c

Addressograph, or

NHS Lothian

Name Angella Cross.

DOB 22/5/67.

Unit no. / CHI

Codes (Y) Yes, (N) No, (N/A) not applicable, (D) Declined (AS) Asleep (I) Independent, (NW) not on ward, (TH) Theatre,

Time of Care Rounding Document the exact time care rounding took place e.g. 0830	09	12	15:30	20:00	20:45	23:00	02:30	05:15				
	08.00 am ← 24 hour period → 07.00 am											
Pressure Area Care												
Waterlow score less than 10 low risk requires only a daily skin review: Use codes for outcome of skin review												
Waterlow 10+ - Visual Skin Check (tick)	N	N	N	N	N	N	N	N				
Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister	NS	NS	NS	N	NC	NS	NS	NS				
Vulnerable areas? (circle areas of damage)	Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other................											
If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan												
Have you changed position since last CR?	Y	Y	Y	Y	Y	Y	Y	Y				
Positioning (R) or (L) side (B) Back (C) Chair	C	C	C	B	B	R	B	R				
Mattress type / Cushion type	*please state type:*											
Elimination												
Do you need the toilet?	I	I	I	I	IND	IND	IND	IND				
Is the patient continent of urine? (at time of Care Rounding)	Y	Y	Y	Y	Y	Y	Y	Y				
Continence product changed/offered?	I	I	I	I	IND	IND	IND	IND				
Catheter care performed?	N/A	N/A	NA	N	NA	NA	NA	NA				
Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact												
Is patient continent of faeces? (at time of Care Rounding)	Y	Y	Y	Y	Y	Y	Y	Y				
Bowel function monitored	Observe bowel function and update daily											
Food, Fluid & Nutrition												
Would you like a drink? Ensure fluids are within easy reach	WR	WR	WR	WR	WR	WR	WR	WR				
Fluid Balance Chart (if clinically indicated)	N	N	N	N	N	N	N	N				
When did you last eat?	B	L	S	D	S	S	S	S				
(B) Breakfast (L) Lunch (D) Dinner (S) Snack (NBM) Nil by Mouth (A) Assistance Update Food Chart if required												
Oral Hygiene Performed (ref to risk assessment)	Y	Y	Y	Y	ND	N	N	N				
Falls												
Appropriate Footwear?	Y	Y	Y	Y	Y	Y	Y	Y				
Walking aid available (and within reach)	N	N	N	N	N	N	N	N				
Area de-cluttered?	Y	Y	Y	Y	Y	Y	Y	Y				
Chair and bed height assessed?	Y	Y	Y	Y	Y	Y	Y	Y				
Falls alarm in use and attached?	Y	Y	Y	Y	N	N	N	N				
Glasses available for use? (if worn) Hearing aid available for use? (if worn)	Y	Y	Y	Y	Y	Y	Y	Y				
Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐												
Pain												
Are you in pain?	N	N	N	N	N	N	N	N				
Analgesia Given?	R	R	R	Y	N	N	N	N				
General												
Peripheral Venous Cannula observed?	N	N	N	N	N	N	N	N				
Observe for signs of inflammation/swelling at every CR session. **Bundle/VIP score to be updated daily**												
Are you comfortable? Y/N	Y	Y	Y	Y	Y	Y	Y	Y				
Anything else I can do for you?	N	N	N	N	N	N	N	N				
Buzzer within easy reach	Y	Y	Y	Y	Y	Y	Y	Y				

Personal Care *Type* Shower *(specify)* Time Given 09:00

Initials – document at time of care delivery	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]				

Ward: AMU Site: RIE Date: 19/10/22

This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency.

1hrly 2 hrly (3 hrly) _____hrly (please circle/complete)

Print name and sign ______________

620045326K /E5171135 F
CROSS Angella
22-May-67 CHI: 220 567 1464
77106 VE Aspinall
44 Woodburn Bank Midlothian
EH22 2EY

NHS Lothian

Codes (Y) Yes, (N) No, (N/A) not applicable, (D) Declined (AS) Asleep (I) Independent, (NW) not on ward, (TH) Theatre,

Time of Care Rounding Document the exact time care rounding took place e.g. 0830	0500	0900	1200	1300	1600	2300						
	08.00 am ← 24 hour period → 07.00 am											
Pressure Area Care												
Waterlow score less than 10 low risk requires only a daily skin review: Use codes for outcome of skin review												
Waterlow 10+ - Visual Skin Check (tick)	✓	—	✓	N	N	N						
Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister	H	NS	H	/	/	)						
Vulnerable areas? (circle areas of damage)	Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other................											
If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan												
Have you changed position since last CR?	Y	I	I	Y	Y	Y						
Positioning (R) or (L) side (B) Back (C) Chair	B	C	B	C	B	N						
Mattress type / Cushion type	*please state type:*											
Elimination												
Do you need the toilet?	I	I	I	N	N	N						
Is the patient continent of urine? (at time of Care Rounding)	Y	Y	Y	Y	Y	Y						
Continence product changed/offered?	N	O	O	O	O	O						
Catheter care performed?	N	NA	NA	NA	NA	N						
Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact												
Is patient continent of faeces? (at time of Care Rounding)	Y	Y	Y	Y	Y	Y						
Bowel function monitored	Observe bowel function and update daily											
Food, Fluid & Nutrition												
Would you like a drink? Ensure fluids are within easy reach	W	I	I	I	I	I						
Fluid Balance Chart (if clinically indicated)	N	N	N	NA	NA	N						
When did you last eat?	S	B	L	L	L	D						
(B) Breakfast (L) Lunch (D) Dinner (S) Snack (NBM) Nil by Mouth (A) Assistance **Update Food Chart if required**												
Oral Hygiene Performed (ref to risk assessment)	N	N	N	N	N	N						
Falls												
Appropriate Footwear?	Y	Y	Y	Y	Y	Y						
Walking aid available (and within reach)	N	N	N	NA	NA	NA						
Area de-cluttered?	Y	Y	Y	Y	Y	Y						
Chair and bed height assessed?	Y	Y	Y	Y	Y	Y						
Falls alarm in use and attached?	N	N	N	NA	NA	N						
Glasses available for use? (if worn) Hearing aid available for use? (if worn)	N	N	N	NA	NA	N						
Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐												
Pain												
Are you in pain?	N	N	N	N	N	N						
Analgesia Given?	N	N	N	NA	NA	N						
General												
Peripheral Venous Cannula observed?	Y	Y	Y	NA	NA	Y						
Observe for signs of inflammation/swelling at every CR session. **Bundle/VIP score to be updated daily**												
Are you comfortable? Y/N	Y	Y	Y	Y	Y	Y						
Anything else I can do for you?	N	N	N	N	N	N						
Buzzer within easy reach	Y	Y	Y	Y	Y	Y						

Personal Care *Type* ______________ *(specify)* **Time Given** ______________

Initials – document at time of care delivery	CP	LR	LR	[illegible]	[illegible]	[illegible]						

Addressograph Label Or	NHS LOTHIAN BLOOD GLUCOSE MONITOR[illegible]G & SUBCUTANEOUS INSULIN PRESCRIBING CHART					Never omit insulin without consulting medical staff
Name: Angella Cross	Pre-admission Insulin	Dose				If on intravenous insulin, document hourly blood glucose readings on the intravenous insulin chart
CHI: 2205671464		Breakfast	Lunch	Teatime	Bedtime	
		UNITS	UNITS	UNITS	UNITS	Ensure insulin is also prescribed "as per insulin chart" on the drug Kardex
		UNITS	UNITS	UNITS	UNITS	

Date	Ketones Time	Blood Glucose (mmol/L) Before Breakfast	Before Lunch	Before Teatime	Before Bed	INSULIN (units) Before Breakfast Type & Units	Prescribed by/ Time / Given by/ Time	Before Lunch Type & Units	Prescribed by/ Time / Given by/ Time	Before Teatime Type & Units	Prescribed by/ Time / Given by/ Time	Before Bed Type & Units	Prescribed by/ Time / Given by/ Time	Hypoglycaemia Time / Treatment
18/10/22		X Time	X Time	X Time Arrival on ward	10.9 Time 2220	UNITS		UNITS		UNITS		UNITS		
19/10		9.3 Time 0600	8.1 Time 1150	Time	Time	UNITS		UNITS		UNITS		UNITS		
20/10		8.7 Time 0630	12.7 Time 11:50	9.1 Time	Time	UNITS		UNITS		UNITS		UNITS		
		Time	Time	Time	Time	UNITS		UNITS		UNITS		UNITS		
21/10		07.25 Time 9.8	12.4 Time	Time	Time	UNITS		UNITS		UNITS		UNITS		
		Time	Time	Time	Time	UNITS		UNITS		UNITS		UNITS		

Addressograph

Name:

DOB:

CHI:

NEWS of 5 or more? Think Sepsis!

In a patient with a **NEWS** of **5 or more** and a known infection, signs and symptoms of infection, or at risk of infection, think **'Could this be sepsis?'** and **escalate care immediately.**

Special Instructions:

Only to be completed under the direction of a senior member of the medical team

A total NEWS of ____ or individual parameter of ____ is acceptable for this patient because ____

Please escalate if ____

Print ____ Sign ____ Designation ____

Date ____ Time ____ *(only valid if signed and dated)*

***Regardless of NEWS always Escalate if concerned about a patient's condition. Escalate immediately if clinical observations cannot be obtained**

NEWS TOTAL	Monitoring Frequency	Clinical Response (Document concerns/decisions in patients clinical notes)
0	Minimum 12 hourly/ 4 hourly in admission areas	• continue routine NEWS monitoring
Total 1 - 4	Minimum 4-6 hourly	• inform registered nurse • registered nurse assessment • review frequency of observations • if ongoing concern, escalate to medical team • consider fluid balance chart
3 in single parameter	Minimum 1 hourly	• registered nurse assessment • medical assessment • management plan to be discussed with senior trainee or above • consider fluid balance chart
Total 5 - 6 **Urgent response threshold**	Minimum 1 hourly	• registered nurse assessment • urgent medical assessment • management plan to be discussed with senior trainee or above • consider senior trainee review if NEWS does not improve following initial medical assessment • consider level of monitoring required • consider anticipatory care planning (ACP) • start fluid balance chart
Total 7 or more **Emergency response threshold**	Continuous monitoring of vital signs	• registered nurse to assess immediately • immediate assessment by senior trainee or above • discuss with supervising consultant • if appropriate contact Critical Care for review • consider anticipatory care planning (ACP) • start fluid balance chart

Codes for recording oxygen delivery on the NEWS2 observations chart

Code	Description	Code	Description
A	breathing air	RM	reservoir mask
N	nasal cannula (document in litres)	TM	tracheostomy mask
SM	simple mask	CP	CPAP mask
V	venturi mask and percentage (e.g device = V, % = 40)	H	humidified oxygen and percentage (e.g device = H, L/min or % = 40)
NIV	patient on NIV system	OTH	Other specify

Date / Time																
Circulation																
Sensation																
Movement																

NEWS Observation Chart

NEWS Key: 0 1 2 3

Parameter	Band	Recorded values (handwritten)
Date / Time		18/10 2220; 19/10 02; 19/10 0600; 0930; 20/10 …; 21/10 … (partly illegible)
Respirations Breaths/min	≥25	
	21-24	
	18-20	20, 20, 19, 18, 19, 18, 18
	15-17	16, 16, 16, 16, 16
	12-14	
	9-11	
	≤8	
SpO₂ Scale 1 Oxygen saturation (%) Use Scale 1 if target range is 94-98%	≥96	96, 98, 96, 96, 96, 98, 96, 96, 96, 96, 96, 96, 96, 96, 96
	94-95	
	92-93	
	≤91	
SpO₂ Scale 2* Oxygen saturation (%) Use Scale 2 if target range is 88-92% eg. in hypercapnic respiratory failure	≥97 on O₂	
	95-96 on O₂	
	93-94 on O₂	
	≥93 on air	
* ONLY use Scale 2 under the direction of a qualified clinician	88-92	
	86-87	
Tick box if using SpO₂ Scale 2 / Sign:	84-85	
	≤83	
Air or Oxygen?	A = Air	RA, A, A, A, A, A, A, A, A, A, A, A, A, A, A
Oxygen is a drug and prescribed by target range	O² L/min or %	
	Device	
Blood Pressure mmHg (Score uses Systolic BP only). If manual BP mark as M	≥220 … ≤50	177/127, 172/64, 133/92, 171/108, 130/80, 146/110, 153/88, 176/121, 142/98, 161/95, 168/98, 187/108, 178/122, 133/100, 171/106, 153/98
Pulse Beats/min (Manual pulse)	≥131 … ≤30	103, 62, 104, 98, 90, 106, 66, 77, 80, 79, 77, 76, 94, 78
Consciousness (Score for new onset of confusion; no score if chronic)	Alert	A, A, A, A, A, A, A, A, A, A, A, A, A, A, A
	New Confusion	
	V	
	P	
	U	
Temperature °C	≥39.1°	
	38.1-39.0°	
	37.1-38.0°	37, 37.2
	36.1-37.0°	36.2, 36.4, 36.9, 36.4, 36.1, 36.2, 36.8, 36.8, 36.8, 36.8
	35.1-36.0°	
	≤35.0°	
NEWS TOTAL		1, 0, 1, 0, 1, 1, 0, 0, 0, 0, 0, 0, 1, 0
Monitoring frequency		4, 4, 4, 4, 4, 4, 4, 12, 12, 12, 12, 12, 12, 12, 12
Escalation of care Y/N		N, N, N, N, N, N, N, N, N, N, N, N, N, N, N
Initials		[illegible]
Urine output recorded Y/N		
Blood Glucose level or N/A		N, N/A, N/A, N, N, N
Pain score (0-10)		0, 0, 0, 0, 0, 0
Nausea score (0-3)		0, 0, 0, 0, 0
Motor Block score (0-4) or N/A		0, 0, 0, N/A

Reproduced from: Royal College of Physicians. National Early Warning Score (NEWS) 2: Standardising the assessment of acute-illness severity in the NHS. Updated report of a working party. London: RCP, 2017.

National Early Warning Score 2 (NEWS2) Chart

620045326K /E5171135 F
CROSS Angella
22-May-67 CHI: 220 567 1464
77106 VE Aspinall
44 Woodburn Bank Midlothian
EH22 2EY
CHI:

Date chart commenced:

This is chart number of this admission

Conscious Level Chart to be completed when clinically indicated

	Date		
	Time		
GLASGOW COMA SCALE – Eyes Open	Spontaneously	4	Eyes closed by swelling = C
	To speech	3	
	To pain	2	
	None	1	
GLASGOW COMA SCALE – Best Verbal Response	Orientated	5	Endotracheal tube or tracheostomy = T
	Confused	4	
	Inappropriate words	3	
	Incomprehensible sounds	2	
	None	1	
GLASGOW COMA SCALE – Best Motor Response	Obey commands	6	Always record the best arm response
	Localise to pain	5	
	Flexion to pain	4	
	Abnormal flexion	3	
	Extension to pain	2	
	None	1	
	Total GCS Score		
Right Pupil	Size		+ reacts - no reaction c. eye closed
	Reaction		
Left Pupil	Size		
	Reaction		
LIMB MOVEMENT – ARMS	Normal power		Record right (R) and left (L) separately if there is a difference between the two sides
	Mild weakness		
	Severe weakness		
	Extension		
	No response		
LIMB MOVEMENT – LEGS	Normal power		
	Mild weakness		
	Severe weakness		
	Extension		
	No response		
	Initials		

Pupil Scale mm 1 • 2 • 3 ● 4 ● 5 ● 6 ● 7 ● 8 ●

REMEMBER
- **Record all observations on NEWS2 chart**
- **Document concerns/decisions in clinical notes**
- **Escalate your frequency of observations**
- If at any point during your assessment you are concerned about your patient - **CALL FOR HELP**

	Assess	Possible Actions
AIRWAY	Is the airway - • patent • at risk • obstructed	• suction if indicated • head tilt, chin lift / jaw thrust • airway adjuncts • administer oxygen • call 2222 if at risk
BREATHING	• respiratory rate • SpO_2 • accessory muscle use • noises +/- percussion, palpation & auscultation • position / posture	• administer prescribed oxygen to maintain saturations 94-98% (NB COPD 88-92%) • monitor SpO_2 / ABGs • consider chest x-ray • treat underlying cause • call 2222 if not breathing
CIRCULATION	• pulse • blood pressure • capillary refill time • core temperature / colour • urine output • consider 4 body cavities for fluid & blood loss (4 + on the floor) • monitor drain losses	• obtain IV access • obtain blood samples • prepare fluid challenge • initiate fluid balance chart • call 2222 if no circulation • consider initiating major haemorrhage protoc[ol] • monitor response to actions
DISABILITY A = Alert V = Voice / Verbal P = Pain U = Unresponsive	• AVPU for initial assessment • GCS, on-going neuro assessment • ABC's & treat hypoxia or hypovolaemia • blood glucose • drugs	• re-assess GCS • check blood glucose if less than 4mmols/litre activate hypoglycaemia protocol • check drug chart • remember accurate documentation
EXPOSURE	• top to toe examination • look for evidence of blood loss / rashes / drains / wounds etc	• control bleeding • treat any underlying conditions identified • reassess • maintain patient's dignity • evaluate actions

Pain and Symptom Assessment and Management

Supportive care - pain: Always score worst pain in the last 24 hours or since last assessment. If the patient has deteriorating health with limited reversibility, refer to **Scottish Palliative Care Guidelines**

Acute Pain: Score current pain on movement, e.g. deep breathing. Refer to Acute Pain Guidelines

Persistent pain - 6 or above which distresses the patient and is unresponsive to guidelines

↓

Call Medical Staff / Senior Nurse / Nurse Practitioner

↓

For further advice contact:

ACUTE	SPECIALIST PALLIATIVE CARE
Mon-Fri: bleep Acute Pain Team Out of Hours: on-call Anaesthetist	Mon-Fri: bleep Palliative Care Team Out of Hours: via Switchboard

Pain Score	Nausea Score	Epidural Motor Block Score please do not (✓) motor block column
0 - None Continue to assess pain at least daily	**0 - No Nausea**	**0 - Full Power**
1 - 3 Mild Continue to assess pain with routine observations, must be at least daily	**1 - Nausea** Consider anti-emetic	**1 - Weak but able to raise legs**
4 - 5 Moderate Assess, administer and review analgesia as appropriate for patient	**2 - Nausea / Vomiting** Administer anti-emetic	**2 - Able to bend knees**
6 - 10 Severe Assess, administer and review analgesia as appropriate for patient	**3 - Persistent Nausea &/or Vomiting** Contact Doctor	**3 - Minimal movement** **4 - Paralysis**
Using appropriate Lothian Guidelines	**Using guidelines prescribe / give anti-emetics and review**	If score 2 or above please immediately contact the Acute Pain Team or on-call Anaesthetist if out of hours

E5171135

E4819058

620045326K

Dr VE Aspinall

Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA

Cross
Angella

44 Woodburn Bank
Dalkeith
Midlothian

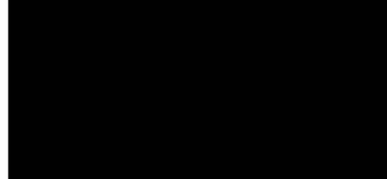
EH22 2EY

283 8775

22/05/1967

55 Female

18/10/2022 12:24



vate Transport

Flow Centre

CLINICAL NOTES:

Clinical note: ACUTE MEDICINE IN ED

CLINICAL ASSESSMENT

PC: 55 F presenting with 3/52 worsening SOBOE, cough

>> At GP: BP 190/145, Temp 39.4 >> was concerned about malignant hypertension

HPC:

>> Recently treated for LRTI in community with course of amox, completed full course >> 2 days later reports chest symptoms again

>> Shortness of breath: this is her main concern. Feels lethargic, worse when lying down and bending forward. Reports far from baseline 3 months ago, now feels out of breath walking 10m on the flat to the bathroom ('puffing'), needs 3 pillows to sleep, disturbing sleeping patterns. Palpitations when walking. Associated with lightheadeness

>> Cough: associated with SOB, worse when lying down. Non-productive of mucus or blood

>> Has had COVID twice and feels breathing has deteriorated since then, most recently in summer 2022

>> Denies (pleuritic) chest pain, intermittent claudication

>> Measures blood pressure at home and usually sits around SBP 175

>> No CIBH, no urinary symptoms, no abdo pain, no headache, no recent weight loss

Background:

Hypertension

T2DM

Anxiety

Previous gallstones

Partial thyroidectomy

Medications:

Mirtazapine, ramipril, propranolol

Drug allergies: NKDA

Social:

E5171135

E4819058

620045326K

Dr VE Aspinall

Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA

Cross
Angella

44 Woodburn Bank
Dalkeith
Midlothian

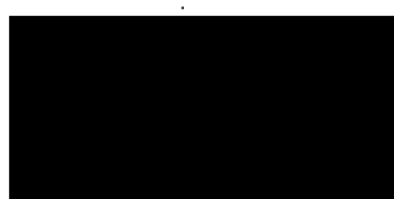
EH22 2EY

283 8775

22/05/1967

55 Female

18/10/2022 12:24



Private Transport

Flow Centre

> Lives at home with daughter (29) who has Down's Syndrome who she is a full time carer for

> Previous worked as a peer support worker

> Never smoked

> No alcohol

Temp: 36.6

NEWS 2

A - own, talking in full sentences

B - RR 20, Sats 97 OA, chest clear

C - WWP, CRT<2, MM, JVPNE, pulse regular, HS I + II + 0, BP 176/122, HR 111

D - Alert

E - Abdo SNT, calves SNT, nil pitting oedema

Investigation results:

Bloods (18/10)

Nil anaemia - Hb 153

Inflammatory markers - CRP 11, WCC not raised

Renal function NAD

Deranged LFTs - ALT 104, Alk-Phos 141, GGT 81 (appears longstanding)

Glucose 7.6

CXR (unreported): No focal consolidation, well-demarcated costophrenic angles, raised right hemidiaphragm, ?left heart border irregularity

ECG: Sinus tachycardia

Problem list:

1. Hypertension

2. Shortness of breath

3. Viral LRTI, ?PE

Treatment and management plan:

E5171135
E4819058
620045326K

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18/10/2022 12:24

ivate Transport

Flow Centre

Plan:

1. Admit as BP and diastolic high with headaches and dizziness - get CTB
2. Stop ramipril and start amlodipine - try solution from tomorrow as says chokes on tablets
3. CT chest and will need PFTs - requested
4. Contact AMB CARE mane and ask if they will get kardia app monitoring for her on DC
5. E+S BPs
6. Resp consult mane please
7. TFTs, K, MG and HBA1c added to bloods

am admitting for control of BP and headaches and investigation of neurological symptoms - can be discharged home for OP investigations after as above on discretion of AMU consultant

Dr Thethy
Consultant

Dr Batya Lepar Doctor

Dr Batya Lepar Doctor

E5171135

E4819058

620045326K

Dr VE Aspinall

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18/10/2022 12:24

ivate Transport

Flow Centre

1. Chase blood cultures
2. Chase bloods: incl CRP, glucose
3. Await formal CXR report
4. E+S BPs
5. Add on D-dimer
6. Urine dip

Destination: Home / Hospital @ Home / OPAT / Ambulatory Care / AMU

atya Lepar F1

nsultant: Dr I Thethy
Email inquiries to RIEacutemedicine@nhslothian.scot.nhs.uk

Update 15:51

Urinalysis: Ketones +; trace leuk/nitrates; trace protein; nil haematuria/glucosuria
D-dimer: 152

Consultant Review - Dr I Thethy **Draft**

Significant Bg of Note:
1. Hypertension on ramipril but noncomplaint with medication
2. Type 2 Diabetes
3. Partial Thyroidectomy - for goitre
4. Previous Gallstones

PC/HPC:
1. Shortness of breath and dry cough post covid since summer last with wheeze intermittently.
2. Exercise tolerance is now 5 minutes on flat ground

E5171135

E4819058

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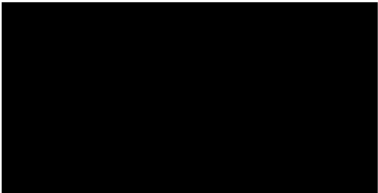


Private Transport

Flow Centre

3. Also has nocturnal symptoms of shortness of breath
4. Has been having palpitations post-covid almost daily sporadic fast and regular with lightheadedness
5. Feels lightheaded on standing up sometimes
6. Having headaches and sometimes tingling in right arm and right legs but no focal neurological deficit as such

Regarding her BP admits to intermittently taking her tablets. Denying any symptoms suggesting urgent management with iv therapy.

OE:
Chest Clear L=R
CVS: JVP NE, HS I+II+0, no oedema
Abdo: SNT, Nil Masses, BS present
Neuro: CN intact. T/P/S/C intact all 4 limbs

Significant of note
1. BP 176/122 and 180/130 on repeat
2. D-dimer 152 >> PE excluded
3. CXR (unreported): No focal consolidation, well-demarcated costophrenic angles, raised right hemidiaphragm, ?left heart border irregularity
4. ECG: Sinus tachycardia
5. Bloods (18/10)
Nil anaemia - Hb 153
Inflammatory markers - CRP 11, WCC not raised
Renal function NAD
Deranged LFTs - ALT 104, Alk-Phos 141, GGT 81 (appears longstanding)
Glucose 7.6

Issues:
1. Hypertension due to intermittent compliance with medications
2. SOB and dry cough - on ACE-I and post -covid
3. Palpitations post-covid, note previous thyroidectomy for goitre and subclinical hypothyroidism on bloods in June
4. Headaches - in relation to high blood pressure and also r sided tingling upper and lower limb - needs managed. if felt to be post covid can always be referred to Prof Carson's clinic on DC

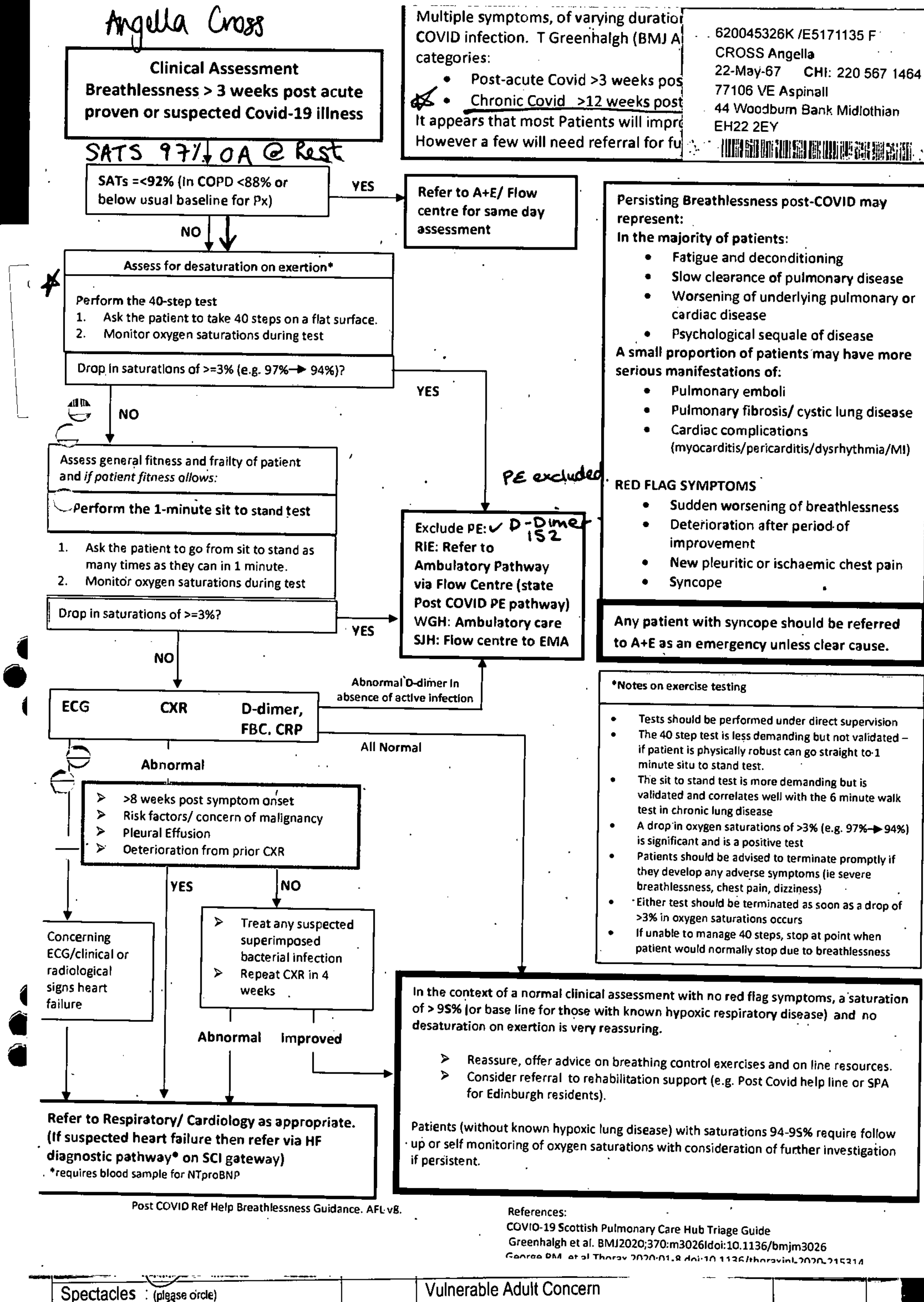
620045326K /E5171135 F
CROSS Angella
22-May-67 CHI: 220 567 1454
77106 VE Aspinall
[illegible] Woodburn Bank Midlothian
EH22 2EY

PATIENT NAME DATE

URINALYSIS RESULT CHART

LEUCOCYTES 2 MINUTES	Neg			Trace-Spur ✓	70 +	125 ++	500 +++
NITRATE 60 SECONDS	Neg			POSITIVE any degree of uniform pink colour ✓			
UROBILINOGEN 60 SECONDS	3.2 0.2 normal ✓	16 1			33 2	66 4	>=131 >=8
PROTEIN 60 SECONDS	Neg	mmol/L g/L mg/dL	trace - spur ✓	0.3 30 +	1 1000 ++	3 300 +++	>=20 >=2000 ++++
PH 60 SECONDS	5	6 ✓	6.5	7	7.5	8	8.5
BLOOD 60 SECONDS	Non- Haemolysed Neg ✓	10 trace-spur	80 ++	Haemoglobin 10 trace-spur	25 +	80 ++	200 +++
SPECIFIC GRAVITY 45 SECONDS	1	1.005	1.01	1.015 ✓	1.02	1.025	1.03
KETONE 40 SECONDS	Neg	mmol/L g/L mg/dL	0.5 0.05 5 trace-spur	1.5 0.05 15 + ✓	4 0.04 40 ++	8 0.08 80 +++	>=16 >=1.8 >=160 ++++
BILIRUBIN 30 SECONDS	Neg				+ ✓	++	+++
GLUCOSE 30 SECONDS	Neg ✓	mmol/L g/L mg/dL	5.5 1 100 trace-spur	14 2.5 250 +	28 5 500 ++	55 10 1000 +++	>=111 >=20 >=2000 ++++
HCG	+VE	-VE ✓	Signature				
MSU SENT	YES	NO ✓					

CONSIDER SENDING MSU, IF ANY OF THE VALUES IN BOLD ARE PRESENT



Angella Cross

Clinical Assessment
Breathlessness > 3 weeks post acute proven or suspected Covid-19 illness

SATS 97% ↓ OA @ Rest

Multiple symptoms, of varying duratio[...]
COVID infection. T Greenhalgh (BMJ A[...]
categories:

- Post-acute Covid >3 weeks pos[...]
- Chronic Covid >12 weeks post[...]

It appears that most Patients will impr[...]
However a few will need referral for fu[...]

620045326K /E5171135 F
CROSS Angella
22-May-67 CHI: 220 567 1464
77106 VE Aspinall
44 Woodburn Bank Midlothian
EH22 2EY

SATs =<92% (In COPD <88% or below usual baseline for Px)

YES → Refer to A+E/ Flow centre for same day assessment

NO ↓

Assess for desaturation on exertion*

Perform the 40-step test
1. Ask the patient to take 40 steps on a flat surface.
2. Monitor oxygen saturations during test

Drop in saturations of >=3% (e.g. 97%→ 94%)?

YES → Exclude PE

NO ↓

Assess general fitness and frailty of patient and *if potient fitness allows:*

Perform the 1-minute sit to stand test

1. Ask the patient to go from sit to stand as many times as they can in 1 minute.
2. Monitor oxygen saturations during test

Drop in saturations of >=3%?

YES → Exclude PE

NO ↓

ECG CXR D-dimer, FBC, CRP

Abnormal D-dimer in absence of active infection → Exclude PE

PE excluded

Exclude PE: ✓ D-Dimer 152
RIE: Refer to Ambulatory Pathway via Flow Centre (state Post COVID PE pathway)
WGH: Ambulatory care
SJH: Flow centre to EMA

Abnormal

- >8 weeks post symptom onset
- Risk factors/ concern of malignancy
- Pleural Effusion
- Deterioration from prior CXR

YES → Refer to Respiratory/ Cardiology

NO →
- Treat any suspected superimposed bacterial infection
- Repeat CXR in 4 weeks

Abnormal → Refer to Respiratory/ Cardiology
Improved → Reassure

Concerning ECG/clinical or radiological signs heart failure

Refer to Respiratory/ Cardiology as appropriate. (If suspected heart failure then refer via HF diagnostic pathway* on SCI gateway)
*requires blood sample for NTproBNP

All Normal ↓

Persisting Breathlessness post-COVID may represent:
In the majority of patients:
- Fatigue and deconditioning
- Slow clearance of pulmonary disease
- Worsening of underlying pulmonary or cardiac disease
- Psychological sequale of disease

A small proportion of patients may have more serious manifestations of:
- Pulmonary emboli
- Pulmonary fibrosis/ cystic lung disease
- Cardiac complications (myocarditis/pericarditis/dysrhythmia/MI)

RED FLAG SYMPTOMS
- Sudden worsening of breathlessness
- Deterioration after period of improvement
- New pleuritic or ischaemic chest pain
- Syncope

Any patient with syncope should be referred to A+E as an emergency unless clear cause.

*Notes on exercise testing
- Tests should be performed under direct supervision
- The 40 step test is less demanding but not validated – if patient is physically robust can go straight to 1 minute situ to stand test.
- The sit to stand test is more demanding but is validated and correlates well with the 6 minute walk test in chronic lung disease
- A drop in oxygen saturations of >3% (e.g. 97%→ 94%) is significant and is a positive test
- Patients should be advised to terminate promptly if they develop any adverse symptoms (ie severe breathlessness, chest pain, dizziness)
- Either test should be terminated as soon as a drop of >3% in oxygen saturations occurs
- If unable to manage 40 steps, stop at point when patient would normally stop due to breathlessness

In the context of a normal clinical assessment with no red flag symptoms, a saturation of > 95% (or base line for those with known hypoxic respiratory disease) and no desaturation on exertion is very reassuring.

- Reassure, offer advice on breathing control exercises and on line resources.
- Consider referral to rehabilitation support (e.g. Post Covid help line or SPA for Edinburgh residents).

Patients (without known hypoxic lung disease) with saturations 94-95% require follow up or self monitoring of oxygen saturations with consideration of further investigation if persistent.

Post COVID Ref Help Breathlessness Guidance. AFL v8.

References:
COVID-19 Scottish Pulmonary Care Hub Triage Guide
Greenhalgh et al. BMJ2020;370:m3026ldoi:10.1136/bmjm3026
George PM et al Thorax 2020-01-8 doi:10.1136/thoraxjnl-2020-215314

Spectacles : (please circle) NA In Situ At home		Vulnerable Adult Concern (Please Inform NIC if applicable)	
Relatives : (please circle) In ED At Home Not Aware		Child protection Concern (Enter on TRAK & inform NIC if applicable)	
Clothing & valuables (please tick) 1) Labelled 2) Documented		4AT test Score = (please enter only if clinically indicated)	

Care Provider must be informed of any clinical changes highlighted from Patient Screening

Time of Round		20⁵⁰			
Clinical Area of ED	D	C			
Initials of Care Round Leader					
Review frequency of Vital Signs & Cardiac Monitoring					
Vital signs frequency		20			
Cardiac monitoring required	Y / N	Y / (N)	Y / N	Y / N	Y / N
Pain Management (Refer to CP for analgesia if required)					
Please note pain score (0-10 Score)		0			
Mobility					
Fully weight bearing	✓	✓			
Requires some assistance and / or uses walking aid					
Non Weight bearing and requires full assistance					
Elimination					
Ask patient if toilet is required	✓				
Patient is Self Caring and can walk to toilet					
Patient is Incontinent and requires to be checked					
Patient has catheter in situ and requires to be checked					
Nutrition / Hydration					
Self Caring	✓	✓			
Patient requires assistance with feeding					
Patient is allowed fluids only					
Patient is NBM					
Patient has IVI in Situ					
Refreshments (Provided / Refused : Please indicate P / R)					
Drink	✓	(P) / R	P / R	P / R	P / R
Snack		P / R	P / R	P / R	P / R
Catered Meal		P / R	P / R	P / R	P / R
Visual Skin Inspection					
Patient is healthy / no concerns	TBA	TBA			
Visible areas of redness					
Broken skin and evidence of Pressure Ulcers					
Invasive devices (please tick if in situ)					
PVC /Arterial Line / Central Line / PVC					
Urinary Catheter / Chest Drain					
Infusion Device					
NG tube / PEG tube / Tracheostomy					
Other					
Family Communication (Please tick)					
Patient & Relatives present & made aware of any changes	✓	✓			
Cubicle Tidy (Please tick)					
Ensure area is tidy and free of obstruction	✓	✓			

Receiving Ward		ED Escort	
Nurse Name		Nurse Name	
Nurse Signature		Nurse Signature	
Date		Date	

LOT 133

Care Provider must be informed of any clinical changes highlighted from Patient Screening

Time of Round	1300/A	2050			
Clinical Area of ED	D	C			
Initials of Care Round Leader	SY	epube			
Review frequency of Vital Signs & Cardiac Monitoring					
Vital signs frequency	1	2°			
Cardiac monitoring required	Y / N (N circled)	Y / N (N circled)	Y / N	Y / N	Y / N
Pain Management (Refer to CP for analgesia if required)					
Please note pain score (0-10 Score)		0			
Mobility					
Fully weight bearing	✓	✓			
Requires some assistance and / or uses walking aid					
Non Weight bearing and requires full assistance					
Elimination					
Ask patient if toilet is required	✓	✓			
Patient is Self Caring and can walk to toilet					
Patient is Incontinent and requires to be checked					
Patient has catheter in situ and requires to be checked					
Nutrition / Hydration					
Self Caring	✓	✓			
Patient requires assistance with feeding					
Patient is allowed fluids only					
Patient is NBM					
Patient has IVI in Situ					
Refreshments (Provided / Refused : Please indicate P / R)					
Drink	✓	P / R (P circled)	P / R	P / R	P / R
Snack		P / R	P / R	P / R	P / R
Catered Meal		P / R	P / R	P / R	P / R
Visual Skin Inspection					
Patient is healthy / no concerns	TBA	TBA			
Visible areas of redness					
Broken skin and evidence of Pressure Ulcers					
Invasive devices (please tick if in situ)					
PVC /Arterial Line / Central Line / PVC	/	|			
Urinary Catheter / Chest Drain	/	|			
Infusion Device	/	|			
NG tube / PEG tube / Tracheostomy	/	|			
Other	/	|			
Family Communication (Please tick)					
Patient & Relatives present & made aware of any changes	✓	✓			
Cubicle Tidy (Please tick)					
Ensure area is tidy and free of obstruction	✓	✓			

Receiving Ward		ED Escort	
Nurse Name		Nurse Name	
Nurse Signature		Nurse Signature	
Date		Date	

NHS Lothian
University Hospital Services
Department of Emergency Medicine

Dr. Dave McKean EO Clinical Director
Ray Middlemiss EO Clinical Nurse Manager
The Royal Infirmary of Edinburgh
51 Little France Crescent, Edinburgh, EH16 4SA
Tel: 0131 242 1300 Fax: 0131 242 1344

A/E no.	E5171135
Previous no.	E4819058
UHPI no.	620045326K
CHI no.	2205671464

Patient Information

Surname: Cross
Forenames: Angella
Date of Birth: 22/05/1967
Age: 55 Yrs
Sex: F
Address: 44 Woodburn Bank
Dalkeith, Midlothian
Postcode: EH22 2EY
Telephone: 283 8775
Contact Address: [redacted]
Edinburgh EH16 5RW
Complaint: PC-3 MONTH HX OF COUGH A ND BREATHLESSNESS, TEMPA TH
Allergies:
Attendances in last 12 months: 0 School :

General Practitioner

Address: VE Aspinall
Newbattle Medical Practice
Blackcot
Mayfield
Midlothian
EH22 4AA
Telephone: 0131 663 1051

Date and Time of Attendance: 18/10/2022 12:24
Incident Date Time: 18/10/2022 11:20
Mode of Arrival: Private Transport
Source of Referral: Flow Centre

Initial Triage Assessment

Presenting Complaint	
History of Presenting Complaint	
Assessment	

Nursing Observations & Assessments

TEMP	°C	SCORE	MIN. FREQ	(please tick)	Blood Sugar	mmols	Pain Score		/ 10	
HR		NEWS 0-1	Hourly		Peak Flow 1)		Analgesia Given	YES ☐	NO ☐	
	/	NEWS 2-4	30mins Min		Peak Flow 2)		Fast Assessment	POS ☐	NEG ☐	
O2%	%	NEWS 5-7	15mins Min		Peak Flow 3)		Onset Time:			
RR		NEWS >7	10mins Min		Alcometer		Weight		Height	
PU		Special Clinical Instructions								
O2 Therapy in Progress	Yes (= +2) No (= 0)	Please indicate any specific clinical observations to be continued or repeated once patient has left OPP								
NEWS SCORE										

Triaged By: Print Name: Signature: Triage Time:

Opp Care & Discharge Record

PVC Insertion - Please initial when complete

Handwash		Gloves	
CHD Skin Prep		Aseptic Insertion	
Dressing Labelled		Paperlite Bundle	
Reason for PVC Insertion:			

Blood Samples - Please tick all that apply

Routine		CRP	
Troponin		Coag	
Amylase		Tox Screen	
BTS		Other (Please state)	

Additional Investigations

ECG - Please tick: Required ☐ Done ☐
Urinalysis - Please tick: Required ☐ Done ☐

MSU Sent	Yes ☐	No ☐
HCG Consent	Yes ☐	No ☐
HCG Result	Yes ☐	No ☐

X-Rays - Please tick

CRX	Yes ☐	No ☐
CT Scan	Yes ☐	No ☐
Other (Please state)		

On Going Care Plan

Speciality Informed (enter time)		Bed Required		Triaged To - Please tick			
Surg:	G.I:	Yes ☐	No ☐	Waiting Room		GP Out of Hours	
Vasc:	Stroke:	Transfer To: (Please tick if required)		Resus		Gynae Triage	
Medics:	Gynae:	WGH		HO		SMMP	
Ortho:	Neuro:	SJH		IC		MIU	
Other (state Specialty)		Other (please state)		Exam		Other (Please state)	

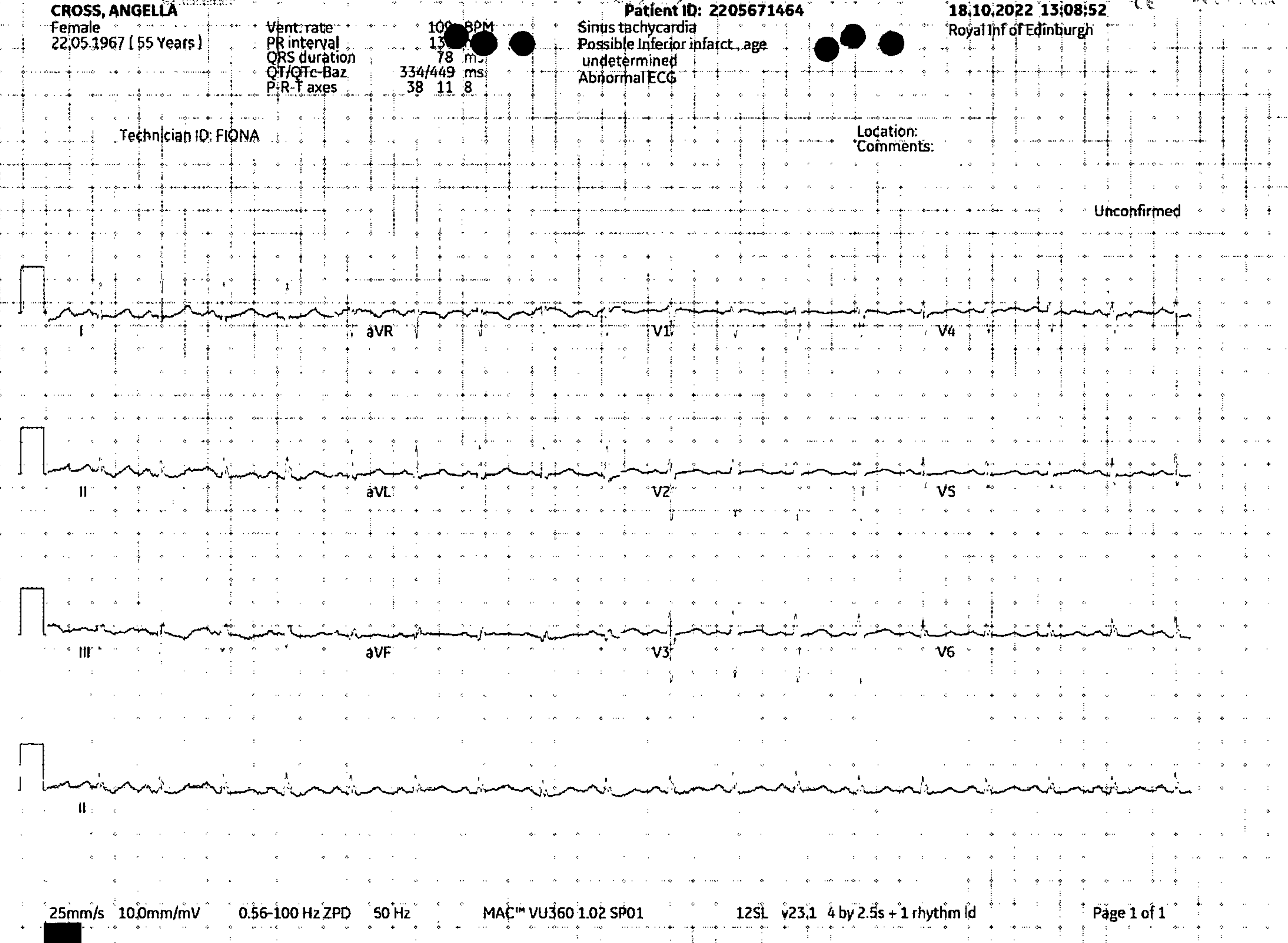
"What Happens To The Patient?"

Clinical Notes

Think:- Other Sources of Information:

Family ☐ Carers ☐ SAS ☐ PRF ☐ EPR ☐ ECS ☐ KIS ☐ GP ☐ Patient Alerts ☐

Care Providers Name: ______________________ Signature: ______________________


CROSS, ANGELLA
Female
22.05.1967 (55 Years)
Vent. rate 109 BPM
PR interval 13
QRS duration 78 ms
QT/QTc-Baz 334/449 ms
P-R-T axes 38 11 8
Patient ID: 2205671464
Sinus tachycardia
Possible Inferior infarct, age undetermined
Abnormal ECG
18.10.2022 13:08:52
Royal Inf of Edinburgh
Technician ID: FIONA
Location:
Comments:
Unconfirmed
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
II
25mm/s 10.0mm/mV 0.56-100 Hz ZPD 50 Hz MAC™ VU360 1.02 SP01 12SL v23.1 4 by 2.5s + 1 rhythm ld
Page 1 of 1

Patient Name	CHI	Date of Birth	Age	GP	GP Practice	GP Practice Code
CROSS ANGELLA	2205671464	22/05/1967	55	Keane, Sonia	Newbattle Medical Practice	77106

Allergies

Description	Date Recorded	Comments
	No ECS data exists	
NKDA		

Sources: [1] ECS ☐ Patient's Drugs ☐ Referrer Kardex ☐ GP Practice ☐ TRAK
☐ Patient ☐ Relative / Carer ☐ Referrer Letter ☐ Comm Pharmacy ☐ Other - Specify ....

Actions: C: Continue W: Withhold S: Stop

Acute Medication (including those greater than 30 days)

Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Source 1°	2°	3°	Action C	W	S	Comments
Amoxicillin 500mg capsules	15 capsule	ONE CAP THREE TIMES A DAY		02/08/2022	02/08/2022	1						
Menthol 1% in Aqueous cream	500 gram	USE AS REQUIRED		09/06/2022	09/06/2022	1						
Indapamide 2.5mg tablets	28 tablet	1 TABLET ONCE A DAY.		09/06/2022	09/06/2022	1						

Repeat Medication

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Source 1°	2°	3°	Action C	W	S	Comments
GP practice	Propranolol 80mg tablets	112 tablet	TAKE ONE TWICE DAILY		24/08/2022	24/08/2022		1	2		✓			PRN
GP practice	Mirtazapine 30mg tablets	28 tablet	1 TABLET ONCE A DAY AT NIGHT		08/10/2021	12/10/2022		1	2		✓			
GP practice	Ramipril 10mg capsules	56 capsule	1 CAPSULE ONCE A DAY		24/08/2022	12/10/2022		1	2				✓	Changed to amlodi-pine.

Patient Name	CHI	Date of Birth	Age	GP	GP Practice	GP Practice Code
CROSS ANGELLA	2205671464	22/05/1967	55	Keane, Sonia	Newbattle Medical Practice	77106

Compliance Device	Name and telephone number for community pharmacy

Completed by	Designation	Grade	Date	Time	Contact Number
E.Duthie E.DUTHIE		FY1	19/10/22	05:00	
Reviewed by	**Designation**	**Grade**	**Date**	**Time**	**Contact Number**

Key Information Summary
No KIS data recorded

Royal Infirmary of Edinburgh
Acute and General Medicine

VTE RISK ASSESSMENT

To be completed within 24 hours of admission

Date: 19/10/22 **Ward:** AMU

Affix label here

Name: Angela Cross

CHI: 2205671464

Part 1: Consider-**Contraindications** to VTE prophylaxis + **Bleeding Risk** (*Tick*)

Platelets <50		Known/suspected bleeding		Awaiting lumbar puncture	
Uncontrolled severe hypertension		CNS surgery within 1 month-discuss with neurosurgery		On apixaban (or similar), warfarin or therapeutic heparin	
Advanced liver disease		Acute stroke/intracranial bleed		On ACS treatment	
Coagulopathy		Cerebral metastases		History of HIT	

ACTION: YES TO ANY OF THE ABOVE, DO NOT PRESCRIBE DALTEPARIN

Other contraindication or other reasons (*e.g. needle phobia, refusal*)..

☐ Dalteparin **NOT** Prescribed-Contraindication as above. *Consider TED Stockings (*tick if relevant*)

Assessed by (name/grade) .... Signature..................................

ASSESSMENT COMPLETED FOR PATIENTS WITH CONTRAINDICATION. FOR REVIEW AFTER 24 HOURS

Part 2: If **NO contraindication**-Consider **Risk Factors** for VTE (*Tick*)

Age >60		Obesity	✓	Immobility		Systemic infection	
Active Cancer		Chronic inflammatory states (e.g. heart failure, inflammatory bowel disease, HIV)		Hormone therapy/ pregnancy		Previous/family history of VTE	
Thrombophilia		Varicose veins		Fracture		Recent surgery/ hospitalisation	

If YES to any of above ↓

If NO ☐ Go to 'ACTION' below

Part 3: Check **Weight and eGFR** (*Tick correct dose and tick the relevant action below*)

eGFR	Weight	Prescribe the correct dose on the kardex	
>10	< 50kg	Dalteparin 2500 units S/C once daily	
>10	50-100 kg	Dalteparin 5000 units S/C once daily	✓
>10	101-150 kg	Dalteparin 5000 units S/C twice daily*	
>30**	>150 kg	Dalteparin 7500 units S/C twice daily*	
≤10 or on renal replacement	Any	Consider mechanical measures. If high thrombotic risk consider Dalteparin 2500 units once daily*. *Monitor anti-Xa levels after 10 days as per LUHD guidelines*	

For eGFR 11-30: Monitor anti-Xa levels after 10 days as per LUHD guidelines.
**Off-license dose; **For extreme weight and eGFR<30ml/min: please consult Haematology for advice*

ACTION: ☑ **FOR DALTEPARIN. PRESCRIBE THE CORRECT DOSE ON THE KARDEX**

☐ Dalteparin **NOT** prescribed-NO significant VTE risk factors. *Consider TED stockings.

Assessed by (name/grade) E. DUTHIE FY1 Signature E. Duth

Part 4: Reassessment after 24 hours (*Tick+explain any changes*)

Continue ☐ Discontinue ☐ Modify/Other changes..................................

Name/grade: .... Signature: ....

***CONTRAINDICATIONS TO TEDS**
- Massive leg oedema
- Pulmonary oedema
- Severe peripheral arterial disease
- Major leg deformity
- Peripheral neuropathy
- Active dermatitis.

Review date: February 2020

Please file with the prescription chart

NHS LOTHIAN

Emergency Department

Adult Majors

Prescription, Administration & Observation Record

620045326K /E5171135 F
CROSS Angella
22-May-67 CHI: 220 567 1464
77106 VE Aspinall
44 Woodburn Bank Midlothian
EH22 2EY

Name
DOB
CHI

The section below must be completed before any medicine is prescribed/given

Previous Adverse Reactions	Weight	Date
NKDA	kgs Actual / Estimate	18/10/22

Once Only Prescription

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber Sign & Print	Time Given	Issued by (Initials)	Checked by if applicable (Initials)
18/10/22	21:23	AMLODIPINE	5mg	oral	[signature]	2135	CP	

Discharge Medication

Date & Time	Medicine (Approved Name)	Dose	Frequency	Route	Quantity	Duration	Prescriber Sign & Print	Issued by (Initials)	Checked by (Initials)

National Early Warning Score 2 (NEWS2) Chart

NEWS Key: 0 1 2 3

Parameter	Range	1	2	3	4	5	Score
	Date:	18/10		18	18/10		
	Time:	1250	1400	18	20 30		
A+B Respirations Breaths/min	≥25						3
	21-24						2
	18-20	20	19		20		
	15-17			16			
	12-14						
	9-11						1
	≤8						3
A+B SpO₂ Scale 1 Oxygen saturation (%) Use Scale 1 if target range is 94-98%	≥96	97		96			
	94-95		94		95		1
	92-93						2
	≤91						3
SpO₂ Scale 2* Oxygen saturation (%) Use Scale 2 if target range is 88-92% eg. in hypercapnic respiratory failure	≥97 on O_2						3
	95-96 on O_2						2
	93-94 on O_2				[illegible]	[illegible]	1
	≥93 on air						
* ONLY use Scale 2 under the direction of a qualified clinician	88-92						
	86-87				[illegible]	[illegible]	1
Tick box if using SpO₂ Scale 2	84-85						2
Sign:	≤83						3
Air or Oxygen?	A = Air	A	A	A	A		
Oxygen is a drug and prescribed by target range	O² L/min or %						2
	Device						
C Blood Pressure mmHg Score uses Systolic BP only	≥220						3
	201-219						
	181-200		185	189		180	
	161-180	176			152		
	141-160						
	121-140						
If manual BP mark as M	111-120		112				
	101-110					130	1
	91-100						2
	81-90	122			91		
	71-80			79			
	61-70						3
	51-60						
	≤50						
C Pulse Beats/min	≥131						3
	121-130						2
	111-120	116	112				
	101-110			106	106		1
Manual pulse	91-100						
	81-90						
	71-80						
	61-70						
	51-60						
	41-50						1
	31-40						3
	≤30						
D Consciousness Score for new onset of confusion (no score if chronic)	Alert	A	A	A	A		
	New Confusion						3
	V						
	P						
	U						
E Temperature °C	≥39.1°						2
	38.1-39.0°						1
	37.1-38.0°		37.3		37.2		
	36.1-37.0°	36.6		37.0			
	35.1-36.0°						1
	≤35.0°						3
NEWS TOTAL		2	3	1	2		
	Monitoring frequency	[illegible]	10	4	2°		
	Escalation of care Y/N	Y	Y	Y	Y		
	Blood Glucose reading or N/A		N	–	N		
	Pain score (0-10)	0	0/10		0		
	Initials	[illegible]	[illegible]	[illegible]	ED		

Reproduced from: Royal College of Physicians. *National Early Warning Score (NEWS) 2: Standardising the assessment of acute-illness severity in the NHS.* Updated report of a working party. London: RCP, 2017.

NEWS of 5 or more? Think Sepsis!

In a patient with a **NEWS** of **5 or more** and a known infection, signs and symptoms of infection, or at risk of infection, think **'Could this be sepsis?'** and **escalate care immediately.**

Signs of Infection

- Temperature <36°c or >38°c
- Heart rate >90 beats pm
- Respiratory rate >20 breaths pm
- New confusion
- WCC <4 or >12
- Blood sugar >7.7 in non-diabetic

Addressograph
620045326K /E5171135 F
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NEWS Total	Monitoring Frequency	Clinical Response
Total 0	Commence on 2 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
Total 1 - 4	Commence on 1 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
3 in one parameter *	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to Nurse In Charge (NIC) and Senior Medic
Total 5 - 6	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Total 7 or more	Commence on 15 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Special Instructions		

*or increase in NEWS score of 2

Conscious Level Chart to be completed when clinically indicated

			Score	Entries	Notes
		Date			
		Time			
GLASGOW COMA SCALE	Eyes Open	Spontaneously	4		Eyes closed by swelling = C
		To speech	3		
		To pain	2		
		None	1		
	Best Verbal Response	Orientated	5		Endotracheal tube or tracheostomy = T
		Confused	4		
		Inappropriate words	3		
		Incomprehensible sounds	2		
		None	1		
	Best Motor Response	Obey commands	6		Always record the best arm response
		Localise to pain	5		
		Flexion to pain	4		
		Abnormal flexion	3		
		Extension to pain	2		
		None	1		
		Total GCS Score			
Right Pupil		Size			+ reacts - no reaction c. eye closed
		Reaction			
Left Pupil		Size			
		Reaction			
LIMB MOVEMENT	ARMS	Normal power			Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness			
		Severe weakness			
		Extension			
		No response			
	LEGS	Normal power			
		Mild weakness			
		Severe weakness			
		Extension			
		No response			
		Initials			

Pupil Scale mm 1 • 2 ● 3 ● 4 ● 5 ● 6 ● 7 ● 8 ●

IV Fluid Prescription

Time Prescribed	Fluid	Volume	Rate	Prescribers Signature	Time Started	Given by (Initials)	Checked by (Initials)	Time Finished

Fluid Balance

INPUT						OUTPUT				
	IV Fluids or SC Fluids IV Medication	IV Line(s)	Oral Input		Input		Urine		Gastric	
Time	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100ml	Running Total	Time	Volume	Running Total	Volume	Running Total

Drug Infusion

Drug Name:

	Time													
	Rate (ml/hr)													
	Volume in Syringe													
Pump No	Total amount Infused													

Drug Name:

	Time													
	Rate (ml/hr)													
	Volume in Syringe													
Pump No	Total amount Infused													