Legal Aspects Team
Health Records Department
Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN

NHS
Greater Glasgow and Clyde

MMA Legal
23 Goodlass Road
Building B
L24 9HJ

Date: 25th June 2026
Your Ref: 100046
Our Ref: LAT/ACCESS/ES
Enquiries to: Emily Svensson
Direct Line: 0141 211 3020
Email: Emily.svensson@nhs.scot

Re: Subject Access Request under the General Data Protection Regulation

PATIENT: ANDREW SHAW **D.O.B: 21/04/1967**

Thank you for your request received **3RD JUNE 2026** in which you seek a copy of your client's personal information.

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

QUEEN ELIZABETH UNIVERSITY HOSPITAL/ NEW VICTORIA HOSPITAL/ GARTNAVEL GENERAL HOSPITAL

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

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

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

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

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

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

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

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

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

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

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

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

Yours sincerely

Legal Aspects Team

ELECTRONIC PATIENT RECORDS

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

Including:

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

Acute Services Division

(1)

NHS Greater Glasgow and Clyde

Surgical Physiotherapy Assessment

Preferred Name:	Consultant:
Nam 2104673933	CHI:
Unit SHAW M Andrew, M 21/04/1967	Ward/Transfers: HDU 6
D.C 30 DOUGLAS DRIVE EAST KILBRIDE Glasgow, Lanarkshire	
Add G75 8JS	Physiotherapist: Lauren O'Hara
	Admission Date:
Postcode:	Referral Date: 12/8/20
Phone No.:	Date 1st Contact: 12/8/20

Diagnosis

Left distal fibular # - Advised by ortho reg that pt. can WB if wearing ankle boot.

HPC

Found behind the wheel of a car by police, not pt's car. Crashed into a lamp post, found to be intoxicated. Blood alcohol -ve but +ve of several drugs. In police custody. c/o generalised pain but cannot localise.

PMH	SH
Nil of note.	Unable to gain SH.
	Smoking Hx
	DH See Kardex.

Andrew Shaw (2) 2104673933

Investigations/relevant information (e.g. CT, MRI, U/S, ECG, Microbiology etc.)

Date Active	Problem List	Add Information	Date Resolved
	1 Unable to comply/participate		
	2 Reduced lung volume		
	3 Sputum retention		
	4 Increased WOB		
	5 Ineffective/inability to cough		
	6 Pain		
	7 Bronchospasm		
12/8/20	8 Reduced mobility		
	9 Decreased Ex tolerance		
	10 Intubated		
	11 Ventilated		
	12 Sedated		
	13 Paralysed		
	14		
	15		
	16		
	17		
	18		

Treatment goals

Be (I) mobile with walking aid

Signature

, LAUREN O'HARA, BS PT

South Glasgow Hospitals

NHS Greater Glasgow and Clyde

Physiotherapy Treatment Records

Name Andrew Shaw Unit Number 2104673933

Date of Referral

Diagnosis:-

Additional Information:-

Date	Details	Signature
13/8/20	(S) Patient no longer under ortho and now under medical. NIS keen for pt. to get UTS to toy and wsken pt. as still extremely drowsy. Seen at ~10am c PT J. Rainey and J. Ingham.	
	(O) Pt. lying in bed on arrival. SIV on 2L O_2 via NIC. Obs ✓	
	- (L) LL PROM: - Ankle = Able to achieve plantar grade, c/o pain.	
	Knee = FROM, c/o pain	
	Hip = Able to bring to midline, c/o pain.	
	- T/F lie → sit, A o3	
	- Sitting balance, (I). // Fitted pt. c walker boot	
	- T/F sit → stand, steady + A o2	
	- Standing balance, steady + A o2 // Flexed (L) knee, able to correct c UP but unable to maintain. Avoiding WB (L) LL due to pain.	
	- T/F stand → sit, steady + A o2	
	Rx - STS x4 -BES ~10 mins	
	- T/F UTS on supportive recliner chair c steady.	
	(A) Patient engaging much better on EOB and c STS. LL pain improved and able to tolerate walking boot. Hoist sling left under pt. in chair to allow NIS to hoist pt. back to bed.	
	(P) r/v '/7. Cont STS px c steady and px WB through (L) LL. UTS daily.	LAUREN O'HARA (BSP)
/ /	/ / /

Date	Andrew Shaw Details 2104673933	Signature
14/8/20	(S) Consent given by pt. Seen at ~ Nam c PT J. Ingham and A. Teiger. Pt had 2 episodes of bradycardia yday but wasn't caught on ECG, being closely monitored. Pts GCS has improved slightly from 13 to 14 as able to report in hospital but otherwise not orientated to time/place. Addictions co-ordinator have been advised to cont. c co-codamol only.	
	(O) Pt lying in bed on arrival. SIV on 2L O_2 via NIC. Obs ✓ - T/F lie → sit. A_o2. // Pt. initiating movement well - Sitting balance, (I) - T/F sit → stand, steady + A_o2. Rx - STS x3 - lateral weight transference px in standing - UTS in bedside chair.	
	(A) Pt managing to WB slightly more onto (L) LL but cont. to be limited due to pain ++. Pt. cont. to use hoist c N/S over W/E.	
	(P) - r/v Mon. 17/8/20. ? T/F c pulpit + A_o2	Lauren O'Hara (BSP) LAUREN O'HARA

SHAW, Andrew M (Mr)
BORN 21-Apr-1967 (59y) GENDER Male
CHI 2104673933

Information Record; Occupational Therapy and Physiotherapy

Last updated by Lauren MCALLISTER (Lauren OHara) 6 years ago (v. 1) Show History

Sensitivity

Content Restricted	No	Sensitivity	Sensitive
If the information on this form merits further restriction than that of Highly Sensitive, please select **Yes** to apply a Privacy Seal		The information on this form **will** be viewable by health and care providers with the appropriate access permissions	

Admission Information

Hospital	Queen Elizabeth University Hospital
Ward	Critical Care Surgical HDU2
Specialty	Trauma And Orthopaedic Surgery
Consultant	Dr Allan
Assessment completed by	Physiotherapist

Personal Details

Consents to assessment	Yes	Details	—
Does the patient have an appointed welfare guardian or power of attorney	No		

Medical History

Relevant past medical history	Nil of note	Reason for referral / management instructions	Left distal fibular #- Advised by ortho reg patient can weight bear if wearing ankle boot.
Present complaint / history of present complaint	Found behind the wheel of a car by police, not patient's car. Crashed into lamp post , found to be intoxicated. Blood alcohol -ve but +ve of several drugs. In police custody. C/o generalised pain but cannot localise. X-ray showed left distal fibular #.	Risks / precautions / contraindications / allergies / red flags	—
Current / pending investigations	No		
Relevant drug history on admission	As per drug prescription chart (Kardex)		
Smoker	—		

Personal and Social Circumstances

Personal and social circumstances

SHAW, Andrew M (Mr)
BORN 21-Apr-1967 (59y) GENDER Male
CHI 2104673933

Accommodation

Accommodation —

Home Information

Home information —

Previous Level of Mobility

Previous mobility —

Previous Transfers

Previous transfers —

Falls

Falls —

Sensory Function

Sensory function —

Self Care

Self care —

Domestic Life

Domestic life —

Social Support

Social support —

Lifestyle and Leisure

Lifestyle and leisure —

Physical Activity

Physical activity —

Employment

Employment —

Finance

Finance —

Form completed by a student No

SHAW, Andrew M (Mr)
BORN 21-Apr-1967 (59y) GENDER Male
CHI 2104673933

Glasgow City HSCP
Health and Social Care Partnership

Interim Chief Officer
Susanne Millar
MA (Hons) CQSW

Adult Mental Health Liaison Service
Queen Elizabeth University Hospital
Central Medical Block (Clock Tower)
Ground Floor
1345 Govan Road
Glasgow
G51 4TF

0141 201-2422

www.glasgow.gov.uk
www.nhsggc.org.uk

Private and Confidential

Date Dictated 18th November 2020
Date Typed 24th November 2020

Our Ref PS/PL

Dr. F. Wylie
Mavor Medical Practice
Hunter Health Centre
Andrew Street
East Kilbride
G74 1AD

Dear Dr. Wylie

Andrew Shaw - DOB 21.04.67 - CHI 2104673933
30 Douglas Drive, East Kilbride, G74 8JS

Diagnosis:
F60.02 - dissocial personality disorder
F10.1 - mental and behavioural disorder due to use of alcohol
F14.1 - mental and behavioural disorder due to use of cocaine
F13.0 - mental and behavioural disorder due to use of sedatives or hypnotics

Legal Status: Informal

I assessed Mr. Shaw on Thursday 18th November 2020 in my capacity as an ST5 in the Adult Mental Health Liaison Service at the Queen Elizabeth University Hospital.

He had been involved in a road traffic accident on 13th November 2020 and the police had chased him. He required a significant amount of sedation as he was very aggressive on arrival to the Accident and Emergency Department. It was found that he was intoxicated with alcohol, benzodiazepines and cocaine. He had a full trauma CT carried out and there were no significant injuries noted.

He was started on GMAWS due to his history of alcohol dependence and according to the ward he had been increasingly more agitated and aggressive stating that he sometimes has thoughts about harming other people. In particular he described having thoughts about harming the staff members however he would

not go into any detail about what he planned to do. He also reported that he heard people talking to him however was unable to elaborate much on this.

When I assessed him he did not offer me any more information. Essentially he reported that he had "betrayed God" and that he had "killed Jesus". He kept repeating these statements however he would not elaborate on them when I asked him some more detailed questions. He was however able to answer questions pertaining to his current physical health and he was able to answer them fairly consistently and without hesitation. He asked me who I was and what I was after I had already explained this to him initially at the beginning of the interview.

On mental state examination he was overweight and dressed in a hospital gown, he was malodorous. His engagement was very poor and he picked and chose what questions to answer. His eye contact was quite intermittent. He appeared a bit agitated at times by flicking his fingers and moving his tongue but this felt a little bit exaggerated. He looked a little bit at the ceiling occasionally however there was no evidence of him actually responding to any external stimuli. His speech was spontaneous but not plentiful. He would not elaborate on anything pertaining to God, Jesus or about that he had let people down. In terms of his mood it was difficult to assess. He did not answer how he felt objectively, his mood was euthymic and reactive. There was no evidence of any thought disorder, there were some hints about religious ideas and potentially of a grandiose nature however he did not really elaborate as outlined on this at all. He reported that he was hearing God however again would not discuss this in any detail though there was no evidence of him responding to external stimuli whilst I was in the room. He would not answer what country we were in or what year it was. In terms of where he thought he was he did tell me that he thought he was in a holding cell. In terms of his insight I did not think he presented as someone who was typically delirious or psychotic and I suspect that he does have insight into the fact he has been charged and perhaps is trying to avoid a custodial sentence.

My impression overall was that this was not a typical presentation of someone who was either delirious or who had a primary psychotic illness. Therefore, the plan will be to discharge him as soon as he is medically fit to leave the ward and he will be discharged back into police custody whereby an assessment of his mental state can be monitored.

Mr. Shaw has therefore been discharged from the Adult Mental Health Liaison Service at this time.

Yours sincerely

Dr. P. Swift
ST5 to Dr. Maria Oto
Adult Mental Health Liaison Service

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NHS Greater Glasgow and Clyde

Glasgow City Council

Glasgow City HSCP
Health and Social Care Partnership

Interim Chief Officer
Susanne Millar
MA (Hons) CQSW

Adult Mental Health Liaison Service
Queen Elizabeth University Hospital
Central Medical Block (Clock Tower)
Ground Floor
1345 Govan Road
Glasgow
G51 4TF

0141 211 6393

www.glasgow.gov.uk
www.nhsggc.org.uk

Private and Confidential

Dr Wyllie
Mavor Medical Practice
Andrew Street
East Kilbride
G74 1AD

Date 24th August 2020
Date Typed 25th August 2020

Our Ref AJB/SS

Dear Dr Wyllie

Re: Andrew Shaw, DOB 21.04.67 – CHI 2104673933
30 Douglas Drive, East Kilbride G75 8JS

Mr Shaw was referred to our service on 14/08/20 and seen by a number of professionals within our service over the period of his stay. I first met Mr Shaw on Friday 21/08/20. He had been admitted to the QEUH following a road traffic accident occurring whilst he was intoxicated most likely with cocaine and amphetamines. From a general medical and surgical point of view his stay was relatively uneventful. He developed an abnormal mental state in line with confusion and was thought to be in substance withdrawal and/or pathological intoxication. He was reviewed by our colleagues in addiction services and commenced on a fixed dose reducing regimen of diazepam. When I attended Mr Shaw on 21/08/20 his mental state was highly abnormal. There was very little contact with me and he made little speech. He appeared to be both distressed and perplexed, possibly hallucinated. I was not able to ascertain orientation. I returned to the ward today. He was somewhat improved although still showing a very abnormal mental state. He was able to describe hearing "voices" although the content and duration of these was difficult to ascertain. He also made reference to what appeared to be religiose thinking.

I discussed Mr Shaw's situation with the attending police officers as he was still in police custody and the ward staff had indicated that he was now considered fit for discharge from their point of view. It appeared that the best course of action was to release Mr Shaw into police custody as he required further questioning and would be appearing in court tomorrow. I had a telephone discussion with Mr McNellis, Forensic CPN, who was covering the courts for mental health tomorrow to give him a handover about Mr Shaw's

current presentation and likely difficulties. I haven't arranged any further follow-up from our team.

Yours sincerely

Dr Adam J Burnel
Consultant in Liaison Psychiatry

Glasgow City HSCP
Health and Social Care Partnership

Interim Chief Officer
Susanne Millar
MA (Hons) CQSW

Adult Mental Health Liaison Service
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1345 Govan Road
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Private and Confidential

Date Dictated 18th August 2020
Date Typed 19th August 2020

Our Ref EL/PL

Dr. F. Wylie
Mavor Medical Practice
Hunter Health Centre
Andrew Street
East Kilbride
Glasgow
G74 1AD

Dear Dr. Wylie

Andrew Shaw - DOB 21.04.67 - CHI 2104673933
30 Douglas Drive, East Kilbride, Glasgow G75 8JS

Mr. Shaw is a 53-year old man who was admitted on 10th August 2020 following an RTA. He was brought to hospital by the police and will be discharged into police custody, charged with driving under the influence of illicit substances (cocaine). Urine drug screen is +ve for Cocaine, Amphetamines, Methamphetamines and Opioids. He has been reviewed by the Addictions Liaison Team with further review planned. He continues on treatment for opiate and benzodiazepine withdrawal..

He has a historical diagnosis of schizophrenia from 2011/2012. He was previously seen by Forensic Psychiatry and was on Risperdal consta depot in 2012/2013 however has not been on antipsychotic medication for many years. It is documented in clinic letters from 2012/2013 that psychotic symptoms were not convincing therefore the diagnosis is possibly disputed. There has been no documented contact with Mental Health Services since 2013.

There is no significant medical history known.

He receives DLA and denies financial stressors. He lives in a council flat and reports living with six other men. He has no known forensic history. His only family is a brother who lives in Ireland and he has no contact with. His mum passed away many years ago.

The staff nurse looking after him states he has seemed "vague" and disorientated since arriving on Ward 10C on 15th August. However there has been no agitation noted. He is compliant with his treatment plan and is eating, drinking and sleeping okay.

I reviewed him at his bedside. Police officers were sitting outside his room. On mental state examination, Andrew appears obese, unkempt, scratching himself frequently, breathing through pursed lips, tearful at times without clear precipitant. His pupils were equal and of normal diameter. He appeared distracted, agitated and with no eye contact. His speech was mumbled, incoherent at times and fairly monosyllabic. His mood is objectively anxious with labile affect, and subjectively he reports low mood. There is no formal thought disorder. He denies any thoughts of suicide or self-harm and denies any homicidal thoughts. There was no delusional ideation. He was however guarded, hesitant and vague with answers given therefore it was difficult to obtain any detail re thought content. He describes persistent visual hallucination of his deceased mother (died many years ago). He also describes "voices in (his) head" present "for years" with no change over the last 5-years. He was disorientated to time, partially orientated to place (e.g. knows he is in a hospital in Glasgow but does not know the name of hospital), and orientated to person. He attributes voice hearing to a perceived diagnosis of schizophrenia. However he does not recognise the negative impact of daily drug use on his mental state.

He recalls the reason for admission, stating "I crashed a car" and understands he has been charged. He states he uses cocaine daily, however was unable to provide further detail. He denies alcohol or cannabis use. He blames cocaine and other substance misuse on the "bad people" he lives with. He states he lives with six other men and he often feels "scared" because these men are part of a drug ring. However he denies selling drugs.

He reports hearing voices in his head "for years", and states they worsened 5 years ago. He states they "shout and scream" but no further detail was obtained. He has not sought help for this in the past other than psychiatric contact in 2012/2013, with no reason given for disengaging with follow up. He retains insight that these voices are not real.

My impression is a likely delirium in the context of illicit substance withdrawal.

He displays possible psychotic symptoms however these are longstanding and he has full insight into these experiences, therefore they are likely pseudo hallucinatory in nature.

Plan:
No changes to management at present. Ongoing Addictions Liaison review. Mr. Shaw has been discharged from the Adult Mental Health Liaison Service at this time as it was not possible to fully assess him for an underlying mental health condition as he is in acute substance withdrawal. I have handed over to the medical staff in Ward 10C that they should re-refer this patient once he has completed his inpatient detox.

Yours sincerely

Dr. Emma Leighton
Specialty Doctor
Adult Mental Health Liaison Service

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NHS Greater Glasgow and Clyde

Glasgow City Council

Patient name ..

Patient CHI ..

2104673933
SHAW
Andrew, M
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS
M
21/04/1967

NHS
Greater Glasgow and Clyde

Emergency Care Nursing Documentation

Presenting complaint - and relevant past medical history including allergies

Date and Time		Name/Signature
15/11/20. 07[10].	Standby - RTC - through fence and bush	
	embankment. Loc to head. No other injuries reported.	AB/

Nursing notes - on admission

Date and Time		Name/Signature
4/20. 07[10].	On arrival - News : , Bloods TS,	
	Pt on scoop and carried unassisted,	
	Pupils equal on situ. GCS 14/15.	
	Pt giving false names. Police have	
	obtained details.	
0800	Attending CT.	JB
0845	returned from CT. Patient too unsettled	
	in CT despite Midazolam and Ketamine	
	being administered. Pt returned to wards	PTO.

Triage

Patient prepared for exam - clothing bagged				Y	N
NEWS Chart	Y	N	X-rays	Y	N
ID band	Y	N			
Peak Flow	Y	N	Please specify		
12-lead ECG	Y	N	Urinalysis	Y	N
IV access	Y	N			
Blood samples	Y	N	Positive findings		
Blood Gas	Y	N	B-HCG	Y	N

Communication

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

Risk Assessments and Screening Tools

SEPSIS	Y	N	GMAWS	Y	N
FAST	Y	N	Adult Support and Protection	Y	N
Swallow Testing	Y	N	Mental Health Triage Assessment	Y	N
Falls Risk (clinical judgeument)	Y	N	Child Protection Concerns	Y	N

Signature:

Patient name .....

Patient CHI .....

or use sticker

NHS
Greater Glasgow and Clyde

Care Rounds Checklist

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

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

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

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

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

Patient name .....

Patient CHI .....

or use sticker

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

NHS
Greater Glasgow and Clyde

PUDRA

1	Pressure Damage	Does the person have redness and/or existing pressure damage? **IF YES, prescribe a minimum of 2 HOURLY Pressure relieving care** to avoid further damage occurring and complete the pressure ulcer interventional plan.

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2	Mobility	Does the person require assistance to mobilise or change position (inappropriate for age)?
3	Continence	Does the person have continence issues with urine and/or faeces (inappropriate for age)?
4	Nutrition	Does the person appear malnourished and/or unable to eat or drink/ PYMS score>2?
5	Skin	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6	Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY Pressure Relieving Care interventions and complete the pressure ulcer interventional plan.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
/ /	:							____hrly	
/ /	:							____hrly	
/ /	:							____hrly	

Complete prevention of pressure ulcer interventional plan below for all patients with redness/pressure damage and for those at risk.

S Skin Inspection	S Surface	K Keep Moving	I Incontinence/ Moisture	N Nutrition	S Self Management/ Shared Care
Check: • Pressure areas ____ hourly • Skin under medical devices ____ hourly • Specify medical devices used	Specify: 1. Mattress 2. Cushion 3. Detail additional pressure redistributing equipment	1. Reposition ____ hourly in bed / chair 2. Overnight patient/carer has agreed to repositioning ____ hourly 3. Specify any manual handling equipment used	1. Skin Care to be carried out ____ hourly 2. Specify products required for increased moisture/ continence management:	1. Optimise nutrition and hydration 2. Refer to MUST	1. Discuss and agree plan with patient/ family/carer YES / NO 2. Prevent Pressure Ulcers" leaflet given to patient/family/ carer YES / NO

Patient name .....

Patient CHI .....

or use sticker

NHS
Greater Glasgow and Clyde

Nursing notes - discharge plannning

Date and Time		Name/Signature

Outcomes and outstanding issues

Date and Time		Name/Signature

Pause for Discharge or Transfer

GGC Red Bag with Patient (nursing home resident)	Y	N
Relatives / Carer with Patient	Y	N
Name Band	Y	N
Nursing Screening Tools Complete	Y	N
Bed Available	Y	N
SBAR complete	Y	N
NEWS Chart NEWS completed within 1 hour of transfer/discharge	Y	N
Prescriptions and fluid charts signed	Y	N
Cannula	Y	N
Notes Complete	Y	N
Analgesia	Y	N
Belongings	Y	N
Transport	Y	N
Signature:		

Contact with relatives

Signature:

Patient name

Patient CHI

2104673933
SHAW M
Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

NHS
Greater Glasgow and Clyde

Nursing notes - ongoing care

Date and Time		Name/Signature
Cont	for ? further sedation.	
	CO^2 monitoring in place.	
	IV fluids commenced as prescribed.	JBurrells

Patient name .....

Patient CHI .....

or use sticker

NHS
Greater Glasgow and Clyde

4AT assessment - for delirium and cognitive impairment

		Circle Score
(1) ALERTNESS This includes patients who may be markedly drowsy (eg. dificult 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 (alert, but not agitated, through assessment) Mild sleepiness (<10 secs) after waking, then normal Clearly abnormal	0 0 4
(2) AMT4 Age, date of birth, place (name of the hospital/building), current year.	No mistakes 1 mistake 2 or more mistakes/untestable	0 1 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.	wAchieves 7 months or more correctly Starts but scores <7 months / refuses to start Untestable (cannot start, unwell, drowsy, inattentive	0 1 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 24hrs.	No Yes	0 4

4 or more	possible delirium + /- cognitive impairment	**TOTAL**	
1-3	possible cognitive impairment		
0	delirium or severe cognitive impairment unlikey (but delirium still possibe if (4) information incomplete		

Frailty Assessment Tool (Healthcare Improvement Scotland)

Step 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?			circle Y or N	
F	**Functional impairment**	(new or worsening) eg difficulty with self care	**Y**	**N**
R	**Resident**	in a care home	**Y**	**N**
A	**Altered mental state**	such as delirium or dementia **(4AT Assessment)**	**Y**	
I	**Immobility/instability**	decline in mobility, difficulty mobilising without help, fall leading to presentation	**Y**	**N**
L	**Living at home with support**	on a daily basis (homecare, one visit or more per day)	**Y**	**N**

If YES to any of the criteria in Step 1 move to Step 2

Step 2 Would this person be better managed by another speciality team at present?	circle Y or N	
Clear need for other specialty input eg exacerbation of known long-term condition such as COPD	**Y**	**N**
Need for HDU/ITU (including non-invasive ventilation)	**Y**	**N**
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit	**Y**	**N**
Head injury with loss of consciousness	**Y**	**N**
Acute abdominal pain/ surgical presentation	**Y**	**N**
Upper GI Bleed	**Y**	**N**
Chest pain with suspected acute coronary syndrome	**Y**	**N**
Trauma with suspected fracture	**Y**	**N**

Are any of the criteria met?

If YES to any criteria in Step 2: Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.

If YES to any criteria in Step 1 and NO to ALL criteria in STEP 2: Prioritise transfer of care to specialist geriatric assessment service.

My Admission Record

NHS Greater Glasgow and Clyde

Name: _____
2104673933 N: _____
SHAW 21/04/196 _____
Andrew, M _____
30 DOUGLAS DRIVE _____
EAST KILBRIDE _____
Glasgow, Lanarkshire G75 8JS _____
At _____ (over)

Hospital: QEUH Ward: A211
Date of Admission: 15/11/20 Time: 1300
Information obtained from: Name:
Patient ☑ Relative ☐ Other ☐ _____
Preferred Name:
Age: 53 Telephone Number:
Consultant: Dr Blyth

Communication

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

Preferred first contact	**Preferred second contact**
Name: ?	Name:
Relationship:	Relationship:
Address:	Address:
Telephone:	Telephone:
Is this person aware of your admission? Yes ☐ No ☐	Is this person aware of your admission? Yes ☐ No ☐
Can we share information with this person? Yes ☐ No ☐	Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

RTA - police chase H.I Multifactorial

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

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

No known allergies ☑

Relevant past medical history

nil known

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

Power of Attorney / Guardianship / Adult with Incapacit

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21/04/196
G75 8J

Does someone have Power of Attorney (POA) for you?

Yes ☐ No ☐

OR

Does someone have Guardianship?

Yes ☐ No ☐

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

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

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

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

Carbapenemase-producing enterobacteriaceae (CPE)

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

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

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

MRSA Screening

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

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

Nasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

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

If **YES inform the IPCT** ☐

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Lifestyle

Smoking

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

Never smoked ☐

Do you use eCigarettes? Yes ☐ No ☐

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

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

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

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

Drugs

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

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

Alcohol

Do you drink alcohol? Yes ☐ No ☐ Pt denies although a/p found nitrazepam

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

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

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

Name (Please PRINT): S. Duncanson Signature: _____

Designation: (6) Date: 15/11/23

My Assessment Record

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1. Breathing and Circulation

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

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

2. Communication

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

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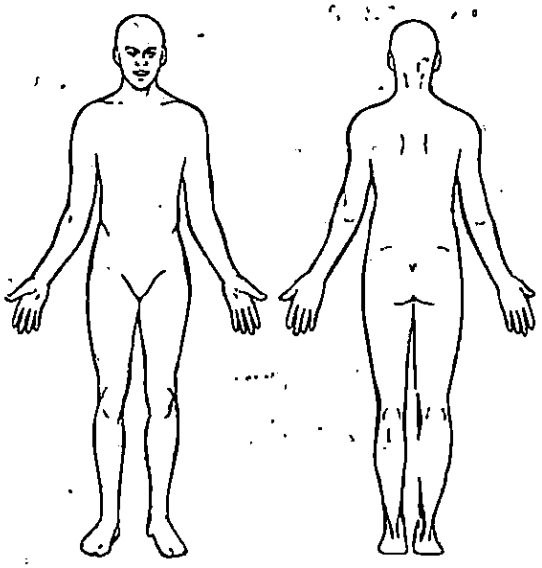
3. Senses

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

Can you describe where and what the pain is like?

Mark current pain on body chart



Have you had treatment / intervention for the pain?

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

Can you describe any chronic pain that you have?

What makes the pain better?

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4. Cognitive Status THINK DELIRIUM

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

N.B. Think Delirium

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

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

and follow the guidance

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

none

What do you like to eat and drink?

most foods

What do you not like to eat and drink?

nothing

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

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

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Assessment of the patient's hydration and nutrition needs

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

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

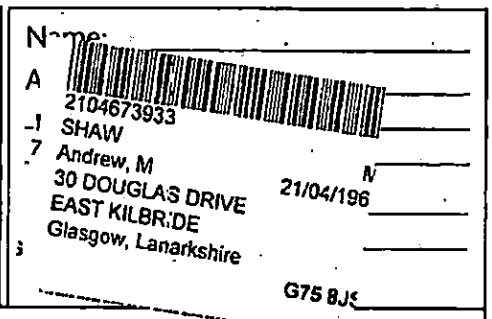
Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?

6. Elimination

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

Assessment of the patient's elimination needs

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



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

What products do you normally use for this continence issue?

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

Date urinary catheter last changed ___/___/___

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

Bowels

When did your bowels last move? ?

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

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

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

What products do you normally use for this continence issue?

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

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

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

Personal Hygiene	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's personal hygiene needs
Independent		✓	
Requires assistance with washing and dressing	✓		A01-2 01a due to sedation

Oral Health	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's oral health needs
No problems	✓		
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			

Dental work	**Yes** ✓	**No** ✓	Description of any cental work
Do you wear dentures?		✓	
Do you have your dentures with you?			
Are your dentures a good fit?			
Do you have any other dental work that we need to be aware of?			

Skin Care	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's skin care needs
No problems	✓	✓	
Skin broken			
Skin oedematous			
Skin discoloured / red			

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

Pressure ulcer identified on admission: Yes ☐ No ☒

Pressure Ulcer Grade: _____

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

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

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

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8. Mobility

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

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

9. Maintaining a Safe Environment

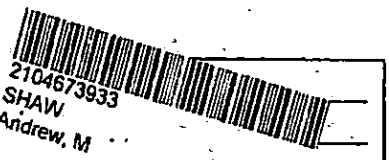
N.B. Complete a falls risk assessment for all patients within 24 hours of admission. If a falls risk is identified complete the falls intervention checklist and document all nursing actions in the care plan.

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

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

10. Sleep and Rest

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



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11. Social Circumstances

Do you:

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

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

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

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

12. Emotional and Spiritual Care

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

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

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

Healthcare Chaplain informed Yes ☐ N/A ☐

13. Person Centred Care

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

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

Informal Support

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

not asked

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

Name: .....

Contact Details: .....

.....

.....

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

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

Yes ☐ No ☐

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

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Required Support

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

Yes ☐ No ☐

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

Has the carer been advised of the Carers Information Line?

Yes ☐ No ☐ Not appropriate at this time ☐

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐ No ☐

Are you:

Employed ☐ Unemployed ☐

Self-employed ☐ Retired ☐

Full time education ☐

not asked

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

Yes ☐ No ☐ Not applicable ☐

Do you have any money worries?

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

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

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

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

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

If yes when was patient referred ___/___/___

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Risk Assessments/Other Documentation

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

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
15/11/20 13:30	Admitted to ARU from ED Resus.	
	Re crashed car in police pursuit. H.I - CT B NAD.	
	Aggressive and combative on Resus.	
	Required Midazolam & Ketamine	
	for Sedation for CT scan	PTO

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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
Contd	GCS 14/15. NEWD (6)	
	20 in situ. SpO2 96%.	
	BP - Stable HR: 66	
	Apyrexial 35.6	
	Nad confusion 2° sedation	
	2° police in attendance.	
	Police surgeon on ward to	
	complete bloods etc	(6). DUNCANSON
15/11/20 14:10	Bloods obtained by police surgeon.	
	1x set to police and 1x set	
	in drug fridge for pt on dlc.	
	(numb. to be stored in fridge).	
	GCS 14/15 but pt more alert	DUNCANSON
	able to dlc O2 therapy.	(6)
15/11/20 15:35	2x blood samples returned to police	
	at their request.	DUNCANSON
	SHO currently reviewing pt.	(6)
15/11/20 17:00	Seen by Dr Blyth: Remains drowsy,	
	Admit GCS overnight. Unmc for □,	
	monitor GCS, Home tomorrow if	
	awake >> Back to custody	(6) DUNCANSON

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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
15/11/20 19[illegible]	Pt remains drowsy. GCS 15/15 Abl to sit up and eat dinner Orientated to time and place but at time of writing sleeping. NEWS (1). NAD this afternoon. Awaiting Urine tox ☐	⑥ DUNCANSON
16/11/20 0315	(9) Patient settled + sleeping at present	
	(2) managing fluids. Nil diet overnight	
	(3) Using bottles at bedside to pass urine. Urine for tox ☐ Sent.	
	(4) Independently mobile about bed Buzzer to hand.	
	(5) Observations as charted News (2).. Remains drowsy but rousable.	
	(6) All medication given as per Kardex.	
	(11) Police remain in attendance.	[illegible] SN
16/11/20 0720	Settled overnight News as charted. Sats ↓ when pt sleeping. Commenced on 2L O2.	
	Police remain in attendance	[illegible] SN

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐ NURSING ☐

Please tick ✔ appropriate directorate

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Date & Time		Signature, Print Name & Designation
16/11/20 1040	W/R Dr Lee; Remand drowsy	
	Plan- observe	
	? back to police	
	custody today.	[illegible]
	STAY AWAKE	
16/11/20 1050	①Assisted with personal hygiene this morning.	
	②Refused breakfast this am.	
	③Not passed urine this shift.	
	④Moving around bed independently. Positional changes encouraged.	
	⑤observations as charted, NEWS 3 due to sats 93% on air, temp 35.4.	
	⑪Still remains relatively drowsy this morning. ?back to police custody later today.	MDaulin⑨. MDaulin⑥
16/11/20 1850	Patient set up for dinner. Appears very knocked off-tearful at times talking about 'the disciples coming'. For review to decide if patient for dlc to police custody or for Medical bed.	MDaulin MDaulin⑥
16/11/20 2030	Patient for transfer to ward 8C. Patient aware. Attempted to phone 8C to give handover but no answer. Police remain in attendance.	

83949 GGC0072

Date & Time		Signature, Print Name & Designation
17/11/20	Andrew admitted to ward 8C	
0340	following RTC and head	
	injury. Andrew not been out	
	of bed since arrival to	
	ward but he states he is	
	usually independent. News	
	as charted - dropped sats	
	to 90% on air - c/o 2L	
	O2 therapy and have asked	
	FYI to review patient. GCS	
	14-15. Andrew sometimes	
	non verbal - ? due to	
	mental health issues.	
	? schizophrenia. Andrew is	
	talking about 'them coming	
	to get him'. Remains in	
	police custody. due to police	
	chase - RTB. and intoxication.	
	Reviewed by FYI and Andrew	
	for psych input. For CXR	
	? PE. Andrew told medical	
	staff of pain in left side	
	when breathing in + out —	Rfrances
	Sats now 93% on 2L. —	RFrances (SN)
0420	For d-dimer. —	RFrances (SN)
17/11/20 1568	Settled day. Care plan reviewed, no changes.	
	Assessments up to date. Independent	
	with personal care. Mobilising independ-	
	ently to the toilet. Fluid and diet as	
	tolerated. Observations as per news chart,	
	news=2. SpO2-92% on air. Patient not	
	tolerating O2 keeps removing it. Monitor	
	as per news protocol. Medication given	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☑

Please tick ✔ appropriate directorate

2104673933
SHAW M
Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

Date & Time		Signature, Print Name & Designation
17/11/20 15:00	as per Kardex. Patient seen by addictions and commenced on regular diazepam. On GMAWS, naw scoring. Remains in police custody. Patient becoming agitated and hearing voices, diazepam given.	
	Ward round - For psych input. No problems to report at present.	Wallace MHAIRAC SN
18/11/20	Andrew has had settled night.	
0430	NEWS as per protocol. O2 Sats 91-92% on air. Patient has refused to keep O2 on. Scored on GMAWS as beginning of shift and had regular diazepam. Remains in police custody. Eating and drinking well. Independent to bathroom.	
	For urgent psych input. No further concerns.	Francis KFRANCIS SN
14:20	Patient independent with ADLs, NEWS 3 due to SpO_2 of 88% on air, refused to apply O_2, due diazepam given earlier, Scored on GMAWS as agitated but refused to take diazepam, Still awaits psych input	
	remains in custody of x2 police	Conroy Watkinson RGN

83949 CGC0072

Date & Time		Signature, Print Name & Designation
19/11/20	Andrew settled night tonight.	
0320	Not scoring on 6mNWS. NEWS	
	stable as charted. Medications	
	given as per kardex. SPO2 96% raw	
	on air. Independent to the bathroom.	
	Remains in police custody. No	Francis
	new concerns.	KMARCUS@
19/11/20 11:15	Settled morning. Remains in police custody.	
	Care plan reviewed, no changes. Assessments	
	up to date. Independent with personal care.	
	Mobilising independently to the toilet. Fluid	
	and diet as tolerated. Observations as per	
	news chart, news=1 SpO2-96%. Monitor as	
	per news protocol. Medication given as per	
	kardex. 6mNWS discontinued. Addictions	
	advised to reduce diazepam, medical	
	staff informed. Await psych and ward	
	round review. No problems to report at	Lwallace
	present.	LWALLACE SN
19/11/20 13:20	Ward round- await further psych input.	Lwallace
	Medically fit. No problems to report at present	LWALLACE SN
20/11/20	Andrew remains in police	
0310	custody. NEWS stable as charted.	
	Medications given as per	
	kardex. Continues on reducing dose	
	of diazepam. Await psych. Appears	
	agitated, was offered meds for	Francis
	agitation but declined any.	KMARCUS@
12:00	Patient independent with	
	personal care, NEWS as	
	charted, due 5mg of	
	diazepam given, remains	
	in police custody.	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐ NURSING ☑

Please tick ✔ appropriate directorate

2104673933
1 SHAW M
7 Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

Date & Time		Signature, Print Name & Designation
	for discharge today into	Carry McDevitt
	custody, only has 1 5mg	RGN
	of diazepam to be given	
20/11	Patient discharged. Medication	
22:55	given to police team - IDL	
	also given. No issues to be	SN
	raised.	S Ahmed

83949 GGC0072

2104673933
1 SHAW
7 Andrew, M 21/04/196
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

NHS ter-Glasgow nd Clyde

NHSGGC Bedrail Risk Assessment

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

Patient Name:

CHI Number:

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

Use guidance on the reverse of this document when completing this Risk Assessment								
	DATE	15/11/20		17/11/20				
	TIME	1330		0020				
	WARD	AW1		8c				
	HOSPITAL	QEUH		QEUH				
SECTION ONE – GENERAL		**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**
1	Is the patient likely to fall, roll, slip or slide from the bed?	✓	✓	✓					
2	Has the patient requested the use of bedrails?	✓	✓	✓					
IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED									
SECTION TWO – COGNITIVE AND PHYSICAL STATUS									
3	Is the patient at risk of climbing out of bed?		✓		✓				
4	Is the patient stressed, delirious or restless?		✓		✓				
5	Is the patient small in stature?		✓		✓				
6	Does the patient have an unusually large or small head that might present an entrapment issue?		✓		✓				
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?		✓		✓				
IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
SECTION THREE – COMMUNICATION									
8	Has the patient been consulted regarding the use of bedrails?	✓		✓					
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition	✓		✓					
10	Has the use of bedrails been discussed with relatives/carers?	✓			✓				
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?	✓		✓					
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?	✓			✓				
IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
SECTION FOUR – DECISION MAKING		**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**
13	Will bedrails be used for this patient at the present time?	✓		✓					
14	Rationale for use of bedrails: (Please insert code in the box on the right)								
	A – Risk of falling from the bed								
	B – Risk of rolling from the bed								
	C – Risk of slipping from the bed								
	D – Risk of sliding from the bed	✓		✓					
	E – Patient request	✓		✓					
15	Bedrail risk assessment completed by:	[illegible]							
16	Bedrails checked by:	[illegible]		[illegible]					
17	Date	15/11/20		17/11/20					

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

A. Alternatives to bed rails:-

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

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

Is patient:-

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

C. Safe use and application of bedrails:-

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

D. Record keeping:-

All of the following should be recorded:-

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

Bedrail risk assessments should be made as follows:-

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

2104673933
SHAW
Andrew, M
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8J

21/04/196

Care Plan

NHS Greater Glasgow and Clyde

Care discussed with patient / Unable	☑ Yes	☐ No	☐ If unable, give reason:
Care discussed with family / Unable	☐ Yes	☑ No	☐ If unable, give reason: none present

Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
15/11/20	Obs as per NEWS. GCS.		15/11/20	Feel better	
18-11-2020	2L O2 therapy				
				5. Hydration and Nutrition	
			15/11/20	normal DAF	
				Weekly MUST.	
	2, 3. Communication and senses				
15/11/20	Can communicate needs				
				6. Elimination	
	4. Cognitive status		15/11/20	Incont of R	17/11
15/11/20	WNCS 2° sedation			Usually continent	
	Alert + orientated.				

2104673933
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Andrew, M 21/04/196
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EAST KILBRIDE
Glasgow, Lanarkshire
G75 8J

Care Plan

NHS Greater Glasgow and Clyde

Date Commenced and Signature	7. Personal Hygiene, oral care, skin care and wound care	Date Discontinued and Signature	Date Commenced and Signature	9. Maintaining a safe environment, Technical Care	Date Discontinued and Signature
15/11/20	(I)		15/11/20	RA	
	Daily PUDRA			x2 rokers	18-11-2020 AM
			18-11-2020 AM	Buzzer available	
			18-11-2020 AM	PVC Careplan.	
				10. Sleep and Rest	
			15/11/20	promote	
			18-11-2020 AM	Encourage natural sleep	
				pattern.	
	8. Mobility				
15/11/20	(I)			12. Privacy, dignity and sexuality	
18-11-2020 AM	Weekly moving and		15/11/20	promote	
	handling risk assessment		18-11-2020 AM	Nursed	
18-11-2020 AM	Weekly Falls risk assessment				
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	
			18-11-2020 AM	Involve Andrew with	
				all care plan.	

285668 Version 1_0 • GCC0127

Care Rounds Checklist

Date: 15/11/20

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

1. Signed _____ Name S. Duncanson Designation (6)
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

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

At
2104573933
1 SHAW M
7 Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Wa Glasgow, Lanarkshire
G75 8JS

NHS Greater Glasgow and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

| | | |

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 16/11/20

Attach Add
2104673933
1 SHAW M
7 Andrew, M 21/04/1957
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
Ward: ARU1 G75 8JS

NHS Greater Glasgow and Clyde

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

1. Signed _____ Name _____ Designation _____
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

NO THANKS

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

		Times	00 35	04 00	06 00	09 20	15:00	21 47														
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	Y	S	N	N														
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N														
S	3	**SKIN INSPECTION** Pressure areas checked:	NT	NT	NT	S	Y	✓														
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	I	–	✓		INT	✓														
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	S	Y	Y														
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	I	B	B	B		B														
		Chair Assist to walk or stand (W/ST)	✓	–	✓		ST	✓														
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	NT	NT	NT	S	I	I														
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N														
		Drink taken?	Y	Y	Y	N	Y	N														
		Food, snack, or supplement taken?	N	NT	NT	N	N	N														
		Has oral hygiene been carried out as per care plan?	N	NT	NT	N	N	I														
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y														
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	NT	NT	NT	N														
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA	NA														
		Care provider / role	AB	SN	SN	N-I SN	N SN	SN														

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 17/11/20

Attach Add
2104673933
1 SHAW
7 Andrew, M M
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
21/04/196
Ward:
G75 8JS

NHS Greater Glasgow and Clyde

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

1. Signed Ramas Name ICMANICIS Designation SN
2. Signed Wallace Name WALLACE Designation SN
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

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

			Times	0205	08	09	13	15	16	19												
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		N	N	N	N	N	N	N												
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.		N	N	N	N	N	N	N												
S	3	**SKIN INSPECTION** Pressure areas checked:		1	1	1	1	1		1												
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		–	/	/	/	/		–												
K	4	**KEEP MOVING** Has the patient moved or walked?		1	1	1	1	1		1												
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		–	/	/	/	/		B												
		Chair Assist to walk or stand (W/ST)		–	/	/	/	/		–												
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		1	1	1	1	1		1												
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?		N	N	N	N	N		N												
		Drink taken?		–	Y	Y	Y	Y		Y												
		Food, snack, or supplement taken?		–	Y	Y	Y	Y		Y												
		Has oral hygiene been carried out as per care plan?		1	1	II	1	1		1												
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		Y	Y	N	Y	Y		Y												
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.		NT	NT	NT	NT	NT		NT												
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.		NC	NA	NA	NA	NA		NA												
		Care provider / role		RC	WS	CS	WS	WS		RC												

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 18/11/20

Attach
2104673933
SHAW
Andrew, M 21/04/196
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
Ward: G75 8JI

NHS Greater Glasgow and Clyde

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

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

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

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

		Times	02 19	06 29	10 14	10	21 25
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	S	N	N	N
S	3	**SKIN INSPECTION** Pressure areas checked:	I	S	N	I	I
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	-	/	/	/	/
K	4	**KEEP MOVING** Has the patient moved or walked?	I	S	N	I	I
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	-	R	/	L	CH
		Chair Assist to walk or stand (W/ST)	-	/	/	/	/
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	S	N	I	I
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	S	N	N	N
		Drink taken?	-	S	Y	Y	Y
		Food, snack, or supplement taken?	-	S	Y	Y	Y
		Has oral hygiene been carried out as per care plan?	/	I	I	I	Y
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	N	NT	NT	NT
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA
		Care provider / role	RN	[illegible]	[illegible]	[illegible]	[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label
Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 19/11/20

Atta
2104673933
SHAW
Andrew, M
21/04/19
Ward

NHS Greater Glasgow and Clyde

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

1. Signed Francis Name FRANCIS Designation SN
2. Signed Wallace Name WALLACE Designation SN
3. Signed _____ Name _____ Designation _____

'Must ... for me. Ask the patient if there is anything they want specifically done today:

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

		Times	08/12	08/19	09/05	13/00	18/03	22/05
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N
S	3	**SKIN INSPECTION** Pressure areas checked:	I	I	I	I	I	I
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	I	-	-	/	/	-
K	4	**KEEP MOVING** Has the patient moved or walked?	I	I	I	I	I	I
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	I	-	-	/	/	-
		Chair Assist to walk or stand (W/ST)	I	-	-	/	/	-
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I. Assistance given = A Incontinent of urine or faeces = IC	I	I	I	I	I	I
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N
		Drink taken?	S	S	Y	Y	Y	Y
		Food, snack, or supplement taken?	S	S	Y	Y	Y	Y
		Has oral hygiene been carried out as per care plan?	S	S	-	I	I	I
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	S	S	Y	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	S	S	NT	NT	NT	NT
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	N	NA	NA	NA
		Care provider / role						

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 20/11/20

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

1. Signed K Francis Name K Francis Designation SN
2. Signed G Name G. McGowan Designation SN
3. Signed S Khuram Name Sahiba Khuram Designation SN

Attach

2104673933
SHAW
Andrew, M
21/04/196
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JI

Ward:

NHS Greater Glasgow and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

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

		Times	01:30	03:30	07:30	11:30	13:30	19:55	22:01												
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	S	N	N	N	N	N	N												
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	S	N	N	N	N	N	N												
S	3	**SKIN INSPECTION** Pressure areas checked:	S	I	I	I	I	I	I												
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	✓	I	–	–	✓	–	✓												
K	4	**KEEP MOVING** Has the patient moved or walked?	S	I	I	Y	Y	Y	Y												
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	✓	I	–	✓	B	L	B												
		Chair Assist to walk or stand (W/ST)	✓	I	–	C	✓	–	✓												
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	B	I	I	I	N	N	N												
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N	N												
		Drink taken?	S	S	Y	Y	Y	Y	Y												
		Food, snack, or supplement taken?	S	S	Y	Y	Y	Y	Y												
		Has oral hygiene been carried out as per care plan?	✓	S	I	I	N	I	I												
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	S	S	Y	Y	Y	Y	Y												
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	M	S	NT	NT	NT	NT	M												
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	N/A	NA	NA												
		Care provider / role	SK	SK	SK	SK	SK	SK	SK												

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

2104673933
SHAW N
Andrew, M 21/04/196
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS
graph label

Ward: 8C

Discharge destination:

Estimated Discharge Date (1) / /

Estimated Discharge Date (2) / /

Final date of discharge : / /

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

Time of Discharge: 22:00 pm

Nurse's signature: S. Andrew

Designation: S/N

Date: 20/11/20

2104673933
SHAW M
Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

FALLS RISK ASSESSMENT

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

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

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

	Ward: A2N1 Date: 15/11/20 Time: 13:20	Ward: 8C Date: 17/11/20 Time: 00:20	Ward: Date: Time: --:--	Ward: Date: Time: --:--	Ward: Date: Time: --:--
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	complete	✓			
2. Check walking aid (if required) is in reach and in use.	no aids	N/A			
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	Buzzer to hand.	✓			
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	Slipper	✓			
5. If glasses are worn, check they are available and in use.	N/A	NA			
6. If hearing aid/s are worn, check they are working and in use.	N/A	NA			

RISK ASSESSMENT

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

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

Highlight risk of fall at the ward safety brief.

Patient Details	

FALLS INTERVENTION CHECKLIST

NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

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

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

Glasgow Assessment and Management of Alcohol

Please Attach Patient Label

2104673933
SHAW
Andrew, M
21/04/19

Estimated Weekly Alcohol Units : _____
Daily Units x Number of Days per Week)
Excessive Weekly Consumption *>14 units/week*

Estimated Date / Time Of Last Drink: _____
(If ≥ 5 Days, Re-consider Alcohol Withdrawal Status)

Presents with or has had previous alcohol withdrawal seizures/ severely agitated withdrawal:

YES: ☐ NO: ☐

IS IT ALCOHOL WITHDRAWAL?

Consider alternative diagnoses such as delirium, encephalopathy, traumatic brain injury especially if symptoms atypical or prolonged (≥5 days since last alcohol)

Fast Alcohol Screening Tool - FAST:

Note : 1 drink = 1 unit of alcohol

1. MEN: How often do you have EIGHT or more drinks on one occasion?
   WOMEN: How often do you have SIX or more drinks on one occasion?

   Never ☐0 Less than monthly ☐1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☐4

2. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

   Never ☐0 Less than monthly ☐1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☐4

3. How often during the last year have you failed to do what was normally expected of you because of drinking?

   Never ☐0 Less than monthly ☐1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☐4

4. In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

   No ☐0 Yes, on one occasion ☐2 Yes, on more than one occasion ☐4

Score of 3 or more: FAST Positive

Total ☐

FAST Positive?
Yes ☐ No ☐

FAST 0-2:	Negative: No action required.
FAST 3-8:	Hazardous Drinking: Advise regarding safe drinking levels and offer information leaflet / advice.
FAST 9-16:	Probable Dependent Drinking: Advice as above and consider referral to Addiction Liaison Service.

EXCEPTIONAL PATIENT GROUP WITH CO-MORBIDITY?

Be aware of Patients with Co-morbidities presenting with features of Alcohol Withdrawal, especially:

- Patients with evidence of liver disease: especially jaundice, encephalopathy
- Patients with other co-morbidity (ie COPD, pneumonia, cerebrovascular disease, reduced GCS, elderly >70, head Injury, pregnancy)

REFER TO SECTION 3 (PAGE 3) FOR MANAGEMENT ADVICE

PLEASE INSERT IN PATIENT'S CASE RECORD ON COMPLETION OF TREATMENT

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Order Number GGC0169

Prophylaxis and Treatment of Wernicke-Korsakoff Syndrome

The guidance applies to all alcohol use disorders: hazardous, harmful and dependent.

ASSESS FOR WERNICKE'S ENCEPHALOPATHY
Does the patient have any of the following signs/ symptoms?

- Confusion
- Decreased consciousness
- Nystagmus
- Ataxia
- Opthalmoplegia
- Hypothermia/ hypotension

YES → Presumptive diagnosis of Wernicke's Encephalopathy (if symptoms otherwise unexplained) **GO TO BOX A**

NO → Assess Risk of Wernicke's Encephalopathy **GO TO BOX B**

BOX A	Day 1-2	Day 3-5	Day 6 onwards
Presumptive Diagnosis of Wernicke's Encephalopathy: This requires URGENT treatment	**Pabrinex IV:** 2 pairs of vials three times a day. **Magnesium** Check Serum Magnesium URGENTLY and give intravenous replacement if deficient.	**Pabrinex IV/IM** 1 pair of vials three times a day	Change to **oral Thiamine** 50mg four times a day **or** continue IV/IM **Pabrinex** at discretion of Medical Team

BOX B	RISK FACTORS for WERNICKE'S	
	Risk Factors	**Severe Risk Factors**
Assessment of Risk of Wernicke's Encephalopathy	Weight loss (MUST=1) Poor diet or vomiting for <5 days Alcoholic Liver Disease Presents with Seizure Age ≤18 or ≥65	Severe Weight loss (MUST≥2) Poor Diet or vomiting for >5 days

No Risk Factors	One Risk factor	Two or more Risk Factors or any single Severe Risk Factor
Oral Thiamine 50mg four times a day	**Pabrinex IV/IM** 1 pair of vials three times a day for **24** hours then change to **oral Thiamine** 50mg four times a day	**Pabrinex IV/IM** 1 pair of vials three times a day for **48** hours then change to **oral Thiamine** 50mg four times a day

Check Magnesium in all patients and correct deficiency

Important notes

- If oral thiamine is indicated but a patient is unable to take medicines by mouth, then consult your ward pharmacist: NG administration may be possible or IM Pabrinex® (1 pair of vials once daily) are alternatives
- Intravenous Pabrinex® should be administered over 30 minutes
- Anaphylaxis is a rare complication of IV Pabrinex® administration and even more uncommon with IM administration. Monitor patient for wheeze, tachycardia, breathlessness and skin rash. Facilities for the administration of adrenaline and other resuscitation should be available.
- Additional vitamin supplementation as clinically indicated by responsible medical team in the context of a general nutritional assessment

Management of Alcohol Withdrawal Syndrome

1. DEPENDENT DRINKING ON SCREENING - HIGH RISK

EXCEPTIONAL PATIENT GROUP WITH CO-MORBIDITY?

- Patients with evidence of liver disease: especially jaundice, encephalopathy
- Patients with other co-morbidity (ie COPD, pneumonia, cerebrovascular disease, reduced GCS, elderly >70, head injury, pregnancy)

YES

NO

1. DEPENDENT DRINKING ON SCREENING - HIGH RISK

Any 2 of the following:

Presents with or has had previous withdrawal seizures or severely agitated withdrawal
High screening score (FAST ≥12)
High initial symptom score (GMAWS ≥4)

YES

FIXED DOSE TREATMENT (Section 2)
PLUS
SYMPTOM TRIGGERED TREATMENT (GMAWS)

NO

SYMPTOM TRIGGERED TREATMENT (GMAWS)

For exceptional patient groups see Section 3

2. FIXED DOSE TREATMENT REGIME: Oral Diazepam (see **Section 5** for patients unable to tolerate oral):

INITIAL DOSE: 20mg Diazepam 6 hourly

REDUCE DOSE: If after 24 hours no additional symptom triggered treatment has been required .

OR

If after ≥48 hours of treatment GMAWS less than 4

REDUCING DOSE: (Not to be prescribed 24hrs in advance. Step down only if GMAWS remains less than 4)

15mg Diazepam 6 hourly for 24 hours
10mg Diazepam 6 hourly for 24 hours
5mg Diazepam 6 hourly for 24 hours
5mg Diazepam 12 hourly for 24 hours

3. EXCEPTIONAL PATIENT GROUPS: SYTMPTOM TRIGGERED TREATMENT ONLY

- Patients with evidence of liver disease especially jaundice or encephalopathy: use oral **Lorazepam** in a symptom triggered fashion: 1-2 mg (up to 12mg in 24 hours, when senior medical review is required as below)
- Patients with other co-morbidity (i.e. COPD, pneumonia, cerebrovascular disease, reduced GCS, elderly (>70), head injury): use Lorazepam as above **OR** Diazepam at 50% of standard GMAWS dose
- In pregnancy use Diazepam at 50% of standard GMAWS dose with senior medical review if more than 30mg required in 24 hours

REVIEW PRESCRIPTION if patient is excessively drowsy

SENIOR MEDICAL REVIEW (ST3 or above) REQUIRED for diagnostic review and possible adjunctive therapy (Section 4): - If patient requires more than 120mg Diazepam in 24 hours

- If patient still requiring full dose treatment 96 hours after last alcohol ingestion

4. SEVERE WITHDRAWAL (aggressive/ uncontrollable/ dangerous behaviour)[1]

- Intravenous Diazemuls up to 40mg over first 30 minutes (up to 2mg/minute; flumazenil to be available) **(Section 5)**
- Adjunctive therapy with Haloperidol 2-5mg IM in first instance and response assessed
- Consultation regarding intensive care support may be necessary in extreme situations

5. PATIENTS UNABLE TO TOLERATE ORAL MEDICATION / PARENTERAL BENZODIAZEPINES

- Patients unable to tolerate oral medication may receive parenteral therapy as an alternative at 50% of the oral dose in the first instance, and response assessed
- Intravenous benzodiazepines should be administered by an experienced member of medical (FY2 or above) or nursing staff who have completed the appropriate Competency Training to administer IV sedation

6. MONITORING

- All patients should be closely observed for signs of over-sedation with regular observations
- Exceptional Patient Groups **(Section 3)**, patients with Severe Withdrawal **(Section 4)** and patients requiring parenteral sedation **(Section 5)** require close monitoring (NEWS) ideally with one-to-one nursing care

[1] *NHSGGC Guideline for use of Intramuscular Medication for Acutely Disturbed Behaviour in Mental Health and Associated Services*

Glasgow Modified Alcohol Withdrawal Scale (GMAWS) **Treatment Option:** GMAWS Only ☐ GMAWS & Fixed Dose ☐

Refused

Date	16/11	17/11	17/11/20	17/11/20	17/11/20	17/11/20	17/11/20	17/11/20	17/11	17/11	17/11	18/11	18/11	18/11	18/11	18/11	18/11	18/11	18/11	18/11
Time	2200	0320	08:10	09:55	11:?	14:00	17:00	19:20	21:15	23:55	02:30	06:10	10:??	11:40	13:20	15:40	16:40	20:30	23:00	
Tremor 0) No tremor 1) On movement 2) At rest	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Sweating 0) No sweat visible 1) Moist 2) Drenching sweats	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	
Hallucination 0) Not present 1) Dissuadable 2) Not dissuadable	0	0	0	0	0	1	1	1	1	0	0	0	0	0	0	0	0	0	0	
Orientation 0) Orientated 1) Vague, detached 2) Disorientated, no contact	0	0	0	0	1	1	1	1	0	0	0	0	0	0	0	0	0	0	0	
Agitation 0) Calm 1) Anxious 2) Panicky	0	0	0	0	1	0	0	0	1	0	0	0	0	2	0	0	0	0	0	
Score	-	-	/	/	2	2	2	2	2	0	0	0	0	3	0	0	0	0	0	
Treatment	nil	nil	/	/	10 mg	10 mg	10 mg	10 mg	10 mg	/	/	/	/	10 mg	/	/	/	/	/	
Staff Signature	RL	RL	LW	LW	[illegible]	LW	LW	[illegible]	RH	RL	RL	RL	RM	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	

Score: (Do not use scoring tool if patient intoxicated, must be at least 8 hours since last drink.)

0 :Repeat Score in 2 hours (Discontinue after scoring on 4 consecutive occasions, except if less than 48hrs after last drink)

1 – 3 :Give 10mg Diazepam: Repeat Score in 2 hours

4 – 8 :Give 20mg Diazepam : Repeat Score in 1 hour

9 – 10 :Give 20mg Diazepam : Repeat Score in 1 hour

EXCEPTIONAL PATIENT GROUPS: SYTMPTOM TRIGGERED TREATMENT
Patients with evidence of liver disease especially jaundice or encephalopathy: use oral **Lorazepam** 1-2 mg
Patients with other co-morbidity (i.e. COPD, pneumonia, cerebrovascular disease, reduced GCS, elderly (>70), head injury): use Lorazepam as above **OR** Diazepam at 50% of standard GMAWS dose.
In pregnancy use Diazepam at 50% of standard GMAWS

PATIENTS MAY REQUIRE TO BE WOKEN FOR CONTINUING ASSESSMENT

CO-EXISTING ILLNESS MAY AFFECT SCORE: SEEK MEDICAL ADVICE IF IN DOUBT

FIXED DOSING & SYMPTOM TRIGGERED DOSING MUST BE NO LESS THAN 1 HOUR APART

All patients should have regular observations documented. Patients receiving high doses of Diazepam should be assessed regularly for over sedation. If a patient requires more than 120 mg of diazepam or 12 mg of lorazepam in 24 hrs a senior medical review and consideration of adjunct therapy (Section 4) is required

APPROXIMATE ORAL BENZODIAZEPINE EQUIVALENCE: 10mg Diazepam = 1mg Lorazepam = 25mg Chlordiazepoxide
Patients should not be discharged on regular benzodiazepine

Developed by the Acute Alcohol Screening & Withdrawal Management Guideline Group Chaired by Dr Ewan Forrest, Consultant Physician and Gastroenterologist, GRI
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Glasgow Assessment and Management of Alcohol

continuation

Please Attach Patient Label

CI 2104673933
NC SHAW
Andrew, M M
30 DOUGLAS DRIVE 21/04/196
A EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS
Postcode:

Estimated Weekly Alcohol Units : _____
Daily Units x Number of Days per Week)
Excessive Weekly Consumption >14 units/week

Estimated Date / Time Of Last Drink: _____
(If ≥ 5 Days, Re-consider Alcohol Withdrawal Status)

Presents with or has had previous alcohol withdrawal seizures/ severely agitated withdrawal:

YES: ☐ NO: ☐

IS IT ALCOHOL WITHDRAWAL?

Consider alternative diagnoses such as delirium, encephalopathy, traumatic brain injury especially if symptoms atypical or prolonged (≥5 days since last alcohol)

Fast Alcohol Screening Tool - FAST:

Note : 1 drink = 1 unit of alcohol

1. MEN: How often do you have EIGHT or more drinks on one occasion?
   WOMEN: How often do you have SIX or more drinks on one occasion?

   Never ☐0 Less than monthly ☐1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☐4

2. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

   Never ☐0 Less than monthly ☐1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☐4

3. How often during the last year have you failed to do what was normally expected of you because of drinking?

   Never ☐0 Less than monthly ☐1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☐4

4. In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

   No ☐0 Yes, on one occasion ☐2 Yes, on more than one occasion ☐4

Score of 3 or more: FAST Positive

Total ☐

FAST Positive?
Yes ☐ No ☐

FAST 0-2:	Negative: No action required.
FAST 3-8:	Hazardous Drinking: Advise regarding safe drinking levels and offer information leaflet / advice.
FAST 9-16:	Probable Dependent Drinking: Advice as above and consider referral to Addiction Liaison Service.

EXCEPTIONAL PATIENT GROUP WITH CO-MORBIDITY?

Be aware of Patients with Co-morbidities presenting with features of Alcohol Withdrawal, especially:

- Patients with evidence of liver disease: especially jaundice, encephalopathy
- Patients with other co-morbidity (ie COPD, pneumonia, cerebrovascular disease, reduced GCS, elderly >70, head injury; pregnancy)

REFER TO SECTION 3 (PAGE 3) FOR MANAGEMENT ADVICE

PLEASE INSERT IN PATIENT'S CASE RECORD ON COMPLETION OF TREATMENT

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Order Number GGC0169

Prophylaxis and Treatment of Wernicke-Korsakoff Syndrome

The guidance applies to all alcohol use disorders; hazardous, harmful and dependent.

ASSESS FOR WERNICKE'S ENCEPHALOPATHY
Does the patient have any of the following signs/ symptoms?

- Confusion
- Ataxia
- Decreased consciousness
- Opthalmoplegia
- Nystagmus
- Hypothermia/ hypotension

YES → Presumptive diagnosis of Wernicke's Encephalopathy (if symptoms otherwise unexplained) **GO TO BOX A**

NO → Assess Risk of Wernicke's Encephalopathy **GO TO BOX B**

BOX A	Day 1-2	Day 3-5	Day 6 onwards
Presumptive Diagnosis of Wernicke's Encephalopathy: This requires <u>URGENT</u> treatment	**Pabrinex IV:** 2 pairs of vials three times a day. **Magnesium** Check Serum Magnesium <u>URGENTLY</u> and give intravenous replacement if deficient.	**Pabrinex IV/IM** 1 pair of vials three times a day	Change to **oral Thiamine** 50mg four times a day **or** continue IV/IM **Pabrinex** at discretion of Medical Team

BOX B

Assessment of Risk of Wernicke's Encephalopathy

RISK FACTORS for WERNICKE'S	
Risk Factors	**Severe Risk Factors**
Weight loss (MUST=1)	Severe Weight loss (MUST≥2)
Poor diet or vomiting for <5 days	Poor Diet or vomiting for >5 days
Alcoholic Liver Disease	
Presents with Seizure	
Age ≤18 or ≥65	

No Risk Factors	One Risk factor	Two or more Risk Factors or any single Severe Risk Factor
Oral Thiamine 50mg four times a day	**Pabrinex IV/IM** 1 pair of vials three times a day for **24** hours then change to **oral Thiamine** 50mg four times a day	**Pabrinex IV/IM** 1 pair of vials three times a day for **48** hours then change to **oral Thiamine** 50mg four times a day

Check Magnesium in all patients and correct deficiency

Important notes

- If oral thiamine is indicated but a patient is unable to take medicines by mouth, then consult your ward pharmacist: NG administration may be possible or IM Pabrinex® (1 pair of vials once daily) are alternatives
- Intravenous Pabrinex® should be administered over 30 minutes
- Anaphylaxis is a rare complication of IV Pabrinex® administration and even more uncommon with IM administration. Monitor patient for wheeze, tachycardia, breathlessness and skin rash. Facilities for the administration of adrenaline and other resuscitation should be available.
- Additional vitamin supplementation as clinically indicated by responsible medical team in the context of a general nutritional assessment

Management of Alcohol Withdrawal Syndrome

1. DEPENDENT DRINKING ON SCREENING - HIGH RISK

EXCEPTIONAL PATIENT GROUP WITH CO-MORBIDITY?

- Patients with evidence of liver disease: especially jaundice, encephalopathy
- Patients with other co-morbidity (ie COPD, pneumonia, cerebrovascular disease, reduced GCS, elderly >70, head injury; pregnancy)

YES

NO

1. DEPENDENT DRINKING ON SCREENING - HIGH RISK

Any 2 of the following:

Presents with or has had previous withdrawal seizures or severely agitated withdrawal
High screening score (FAST ≥12)
High initial symptom score (GMAWS ≥4)

YES

FIXED DOSE TREATMENT (Section 2)
PLUS
SYMPTOM TRIGGERED TREATMENT (GMAWS)

NO

SYMPTOM TRIGGERED TREATMENT (GMAWS)

For exceptional patient groups see Section 3

2. FIXED DOSE TREATMENT REGIME: Oral Diazepam (see **Section 5** for patients unable to tolerate oral):

INITIAL DOSE: 20mg Diazepam 6 hourly

REDUCE DOSE: If after 24 hours no additional symptom triggered treatment has been required

OR

If after ≥48 hours of treatment GMAWS less than 4

REDUCING DOSE: (Not to be prescribed 24hrs in advance. Step down only if GMAWS remains less than 4)

15mg Diazepam 6 hourly for 24 hours
10mg Diazepam 6 hourly for 24 hours
5mg Diazepam 6 hourly for 24 hours
5mg Diazepam 12 hourly for 24 hours

3. EXCEPTIONAL PATIENT GROUPS: SYTMPTOM TRIGGERED TREATMENT ONLY

- Patients with evidence of liver disease especially jaundice or encephalopathy: use oral **Lorazepam** in a symptom triggered fashion: 1-2 mg (up to 12mg in 24 hours, when senior medical review is required as below)
- Patients with other co-morbidity (i.e. COPD, pneumonia, cerebrovascular disease, reduced GCS, elderly (>70), head injury): use Lorazepam as above **OR** Diazepam at 50% of standard GMAWS dose
- In pregnancy use Diazepam at 50% of standard GMAWS dose with senior medical review if more than 30mg required in 24 hours

REVIEW PRESCRIPTION if patient is excessively drowsy
SENIOR MEDICAL REVIEW (ST3 or above) REQUIRED for diagnostic review and possible adjunctive therapy (Section 4): - If patient requires more than 120mg Diazepam in 24 hours
- If patient still requiring full dose treatment 96 hours after last alcohol ingestion

4. SEVERE WITHDRAWAL (aggressive/ uncontrollable/ dangerous behaviour)[1]

- Intravenous Diazemuls up to 40mg over first 30 minutes (up to 2mg/minute; flumazenil to be available) **(Section 5)**
- Adjunctive therapy with Haloperidol 2-5mg IM in first instance and response assessed
- Consultation regarding intensive care support may be necessary in extreme situations

5. PATIENTS UNABLE TO TOLERATE ORAL MEDICATION / PARENTERAL BENZODIAZEPINES

- Patients unable to tolerate oral medication may receive parenteral therapy as an alternative at 50% of the oral dose in the first instance, and response assessed
- Intravenous benzodiazepines should be administered by an experienced member of medical (FY2 or above) or nursing staff who have completed the appropriate Competency Training to administer IV sedation

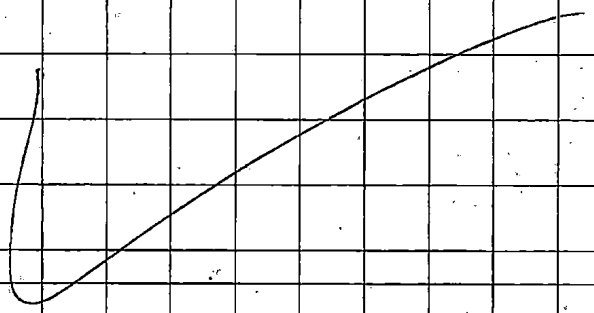
6. MONITORING

- All patients should be closely observed for signs of over-sedation with regular observations
- Exceptional Patient Groups **(Section 3)**, patients with Severe Withdrawal **(Section 4)** and patients requiring parenteral sedation **(Section 5)** require close monitoring (NEWS) ideally with one-to-one nursing care

[1] *NHSGGC Guideline for use of Intramuscular Medication for Acutely Disturbed Behaviour in Mental Health and Associated Services*

Glasgow Modified Alcohol Withdrawal Scale (GMAWS) **Treatment Option: GMAWS Only ☐ GMAWS & Fixed Dose ☐**

Date	19/11	19/11																	
Time	0812	0630																	
Tremor 0) No tremor 1) On movement 2) At rest	0	0																	
Sweating 0) No sweat visible 1) Moist 2) Drenching sweats	0	0																	
Hallucination 0) Not present 1) Dissuadable 2) Not dissuadable	0	0																	
Orientation 0) Orientated 1) Vague, detached 2) Disorientated, no contact	0	0																	
Agitation 0) Calm 1) Anxious 2) Panicky	0	0																	
Score	0	0																	
Treatment	✓	✓																	
Staff Signature	KF	KL																	



Score: (Do not use scoring tool if patient intoxicated, must be at least 8 hours since last drink.)

0 :Repeat Score in 2 hours (Discontinue after scoring on 4 consecutive occasions, except if less than 48hrs after last drink)

1 – 3 :Give 10mg Diazepam: Repeat Score in 2 hours

4 – 8 :Give 20mg Diazepam : Repeat Score in 1 hour

9 – 10 :Give 20mg Diazepam : Repeat Score in 1 hour

EXCEPTIONAL PATIENT GROUPS: SYTMPTOM TRIGGERED TREATMENT
Patients with evidence of liver disease especially jaundice or encephalopathy: use oral Lorazepam 1-2 mg
Patients with other co-morbidity (i.e. COPD, pneumonia, cerebrovascular disease, reduced GCS, elderly (>70), head injury): use Lorazepam as above OR Diazepam at 50% of standard GMAWS dose.
In pregnancy use Diazepam at 50% of standard GMAWS

PATIENTS MAY REQUIRE TO BE WOKEN FOR CONTINUING ASSESSMENT

CO-EXISTING ILLNESS MAY AFFECT SCORE: SEEK MEDICAL ADVICE IF IN DOUBT

FIXED DOSING & SYMPTOM TRIGGERED DOSING MUST BE NO LESS THAN 1 HOUR APART

All patients should have regular observations documented. Patients receiving high doses of Diazepam should be assessed regularly for over sedation. If a patient requires more than 120 mg of diazepam or 12 mg of lorazepam in 24 hrs a senior medical review and consideration of adjunct therapy (Section 4) is required

APPROXIMATE ORAL BENZODIAZEPINE EQUIVALENCE: 10mg Diazepam = 1mg Lorazepam = 25mg Chlordiazepoxide
Patients should not be discharged on regular benzodiazepine

Developed by the Acute Alcohol Screening & Withdrawal Management Guideline Group Chaired by Dr Ewan Forrest, Consultant Physician and Gastroenterologist, GRI
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MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date_____ Time_____ of initial height and weight on admission to hospital		Actual	*Patient reported	*If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height	_____ cm	☐	☑	Unable to complete DNA
Admission Weight	140 Kg	☑	☐	

*Obtain accurate height/weight and rescreen as soon as possible

Patients reported normal weight _____ Unable to Recall ☑

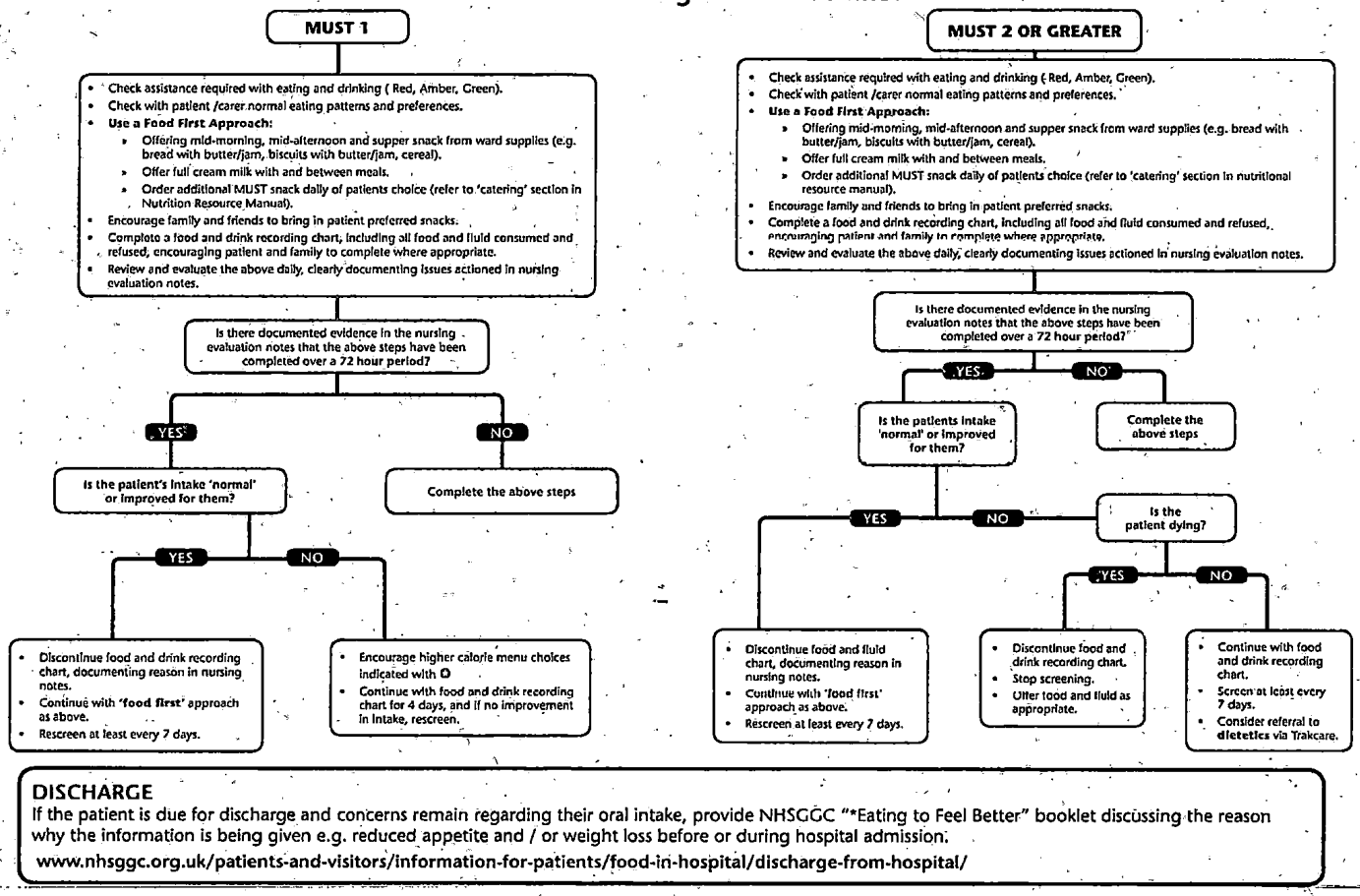
Any unplanned weight loss in the last 6 months Yes ☐ how much_____ No ☐ Don't Know ☑

Date	17/11							
Time	0625							
Ward	SC							
Oedema/ Ascities present Y/N	N							
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes	CH							
Weight (kgs)	140·0							
BMI	40+							
Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days								
Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	0							
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	0							
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	0							
Step 4 Overall Risk of Malnutrition TOTAL	0							
Rescreen on	-							
Signature	[illegible]							

Step 5 Management Guidelines (excludes patients who are Nil by Mouth)

Overall Risk of Malnutrition	Ensure plan of care for specific nutritional requirements, MUST score and plans to improve / increase nutritional intake are documented in the patients care plan
0	**LOW RISK** - Repeat screening every 7 days
1	**MEDIUM RISK** - Follow the flowchart for MUST 1 overleaf
2 or greater	**HIGH RISK** - Follow the flowchart for MUST 2 or greater overleaf

MUST STEP 5 Management Guidelines



DISCHARGE

If the patient is due for discharge and concerns remain regarding their oral intake, provide NHSGGC "*Eating to Feel Better" booklet discussing the reason why the information is being given e.g. reduced appetite and / or weight loss before or during hospital admission.

www.nhsggc.org.uk/patients-and-visitors/information-for-patients/food-in-hospital/discharge-from-hospital/

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21/04/1967

ic (Inpatient) Moving and Handling Assessment Form

	Named Nurse:		Person is totally independent (tick here and go to date box)
In			

Weight	Height
Kg	cm
BMI	

Risk of Falls: Yes | No

Problems with comprehension, behaviour, co-operation (specify):
Usually (I) - sedated. OG.

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

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

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

3. Toileting

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

4. Move on / off bed pan

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

5. Move up / down bed

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

6. Lateral Transfer to / from trolley / bed

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

7. Sit up over side of bed

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

8. Into Bath or Shower

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

9. Walking

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

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:	15/11/20	17/11/20	18/11/20
Assessor's signature:			
Proposed Review date:	22/11/20	24/11/20	25/11/20

Continuation Sheet

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

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

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

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

3. Toileting

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

4. Move on / off bed pan

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

5. Move up / down bed

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

6. Lateral Transfer to / from trolley / bed

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

7. Sit up over side of bed

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

8. Into Bath or Shower

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

9. Walking

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

10. Other Instructions / Observations / Equipment Used

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

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

2104673933 1 SHAW 7 Andrew, M M 30 DOUGLAS DRIVE 21/04/1967 EAST KILBRIDE h Glasgow, Lanarkshire G75 8JS	Hospital: QEUH Ward: A12 L	**Points to consider:** • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

1 Pressure Damage	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan overleaf.

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2	Mobility	Does the person require assistance to mobilise?
3	Continence	Does the person have continence issues with urine and/or faeces?
4	Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5	Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?
6	Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY pressure relieving care interventions and complete the pressure ulcer interventional plan overleaf.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
15/11/20	15:00	N	N	N	N	N	N	4 hrly	
17/11/20	00:20	N	N	N	N	N	N	4 hrly	KL
18/11/20	00:10	N	N	N	N	N	N	4 hrly	KL
19/11/20	00:10	N	N	N	N	N	N	4 hrly	KL
20/11/20	00:10	N	N	N	N	N	N	4 hrly	KL
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
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/ /	:							__hrly	
/ /	:							__hrly	

Complete prevention of pressure ulcer interventional plan overleaf for all patients with redness/pressure damage and for those at risk.

Prevention of Pressure Ulcer Intervention Plan

NHS Greater Glasgow and Clyde

Attach Addressograph

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

Outcome: To prevent pressure ulcer development through establishment of effecting work practices in line with SSKINS bundle.

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____

annula

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21/04/196 nce

Write or affix patient label

Name: _____ CHI: _____

DOB: _____ Address: _____

Ward: _____ Hospital: _____

NHS Greater Glasgow and Clyde

n criteria: Please complete this section at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☐ Resuscitation/Chest Pain ☐ IV Drugs ☑ Fluids ☐ Transfusion ☐

PVC inserted: Day 0	Date: 15/11/20 Hospital: QEUH Area: ED ☑ Theatre ☐ ITU/HDU ☐ Ward ☐ _____ Unknown ☐ _____
Insertion site:	R Hand ☐ R Arm ☑ R Foot ☐ L Hand ☐ L Arm ☐ L Foot ☐ Other: _____
Colour of cannula:	Blue ☐ Pink ☐ Green ☑ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☑ No ☐ If No, state reason: _____

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? (Diagnostics, Resuscitation/ Chest Pain, IV Drugs, Fluids, Transfusion)	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 1 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: ___/___/___ **Reason for keeping PVC in after 72 hrs/ 3 days:** _____

***Date PVC Removed:** 15/11/20

***Reason For Removal:** dislodged

Modified Visual Infusion Phlebitis (VIP) Score

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis : Observe cannula
One of the following is evident : slight pain or redness near site	1	Possible first signs : Observe cannula
Two or more of the following are evident: pain, redness, swelling	2	Early stage of phlebitis : Remove & resite cannula
All of the following are evident: pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: Remove & resite cannula Seek further advice
As above including: palpable vencus cord	4	
As above including: pyrexia	5	

DRIFT

Intravascular devices are associatec with an increased risk of phlebitis, thrombosis, local infection and S. aureus bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids ? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → Can I switch my patient from IV to oral antibiotics?

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature ≤ 37.9°C, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE is available reliably** (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, S. aureus bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abcess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy. Record the intended duration on the medicine kardex

YES

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

NO

NEWS 2 Key | 1 | 2 | 3

| | | |

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

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	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

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

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed.....

Medical:.....

Date:.....

Glasgow Coma Scale

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

Date: 21/4 | Time: 1140 1520 1900 2300 0300 0700 1100 1500 1900 2300

Eyes closed by swelling = NT: E 4 3 2 1 NT
Eyes opening: Spontaneously 4; To sound 3; To pressure 2; None 1; Not testable NT
Endotracheal tube or tracheostomy = NT: V 5 4 3 2 1 NT
Obeys commands 6; Localising pressure 5; Normal flexion 4; Abnormal flexion 3; Extension 2; None 1; Not testable NT
Always record the best response: M 6 5 4 3 2 1 NT
Oriented 5; Confused 4; Words 3; Sounds 2; None 1; Not testable NT
TOTAL: 11 13 14 15 14 15 15 15 15 15
Right size: P 4 3 3 3 3 3 3 3 3 3
Right reaction: U 4 4 4 4 4 4 4 4 4 4
Left size: P 4 3 3 3 3 3 3 3 3 3
Left reaction: L 4 4 4 4 4 4 4 4 4 4
Record right (R) and left (L) separately if there is a difference between the two sides: A 6 4 1 1 1 1 1 1 1 1
Normal power; Mild weakness; Severe weakness; Spastic flexion; Extension; No response
Record right (R) and left (L) separately if there is a difference between the two sides: L 6 4 1 1 1 1 1 1 1 1
Normal power; Mild weakness; Severe weakness; Spastic flexion; Extension; No response

Pain Score

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

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

Pain Function Score

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

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nhs • 316654 v5.0 • GGC0264

NEWS 2 Key | 1 | 2 | 3

| | | |

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

continuation.

2104673933
SHAW
Andrew, M
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JL
21/04/196

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%
Signature:
Print Name:
Dr/ANP initials ONLY:
Date:

Sp02 Scale 2 Target 88-92%
Signature: Jmem
Print Name: MORRIS
Dr/ANP initials ONLY:
Date: 20/11/20

Patient on home oxygen Y☐ N☒
If yes, add details of oxygen therapy

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed .....

Medical: .....

Date: .....

Glasgow Coma Scale

| Date: | | MET | | |

My Admission Record

NHS Greater Glasgow and Clyde

Name: _____
A 2104673933 _____
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Glasgow, Lanarkshire
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Hospital: QEUH Ward: MHTPD
Date of Admission: 11/8/20 Time: 0700
Information obtained from: Name:
Patient ☐ Relative ☐ Other ☑ medical notes
Preferred Name:
Age: Telephone Number:
Consultant:

Communication

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

Preferred first contact

Name: Unknown
Relationship:
Address:
GP Contacted Nil Documented NOK.
Telephone:
Is this person aware of your admission?
Yes ☐ No ☐
Can we share information with this person?
Yes ☐ No ☐

Preferred second contact

Name: JIM FRZER
Relationship: (lawyer) given by patient.
Address:
Telephone: 0141 420 1234
Is this person aware of your admission?
Yes ☐ No ☐
Can we share information with this person?
Yes ☐ No ☐

Presenting Complaint / Diagnosis

Found slumped in car. GCS. ? overdose Ethanol <10.

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

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

No known allergies ☐ Penicillin

Relevant past medical history

Frequent attender ED drug + alcohol misuse
Forensic psychiatric hx - hallucinations++

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

Power of Attorney / Guardianship / Adult with Incapacity

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Does someone have Power of Attorney (POA) for you?

Yes ☐ No ☑

OR

Does someone have Guardianship?

Yes ☐ No ☐

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

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

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

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

Carbapenemase-producing enterobacteriaceae (CPE)

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

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

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

MRSA Screening

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

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

Nasal ☑ Perineum ☑ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

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

If **YES inform the IPCT** ☐

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Lifestyle

Smoking

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

Never smoked ☐

Do you use eCigarettes? Yes ☐ No ☐

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

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

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

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

Drugs

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

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

_____

_____

Alcohol

Do you drink alcohol? Yes ☐ No ☐

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

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

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

Name (Please PRINT): C. BRADLEY Signature: C. Bradley

Designation: SIN Date: 11/8/20

My Assessment Record

Nam
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1. Breathing and Circulation

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

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

2. Communication

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

Name: _____

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3. Senses

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

Can you describe where and what the pain is like?

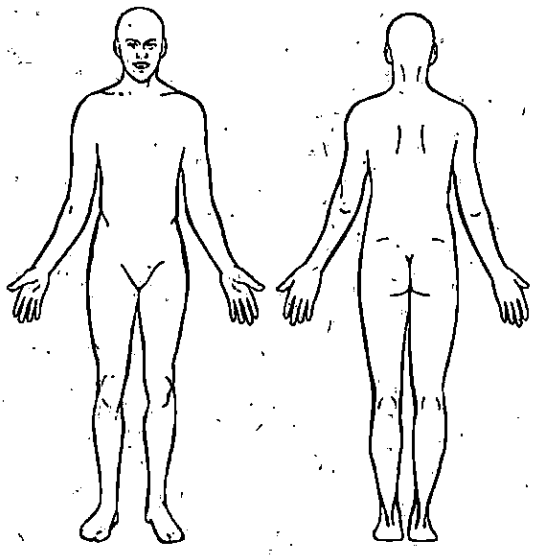
Have you had treatment / intervention for the pain?

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

Can you describe any chronic pain that you have?

What makes the pain better?

Mark current pain on body chart



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4. Cognitive Status THINK DELIRIUM

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

N.B. Think Delirium

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

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

and follow the guidance

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

What do you like to eat and drink?

What do you not like to eat and drink?

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

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

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Assessment of the patient's hydration and nutrition needs

Normal diet and fluids as GCS allows.

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

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

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

6. Elimination

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

Assessment of the patient's elimination needs

Has not passed urine since ED admission.

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

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

What products do you normally use for this continence issue?

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

Date urinary catheter last changed ___/___/___

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

Bowels

When did your bowels last move?

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

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

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

What products do you normally use for this continence issue?

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

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

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

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

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

Pressure ulcer identified on admission: Yes ☐ No ☐

Pressure Ulcer Grade: _____

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

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

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

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8 Mobility

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

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

9 Maintaining a Safe Environment

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

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

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

10. Sleep and Rest

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

Name: _____
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11. Social Circumstances

Do you:

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

Other please specify_____ ☐

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

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

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

12. Emotional and Spiritual Care

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

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

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

Healthcare Chaplain informed Yes ☐ N/A ☐

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13. Person Centred Care

What matters and is important to you whilst you are in hospital?

This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

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

Informal Support

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

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

Name: .....

Contact Details: .....

.....

.....

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

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

Yes ☐ No ☐

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

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Required Support

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

Yes ☐ No ☐

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

Has the carer been advised of the Carers Information Line?

Yes ☐ No ☐ Not appropriate at this time ☐

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐ No ☐

Are you:

Employed ☐ Unemployed ☐

Self-employed ☐ Retired ☐

Full time education ☐

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

Yes ☐ No ☐ Not applicable ☐

Do you have any money worries?

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

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

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

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

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

If yes when was patient referred ___/___/___

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Risk Assessments/Other Documentation

Additional NHSGGC Documentation	Required		Required documents completed		Date, Print and Sign when completed
	Yes ✓	No ✓	Yes ✓	No ✓	
Glasgow Assessment and Management of Alcohol (GAMA)					
Generic Pain Scale Assessment Chart					
Abbey Pain Scale (if unable to self report pain)					
4AT and TIME for Detection, Management and Prevention of Delirium					
Getting to Know Me – Relatives to complete					
What Matters to Me					
Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)					
Malnutrition Universal Screening Tool (MUST)	✓				
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan				✓	
Bristol Stool Chart	✓				11/8 CB
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓				11/8 CB
Adult Wound Assessment and Management Chart					
Moving and Handling Assessment	✓				11/8 CB
Falls Risk Assessment	✓				11/8 CB
Bedrail Risk Assessment	✓				11/8 CB

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
11/8/20	Patient transferred from ED for	
0700	airway and circulatory monitoring.	
	Found slumped in car at wheel	
	by Traffic Police. Currently under	
	Police Custody x2 arrest warrants	
	in place.	
	On admission : Resp: Sats 90% on	

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Affix patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
11/8/20	2L O2 therapy via nasal cannulae – P4L.	
0700	RR 34. No cough/spit. Snoring but	
	maintaining own airway at present.	
	CVS: Maintains in sinus tachycardia	
	at 101bpm. BP 107/77. Apyrexial	
	warm and well perfused.	
	Renal: egfr >60. Has still to pass	
	urine. ? IV fluids – await medical	
	review.	
	GI: BM 8.8mmols. Normal diet and	
	fluids as CCS allows. Bowels inactive.	
	Neuro/Pain: Initially shouting out	
	but obeying commands. Sore at	
	moving. Has #(L) ankle – No cast etc.	
	Now eye opening to speech.	
	obeying commands: Confused	
	PEARL size 4.	
	Skin: Pressure areas intact. 4' care	
	raindins.	
	Micro: CRP 11 WCC 19.6. Covering	
	with IV Aciclovir and IV Ceftriaxone.	
	Family: NOK not documented.	
	Plan: CT head	
	If CCS to for further ICU review.	C. Bradley (CS)
07.30	Unable to CT head as became	
11/8/30	aggressive and agitated.	C. Bradley (CS)

Name: [redacted]
Address: 2104673933
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DoB:
CHI:
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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
1045	Patient to be transferred to Surgical	
11/8	HDU, under Surgical c/v next due to query head injury. Patient for CT head escorted by ICU due to the potential sedation, patient will need. Patient carries on 2L nasal cannula, SpO_2 - 95%, monitoring is sinus tach - 110 BPM remain normal tension 112/65, MAP - 78, GCS fluctuating between 12-14, staff nurse attempted x2 catherisation, unsuccessful. Bladder scan indicates 215 mls in bladder.	C.Creighton staff
	IV fluids continue 6°	C.Creighton SL
11/8/20 15.45pm	Patient transfered from medical HDU following being admitted with police as he was found slumped inside a car at the wheel. Assessed by DR Allan who requested a CT scan if tolerated. Patient managed CT which came back negative See notes.	
	RESP: Currently on 2L	Anne Coonagan
	nasal Cannula Sats 93%-	P Gaughan
	96%. RR 34-14 bpm able	Rens STN.

Patient

Patient

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NHS
Greater Glasgow and Clyde

Emergency Care Nursing Documentation

Presenting complaint - and relevant past medical history including allergies

Date and Time		Name/Signature
11/05/20.	↓GCS 1? Intoxicated 1? O/D	
0140.		

Nursing notes - on admission

Date and Time		Name/Signature
	ECG ET Bloods inc ethanol.	
	SpO2 ↓ 90% on room air	
	commenced on 2L O2 n/c.	
	NEWS (8).	
	?what Pt has taken.	LWON GN, LK
0245	Medical staff aware of	
	patients current NEWS 10	K Boyle / STIN
	and GCS 10.	
	2x dog tag chains taken off Pt +	

Triage

Patient prepared for exam - clothing bagged			(Y)	N	
NEWS Chart	(Y)	N	X-rays	(Y)	N
ID band	Y	N			
Peak Flow	Y	(N)	Please specify		
12-lead ECG	(Y)	N	Urinalysis	Y	N
IV access	(Y)	N			
Blood samples	(Y)	N	Positive findings		
Blood Gas	(Y)	N	B-HCG	Y	N

Communication

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

Police in attendance.

name,relationship,location,particular concerns

Risk Assessments and Screening Tools

SEPSIS	Y	N	GMAWS	Y	N
FAST	Y	N	Adult Support and Protection	Y	N
Swallow Testing	Y	N	Mental Health Triage Assessment	Y	N
Falls Risk (clinical judgeument)	Y	N	Child Protection Concerns	Y	N

Signature:

Patient name .....

Patient CHI .....

or use sticker

NHS
Greater Glasgow and Clyde

Care Rounds Checklist

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

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

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

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

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

Patient name .....

Patient CHI .....

or use sticker

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

NHS Greater Glasgow and Clyde

PUDRA

1	Pressure Damage	Does the person have redness and/or existing pressure damage? **IF YES, prescribe a minimum of 2 HOURLY Pressure relieving care** to avoid further damage occurring and complete the pressure ulcer interventional plan.

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2	Mobility	Does the person require assistance to mobilise or change position (inappropriate for age)?
3	Continence	Does the person have continence issues with urine and/or faeces (inappropriate for age)?
4	Nutrition	Does the person appear malnourished and/or unable to eat or drink/ PYMS score>2?
5	Skin	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6	Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY Pressure Relieving Care interventions and complete the pressure ulcer interventional plan.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
/ /	:							_____hrly	
/ /	:							_____hrly	
/ /	:							_____hrly	

Complete prevention of pressure ulcer interventional plan below for all patients with redness/pressure damage and for those at risk.

S Skin Inspection	S Surface	K Keep Moving	I Incontinence/ Moisture	N Nutrition	S Self Management/ Shared Care
Check: • Pressure areas _____ hourly • Skin under medical devices _____ hourly • Specify medical devices used	Specify: 1. Mattress 2. Cushion 3. Detail additional pressure redistributing equipment	1. Reposition ____ hourly in bed / chair 2. Overnight patient/carer has agreed to repositioning _____ hourly 3. Specify any manual handling equipment used	1. Skin Care to be carried out _____ hourly 2. Specify products required for increased moisture/ continence management:	1. Optimise nutrition and hydration 2. Refer to MUST	1. Discuss and agree plan with patient/ family/carer YES / NO 2. Prevent Pressure Ulcers" leaflet given to patient/family/ carer YES / NO

Patient name .....

Patient CHI .....

or use sticker

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Nursing notes - discharge plannning

Date and Time		Name/Signature

Outcomes and outstanding issues

Date and Time		Name/Signature

Pause for Discharge or Transfer

GGC Red Bag with Patient (nursing home resident)	Y	N
Relatives / Carer with Patient	Y	N
Name Band	Y	N
Nursing Screening Tools Complete	Y	N
Bed Available	Y	N
SBAR complete	Y	N
NEWS Chart NEWS completed within 1 hour of transfer/discharge	Y	N
Prescriptions and fluid charts signed	Y	N
Cannula	Y	N
Notes Complete	Y	N
Analgesia	Y	N
Belongings	Y	N
Transport	Y	N
Signature:		

Contact with relatives

Signature:

Patient name

Patient

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Andrew, M
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Glasgow, Lanarkshire G75 8JS

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Nursing notes - ongoing care

Date and Time		Name/Signature
	put in specimen bag.	
	IV access in situ. 1000ml	
	IV saline in situ.	
	Pt escalated to consultant	
	again as Pt ↑agitated /	
	RRsps ↑ 40-LFT.	
	Attended A&E / (L) ankle x-ray.	
	shows #	
	GCS currently 13.	
	will need HDU care / med beg	
	will RV in ED.	LWOW SN, LK
	Legs covered in Grazes /	
	cleaned and dressed.	
	Ethanol not received -ve sent	
	Med beg in to RV Pt at present.	
	?for CT Head - will likely need	
2400	for IV Acidair / ceftriaxone	
	Pt did not tolerate CT.	
	?for intubation.	LWOW SN, LK
0455	Patient now reviewed	
	by ITU medical staff	
	Now for Admission to	
	HDU. If GCS worsens	
	for ITU	

Patient name .....

Patient CHI .....

or use sticker

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4AT assessment - for delirium and cognitive impairment

		Circle Score
(1) ALERTNESS This includes patients who may be markedly drowsy (eg. dificult 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 (alert, but not agitated, through assessment) Mild sleepiness (<10 secs) after waking, then normal Clearly abnormal	0 0 4
(2) AMT4 Age, date of birth, place (name of the hospital/building), current year.	No mistakes 1 mistake 2 or more mistakes/untestable	0 1 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.	wAchieves 7 months or more correctly Starts but scores <7 months / refuses to start Untestable (cannot start, unwell, drowsy, inattentive	0 1 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 24hrs.	No Yes	0 4

4 or more	possible delirium + /- cognitive impairment	**TOTAL**	
1-3	possible cognitive impairment		
0	delirium or severe cognitive impairment unlikey (but delirium still possibe if (4) information incomplete		

Frailty Assessment Tool (Healthcare Improvement Scotland)

Step 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)? circle Y or N

F	**Functional impairment**	(new or worsening) eg difficulty with self care	**Y**	**N**
R	**Resident**	in a care home	**Y**	**N**
A	**Altered mental state**	such as delirium or dementia (**4AT Assessment**)	**Y**	**N**
I	**Immobility/instability**	decline in mobility, difficulty mobilising without help, fall leading to presentation	**Y**	**N**
L	**Living at home with support**	on a daily basis (homecare, one visit or more per day)	**Y**	**N**

If YES to any of the criteria in Step 1 move to Step 2

Step 2 Would this person be better managed by another speciality team at present? circle Y or N

Clear need for other specialty input eg exacerbation of known long-term condition such as COPD	**Y**	**N**
Need for HDU/ITU (including non-invasive ventilation)	**Y**	**N**
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit	**Y**	**N**
Head injury with loss of consciousness	**Y**	**N**
Acute abdominal pain/ surgical presentation	**Y**	**N**
Upper GI Bleed	**Y**	**N**
Chest pain with suspected acute coronary syndrome	**Y**	**N**
Trauma with suspected fracture	**Y**	**N**

Are any of the criteria met?

If YES to any criteria in Step 2: Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.

If YES to any criteria in Step 1 and NO to ALL criteria in STEP 2: Prioritise transfer of care to specialist geriatric assessment service.

Acute Services Division

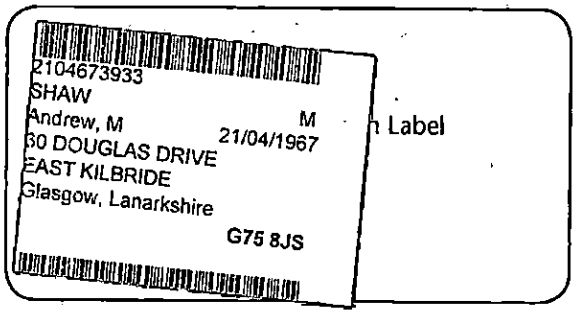
NHS Greater Glasgow and Clyde

MRSA Screening

Hospital: QMH

Ward: MHD4

Date: 11 / 8 / 20



A. Clinical Risk Assessment (CRA) - for patients >23 hours	Yes	No	Not Known
1. Has the patient ever had a previous positive MRSA result?	☐	☐	☐
2. Has the patient been admitted from a care home / institutional setting or another hospital?	☐	☐	☐
3. Does the patient have a wound / ulcer or invasive device which was present prior to admission?	☐	☐	
If **'Yes'** to any question **or** if the patient is within (or admitted to) a High Impact Specialty* complete section B **('Not known' = 'No')**			
*** Orthopaedics / Vascular / Renal / Critical Care** (please circle)			

B. MRSA Swabs taken (✔):	
Other(s).....	Nose ☐
.....	Perineum ☐
.....	Patient refused ☐
.....	

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CLINICAL NOTES - MEDICAL ☐
NURSING ☑

Please tick ✔ appropriate directorate

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Glasgow, Lanarkshire
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Date & Time	CONT..	Signature, Print Name & Designation
11/8/20 16:00	to cough + clear.. Heavy snoaring when sleeping	
	CARDIO: Monitoring in Sinus Tachy to Sinus Rhythm HR 92-98 bpm BP 130/85 map 86-100 Apyrexial BM 6.1mmols	
	RENAL: No urine passed until 16:00 hr when Catheter was unseted after several times however patient was very unsettled pulling this & it was removed after CT Scan 700mls in total. Currently has asked for a bottle but not passed anything.	
	GASTRO: Able to have diet + fluid as ACS allows ACS 14/15. Bowels not moved as of yet	
	Neuro / Pain: Currently Confused to day + time Can follow instructions at times. Complaints of pain in Shoulder & Complaints of pain in foot which has a confirmed Small break in ankle. Pain Seems to be a	Orla Connelsn P. Gourlay ST/N

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Date & Time	CONT.	
11/8/20 16:30	b it better this afternoon Medication given as per Kardex SKIN/LINES: Skin & pressure areas dry + intact. Scraps + bruises to knees + arms patent arrived to A+E like this. Currently sleeping at time of writting notes	over coccygeal SN. P. Gourley Peny ST/N.
18/8/20 18:00	DR requested urine dip drug test however not passed urine to do this, I will continue to try.	P. Gourley Peny ST/N
11/8/20 18:15	Collected moon boot from A+E however patients foot to big will ask physio tomorrow if they can get one that fits PVA removed from left arm as it tissued AWI insitu. X-Ray taken of (R) foot and (L) Shoulder dr ward.	P. Gourley Peny ST/N
12/8/20 05:00	Patient was slightly unsettled had of the night, but settled down Neesike. Airway + Intact & Patent Breathing + On (2-4) L NC SPO2 (92-98)%. Keep on taking NC off, despite of regular to keep them on. Tube Cont.	Lt A

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CLINICAL NOTES - MEDICAL ☐ NURSING ☑

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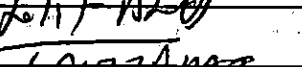
HDU6

Date & Time		Signature, Print Name & Designation
11/8/12 0500	resp rate (26-30) rpm, shallow short breaths.	
	Circulation + BP unsupported, normal tension, SR heart rate (85-93) bpm	
	Afebrile	
	BM 6.5	
	Patients pressure areas are intact, on 4° pulmonal turn.	
	Patient took some water before midnight.	
	IV fluid stopped as patient kept folding his arm at the PIC site.	
	Neuro obs.	
	13/15 ↗ eyes opening to speech obeys commands, confused	
	Pupils are equal & reacting.	
	limb movement Right upper & lower limb have normal	
	power whereas left upper & lower limb have - mild	
	weakness	
	Patient hasn't passed any urine yet.	
11/8/12 0515	Patient has had some regular	
	paracetamol & codeine 30mg,	
	prescribed for Oromorph.	

83949 GGC0072

Date & Time		Signature, Print Name & Designation
11/8/20	Patient was given positional	
0730	clexane, still very confused	2104673933
	and mumbling, recognised by	SHAW M
	name & DOB, but very	Andrew, M 21/04/1967
	confused GCS 13/15	30 DOUGLAS DRIVE
	Clexane given PR normally,	EAST KILBRIDE
	however patient refused	Glasgow, Lanarkshire
		G75 8JS
		
12/8/20	Patient has been drowsy all day.	
1600.	Sleeping on and off, however	
	appears comfortable.	
	OBS: requiring 4L NC maintaining	
	sats 92% and above today.	
	Cardiovascularly stable,	
	unsupported and BP ~~stable~~	
	normotensive. Monitoring in	
	SR throughout. afyrexial.	
	Patients back red on turning	
	however intact. Has been	
	taking sips of water. Ice cream	
	and ice lolly this afternoon.	
	Patient obeys commands and	
	opens eyes to speech. Catheter	
	in place as of 11am. Drained 380ml	
	straight away. See fluid balance	
	Chart. Co-Codamol not given (14)	
	due to drowsiness. However,	
	managed to give # at 1600	
	as per Icarda. PRN oramorph	
	given before physio this am.	
	Physio carried out a bed	
	edge sit. Medical notes have	
	a plan to allow pt to weight-	
	bear. Drug Urine test also... cont..	

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CLINICAL NOTES - MEDICAL ☐
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Please tick ✔ appropriate directorate

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Date & Time	Continued . . .	Signature, Print Name & Designation
12/8/20	Carried out this afternoon.	
1600	Toxic screen :-	
	Cocaine +ve	
	Amphetamine +ve	
	Methamphetamine +ve	
	Opiod +ve	
	Benzos +ve	
	THC -ve.	
	Medical staff aware.	
	All personal care needs also	
	carried out throughout the	
	day. Bed bath this morning	
	pt refused a shave. ~~or~~ Regular	
	oral sponge and vaseline	
	to lips.	Emylie SN
1700	Patient had strawberry	
	mouse and ice cream.	
	Is currently asleep. Clexane	
	given. BM 7.1.	Emylie SN.
13/8/20	Patient has been drowsy since	
0100	the beginning of the shift,	
	arousable while carrying out	
	ADLs, still drowsy 13/15	
	can be aroused to speech,	
	confused and talking things	
	that are not making	
	sense, left upper & lower	Lolit Shett
	limb has mild weakness	CAPT ASMAZZ
	cont. —	SN (RN)

83949 GGC0072

Date & Time		Signature, Print Name & Designation
13/8/20 0100	Airway + Patient airway is patent & intact Breathing + On 4L NC, SpO2 (96-98)-/. respiratory rate (22-25) rpm Circulation + B.P unsupported stable, cardiovascularly systolic B.P (134-141) MAP (88-97) SR, H.R (94-96) bpm Apyrexial O/N BM 6.2 Patient took few sips of water O/N, around midnight after having some water patient started to cough vigorously possibly aspirated which settled down after few min. Renal function + Urinary catheter insitu, passing an average of 30ml/hr. not on IV fluid, due to the PVC location as it start to alarm as soon as attached to fluid Medical staff are aware of that and would like patient to be encouraged for oral intake instead. Patient's skin is intact, pressure area are intact, c/o sore left ankle painful while moving	2104673933 SHAW M Andrew, M 21/04/1967 30 DOUGLAS DRIVE EAST KILBRIDE Glasgow, Lanarkshire G75 8JS CAL I MAN S/N(N)

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CLINICAL NOTES - MEDICAL ☐ NURSING ☑

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Date & Time		Signature, Print Name & Designation
13/8/20	Patient was offered his	
0730	morning medication (co-codamol) which	
	he refused to take and	
	said "not in pain".	
13/8/20 1330	R/V by Dr Allan critical care consultant. Still appears drowsy and confused. Continue to monitor in HDU until has resolved.	
	(A) maintaining own airway	
	(B) Now on room air, aim for sats >90%. Sats 92-94% on room air. Resp rate remains high 20-28.	
	(C) Monitoring in sinus rhythm, HR 78-87 bpm. Bp stable, 130/80 MAP 94. Warm and well perfused. Apyrexial.	
	(D) GCS 14/15. Remains confused and unable to tell staff where he is etc. No complaints of pain. Regular co-codamol given. Catheter insitu draining good volumes. Nil PR today. 1 x PVC to left arm, not currently in use. Taking oral diet and fluid, no issues or concerns. Remains very drowsy, will continue to	→(CONT) (B4)

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Date & Time		Signature, Print Name & Designation
13/8/20 1330	monitor.	2104673933 SHAW Andrew, M - -- 21/04/1967 M 30 DOUGLAS DRIVE EAST KILBRIDE Glasgow, Lanarkshire G75 8JS
	(E) Pressure areas intact, 1x moisture break / blister on (L) buttock. Will continue to R/V. Assist x 3 up to sit today with hoist. Able to stand at ~~him~~ side of bed with stand aid today. Can put weight through left foot, movement improving. No further issues at present.	S. Harvey Sharvey (SN)
16[00]	Patient has had 3 episodes of Severe brady this afternoon. HR dropped as low as 29 Bpm and then again to the low 40's. 12 lead ECG carried out, unable to catch moments of brady showing Sinus rhythm. Medics aware, Continue to monitor	S. Harvey Sharvey (SN)
17[20]	R/V by Dr Allan believes H/R could be related to sleep apnoea. No further	S. Harvey Sharvey (SN)
14/8/20 0130	- Observations stable. SpO2 96/94% on 2L O² via nasal cannula. RR 21-29. Coughing & expectorating at times. Cardiac monitoring in a sinus rhythm 75-85 bpm. BP systolic 113-114 diastolic 60-63 map 78-80. Temp 35.5-36.1	
	- Urinary catheter patent and draining volumes fair 70-90 mls 2°.	N. C — (5)
	Bowels not active.	N. Callender. S/N

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CLINICAL NOTES - MEDICAL ☐ NURSING ☑

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Date & Time		Signature, Print Name & Designation
14/8/20	- No IV fluids running	
cont	Taking good volumes of oral fluids when aware.	
	- Declined cocodamol @ 10pm No complaints of any pain, looks comfortable. No nausea or vomiting	
	- Assisted with positional changes but pt moving around and removing pillows Moisture leison noted on sacrum. Buttocks red	
	- XL patent PVC. VIP 0.	
	- GCS 13/15 PEARL. Not communicating, only saying the occasional words Obeying commands. Settled and sleeping for most of the night so far.	
	- Police in attendance all night.	
	- Occasional episodes of bradycardia ↓35bpm. Lasting 1-2 per seconds.	N. C ~ (5)
	- No new concerns at this time.	N. Callender. S/N
14/8/20 1115	Ward round :- Continue HDU monitoring, Neuro obs. Check mgt. Urine dip.	
	(A) airway intact	
	(B) RA - 2L O2 via Nasal canula, aim for sats >90%. Sats 94 - 98%. Resp rate 16-20. chest sounds clear this morning. Not coughing or expectorating.	
		→ CONT Shanest

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Date & Time		Signature, Print Name & Designation
14/8/20 1115	© monitoring in sinus rhythm. Patient continues to have brady episodes, HR ↓ to 35-39 Bpm and then returns to normal very quickly. Had one episode of extreme tachy HR↑ 180 Bpm, again returned to normal very quickly. Unable to catch abnormal rhythm under 12 lead ECG. Doctors aware, continue to monitor. Bp stable 146/73 MAP 85. 1 x PVC to left arm, ? remove as is not in use.	
	ⓞ Apyrexial. Very sweaty and clamy today. Showing signs of withdrawal, very unsettled today. Seen by addictions, will come back on monday and review further when patient more alert and orientated. GCS 13-14 today. Still remains muddled however alot more alert than previously had been. Able to tell staff he is in hospital, unsure of year etc when asked. When asked about what had brought him into	→CONT (8)

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☑

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2104673933
SHAW
Andrew, M
M
21/04/1967

Date & Time		Signature, Print Name & Designation
4/8/20 1115	hospital he stated "he didn't know what they had given him" and that "he doesn't take anything". Police remain in attendence. Catheter insitu, volumes satisfactory. For urine culture to be sent today. (E) Assist x 1 with hygiene needs in bed today. Assist x 3 and stand aid up to sit today. Will require hoist back to bed as per physio instictions. Encourage oral diet and fluid which is managed well today. Patient alot more alert and orientated when sat up in chair at bedside. encouraged to sit up for long periods.	S. Haney Shaney (SN)
1430	Hoisted back to bed this afternoon.	
	Patient allert and orientated @ GCS 15/15.	S. Haney Shaney (SN)
1430	moisture leison noted on buttock -	Shaney (SN)
1620	Patient had multiple episodes of Sinus tachy, ~~witness~~ & Witnessed by FY1 and FY2. ECG carried out, unremarkable.	→ CONT (SN)

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Date & Time		
13/8/20 1620	Now complaining of intermitant chest pain. For a troponin level added onto the bloods. D/N cardio.	S. Harvey Sharvey (SIN)
14/8/20	Family settled overnight.	
0300	Slept for long spells -	
	Eyes opening spontaneously.	
	Obeying commands.	
	States he is in hospital in Glasgow. Pupils are 3- equal + reacting.	
	Normal tone in both U+L hands + leg slightly weaker than R, # L leg ankle mm 15/9.	
	Remains quite sleepy.	
	Doesn't converse much.	
	Spo2 98% on 2L via nasal cannula.	
	RR 16-18 Apyrexial. HR 80-90	
	Bp 115/69.	
	Took co-codamol prior to setting.	
	Can be quite restless in the bed at times.	
	Can eat + drink, needs encouragement.	
	Catheter in 2hrly cds - same	
	Satisfactory.	Mhairi
	NFPK.	Mhairi RGN
15/8/20 1200	Patient was seen by F/Y2 McLaughl and the plan is	
	Ward F+I	
	Daily bloods	L Hallett
	D/C when ok'd by OK	TANZANIAN STUDENT (SIN)

TBC

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐ NURSING ☑

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Date & Time		Signature, Print Name & Designation
15/8/20 1200	Cont. Airway ↑ Patent Breathing ↑ On (2-3)/ NC, SpO2 (96-98)-l. , respiratory rate (18-22) rpm Circulation ↑ Cardiovascularly stable, normotensive , SR , heart rate (65-94) bpm MAP (87-100) Apyrexial BM 6.9 Patients skin is warm to touch, well perfused , mottled lesion to left buttock, skin is easily getting red at base so req. 4° turn. Renal function ↑ Patient is catheterised and passing (30-45) ml/hr. Patient can eat & drink, took some porridge this morning and small lunch, had some Orange juice am & for lunch Staff contacted patients lawyer Mr. Jim Friel's number 0141 4203134 as provided by patient - left a message for the lawyer, to contact the hospital Patient was crying this morning, so sent away COVID-19 Screen	[signature] CHARGE NURSE 15/8/20

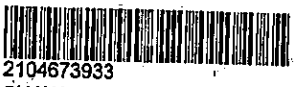
83949 GGC0072

Date & Time		Signature, Print Name & Designation
15/8	Patient transferred to ward 10C	
15:15	from HDU. News as charted on	
	arrival. 2L O^2 in situ. GCS	
	14/15. Vague, unable to remember	
	what happened. Catheter patent.	
	Skin checked. Moisture lesion to	
	(L) buttock. Patients current NOK	
	is Lawyer. No MUST documented -	
	to be obtained ☐. Patient	
	bedrest at present. AWI in	
	situ. MRSA swabs obtained.	
	Covid19 swab taken before	
	transfer - results pending -	
	Bruising to (L) shoulder, Medical	
	notes state Weber A # on (L)	
	side. for ankle boot and F/u	
	6 weeks # clinic. (L) Foot	
	swollen. Addiction to review	
	again on monday. Settled at	
	present. Under police custody.	
17/08/20	Patient complained of chest pain	
2:30	and was very agitated. Stated he	
	wanted his catheter out - Spoke to	
	Fyi who came to R/V. Patient	
	catheter removed. Patient ECG	
	carried out. Patient had bloods taken	
	which showed no ↑ troponin. Patient	
	had GTN spray. IV morphine given	
	for Pain Observations as per NEWS	
	Chart. Patient became very agitated	
	due to catheter being in. Catheter	
	now removed. Patient for regular	
	observations. GCS 15/15. SPO2 on	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☑

Please tick ✔ appropriate directorate


2104673933
SHAW
Andrew, M
M
21/04/1967

Date & Time		Signature, Print Name & Designation
"Cont"	with medical staff who state	
16/06/20	this is not an MI, and an	
02:30	anxiety attack. Patient no	
	longer ~~hyperventilating~~ hyperventilating	
	Has yet to pass urine. Patient	
	assisted with personal care	
	and postional changes. to	
	remain on 2hourly observation	
	checks. Currently sleeping	
	will continue to monitor.	
06:10	patient had settled night observations	
	carried out every 4 hours at medical	
	request GCS 15/15 Patient declining	
	postional changes. Patient remains	
	HOT & clammy but states he feels	
	well. Still not passed urine. will continue	
	to monitor.	
16/8/20	NEWS 2. due to O2 therapy FYI	
19:00	reviewed and 96 DFI18 for ~~DNR~~ withdrawal	
	and is more settled no more complaints	
	of chest pain, on diazepam. On diazepam	
	BD. Incontinent of urine. Remains under	
	police custody BY a moonboot. 2° Active	
	care	
17-06-20	patient's night been settled	
00:40	night observations as per news	
	Chart. All medication as per	
	Kardex. Patient declining Postional	
	Change(s). Passing urine via bottle	

83949 GGC0072

Date & Time		Signature, Print Name & Designation
	Patient appears settled & comfortable remains in police custody. Will continue to monitor.	
0545	patient declined postional changes overnight. Changing own postion at times. Will continue to monitor.	
17/08/20 1620	Patient been fairly settled over the course of the day. all medications as per kardex. Paracetamol given. observations as charted news-2 due to O2 therapy - Patient active care as charted. Patient await review by PT for moonboot, patient then for mobilisation. Patient remains in Police custody. Await addiction RN and Psych RN referrals made. Patient assisted with personal hygiene this morning - all diet and fluid, normal. Passing good volumes of urine - Patient settled. No further concerns	Reoper rebeccareoper SWS
18/8/20 0020	All care given as planned. Medication as per Kardex. Observation as per charted. NEWS (3) Oxygen therapy of 2L. SpO_2 = 95, Comminating well and is alert. Tolerating normal diets and fluids. Passing urine spontaneously using bottles. No bowel movement. Patient is moving around bed well. Active care 2-3 hours and uptodate. Patient requires assistance with personal care. Patient went for a CT Scan this evening. Patient seems settled tonight.	~~Ashoo~~ leasinge RN
03[20]	Patient attended CXR at evening - awaiting review.	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐ NURSING ☑

Please tick ✔ appropriate directorate

2104673933
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Glasgow, Lanarkshire
G75 8JS

Date & Time		Signature, Print Name & Designation
18/8. 15.30	Settled. News as charted. Medicat given as prescribed (1) with personal hygiene. Awt PT input - for Moonboot. Reviewed by psych, no input at present, will come and review again at end of the week. Tolerating diet & fluids - o² therapy in situ when tolerated. Remains vague. Aware in hospital -	JOH SN SDick.
19/08/20 03'15	Medicamentation not given as patient refused. NEWS 3. Commence on O₂ therapy. Passing urine using bottles. Bowels inactive. Taking fluids. Independent with personal changes. No issues overnight	
19/8. 12.15	Settled. News as charted. Medicat given as prescribed. Assisted with hygiene. Up to sit by PT. Tolerating diet & fluids. Passing urine. Reviewed by addictions. Commenced on diazepam ? to help with hallucinations / withdrawals. will contact ward again on Friday. ? patient has drug induced psychosis.	JOH SN SDick.

Date & Time		Signature, Print Name & Designation
16.30	Remains slightly agitated but settled. News as charted. Assisted back to bed. Follow SOWS chart for analgesia. Passing urine. Tolerating diet & fluids.	J Ng SN Sajida
20/08/20 08:00	Medication given as prescribed. NEWS 0. Passing urine using bottles. Patient agitated and in pain at evening. PRN Diazepam 60 mg given (SOWS 5). Independent with positional changes. Bowels inactive.	Ummu SN
20/8. 14.30	Settled. News as charted. Medication given as prescribed. Cont on reducing dose diazepam. Cont PT at present. Mobile with Argo walker and assistance at present. Still not fit for D/C at present. Police updated. Passing urine. Tolerating diet & fluids. Assisted with hygiene.	J Ng SN Sajida.
12m	NEWS 2 Sp O2 93% Oromouth pain prior to pethidine	marin Lwt (5)
21.8.20	Slept long spells Changed ~~clothes~~ own position overnight	Lwt.

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☑

Please tick ✔ appropriate directorate

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Date & Time		Signature, Print Name & Designation
21/8/20.	Pt independent with personal care this morning. All	
Day	meds given as per Kardex. Tolerating diet and	
	fluids well. NEWS (0). Pt co-operating slightly	
	better with mobility today. Breakthrough analgesia	
	given. S/B ~~additions~~ evening. Liaison also want to check	
	in again once course of diazepam has been	
	completed. For r/v only next week. S/B addiction	
	liaison - to continue reg diazepam (guidelines in	
	Kardex for reduction). Dihydrocodeine should	
	be reduced before discharge. No further input re-	ASTHANA SIN
	quired from addictions. Will continue to monitor	
21/8/20	Slept well overnight.	
NIS.	Pressure areas dry and intact.	
	Using bottles to pass urine.	
	Observations stable. EWS=0	
	Not scoring on SAWS.	
	Medication as per kardex.	
	Police remain in attendance	
	ACP completed. 3 hourly.	M. GRACIE M. SIN
22/8/20	All planned care given. observation	
1410	as charted. NEWS (2) due to SpO2	
	of 92%. Communicating with staff.	
	Patients tolerating normal fluids and	
	diet. Passing urine spontaneously,	
	no bowel movement. Active care	
	up to date, 2-3 hourly position change	
	Mobilising with steady & AO2, and	
	has been on the chair. Patient is now	
	on diazapam reducing dose for 5 days.	~~ASHOOR~~ A.IGBAJONGO STN

Date & Time		Signature, Print Name & Designation
11am	NEWS 2 SpO2 92%	
	Oxygen @ 2L/min via	
	Vpu	Lutrell
23/8/20	appeared to sleep well	—
	Remains in police custody	
11pm	Independent ↓ personal hygiene	
	diet and fluids taken	
	passing urine spontaneously	
	up to pit using steady + SOV	
	to transfer, all due meds	
	given as charted, NEWS 2	
	0/0 pats, all obs stable	D. Antao
23/08/20 1420	All care given as planned. Observation as charted. NEWS (2) due to temp 35.7°C and BP 103/64. Patient has had a wash in the chair. Communicating with staff, tolerating normal diets and fluids. Passing urine spontaneously. 3 hourly active care up to date. Skin intact and mobilising with a steady x A02. Medication as per Kardex, NO further issues	~~Athoo~~ Akalonjo RN/M
1pm	NEWS 1 SpO2 96%	
	Up to bath Vpu + BO	
	Progress ~~was~~ well	Lutrell
24.8.20	Slept soundly overnight	M.
24/8	NEWS 2. SPO2 96%. RA +	
Mcee	temp 35.7. Discharged w/	
	appointment letter + TOC.	Brenda
	Transported by police.	

Record of Communication with Relatives / Carers

NHS Greater Glasgow and Clyde

This form should be stored at the front of the patient's nursing notes during the period of admission and then filed on discharge.

Hospital: QEUH Ward: MHOU

Name: 2104673933 SHAW Andrew, M M
Addres 30 DOUGLAS DRIVE EAST KILBRIDE Glasgow, Lanarkshire G75 8JS
DoB: 21/04/1967
Chi nur

Support and Care Arrangements

No Carer identified ✓ If NO following section N/A

IDENTIFYING	Yes ✓	No ✓
Have support and care arrangements been confirmed with relative / carer? N.B. record details below including details of any existing support plans		
INVOLVING	Yes ✓	No ✓
Have progress and on-going support needs been discussed with relative / carer?		
Have the carer's views / opinions / requests on discharge plan been noted?		
Has the carer given consent to share their views with the patient?		
SUPPORTING	Yes ✓	No ✓
Has the carer been advised of what support is available to them?		
Has the "Are you looking after someone?" flyer been given to the carer?		
Have you referred to a support service?		
Has the offer of support been declined by the carer?		

Record Name of who discussed with; details of discussion; action agreed.

Date	Record of Communication	Print and Sign Name	Staff Code
15/8/20	I phoned the patients lawyer Jim Fried this morning at 0141 420 1234 and left a message to contact the ward, based on information provided by the patient	[signature] CAIRNHILL	C/O (N)

Staff Codes: **N** – Nursing. **M** – Medical. **P** – Physiotherapist. **OT** – Occupational Therapist. **SW** – Social Worker. **SLT** – Speech and Language Therapist. **D** – Dietician. **O** – Other.

Carers Information Line: 0141 353 6504
NHSGGC Support & Information Services: 0141 452 2387

Record Name of who discussed with; details of discussion; action agreed.			
Date	Record of Communication	Print and Sign Name	Staff Code

NHSGGC Bedrail Risk Assessment

2104673933
SHAW M
Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

NHS Greater Glasgow and Clyde

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

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

Use guidance on the reverse of this document when completing this Risk Assessment								
	DATE	11/8/20		11/8/20		15/8		23/8/20
	TIME	0700		2300		1600		1400
	WARD	MAIN		MAIN		10C		10C
	HOSPITAL	QEUH		QEUH		QEUH		QEUH
SECTION ONE – GENERAL		**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**
1	Is the patient likely to fall, roll, slip or slide from the bed?	✓		✓			✓		✓
2	Has the patient requested the use of bedrails?		✓		✓		✓		✓
IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED									
SECTION TWO – COGNITIVE AND PHYSICAL STATUS									
3	Is the patient at risk of climbing out of bed?	✓		✓		✓		✓	✗
4	Is the patient stressed, delirious or restless?	✓		✓		✓		✓	✗
5	Is the patient small in stature?		✓		✓		✓		✓
6	Does the patient have an unusually large or small head that might present an entrapment issue?		✓		✓		✓		✓
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?		✓		✓		✓		✓
IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
SECTION THREE – COMMUNICATION									
8	Has the patient been consulted regarding the use of bedrails?	✓		✓			✓		✓
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition	✓		✓			✓	✓	✗
10	Has the use of bedrails been discussed with relatives/carers?	✓		✓			✓		N/A
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?		✓		✓		✓		✓
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?	✓		✓		✓		✓	
IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
SECTION FOUR – DECISION MAKING		**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**
13	Will bedrails be used for this patient at the present time?	✓		✓		✓		✓	
14	Rationale for use of bedrails: (Please insert code in the box on the right)								
	A – Risk of falling from the bed	✓		✓			✓	✓	
	B – Risk of rolling from the bed	✓		✓					
	C – Risk of slipping from the bed	✓		✓					
	D – Risk of sliding from the bed	✓		✓					
	E – Patient request	✓							
15	Bedrail risk assessment completed by:	G. Bradley		[illegible]		D Cole		[illegible]	
16	Bedrails checked by:	GB		[illegible]					
17	Date	11/8/20		11/8/20		15/8/20		23/8/20	

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

A. Alternatives to bed rails:-

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

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

Is patient:-

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

C. Safe use and application of bedrails:-

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

D. Record keeping:-

All of the following should be recorded:-

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

Bedrail risk assessments should be made as follows:-

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

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2104673933
SHAW M
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EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

Care Plan

NHS
Greater Glasgow and Clyde

Care discussed with patient ☐ Yes ☐ No ☐ Unable	If unable, give reason:
Care discussed with family ☐ Yes ☐ No ☐ Unable	If unable, give reason:

Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
11/8 CB	1° HDU observations				
11/8 CB	c/o cardiac monitoring				
				5. Hydration and Nutrition	
			11/8 CD	Diet and fluids as GCS allows	
			11/8 CB	Food Record Chart in-situ.	
	2, 3. Communication and senses				
11/8 CB	maintaining own airway				
11/8 CB	drowsy @ times / combative @ times				
				6. Elimination	
	4. Cognitive status		11/8 CD	c/o urinals and bedpan whilst GCS 1 Up to toilet	
11/8 CB	GCS 13/15				

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21/04/1967

Care Plan

NHS
Greater Glasgow and Clyde

Date Commenced and Signature	7. Personal Hygiene, oral care, skin care and wound care	Date Discontinued and Signature	Date Commenced and Signature	9. Maintaining a safe environment, Technical Care	Date Discontinued and Signature
	Bed bath with assistance			Bed rails in situ	
	L' care raindrops			Police Custody	
				Buzzer to hand.	
			22/8/20-ME	ACP 3 hourly	
				10. Sleep and Rest	
				Promote restful environment	
	8. Mobility				
	Bedrest			12. Privacy, dignity and sexuality	
22/8/20 ME	Steady + aO2.			Maintain at all times	
21/8	Argo Walker +				
	heavy moon boot.				
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

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Care Rounds Checklist

Date: 11/8/20

A2104673933
SHAW M
Andrew, M 21/04/1967
M
Ian.Bradley2

NHS Greater Glasgow and Clyde

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

1. Signed G.Bradley Name G.BRADLEY Designation S/N
2. Signed [illegible] Name L.DOHERTY Designation S/N
3. Signed [illegible] Name LAIZA AMAM Designation S/N (NS)

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

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

			Times	06 40	12 30	15 00	18 45	21 02	23 45
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		Y	Y	Y	Y	Y	Y
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.		N	Y	N	N	N	N
S	3	**SKIN INSPECTION** Pressure areas checked:		Y	Y	Y	Y	Y	Y
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		INT	INT	INT	INT	S INT	S INT
K	4	**KEEP MOVING** Has the patient moved or walked?		Y	Y	Y	Y	Y	Y
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		B	L	B	L	R	L
		Chair Assist to walk or stand (W/ST)			/	/	/	/	/
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		N	A	A	A	N	N
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?		Y	Y	Y	Y	N	N
		Drink taken?		N	N	N	N	S Y	Y
		Food, snack, or supplement taken?		N	N	N	N	N	N
		Has oral hygiene been carried out as per care plan?		N	N	N	N	Y	N
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		N/A	NA	Y	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.		NA	NA	NT	NT	NT	NT
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.		N/A	NA	NA	NA	N/A	N/A
		Care provider / role		SB/S	PG/G	PG/G	PG/G	LM/SN	LM/SN

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

ml • 278936 v2.1 • GCC0098

Day: Admit HDU / ERAS / Post op day: 11/8/20

Consultant:

2104673933 M
SHAW
Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire G75 8JS

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

Sedation Score	
A	Awake / Alert
V	Asleep roused by speech
P	Physical Stimulation (e.g. shaking) when required to waken
U	Unconscious / not roused by speech or shaking

Nausea Score	
0	None; No treatment required
1	Mild; not distressing; no retching/vomiting CONSIDER TREATMENT
2	Moderate; Troublesome; occasional retching/vomiting TREATMENT REQUIRED
3	Severe; Distressing; frequent retching/vomiting URGENT REVIEW REQUIRED

Air Entry				Secretions				Amount	
✓	Present	D	Dull	M	Mucoid	B	Bld stain	1	Scanty
H	Harsh	▾	Dull to Base	MP	Mucopurulent			2	Moderate
Q	Quiet	W	wheeze	P	Purulent			3	Profuse

C= Cough, C+cl = Cough and clear, C/ncl= cough and not clearing

Length of stay Balance: **Previous 24hr Balance:**

	Input (mls)								Output (mls)								
	Oral						Hourly Total	Running Total	Urine	NG	Stoma/bowel				Hourly Total	Running Total	Balance
08:00																	
09:00																	
10:00																	
11:00																	
12:00																	
13:00																	
14:00																	
15:00																	
16:00																	
17:00																	
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20:00																	
21:00																	
22:00																	
23:00																	
24:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
Totals																	

Affix label here

Day: _____ HDU / ERAS / Post op day: _____

Consultant: _____

NHS Greater Glasgow and Clyde

Daily Goals (ERAS Patients - see pathway)

Aims For Today (goals, bp target, target ABGs, tests, procedures, results)

Respiratory: Aim SpO_2 pO_2: pCO_2:
Chest Physio: Yes / No

Renal / Fluid balance:
Sips / Normal / IV / Needs Encouragement / NBM

Fluid Balance Goal for Next 24 hours:

Cardiovascular: Aim Map: Systolic:

Gastrointestinal:
NBM / Clear Fluids / Soft / Light / Normal / NG / TPN / Encouragement

Neurology:

Rehab: Suitable for Physio? No / Mobilise / Dangle / Out to sit

Wounds:

Microbiology:

Suitable for Discharge to the Ward? Yes / No / Only if bed required

Question for Visiting Specialities

Pain Review / Plan

Are any Drug levels required or any supplementary Blood tests or Investigations?

Can and Drains or Lines be removed today?

Secondary Review

Medication Review

Can any Drugs be discontinued?

Can any IV Drugs be changed to Oral?

Can any regular medications be restarted?

EnoxaparinY/N TEDS on Y/N
Flotron Boots Y / N

DNACPR Completed?
Yes / No / Not applicable

AWI Required? Yes / No
Review Date:

Affix label here

Date: _____

HDU / ERAS / Post op day: _____

Consultant: _____

Arterial Blood Gases

Time																
$FI0_2$																
H^+																
pCO_2																
pO_2																
Na^+																
K^+																
Glucose																
Lactate																
Hb																
SO_2																
BE																
HCO_3																

Lines / Indwelling Devices

Line type	Date	Due Changed	Date & Initial change	Line type	Date	Due Changed	Date & Initial change
Central line Transducer				Chest drain Bottle			
Arterial line Transducer				Wound drain /Bag			
NG Tube				Local Block Line			
NG Drainage Bag				Sub-Cut Line			
Uromeler							
Epidural							
Tracheostomy							
O2 / NIV circuit							
Nebuliser Circuit							
Chest Drain							

Record of Care

	Day Shift		Night shift
08:00		20:00	
09:00		21:00	
10:00		22:00	
11:00		23:00	
12:00		24:00	
13:00		01:00	
14:00		02:00	
15:00		03:00	
16:00		04:00	
17:00		05:00	
18:00		06:00	
19:00		07:00	

NHS Greater Glasgow and Clyde

Affix label here

y: Admit HDU / ERAS / Post op day: 11 20

Consultant:

Safety Checks / Damp Dusting	
Day Shift: (initial)	S
Safety Checks:	/
Alarm Checks:	/ 10
Night Shift: (initial)	
Safety Checks:	/
Alarm Checks:	/

Time	08:00	09:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00
FIO_2	4L																							2L
Mode	NC																							n/c
Hi-flow Flow rate	/																							
IPAP/PS	/																							
EPAP/PEEP	/																							
Humidifier Temp	/																							
SpO_2	94%																							
Resp rate	34																							
Air entry	VV																							VV
Secretion/Suction	NIL																							NIL
Pain Score																								5
Sedation Score																								V
Nausea Score																								5
Blood Glucose																								8.8
Rhythm	ST																							SR
CVP																								

Observations		Temperature
	200	
	190	
	180	41
	170	
	160	40
	150	
	140	39
	130	
	120	38
	110	
	100	37
	90	
	80	36
	70	
NIBP = ▲	60	35
ABP = ^	50	
Pulse = •	40	34
Temp = X	30	
	MAP	

35.7
37.7
37
36.7
(92)

Day: 1 HDU / ERAS / Post op day: 11/8/20

Consultant: Critical Care

2104673933
SHAW M
Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

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

Sedation Score	
A	Awake / Alert
V	Asleep roused by speech
P	Physical Stimulation (e.g. shaking) when required to waken
U	Unconscious / not roused by speech or shaking

Nausea Score	
0	None; No treatment required
1	Mild; not distressing; no retching/vomiting CONSIDER TREATMENT
2	Moderate; Troublesome; occasional retching/vomiting TREATMENT REQUIRED
3	Severe; Distressing; frequent retching/vomiting URGENT REVIEW REQUIRED

Air Entry				Secretions				Amount	
✓	Present	D	Dull	M	Mucoid	B	Bld stain	1	Scanty
H	Harsh	▾	Dull to Base	MP	Mucopurulent			2	Moderate
Q	Quiet	W	wheeze	P	Purulent			3	Profuse

C= Cough, C+cl = Cough and clear, C/ncl= cough and not clearing

Length of stay Balance: Previous 24hr Balance:

	Input (mls)								Output (mls)								
	Oral	IVF	IV Drugs				Hourly Total	Running Total	Urine	NG	Stoma/bowel				Hourly Total	Running Total	Balance
08:00	NBM	125					125	125	NPU								
09:00	NBM	125					125	250	NPU								
10:00	NBM	125					125	375									
11:00	NBM	83					83	458									
12:00	NBM	83					83	521	NPU								
13:00	NBM	83					83	604	NPU	bladder	scanned	650mls					
14:00		83					83	687	CATHETER	IN						700	
15:00		83	250				83	770	CATHETER	OUT							
16:00		83					333	1103	NPU								
17:00		83					83	1086	NPU								
18:00		83					83	1169	NPU								
19:00		83					83	1252	NPU								+557
20:00	Sips	83					83	1335	NPU								
21:00																	
22:00	100	/					100	1435	HNPUD								+735
23:00																	
24:00									NPU								
01:00																	
02:00									NPU								
03:00																	
04:00									NPU								
05:00																	
06:00	Sips																
07:00	Sips								NPU								
Totals																	

Affix label here

Day: 1 HDU / ERAS / Post op day: 11.8.20

Consultant: _____

NHS Greater Glasgow and Clyde

Daily Goals (ERAS Patients - see pathway)

Aims For Today (goals, bp target, target ABGs, tests, procedures, results)

Respiratory: Aim SpO_2 88-92 pO_2: pCO_2:
Chest Physio: Yes / No

Renal / Fluid balance:
Sips / Normal / IV / Needs Encouragement / NBM

Fluid Balance Goal for Next 24 hours:

Cardiovascular: Aim Map: Systolic:

Gastrointestinal:
NBM / Clear Fluids / Soft / Light / Normal / NG / TPN / Encouragement

Neurology:

Rehab: Suitable for Physio? No / Mobilise / Dangle / Out to sit

Wounds:

Microbiology:

Suitable for Discharge to the Ward? Yes / No / Only if bed required

Question for Visiting Specialities

Pain Review / Plan

Are any Drug levels required or any supplementary Blood tests or Investigations?

Can and Drains or Lines be removed today?

Secondary Review

Medication Review

Can any Drugs be discontinued?

Can any IV Drugs be changed to Oral?

Can any regular medications be restarted?

EnoxaparinY/N TEDS on Y/N
Flotron Boots Y / N

DNACPR Completed? Yes / No / Not applicable

AWI Required? Yes / No
Review Date:

Affix label here

Date: _____

HDU / ERAS / Post op day: _____

Consultant: _____

Arterial Blood Gases

Time	0018																
FIO_2	UE																
H^+	46.3																
pCO_2	7.7																
pO_2	11.3																
Na^+	135																
K^+	4.2																
Glucose	8.2																
Lactate	1.2																
Hb	151																
SO_2	96.7																
BE																	
HCO_3	30.6																

Lines / indwelling Devices

Line type	Date	Due Changed	Date & Initial change	Line type	Date	Due Changed	Date & Initial change
Central line Transducer				Chest drain Bottle			
Arterial line Transducer				Wound drain /Bag			
NG Tube				Local Block Line			
NG Drainage Bag				Sub-Cut Line			
Urometer							
Epidural							
Tracheostomy							
O2 / NIV circuit							
Nebuliser Circuit							
Chest Drain							

Record of Care

	Day Shift		Night shift
08:00		20:00	
09:00		21:00	
10:00		22:00	
11:00		23:00	
12:00		24:00	
13:00		01:00	
14:00		02:00	
15:00		03:00	
16:00		04:00	
17:00		05:00	
18:00		06:00	
19:00		07:00	

NHS Greater Glasgow and Clyde

2104673933
SHAW
Andrew, M
M
21/04/1967
30 DOUGLAS DRIVE

Day: 1 HDU / ERAS / Post op day: 1/5/26

Consultant: MEDICAL (Crit Care)

Safety Checks / Damp Dusting	
Day Shift: (Initial)	Night Shift: (Initial)
Safety Checks:	Safety Checks:
Alarm Checks:	Alarm Checks:

Time	08:00	09:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00
FIO2	4L	4L	4L	2L		2L		2L		2L		2L	2L		2L		2L		2L		4L			4L
Mode	NC	NC	NC	NC		NC		NC											NC		NC			NC
Hi-flow Flow rate	/	/	/	/																				
IPAP/PS	/	/	/	/																				
EPAP/PEEP	/	/	/	/																				
Humidifier Temp	/	/	/	/																				
SpO2	94%	95%	95%	-		95		98		96		96	94		93		92		91		98			98
Resp rate	34	24	30	31		19		20		14		31	30		30		26		26		30			28
Air entry	V	~	V	V																				
Secretion/Suction	NIL	NIL	NIL	NIL		NIL		NIL		NIL		NIL	nil		NIL		nil		NIL		nil			nil
Pain Score	5	5	0	0		0		0		0		0	0		5		5		5		5			5
Sedation Score	V	V	V	V		V		V		V		V	V		V		V		V		V			V
Nausea Score	5	5	0	0		0		0		0		0	0		5		5		5		5			5
Blood Glucose									6.1						6.5									
Rhythm	ST	SR	ST	SR		SR		SR		SR		SR	SR		SR		SR		SR		SR			SR
CVP																								

Observations

200	35.8		36	36.6		35.9		36.2		36.8		36.9	36.7		36.9		36.5		35.7		36.4			36.5
190																								
180																								
170																								
160																								
150																								
140								130		124														139
130												180						117						
120	113	114	112			108							114		116		112				112			138
110																								
100													98				94							137
90												84	84											
80																	77							136
70				75																	63			
60								87		77					66									135
50	64	64	65			75													54					
40																								134
30																								
MAP	78	78		86		87		15		89		101	(94)		80		(87)		73		79			(71)

NIBP = ▲
ABP = ^
Pulse = •
Temp = X

Temperature

2104673933

Care Rounds Checklist

Date: 12/8/25

Attach

SHAW M
Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

Ward: MDU6

NHS Greater Glasgow and Clyde

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

1. Signed [illegible] Name [illegible] Designation S/N/BSL
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

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

		Times	0330	0630	0930	1100	1500	2000
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	Y	Y	N	N	N	Y
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	Y	N	N
S	3	**SKIN INSPECTION** Pressure areas checked:	Y	Y	Y	N	Y	Y
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	INT	INT	INT	-	R	INT
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y	Y
		Bed Right side (30° tilt) – **R** Left side (30° tilt) – **L** Back – **B**	B	R	B	L	B	R
		Chair Assist to walk or stand (**W/ST**)						
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	N	N	N	A (Cam)	(Cath)	IC
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N
		Drink taken?	N	Y	N	Y	Y	Y
		Food, snack, or supplement taken?	N	N	N	N	N	N
		Has oral hygiene been carried out as per care plan?	Y	Y	N	N	N	N
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	N	N	N	N	N	N
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	N/A	N/A	N/A	N/A	N/A	N/A
		Care provider / role	SHD	SHD	[illegible]	[illegible]	[illegible]	[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label
Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

Day: 2 HDU / ERAS / Post op day: 12/8/20

Consultant: Critical Care

2104673933
SHAW M
Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

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

Sedation Score	
A	Awake / Alert
V	Asleep roused by speech
P	Physical Stimulation (e.g. shaking) when required to waken
U	Unconscious / not roused by speech or shaking

Nausea Score	
0	None; No treatment required
1	Mild; not distressing; no retching/vomiting CONSIDER TREATMENT
2	Moderate; Troublesome; occasional retching/vomiting TREATMENT REQUIRED
3	Severe; Distressing; frequent retching/vomiting URGENT REVIEW REQUIRED

Air Entry				Secretions				Amount	
✓	Present	D	Dull	M	Mucoid	B	Bld stain	1	Scanty
H	Harsh	▾	Dull to Base	MP	Mucopurulent			2	Moderate
Q	Quiet	W	wheeze	P	Purulent			3	Profuse

C= Cough, C+cl = Cough and clear, C/ncl= cough and not clearing

Length of stay Balance: +735 Previous 24hr Balance: +735

	Input (mls)								Output (mls)								
	Oral						Hourly Total	Running Total	Urine	NG	Stoma/bowel				Hourly Total	Running Total	Balance
08:00																	
09:00	SIPS.																
10:00									380								
11:00									110								490
12:00	SIPS								55								545
13:00									30								575
14:00																	
15:00									60								635
16:00	50ml							50	25								660
17:00	100ml							150									
18:00									55								715
19:00									15								730
20:00	100						100	250	20						20	750	-500
21:00																	
22:00									80						80	830	-580
23:00																	
24:00	50						50	300	60						60	890	-590
01:00																	
02:00									30						30	920	
03:00																	
04:00								300	100						100	1020	-720
05:00																	
06:00																	
07:00	50						50	350	90						90	1110	-760
Totals																	

2104673933
SHAW M
Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

Day: 2 HDU / ERAS / Post op day: 12/8/20

Consultant: Critical Care

NHS Greater Glasgow and Clyde

Daily Goals (ERAS Patients - see pathway)

Aims For Today (goals, bp target, target ABGs, tests, procedures, results)

Respiratory: Aim SpO_2 pO_2: pCO_2:
Chest Physio: Yes / No

Renal / Fluid balance:
Sips / Normal / IV / Needs Encouragement / NBM

Fluid Balance Goal for Next 24 hours:

Cardiovascular: Aim Map: Systolic:

Gastrointestinal:
NBM / Clear Fluids / Soft / Light / Normal / NG / TPN / Encouragement

Neurology:

Rehab: Suitable for Physio? No / Mobilise / Dangle / Out to sit

Wounds:

Microbiology:

Suitable for Discharge to the Ward? Yes / No / Only if bed required

Question for Visiting Specialities

Pain Review / Plan

Are any Drug levels required or any supplementary Blood tests or Investigations?

Can and Drains or Lines be removed today?

Secondary Review

Medication Review

Can any Drugs be discontinued?

Can any IV Drugs be changed to Oral?

Can any regular medications be restarted?

EnoxaparinY/N TEDS on Y/N
Flotron Boots Y / N

DNACPR Completed? Yes / No / Not applicable

AWI Required? Yes / No
Review Date:

2104673933
SHAW
Andrew, M
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

M
21/04/1967

Date: 12/8/20
HDU / ERAS / Post op day: 2
Consultant: Critical Care

Arterial Blood Gases

Time																
FIO_2																
H^+																
pCO_2																
pO_2																
Na^+																
K^+																
Glucose																
Lactate																
Hb																
SO_2																
BE																
HCO_3																

Lines / indwelling Devices

Line type	Date	Due Changed	Date & Initial change	Line type	Date	Due Changed	Date & Initial change
Central line Transducer				Chest drain Bottle			
Arterial line Transducer				Wound drain /Bag			
NG Tube				Local Block Line			
NG Drainage Bag				Sub-Cut Line			
Urometer							
Epidural							
Tracheostomy							
O2 / NIV circuit							
Nebuliser Circuit							
Chest Drain							

Record of Care

	Day Shift		Night shift
08:00		20:00	
09:00		21:00	
10:00		22:00	
11:00		23:00	
12:00		24:00	
13:00		01:00	
14:00		02:00	
15:00		03:00	
16:00		04:00	
17:00		05:00	
18:00		06:00	
19:00		07:00	

NHS Greater Glasgow and Clyde

2104673933
SHAW
Andrew, M
30 DOUGLAS DRIVE
EAST KILBRIDE
M
21/04/1967

Day: 2 HDU / ERAS / Post op day: 12/0/23

Consultant: Critical Care

Safety Checks / Damp Dusting	
Day Shift: (Initial)	Night Shift: (Initial)
Safety Checks: /	Safety Checks: /
Alarm Checks: /	Alarm Checks: /

Time

	2:00	13:00	14:00	15:00	16:00	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	06:00	07:00
FIO_2	4L	4L		4L	4L	4L	4L	4L	4L				4L				4L			
Mode	NC	NC		NC	NC	NC	NC	NC	NC				NC				NC			
Hi-flow Flow rate																				
IPAP/PS																				
EPAP/PEEP																				
Humidifier Temp																				
SpO_2	96	96		94	97	97	96	96	98				96				96			
Resp rate	29	29		26	30	30	36	26	22				26				29			
Air entry																				
Secretion/Suction																	N/C			
Pain Score																	5			
Sedation Score																	1			
Nausea Score																	5			
Blood Glucose						7.1			6.2											
Rhythm	SR	SR		SR	SR	SR	ST	SR	SR				SR				SR			
CVP																				

Observations

	2:00	13:00	14:00	15:00	16:00	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	06:00	07:00
200									36.5°C				36.8°C				36.7°C			
190																				
180																				
170																				
160																				
150													141							
140	124	126	134			95	140	132	134											
130				122	129											134				
120																				
110																				
100	94	100	94	94	92	99	98	91	94				96				86			
90	91		90																	
80		80			80		81	78	74				78				77			
70		76		76	80															
60																				
50																				
40	36.5	36.3		36.5	36.9		37.3	37.1												
30																				
MAP	98	108	103	91	94	95	86	112	98	90	(88)		(77)				(93)			

NIBP = ▲
ABP = ^
Pulse = ●
Temp = X

Temperature: 41, 40, 39, 38, 37, 36, 35, 34

Care Rounds Checklist

Date: 13/8/2023

2104673933
SHAW
Andrew, M M
30 DOUGLAS DRIVE 21/04/1967
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS
Ward: MDU6

Attach

NHS Greater Glasgow and Clyde

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

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

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

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

		Times	06 00	03 00	06 00	09 30	12 30	16 00	18 10	22 00
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	Y	Y	Y	Y	Y	Y	Y	Y
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N	N	N
S	3	**SKIN INSPECTION** Pressure areas checked:	Y	Y	Y	Y	Y	Y	Y	Y
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	SM	SM	SM	M	M	M	M	M
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y	Y	Y	Y
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	L	R	L	–	L	B	R	L
		Chair Assist to walk or stand (W/ST)	HOI	HOI	HOI	CH	–	–	–	HOI
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	SOI	SOI	SOI	IOC	IOC	IOC	IOC	IOC
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N	N	N
		Drink taken?	Y	N	JUICE	Y	Y	Y	Y	Y
		Food, snack, or supplement taken?	N	N	N	N	N	N	N	N
		Has oral hygiene been carried out as per care plan?	Y	Y	N	Y	N	N	N	NT
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	N	N	N	NT	NT	NT	NT	NT
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	N/A	N/A	N/A	NA	NA	NA	NA	NA
		Care provider / role	HCA	HCA	HCA	RN	RN	RN	RN	RN (5)

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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152.4kg

Day: 3 HDU / ERAS / Post op day: 13/8/25

Consultant: Critical Care

2104673933
SHAW
Andrew, M
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS
M
21/04/1967

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

Sedation Score	
A	Awake / Alert
V	Asleep roused by speech
P	Physical Stimulation (e.g. shaking) when required to waken
U	Unconscious / not roused by speech or shaking

Nausea Score	
0	None; No treatment required
1	Mild; not distressing; no retching/vomiting CONSIDER TREATMENT
2	Moderate; Troublesome; occasional retching/vomiting TREATMENT REQUIRED
3	Severe; Distressing; frequent retching/vomiting URGENT REVIEW REQUIRED

Air Entry				Secretions				Amount	
✓	Present	D	Dull	M	Mucoid	B	Bld stain	1	Scanty
H	Harsh	▾	Dull to Base	MP	Mucopurulent			2	Moderate
Q	Quiet	W	wheeze	P	Purulent			3	Profuse

C= Cough, C+cl = Cough and clear, C/ncl= cough and not clearing

Length of stay Balance: −25 Previous 24hr Balance: −760

	Input (mls)									Output (mls)									
	Oral							Hourly Total	Running Total	Urine	NG	Stoma/bowel					Hourly Total	Running Total	Balance
08:00	Nil							0	0	30							30	30	−30
09:00																			
10:00	500							500	500	90							90	120	48:07
11:00	200							200	700										
12:00	200							200	900	100							100	220	
13:00																			
14:00	200							200	1100	140							140	360	+740
15:00																			
16:00										320							320	680	
17:00																			
18:00	200							200	1300	100							100	780	+520
19:00																			
20:00	200							200	1500	60							60	840	
21:00	200							200	1700										
22:00	100							200	1900	70							70	910	
23:00																			
24:00	50							50	1950	90							90	1000	+950 ml
01:00																			
02:00										85							85	1085	
03:00	100							100	2050										
04:00										70							70	1155	
05:00																			
06:00	150								2200	90							90	1245	
07:00																			+955 ml
Totals																			

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SHAW M
Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

Day: 3 HDU / ERAS / Post op day: 13/8/2020

Consultant: Critical Care

NHS Greater Glasgow and Clyde

Daily Goals (ERAS Patients - see pathway)

Aims For Today (goals, bp target, target ABGs, tests, procedures, results)

Respiratory: Aim SpO_2 pO_2: pCO_2:
Chest Physio: Yes / No

Renal / Fluid balance:
Sips / Normal / IV / Needs Encouragement / NBM

Fluid Balance Goal for Next 24 hours:

Cardiovascular: Aim Map: Systolic:

Gastrointestinal:
NBM / Clear Fluids / Soft / Light / Normal / NG / TPN / Encouragement

Neurology:

Rehab: Suitable for Physio? No / Mobilise / Dangle / Out to sit

Wounds:

Microbiology:

Suitable for Discharge to the Ward? Yes / No / Only if bed required

Question for Visiting Specialities

Pain Review / Plan

Are any Drug levels required or any supplementary Blood tests or Investigations?

Can and Drains or Lines be removed today?

Secondary Review

Medication Review

Can any Drugs be discontinued?

Can any IV Drugs be changed to Oral?

Can any regular medications be restarted?

EnoxaparinY/N TEDS on Y/N
Flotron Boots Y / N

DNACPR Completed?
Yes / No / Not applicable

AWI Required? Yes / No
Review Date:

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EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

Date: 13/8/2020
HDU / ERAS / Post op day: 3
Consultant: Critical Care

Arterial Blood Gases

Time																
$FI0_2$																
H^+																
pCO_2																
pO_2																
Na^+																
K^+																
Glucose																
Lactate																
Hb																
SO_2																
BE																
HCO_3																

Lines / indwelling Devices

Line type	Date	Due Changed	Date & Initial change	Line type	Date	Due Changed	Date & Initial change
Central line Transducer				Chest drain Bottle			
Arterial line Transducer				Wound drain /Bag			
NG Tube				Local Block Line			
NG Drainage Bag				Sub-Cut Line			
Urometer							
Epidural							
Tracheostomy							
O2 / NIV circuit							
Nebuliser Circuit							
Chest Drain							

Record of Care

	Day Shift		Night shift
08:00		20:00	
09:00		21:00	
10:00		22:00	
11:00		23:00	
12:00		24:00	
13:00		01:00	
14:00		02:00	
15:00		03:00	
16:00		04:00	
17:00		05:00	
18:00		06:00	
19:00		07:00	

NHS Greater Glasgow and Clyde

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30 DOUGLAS DRIVE
EAST KILBRIDE

M
21/04/1967

y: 3 HDU / ERAS / Post op day: 1, 2, 3

Consultant: Critical Care

Safety Checks / Damp Dusting	
Day Shift: (initial)	Night Shift: (initial) NC
Safety Checks: /	Safety Checks: NC
Alarm Checks: /	Alarm Checks: NC

Time	13:00	14:00	15:00	16:00	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	06:00	07:00
FIO_2		RA		2L		2L		2L		2L		2L		2L		2L		2L	
Mode				NC		NC		NC		NC		NC		NC		NC		NC	
Hi-flow Flow rate																			
IPAP/PS																			
EPAP/PEEP																			
Humidifier Temp																			
SpO_2		94		95		99		97		97		97		99		92		96	
Resp rate		26		25		26		21		29		21		19		24		20	
Air entry																			
Secretion/Suction								NIL		NIL		NIL		NIL		NIL		NIL	
Pain Score		NIL		NIL		NIL		0		0		S		0		S		S	
Sedation Score		S		V		A		A		A		V		A		V		V	
Nausea Score		Ø		0		0		0		0		S		0		S		S	
Blood Glucose		S		6.8															
Rhythm		SR		SR		SR		SR		SR		SR		SR		SR		SR	
CVP																			
200																			
190																			
180																			
170																			
160																			
150																			
140																			
130																			
120																			
110																			
100																			
90																			
80																			
70																			
60																			
50																			
40																			
30																			
MAP		(76)		(84)		(85)		(78)		(78)		(77)		(88)		101		(100)	

Observations

NIBP = ▲
ABP = ^
Pulse = •
Temp = X

Temperature

41 40 39 38 37 36 35 34

Care Rounds Checklist

Date: 14/8/20

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30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

NHS Greater Glasgow and Clyde

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

1. Signed N. C Name N. Callender Designation S/N
2. Signed S.Harvey Name S.Harvey Designation S/N
3. Signed [illegible] Name [illegible] Designation C/1

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

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

		Times	0900	0300	0600	1000	1400	1800	2200
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	4	4	4	Y	Y	Y	4
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N	N
S	3	**SKIN INSPECTION** Pressure areas checked:	4	4	4	Y	Y	Y	4
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	M	M	M	M	M	M	M
K	4	**KEEP MOVING** Has the patient moved or walked?	4	4	4	Y	Y	Y	4
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	L	R	B	/	B	R	B
		Chair Assist to walk or stand (W/ST)	W/ST	W/ST	W/ST	Ch	/	/	
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	IDC	IDC	IDC	IDC	IDC	IDC	IDC
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N	N
		Drink taken?	4	4	4	Y	Y	Y	4
		Food, snack, or supplement taken?	NT	NT	NT	Y	Y	Y	N
		Has oral hygiene been carried out as per care plan?	NT	NT	NT	N	N	N	N
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	4	4	4	Y	Y	Y	4
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	NT	NT	NT	NT	N/F
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	n/a	n/a	n/a	No	NA	NA	n/a
		Care provider / role	NC 5	NC 5	NC 5	SW	SW	SW	E/1

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Day: 14/8/20 HDU / ERAS / Post op day: 4

Consultant: Crit care

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EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

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

Sedation Score	
A	Awake / Alert
V	Asleep roused by speech
P	Physical Stimulation (e.g. shaking) when required to waken
U	Unconscious / not roused by speech or shaking

Nausea Score	
0	None; No treatment required
1	Mild; not distressing; no retching/vomiting CONSIDER TREATMENT
2	Moderate; Troublesome; occasional retching/vomiting TREATMENT REQUIRED
3	Severe; Distressing; frequent retching/vomiting URGENT REVIEW REQUIRED

Air Entry				Secretions				Amount	
✓	Present	D	Dull	M	Mucoid	B	Bld stain	1	Scanty
H	Harsh	▾	Dull to Base	MP	Mucopurulent			2	Moderate
Q	Quiet	W	wheeze	P	Purulent			3	Profuse

C= Cough, C+cl = Cough and clear, C/ncl= cough and not clearing

Length of stay Balance: +695ml Previous 24hr Balance: +955ml

	Input (mls)								Output (mls)								
	Oral						Hourly Total	Running Total	Urine	NG	Stoma/bowel				Hourly Total	Running Total	Balance
08:00	200						200	200	70						70	70	+130
09:00	100						100	300									
10:00	200						200	500	120						120	190	+310
11:00	200						200	700									
12:00	200						200	900	200						200	390	+510
13:00							2										
14:00	200						200	1100	220						220	610	+490
15:00	200						200	1300									
16:00	200						200	1500	400						400	1010	+490
17:00																	
18:00	100						100	1600	180						180	1190	+410
19:00																	
20:00									140						140	1290	
21:00																	
22:00	100						100	1700	80						80	1370	
23:00																	
24:00								1900	60						60	1430	
01:00																	
02:00									70						70	1500	
03:00																	
04:00									60						60	1560	
05:00																	
06:00																	
07:00	200						200	1900	80						80	1640	+260
Totals																	

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Glasgow, Lanarkshire
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Day: 14/8/20 HDU / ERAS / Post op day: 4

Consultant: Crit care

NHS Greater Glasgow and Clyde

Daily Goals (ERAS Patients - see pathway)

Aims For Today (goals, bp target, target ABGs, tests, procedures, results)

Respiratory: Aim SpO_2 pO_2: pCO_2:
Chest Physio: Yes / No

Renal / Fluid balance:
Sips / Normal / IV / Needs Encouragement / NBM

Fluid Balance Goal for Next 24 hours:

Cardiovascular: Aim Map: Systolic:

Gastrointestinal:
NBM / Clear Fluids / Soft / Light / Normal / NG / TPN / Encouragement

Neurology:

Rehab: Suitable for Physio? No / Mobilise / Dangle / Out to sit

Wounds:

Microbiology:

Suitable for Discharge to the Ward? Yes / No / Only if bed required

Question for Visiting Specialities

Pain Review / Plan

Are any Drug levels required or any supplementary Blood tests or Investigations?

Can and Drains or Lines be removed today?

Secondary Review

Medication Review

Can any Drugs be discontinued?

Can any IV Drugs be changed to Oral?

Can any regular medications be restarted?

EnoxaparinY/N TEDS on Y/N
Flotron Boots Y / N

DNACPR Completed?
Yes / No / Not applicable

AWI Required? Yes / No
Review Date:

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Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

Date: 14/8/20
HDU / ERAS / Post op day: 4
Consultant: Crit care

Arterial Blood Gases

Time															
FIO_2															
H^+															
pCO_2															
pO_2															
Na^+															
K^+															
Glucose															
Lactate															
Hb															
SO_2															
BE															
HCO_3															

Lines / indwelling Devices

Line type	Date	Due Changed	Date & Initial change	Line type	Date	Due Changed	Date & Initial change
Central line Transducer				Chest drain Bottle			
Arterial line Transducer				Wound drain /Bag			
NG Tube				Local Block Line			
NG Drainage Bag				Sub-Cut Line			
Uromotor	12/8/20	19/8/20					
Epidural							
Tracheostomy							
O2 / NIV circuit							
Nebuliser Circuit							
Chest Drain							

Record of Care

	Day Shift		Night shift
08:00		20:00	
09:00		21:00	
10:00		22:00	
11:00		23:00	
12:00		24:00	
13:00		01:00	
14:00		02:00	
15:00		03:00	
16:00		04:00	
17:00		05:00	
18:00		06:00	
19:00		07:00	

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...y: 4 HDU / ERAS / Post op day: 14...20

Consultant: Crit Care

Safety Checks / Damp Dusting	
Day Shift: (initial)	Night Shift: (initial)
Safety Checks: /	Safety Checks: /
Alarm Checks: /	Alarm Checks: /

Time	08:0..				13:00	14:00	15:00	16:00	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	06:00	07:00
FIO2	2L	2L	2L			2L		2L		2L		2		2		2		2		2		2	
Mode	NC	NC	NC			NC		NC		NC		NC		NC		NC		NC		NC		NC	
Hi-flow Flow rate																							
IPAP/PS																							
EPAP/PEEP																							
Humidifier Temp																							
SpO2	96	96	98			98		96		97		98		96		98		98/96		96/98		96/96	
Resp rate	19	18	20			18		16		22		20		18/20		18		16		18		16	
Air entry	✓																						
Secretion/Suction	Nil	Nil	Nil			Nil		C+C		C+C		C+C											
Pain Score	0	0	0			0		0		0		0		0		0		2		2		0	
Sedation Score	V	V	A			A		A		A		A		A		A		V		V		A	
Nausea Score	0	0	0			0		0		0		0		0		0		0		0		0	
Blood Glucose																							
Rhythm	SR	SR	SR			SR		SR		ST		SR		SR		SR		SR		SR		SR	
CVP																							
Temperature	36.0		35.9			36.0		36.2		36.6		36.5		36.1		36.2		36.1				36.6	

Observations

	200	190	180	170	160	150	140	130	120	110	100	90	80	70	60	50	40	30
NIBP = ▲																		
ABP = ^																		
Pulse = •																		
Temp = X	MAP																	

Temperature: 41, 40, 39, 38, 37, 36, 35, 34

MAP: (102) (90) (85) (107) (100) (97) (95) 104 91 89 82 99

Day: 15/8/20 (HDU) / ERAS / Post op day: 5

Consultant: Critical care

2104673933
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Andrew, M
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EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

M
21/04/1967

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

Sedation Score	
A	Awake / Alert
V	Asleep roused by speech
P	Physical Stimulation (e.g. shaking) when required to waken
U	Unconscious / not roused by speech or shaking

Nausea Score	
0	None; No treatment required
1	Mild; not distressing; no retching/vomiting CONSIDER TREATMENT
2	Moderate; Troublesome; occasional retching/vomiting TREATMENT REQUIRED
3	Severe; Distressing; frequent retching/vomiting URGENT REVIEW REQUIRED

Air Entry				Secretions				Amount	
✓	Present	D	Dull	M	Mucoid	B	Bld stain	1	Scanty
H	Harsh	▾	Dull to Base	MP	Mucopurulent			2	Moderate
Q	Quiet	W	wheeze	P	Purulent			3	Profuse

C= Cough, C+cl = Cough and clear, C/ncl= cough and not clearing

Length of stay Balance: +955ml [redacted] Previous 24hr Balance: +260 ml

	Input (mls)								Output (mls)								
	Oral						Hourly Total	Running Total	Urine	NG	Stoma/bowel				Hourly Total	Running Total	Balance
08:00	100						100	100	70						70	70	
09:00								100									
10:00								100	80						80	150	-50
11:00	260						200	300									
12:00									90						90		
13:00																	
14:00																	
15:00																	
16:00																	
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																	
06:00																	
07:00																	
Totals																	

2104673933 M
SHAW 21/04/1967
Andrew, M
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire G75 8JS

Day: 15/8/20 (HDU) ERAS / Post op day: 5

Consultant: critical care

NHS Greater Glasgow and Clyde

Daily Goals (ERAS Patients - see pathway)

Aims For Today – (goals, bp target, target ABGs, tests, procedures, results)

Respiratory: Aim SpO_2 pO_2: pCO_2:
Chest Physio: Yes / No

Renal / Fluid balance:
Sips / Normal / IV / Needs Encouragement / NBM

Fluid Balance Goal for Next 24 hours:

Cardiovascular: Aim Map: Systolic:

Gastrointestinal:
NBM / Clear Fluids / Soft / Light / Normal / NG / TPN / Encouragement

Neurology:

Rehab: Suitable for Physio? No / Mobilise / Dangle / Out to sit

Wounds:

Microbiology:

Suitable for Discharge to the Ward? Yes / No / Only if bed required

Question for Visiting Specialities

Pain Review / Plan

Are any Drug levels required or any supplementary Blood tests or Investigations?

Can and Drains or Lines be removed today?

Secondary Review

Medication Review

Can any Drugs be discontinued?

Can any IV Drugs be changed to Oral?

Can any regular medications be restarted?

EnoxaparinY/N TEDS on Y/N
Flotron Boots Y / N

DNACPR Completed?
Yes / No / Not applicable

AWI Required? Yes / No
Review Date:

2104673933

SHAW
Andrew, M
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

M
21/04/1967

Date: 15/8/20

HDU / ERAS / Post op day: 5

Consultant: critical care

Arterial Blood Gases

Time																	
$FI0_2$																	
H^+																	
pCO_2																	
pO_2																	
Na^+																	
K^+																	
Glucose																	
Lactate																	
Hb																	
SO_2																	
BE																	
HCO_3																	

Lines / indwelling Devices

Line type	Date	Due Changed	Date & Initial change	Line type	Date	Due Changed	Date & Initial change
Central line Transducer				Chest drain Bottle			
Arterial line Transducer				Wound drain /Bag			
NG Tube				Local Block Line			
NG Drainage Bag				Sub-Cut Line			
Urometer							
Epidural							
Tracheostomy							
O2 / NIV circuit							
Nebuliser Circuit							
Chest Drain							

Record of Care

Day Shift		Night shift	
08:00		20:00	
09:00		21:00	
10:00		22:00	
11:00		23:00	
12:00		24:00	
13:00		01:00	
14:00		02:00	
15:00		03:00	
16:00		04:00	
17:00		05:00	
18:00		06:00	
19:00		07:00	

2104673933
SHAW
Andrew, M
M
21/04/1967

fix label here

Day: 5/8/20 (HDU) / ERAS / Post op day: 8

Consultant: Cart Crie

Safety Checks / Damp Dusting	
Day Shift: (initial)	Night Shift: (initial)
Safety Checks:	Safety Checks:
Alarm Checks:	Alarm Checks:

	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	24:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00
Mode	NC / 4L																					
Hi-flow Flow rate																						
IPAP/PS																						
EPAP/PEEP																						
Humidifier Temp																						
SpO_2	97-A / 96																					
Resp rate	20 / 18																					
Air entry																						
Secretion/Suction	Nil / GC																					
Pain Score	3/10 / 8/10																					
Sedation Score	A / A																					
Nausea Score	0 / 0																					
Blood Glucose	6.9																					
Rhythm	SR / SR																					
CVP																						

Observations																						
200	36.5		36.2																			
190																						
180																						
170																						
160																						
150																						
140	130																					
130			119																			
120																						
110																						
100	94																					
90	86																					
80																						
70			74 / 71																			
60																						
50																						
40																						
30																						
MAP	(130)		(80)																			

NIBP = ▲
ABP = ^
Pulse = •
Temp = X

Temperature: 41, 40, 39, 38, 37, 36, 35, 34

Care Rounds Checklist

Date: 15/8/20

Att
2104673933
SHAW
Andrew, M
30 DOUGLAS DRIVE
Wi EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS
M
21/04/1967

NHS Greater Glasgow and Clyde

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

1. Signed [illegible] Name MARLENE Designation C/A -
2. Signed [illegible] Name CAIT BRATT Designation S/N (NS/
3. Signed _____ Name _____ Designation _____

'Mi [illegible] nt if there is anything they want specifically done today:

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

		Times	15.18.22						
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	M	Y	Y	Y	Y	Y	NO
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N	Yes
S	3	**SKIN INSPECTION** Pressure areas checked:	Y	Y	Y	Y	Y	Y	Yes
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	M	M	M	M	R/M	R/M	R/M
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y	Y	Yes
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	[illegible]	R	L	L	L	B	B
		Chair Assist to walk or stand (W/ST)					T	–	walked
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	C/IC	IC	IC	C	C	NA
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N	NO
		Drink taken?	Y	Y	Y	Y	Y	Y	Yes
		Food, snack, or supplement taken?	N	[illegible]	N	Y	N	Y	Yes
		Has oral hygiene been carried out as per care plan?	N	Y	Y	NT	N	Y	NO
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y	Yes
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	N/T	NT	NT	NT	N	N	NO
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	N	N/A	N/A	N/A	N/A	N/A	N/A
		Care provider / role	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 16-08-20

Attach Addres

2104673933
SHAW M
Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

Ward: 10C

NHS Greater Glasgow and Clyde

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

1. Signed _____ Name _____ Designation SN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

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

			Times:	01:00	03:00	05:00	19:00	21:30
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		NO	NO	NO	NO	NO
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.		YES	NO	YES	YES	YES
S	3	**SKIN INSPECTION** Pressure areas checked:		YES	NO	YES	NO	NO
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		INT	INT	INT	–	–
K	4	**KEEP MOVING** Has the patient moved or walked?		YES	YES	YES	YES	YES
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		R	R	R	R	R
		Chair Assist to walk or stand (W/ST)		–	–	–	–	–
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		NPU	NPU	NPU	PU	PU
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?		NO	NO	NO	NO	NO
		Drink taken?		–	–	–	YES	YES
		Food, snack, or supplement taken?		–	–	–	YES	YES
		Has oral hygiene been carried out as per care plan?		–	–	–	NO	NO
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		YES	YES	YES	YES	YES
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.		NT	NT	NT	NT	NT
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.		NAD	NAD	NAD	NAD	NAD
		Care provider / role		SN	SN	SN	SN	SN

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name
16/05/16	21:30	3,4	Patient declined postional changes	

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Care Rounds Checklist

Date: 17/08/20

2104673933
SHAW
Andrew, M
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS
M
21/04/1967
Attach Ad
Ward: 10C

NHS Greater Glasgow and Clyde

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

1. Signed [signature] Name [signature] Designation SN
2. Signed [signature] Name A. Kasongo Designation ST1/N
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:
NO thank you

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

			Times	01	05	05	0600	0715	1130	1350	1650	1900	2205	2305							
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		NO	NO	NO	N	N	N	N	N	N		N						
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.		NO	NO	NO	N	Y	N	N	N	N	0	N						
S	3	SKIN INSPECTION Pressure areas checked:		done	done	done	declined	Y	Y	Y	Y	Y	F	Y						
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)						int/c	int/c	int/c	int/c	int/c		int/c						
K	4	KEEP MOVING Has the patient moved or walked?		done	done	done	declined	Y	Y	Y	Y	Y	F	Y						
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B						B	L	L	B	B		R						
		Chair Assist to walk or stand (W/ST)		/	/	/						/		/						
I	5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		NT	PU	NO	NO	PU	PU	PU	PU	/		PU						
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?		NO	NO	NO	NO	N	N	N	N	N	W	N						
		Drink taken?		YES	YES	NO	Y	Y	Y	Y	Y	Y	A	A						
		Food, snack, or supplement taken?		NO	NO	NO	Y	Y	Y	Y	Y	/	K	Y						
		Has oral hygiene been carried out as per care plan?		NO	NO	NO	N	N	N	N	N	/	K	N						
	7	ENVIRONMENT Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		YES	YES	YES	Y	Y	Y	Y	Y	Y	D	Y						
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.		NT	NT	NT	NT	NT	NT	NT	NT	Y		NT						
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.		NA	NA	NA	NA	NA	NA	NA	NA	NA		NA						
		Care provider / role		[sig]	[sig]	[sig]	[sig]	[sig]	[sig]	[sig]	[sig]	CD	AK	[sig]						

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 17/3/20

Attach Addi
2104673933
SHAW
Andrew, M
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS
M
21/04/1967

NHS Greater Glasgow and Clyde

Ward: 10C

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

1. Signed MABOTO Name A Adasonjo Designation ST/N
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

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

'Must dos' for me. Ask the patient if there is anything they want specifically done today:
NO thank you

		Times	01:30	04:00	05:00	8:00	10:00	12:00	14:00	17:00	19:00	20:15	23:45
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	N	N	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	N	N	N
S	3	**SKIN INSPECTION** Pressure areas checked:	N	Y	N	N	N	N	Y	Y	Y	Y	Y
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	–	MR	/	/				Y/M	MB	M/B	
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
		Bed Right side (30° tilt) – **R** Left side (30° tilt) – **L** Back – **B**	L	B	R	R	R	B	D	/	B	R	B
		Chair Assist to walk or stand (W/ST)	–	–	–	/		/				T	T
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	N	N	N	N	N	N	N	N	I	I	
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	Y	Y	Y	Y	Y	Y	N	N
		Drink taken?	N	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
		Food, snack, or supplement taken?	N	N	N	Y	Y	Y	Y	Y	Y	NT	NT
		Has oral hygiene been carried out as per care plan?	N	N	N	Y	Y	Y	Y	Y	Y	NT	NT
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	NT	Y	Y	N	Y	Y	NT	NT	NT
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA				NA		NA	NA	
		Care provider / role		AW									

Care Rounds Variance Sheet

Attach Addressograph Label Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name
18/8/20	8:00	(6)	Patient has refused breakfast	Egillespie

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Care Rounds Checklist

Date: 19.08.2020

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

1. Signed _____ Name J. MOULDEN Designation SN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach / 2104673933
SHAW M
Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

Ward: 100

NHS Greater Glasgow and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

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

			Times	02:30	04:55	06:45	08:00	09:10	10:00	11:50	13:00	14:15	15:50	17:00	19:40	21:25				
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		N	N	N	N	N	N	N	N	N	N	N	N	N				
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.		N	N	N	N	N	N	N	N	N	N	N	N	N				
S	3	**SKIN INSPECTION** Pressure areas checked:		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	RR	Y	Y				
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		MB	MB	MB	MB	I	I	I	MB	MB	MB	MB	MB	MB	MB				
K	4	**KEEP MOVING** Has the patient moved or walked?		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y				
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		R	R	B	B	B	B	B	—			L	R	L				
		Chair Assist to walk or stand (W/ST)		I	I	I	I	I	I	I	ST									
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		I	I	I	I	I	I	I	I	I	I	I	I	I				
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?		N	N	N	N	N	N	N	N	N	N	N	N	N				
		Drink taken?		NT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y				
		Food, snack, or supplement taken?		NT	N	N	Y	Y	Y	Y	Y	Y	Y	Y	N	N				
		Has oral hygiene been carried out as per care plan?		NT	N	N	Y	Y	Y	Y	Y	Y	Y	Y	N	N				
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y				
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.		NT	Y	Y	Y	Y	Y					Y	Y					
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.		NA																
		Care provider / role		AW	KY	KY	KY	KY	KY	KY	SW	KY	KY	KY	KY	KY				

Care Rounds Variance Sheet

Attach Addressograph Label	NHS Greater Glasgow and Clyde
Ward:	

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name
19/8/20	8		Patient has Refused to wash.	EGillespie
	9:30pm		Patient has " " wash	M. Gillespie
		—		

Care Rounds Checklist

Date: 20.08.2020

Attach

2104673933 M
SHAW 21/04/1967
Andrew, M
30 DOUGLAS DRIVE
Ward: EAST KILBRIDE
10C Glasgow, Lanarkshire G75 8JS

NHS Greater Glasgow and Clyde

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

1. Signed _____ Name J. MOULSON Designation SN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

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

			Times	21	03	05	09	13	15	17	19	21							
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		N	N	N	N	N	N	~	N	N	M						
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.		N	N	N	N	N	N	~	N	N	M						
S	3	**SKIN INSPECTION** Pressure areas checked:		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y						
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		MB	MB	MB	MB	MB	MB	MB	MB	MB	MB						
K	4	**KEEP MOVING** Has the patient moved or walked?		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y						
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		L	R	L	R	L	R	-	R	B	L						
		Chair Assist to walk or stand (W/ST)						✓	Ch	Ch	Ch								
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		I	I	I	I	I	I	I	I	I	I						
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?		N	N	N	N	N	N	N	N	N	N						
		Drink taken?		Y	N	Y	Y	Y	Y	Y	Y	Y	Y						
		Food, snack, or supplement taken?		N	N	N	N	Y	Y	Y	W	Y	Y						
		Has oral hygiene been carried out as per care plan?		I	I	I	I	I	I	Y	N	I	I						
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y						
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.		Y	Y	Y	I	N	N	~	N	N	N						
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.						N	N	~	N	N	N						
		Care provider / role		SN	SN	SN	SN	SN	SN	SN	SN	SN	SN						

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 24-8-10

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

1. Signed _____ Name _____ Designation _____
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attac
2104673933
SHAW M
Andrew, M 21/04/1967
30 DOUGLAS DRIVE
Ward: EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

NHS Greater Glasgow and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

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

			Times	07 20	05 40	09 30																	
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		N	N	N																	
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.		N	Y	N																	
S	3	**SKIN INSPECTION** Pressure areas checked:		Y	Y	Y																	
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		INT	INT	INT																	
K	4	**KEEP MOVING** Has the patient moved or walked?		Y	Y	Y																	
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		R	B	R																	
		Chair Assist to walk or stand (W/ST)																					
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		✓	✓	I																	
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?		N	N	N																	
		Drink taken?		N	Y	Y																	
		Food, snack, or supplement taken?		S	N	N																	
		Has oral hygiene been carried out as per care plan?		S	N	N																	
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		Y	Y	Y																	
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.		N	N	N																	
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.		N/A	N/A																		
			Care provider / role																				

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 23-8-20

Attach Addressograph Label

2104673933 M
SHAW
Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

Ward: HDC

NHS Greater Glasgow and Clyde

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

1. Signed [signature] Name A. Kasongo Designation ST/N
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

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

No thank You

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

		Times	08 30	11 00	13 06	15 30	20 00	23 30										
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N										
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	Y	N	Y	Y										
S	3	**SKIN INSPECTION** Pressure areas checked:	Y	Y	Y	Y	Y	Y										
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	I	I	I	I	M	I										
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y	Y										
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	R	CH	B	B		B										
		Chair Assist to walk or stand (W/ST)	—	W	W	—	W	—										
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	N	N	N	I	A	A										
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N										
		Drink taken?	Y	Y	Y	Y	Y	Y										
		Food, snack, or supplement taken?	Y	N	Y	Y	Y	Y										
		Has oral hygiene been carried out as per care plan?	N	Y	Y	I	N	—										
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y										
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	NT	—	N	NH										
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	—	NA	NA										
		Care provider / role	AK SW	AK SW	AK SW	AK SW	AK	AK SW										

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

ml • 278936 v2.1 • GGC0098

Care Rounds Checklist

Date: 22/8/20

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

1. Signed M. — Name M.GRACIE Designation SW
2. Signed ~~A.Kasango~~ Name A.Kasango Designation ST/N
3. Signed _____ Name _____ Designation _____

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

Attac
2104673933
SHAW M
Andrew, M 21/04/1967
30 DOUGLAS DRIVE
Ward EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

NHS Greater Glasgow and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:
No thank you

		Times	00	03 06	09	11 50	14 00	17 00	21 23											
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N	N											
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	Y	N											
S	3	**SKIN INSPECTION** Pressure areas checked:	Y	Y	Y	Y	Y	N	Y											
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	INT	INT	/	INT	INT	/	I											
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y	Y	Y											
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B	L	L	CH	B	R	B											
		Chair Assist to walk or stand (W/ST)	/	/	/	W	/		A											
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	I	I	I	I	I	I											
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N	N											
		Drink taken?	Y	Y	Y	Y	Y	Y	Y											
		Food, snack, or supplement taken?	N	N	/	Y	Y	Y	Y											
		Has oral hygiene been carried out as per care plan?	N	N	/	I	I	I	/											
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y	Y											
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	N	N	NT	N	N	NT	NT											
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	N	N/A	NA	NA											
		Care provider / role	MC SW	MC SW	SW	S	MC	AC ST	SW											

Care Rounds Variance Sheet

Attach Addressograph Label Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • CGC0098

Care Rounds Checklist

Date: 21.8.20.

Attach Addressograph Label
ANDREW SHAW

Ward: 10C

NHS Greater Glasgow and Clyde

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

1. Signed _____ Name A. PATTERSON Designation HCA
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

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

		Times	00/45	02	03/45	07	8	10/11	12/13	13/33	14/40	16/11	17/505	19/30					
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	H	N	N	N	N	N	N	N	N	N	N	N					
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	H	N	N	N	N	N	N	N	N	N	N	N					
S	3	**SKIN INSPECTION** Pressure areas checked:	N	N	N	N	N	N	N	Y	Y	Y	Y	Y					
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	✓	/	/	/		—	—	INT	INT	INT	INT	INT					
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	R	L	B	L	B	B	B	B	B	B	CH	B	B	R			
		Chair Assist to walk or stand (W/ST)	1	1	1	1	1	1	1	Rem	/	W	ST	/	/				
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	N	N	N	N	N	N	N	I	I	I	I	I	I				
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	Y	N	N	N	N	N	N	N	N				
		Drink taken?	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	N	Y				
		Food, snack, or supplement taken?	N	N	N	N	Y	N	Y	Y	Y	Y	N	N	N				
		Has oral hygiene been carried out as per care plan?	N	N	N	N	Y	N	Y	N	N	N	N	Ø	N				
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y				
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	Y	N	N	N	N	N	N	N	N	N	N	N	N				
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	N/A	N/A	N/A	N/A	N/A	N	N	N	N	N	N	N	N/A				
		Care provider / role																	

Care Rounds Variance Sheet

Attach Addressograph Label Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name
	800	6	Patient Refused Breakfast Wishes to be left to Sleep.	Egwuatu

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Glasgow, Lanarkshire
G75 8JS

M
21/04/1967

FALLS RISK ASSESSMENT

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

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

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

	Ward: MHDU Date: 11/8/20 Time: 07:00	Ward: HDU 6 Date: 11/8/20 Time: 23:50	Ward: 10C Date: 15/8/20 Time: ----:----	Ward: 10C Date: 22/8 Time: 22:02	Ward: Date: Time: ----:----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	✓	✓	Bedrest	ago walk ✓	
2. Check walking aid (if required) is in reach and in use.	N/A	N/A	N/A	✓	
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	✓	✓	✓	✓	
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	✓	✓	N/A	✓	
5. If glasses are worn, check they are available and in use.			N/A	NA	
6. If hearing aid/s are worn, check they are working and in use.	N/A	N/A	N/A	NA	

RISK ASSESSMENT

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

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

Highlight risk of fall at the ward safety brief.

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Glasgow, Lanarkshire
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FALLS INTERVEN..JN CHECKLIST

NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

	Ward: MHDU Date: 11/8/20 Time: 07:00	Ward: MHDU Date: 11/8/20 Time: 20:00	Ward: 10C Date: 15/8 Time: 16.00	Ward: 10C Date: 23/8/20 Time: 14:00	Ward: Date: Time: --:--
BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)					
Assess if a low bed is required (Patient care plan 9)					
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)	✓	✓	✓	✓	
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)	✓	✓	✓	✓	
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.	✓	✓	✓	✓	
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)	✓	✓	✓	✓	
Document continence problems and link to care rounding (Patient care plan 6)	✓	✓	✓	✓	
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)					
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.					
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)		n/a			
Update the ward team of the patient's mobility status. (Patient care plan 8)	✓	✓	✓	✓	
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)	✓	✓	✓	✓	
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)					
Signature of nurse completing interventional plan / or update	G. Bradley			Akasongo	

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

Fluid Balance Chart

2104673933
SHAW M
Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

Hospital: QEUH
Ward: NDU 6
Date: 15/8/2020

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☑
If yes how many mls in 24 hours? _____

Fluid balance from previous 24hrs
+/- _____

Does patient require thickened fluids?
Yes ☐ No ☑ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00										60						60	LH
01:00																~~+30~~	
02:00										70						130	LH
03:00																	
04:00										60						190	LH
05:00																	
06:00																270	LH
07:00	WATER	250							250	80							
08:00	WATER	150							300	70						340	LH
09:00																	
10:00										80						420	LH
11:00	Orange Jx.	200							500								
12:00																	
13:00																	
14:00																	
15:00																	
16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
								*Total Intake	[redacted]						*Total Output	[redacted]	

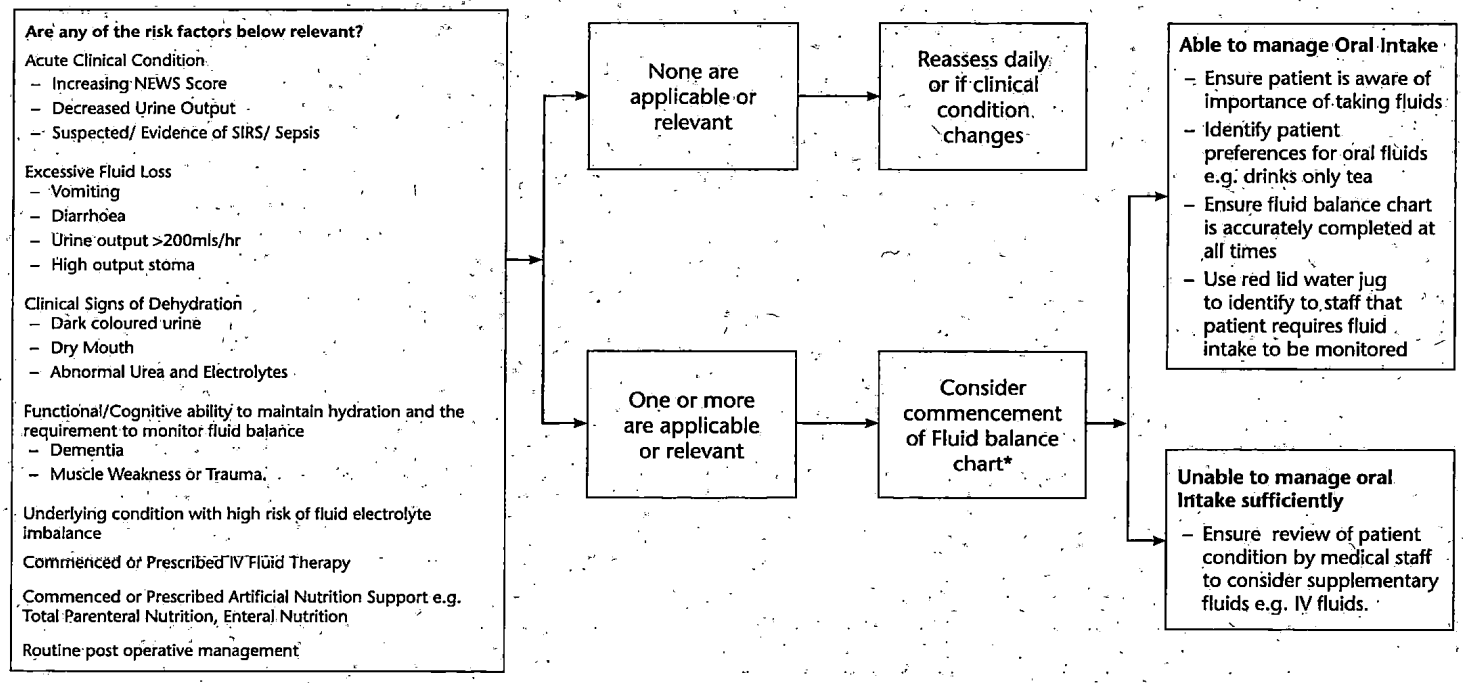
*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2

Fluid Balance Chart

2104673933
SHAW
Andrew, M M
21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

Hospital: QEUH
Ward: 10C
Date: 18/3/20

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☑
If yes how many mls in 24 hours? _____

Fluid balance from previous 24hrs
+/- _____

Does patient require thickened fluids?
Yes ☐ No ☑ Stage _____

Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3

Signature: AK Designation: SIN

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume	INPUT							OUTPUT	
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00	Tea	150															
08:00																	
09:00																	
10:00																	
11:00																	
12:00	~~WATER~~	150						300									
13:00																	
14:00																	
15:00																	
16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
								*Total Intake	[redacted]						*Total Output	[redacted]	

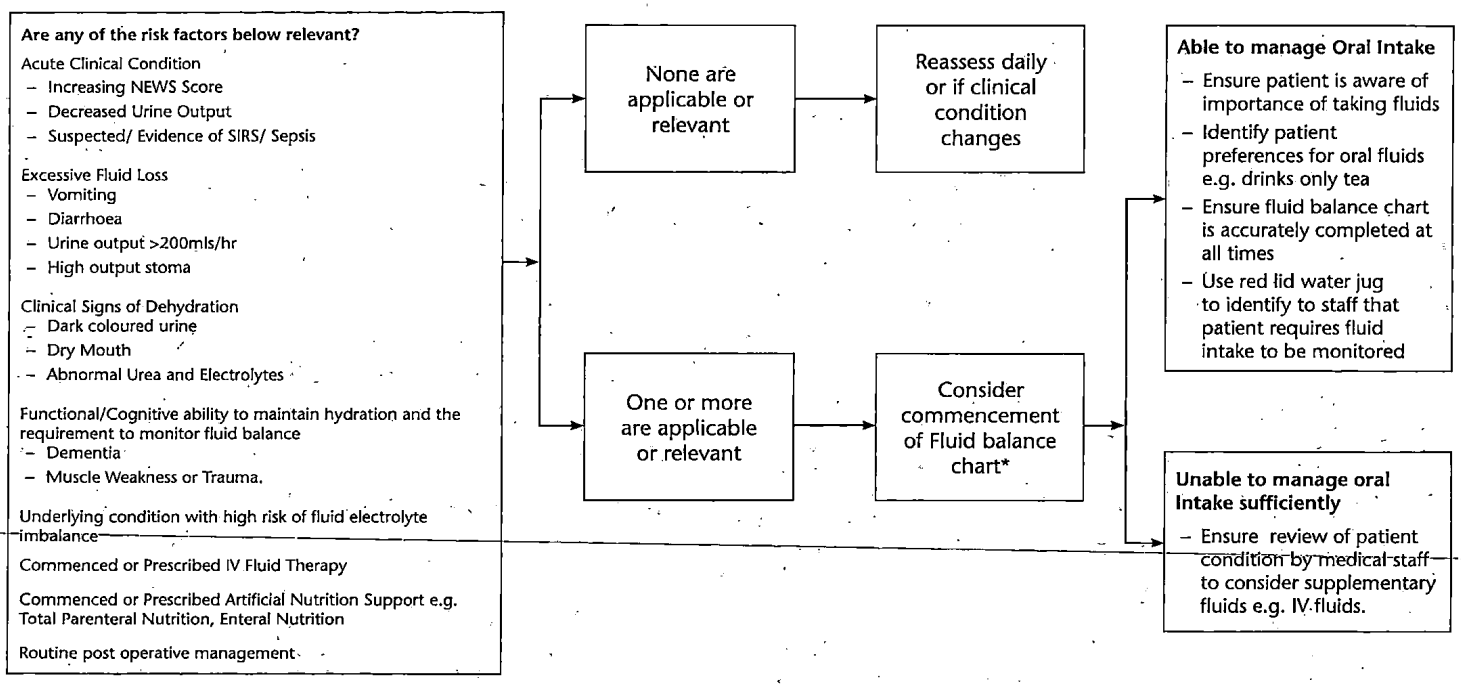
*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

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Glasgow, Lanarkshire
G75 8JS

Adult Urethral Urinary Catheter(UUC)

Insertion & Maintenance Care Plan

Catheter Batch Label

NHS Greater Glasgow and Clyde

Insertion – Complete all sections

Date and time inserted	Urethral Urinary Catheter inserted	Gauge	mls in balloon	Inserted by (Print name & designation [if known])
12/8/20	Hospital ____ ED ☐ Theatre ☐ ITU/HDU ☐ Ward HDU6	14	10	CONSULTANT RUSSELL ALLEN

Clinical indication for urethral urinary catheterisation	Long term urethral urinary catheter ☐ (> 28 days)	Short term urethral urinary catheter ☐ (≤ 28 days)
Pt Had Not Pwd for 24 HOURS		

Patient had urethral urinary catheter inserted in the community/out with NHS GGC Yes ☐ No ☐ Date UUC inserted (if known) ____

Insertion Criteria		Comments
Alternatives to urethral urinary catheterisation considered	Yes ☐ No ☐	
Hand hygiene is performed immediately before urethral urinary catheter insertion	Yes ☐ No ☐	
Aseptic technique performed at insertion	Yes ☐ No ☐	
Urethral Urinary catheter of smallest gauge used and balloon filled to recommended level	Yes ☐ No ☐	
Urethral meatus cleaned with sterile saline and sterile lubricant used	Yes ☐ No ☐	
Aseptic technique maintained when connecting urethral urinary catheter to closed drainage system	Yes ☐ No ☐	

DAILY MAINTENANCE: FOR ALL PATIENTS WITH A URETHRAL URINARY CATHETER:

- Staff must wear gloves and apron and perform hand hygiene before and after urinary catheter procedures
- The drainage bag must be emptied when clinically indicated using a clean disposable container for each patient. Please refer to Insertion and maintenance of adult indwelling urethral urinary catheter SOP.

Maintenance – To be completed daily (observe for signs and symptoms of infection)

Please regard Day 1 as day of insertion or the day patient is admitted to hospital with Urethral Urinary Catheter.	Ward	Does the patient still require a urethral urinary catheter?	Is the urethral urinary catheter connected to a closed drainage system and changed in line with manufacturer's instructions?	Daily meatal hygiene has been carried out? (soap and water)	Urine drainage bag is situated below the level of the bladder and not in contact with any surface e.g. floor?	Signature and Print Name
Day 1 12/8/20	HDU6	Yes ☐ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	[illegible]
Day 2 13/8/20	HDU6	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	[illegible]
Day 3 14/8/20	HDU6	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	N CA N. Callender.

Date removed: 15/08/20 Time removed: 22.00 Reason for Urethral Urinary Catheter removal: Actduction Removed by: [illegible]

CHI Number: _____

Maintenance – To be completed daily (observe for signs and symptoms of infection)						
	Ward	Does the patient still require a urethral urinary catheter?	Is the urethral urinary catheter connected to a closed drainage system and changed in line with manufacturer's instructions?	Daily meatal hygiene has been carried out?	Urine drainage bag is situated below the level of the bladder and not in contact with any surface e.g. floor?	Signature and Print Name
Day 4 15/8/20	10c	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 5 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 6 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 7 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 8 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 9 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 10 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 11 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 12 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 13 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 14 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 15 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 16 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 17 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 18 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 19 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 20 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 21 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 22 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 23 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 24 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 25 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 26 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 27 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 28 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

2104673933
SHAW
Andrew, M M
30 DOUGLAS DRIVE 21/04/1967
EAST KILBRIDE
Glasgow, Lanarkshire -
G75 8JS

CHI: _____
Address: _____
Hospital: _____

NHS Greater Glasgow and Clyde

Insertion criteria and justification at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☑ **Resuscitation/Chest Pain** ☐ **IV Drugs** ☐ **Fluids** ☐ **Transfusion** ☐

PVC inserted: Day 0	Date: 11 / 8 / 20 Hospital: _____ Area: ED ☑ Theatre ☐ ITU/HDU ☐ Ward ☐ _____ Unknown ☐ _____
Insertion site:	R Hand ☐ R Arm ☑ R Foot ☐ L Hand ☐ L Arm ☐ L Foot ☐ Other: _____
Colour of cannula:	Blue ☐ Pink ☐ Green ☑ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☑ No ☐ If No, state reason: _____

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? (Diagnostics, Resuscitation/ Chest Pain, IV Drugs, Fluids, Transfusion)	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day 11/8/20	Yes ☑ No ☐ If No, remove PVC and record date and reason*:	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☑ N/A ☐	LD
Day 1 Check 2 Night 11/8/20	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☐ N/A ☑	LJ
Day 2 Check 1 Day 12/8/20	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☑ N/A ☑	LJ
Day 2 Check 2 Night 12/8/20	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☐ N/A ☑	LJ
Day 3 Check 1 Day 13/8/20	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☐ No ☑	Yes ☐ No ☐ N/A ☑	
Day 3 Check 2 Night 13/8/20	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☐ N/A ☑	NC

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: 14/8/20 **Reason for keeping PVC in after 72 hrs/ 3 days:** Difficult access

***Date PVC Removed:** ___/___/___

***Reason For Removal:** _____

Modified Visual Infusion Phlebitis (VIP) Score

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis : **Observe cannula**
One of the following is evident : slight pain or redness near site	1	Possible first signs : **Observe cannula**
Two or more of the following are evident: pain, redness, swelling	2	Early stage of phlebitis : **Remove & resite cannula**
All of the following are evident: pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: **Remove & resite cannula** **Seek further advice**
As above including: palpable venous cord	4	
As above including: pyrexia	5	

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and S. aureus bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids ? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → Can I switch my patient from IV to oral antibiotics?

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature ≤ 37.9°C, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE is available reliably** (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, S. aureus bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abcess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy.
Record the intended duration on the medicine kardex

YES

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

NO

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

Write or affix patient label

2104673933
SHAW
Andrew, M M
30 DOUGLAS DRIVE 21/04/1967
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

Name: _____ CHI: _____
DOB: _____ Addre
Ward: _____ Hospit

NHS Greater Glasgow and Clyde

Insertion criteria: Please complete this section at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☐ Resuscitation/Chest Pain ☐ IV Drugs ☐ Fluids ☐ Transfusion ☐

PVC inserted: Day 0	Date: 11/8/20 Hospital: QEUH Area: ED ☑ Theatre ☐ ITU/HDU ☐ Ward ☐ _____ Unknown ☐ _____
Insertion site:	R Hand ☐ R Arm ☑ R Foot ☐ L Hand ☐ L Arm ☐ L Foot ☐ Other: _____
Colour of cannula:	Blue ☐ Pink ☐ Green ☑ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: _____

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? Diagnostics Resuscitation/ Chest Pain IV Drugs Fluids Transfusion	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day 14/8/20	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☐ N/A ☑	
Day 1 Check 2 Night 14/8/20	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: ___/___/___ Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: 15/8/20

*Reason For Removal: dislodged.

Modified Visual Infusion Phlebitis (VIP) Score

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis : **Observe cannula**
One of the following is evident : slight pain or redness near site	1	Possible first signs : **Observe cannula**
Two or more of the following are evident: pain, redness, swelling	2	Early stage of phlebitis : **Remove & resite cannula**
All of the following are evident: pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: **Remove & resite cannula**
As above including: palpable venous cord	4	**Seek further advice**
As above including: pyrexia	5	

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and S. aureus bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids ? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → Can I switch my patient from IV to oral antibiotics?

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature ≤ 37.9°C, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE is available reliably** (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, S. aureus bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abcess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy.
Record the intended duration on the medicine kardex

YES

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

NO

2104673933
SHAW M
Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

ar Cannula

enance

Write or affix patient label

Name: _____ CHI: _____

DOB: _____ Address: _____

Ward: _____ Hospital: _____

NHS Greater Glasgow and Clyde

tion criteria: Please complete this section at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☐ **Resuscitation/Chest Pain** ☐ **IV Drugs** ☐ **Fluids** ☐ **Transfusion** ☐

PVC inserted: Day 0	Date: 14/8/20 Hospital: QEUH Area: ED ☐ Theatre ☑ ITU/HDU ☐ Ward ☐ _____ Unknown ☐ _____
Insertion site:	R Hand ☐ R Arm ☐ R Foot ☐ L Hand ☐ L Arm ☑ L Foot ☐ Other: _____
Colour of cannula:	Blue ☐ Pink ☐ Green ☑ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☑ No ☐ If No, state reason: _____

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? (Diagnostics, Resuscitation/ Chest Pain, IV Drugs, Fluids, Transfusion)	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day 15/8/20	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☐ N/A ☑	GJ
Day 1 Check 2 Night 15/08/20	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☑ No ☐ N/A ☑	CM
Day 2 Check 1 Day 16/08/20	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☐ N/A ☑	CM
Day 2 Check 2 Night 16/0820	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☑ No ☐ N/A ☑	CM
Day 3 Check 1 Day 17/08/20	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☑	Yes ☐ No ☐ N/A ☑	CM
Day 3 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: ___/___/___ **Reason for keeping PVC in after 72 hrs/ 3 days:** _____

***Date PVC Removed:** ___/___/___

***Reason For Removal:** _____

Modified Visual Infusion Phlebitis (VIP) Score

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis : **Observe cannula**
One of the following is evident : slight pain or redness near site	1	Possible first signs : **Observe cannula**
Two or more of the following are evident: pain, redness, swelling	2	Early stage of phlebitis : **Remove & resite cannula**
All of the following are evident: pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: **Remove & resite cannula**
As above including: palpable venous cord	4	**Seek further advice**
As above including: pyrexia	5	

DRIFT

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- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids ? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

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Review need for IV antibiotics DAILY:
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CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy. Record the intended duration on the medicine kardex

YES

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

NO

(Inpatient) Moving and Handling Assessment Form

2104673933
SHAW M
Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

Named Nurse:		Person is totally independent (tick here and go to date box)	

Kg
BMI
cm

Problems with comprehension, behaviour, co-operation (specify):
↓GCS

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

Risk of Falls: Yes | No

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

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

3. Toileting

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

4. Move on / off bed pan

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

5. Move up / down bed

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

6. Lateral Transfer to / from trolley / bed

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

7. Sit up over side of bed

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

8. Into Bath or Shower

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

9. Walking

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

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:	11/8/20	16-08-20	21-8
Assessor's signature:	C. Bradley	[illegible]	[illegible]
Proposed Review date:	15/8/20	22-08-20	26/8

Continuation Sheet

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

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

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

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

3. Toileting

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

4. Move on / off bed pan

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

5. Move up / down bed

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

6. Lateral Transfer to / from trolley / bed

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

7. Sit up over side of bed

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

8. Into Bath or Shower

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

9. Walking

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

10. Other Instructions / Observations / Equipment Used

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

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name	
Address	2104673933 SHAW Andrew, M 30 DOUGLAS DRIVE EAST KILBRIDE Glasgow, Lanarkshire G75 8JS
CHI No.	M 21/04/1967
DoB	

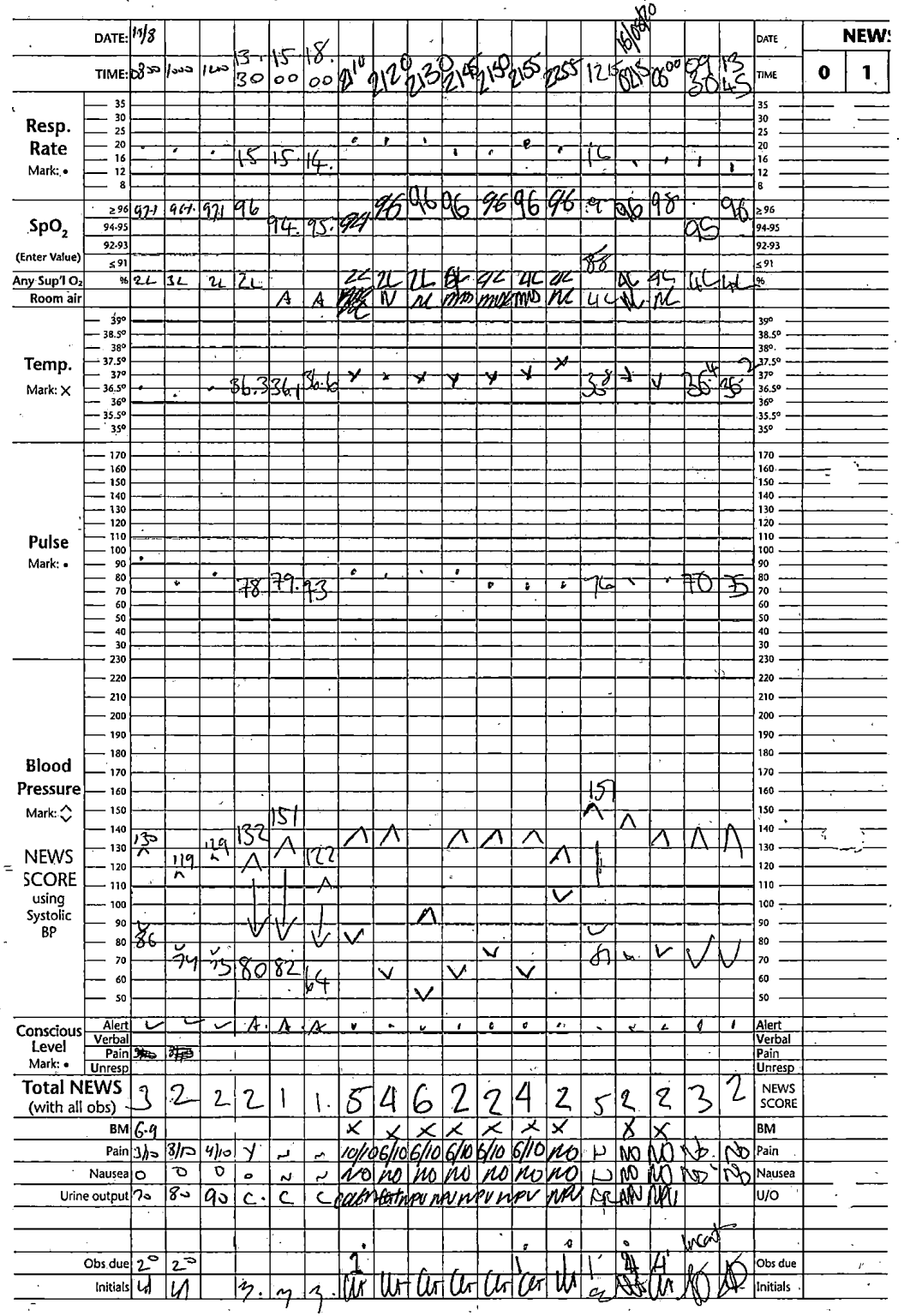
	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more **or** 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


DATE
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1
Resp. Rate
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SpO2
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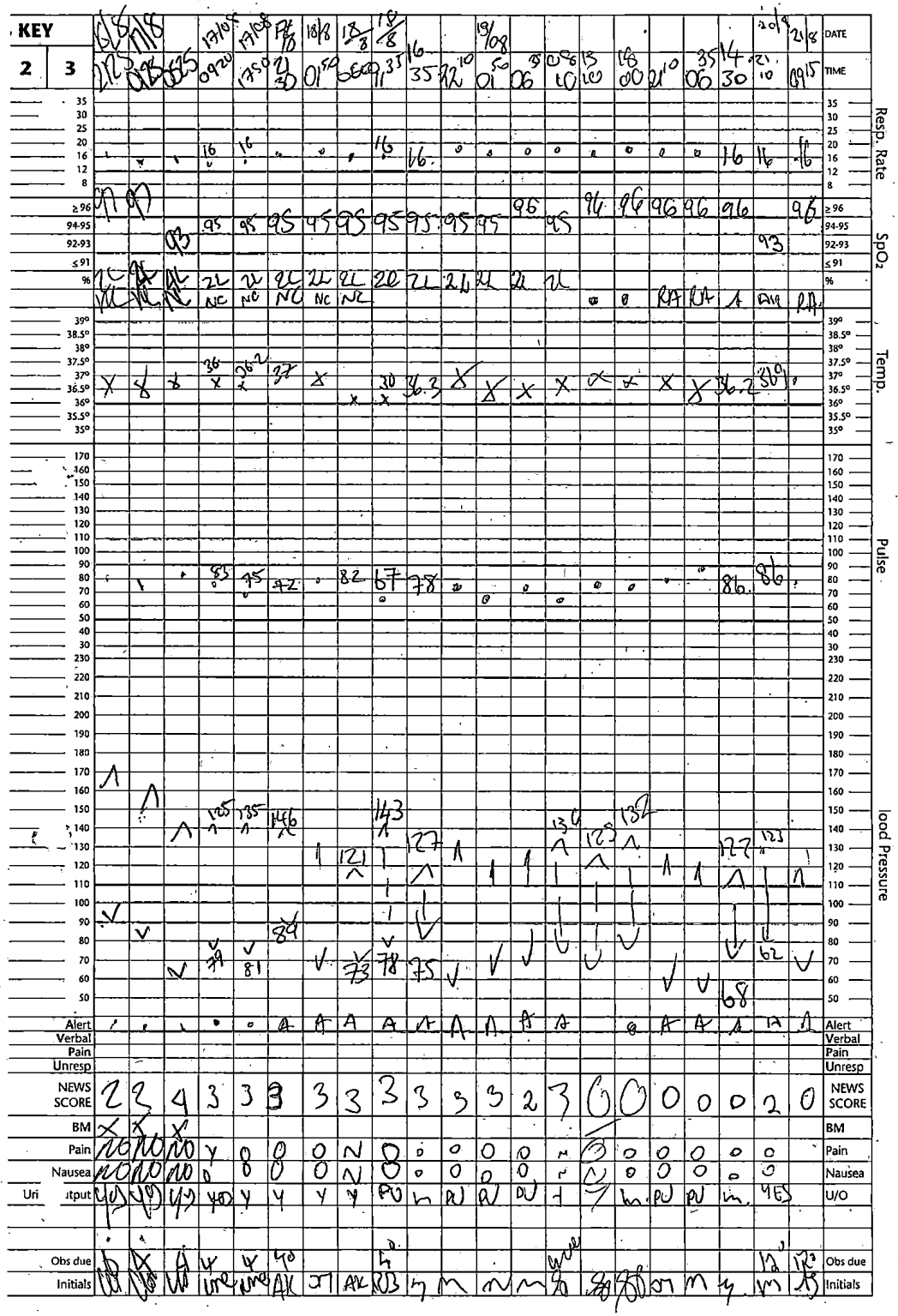
Any Sup'l O2
Room air
Temp.
Mark: X
Pulse
Mark: •
Blood Pressure
Mark: ◇
NEWS SCORE using Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
NEWS SCORE
BM
Pain
Nausea
Urine output
U/O
Obs due
Initials


KEY
2
3
DATE
TIME
Resp. Rate
SpO2
Temp.
Pulse
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
Urine Output
Obs due
Initials

Glasgow Coma Scale

Pupil size (mm) 1 2 3 4 5 6 7 8

2104673933
SHAW
Andrew, M
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS
M
21/04/1967

Neurological Observations

Date:				13	15	14	15	02	18	00	12	16											
Time:				30	00	00																	
COMA SCALE – E Eyes open	Spontaneously	4		0	0	0	0	0	1	0	0	0											
	To speech	3																					
	To pain	2																					
	None	1																					
V Best Verbal response	Orientated	5		4			5	0	1	0	0	1											
	Confused	4		0	0	0				0													
	Inappropriate words	3																					
	Incomprehensible sounds	2																					
	None	1																					
M Best motor response	Obeys	6		0	0	0	0	0	1	0	0	1											
	Localises	5																					
	Flexion - withdrawal	4																					
	Flexion - abnormal	3																					
	Extension to pain	2																					
	None	1																					
TOTAL SCORE				14	14	14	15	15	15	15	15	15											
PUPILS R	Size			3	3	3	3	3	3	3	3	3											
	Reaction			+	+	+	+	+	X	+	+	+											
PUPILS L	Size			3	3	3	3	3	3	3	3	3											
	Reaction			+	+	+	+	+	X	+	+	+											
LIMB MOVEMENT – ARMS	Normal power			R	R	R	R	R	R	R	R	R											
	Mild weakness			L	L	L	L	L	V	L	V	L											
	Severe weakness																						
	Spastic flexion																						
	Extension																						
	No response																						
LEGS	Normal power			R	R	R	R	R	R	R	R	R											
	Mild weakness			L	L	L	L	L	V	L	L	L											
	Severe weakness																						
	Spastic flexion																						
	Extension																						
	No response																						

Eyes closed by swelling = C

Endotracheal tube or tracheostomy = T

Usually record the best arm response

+ reacts – no reaction c. eyes closed

Record right (R) and left (L) separately if there is a difference between the two sides

Pain Score

Ask the patient to rate his/her pain by choosing a number between 0 and 10. Use the diagram below to assist the patient. If patient's pain is chronic, use generic tool. If patient is unable to communicate, use observational tool.

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

Nausea and Vomiting	
0	= None
1	= Mild (*Not distressing – no retching/vomiting*)
2	= Moderate (*Troublesome – occasional retching/vomiting*)
3	= Severe (*Distressing – frequent retching/vomiting*)

Management Plan and Patient Exclusions

Date and Time	Notes	Signed
18/05/2005	08:15 Patient found without O2 therapy on, now back in place	

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name
Address
2104673933
SHAW
Andrew, M
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS
CHI No.
DoB
M
21/04/1957

	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

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

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.

16

DATE: 23 01 01 02 03 04 05

TIME: 23:38 | 2130 | 2035 | 05:56 | 06:30

NEWS 0 1

Resp. Rate Mark: •

35 30 25 20 16 12 8

22 24

SpO2 (Enter Value)

≥96 94-95 92-93 ≤91

95 95 97 98 96 99 96 96 98 95

Any Sup'l O2 %

2L 2L 2L 2L 2L 2L 2L

Room air (A) (A)

Temp. Mark: X

39° 38.5° 38° 37.5° 37° 36.5° 36° 35.5° 35°

Pulse Mark: •

170 160 150 140 130 120 110 100 90 80 70 60 50 40 30

115

Blood Pressure Mark: ◇

230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50

116 148 151 114 115 110 90 78 99 84 77 58

NEWS CORE using Systolic BP

Conscious Level Mark: •

Alert Verbal Pain Unresp

Total NEWS (with all obs)

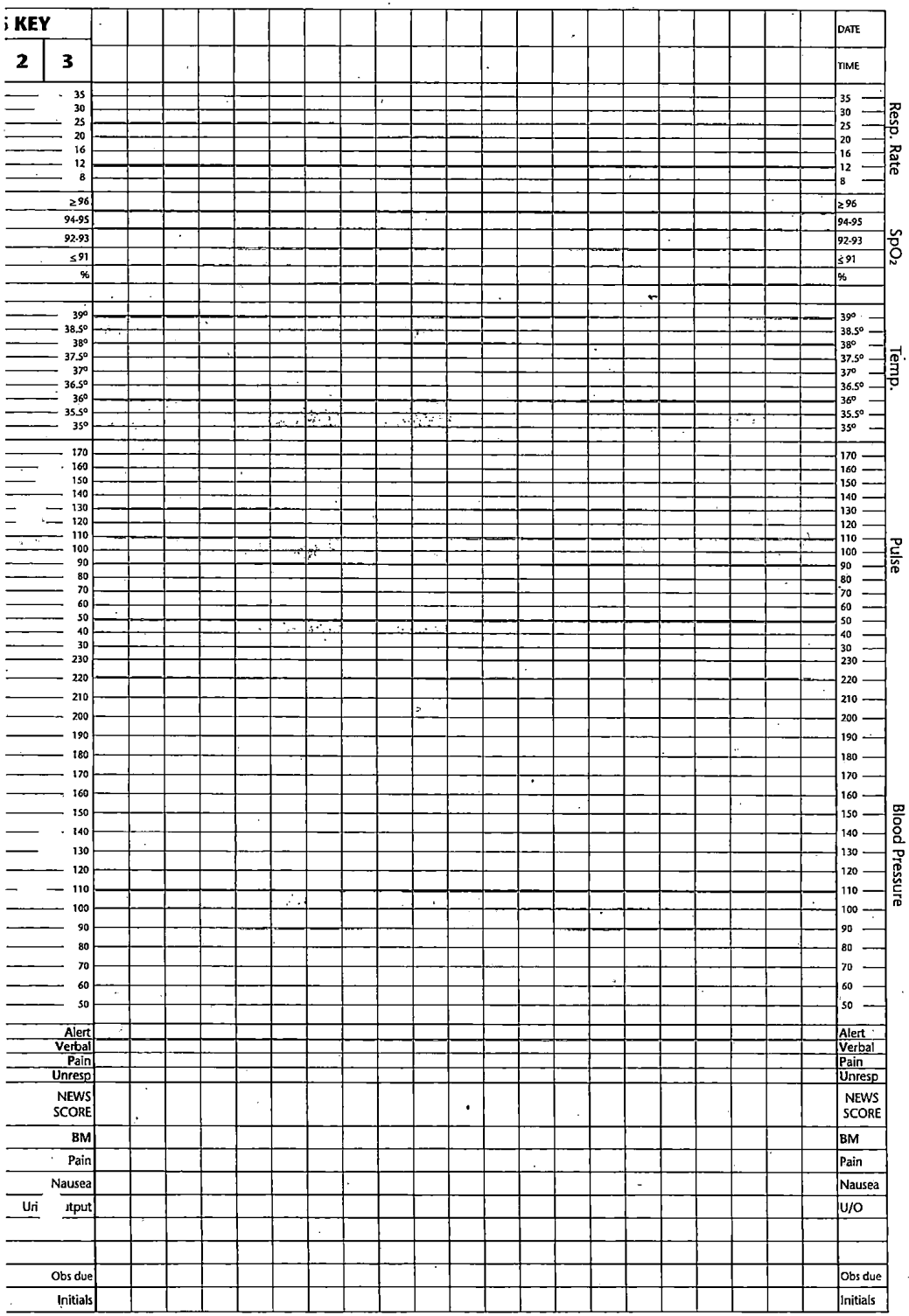
8 (8) 10 10 10 10 10 10

BM Pain Nausea Urine output

Obs due

Initials LK LK LK EH EH EH EH

DATE TIME NEWS SCORE BM Pain Nausea U/O Obs due Initials


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥96
94-95
92-93
≤91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
Blood Pressure
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
Uri tput
U/O
Obs due
Initials

Glasgow Coma Scale

Pupil size (mm)

1 2 3 4 5 6 7 8

2104673933
SHAW
Andrew, M M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

Neurological Observations

| | | |

2104673933
SHAW
Andrew, M
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

M
21/04/1967

OBSERVATION CHART

NHS Greater Glasgow and Clyde

Date: 12/8 | 13/8 | 14/8

Time: 1118 | 1118 | 1118 | 1218 | 1218 | 1218 | 1218 | 1218 | 1218 | 1218 | 1218 | 0400 | 0800 | 0800 | 1200 | 1400 | 1600 | 1800 | 2000 | 2200 | 0000 | 0200 | 0400 | 0600 | 0800 | 1000 | 1200 | 1400 | 1600 | 1800 | 2200

Coma Scale

Eyes open
- Spontaneously 4
- To speech 3
- To pain 2
- None 1

Best motor response
- Obeys commands 6
- Localise pain 5
- Normal flexion to pain 4
- Abnormal flexion to pain 3
- Extension to pain 2
- None 1

Best verbal response
- Orientated 5
- Confused 4
- Inappropriate words 3
- Incomprehensible sounds 2
- None 1

Eyes closed by swelling = C

Usually record the best arm response.

Endotracheal tube or tracheostomy = T

Pupil Scale (mm)

1 2 3 4 5 6 7 8

Blood pressure and Pulse rate: 240 230 220 210 200 190 180 170 160 140 130 120 110 90 80 70 60 40 30 20 10

Respiration

Temperature °C: 40 39 38 37 36 35 34 33 32 31 30

Pupils

Right	Size	2	2 2 2 2 3 3 3 3 3 3 3 3 3 2 4 3 3 3 3 3 3 3
	Reaction	✓	↑ ↑ +
Left	Size	2	2 2 2 2 3 3 3 3 3 3 3 3 3 2 4 3 2 3 3 3 3 3
	Reaction	✓	+ ↑ ↑ ↑ + + + + + + + + + + + + + + + + + +

+ reacts
- no reaction
c. eye closed

Limb Movement

Arms

Normal power	R R R R L L L L L L L L L L L L L L L L L R
Mild weakness	L L L L L L L R/L R R R R R R R R R R R R R
Severe weakness	
Spastic flexion	
Extension	
No response	

Legs

Normal power	R R R L L L L L R R R R R R R R R R R R R L
Mild weakness	L L L L L L L R/L R R R R L L L L L L L L L
Severe weakness	
Spastic flexion	
Extension	
No response	

Record right (R) and left (L) separately if there is a difference between the two sides.

VI MEDICAL ILLUSTRATION • A&E • 5923

Basic Guide for Performing Neurological Observations

1. Frequency of performing observations: **This is the minimum recommended.**

   More frequent observations should be carried out if the clinical condition requires it.

- On arrival i.e. following transfer from another area. Should be compared to previous recording and any deterioration discussed with medical staff.
- At half hourly intervals for 2 hours.
- At hourly intervals for 4 hours.
- At 2 hourly intervals for 6 hours.
- At 4 hourly intervals until fit for discharge.

2. Examples of neurological deterioration that should be reported immediately to medical staff:

- Development of agitation or abnormal behaviour. (Do not automatically attribute to effects of alcohol or drug abuse.)
- Sustained decrease in conscious level of at least one point in the motor or verbal response, or two points in the eye opening response.
- Development of severe or increasing headache.
- Persisting vomiting.
- New or evolving neurological signs i.e. pupil inequality, asymmetry of limb or facial movement.

Eyes Open

- Conscious patients sense your approach and open their eyes spontaneously.
- Verbal stimulus may be normal, repeated or loud, recognisably use their name (beware not to touch at this time- use only verbal).
- Painful stimulus is applied by trapezius squeeze (use thumb and two fingers to hold and squeeze 2 inches of trapezius muscle where the head/neck meets the shoulder). If eyes do not open in response, squeeze the side of the patient's finger (3rd or 4th) between your thumb and a pen.

Best Motor Response

- **Obey commands.** The patient understands and carries out instructions e.g. lift up arms, hold up thumb, squeeze hands - always ask patient to release grip in order to eliminate primitive reflex. Be aware of possible hearing/speech disorders.
- **Localise pain.** The patient must bring hand up beyond level of the clavicle in response to central painful stimulus (trapezius, finger squeeze).

  Patients may localise to irritants such as O_2 masks or N/G tubes. Best arm response is used as leg response may be a spinal reflex only.
- **Flexion to pain.** The patient may flex or bend their arm towards source of pain but do not actually localise or try to remove the source. Response is variable with each stimulus.
- **Abnormal flexion.** The patient may flex or bend the arm at elbow and rotate wrist (spastic posture) whilst drawing arm across chest. Response is slower than in normal flexion to pain.
- **Extension to pain.** The patient may extend or straighten arm at elbow or may rotate arm towards.
- **No response to pain.** Beware absence of response may be due to high spinal injury or muscle paralysing drugs.

Best Verbal Response

- **Orientation.** The patient knows who they are, where they are, month and year and why they are where they are.
- **Confusion.** The patient holds a conversation but cannot answer accurately, talks in sentences, unaware of self or environment.
- **Inappropriate words.** The patient replies in words said at random, often shouts or swears.
- **Incomprehensible sounds.** You may have to use both verbal and painful stimulus to get a response. Patient may moan or groan (beware of English language ability).
- **No response.** Beware of possible hearing/speech disorders.

Pupils

- **Size.** Look at pupil before shining light into the eye. Both should be equal in size (beware drugs affecting size). Beware pre-existing irregularities e.g. cataracts, blindness etc. Shape is normally round.
- **Reaction.** Should be 'consensual' reaction i.e. where both eyes constrict as light shone into one (bring light in from side of eye).

Vital Signs

- **Temperature.** Alterations may be due to damage to hypothalamus. Raised temperature also increases demand for O_2 by brain cells so regulation is important.
- **Blood pressure and pulse.** Haemorrhage from an extra-cranial site may lead to falling blood pressure and rising pulse and if under treated, shock may cause neurological deterioration. Rising blood pressure and slowing of pulse can be a sign of increasing intra-cranial pressure.
- **Respirations.** Reduced conciousness may cause hypoxia through inadequate respiration or an obstructed airway. Hypoxia may cause neurological deterioration. Changes in rate and pattern may indicate a rise in intra-cranial pressure.

Limb movement

- **Normal power.** The patient matches resistance applied to any joint movement (pulls you towards them or pushes you away).
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References

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Compiled by Mrs. B. Wellington, Clinical Nurse Specialist (Orthopaedics) on behalf of SGUH SIGN No 46 Local Guideline Development Group, March 2002

Lead Clinician Mr. T. Parke, Clinical Director for A&E.

Next review date: March. 2003

OBSERVATION CHART

NHS Greater Glasgow and Clyde

2104673933
SHAW
Andrew, M
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

M
21/04/1967

Date: 15/6

Time: 0800 1233

Coma Scale

Eyes open
- Spontaneously: 4 4 4 4
- To speech
- To pain
- None

Eyes closed by swelling = C

Best motor response
- Obeys commands: 6 6 6 6
- Localise pain
- Normal flexion to pain
- Abnormal flexion to pain
- Extension to pain
- None

Usually record the best arm response.

Best verbal response
- Orientated: 5
- Confused: 4 4 4
- Inappropriate words
- Incomprehensible sounds
- None: 1

Endotracheal tube or tracheostomy = T

Pupil Scale (mm)

1 2 3 4 5 6 7 8

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Respiration

Temperature °C: 40 39 38 37 36 35 34 33 32 31 30

Pupils

Right	Size	3 3 3 3
	Reaction	+ + + +
Left	Size	3 3 3 3
	Reaction	+ + + +

+ reacts
- no reaction
c. eye closed

Limb Movement

Arms
- Normal power: L L R L
- Mild weakness
- Severe weakness
- Spastic flexion
- Extension
- No response

Legs
- Normal power: L R L
- Mild weakness: L L L
- Severe weakness
- Spastic flexion
- Extension
- No response

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Lead Clinician Mr. T. Parke, Clinical Director for A&E.

Next review date: March. 2003

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

2104673933 SHAW Andrew M M 21/04/1967	Hospital: QEUH Ward: MHDU/10C	**Points to consider:** • Use within 6 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

1 **Pressure Damage**	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY Active Care to avoid further damage occurring and complete the pressure ulcer interventional plan overleaf.

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
13/08/20	moisture @ cleft-bottock.		/ /		
/ /			/ /		
/ /			/ /		

2	Mobility	Does the person require assistance to mobilise?
3	Continence	Does the person have continence issues with urine and/or faeces?
4	Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5	Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?
6	Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY Active Care interventions and complete the pressure ulcer interventional plan overleaf.

If NO to all statements, continue Active Care Prescribing as assessed for individual need and re-assess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
11/8/20	06:50	N	Y	N	N	N	N	4 hrly	GB
11/8/20	18:00	NO	Yes	NO	Yes	NO	yes	4 hrly	G
12/8/20	04:00	NO	Y	N	N	N	Y	4 hrly	M
13/8/20	01:00	NO	Y	N	N	N	Y	4 hrly	M
14/8/20	0100	NO	Yes	NO	Yes	Yes	Yes	4 hrly	N.C
15/8/20	0100	N	Y	N	Y	Y	Y	4 hrly	
16/08/20	0200	YES	YES	NO	YES	YES	YES	2-3 hrly	
17/08/20	0040	YES	YES	NO	YES	YES	YES	2-3 hrly	
18/08/20	00:20	Y	Y	N	Y	Y	Y	2-3 hrly	AK (STN)
19/08/20	03:20	Y	Y	N	Y	Y	Y	2-3 hrly	
20/08/20	04:00	Y	Y	N	Y	Y	Y	2-3 hrly	
21/8/20	0300	N	Y	N	Y	N	Y	3 hrly	M
22/8/20	04:00	N	Y	N	N	N	N	3 hrly	M.C
24/8/20	0310	N	Y	N	N	N	Y	4 hrly	

Complete prevention of pressure ulcer interventional plan overleaf for all patients with redness/pressure damage and for those at risk.

Prevention of Pressure Ulcer Inte[illegible]ention Plan

NHS Greater Glasgow and Clyde

2104673933
SHAW Andrew, M M 21/04/1967
Ian Bradley2

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

Outcome: To prevent pressure ulcer development through establishment of effecting work practices in line with SSKINS bundle.

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCONTINENCE / MOISTURE	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of initial plan: 11/8/20	Check: • Pressure areas 4 hourly. • Skin under medical devices 4 hourly. • Specify medical devices used:	Specify: • Mattress: Soft foam • Cushion: • Detail additional pressure redistributing equipment: Pillows	• Reposition 4 hourly in bed and chair. • Overnight patient / carer has agreed to repositioning 4 hourly • Specify any manual handling equipment used:	• Skin care to be carried out PM hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree plan with patient / family/ carer YES ☑ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☑ NO ☐	Date discontinued:
Date Reviewed: 16-08-20	Check: • Pressure areas 2-3 hourly. • Skin under medical devices 2-3 hourly. • Specify medical devices used:	Specify: • Mattress: Soft foam • Cushion: • Detail additional pressure redistributing equipment:	• Reposition 2-3 hourly in bed and chair. • Overnight patient / carer has agreed to repositioning 2-3 hourly • Specify any manual handling equipment used:	• Skin care to be carried out 2-3 hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☑	(GSN Date discontinued:
Date Reviewed:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition ____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out ____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐	Date discontinued:

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

2104673933 SHAW M Andrew, M 21/04/1967 30 DOUGLAS DRIVE EAST KILBRIDE Glasgow, Lanarkshire G75 8JS	Hospital: BRW Ward: 10C	**Points to consider:** • **Use within 6 hrs of admission to care area** • **Re-assess daily and more frequently if a person's condition changes**

1	**Pressure Damage**	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY Active Care to avoid further damage occurring and complete the pressure ulcer interventional plan overleaf.

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2	**Mobility**	**Does the person require assistance to mobilise?**
3	**Continence**	**Does the person have continence issues with urine and/or faeces?**
4	**Nutrition**	**Does the person appear malnourished and/or unable to eat or drink?**
5	**Skin**	**Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?**
6	**Judgement**	**In your clinical judgement, is this person at risk of developing pressure damage?** **If Yes, please give details:**

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY Active Care interventions and complete the pressure ulcer interventional plan overleaf.

If NO to all statements, continue Active Care Prescribing as assessed for individual need and re-assess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
24/8/20	00:10	N	Y	N	N	N	Y	4 hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	

Complete prevention of pressure ulcer interventional plan overleaf for all patients with redness/pressure damage and for those at risk.

Prevention of Pressure Ulcer Inter ntional Plan

NHS Greater Glasgow and Clyde

Attach Addressograph

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

Outcome: To prevent pressure ulcer development through establishment of effecting work practices in line with SSKINS bundle.

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCONTINENCE / MOISTURE	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of initial plan: 24/8	Check: • Pressure areas 4 hourly. • Skin under medical devices n/a hourly. • Specify medical devices used:	Specify: • Mattress: foam • Cushion: • Detail additional pressure redistributing equipment:	• Reposition 4 hourly in bed and chair. • Overnight patient / carer has agreed to repositioning n/a hourly • Specify any manual handling equipment used:	• Skin care to be carried out n/a hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued:
Date Reviewed:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition ____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out ____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐	Date discontinued:
Date Reviewed:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition ____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out ____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐	Date discontinued:

SBAR Handover Sheet

S — SITUATION

Date of admission	11/8/22
Date of transfer	15/8/22
Receiving Nurse signature	DCL
Nurse giving handover	Lolith Lord
Ward	10(C)
Time	1325

Admitting complaint: Car crash.

Primary diagnosis: Polytrauma, Positive toxicity screen

Receiving Consultant: Orthopaedics

Relatives informed of transfer? ☑ Yes ☐ ~~No~~

If No, why not? Left message to parents lawyer.

2104673933
SHAW
Andrew, M
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS
M
21/04/1967

B — BACKGROUND

Relevant past medical history/ Allergies (insert refer to NAD if sufficient): Unknown

Brief summary of HDU/ITU stay: (minimal info required) Neuro obs, disoriented, required O2

Social circumstances (include any referral with child protection/ adult protection /OPAC): Lives on his own.

Mobility / Safety requirements

Independent	☐ Yes ☑ ~~No~~
With assistance	☑ ~~Yes~~ ☐ No
If yes how many?	2
Aids reqd?	☑ ~~Yes~~ ☐ No
If yes state equipment	Hoist (sliding sheet)
Physio	☑ ~~Yes~~ ☐ No
CANNARD	☑ ~~Yes~~ ☐ No

Infection Control Risk Management

Known infection control risk? ☐ Yes ☑ ~~No~~

If yes, give details:

Isolation required? ☐ Yes ☑ ~~No~~

Recent samples sent (include date(s))	Covid-19 (15/8/22
Recent bacteriology result(s)	
Urine result	Tox screen +ve for cocaine, amphetamine, methamphetamine, opioids, benzos.

A — ASSESSMENT

Patient oriented	☑ ~~Yes~~ ☐ No	Please include documentation below with transfer
Peripheral line	☑ ~~Yes~~ ☐ No	Insert date: 14/8/22 Time: ____
Arterial line	☐ Yes ☑ ~~No~~	Insert date: ___/___/___ Time: ____
Central line in-situ	☐ Yes ☑ ~~No~~	Insert date: ___/___/___ Time: ____
Check kardex on transfer	☑ ~~Yes~~ ☐ No	
IV medication (Discuss requirements)	☐ Yes ☑ ~~No~~	☐ Check kardex on transfer
IV fluids	☐ Yes ☑ ~~No~~	Current rate/Type ____
NG	☐ Yes ☑ ~~No~~	Insert date: ___/___/___ Time: ____
Urinary catheter	☑ ~~Yes~~ ☐ No	Insert date: 12/8/22 Time: ____

O2 therapy:

HFNO	☐	Flow rate (2-3)L O2 % ____
Face Mask	☐	O2 % ____
Nasal Cannula	☑	O2 % ____
Tracheostomy	☐	O2 % ____ care plan

(only if appropriate)
Resuscitation status:
DNACPR form included ☐
Incapacity form included ☐

Skin condition
Intact: ☑ ~~Yes~~ ☐ No
If No: document area of broken skin:

Waterlow score
Referred to tissue viability
☐ Yes ☑ ~~No~~

Nutritional requirements (circle appropriate)
Diet: (Normal) Special /NBM/ PEG /NG/ PN

MUST score	☐ Yes	☐ No
Referral to Dietician	☐ Yes	☑ ~~No~~
SALT assessment	☐ Yes	☑ ~~No~~
Alcohol Mgt Plan	☐ Yes	☐ No
Addiction liaison referral	☑ ~~Yes~~	☐ No
AMT 4 Complete	☐ Yes	☐ No

Document s to be included in Transfer (if applicable)

☑ ~~Medical notes~~	☑ ~~NEWS Chart~~
☐ ~~Nursing notes~~	☑ ~~HDU 24hr chart~~

Drug Kardex	☑
Patients Own medication	☐
CAUTI chart	☑
ENAD completed	☐
Care plan	☑
Property / Valuables	☐
NG care plan/MUST chart	☐
Waterlow chart	☑
PVC Chart	☑
Turning chart/SKINN	☑
Wound chart	☐

R — RECOMMEND

Referrals (specify): Seen by addiction team (review on 17/8/22)

Plan of care / Medical orders / Investigations/ Results

NHS Greater Glasgow & Clyde

24576

Patient's Property and Valuables Accepted for Safekeeping

Hospital: QEUH. Ward: ED. Date of Admission: 11/08/20.

Patient's full name: ANDREW M SHAW.

Permanent address: 30 DOUGLAS DRIVE G75 8JS.

1. Cash etc.

a) Bank Notes

b) Coins 5 x £1, 3 4 x 50p, 2 x 50p, 1 x 0p

c) Cheque, Giro etc (specify) 1 x 2p, 1 x 20p

	Amount	
Total	£6	52.

2. Bank/Building Society Books, Credit/Debit Cards etc

Name of Bank/Building Society	Cheque book, Card, Pay in book	Comments

3. Pension Books etc

Type of Pension	Book No	Comments

4. Other Property/Valuables/Jewellery/Watches/Phones/Keys etc (specify)

2 x white metal dog tag chains

"Major Allister Adams LLB 00687980146"

"Major Allister Adams LLB".

5. Clothing

Pyjamas		Shirt	1x grey polo shirt	Other items
Nightdress		Jumper		
Dressing Gown		Trousers		
Slippers	L R	Shoes	(L) (R) - Blue shorts.	
Vest		Boots	L R = Nike Airmax (blue/grey)	
Pants		Coat		
Socks		Jacket		
Bra		Towel		
Slip		Electric Razor		
Tights		Toilet Bag & Contents		
Skirt				
Blouse				

I agree that the property and valuables noted above represent a true list of property and valuables handed over by me for safe keeping and that any other property and valuables retained by me are held on my own responsibility.

Signature of patient or staff member [signature] Status SN.

Signature of officer receiving items listed above: [signature]

Status [illegible] Date [illegible]

92627 GGC0077

NHS Greater Glasgow & Clyde

24576

Patient's Property and Valuables Accepted for Safekeeping

Hospital: QEUH. Ward: ED. Date of Admission: 11/08/20

Patient's full name: ANDREW M SLIAW.

Permanent address: 30 DOUGLAS DRIVE G75 8JS.

1. Cash etc.

a) Bank Notes

b) Coins 5x£1, 34x50, 2x50p, 1x10p

c) Cheque, Giro etc (specify) 1x2p, 1x20p

	Amount	
Total	£6	52.

2. Bank/Building Society Books, Credit/Debit Cards etc

Name of Bank/Building Society	Cheque book, Card, Pay in book	Comments

3. Pension Books etc

Type of Pension	Book No	Comments

4. Other Property/Valuables/Jewellery/Watches/Phones/Keys etc (specify)

2x white metal dog tag chains

"Major Allister Keyring LL45 0068-K180446"

"Major Allister Keyring LL13"

5. Clothing

Pyjamas		Shirt	1x grey polo shirt	Other items
Nightdress		Jumper		
Dressing Gown		Trousers	- blue shorts.	
Slippers	L R	Shoes	(L) (R) - Nike Air Max	
Vest		Boots	L R	(blue/grey)
Pants		Coat		
Socks		Jacket		
Bra		Towel		
Slip		Electric Razor		
Tights		Toilet Bag & Contents		
Skirt				
Blouse				

I agree that the property and valuables noted above represent a true list of property and valuables handed over by me for safe keeping and that any other property and valuables retained by me are held on my own responsibility.

Signature of patient or staff member [signature] Status SN.

Signature of officer receiving items listed above: [signature]

Status _____ Date _____

92627 GGC0077

62561

NHS GREATER GLASGOW AND CLYDE

INTERIM WARD RECEIPT

Receipt of Patients Money and Valuables handed over for safekeeping

2104673933
SHAW
Andrew, M
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS
M
21/04/1967

HOSPITAL: QEUH

To be completed by Nursing Staff

Date: 11/08/20

Ward: A&E Unit No: CHI No: 2104673933

Patient's Name: Andrew Shaw

Home Address: 30 Douglas, Drive
East Kilbride, Glasgow, Lanarkshire

Next of Kin: or Relationship:

DETAILS OF MONEY AND VALUABLES RECEIVED

Cash	£ 6 p 50	Description
No. of Watches		
No. of Rings		
Bankcards		
Other Items		x2 white Metal (Dog tags)
Shoes x1 pair		Blue Nike Airmax's

Listed by Date Checked by Date 11/08/20

FOR OFFICE USE:

Cashier		Signature	Date
Night Safe		Signature	Date
Returned by		Signature	Date
*Taken by		Signature	Date

Name Relationship to patient *(if not patient)

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patient's name: 2104673933 SHAW Andrew, M M 21/04/1967

Unit number:

CHI number:

Ward: 10C

Discharge destination: police custody.

Estimated Discharge Date (1) / /

Estimated Discharge Date (2) / /

Final date of discharge : 24/8/20

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

Time of Discharge: 1100

Nurse's signature: Designation: Band 4 Date: 24/8/20

Previous Patient Notes for Gastroenterology (newest at the top).

Note: Specialty search returns patient notes from 13th November 2018 onwards. Patient notes older than that date, tagged Historical Notes, that don't have a specialty assigned can only be viewed within the Patient Notes section in the Clinical Documents tree.

Patient Note		**Inpatient Note**
Date/Time: 02-Feb-2021 15:31	**Created By:** Consultant Gastroenterologist and Hepatologist - Jude Morris	**Role:** Doctor - GGC
Specialty: Gastroenterology	**Organisation:**	Sensitive
Note: NOv 2020 IDL=FDL.		

Previous Patient Notes for Physiotherapy (newest at the top).

Note: Specialty search returns patient notes from 13th November 2018 onwards. Patient notes older than that date, tagged Historical Notes, that don't have a specialty assigned can only be viewed within the Patient Notes section in the Clinical Documents tree.

Patient Note		**Inpatient Note**
Date/Time: 24-Aug-2020 13:22	**Created By:** Physiotherapy Assistant Practitioner - James Grant	**Role:**
Specialty: Physiotherapy	**Organisation:** Queen Elizabeth University Hospital	Sensitive

Note:

PT
S/consented @11.00am
O/supine in bed
sit to stand from supine - INDEP
Gait - WZF supervision 10m step through pattern and T/F into chair
RX/ 1-Bed T/F
2-Gait 10m WZF
A/managed well WZF steady and safe
P/D/C PT patient taken into police custody

Patient Note		**Inpatient Note**
Date/Time: 23-Aug-2020 12:10	**Created By:** Physiotherapist - Ross Munro	**Role:** AHP - GGC
Specialty: Physiotherapy	**Organisation:**	Sensitive

Note:

S//Patient consented to Rx at 1150. Seen with B Colvin (PT).

O//PAtient up sitting in chair//looking agitated on approach//only answering one word answers
SpO2 88% eventually increased to 93% with DBE's ~ 2 minutes
BP 142/82 Pulse 73

STS - AO1 to Arjo
Gait - mobile with Arjo AO2//step too pattern//struggling to clear left leg on swing through//leaning back in walker, needing reminded to keep chest close to frame
Stand to sit - able to place right hand on arm of chair to assist self in sitting

A//Patient while up mobilised well however unable to converse with PT's regarding pain levels etc

P//Review 1/7

RM
B5PT

Patient Note		**Inpatient Note**

Date/Time: 21-Aug-2020 15:30	**Created By:** Physiotherapy Assistant Practitioner - James Grant	**Role:**
Specialty: Physiotherapy	**Organisation:** Queen Elizabeth University Hospital	Sensitive

Note:

PT
S/consented @ 3.00pm
O/supine in bed
sit to stand from supine - A02
Gait - ARJO walker A02 4m step to pattern and T/F into chair
RX/ 1-Bed T/F
2-Gait 4m ARJO
A/slow to progress
P/continue to increase mobility ARJO A02

Patient Note		**Inpatient Note**
Date/Time: 20-Aug-2020 13:56	**Created By:** Physiotherapist - Major Trauma - Jill Blackwood	**Role:** AHP - GGC
Specialty: Physiotherapy	**Organisation:**	Sensitive

Note:

S. Consented to PT RV with myself & PT Louis Smith at 13.20. No changes since yesterday - M/S keen for pt to be D/C'd to police custody.
O. UTS in bedside chair, obs stable, walker boot in situ L LL
STS attempted pushing from chair but pt unable // pt not making contact with sole of walker boot on L & trunk pushing backwards
STS achieved pulling up on arjo walker with R, flexed posture in standing, reduced W/B on L LL
Mobilised approx. 8 steps with arjo walker & Ao2 // initially minimal W/B down through L LL but improved with facilitation from PT, small steps, clearing floor mostly, dragging R foot forward on last couple steps.
Returned to sit in chair with VPs
Rx
1. STS Px to arjo walker
2. Mobilised with arjo walker as above
A. Slowly progressing, needs further Px with arjo walker. Pain limiting.
P. Cont. 1/7 with gait re-ed.
Jill Blackwood B5PT

Patient Note		**Inpatient Note**
Date/Time: 19-Aug-2020 12:25	**Created By:** Physiotherapist - Major Trauma - Jill Blackwood	**Role:** AHP - GGC
Specialty: Physiotherapy	**Organisation:**	Sensitive

Note:

S. Consented to PT RV with myself & PT Louis Smith at 11.40. C/O pain in L shoulder - on RV of notes X-ray hasn't been carried out despite being requested. Pt for further psych RV 1/7, remains distracted, no eye contact, pursed breathing & scratching at self but this was stable t/o Rx.
O. Lying in bed on R side on arrival, obs stable
lie to sit indep

Indep sitting over EOB
Q/C of L shoulder // approx 30-40 deg of elevation only, PROM flexion to 80 degrees & limited by pain.
Ao1 to put on L walker boot, too painful to achieve plantargrade approx. half an inch from bottom of boot.
STS using pulpit to pull up on R // flexed trunk, c/o pain w/b through L UL, unable to step due to pain so sat back on bed
STS with VPs only to stedy
TF bed to chair with stedy Ao2
Unable to flex knee to plant L foot on ground so holding out in extension // offered to remove boot but declined
Rx
1. Bed TF x 1
2. Q/C of L shoulder
3. STS attempted to pulpit
4. TF UTS with stedy
5. Updated pt board // TFs with stedy & Ao2, walker boot on L
A. Pain limiting stepping, particularly L shoulder - ? underlying boney or rotator cuff injury.
P. Progress mob as able, liaise with M/S re. L shoulder - X-ray has been taken but not reported so will chase this.
Jill Blackwood B5PT
2.

Patient Note		**Inpatient Note**
Date/Time: 13-Aug-2020 10:31	**Created By:** Lauren OHara	**Role:** AHP - GGC
Specialty: Physiotherapy	**Organisation:**	Sensitive

Note:

Physio;
S- Patient no longer under ortho and now under medical so notes continued on paper.

Patient Note		**Inpatient Note**
Date/Time: 12-Aug-2020 14:57	**Created By:** Lauren OHara	**Role:** AHP - GGC
Specialty: Physiotherapy	**Organisation:**	Sensitive

Note:

Physio 12/8/20;
S- Spoke with FY1 who had spoken with ortho who have reported patient not for further x-rays and to continue with conservative management and to WB with orthotic boot. FY1 reviewed patient's CT which showed no hip or shoulder #.
P- R/v 1/7 and do BES and STS if patient more compliant and pain better controlled.

Patient Note		**Inpatient Note**
Date/Time: 12-Aug-2020 14:45	**Created By:** Lauren OHara	**Role:** AHP - GGC
Specialty: Physiotherapy	**Organisation:**	Sensitive

Note:

Physio 12/8/20;
S- Brief consent obtained from patient. Seen at ~10.30am with PT J Ingham and A Teiger. Patient has sustained a left distal fibular # which is to be managed conservatively with ankle boot and can FWB. Patient for further x-ray of left ankle and left shoulder due to left shoulder pain on palpation. Patient extremely sore prior to Rx so requested oramorph prior to intervention. Patient extremely disorientated and drowsy, due to illegal substances. Unable to obtain social hx due to same.

O- Patient lying in bed on arrival. S/V on 4L O2, SpO2 96% (aiming SpO2 >92%).
Swelling of left foot ++ and grazes to both knees. Patient lying with left hip externally rotated, pain ++ when bringing leg into midline.

Right UL and LL AROM with no issues.
Left knee, able to flex and ext on request.
Left ankle, unable to DF or PF on request. Unable to achieve passive plantar grade by ~10 degrees due to pain +++

T/F lie-sit, Ao3. C/O throughout but unable to vocalise area of pain.
Sitting balance; indep. Poor compliance with following commands, incoherent due to illegal substances
T/F sit-lie, Ao3
Bed mobility, Ao3 with slide sheets

Rx- BES ~10mins

A- Patient not able to fully comply due to cognitive status secondary to illegal substances. Patient unable to achieve plantar grade of left ankle due to pain +++ so would not tolerate orthotic boot at present. Patient awaiting further x-ray of left ankle and shoulder so await these results before progressing rehab. ? left hip # due to pain over greater trochanter when assessed by FY1 and pain with moving leg and patient's preference to sit with hip ext rotated.

P- R/v 1/7, discuss with ward round regarding x-ray and ability to WB.

Previous Patient Notes for Acute Specialties GGC (newest at the top).

Note: Specialty search returns patient notes from 13th November 2018 onwards. Patient notes older than that date, tagged Historical Notes, that don't have a specialty assigned can only be viewed within the Patient Notes section in the Clinical Documents tree.

Patient Note		**Inpatient Note**
Date/Time: 22-Aug-2020 12:38	**Created By:** Rotational Physiotherapist 20210712 MJ - INCO390161 - Rachel Egan	**Role:** AHP - GGC
Specialty: Acute Specialties GGC	**Organisation:**	Sensitive

Note:

Physio

S/ Request from HCSW for assistance as NS busy with another pt. Pt consent. Agreed to mobilise from toilet to bedside chair. HCSW Christine present throughout.

O/ News as charted.
Pt sitting on shower chair. Moonboot insitu.
STS with AO2 and Argo walker
Standing with Argo walker and AO2
Gait: pt mobilised ~6m back to bedside chair with Argo walker and AO2, VP for gait re-ed, step through pattern. Safe and steady
STS to bedside chair with AO2.

Rx:
1) TF px
2) Mob px
3) Gait re-ed

A/ NS to mobilise with argo walker and NS, Board updated.

P/ Review 1/7 to progress as able

Patient Note		**Inpatient Note**
Date/Time: 22-Aug-2020 12:27	**Created By:** Rotational Physiotherapist 20210712 MJ - INCO390161 - Rachel Egan	**Role:** AHP - GGC
Specialty: Acute Specialties GGC	**Organisation:**	Sensitive

Note:

Physio

S/ Consent gained. J.Grant (AP) present throughout. Pt requesting use of toilet.

O/ News as charted.
Pt lying in bed o/a, AO1 for moonboot and footwear
LTS indep, pt erratic shuffling to edge of bed
STS with argo walker
Standing with Agro with AO2, VP to extend hips and knees
Gait: pt mob ~5m to toilet with argo walker and AO2, VP gait re-ed
STS to toilet with AO2 and Argo walker. NS aware and pt to buzz when finished.

Rx:
1) TF px
2) Mobility px
3) Gait re-ed

A/ Pt managed well mobilising to toilet with argo and AO2. NS to mobilise with Argo walker and AO2 to toilet. Board updated

P/ Review 1/7 to progress mobility as able.

Patient Note		**Inpatient Note**
Date/Time: 18-Aug-2020 12:11	**Created By:** Physiotherapist - Louis Smith	**Role:** AHP - GGC
Specialty: Acute Specialties GGC	**Organisation:**	Sensitive

Note:

S. Pt declined input at 1145 with myself and AP J Grant. Previous PT notes indicate that Pt was TF with stedy + Ao2 and they were querying Ax with pulpit.

O. Lying in bed
Ankle movement // minimal, though this may be more about engagement as he wasn't really following any commands

Rx/
Spoke through bed exercises though he showed little to no engagement with the process.

A. Minimal engagement. Appears distracted and disengaged but that may just be his normal.

P. R/v in 1/7

Patient Note		**Inpatient Note**
Date/Time: 17-Aug-2020 12:25	**Created By:** Physiotherapist - Louis Smith	**Role:** AHP - GGC
Specialty: Acute Specialties GGC	**Organisation:**	Sensitive

Note:

S. Attempted to r/v Pt this morning at 1115 with AP J Grant. However Pt was not fit to be seen. He was very restless, agitated and struggling to follow conversation or commands.

A. At present he is not safe to be seen.

P. R/v when safe to mobilise
Needs a moonboot

NHS GGC Hospitals, Admission Document

NHS Greater Glasgow and Clyde

Affix Label

CHI: 2104673933

Queen Elizabeth University Hospital

Total Att: 4

12 Mth Att: 1

Title: MR.

SHAW **Andrew Martin**

DOB **21/04/1967** Age: **53y** Sex: **Male**

30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow
Lanarkshire
G75 8JS

Next of kin: **KNOWN, NOT**
Relationship: **Unknown**

GP: **FR Wyllie**
01355 573790

Attendance Date: **15/11/2020** Arrival Time: **07:09**

Registration Time: **07:09** Date of Incident: **15/11/2020**

Major Incident Desc:

Reason for Attendance: **stand by**

Affix Label

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **15/11/2020 07:12** Nurse name: **Nurse Gemma Buntain**

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

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

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **standby**

2104673933
SHAW
Andrew, M
M
21/04/1967

Date	Emergency Department Notes
14/4/2020	Ambulance Proforma reviewed (Yes) / No Seen by (Doctor) Kimberley ED Time seen

53 → Handed over from night team → At 08:00 when handed over. Agitated + moving/. not cooperating despite Midazolam. Moved back to Resus for debrief.
Hx of been involved in chase with police - ? failed to stop, hit fence + car landed in 15ft embankment. left vehicle, fell. Hx from PRF + police.

PMHx: unknown
Bld Hx: Nil
Allergies: Nil
Social Hx: unknown
smell of alcohol

O/E: A - patent, speaks in sentences
breaths even pain

B - RR 22
Sats 100% (RA)

AE: Rt + Lt Haemothorax on Xray

C - HR reg
BP 141/90
Well perf

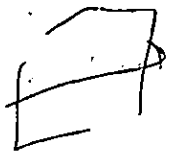
NAD
cap refill < 2 secs
No obv long bone injury

D - GCS 14/15, 2/4, PERRL 4mm 5, FAST -ve BM 7.1

pedal tenderness left

No epistaxis
No haemothympanum
No vomiting

E - T 35.5



Extensive abrasions left

Police liaison in ED.

2104673933 M
SHAW 21/04/1967
Andrew, M

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen

Differential Diagnosis/Problem List

- RTC
- ? intoxicated driver, ? drugs driving or taking substances
- agitated

NEWS ☐ 0-7
RED FLAG ☐ (Tick)
SEPSIS ☐
CURB 65 ☐

Done/ completed	Immediate Managment Plan
	- IV access + bloods + VBG.
	- CT head/neck/ thorax/abd/pelvis
	- moved back to ward to be detained to police under MHA CT appr
09:50	- released from CT → NEWS 1 & await results
	- CT - no acute injury but scan on + to view defect in upper + low limbs
	- absolute behaviour, if escalates → discuss to police

Signature: Designation: SHO Page No:

PLEASE

Printed: 15/11/2020 07:41:01

Patient Sample Report

Status: **ACCEPTED**
Analyzed: 15/11/2020 07:40:50
Sample Type: **Venous**
Sample Number:
Operator ID: JILL BUCKLEY0

Patient	
ID:	2104673933
Last Name:	**SHAW**
First Name:	**ANDREW**
Gender/Age:	Male, 53 years
Birth Date:	21/04/1967
Cartridge	
Lot No.:	200901F
S/N:	00000000500097678
Exp. Date:	05/12/2020
Analyzer	
Model:	GEM® *Premier 5000*
Area:	AH_L0ED_A
Name:	ED-POD
S/N:	17030622

Results			Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)						
cH	47.9	nmol/L	[--	--	--	--]
pCO_2	9.6	kPa	[--	--	--	--]
pO_2	2.3	kPa	[--	--	--	--]
Na^+	136	mmol/L	[--	133	146	--]
K^+	4.1	mmol/L	[--	3.5	5.3	--]
Cl^-	102	mmol/L	[--	95	108	--]
Ca^{++}	1.25	mmol/L	[--	1.15	1.27	--]
Hct	58	%	[--	--	--	--]
Glu	↑ 7.1	mmol/L	[--	3.5	6.0	--]
Lac	0.9	mmol/L	[--	0.6	2.2	--]
CO-Oximetry						
tHb	172	g/L	[--	--	--	--]
O_2Hb	↓ 20.9	%	[--	95.0	98.0	--]
COHb	0.5	%	[--	0.5	1.5	--]
MetHb	↓ 0.0	%	[--	0.5	1.5	--]
HHb	↑ 78.6	%	[--	0.0	5.0	--]
sO_2	↓ 21.0	%	[--	95.0	98.0	--]
Derived						
BE(B)	8.2	mmol/L	[--	--	--	--]
$HCO_3^-(c)$	37.1	mmol/L	[--	--	--	--]
Hct(c)	52	%	[--	--	--	--]

↑↓ Outside Reference Range

Other Information

Operator Entered		
Temp	37.0	°C

In-Patient Admission Notes

Patient ID label

Seen By: Rlabel Print: R. LEITCH Time Seen: 15:30 Pg. No:

PRF Reviewed Yes / No

Presenting Complaint(s)	
Presenting complaint	RTA
History of presenting complaint	- Brought to hospital after having to stop during a car chase by Police; subsequently crashed the car down ~15 foot embankment & ? ran away prior to calling & complaining of feeling dizzy. - Taken as a standby to ED resus & was agitated & uncooperative so required IV sedation to enable trauma CT sequence → given total of 10mg IV midazolam + 40mg IV ketamine between 08:15 - 08:50 today. - Has slept most of the afternoon; now drowsy but rousable & GCS 14/15 (E4 V4 M6). Orientated to place (hospital) but not time → ? accuracy of this as he is aware of continued Police presence outside room. - Small laceration (partial thickness) to ② forehead → steristrips applied & covered with dressing in ED.

Past Medical History / Review of portal
? Schizophrenia (diagnosis disputed) Undisplaced ② Weber A fx of ankle

Systemic Enquiry

Patient ID label

MEDICINES RECONCILIATION – Acceptable to staple fully completed Emed Rec

Source of medication history (>1 source preferred)
☐ Patient/Relative/carer ☐ GP Phone call ☑ ECS
☐ Patient own drugs ☐ Com. Pharmacist ☐ GP letter/summary
☐ Repeat Prescription

Other (please specify) * GCS not updated since 30/8/20 *

Admission Medicines			Plan for Medicines (Dr complete)				Comments Reason for alteration
Name	Dose	Freq	Continue	Amend	Withhold	Stop	
* No recent GCS, need to clarify meds with GP when they open borrow IC remains as an IP							

Allergies	List any over-the-counter or alternative medicines
Amoxicillin	Do medicines need further clarification ? ☐ Yes ☐ No
List collected by : R LEITCH	Plan approved by :
Designation : C-1 Date : 15/11/20	Designation : Date :

Pharmacy review	Comments

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

Patient ID label

Social History \ Family History

Smoking History

Ex-smoker/Smoker _____ cpd _____ yrs ☐ Never smoked

Alcohol History

_____ Units/week FAST score if excess _____

Recreational Drugs **Driving Status**

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

Reports he does not live in his own house but lives with different friends
→ refuses to elaborate further. Uncooperative.

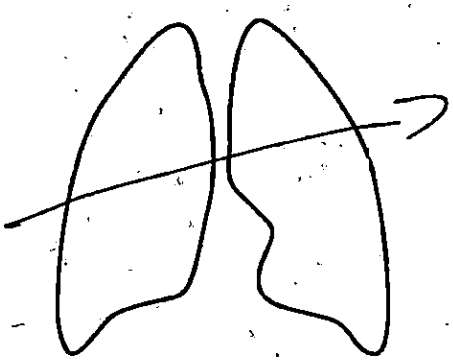
General Examination

Temp:	RR:
Pulse:	CBG:
SpO_2:	Weight:
BP:	Urinalysis:

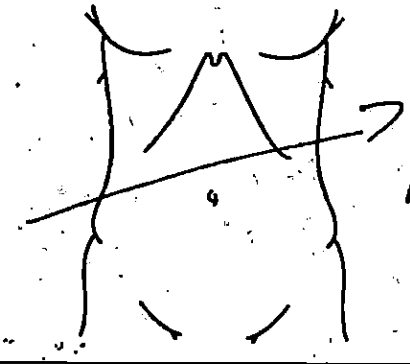
General Appearance:

- Unkempt + overweight
- Legs are covered in mud
- Uncooperative during discussion but follows commands correctly.

Respiratory



Gastrointestinal System



Cardiovascular

HS = 1+2+0, CRT < 2s

Locomotor

Normally independent.

Patient ID label

Neurological system

GCS: 14/15 E: 4/4 M: 6/6 V: 4/5

AMT 4 = age, DOB, place, year ✓ ✓ ✓ ✗

AMT score 3/4

Is the patient more confused/drowsy than normal: Y / N
If yes complete 4AT / TIME

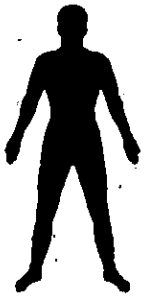
Pupils/fundoscopy:

Cerebellar and extrapyramidal: Grossly neurologically intact

Cranial Nerves:

Neck:

Reflexes:



	RUL	LUL	RLL	LLL
Tone	N	N	N	N
Power	5/5	5/5	5/5	5/5
Co-ordination	N	N	N	N
Sensation	N	N	N	N

Plantars: R L

Skin/Other

Patient ID label

NAD acute on CT head/C-spine/CAP

Key Results :

CXR Not undertaken ECG 82 bpm SR
QTc 466ms

(Differential) diagnosis

- RTA → ? whilst under the influence of alcohol or illicit drugs

NEWS ☐
Red Flag ☐
Sepsis ☐
CURB 65 ☐

Management Plan

- Continue to monitor as he recovers from IV sedation given in ED resus to enable brain CT sequence.
- Encourage PO intake
- Urine toxicology screen
- ? (P) for D/C later today or tomorrow morning into Police custody

☐ Thromboprophylaxis assessed ☐ Medicine Reconciliation ☐ 4AT/TIME
☐ Antimicrobial

Signature: R Leitch PRINT NAME R-LEITCH
PRINT GRADE C-1= Page:

Patient ID label

Resuscitation Decision
Resuscitation status: **FOR RESUSCITATION / DNA CPR** (please circle)
If DNA CPR → Complete appropriate form

Senior Medical review

☐ Thromboprophylaxis assessed
☐ Antimicrobial
☐ Medicine Reconciliation
☐ DNACPR
☐ 4AT/TIME
☐ AWI if appropriate

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

Patient ID label

Medical patient thromboprophylaxis decision aid – ENSURE BLACK BOX COMPLETED

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

☐ Yes

☐ No

- No thromboprophylaxis
- Reassess (every 72 hours minimum)and document
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)

Does the patient have any of the following risk factors? Tick if apply			
Active cancer or cancer treatment		Use of oestrogen containing contraceptive	
Age> 60		Hormone replacement therapy	
Dehydration		Pregnancy or <6 weeks post partum (seek specialist advice)	
Known thrombophillia		Critical care admission	
BMI >30		Varicose veins with phlebitis	
Personal/1st degree relative history of VTE		Current significant medical condition e.g. infection, inflammation, cardio resp disease	
Hip fracture			

☐ Yes

☐ No

Does the patient have any of the following contraindications? Tick if apply			
Active bleeding		Untreated inherited bleeding disorder	
Acquired bleeding disorder		Thrombocytopaenia <75 x109/l	
Thyroid, spinal, posterior eye or neurosurgery		Other procedure with high bleeding risk (discuss with senior)	
Concurrent use of anticoagulants e.g. warfarin with INR>2		Uncontrolled hypertension (>230/120)	
Acute stroke		Varicose veins	
Recent (<4 hours) or expected (within 12 hours) lumbar puncture, epidural or spinal anaesthetic			
Other - Document			

- Discuss with senior clinical staff regarding thromboprophylaxis
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)
- Consider mechanical prophylaxis unless contraindicated
- Reassess (every 72 hours minimum)and document

☐ No

☐ Yes

Enoxaparin 40mg (reduce to 20mg if weighs < 50kg or eGFR <30)

- Reassess every 72 hours minimum
- Ensure patient informed (see information leaflet)

Patient informed ☐ Yes ☐ N/A
(only n/a if due to cognitive impairment or similar)
If N/A why? _____
Assessed by _____
Date _____

Pa
2104673933
SHAW
Andrew, M
M
21/04/1967

Results

Date		15/11							
Time		07:15							
Parameter	Ref Range								
Hb	Male: 130-180 Female: 110-165	170							
WCC	4.0 - 11.0	11-4							
Plts	150 - 450	240							
MCV	80 - 100	93-0							
Neut	2.0 - 7.5	8-4							
PT	9.0 - 13.0								
APTT	27.0 - 38.0								
Fibrinogen	1.7 - 4.0								
INR	( )								
Thromb T	11-15 secs								
D-Dimer	0 - 250								
Na+	133 - 146	141							
K+	3.5 - 5.3	4-5							
Cl-	95 - 108	101							
HCO3-	22 - 29								
Urea	2.5 - 7.8	4-4							
Creat	40 - 130	81							
eGFR		>60							
Glucose	3.5 - 6.0	(6-3)							
Protein	60 - 80								
Albumin	35 - 50	41							
AlkP	30 - 130	96							
Bil	<20	15							
ALT	<50	19							
AST	<40	20							
GGT	Male: <70 Female: <40								
ESR	Male: 1 -10 Female: 1 - 12								
CRP	<10	8							
Troponin hs I	Male: 0 - 34 Female 0 - 16								
CK	Male: 40 - 230 Female: 25 - 200								
Corr Ca++	2.20 - 2.60	2.41							
PO4-	0.8 - 1.5								
Mg++	0.70 - 1.00								
Alcohol									
Paracetamol	<100 @4 hr								
Salicylate									
AST	<40								
Amylase	<100								
LDH	170 - 380								
Folate									
B12	200 - 900								
Ferritin	Male: 20 - 300 Female: 15 - 200								
TSH	0.35 - 5.00								
Free T4	9.0 - 21.0								
Digoxin	0.5 – 2.0								

2104673933
SHAW M
Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

Post Take Ward Round IAU/ARU

Consultant: BLYTH ARU1 Date: 15/11/20 Time: 5 PM

Summary

Brought in Police after car chase and RTA
In police custody
Agitated in ED → Ketamine 40 | Midaz 10
Receiving Trauma CT series
Has woken up somewhat but still very sleepy. Resps ok. Obs ok

Temp:
Pulse:
BP:
SpO_2:
FiO2:
RR:

Diagnosis:

Sedated; likely toxicity + illicit drug use.

Plan:

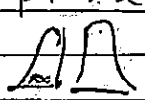
Observe overnight
Urine tox sent if possible
If wakes up → discharge ~~to~~ home to Police custody.

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

Signature: _____
Designation: RMO
Bleep Number: _____

Patient ID label

Continuation Sheet

Date: Time	
16/11/2020 10:35 am	WR- Lee (ARM) E4M6V4 → 14/15 lying in bed → not been cop → 1. sit out of bed 2 Not fit to discharge to custody 3 observe for a few more hours. (A-Lee (con-)
17/11/20 03:50	L. LOI by 1 H@N – ATSP – ↑ O_2 requirement ↳ 93% on 2L. – A – patent & maintained B –  air entry bilaterally RR 16 crep on R base ~~Earthlight~~ NO AT WOB. C – HSI+II+0 BP 110/70 HR 82. Calves SNT D – alert but hearing voices said "people/ everyone is shouting at him". E – No abdo pain. – patient feels slight SOB (L) chest / rib pain ↳ worse on inspiration & also on palpation. ↳ does not radiate ~~eg~~ anywhere ~~bo~~ Note: CT head thorax, abdo pelvis on 15/11/20 → No acute findings, no bony injury – had 10mg midazolam & 50mg Pethidine in ED – also complaining of headache (note: head laceration)

2104673933
SHAW M
Andrew, M 21/04/1967

Continuation Sheet

Date, Time

Imp : ? pneumothorax
? PE

(P) – 1. CXR
2. D-dimer +/- CTPA.
3. psych input during day time.
D/w ward suppt doctor Dr Adegbo – happy with plan.

(+) cocaine.
(+) 32d.

17/11/20 11.10AM Acute Addiction Liaison (214 0238)
Unable to fully assess pt due to clinical condition.
He appears to be hearing voices saying everyone is shouting at him and noise is stopping it. Looks restless, mild agitation.
He reports to taking 20-30 stesolt diazepam daily - TO stop the voices plus cocaine and Amphetamine
Says he does not drink alcohol.
note Urine results 15/11/20 +ve Benzos +ve cocaine, -ve alcohol.
Similar presentation 3 months ago.
Plan suggest: Discussed with Judy Moore
(1) Diazepam 10mg x 3 daily as per page 22 of guideline on the Management of Problematic Drug use, 2019-2022.
(2) Awaiting Psychiatric assessment for further advice.
Re-Refer if needed.
Many Thanks PAM CHANNON

Sen Nurse

Patient ID label

Andrew Slaw

2164673933

Continuation Sheet

Date: Time 17-11-20

Practice Development Nurse - Mental Health

J Orman

Attended ward. Parent appears extremely agitated & distressed. Whispering that 'they are trying to kill me'. Also stated that he needed to kill me. Police state he is need to have a hx of schizophrenia on their system. Police will be worth present for the foreseeable future.

J Orman

Any issues overnight, call duty Psych Verndale on 0141-211-3600.

18/11/20 MDT

Ongoing Thought D/O / Hallucinations.

Assaulted last night threatening to unit staff.

AIW & review.

18.11.20 D. Swift STS & Liaison

- Thanks for referral
- (H+S) noted
- Parent not engaging that much in the interview process
- tells me he has "let God down". Implied that he is seeing things from God, but unable to elaborate on this.
- "I let them down" really about God, but unable to explain this.
- Able to answer questions with regards to his physical health quite quickly - but delayed when answering questions related to his

Patient ID label

Andrew Shaw

210467 3933

Continuation Sheet

Date: Time

Current experience

Admits to having been in psych before but will not say why.

He did not answer questions about his year / early life

MSE - overweight / malcdraw

- flicky hx forest fly hx tgue

- occasionally looking up at the ceiling

S - Spontaneous but not prompt

M - Subj - difficult to assess - worthless

- not discussed

T - Difficult to exclude at present

P - ? looking at the ceiling - ? visual hallucinations - difficult to know

C - Unable to assess orientation. Might be easier in a tidy environment

- I - Not fully assessed.

- Difficult to assess at present.

- Likely to be aware he is in trouble with the police

Imp - Difficult to fully exclude psychosis in this case, however he doesn't present as someone who typically is delivering or responding to psychosis at present.

Plan - Suggest ECG for QTc Phase

- If requires sedation and ECG not been done suggest Olanzapine 2.5mg - 5mg in the first instance

- Lorazepam 2mg PO can be given but only after 1 hour after olanzapine.

Patient ID label

2104673933 21/04/1967
SHAW
Andrew Martin

Nursing Documentation

Done/ Time	
	- I will suggest that we Review Neuro obs to assess neuro state. SF

Once only prescriptions (inlcuding tetanus prophylaxis)

Date Given	Drug (Block Capitals)	Dose	Method of administration	Time of administration	Signature	Given by
14/4	Midazolam	5 mg	IV	08:15		
	Midazolam	5 mg	IV	08:30		
	Vecuronium	4 mg	IV	08:50		

Discharge prescription packs

Date Given	Drug (Block Capitals)	Dose	Method of administration	Frequency	Signature	Given by

DISCHARGE CODES: Please Circle								Time Ready to Depart	
1. Admission	2. Discharge		3. Refer to G.P.		4. Transfer to other hospital (see below)				
5. Died	6. Refer to O.P. Clinic (see below)		7. Irregular Discharge		8. D.O.A.			Discharge Time	
Ward No. (if admitted)			Transfer to Hospital					Consultant (if admitted)	
Outpatient clinic specialty						Admission or specialty clinic consultant			
Clinic Referred to	AE	OP DVT	DME Falls	TIA	Medical	Surgical	First Seizure	Others Specify	

WARD ROUND/DAILY CONTINUATION

Mr A Shaw
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow
Lanarkshire
G75 8JS

Ward round assessment
Seen by (print): Monet
Date: 17/11/2020 Time:
Location: BC

Ward round notes:

KTA

Lying to evade police } 15/11.

→ Urine ⊕ cocaine / 52d
⊖ ethanol.

→ News: 4: Sats 88% RA
BP 110/79

Obese & lying v flat.

→ Sats 94 on 2L
Chest: clear
Inr ↑chy
" take the serum to make the wires go away"

PTD

Clinical checklist

VTE prophylaxis?	If IV cannula can it be removed?	If urinary catheter can it be removed?	Antibiotic review or oral switch? documented? stop duration
required? Y N prescribed? Y N	Yes ☐ No ☐	Yes ☐ No ☐	
Is an AWI form required?	Is there a treatment escalation plan documented?	Do any of the following need prescribed?	
Yes ☐ No ☐	Yes ☐ No ☐	IV fluids Insulin Warfarin	

gfg

Target discharge date;

Signed:

WARD ROUND/DAILY CONTINUATION

Pt had CPN in a while.

→ Needs ψ and Addictions
? harmonic MH assessment due to
Police custody issues.

→ when O2 as able.
MOBILISE

* Almost exactly same presentation
3/12 ago leading to RTA.

17/11/2020 16:13 F: GSSA Fy1

Psychiatry referral requested.
Please see document attached

18/11/2020 09:25 F GSSA Fy1

D/w MH Liaison. ψ

They have received referral.
→ will make his case priority

WARD ROUND/DAILY CONTINUATION

Patient details

Andrew Shaw
2104673983

Ward round assessment

Seen by (print): OUGRASLW
Date: 18/11/20 Time:
Location: 8C

Ward round notes

Background & history Noted.
Admitted with RTA w.
In police custody.

Bloods
U&E (N)
CRP 27
LFT (N)
Cxray

NHS reports Patient agitated last night hearing voices telling him to hurt staff.
Dtw & review — referral sent
Today → settled mn ↓ → will chase again.
Normal Hallucinations ↓ evidence of thought D/O → He hurt Jesus & Disciples want to kill him & people asking him to do Devilish things.

(P) & review & to provide take over patient

Clinical checklist

VTE prophylaxis? required? (Y) N prescribed? (Y) N	If IV cannula can it be removed? Yes ☐ No ☐	If urinary catheter can it be removed? Yes ☐ No ☐	Antibiotic review or oral switch? documented? stop duration
Is an AWI form required? Yes ☐ No ☐	Is there a treatment escalation plan documented? Yes ☐ No ☐	Do any of the following need prescribed? IV fluids Insulin Warfarin	

Target discharge date;

gfg

Signed:

WARD ROUND/DAILY CONTINUATION

18/6/25
15:30 Y seen please see Note overleaf.
Medications reviewed as per Y.

Patient details

Ward round assessment
Seen by (print): [illegible]
Date: 19/11/20 Time:
Location: [illegible]

Ward round notes

53 ♂ settled (tf) present. No issues reported overnight
Medically stable
Still [illegible] voices shouting (a) hum
cyst telling him to do stuffs
Not convinced he has psychotic
Bowels
PRN meds in
place for ? getting

Sats 96% RA NEWS 1

↓ dose of regular Diazepam
Further ↓ remain today.
MO

[signature]

Clinical checklist

VTE prophylaxis? required? Y N prescribed? (Y) N	If IV cannula can it be removed? Yes ☐ No ☐ N/A	If urinary catheter can it be removed? Yes ☐ No ☐	Antibiotic review stop or oral switch? duration documented?
Is an AWI form required? Yes ☐ No ☐	Is there a treatment escalation plan documented? Yes ☐ No ☐	Do any of the following need prescribed? IV fluids Insulin Warfarin	

gfg

Target discharge date:

Signed: [signature]

Mr A Shaw
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow
Lanarkshire
G75 8JS

Ward round assessment

Seen by (print): MOREU

Date: Time:

Location: 8C. 20/11/20

Ward round notes

- ? back to mx mental health baseline
- If yes : and ψ say yes
  - then → discharge one
  - mx BzD reduction = sat am.
  - But could go to police custody Drug Lt Mons
- If ongoing MH issues
  - → ψ to take ax care

Clinical checklist

VTE prophylaxis? required? Y N prescribed? Y N	If IV cannula can it be removed? Yes ☐ No ☐	If urinary catheter can it be removed? Yes ☐ No ☐	Antibiotic review stop or oral switch? duration documented?
Is an AWI form required? Yes ☐ No ☐	Is there a treatment escalation plan documented? Yes ☐ No ☐	Do any of the following need prescribed? IV fluids Insulin Warfarin	

gfg

Target discharge date;

Signed:

20/11/2020 FGABA Fyi.

12:41 D/w Scott Farmer. Fyi:

They are happy to dic him.

Referral Form

Referral to: Adult Mental Health Liaison Service

Monday to Friday - 9:00am to 5:00pm.

Ages seen: 18 up to & including 64 years of age

We aim to see the patient within 3 working days. Referrals are prioritised by clinical need. Please refer as early in the day as possible.

All **self-harm referrals** should be phoned through directly as per contact information on staffnet page **without** completion of the below form.

Hospital: *	QEUH	Ward *	8c
Patient Name: *	Andrew Shaw		
DOB: *	21/04/1967	CHI:	2104673933
30 douglas drive east Kilbride Glasgow, Lanarkshire G75 8JS			
Is the Patient Aware of this Referral *	Yes		
Is the Patient detained under a MHA (Y/N) *	No		
Is the Patient being treated under an AWI *	No		

Presenting complaint *(include description of symptoms, onset, precipitants, current state and relevant investigations)*

Mr. Shaw was admitted on 15/11/2020 with after RTA. Brought in by police – in custody. Has tested positive for ethanol, cocaine and benzodiazepine on urine toxicology. Has had been experiencing hallucinations. Almost exactly same presentation 3 months ago.

Medical History	Drug misuse, hallucination
Drug & Alcohol Use	yes

Reason for the Referral * (*include a clear question that you wish us to approach, e.g. if for capacity assessment include which decision this relates to and detail the opinion of the referring team)*

We would like psychiatry input for this patient please – with regards to suicidal intent, psychiatry, and drug misuse. He still hears people speaking to him – asking him to do dangerous things and saying hurtful things. He does agree to have taken different recreational drugs and attributes these to causing his symptoms. He has low mood currently, difficulty concentrating. Sometimes has thoughts of hurting himself or others.

Referrer's Details:

Name: *	Dr Fortis Gaba	Contact Details *	82621
Date:	17/11/2020	Other	

Please save a copy of this form and send via email to:
AdultLiaison.PsychiatryService@ggc.scot.nhs.uk

Please note we do not routinely assess capacity as this is a generic competency for all doctors.
Any doctor can inform SW about capacity in the SMAT process.

If you do consider that a psychiatric opinion is needed then you must provide the following information:

1. Capacity to make what decision?
2. What is your service's opinion about capacity and why is a specialist second opinion needed?
3. What cognitive and functional assessments have been conducted? (eg ACE-III & OT assessment).
4. What is the proposed treatment/intervention? What would the risks be if the patient is not agreeing to the proposed intervention? Does the patient understand these risks?

Patient Information		Date:	15/11/2020
		Incident Number:	CR006956778
Age/Gender:	53 years 6 months 25 days Old Male		
Address:	[SHAW ?]	Incident Type:	EMG
DOB:	21/04/1967	Incident Location:	AT RODGER DRIVE STONELAW ROAD RUTHERGLEN GLASGOW, G73 2PQ
CHI:			
Ethnicity:			

Scottish Ambulance Service

Presenting Complaint

RTC

Additional Comments

999 call 53 yr old male was being pursued by police after failing to stop .....he drove straight through a t junction and went into a metal fence and down a 15 ft grass embankment .....police witnessed him exit the vehicle and collapse onto the floor ....o/e , alert to voice , no obvicus injuries found on head to toe , small laceration to [l] side of forehead , denied any alcohol or drug use .....fully immobilised and standby at qeuh .....

PATIENT ASSESSMENT

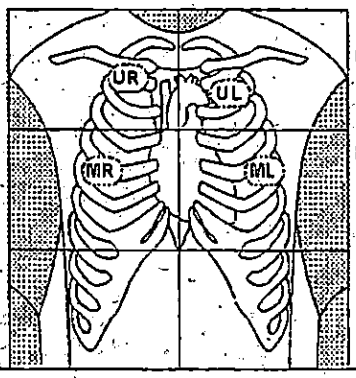
ACVPU	Voice	<C>	No
A	Clear		

B Breathing Adequately: Yes — Respiratory Rate 20 — SPO2 90

Oxygen Given: Yes

Normal Air Entry

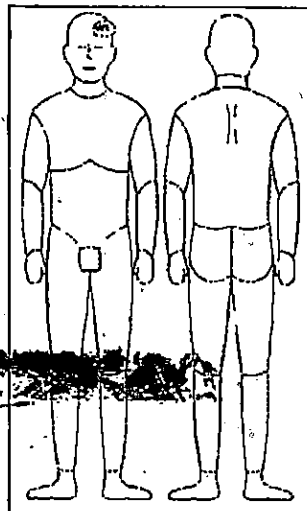
Normal Air Entry



C	Pulse Rate	BP	Cap Refill	ECG Rhythm
	78	93/64	>2 Secs	
	Rhythm	Arm	Central/Peripheral	ECG
	Reg	Right	Peripheral	3 Lead
	IV(R)			
	ACF			

D	GCS	Eyes	Voice	Motor	PEARL
	14	To Speech (3)	Orientated (5)	Obeys Commends (6)	

E



Wounds

ID	Body Part	Wounds	Treatments
W1	Head	Laceration	None

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
06:50	80	20	112/80	100	>2s	14	Voice		34.6	6.6	Sinus Rhythm				E1004263
06:15	90	20	104/84	100	>2s	14	Voice		34.6	6.6	Sinus Rhythm				E1004263
05:50	78	20	93/64	90	>2 Secs	14	Voice		34.6	6.6	Sinus Rhythm				E1004263

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
06:50	20 (0)	100 (0)		2	112 (0)	80 (0)	Voice (3)	34.6 (3)	8
06:15	20 (0)	100 (0)		2	104 (1)	90 (0)	Voice (3)	34.6 (3)	9
05:50	20 (0)	90 (3)		2	93 (2)	78 (0)	Voice (3)	34.6 (3)	13

HISTORY

AMPLE

Allergies	Unknown
Medication	? NONE
Last Eaten	Unknown

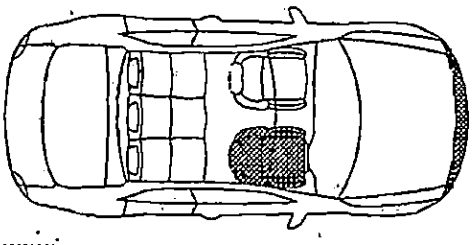
Social History

Lives alone	Don't Know

TRAUMA

RTC

Vehicle vs	STEEL FENCE	Vehicle Speed	40



Patient	Trapped	Duration (Mins)	Intrusion	Position	Safety Devices
Position Of Patient	No		No Intrusion	Front Right Seat	Air Bags Deployed

OTHER

Additional Resources (On Scene)

Resources	Special Operations Response Team

18/5/2020

SAS Co Responders | Police Scotland | Incident Number: CR00695778

CLOSE RECORD

Treatment On Scene	Emergency		

Conveyance

Transport To Hospital	Emergency driving	Pre Alert	Yes

Patient Accompanied By POLICE

INCIDENT LOG

Time Call Received	05:30	Allocated	05:31	Mobile	05:31
First Resource On Scene		Crew On Scene	05:41	Crew Left Scene	06:44
Crew At Hosp	06:55	Receiving Hospital	QUEEN ELIZABETH UNIVERSITY HOSPITAL	Clear Time	

Crew ID	Crew Grade	
E0026093	Paramedic	Driver
E1004263	Ambulance Technician	YES
		NO

MWI

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

63051

Affix Label

Queen Elizabeth University Hospital

CHI: 2104673933

Total Att: 3

12 Mth Att: 0

Title: **MR**

SHAW **Andrew Martin**

DOB **21/04/1967** Age: **53y** Sex: **Male**

30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow
Lanarkshire
G75 8JS

Next of kin: **KNOWN, NOT**
Relationship: **Unknown**

GP: **FR Wyllie**
01355 573790

Attendance Date: **10/08/2020** Arrival Time: **23:29**

Registration Time: **23:29** Date of Incident: **10/08/2020**

Major Incident Desc:

Reason for Attendance: **bibp - intoxicated**

Affix Label

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **10/08/2020 23:38** Nurse name: **Nurse Shona Gerrie**

Temp	**35.4**	C
HR	**104**	bpm
BP	**114/90**	mmHg
MAP	**98.00**	mmHg
RR	**22**	bpm
SpO2	**95**	%
Oxygen	**21**	%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **"BIBP, unable to assess in custody, ?under influence of drugs and alcohol. Refusing to answer questions. "**

Child Asses

2104673933
SHAW

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

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

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

DO NOT WRITE HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By
11/8/2020	Ceftriaxone	2g	IV	03:45		EH/LL
11/8/2020	Aciclovir.	800mg	IV	03:45		LL

Date	CLINICAL NOTES
Seen by (Dr)	IAN SEXTON Time seen 23.30

53 → BIB Police Cnde Arrest

Pc. Intoxicated
? Drugs
? alcohol

Found behind the wheel of a car.
by police - Not his car.
No sign of RTC.
Walking at scene. Intoxicated
Custody sergeant would not accept.
Healthcare team not contacted.

o/e obs Sinus tachy 100–110
114/90 Gluc 10 VBG pH 7.4
40
pCO_2 6-8
Lac 2-4
HS I–II +0.
Chest Air E=E.

Abdo (↑ BMI
SNT.
BS ↓

Many old bruises - Arms to R+L knee.
No HI. Many neck pain
PERL 4mm. GCS 4 6 4 14.

Date	CLINICAL NOTES

Inj - Intoxicated ? Cause

→ Bloods
RCC
Observe until fit for d/c

– [signature] Cons

03:00 – GCS (13) E-4 M-5 V-4 Confused, Agitated. Aggressive.
Cons.

Bloods unremarkable. * Glucose + ethanol not received? → Send Rpt.

(on 2L) ABG – H^+ 46.4
CO_2 7.5 (Bic 30.1) – No evidence HI.
O_2 13.6
Gluc 9.6 – Will need HOH care.
Lac 1.1 Med Reg will kindly RV.

[signature] Cons.

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

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

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

Discharge Prescription Packs

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

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☑
NURSING ☐

Please tick ✔ appropriate directorate

ANDREW SHAW.
2104673933.

Date & Time	MCLYMONT FY2	Signature, Print Name & Designation
11/08/2020	Written in retrospect	
16:23	Attempted to catheterise (x2) chaperoned by Auxiliary Nurse Lynn Keegan.	
	Pt very agitated and unable to pass. No obvious complications	MCLYMONT FY2 7670809.
11/08/20	MCLYMONT FY2	
17:30	Spoke c ortho reg on 82722 re: distal fibular # on XR.	
	Advised ankle boot to stabilise joint during weight-bearing, and repeat XR to get better views AP + Lat as appears to be avulsion ~~#~~.	
	Nursing staff inform me ongoing (L) shoulder pain (L) shoulder ~~if~~ not well visualised on CT ~~despite~~ ~~it~~ no mention on report	
	Plan: (L) Shoulder XR	MCLYMONT FY2 7670804
	(L) Ankle XR	

83949 GGC0072

Date & Time		Signature, Print Name & Designation
12/8/20 9:30	WR - Allan	
	RTA → Police custody	
	Trauma CT → No injuries	
	Remains GCS 13/14/15 Many all Subsequently	
	Requiring 2-4 Lt O2 to maintain sats 98%	
	Agitated	
	BD maintained	
	Failed to pass urine ~16 hrs	
	→ Tox screen	
	Catheter	
	Air sats >90% only	
	Oral fluids only	
	Document full secondary survey	
	ABG	
12/8/20 10:37	McCLYMONT FY2	
	Tox Screen neg	
	Cocaine +ve	
	Amphetamine +ve	
	Methamphetamine +ve	
	Opioid +ve	
	Benzos +ve	
	THC -ve.	
	Secondary Survey written in retrospect on progress sheet.	McCLYMONT FY2

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐ NURSING ☐

Please tick ✔ appropriate directorate

Mr A Shaw
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow
Lanarkshire
G75 8JS

Date & Time	MCCLYMONT FY2	Signature, Print Name & Designation
12/8/20 14:41	Spoke c ortho reg on call, 82735 redirected from 82722, for update on # plan. He advised Weber A fracture c no talar shift and no incongruence fg joint.	
	Plan: Ankle Boot. Allow to weight-bear Ortho follow up in 6/52	PMcL PAUL McCLYMONT FY2 7670804
	WR. Allen	
	Little change Still appears to be hallucinating + disinhibited	CC53 0 clams
	+ve drug screen Negative CT	
	Sats 95-100% on & C N. C Chest clear	
	→ Aim to get C+P if swallow OK. Need to stay in AMU until CCS cleared	

83949 GCC0072

Date & Time		Signature, Print Name & Designation
14/8/20	Acute Addiction liaison 2110238	
11:31	Andrew not open to addiction services in the community. no background available Discussed with staff nurse - advised has been very drowsy since admission. Slowly improving noted tox screen Cocaine, amphetamine, methamphetamine, opioid and benzodiazepine positive. Suggest: ① Not currently fit enough to be fully assessed. Monitor for Benzodiazepine withdrawal as per pg10 of acute drug guidelines (supplied) and opiate withdrawal as per pgs 21/23 of same guidelines (also supplied). Unclear at this time if his drug use is regular. ② We will return on Monday 17/8/20	Emma Johnston (addiction nurse)
	* full drug guidelines available on staff net *	
15/8/20	Bradley FI Written in retrospect	
1221:50	ATSI re Chest pain	
	ECG - ? ST elevation in V2.	
	Discussed with Cons Medic reg.	
	Explained scenario, ? ECG Δs, Trop taken.	
	Advised to wait for Trop before instigating STEMI protocol.	
	Plan - ① Alw Trop.	Bradley FI

NHS Greater Glasgow and Clyde
QEUH SHDU
Daily progress record

Patient Ia
2104673933
SHAW
Andrew, M
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS
M
21/04/1967

Reviewing Doctor, Grade, Consultant:	Post-op Day:	HDU Day:	D
T McGowan FY2		4	14/8/20

Issues and Progress

S 53 year old male RTA 4/7 ago
Toxicology tve for various substances on admission
(Cocaine, amphetamines, methamphetamine, opiods, benzodiazepines)
Trauma CT -> no injuries
GCS 13 since admission

B Unknown PMH

A
- Patient much more alert today, GCS 14/15 awake in hospital, not otherwise orientated time/place
(L) Ankle bruising on lateral/dorsal aspect -> Continue Morphine with moorlat c/s Dr orthopaedics
WS 1+11+0 regular

L=R
No added sounds
+ fremitus
Soft
BS present and equal
LOB 27+ days
- Pupils equal and reactive
- Neurologically intact Normal L=R
- Gives SNT Sensation Normal L=R

Cuffed in situ
Some red-staining urine in collection tube.

NEWS SpO_2 Scale 96% (on 2L)
- RR 19 Sinus rhythm
- BP 132/92 MAP 102
- HR 76

Bloods
Na	139
K	4.0
eGFR	>60
(Calc)	2.32
Phos	0.87
WC	11.1
Hb	145

ECG 14/8 Sinus rhythm

CXR 11/8
- No obvious #
- Some bony atelectasis evident

CT 11/8
- No significant traumatic injury

Complaints Mx to E
(3) Headache ongoing
(2) Chest pain/Epigastric pain
(3) Multiple episodes bradycardia (x2) yesterday
-> Not caught on ECG when taken

Signed: _____

Plan for day

(1) Analgesia
(2) ECG ↑ tachy/bradycardia to catch rhythm
(3) Addiction specialist referral
(4) Add on: MS/Mrs to bloody today
(5) Continue neuro observations
(6) Urine dip +/- send for culture
(7) Continue Physiotherapy

Fluid balance/urine output goal	Eating + Drinking → push oral fluids
Need for Micro review?	Not currently (urine dip pending)
Analgesia	Co-codamol
Thromboprophylaxis	(LMWH) TEDS Treatment dose Contraindication
Can lines or drains be removed?	
Feeding	Sips (Oral diet) NG TPN NBM
Family update needed?	Yes / (No)
Ready for discharge?	Yes / (No) Discharge specialty:

Parent Team Review

Evening Review

Signed: _____

NHS Greater Glasgow and Clyde
QEUH SHDU
Daily progress record

Patient Ia
2104673933
SHAW M
Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

Reviewing Doctor, Grade, Consultant:	Post op Day:	HDU Day:	D
Melaugh FY2		5	15/8/20

Issues and Progress

S 53 Y.O MALE Admitted after OTA 5/7 ago (in police custody / Police present)
Toxicology +ve Cocaine, completeness, methamphetamines, Opiods, benzodiazepines (no alcohol)

J Unknown PMH.
Patient not able to elaborate

A · GCS 15, Oriented to time & place. · Bloods Na 139 K 4.0 Cl 103 60 Mg 0.77 CRP 86 (75) WCC 11.1 Hb 145 Plts 244 Creat & renal function normal, requires culture INTACT.
LLR HISTFIL +0
SVT BS Paroxysmal

LR 84
O_2 98% on RA
BP 120/75
RR 25

ECG Sinus rhythm
XR Chest No evidence consolidation
XR Ankle Left Minimally displaced # lateral malleolus + associated soft tissue swelling (limited view as per orthopaedics) Stable & full assessment of neurovascular status could not be made

· No new episodes tachycardia, normal
· Troponin (NAD)
· Headache resolved.

Signed:

Plan for day

1. Ward fit (orthopaedics)
2. E+D
3. Daily bloods
4. D/C when safe OK → Weber A # c NWB Shut (A) Ankle boot. Follow up as OP GP/52 out D/C

Fluid balance/urine output goal	E+D
Need for Micro review?	N/A
Analgesia	Co-codamol + PRN oramorph
Thromboprophylaxis	(LMWH) TEDS Treatment dose Contraindication — LMWH BD
Can lines or drains be removed?	
Feeding	Sips (Oral diet) NG TPN NBM
Family update needed?	Yes / No
Ready for discharge?	Yes / No Discharge specialty:

Parent Team Review

Evening Review

Signed: _____

2104673933
SHAW M
Andrew. M. 21/04/1967

12/08/2020
10:40
AC McGymont RN

SECONDARY SURVEY

Under remit of Orthopaedics

	BODY REGION FINDINGS	
HEAD	NONE	Pupils constricted but reactive Disoriented to time + place
FACE	(NONE)	
NECK	(NONE)	
CHEST	NONE	Tender at both clavicles and when palpating along ribs Bilateral vesicular breathing ± no added sounds. HS hard to ausculate
ABDO	NONE	 (L) flank + RIF pain Abdo soft BS nve No rebound tenderness, Rovsing -ve, Murphy -ve
PELVIS	NONE	Unable to palpate ASIS Tender (L) greater trochanter
UPPER LIMBS	NONE	Tender (L) shoulder + both wrists
LOWER LIMBS	NONE	Tender (L) knee Bruising to (L) ankle at # site, ± significant tenderness Abrasions to (L) knee Feet warm Pt non-compliant ±
LOG ROLL/BACK	NONE	N/A - Nursing staff reported no issues when washing
RECTAL	NONE	Not Required.
ECG	NONE	MANDATORY IN PATIENTS OVER 40 NAD
OTHER		

Patient ID label:

ANDREW SHAW
2104673933

Surgical HDU – Admission Document
Queen Elizabeth University Hospital, Glasgow

NHS
Greater Glasgow and Clyde

Date: 11/08/2020	Time: 12:37.
Reviewing Doctor: PAUL MCCLYMONT.	Grade: FY2

Admission Mode:	Emergency: ✓	Elective;	ITU Stepdown:	
Admitted From:	Theatre:	Ward:	A&E:	~~ITU~~: HDU
Speciality: CRITICAL CARE		Speciality Consultant: AZLAN		

Operation/Procedure: Admitted via ED. Judged not for medical HDU while a/w CT ? polytrauma

Admission History (if relevant)

Mostly from notes + collateral hx from police officers present.
~22:00 note. pt crashed into lamp-post + drove away. Found by police behind wheel + appearing drunk. Blood alcohol was -ve.

~~**Relevant Intra-operative findings/complications:**~~

Pt c/o generalised pain but cannot localise.
C/O needs to pass urine but unable to. Moving about bed.
Disorientated to time, + place + ~~p~~ Orientated to person.
Believes he is being experimented on, but did not expand.

PMH	Drug History (complete Med Rec sheet)	Social History
Unknown	Citalopram 20mg OD ↳ Last collected 2017. Allergy Amoxicillin	Unclear.

Relevant Recent Investigations

Examination Findings Very difficult due to pt not complying

General
Appears agitated + drowsy

CNS
Pupils equal + reactive.
Strength reduced ~4/5 at UL
Alert, disoriented

Respiratory

Bilateral vesicular breathing c̄ no added sounds.
Difficult to auscultate

Cardiovascular
HS1+1+0 (difficult to auscultate)

Gastrointestinal

Generalised abdo tenderness. Nb
Abdo soft. Worst at RIF ? hip pain.
BS present

Renal
a/w catheter

MSK/Trauma
Moving around + not following instructions to remain still as ? tk
Some truncal tenderness

Lines/drains
Nil

Plan – if needing clarifying contact Surgeon/Anaesthetist

General
- Toxicology Screen
- Trauma CT.
- AWI.

Analgesia:
PRN Morphine, Codeine + Paracetamol
c̄ Anti-emetics

Antibiotics/Infection:
On CEFTRIAXONE + ACICLOVIR

Thromboprophylaxis:
A/W CT.

Feeding: ~~BD~~ NBM a/w CT.

Drains:

Fluid Therapy: HARTMANNS 6°
Standard: 83ml/hr 0.18%NaCl/4% Dex
ERAS protocol:
Additional/alternative:

CVS Targets
MAP >
U/O >
Other:

Sepsis 6 (If relevant tick each intervention DELIVERED)

Fluid challenge	Antibiotics	Lactate	Cultures	Catheter	Oxygen Therapy

NHS Greater Glasgow and Clyde
QEUH MHDU
Daily progress record

Patient label here
ANDREW SMITH
2104 673933

Reviewing Doctor, Grade, Consultant: WRIGHT

HDU Day:

Date and time: 11/08/20 09:01

Ward Round Note

SSyrdd (1)

FamPdue - RIH → Crashed up

off the lights & speed

CCS E2115 V2

chest pain

Sudden (L) arm

pain

(P) • Vast trauma Q ... pain

• ICU will keep eye on ... the pain

• RJ post ...

Hb 168
WCC 19.6
Plts 25
U/E (N)
LFTs (N)
CRP 11
Hb42
pO2 67
pO2 11.0
HCO3 30
La 2.0
Clear
ECG - SR, rate 89, no acute
CXR - bilateral ...

8/8/20 Allen HGH

1330 Difficult case given need for CT but would need sedation or GA for him GCS is definitely improving + now although delirious he is holding full conversations + moving around in bed.
I would suggest given his weight the risk of sedation for CT would outweight the benefit of getting the CT. Also as GCS improves I expect he will tolerate CT without sedation.

→ Try CT ✗ sedation - If not possible abandon until bette
If any ↓ in GCS → GA + CT immediately
Once Allan needs full secondary survey
(Catheter has been placed → >1L resulted)

8/8/20 Pharmacy - K. FITZPATRICK
Acidonor Rx Δ to 70mg/kg 8hrly (IBW) Δm (plasma) 8570s

Cons.

11/8/20 Allen
Currently settled. GCS had improved to E4 M6 V4
Nil on CT, likely drug related GCS.
→ Mainly agreed. Aim for full plan when needs of the input re ankle

Cons

FEEDING PLAN REVIEWED	Y/N
DRUGS REVIEWED	Y/N
THROMBOPROPHYLAXIS REVIEWED	Y/N
GLUCOSE CONTROL REVIEWED	Y/N
LINES REVIEWED	Y/N
SUMMARY UP TO DATE	Y/N
FAMILY UPDATE REQUIRED	Y/N
IF APPLICABLE: AWI FORM COMPLETE & VALID	Y/N N/A
IF APPLICABLE: DNACPR FORM COMPLETE & VALID	Y/N N/A
READY FOR STEP DOWN TO WARD	Y/N DATE/TIME READY:
ALLOCATION ON STEP DOWN (IF READY)	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☑ NURSING ☐

Please tick ✔ appropriate directorate

2104673933
SHAW
Andrew, M M
21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

Date & Time	[illegible]	Signature, Print Name & Designation
11/8/20		
	Seen in HD	
ED-HD	GCS E-2	
	V-2 - on one occasion woke	
	M-6 & answered yes to	
	?neck pain.	
	Has been v. agitated in ED (on	Palpation of neck
		positive)
	No C/S/O C/S/A (Accepted in ED)	
	Plan:	
	no obvious ext. CAP/MSK C/S/O	
	Chest clear Auscultation	
	Abdo soft	
	Non-tender.	
	Neurological obs GCS max	
	occasionally agitated & requiring sedation	
	Found in CAR	
	? Inter cranial event/infection	
	? 2° intoxicants	
	Clear CNS infection (CCT/Accident Report	
	CTB	(From ED)
	in ML.	

83949 GGC0072

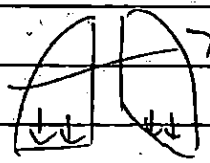
Date & Time		Signature, Print Name & Designation
11/06/2020	Henderson ICM cons	
0530	In police custody	
	Reportedly found in a car that was not	
	his own, with no evidence of RTA	
	Ethanol level C10. Apparently shake off last multiple (L)	
	Agitated + drowsy at points	
	In between of CT. Empiric CNS infection cover.	
	No significant PMH on portal. ↑BMI.	
	No active medicines on ECS.	
	(A) Patent	
	(B) RR 27 SpO_2 93 2L/min O_2 NC.	
	CO_2 6.7 H+ 42 PaO_2 11.0 HCO_3 29.6. CXR unremarkable.	
	(C) 110/77 P106. Lactate 2.0	
	(D) GCS E_3 V_4 M_6	
	PEARL: 3mm.	
	No external evidence of head injury.	
	Had Cef + acidotic. from ED.	
	Imp: I agree that CT would be worthwhile (Head)	
	Sedation for CT would not be appropriate	
	(habitus, ↑HCO_3 ? balanced ↑CO_2 ? OSA/OHV)	
	Balancing the merits of GA for CT vs	
	strategy of watchful waiting I think he	
	should be observed in HDU setting.	
	Suggest	
	MHOR.	
	c/w Cef + acidotic now commenced.	
	CT	
	If ↓GCS or unbalanced very agitated please	
	let us know.	
		Henderson Cons.
		83081

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☑ NURSING ☐

Please tick ✔ appropriate directorate

2104673933
SHAW M
Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

Date & Time		Signature, Print Name & Designation
13/8/20	C. LUCEY FYI – Written in retrospect	
1800		
	Pt review following 2x episodes of	
	bradycardia (29-44 bpm)	
	→ short lived (seconds) and self resolving	
	→ occurred whilst pt asleep	
	→ nil associated desaturation / hypotension	
	→ regular co-codamol today, nil other opiates / drugs contribute	
	o/e – HR 76, pulse regular	to sedation
	SpO2 97% on 2l NC	
	RR 18	
	BP 110/73	
	Apyrexial	
	→ Pt sleepy + drowsy, eye opening to voice	
	→ Orientated to T/P/P	
	→ PEARL	
	 reduced air entry b basally	
	otherwise chest clear, nil added	
	RR 18, SpO2 97% 2l NC	
	HS I+II+0, radial pulses regular, nil R-R delay	
	WWP ✓ CRT <2	
	Calves SNT	
	Imp / ↑BMI contributing to ↓ventilation	
	and background of known obstructive	
	sleep apnoea likely cause of brief	P.T.O
	bradycardic episodes	→

Date & Time		Signature, Print Name & Designation
13/8/20	C. MCEY (cont)	
1800	→ Plan/ Repeat ECG → NAD ✓	
	Monitor for signs of haemodynamic	
	compromise	
	Discuss w/ senior	C. MCEY
		FYI

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐ NURSING ☐

Please tick ✔ appropriate directorate

2104673933
SHAW
Andrew, M
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS
M
21/04/1967

Date & Time	FY1 G. Miller	Signature, Print Name & Designation
15/8/16	- ATSP by FY1 Dr Broadley as Andrew complaining	
22:00	of epigastric pain / chest pain.	
	- History re-visited. Has had this chest pain	
	previously (1 x yesterday, lasts 30-40 minutes,	
	self resolved).	
	- Pain today ~30 minutes, central chest /	
	epigastric, around upper abdomen (band-like)	
	and left side of chest.	
	- Cannot confirm whether left sided chest pain	
	is new or not given recent RTA.	
	- Pain 4/5 out of 10, settling with analgesia	
	- Has been sweaty all day	
	- No sense impending doom	
	- dizzy, no blackouts.	
	- ++ familial cardiac hx (mother passed	
	from MI age 54, brother 3x MI).	
	- Obs stable	
	- ECG: ?3mm STE V2 (late ECG 21:48 looks resolved).	
	Dr Broadley kindly discussed w/ med	
	reg on call - advised await Troponin	
	before initiating ACS rx.	
	Imp: ? ACS	G. Miller
	? pain from RTA + anxiety	#82716.
	Have updated Andrew who is happy with	
	above plan. Looks more settled.	

83949 GGC0072

Date & Time		Signature, Print Name & Designation
16/08/20 01:10	FY2 G. MILLER	
	- Troponin < 4 (REF 0-34)	
	- Andrew settled	
	- No need for repeat troponin / ACS rx at present.	
	Happy to be re-contacted if develops further chest pain.	G. MILLER #82716
16/08/20	WR - Mr Mack	
	NEWS 2 (95% on 4l)	
	CT-Cspine, X-RAY ① Shoulder Ankle	
	plan ① fract ankle fracture ↳ fracture conservatively	FY1
	② Psychatric review	
	③ Med review	
16/08	Mohammad Sajjad - FY1	
	- Nurses reported patient hallucinations	
	- ~~on admission patient was admitted~~	
	- Patient tox Screen was positive for:	
	• Cocaine • Amphetamine, • Benzodiazepine • Methamphetamine • opiods	
	- this may account for hallucinations if patient was ~~hallucinating~~ in the morning	
	- not known to Psychiatry	
	- did not feel psychiatry would have much input	SAJJAD FY1

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☑ NURSING ☐

Please tick ✔ appropriate directorate

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Andrew, M 21/04/1967
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Date & Time		Signature, Print Name & Designation
17.08.20	Suite Addiction liaison.	
1100hrs	Some discrimination :- Day, month, year. Stated no alcohol excess. Also stated takes cocaine daily, but no other regular drug use. When I discussed urine drug screen results he shrugged a "bad friend" joked his keys then they put him in a car. Stated they did this because he refused to do what they were telling him to do. Said he hasn't lived at address in East Kilbride for last 4 years - Has been struggling with group of "visions" at times. Was guarded and didn't wish to disclose address, said frightened. Stated he has no debts from daily cocaine use - he just "does what he's told to" by group of people he had been living with - "it's all got too much, for too long. Going on for years." Appeared distracted - visual disturbances, began guarded when asked about drugs. Said he was diagnosed with schizophrenia at age 22 years old by a Dr. Campbell ? - unable to recall where she was based - "was retired", doesn't trust any other doctors / psychiatrist. Stated	

Date & Time		Signature, Print Name & Designation
	never in pt. in Y and never harmed himself. No family contact - only one brother who lives in Ireland - no contact. Doesn't appears to have ever been seen by ~~psychiatrics~~ addiction services in the past.	
	Suggestion: -	
	(1) Please refer patient to liaison psychiatry, they are expecting referral - I discussed with them this morning.	
	(2) If information patient has provided this morning is genuine - possible vulnerable adult. Unclear at this point until may Y issues screened.	
	(3) We shall review in 2 days to conclude if there is any role for our service.	
	Anne Marie Lustrey (Senior Addiction Nurse)	
18/20	F2 ONTO BONGORN	
16:30	→ Psych referral sent. Informed that turnaround time is 2-3 days → Referral sent to AdultLiaison.Psychiatryservice @ ggc.scot.nhs.uk BONGORN F2	
19/8/20	F2 ONTO BONGORN	
16:30	→ Cardio referral sent in view of persistent chest pain → Pls do troponin, CXR, repeat ECG F2 BONGORN	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☑ NURSING ☐

Please tick ✔ appropriate directorate

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Date & Time		Signature, Print Name & Designation
17/8/20	F2 on FFD Boongard	
16:38	Reviewed patient in view of chest pain	
	Background: 53/m admitted due to RTA (motorcycle) sustaining ankle #, (L) being managed conservatively	
	pmHx: no known cardiac condition / ~~no previous~~ ? schizophrenia	
	PSHx: allegedly diagnosed 4-5 yrs ago - not on any antipsychotic medication	
	PSHx: ~~dpo~~ cocaine user; (+) tox screen	
	Course: Seen by ward doctors 15/8 for similar chest pain. Initial ECG - ? ST elevation V2 but resolved in later ECGs. Initial + repeat Trop <4. Continued on analgesics	
	A - patent	
	B - O_2 = 95% on 2L via NC RR = 16 chest: clear no need. vein engorgement point tenderness on (L) 2nd-3rd ~~ICS~~ ICS, no skin changes	
	C - HR = 82 BP = 125/79 S1 S2 NAD	
	D - alert, oriented	
	E - T = 36	
	On review: still with chest pain 6/10 - for 2 days now	
	denies headache, abdominal pain, vomiting, lightheadedness, pre-syncope	

Date & Time		Signature, Print Name & Designation
	> Meds reviewed: on analgesics and PRN & TN	
	.) PRN:	
	repeat FBC now	
	Troponin	
	CXR	
	referred to Cardio thru email	
	Will handover to oncall team	
	Inform if with issues / further concern	
	FU planned	
26/8/20. 1095.	Liaison Psych rv Dr Leighton, specialty Dr Y.	
	-Thankyou for referral.	
	-53yo ♂	
	-Admitted 26/8/20 following RTA → BIBP in custody, under influence of cocaine.	
	-Urine tox screen +ve for cocaine, amphetamines, methamphetamines, opiates & benzos.	
	-Hx BG → Dx schizophrenia historically from 2011/2012 → previously seen by forensic psych + was on risperidone depot but documented medn lapses. Thus psychosis Sx were not convincing :- Dx disputed/unclear.	
	-Has not been on antipsychotic medication for many years. NO documented contact with mental health services since 2013.	
	-Will organise medical history	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☑
NURSING ☐

Please tick ✔ appropriate directorate

2104673933
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Date & Time	Psych ir contd.	Signature, Print Name & Designation
16/8/20		
1100	-History from staff nurse looking after him ⇒ has seemed "vague" and disinterested last few days on the ward -Nil agitation + no management problem. -compliant with treatment / Rx -E+D + sleeping ok.	
	-Note has been reviewed by addictions + srv ongoing. -Mx continues on Dihydrocodeine 60mg BDS for opiate w/d.	
	Seen @ bedside, distracted @ times and no eye contact, appears agitated, breathing through pursed lips, scratching self frequently, obese + unkempt, fearful -Speech muffled + monosyllabic. -mood low subj, anxious obj with labile affect -nil F/O -Denies any suicidal or homicidal thoughts. Nil delusional ideation. Guarded + hesitant :. very difficult to obtain any detail. -Describes visual hallucinations of his mum "for years" + voices in his head "chatting all the time" → no detail given + no change over last 10 years	

Date & Time	Ward.	Signature, Print Name & Designation
6/8/22 11.10.	disoriented to time + place hospital ✓ Glasgow ✓ day ✗ Month ✗ ↓ year ✗ can't recall name of hospital - oriented to person. + attributes voice hearing to diagnosis of Schizophrenia. Lacks insight into +ve effects of daily drug use. • Denies alcohol. Denies cannabis uses cocaine daily → blames this on the "bad people" he lives with in council flat. Feels "scared" by these people as he states they belong to drug ring. • recalls reason for admission → blames others for putting him in a vehicle under the influence. SH → receives DLA + denies financial problems. Lives in council flat with 6 males. Only family is brother who stays in Ireland (no contact) Mum passed away many yrs ago. Impression: likely delirium in context of illicit substance withdrawal ? possible drug-induced psychosis Symptoms → hallucinating + he has full insight into this - less likely. →	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☑ NURSING ☐

Please tick ✔ appropriate directorate

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Date & Time	Psych consult	Signature, Print Name & Designation
18/8/12	(P) no changes @ present	
11:15.	- ongoing addictions liaison rv.	
	- liaison psych will rv again later	
	in wk → further assessment needed	
	Keep	
	Electronic	
	Specialty Dr Psych	
18/8/12	Cardio ST4	
13:10		
	D/W Andrew	
	- pain ↑ ↓ movement	
	- L sided rand nbs, through to back	
	- no autonomic features	
	- constant for 5 days - since accident	
	✱ Tender on palpation ✱	
	ECGs - no changes, SR throughout	
	- no ST elevation - multiple ECGs with poor quality wandering baseline	
	Troponin at 14th & 15th <4	
	↳ ∴ reassured no cardiac cause.	
	hip musculoskeletal non cardiac margin	
	℞ analgesia	McCurdie ST4

Date & Time		Signature, Print Name & Designation
18/8/20 1337	Phone Call from Psychiatry - 7A1 Ward LOR	
	Psychiatry has reviewed this patient this morning. However, patient was in delirium and assessment was difficult likely due to withdrawal sx from medications. Psychiatry called to inform that if further assessment is needed, re-referral can be done for that to happen.	Yseult 7A1.
08.20 (10th)	Acute Addiction Liaison Note input from Y thanks. Reviewed remains difficult to assess - appears more distressed than previously. On questioning stated that he did take Diazepam daily - states doesn't like them why took them "because told to". Stated never injected / used heroin, but then said they injected unknown substance into his toes - Referring to men he was living with. Suggestion:- (1) At this point would be suggested to utilise p.22 of guidelines - Consider lower starting dose of 10mg Diazepam three times daily. (2) Only administer dihydrocodeine if scoring on SOWS 5 or more. p.23 guidelines. (3) Please phone Y if becomes further distressed / psychotic symptoms (4) We shall review on Friday	Anne Marie Parkes Addiction (Senior Nurse)

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐ NURSING ☐

Please tick ✔ appropriate directorate

2104673933 M
1 SHAW 21/04/1967
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Glasgow, Lanarkshire G75 8JS

Date & Time		Signature, Print Name & Designation
19/08/20	WR - Prof Meek	
	Discharged from orthopaedics once physio happy	
	Follow-up in 2 weeks	R.MAYWAH
	Addictions concerned about him	Maywah
	For another psych opinion before discharge	FY1
19/08/20	Physio query about X-ray (L) shoulder since patient experiencing limited ~~mobility~~ ROM in (L) shoulder & complaining of (L) shoulder pain.	
	X-ray not reported by radiology but has been reviewed by registrar 'Dr Brown' on the wards - confirmed no fracture can be seen on X-ray (L) shoulder.	
	Imp: ~~rotacuff~~ possibly rotator cuff injury	R.MAYWAH
	b/o to discuss plan on ward round	FY1
20/08/20	WR - Prof Meek	
	Discussed shoulder pain with Prof Meek -- NOT for ultrasound, X-ray shows no fracture/acute pathology.	
	Addictions team started him on 10mg diazepam TDS but this can ~~be~~ be weaned down in police custody.	R.MAYWAH FY1
20/08/20	~~b~~ Phone call from liaison psychiatry.	
	Discussed that psychiatry assessment will be difficult with ongoing delirium. Explained that PO diazepam 10mg TDS has been started as per Addiction Services. Has agreed to review him on Friday 21/08/2020.	R.MAYWAH FY1

Date & Time	ACUTE ADDICTION LIAISON	Signature, Print Name & Designation
21/8/20	Reviewed today as planned. Did	
10⁴⁵	not really participate in discussion	
	with myself.	
	SUGGESTED PLAN	
	(1) Continue regular diazepam reduction -	
	guidelines in Hudex	
	(2) If receiving regular dihydrocodein for	
	opiate withdrawal, this should be	
	reduced gradually prior to discharge.	
	Naked not requiring regularly at this time	
	however.	
	(3) No further input required from addictions	
	currently. Re-refer if any further support	Stephen Downs
	required	Addiction Liaison Nurse
	WR – Chest	
21/8	NEWS - 2 (93% SpO2 on air)	
	To be reviewed by psy today	
21/8/20	Seen Ax. Note above. Also d/w SW + PT +	
	police in attendance. @ i/v limited rapport,	
	Hd sp. Sp. latency ↑, content ± always related to	
	questions. Appr tense, anxious, perplexed. Agitated	A.J. Burnett
	but never aggr. Possibly a little guarded. Not clear if	Seen
	hallucinating but could be. MSE seems consistent	82422
	w/ contacts ± different professionals.	
	⇒ Picture is of marked ↑ in state but could be ± dual.	
	He will need further review early next wk.	
	It would be good to see once Diaz is done.	
22/8/20	- WR David Shields.	
	- Plan for discharge back to police custody asap	
	on reducing course of diazepam	PR

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☑
NURSING ☐

Please tick ✔ appropriate directorate

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Glasgow, Lanarkshire
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Date & Time		Signature, Print Name & Designation
23/8/20	WR Mr Chen	
	Plan as 22/8	
	Awaiting ↓ r/v early next week	
		[signature] 7730986
24/08/20	WR – HRYCAIC	
	Full normal power in legs [lower limbs legs].	
	No medical reasons why he can't mobilise – compliance issue.	
	Plan: Discharge with orthopaedic follow-up	
	Awaiting confirmation from psychiatry	R. MAYWAH
		FY1
24/8/20	Please Ax. Note above. Rev sitting up in bed. Slurry more c.c., more spontaneous sp. Evident sp latency. V. Dizzy odd response ideation. Describing "voices" + seeing his family. Appears troubled + slightly perplexed. Not clearly orientated. o/s desc ↑ functional below: attend to some ADLs.	[signature] A. TURNER
	D/w Blue attending. Charges appear more serious than simple drowsy under influence.	Hon 624/22
	⇒ D/c from CLAS. To will alert court + CJW service as due court tom.	
	D/c to Blue custody.	

Date & Time		Signature, Print Name & Designation

Printed: 11/08/2020 00:18:28

Patient Sample Report

Status: **ACCEPTED**
Analyzed: 11/08/2020 00:18:17
Sample Type: **Venous**
Operator ID: Kalila Simpson0

Patient

ID:	2104673933
Last Name:	**SHAW**
First Name:	**ANDREW**
Gender/Age:	Male, 53 years
Birth Date:	21/04/1967

Cartridge

Lot No.:	200422H
S/N:	000000000500067422
Exp. Date:	26/08/2020

Analyzer

Model:	GEM® *Premier 5000*
Area:	AH_L0ED_B
Name:	ED-MAJ-IN
S/N:	17030619

Results

			Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)						
cH	40.8	nmol/L	--	--	--	--
pCO_2	6.8	kPa	--	--	--	--
pO_2	4.5	kPa	--	--	--	--
Na^+	↓ 130	mmol/L	--	133	146	--
K^+	4.7	mmol/L	--	3.5	5.3	--
Cl^-	100	mmol/L	--	95	108	--
Ca^{++}	↓ 1.13	mmol/L	--	1.15	1.27	--
Hct	55	%	--	--	--	--
Glu	↑ 10.0	mmol/L	--	3.5	6.0	--
Lac	↑ 2.4	mmol/L	--	0.6	2.2	--
CO-Oximetry						
tHb	174	g/L	--	--	--	--
O_2Hb	↓ 61.4	%	--	95.0	98.0	--
COHb	1.2	%	--	0.5	1.5	--
MetHb	↓ 0.3	%	--	0.5	1.5	--
HHb	↑ 37.1	%	--	0.0	5.0	--
sO_2	↓ 62.3	%	--	95.0	98.0	--
Derived						
BE(B)	4.7	mmol/L	--	--	--	--
$HCO_3^-(c)$	30.9	mmol/L	--	--	--	--

↑↓ Outside Reference Range

Other Information

Operator Entered

Temp	37.0	°C

Printed: 11/08/2020 03:10:55

Patient Sample Report

Status: **ACCEPTED**
Analyzed: 11/08/2020 03:10:44
Sample Type: **Arterial**
Operator ID: JOE CAMPBELL1

Patient

ID:	2104673933
Last Name:	**SHAW**
First Name:	**ANDREW**
Gender/Age:	Male, 53 years
Birth Date:	21/04/1967

Cartridge

Lot No.:	200422H
S/N:	000000000500067422
Exp. Date:	26/08/2020

Analyzer

Model:	GEM® *Premier 5000*
Area:	AH_L0ED_B
Name:	ED-MAJ-IN
S/N:	17030619

Results

			Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)						
cH	↑ 45.4	nmol/L	--	36.0	44.0	--
pCO_2	↑ 7.5	kPa	--	4.6	6.0	--
pO_2	13.6	kPa	--	10.5	14.0	--
Na^+	134	mmol/L	--	133	146	--
K^+	4.8	mmol/L	--	3.4	6.0	--
Cl^-	100	mmol/L	--	95	108	--
Ca^{++}	1.22	mmol/L	--	1.15	1.27	--
Hct	53	%	--	--	--	--
Glu	↑ 9.6	mmol/L	--	3.5	6.0	--
Lac	1.1	mmol/L	--	0.6	2.2	--
CO-Oximetry						
tHb	166	g/L	--	--	--	--
O_2Hb	96.4	%	--	95.0	98.0	--
COHb	0.6	%	--	0.5	1.5	--
MetHb	↓ 0.4	%	--	0.5	1.5	--
HHb	2.6	%	--	0.0	5.0	--
sO_2	97.4	%	--	95.0	98.0	--
Derived						
BE(B)	2.8	mmol/L	--	--	--	--
$HCO_3^-(c)$	30.1	mmol/L	--	--	--	--

↑↓ Outside Reference Range

Other Information

Operator Entered

Temp	37.0	°C

Department of Trauma & Orthopaedics
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
G51 4TF

Mr Andrew Shaw - CHI: 2104673933

Admitted Date: 11.08.2020

Mr Alex Hyrcaiczuk (OCR) – Orthopaedic Ward Round

Dictated: 24.08.20.
Typed: 24.08.20
Ref: AH/CG
Ward: 10C

Mr Shaw was involved in a road traffic collision a number of days ago. On review I note that he has previously been reporting a loss of power in his legs preventing mobilisation. On review today he has full power in his quads, knee, foot and ankle. This is bilateral. He is complaining of pain over his fibula on the left which is to be expected following his fracture. There is no medical reason why he cannot mobilise fully. There is no concern from my point of view about his safety to mobilise and I understand that he is likely to go back to Police custody where there will be support available for him to ensure that he is able to do so in a safe fashion.

I note that Mr Shaw is being reluctant to engage with the physiotherapy services today and I do note feel this preclude an ongoing hospital stay. I am happy that he can be discharged from hospital and no orthopaedic follow up.

I note that Mr Shaw is reporting an inability to move his legs or fully engage with physiotherapy since he was admitted with his injury. It has been observed by Nursing Staff that he has been mobile around the bed comfortably without any direct observation or presence of staff.

On review today he is sitting on the edge of the bed comfortably with both hips flexed at 90°. At my request he is able to climb into bed lifting his legs fully against gravity with full power.

Examining him in the bed he has MRC 5/5 in L2 – S1 bilaterally. He has got slight weakness of left ankle plantar flexion reportedly secondary to pain over the lateral malleolus. We know he has an undisplaced Webber A ankle fracture here. He has no neurology of the lower limb and is able to pee without any difficulty.

I note there has been limited engagement with physiotherapy at this stage but I do necessarily feel there is any medical reason to predicate any extended hospital stay. He can have a moon boot for his ankle fracture and mobilise as pain allows.

The ward will chase up with the Psychiatrists how to review him on Friday to re-review today and the plan will be for discharge him from hospital.

Pan scan demonstrates no other orthopaedic injuries that require follow up.

Mr Peter Chan - Orthopaedic Ward Round

Dictated: 23/08/2020
Typed: 23/08/2020
Ref: PC/EB
Ward: 10C

There is no change in this man's condition. NEWS is currently zero but his mobility and his communication remains poor at best. He was reviewed by Psych on Friday and they will want to review him again once his reducing dose of Diazepam has been completed.

Dr Dave Shields, ST7 (OCR) - Orthopaedic Ward Round

Dictated: 22/08/2020
Typed: 22/08/2020
Ref: DS/EB
Ward: 10C

Andrew Shaw has a left, stable distal fibula fracture which is simply managed by a moon boot. He is, however, in custody of the Police on account of the events leading up to his RTA and needs to present to Court (virtually). Unfortunately due to his habitus and the fact that he is on Diazepam for withdrawal and his ankle injury is requiring a hoist to get him to the toilet and back. He is not conscious for many hours of the day. We have reduced his Diazepam with a view to him being off it in the next few days. As soon as he is suitably mobile (i.e. to the toilet and back) he will be discharged to Police custody.

Mr Pete Chan - Orthopaedic Ward Round

Dictated: 21/08/2020
Typed: 21/08/2020
Ref: PC/JM
Ward: 10C

This man was brought in five days ago after a road traffic accident. His orthopaedic injury is an undisplaced left Weber A fracture of his ankle.

This morning he is lying on his bed and is not responding to any questions. I note that he is on a reduced dose of Diazepam as he has a history of addictions.

He has previously been seen by Addictions and they are due to review him again today as well as Psychiatry.

Professor Dominic Meek – Orthopaedic Ward Round

Dictated: 19.08.20.
Typed: 19.08.20.
Ref: RMDM/CG
Ward: 10C

Psychiatry are just going to see him at outpatient and really from an Orthopaedic point of view he can be discharged once physiotherapy has got his boot sorted for his ankle.

Professor Dominic Meek - Orthopaedic Ward Round

Dictated: 18/08/2020
Typed: 18/08/2020
Ref: RMDM/MD
Ward: 10C

No real acute orthopaedic issue now. Really just waiting for Psychiatric and Medical review.

Professor Dominic Meek - Orthopaedic Ward Round

Dictated: 17/08/2020
Typed: 17/08/2020
Ref: RMDM/GG
Ward: 10C

He is still pending reviews with other specialities and will get the boot onto him for mobilising. He can get rid of the boot in 4 weeks time

Professor Dominic Meek - Orthopaedic Ward Round

Dictated: 16/08/2020
Typed: 16/08/2020

Ref: RMDM/EB
Ward: 10C

This gentleman appears to be just transferred up from HDU without any consultation with Orthopaedics. He had a previous issue with psycho hallucinations. His history is unclear but was apparently intoxicated. From an Orthopaedic point of view he has a Weber A fracture of his left ankle which can be managed conservatively with a walking boot which he will have for four weeks. X-rays of his shoulder are unremarkable as was clinical examination. He has had CT cervical spine, thorax and abdomen which is reported as no gross abnormalities. He is a little bit still confused this morning so we will have reviewed by both the Physicians and the Psychiatrists prior to considering discharge.

2/4/26 ANDREW SHAW 58 ♂

2104673933
SHAW
Andrew, M
21/04/1967
FLAT 1
14 HILLHEAD AVENUE
Glasgow, Lanarkshire
G73 4NJ

GBS. 98'

W/P Levendale → son/wife/2

few ~~months~~ years'
hayfever, eczema. oft/brother.

onep 20. ✓
salb inh. ✓

noct. SOB 3-4/wk.

stable s/d

cough
spit. teaspoon green, clear ± haemo

schizophrenia
PTSD.
Substance misuse
COC

wife/2
sons' univ 3-4/s.

wt →

O/E sput mixed
cong.

°COC/nasal.

fast ♀. °pred/IBs.

fbnt
fECG
CT 2020 atelectasis

°gut/bowels
int working

→ CXR ✓ rpt ☐

~~sputum~~

d/c:
PET mitral/aortic → rpt
± TTE (mod) ECG/LFTs

FBC/RFT/LFTs/mg.
declines gwins.

Asthma Control Questionnaire

Date: 2/9/26

2104673933
SHAW M
Andrew, M 21/04/1967
FLAT 1
14 HILLHEAD AVENUE
Glasgow, Lanarkshire
G73 4NJ

Please complete the 6 Questions below about how your asthma has been in the past week

Circle the number of the response that best describes how you have been **during the past week**

1. On average, during the past week, how often were you **woken by your asthma** during the night?

3 or 4

0 Never
1 Hardly Ever
(2) A few minutes
3 Several times
4 Many Times
5 A great many times
6 Unable to Sleep because of asthma

2. On average, during the past week, how **bad were your asthma symptoms when you woke up** in the morning?

Bad

0 No symptoms
1 Very mild symptoms
2 Mild symptoms
3 Moderate symptoms
(4) Quite severe symptoms
5 Severe symptoms
6 Very severe symptoms

3. In general, during the past week, **how limited were you in your activities** because of your asthma?

limited

3.7

0 Not limited at all
1 Very slightly limited
2 Slightly limited
3 Moderately limited
(4) Very limited
5 Extremely limited
6 Totally limited

4. In general, during the past week, how much **shortness of breath** did you experience because of your asthma?

Every day / Night

0 None
1 A very little
2 A little
3 A moderate amount
4 Quite a lot
(5) A great deal
6 A very great deal

5. In general, during the past week, how much of the time did you **wheeze**?

4 / 5

0 None
1 Hardly any of the time
2 A little of the time
3 A moderate amount of the time
(4) A lot of the time
5 Most of the time
6 All of the time

6. On average, during the past week, how many puffs of **short-acting bronchodilator** (e.g. Ventolin) have you used **each day**?

8

0 None
1 1-2 puffs most days
2 3-4 puffs most days
(3) 5-8 puffs most days
4 9-12 puffs most days
5 13-16 puffs most days
6 More than 16 puffs most days

Total Score: _____

ACQ-6 Score: [Total ACQ÷6] 22

NHS
Greater Glasgow and Clyde

Patient label
2104673933
SHAW
Andrew, M
FLAT 1
14 HILLHEAD AVENUE
Glasgow, Lanarkshire
G73 4NJ
M
21/04/1967

The patient attended Asthma Clinic at GARTNAVEL.

Hospital on 2/4/26 and I would advise a change to drug therapy from

to

or additional therapy of FOSTAIR 100/6

as detailed below. Full letter to follow.

Additional Comments:

DRUG (print)	DOSE	FREQUENCY	DURATION / REVIEW DATE
FOSTAIR 100/6	2 puffs	bd + 1 puff	max 8 puffs/d + INHALER TECHNIQUE

Yours Sincerely

Signature: Liane

Name (print) COWAN Grade: CON 5 Ext. No:

White copy to - G.P. Pink copy - *File this copy in Case Records*

00545 GGC0004

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

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

Dept. Contact Details:
Tel: 0141 452 2930/2931
Fax: 0141 201 2804
Email:

Date Completed: 15/11/2020

Consultant: Dr Cieran McKiernan

FR Wyllie
Mavor Medical Practice
Hunter Health Centre
Andrew Street
East Kilbride
Glasgow
G74 1AD

Dear FR Wyllie

Re: **Shaw Andrew Martin** DOB: **21/04/1967** CHI: **2104673933**
30 DOUGLAS DRIVE
Glasgow G75 8JS

Attended on: **15/11/2020 at 07:09 hrs.** Departed on: **15/11/2020 at 11:09 hrs.**
Discharge Type: **02 - Admitted** Destination: **Admission to this Hospital**
Previous ED Attendance in last 12 months: **1**

Presenting complaint
stand by

Nursing Assessment:
standby

Investigations in ED:

1. Ethanol
2. Amylase
3. Bone Profile
4. CRP
5. Glucose
6. LFT
7. Urea and Electrolytes
8. Coagulation screen
9. Full Blood Count
10. Group and Save
11. CT Head
12. CT Thorax abdomen pelvis with contrast
13. CT Spine cervical

Diagnosis:

Diagnosis	Side	Site
Mod Mental Retardation Signif Impairment of Behav Req Attention/ treatment		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Katerina Kimberley
Doctor

Copies to:

1. FR Wyllie (GP)

School Address:

Clinical letter - Others:

NHS
Greater Glasgow and Clyde
New Victoria Hospital
Grange Road
Glasgow
G42 9LF

Dr Sarah Thomson
Consultant Psychiatrist
Leverndale Hospital
510 Crookston Road
Glasgow
G53 7TU

Main Switchboard: 0141 201 6000
Department: Cardiology
Contact Tel: 0141 451 6120
Enquiries to: louise.kinnear@nhs.scot
Letter Date: 04/03/2026
Reference: SR/LK
Dictated Date: 02/03/2026
Transcribed Date: 04/03/2026

Dear Dr Thomson ,

Andrew Martin Shaw; D.O.B: 21/04/1967; CHI: 2104673933
Flat 1, 14 Hillhead Avenue, Glasgow, Lanarkshire, G73 4NJ

Mr Shaw failed to attend his cardiology outpatient appointment once more and will not be reappointed routinely.

Clearly risk factor modification is paramount here and I have copied this letter to Andrew's primary care team who may be better placed to engage with him.

With kind regards,

Yours sincerely

Dr Sam Rodgers

Consultant Cardiologist

Electronically Signed: ,

cc. COPY TO GP

Clinical letter - GP:

NHS
Greater Glasgow and Clyde

New Victoria Hospital
Grange Road
Glasgow
G42 9LF
Main Switchboard: 0141 201 6000
Department: Cardiology
Contact Tel: 0141 451 6129
Enquiries to: elle.tinney@nhs.scot
Letter Date: 09/02/2026
Reference: SD/MB
Dictated Date: 20/01/2026
Transcribed Date: 04/02/2026

Dr. JJ Canning
Drs Jordan canning & foy
Rutherglen Primary Care Centre
130 Stonelaw Road rutherglen
Glasgow
G73 2PQ

Dear Dr Canning,

Andrew Martin Shaw; D.O.B: 21/04/1967; CHI: 2104673933
Flat 1, 14 Hillhead Avenue, Glasgow, Lanarkshire, G73 4NJ

Unfortunately, Mr Shaw did not attend his appointment at the cardiology clinic. A further appointment will be sent out in due course.

Yours Sincerely,

Dr Stephen Dobbin

Consultant Cardiologist

Electronically Signed: Dr Stephen Dobbin, Consultant

cc.

Clinical letter - GP: Referral update

NHS Greater Glasgow and Clyde

Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN
Main Switchboard: 0141 211 3000
Department: Specialist Weight Management Service
Lightburn Hospital 966 Carntyne Road Glasgow G32 6NB
Contact Tel: 0141 232 1750
Enquiries to: ggc.gwms@nhs.scot

Letter Date: 28/01/2026
Reference: GC/SA
Dictated Date: 11/12/2025
Transcribed Date: 26/01/2026

Dr. JJ Canning
Drs Jordan canning & foy
Rutherglen Primary Care Centre
130 Stonelaw Road rutherglen
Glasgow
G73 2PQ

Dear Dr Canning,

Andrew Martin Shaw; D.O.B: 21/04/1967; CHI: 2104673933
Flat 1, 14 Hillhead Avenue, Glasgow, Lanarkshire, G73 4NJ

Thank you for your recent referral regarding the above patient and outlining the reasons for your request to expedite this patient's SWMS intervention.

His case was reviewed at our SWMS Exceptions meeting. After multidisciplinary consideration, we agreed the patient is clinically appropriate for SWMS; however, on the basis of the information available, the case does not meet the threshold for prioritisation ahead of others currently waiting.

To maintain fairness and safety, we apply a consistent prioritisation process across all expedited requests and schedule patients in line with service capacity. Should new clinical information arise that materially changes the level of urgency, please share it and we will review the case promptly.

Yours sincerely

SWMS Senior Team Leads

Specialist Weight Management Service (SWMS)

Electronically Signed:,

cc.

Queen Elizabeth University Hospital
Fracture Liaison Service (FLS)
Osteoporosis Nurse Specialists:
Sr Marion Harkness, Sr Angela Collie (QEUH)
Sr Margaret French, Sr Deborah Nelson & Sr Leigh Robertson (WG ACH)
Enquiries: 0141 451 6097

NHS Greater Glasgow and Clyde

Ref: AC/AC/2104673933

20-Aug-2020

Dr. FRASER WYLLIE
HUNTER HEALTH CENTRE
ANDREW STREET
EAST KILBRIDE
G74 1AD

Dear Dr. WYLLIE,

Andrew Shaw, DOB: 21-Apr-1967
30 Douglas Drive
East Kilbride
Glasgow
Lanarkshire
G75 8JS

CHI: 2104673933

Your patient recently attended hospital having sustained a fracture and they were subsequently assessed for osteoporosis / fracture risk on the above date.

The outcome at this stage is as circled below:

a) An appointment for full assessment by the FLS with DXA will be arranged
b) Further assessment including DXA is not indicated – treatment as recommended
c) He/she declined further assessment &/or treatment
d) See below

Osteoporosis Risk Factors
(None)

Fracture Risk Factors
History of previous fracture (>50yr)

Fracture History
Left Ankle (Aged 53)

Treatment Recommendations
(None)

Lifestyle Recommendations
(None)

Densitometry: This patient had high impact fracture therefore does not require bone densitometry

This patient's fracture history was obtained through radiology or virtual fracture clinic reports; he/she has not been seen in person by the fracture liaison service.

Fracture sustained is related to an RTA thus intervention by the FLS is not required.

Yours sincerely

Sister Angela Collie
Osteoporosis Specialist Nurse

Dr S Gallacher
Consultant Physician

Clinic Letter

NHS
Greater Glasgow and Clyde

Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN
0141 211 3000

Dr. JJ Canning
Drs Jordan canning & foy
Rutherglen Primary Care Centre
130 Stonelaw Road rutherglen
Glasgow
G73 2PQ

Main Switchboard:
Department: Respiratory Medicine
Contact Tel: 0141 451 6099
Enquiries to: megan.rutherford2@nhs.scot
Letter Date: 02/04/2026
Reference: DC/MR
Dictated Date: 02/04/2026
Transcribed Date: 08/04/2026

Dear Dr. JJ Canning,

Andrew Martin Shaw; D.O.B: 21 Apr 1967; CHI: 2104673933
FLAT 1, 14 HILLHEAD AVENUE, Glasgow, Lanarkshire, G73 4NJ

Attendance: Specialty - Respiratory Medicine; Clinic - GGDCRE03N-DR COWAN RESP EXTRA CLINIC
Date and Time of Appointment - 02/04/2026 11:20

Clinical Comments:

Diagnosis:
1. Likely late onset asthma - eosinophilic, elevated FeNO, normal spirometry
2. Hay fever, eczema
3. Never smoker
4. Schizophrenia
5. PTSD
6. Substance misuse
7. Elevated BMI

Current Medications: Please start Fostair 100/6 2 puffs bd with an extra puff as required to a max of 8 puffs per day with instruction on inhaler technique; stop Salbutamol inhaler; continues Omeprazole.

I saw this 58 year old gentleman for review at the asthma clinic following a referral from Leverndale whilst an inpatient with breathlessness and wheeze. He tells me that he has had symptoms for a few years. He has hay fever and eczema. There is no family history of asthma and he has never smoked. He is woken with breathlessness 3 or 4 nights of the week and using his reliever inhaler 5 times a day. He has a cough productive of a teaspoon of sputum per day which is cleared OK. No haemoptysis. He is wheezy at times. He is breathless on exertion at MRC 3-4/5. Weight static. No

gastroesophageal reflux symptoms or nasal symptoms. In the past year, he has not had any oral steroids or antibiotics. He has no pets or birds at home. He is not working.

At clinic today, oxygen saturations were 98%. ACQ 3.7. Examination revealed slight nasal congestion.

Spirometry today was within the normal range. FeNO was elevated at 96 parts/billion. I updated his chest X-ray and to my eye, it looks OK. Formal report awaited.

I note that he is previously eosinophilic.

I think that it is likely that this gentleman has asthma given the FeNO, blood eosinophils and the clinical picture.

I would be grateful if he could be started on Fostair 100/6 2 puffs bd with an extra puff as required to a max of 8 puffs per day with instruction on inhaler technique.

I have requested some asthma related blood tests today. I offered to refer him to the Glasgow weight management service but he declined.

I have asked for him to be given a peak flow meter and diary. If he keeps a record of am/pm peak flows for 2-3 weeks, he could then be given a personalised asthma plan based on the readings:

1. If increase in asthma symptoms, to monitor peak flow regularly
2. If peak flow <80% of best, to double up Fostair to 4 puffs 2 x daily for a few days until symptoms settle
3. If peak flow <60% of best, to see GP for Prednisolone 30mg daily until peak flow >80% of best, then 15mg daily for the same number of days, then stop

I have not arranged further review at the asthma clinic for now and have discharged him back to your care. If necessary, consideration could be given to sequential trials of increased inhaled corticosteroid (if blood eosinophils or FeNO are elevated) +/- Montelukast +/- LAMA, each for at least 2-3 months and each continued long term if found beneficial. Please refer him back should he have troublesome symptoms and/or repeated exacerbations despite these measures.

Yours sincerely

Dr Douglas Cowan

Consultant Respiratory Physician

Electronically Signed: Dr Douglas Cowan, Consultant

cc. Mr Andrew Shaw
Flat 1
14 Hillhead Avenue
Glasgow
G73 4NJ

Outlook

AS 2104673933

From Daniel Gordon (NHS Greater Glasgow & Clyde) <daniel.gordon3@nhs.scot>
Date Thu 21/08/2025 7:15 PM
To Nida Saleemi (NHS Greater Glasgow & Clyde) <nida.saleemi@nhs.scot>
Cc Liz Porteous <Liz.Porteous@nhs.scot>

Dear Dr Saleemi,

Thanks for your referral regarding Andrew Shaw.

I note his symptoms are chronic and span years. You mention wheeze and breathlessness, as well as one instance of raised eosinophils, suggesting a possible element of allergic airways inflammation. This raises the possibility of asthma - to rule this in/out I would suggest arranging pulmonary function tests with a FeNo and bronchodilator reversibility testing as per the recent NICE/BTS/SIGN guidelines on diagnosing asthma. Is there any family history of asthma or any other features to suggest this (e.g. Diurnal variation)?

What antipsychotic is he on? I believe both first and second generation antipsychotics can be associated with a raised eosinophil count. You say he is a non-smoker - is this never-smoker or ex-smoker?

I would agree with your suggestion his dyspnoea is likely to be multifactorial in view of his BMI. His most recent imaging is unremarkable. Given his BNP heart failure is unlikely here and an echo is unwarranted.

If the clinical symptoms and history are suggestive of asthma, and the PFTs are supportive (see the above guidelines for reference here) then you could trial him on Anti-Inflammatory Reliever therapy - Symbicort as required. Should these be normal this would be reassuring. Weight loss is likely to be his biggest friend here but the metabolic syndrome that accompanies antipsychotics will no doubt pose a big challenge here.

Best wishes,

Dr Danny Gordon
ST5 Respiratory Registrar
Queen Elizabeth University Hospital

Immediate Discharge Letter - Amendments

This version of the document supersedes earlier versions.

Additional Information: Conn Talbot, 20-Nov-2020 20:23
Pt discharged on 20/11/20 with 1 more dose of diazepam 5mg to take on morning of 21/11/20

Immediate Discharge Letter

Highly Sensitive: No
Consent for Sharing Withheld: No

NHS Greater Glasgow and Clyde

FRASER WYLLIEMavor Medical Practice,Hunter Health Centre,Andrew Street, East Kilbride, G74 1AD

Queen Elizabeth Hospital,1345 Govan Road,Glasgow G51 4TF
Main Switchboard: 0141 2011100
Date of Completion: 20-Nov-2020

Dear FRASER WYLLIE,

Name	CHI	DoB	Address
Andrew Shaw	**2104673933**	**21-Apr-1967**	**30 DOUGLAS DRIVE, EAST KILBRIDE, Glasgow, Lanarkshire, G75 8JS**

Admitted	Type	Discharged	Destination
15-Nov-2020 11:09	IP	20-Nov-2020	

Specialty	Consultant	Ward	Telephone
Gastroenterology	Morris	QEUH Ward 8C General Medicine	0141 2011100

Primary Diagnosis
There is no data to display.

Secondary Diagnosis
There is no data to display.

Significant Operations / Procedures:
nil

Last Discharge Review: Anna Smith (Anna Smith3 - FY2 Medical Microbiology) on 20 Nov 2020 18:28

Discharge Medication:

Active Drug Name	Route	Dose	Disp	Reason	Further Details	ECS	Since Admission
Diazepam 5mg tablets	oral	1 tablet twice daily , Last dose 21/11/20 morning. , Fixed Period 1 Day(s) from 20 Nov 2020	Yes				Added

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

Dispensing Comments
Dispensed: Claire Carruthurs Checked: Nicola Bett 20/11/2020

Withheld Medication:

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

Stopped Medication:

Date	Stopped Drug Name	Route	Dose	Note	Stopped Reason
2020-11-20	Dihydrocodeine 30mg tablets	oral	2 tablets four times daily when required , Only if pain unbearable		Patient improved
2020-11-20	Omeprazole 20mg dispersible gastro-resistant tablets	oral	1 tablet once daily		Patient improved
2020-11-20	Paracetamol 500mg tablets	oral	2 tablets four times daily when required		Patient improved

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

Clinical Comments:	Dear Doctor, Thank you for your continued care,

	Mr Andrew Shaw was admitted to QEUH on 15/11/2020 after an RTA - failing to stop during a car chase by police. In hospital - suffered from hallucinations - "voices telling him to hurt himself or staff". Diagnosis: Likely due to drug withdrawal In hospital: Seen by addiction liaison service and psychiatry service Investigations in hospital: Urine Toxicology screen: positive for ethanol, cocaine and ethanol. Bloods are normal CT head: negative CXR: No significant interval change Medication changes: - has taken 5mg of diazepam (Saturday 21/11/2020) before discharge Follow up: - discussed case with GP secretary - (Dr. Fraser is his GP) - for follow up with community mental health professional Medically fit for discharge. Warm regards, Ward 8c QEUH
Discharge Comments:	
Follow Up:	Yes community mental health professional to follow up in the community
Results Awaited:	No
Pharmacist Comments:	
Final Discharge Letter to Follow:	Yes

Yours sincerely,

Fortis Gaba

Prescription Review
Medications reviewed by pharmacist: Andrew Laird (Pharmacist)
Checked by: Nicola Bett (pharmacist)
Discharged by: Gary McDowall (Staff Nurse)

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No
Consent for Sharing Withheld: No

FRASER WYLLIEMavor Medical Practice,Hunter Health Centre,Andrew Street, East Kilbride, G74 1AD

Queen Elizabeth Hospital,1345 Govan Road,Glasgow G51 4TF
Main Switchboard: 0141 2011100
Date of Completion: 24-Aug-2020

Dear FRASER WYLLIE,

Name	CHI	DoB	Address
Andrew Shaw	**2104673933**	**21-Apr-1967**	**30 DOUGLAS DRIVE, EAST KILBRIDE, Glasgow, Lanarkshire, G75 8JS**

Admitted	Type	Discharged	Destination
11-Aug-2020 06:28	IP	24-Aug-2020	Legal Establishment, including Prison

Specialty	Consultant	Ward	Telephone
Orthopaedics	Chan	QEUH Ward 10C Orthopaedics	0141 2011100

Primary Diagnosis
There is no data to display.

Secondary Diagnosis
There is no data to display.

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

Last Discharge Review: Rachna Maywah (Rachna Maywah - FY1) on 24 Aug 2020 13:02

Discharge Medication:

Active Drug Name	Route	Dose	Disp	Reason	Further Details	ECS	Since Admission
Dihydrocodeine 30mg tablets	oral	2 tablets four times daily when required , Only if pain unbearable	Yes				Added
Omeprazole 20mg dispersible gastro-resistant tablets	oral	1 tablet once daily	Yes				Added
Paracetamol 500mg tablets	oral	2 tablets four times daily when required	Yes				Added

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

Dispensing Comments
There is no data to display.

Withheld Medication:

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

Stopped Medication:

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

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

Clinical Comments:	Dear Doctor, This 53 year old male was admitted to the orthopaedics ward from HDU for a left ankle fracture after a RTA. He was BIBP heavily intoxicated. Diagnosis: Undisplaced left Weber A fracture of the ankle Management: Conservative with a moon boot for 4 weeks from 17/08/2020

	VTE Prophylaxis: Nil - able to weight-bear on moon boot. He had a course of clexane during this admission. Summary of Admission: During this admission, he complained of some chest pain. An ECG was normal and a troponin level was < 4. Cardiology reviewed him and the pain was attributed as musculoskeletal. This is now better. His toxicology screen was positive for various drugs on admission including cocaine, amphetamine, opioids, benzodiazepine and methamphetamine. Addiction services have been reviewing him on a regular basis and he was started on 10mg diazepam TDS. This has been weaned down during this admission and he no longer requires any further dose. He reported having audible hallucinations. He has been reviewed by liaison psychiatry on multiple occasions during this admission and attributed the hallucinations to drugs withdrawal. They have no further input in his care and are happy to discharge him back to police custody. Thank you for your ongoing care for this patient Regards, Rachna Maywah FY1 Orthopaedics
Follow Up:	No Nil
Results Awaited:	No
Pharmacist Comments:	
Final Discharge Letter to Follow:	Yes

Yours sincerely,

Rachna Maywah

Prescription Review
Checked by: Rachna Maywah (FY1)
Discharged by: Sarah Lafferty (Charge Nurse)

NHS
Greater Glasgow and Clyde

CONFIDENTIAL

ECG Department
New Victoria Hospital
55 Grange Road
Glasgow
G42 9LL

Eastvale Resource Centre
130a Stonelaw Road
Rutherglen
G73 2PQ

Tel: 01698-754100

Date: 5 February 2026
Dict: 4 February 2026
Ref: GMC/AM
CHI: 210 467 3933

RECEIVED 10 FEB 2026

Dear Colleague

ANDREW SHAW 21.04.67
FLAT 1 14 HILLHEAD AVENUE RUTHERGLEN GLASGOW G73 4NJ

I am writing to request an outpatient ECG for Mr Shaw. He is a man who suffers from angina and has significant risk factors in the form of diabetes, being overweight and a very sedentary lifestyle. He is also on a range of medications including psychotropic medications which can contribute to his cardiac risk.

His cardiac symptoms have escalated since his discharge from hospital last year. I would be grateful therefore if an ECG could be undertaken and reviewed by your Cardiology team with any further investigations you deem required thereafter being put in place.

I have also asked Mr Shaw's GP to monitor his cardiac profile in the community.

Yours faithfully

Dr G McMillan
Consultant Psychiatrist
BSc.(Hons), MB. ChB. FRCPsych

CC Dr Jordan, Jordan and Canning Practice, RHC
CC Charge Nurse Mark Hume, CPN, Eastvale Resource Centre

MEDICINE **PRESCRIPTION FORM** Hospital Name: .....

MEDICINES RECONCILIATION

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

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

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the symptomatic relief policy & local protocol:

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

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

PATIENT DETAILS

Hospital
DOB:
Date of /
Consult

2104673933
SHAW M
Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

Height:
Weight:
Surface area:
Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
17/11	DALTEPARIN	18000 unit	SC	0630	L. Coi	CL	0655

TARGET OXYGEN SATURATIONS

Please CIRCLE a target saturation and prescribe oxygen on the Regular Prescription section.

94 – 98%	88 – 92% (e.g. in hypercapnic respiratory failure)	Other (please specify)

On Home Oxygen? Yes / No _____ L/min

DATE: ____/____/____ PRESCRIBER (PRINT & SIGN): _____

	DATE →																							
	MONTH →																							
	RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)																							
IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N																								
ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N																								
SIGNATURE OF ASSESSOR																								
ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N																								

Parenteral Drugs : Regular Prescription

																								Patient's Own Medicine
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	A DRUG DOSE / ROUTE / DATE PRESCRIBER (PRINT & SIGN) ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	STOPPED DATE: INITIALS:	Other time																					For Use Y/N
			0700-0900																					Qty:
			1200-1400																					Date:
			1600-1800																					Assessed by:
			2200-2400																					Ordered from Pharm.
			Other time																					
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	B DRUG DOSE / ROUTE / DATE PRESCRIBER (PRINT & SIGN) ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	STOPPED DATE: INITIALS:	Other time																					For Use Y/N
			0700-0900																					Qty:
			1200-1400																					Date:
			1600-1800																					Assessed by:
			2200-2400																					Ordered from Pharm.
			Other time																					
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	C DRUG DOSE / ROUTE / DATE PRESCRIBER (PRINT & SIGN) ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	STOPPED DATE: INITIALS:	Other time																					For Use Y/N
			0700-0900																					Qty:
			1200-1400																					Date:
			1600-1800																					Assessed by:
			2200-2400																					Ordered from Pharm.
			Other time																					

REVIEW THE NEED FOR IV ANTIBIOTIC DAILY. SWITCH TO ORAL THERAPY AS SOON AS POSSIBLE (SEE IVOST POLICY)

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

D DRUG

DOSE | ROUTE | DATE

STOPPED DATE:
INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

E DRUG

DOSE | ROUTE | DATE

STOPPED DATE:
INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

F DRUG

DOSE | ROUTE | DATE

STOPPED DATE:
INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

G DRUG

DOSE | ROUTE | DATE

STOPPED DATE:
INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE: 17 | 18 | 19 | 20
MONTH: 11 | 11 | 11 | 11

Patient's Own Medicine

H DRUG: DIAZEPAM
DOSE: 10 mg | ROUTE: PO | DATE: 17/11 | STOPPED DATE: 19/11 | INITIALS: STMR
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: TDS
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☑
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

J DRUG: DIAZEPAM
DOSE: 5mg | ROUTE: PO | DATE: 19/11 | STOPPED DATE: 21/11 | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ NEW DOSE ☑ NEW MEDICATION ☐
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time
For Use Y/N | Qty: | Date: | Accessed by: | Ordered from Pharm.

K DRUG: DIAZEPAM
DOSE: 5mg | ROUTE: PO | DATE: 20/11 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ NEW DOSE ☑ NEW MEDICATION ☐
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

L DRUG: DIAZEPAM
DOSE: 5mg | ROUTE: PO | DATE: 20/11 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ NEW DOSE ☑ NEW MEDICATION ☐
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

S DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

T DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

V DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

W DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

M DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

N DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

P DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

R DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

X DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

All Routes: As Required Prescriptions

Patient's Own Medicine

| | | |

							Patient's Own Medicine
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	RR DRUG	DOSE / ROUTE / INDICATION	PRESCRIBER (PRINT & SIGN) / MAX.FREQ.	STOPPED DATE: INITIALS: DATE:	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	DATE / TIME / DOSE / GIVEN BY	For Use Y/N; Qty:; Date:; Assessed by:; Ordered from Pharm.
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	SS DRUG	DOSE / ROUTE / INDICATION	PRESCRIBER (PRINT & SIGN) / MAX.FREQ.	STOPPED DATE: INITIALS: DATE:	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	DATE / TIME / DOSE / GIVEN BY	For Use Y/N; Qty:; Date:; Assessed by:; Ordered from Pharm.
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	TT DRUG	DOSE / ROUTE / INDICATION	PRESCRIBER (PRINT & SIGN) / MAX.FREQ.	STOPPED DATE: INITIALS: DATE:	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	DATE / TIME / DOSE / GIVEN BY	For Use Y/N; Qty:; Date:; Assessed by:; Ordered from Pharm.
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	VV DRUG	DOSE / ROUTE / INDICATION	PRESCRIBER (PRINT & SIGN) / MAX.FREQ.	STOPPED DATE: INITIALS: DATE:	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	DATE / TIME / DOSE / GIVEN BY	For Use Y/N; Qty:; Date:; Assessed by:; Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

2104673933
SHAW M
Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

Name

CHI No

Drug Allergies / Sensitivities **None Known** ☐ **Yes** ☑ **(provide details below)**

Amoxicillin

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

Warning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed by a doctor.

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

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).

2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).

3. Print & Sign your full name clearly against each prescription entry.

4. Time should be recorded in 24hr format e.g. 0600, 1800.

5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.

6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.

7. The following metric unit abbreviations must be used –

Milligram = mg | Gram = g
Millilitre = ml | Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

8. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - Intrathecal **must be written in full.**

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.

2. Insert initials in the relevant date column and time row each time a drug is administered.

3. Check that all drugs prescribed at a certain time have been administered.

4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

(3) Patient refused
(4) Drug not available
(5) Nil by mouth/fasting
(6) Patient unavailable
(7) Patient asleep
(8) Time varied on doctor's instructions
(9) Dose withheld on doctor's instructions
(10) Nausea/vomiting
(11) Unable to swallow
(12) No intravenous access
(13) Patient Self-Administration of Medicine
(14) Other - Record in nursing notes
(15) Prescription clarification required

Cat. No. 40995 Ver 4, 09/2010 GGC0029

MEDICINE | **PRESCRIPTION FORM** | Hospital Name: .....

MEDICINES RECONCILIATION

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

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

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the symptomatic relief policy & local protocol:

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

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

PATIENT DETAILS

Hospital Number: 2104673933 SHAW Andrew Martin 21/04/1967	Height:
DOB:	Weight:
	Surface area:
Date of Admission: __/__/__	Ward:
Consultant Name:	

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
14/8	CHLORPHENAMINE	4mg	O	12:43			16:00
15/8	MORPHINE (TITRATE)	1-10mg	I.V.	21:30	G. MILNER	5mg given	Gm/Rn 21:40
15/8	METOCLOPRAMIDE	10mg	I.V.	21:40	G. MILNER	* NOT GIVEN *	
15/8	OXYCODEH	5mg	Oral	21:40	G. MILNER		21:40
15/8	CHLORPHENAMINE	4mg	oral	22:00	G. MILNER		22:05
16/8	Chlorphenamine	4mg	Oral	1445	R. BOWGEN		1534

TARGET OXYGEN SATURATIONS

Please CIRCLE a target saturation and prescribe oxygen on the Regular Prescription section.

94 – 98%	88– 92% (e.g. in hypercapnic respiratory failure)	Other (please specify)

On Home Oxygen? Yes / No _____ L/min

DATE: _____/_____/_____ PRESCRIBER (PRINT & SIGN): _____

	DATE	11																							
	MONTH	8																							

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

IS DRUG THROMBOPROPHYLAXIS INDICATED?	Y / N
ARE ANTIEMBOLISM STOCKINGS INDICATED?	Y / N
SIGNATURE OF ASSESSOR	
ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N	

Parenteral Drugs : Regular Prescription

Patient's Own Medicine

A DRUG: CEFTRIAXONE

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE: 2g | ROUTE: IV | DATE: 10/8 | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN):

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

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

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

B DRUG: Ascaptar

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE: 800 | ROUTE: IV | DATE: 10/8 | STOPPED DATE: 11/8 | INITIALS:

PRESCRIBER (PRINT & SIGN):

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

Other time	0700-0900	1200-1400	1600-1800	2200-2400	Other time
	X				20

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

C DRUG: Aciclovir

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☑

DOSE: 890mg | ROUTE: IV | DATE: 10/8/20 | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN): Dr FITZPATRICK PR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: 10mg/kg IBW estimate

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

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

REVIEW THE NEED FOR IV ANTIBIOTIC DAILY. SWITCH TO ORAL THERAPY AS SOON AS POSSIBLE (SEE IVOST POLICY)

TDS

Parenteral Drugs: Regular Prescription

DATE → 11 12 13 14 15 16 17 18 19 20 21 22 23 24
MONTH → 6 8 8 8 8 8 8 8 8 8 8 8 8 8

Patient's Own Medicine

D DRUG CLEXANE.
DOSE 40mg | ROUTE SC | DATE 11/8/20 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN) MCCLYMONT FY2
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☑
Other time 0700-0900 1200-1400 1600-1800 2200-2400 Other time
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

E DRUG
DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN)
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐
Other time 0700-0900 1200-1400 1600-1800 2200-2400 Other time
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

F DRUG
DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN)
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐
Other time 0700-0900 1200-1400 1600-1800 2200-2400 Other time
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

G DRUG
DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN)
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐
Other time 0700-0900 1200-1400 1600-1800 2200-2400 Other time
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE → 11 12 13 14 15 16 17 18 19 20 21 22 23 24
MONTH → 8 8 8 8 8 8 8 8 8 8 8 8 8 8

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

Patient's Own Medicine — For Use Y/N; Qty:; Date:; Assessed by:; Ordered from Pharm.

H
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐
DRUG: Paracetamol
DOSE: 1g | ROUTE: O | DATE: 11/8/20
PRESCRIBER (PRINT & SIGN):
STOPPED DATE: 11/8 INITIALS: LM
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: & LIQUID SUSPENSION PRN

J
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐
DRUG: CO-codamol
DOSE: 30/500 ~~x2~~ | ROUTE: PO | DATE: 11/8
PRESCRIBER (PRINT & SIGN):
STOPPED DATE: 15/11/08 INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

K
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☑
DRUG: OMEPRAZOLE
DOSE: 20mg | ROUTE: PO | DATE: 14/8/20
PRESCRIBER (PRINT & SIGN): C-LUCEY
STOPPED DATE: INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

L
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐
DRUG: DIHYDROCODEINE
DOSE: 60mg | ROUTE: PO | DATE: 15/11/06
PRESCRIBER (PRINT & SIGN):
STOPPED DATE: 19/08 INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE: 19 20 21 22 23 24 25
MONTH: 8 8 8 8 8 8 8

M
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☑
DRUG: DIAZEPAM
DOSE: 10 mg | ROUTE: PO | DATE: 19/08 ~~FOS~~
PRESCRIBER (PRINT & SIGN): R MAYWAH
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: As per Addictions - pg 22 Guidelines
STOPPED DATE: INITIALS:
Other time / 0700-0900 / 1200-1400 / 1600-1800 / 2200-2400 / Other time

N
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐
DRUG: DIAZEPAM
DOSE: 5mg | ROUTE: PO | DATE: 22/8
PRESCRIBER (PRINT & SIGN): Patrick Breen (PATRICK BREEN)
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
STOPPED DATE: 22/8 INITIALS: PB
Other time / 0700-0900 / 1200-1400 / 1600-1800 / 2200-2400 / Other time

P
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐
DRUG: DIAZEPAM
DOSE: 5mg | ROUTE: PO | DATE: 22/8
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: BD for 7
STOPPED DATE: 24/8/08 INITIALS:
Other time / 0700-0900 / 1200-1400 / 1600-1800 / 2200-2400 / Other time

R
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐
DRUG: DIAZEPAM
DOSE: 5mg | ROUTE: PO | DATE: 24/8
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: BD for 1/7
STOPPED DATE: INITIALS:
Other time / 0700-0900 / 1200-1400 / 1600-1800 / 2200-2400 / Other time

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

S DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

T DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

V DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

W DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

X DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

All Routes: As Required Prescriptions

Patient's Own Medicine

BEFORE ADMISSION	NEW DOSE	NEW MEDICATION	DRUG	DOSE	ROUTE	INDICATION	PRESCRIBER (PRINT & SIGN)	MAX. FREQ.	DATE	STOPPED DATE	STOPPED INITIALS	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
☐	☐	☑	LL PARACETAMOL	1000mg	O	PAIN	MCILMOYL FY2	4x DAILY	11/8/20		PM						
☐	☐	☐	MM CODEINE	30mg	O	PAIN	MCILMOYL FY2	4x DAILY	11/8/20	11/8	LM						
☐	☐	☑	NN MORPHINE	2.5-5mg	SC	PAIN	MCILMOYL FY2	4x DAILY	11/8/20	11/9	LM						
☐	☐	☑	PP CYCLIZINE	50mg	IV/O	NAUSEA	MCILMOYL FY2	3x DAILY	11/8/20								

	11/8																							
DATE																								
TIME	2045																							
DOSE	30mg																							
GIVEN BY	LM																							

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

| | | |

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

Warning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed by a doctor.

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
1/8	Paracetamol						

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).
2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).
3. Print & Sign your full name clearly against each prescription entry.
4. Time should be recorded in 24hr format e.g. 0600, 1800.
5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.
6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.
7. The following metric unit abbreviations must be used –

Milligram = mg — Gram = g
Millilitre = ml — Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full.**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

8. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - Intrathecal **must be written in full.**

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.
2. Insert initials in the relevant date column and time row each time a drug is administered.
3. Check that all drugs prescribed at a certain time have been administered.
4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

(3) Patient refused	(7) Patient asleep	(11) Unable to swallow	(14) Other - Record in nursing notes
(4) Drug not available	(8) Time varied on doctor's instructions	(12) No intravenous access	(15) Prescription clarification required
(5) Nil by mouth/fasting	(9) Dose withheld on doctor's instructions	(13) Patient Self-Administration of Medicine	
(6) Patient unavailable	(10) Nausea/vomiting		

Cat. No. 40995 Ver 4, 09/2010 GGC0029

Patient name: 2104673933
Date of birth: SHAW Andrew, M 21/04/1967 M
CHI No: 30 DOUGLAS DRIVE EAST KILBRIDE Glasgow, Lanarkshire G75 8JS

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg) ..... Height (cm) .....

Prescription details									Administration details				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments
11/8/25	07[20]	(N) Saline	1000mls	IV	4°		CATRIONA		11/08/25	0300	EH		
		0.9% NaCl	5ml	IV	4°				11/8	0710	GB		
11/8		Hartmanns	500	IV	6°				11/10	1650	PG	CO	
11/8		Hartmanns	500	IV	6°								

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

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow (drops/min) = Volume of fluid (ml) x 20 / Duration of admin (min)

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

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

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

SCAN WITH ANY POA/GUARDIANSHIP PAPERWORK UNDER LEGAL NOTICES ON DISCHARGE

NHS Greater Glasgow and Clyde

Sticker or Name, DOB, CHI and address
ANDREW SHAW.
2104673933.

Ward HDU 6.

Date completed 11/8/20.

Date revoked _____

Capacity Documentation For Medical Treatment

Section A - Assessment of Capacity

Capacity is assumed unless there is evidence of incapacity

☑ I believe that this person has attained the age of 16 and lacks capacity with regards to the proposed interventions because of mental disorder or inability to communicate because of physical disability. This is because they are unable to: (tick at least one of the following)

- ☐ Understand that a decision about the proposed treatment is required
- ☑ Believe, understand when presented in appropriate language, retain memory of, or weigh and balance information about the proposed treatment
- ☐ Communicate a decision, including with help of mechanical or other aids
- ☑ Understand appropriately the benefits, risks and alternatives including the consequences of not receiving the proposed treatment
- ☐ Reasonably recall the previous making of a decision about treatment

If the person lacks capacity consider whether they may be a vulnerable adult – if so refer Social Work

Section B – Welfare Attorney/Guardian

I have made reasonable enquiries to ascertain if anyone has been appointed as Welfare Guardian/Attorney or holds an intervention order for this patient and:

☑ I believe that no one has been appointed. If so the nearest relative should be consulted.

OR

☐ I believe that the undernoted has been appointed. If so then consent must be sought from them if possible.

Name: _____

Contact Details: _____

If there is a Welfare Guardian/Attorney please obtain a photocopy of the document and file in the clinical record (may be available on Clinical Portal – if not ask the Welfare Attorney/Guardian)

☐ requested Signed _____ Date _____ ☐ obtained Date _____

To revoke a statement of incapacity, score through and date the above box and the Section 47

ADULTS WITH INCAPACITY
(SCOTLAND) ACT 2000

Certificate of Incapacity under Section 47 of the Adults with Incapacity (Scotland) Act 2000

I PAUL MCLYMONT (name)

of THE QUEEN ELIZABETH UNIVERSITY HOSPITAL, 1345 GOVAN ROAD, GLASGOW (address)

*am the medical practitioner primarily responsible for the medical treatment of; or

*am a person who is *a ~~dental practitioner/an ophthalmic optician/a registered nurse~~ and who satisfies such requirements as are prescribed by the Adults with Incapacity (Requirements for Signing Medical Treatment Certificates) (Scotland) Regulations 2007 and who is primarily responsible for treatment of the kind in question of:

ANDREW SHAW (name)

of 30 DOUGLAS DRIVE, EAST KILBRIDE, G75 8DS (address) 2 0 0 4 6 7 (date of birth)

for whom the *guardian/welfare attorney/person appointed by intervention order/nearest relative/carer

is

I have examined the patient named above on 0 0 0 8 2 0 (date). I am of the opinion that *he/she is incapable within the meaning of the Adults with Incapacity (Scotland) Act 2000 ("the 2000 Act") in relation to a decision about the following medical treatment:

MEDICAL & NURSING CARE.

because of (nature of incapacity) DELIRIUM THAT IS LIKELY DRUG-INDUCED.

This incapacity is likely to continue for 1 WEEK. months.

*I therefore consider it appropriate for the authority conferred by section 47(2) of the 2000 Act to subsist from:

0 0 0 8 2 8 (date of examination) until 0 8 0 8 2 0, being a period which does not exceed one year from the *date of the examination on which this certificate is based/date of revocation of the certificate issued previously by me; or

*I am of the opinion that (a) *he/she is suffering from *a severe or profound learning disability/dementia/a severe neurological disorder; and (b) *what he/she is suffering from is unlikely to improve within the meaning of the Adults with Incapacity (Conditions and Circumstances Applicable to Three Year Medical Certificates) (Scotland) Regulations 2007/ Y Y and therefore consider it appropriate for the authority conferred by section 47(2) of the 2000 Act to subsist until:

D D M M Y Y being a period which does not exceed three years from the *date of the examination on which this certificate is based/date of revocation of the certificate issued previously by me.

The authority conferred by section 47(2) of the 2000 Act shall subsist for the period specified above or until such earlier date as this certificate is revoked.

In assessing the capacity of the patient, I have observed the principles set out in section 1 of the 2000 Act.

Signed Paul McLymont Date 0 0 0 8 2 0

*delete as appropriate

Section D Treatment plan

for patients receiving ongoing treatment under the terms of part 5 of the Adults with Incapacity (Scotland) Act 2000

You must tick both boxes to continue

☐ I have examined the patient named above on (date) 11/8/20 and consider that he/~~she~~ needs to undergo procedures to safeguard or promote physical or mental health in relation to the treatment plan below. I have assessed his/~~her~~ capacity to consent to treatment in relation to each area of intervention

☐ I have no reason to believe that any of the proposed treatments are contrary to wishes expressed by the patient, even when they had greater capacity, or to views that are consistent with their moral, cultural, family and experiential back ground

Signature Paul McClymont Print PAUL MCCLYMONT Designation/Grade FY2

Disorder/Intervention (see note A)	Date	Capacity (C = capable I = Incapable)
1. Fundamental healthcare procedures including all measures to support the following: Nutrition, hydration, hygiene, skin care and integrity, elimination, relief of pain and discomfort, mobility, communication, eyesight, hearing and simple oral hygiene.	11/8/20	I
2. Prevention and treatment of infection	N/A 11/8/20	
3 Prevention of Deep Venous Thrombosis	N/A at present.	
4. AHP interventions	C	
5. Continuing management of existing long term conditions Please specify conditions	N/A.	
6. RADIOLOGICAL IMAGING	11/8/20	I

Remember that some treatments require to be named specifically on the treatment plan. These include sedation for agitation, and any treatment which usually requires verbal consent. Covert medications must be named on the treatment plan and also require their own care plan (download from Mental Welfare Commission website). This list is not exhaustive. Section 47 does not cover discharge planning or deprivation of liberty.

Any treatment which would usually require signed consent requires a separate certificate of incapacity.

Member of staff consulting family/carers to sign:

I have discussed with the patient's representative as below

Welfare Guardian/ Power of Attorney (if one appointed):

☐ Name _____ Relationship _____ OR

Relative/ Carer/ Other individual most involved in persons care (if no Welfare Guardian/Power of Attorney):

☐ Name _____ Relationship _____

Signed _____ Print _____ Date _____

If additional items added to the treatment plan they must be discussed separately
All additional section 47 forms to be attached at section C

ADULTS WITH INCAPACITY (SCOTLAND) ACT 2000

This plan is intended to guide healthcare professionals who are caring for patients who have multiple and complex needs. It should be attached to a certificate of incapacity and retained in the patient's multidisciplinary case record.

A. Under the Act, you can only intervene if it will benefit the patient. Your intervention must be the least restrictive in relation to the patient's freedom in order to achieve the required benefit. You must take the patient's view into account and you must consult other relevant people, where reasonable and practicable.
Include all present or foreseeable disorders and/or interventions for physical and mental disorders not included in "Fundamental Healthcare Procedures" (see note B). You should consider the patient's capacity to consent to each intervention. Under the Act, the patient is incapable if he/she is incapable of acting, or making decisions, or communicating decisions, or understanding decisions, or retaining the memory of decisions.
Exclude all interventions that require express (signed) consent of the patient. Interventions of this sort need a separate certificate of incapacity. *For example, if you write "coronary heart disease and hypertension" on the plan, this authorises you to prevent disease with aspirin, or treat disease with anti-hypertensive drugs, but not operate or bypass blocked arteries.*

You may not include on this form any treatment regulated under section 48 of the Act. Please consult the regulations and separate guidance issued on these treatments. These treatments are:

Sterilisation where there is no serious malfunction or disease of the reproductive organs
Surgical implantation of hormones for the purpose of reducing sex drive
Drug treatment for the purpose of reducing sex drive, other than surgical implantation of hormones
Electro-convulsive therapy (ECT) for mental disorder
Abortion
Any medical treatment which is considered likely by the medical practitioner primarily responsible for that treatment to lead to sterilisation as an unavoidable result.

B. Fundamental healthcare procedures include all measures to promote or safeguard the following: nutrition, hydration, hygiene, skin care and integrity, elimination, relief of pain and discomfort, mobility, communication, eyesight, hearing and simple oral hygiene.

C. The Act requires you to take the views of others into account when deciding on an intervention. You should discuss this plan with professional carers and relatives of the patient. Any person with an interest in the welfare of the patient may appeal a treatment decision to the Sheriff. If the patient has a Welfare Attorney or Guardian with the authority to consent to treatment, you must consult this person where reasonable and practical. You can find out if your patient has a Welfare Attorney or Guardian by contacting the Public Guardian on 01324 678300. If this person disagrees with any element of your plan, you must refer to the Code of Practice for details of the dispute resolution process by the Mental Welfare Commission for Scotland, tel: 0131 313 8777.

D. Includes conditions diagnosed previously such as hypertension or diabetes. You may find that you need to treat a condition that is not specified in your treatment plan. If this is a short lived condition, a separate certificate in relation to it might suffice. If it is a condition that is likely to need ongoing intervention, you should consider rewriting the treatment plan.
The treatment plan is only valid for the period specified in the certificate of incapacity. The maximum period is **one year** or three years where the patient suffers from a severe or profound learning disability; dementia; a severe neurological disorder and the condition is unlikely to improve.

SHAW, ANDREW ID: 2104673933 18-Nov-2020 16: 2 QUEEN ELIZABETH UNIVERSITY HOSPITAL

21-Apr-1967
Male

Vent. rate 72 bpm
PR interval 148 ms
QRS duration 96 ms
QT/QTc 398/435 ms
P-R-T axes 27 41 58

Normal sinus rhythm
Septal infarct, age undetermined
Abnormal ECG

Loc: 1368 Opt:

[redacted]

Technician:
Test ind:

Referred by:

2104673933
1 SHAW M
7 Andrew, M 21/04/196
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8J

Unconfirmed

100 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + 1 rhythm ld MAC55 0103 12SL™ v241

MQE 9402-024 © Graphic Controls Ltd Printed in UK

L 450 ms.
OK to start meds.

SHAW, ANDREW ID: 2104673933 18-Nov-2020 16: 3 QUEEN ELIZABETH UNIVERSITY HOSPITAL

21-Apr-1967
Male

Vent. rate .. bpm
PR interval 146 ms
QRS duration 96 ms
QT/QTc 394/443 ms
P-R-T axes 29 64 62

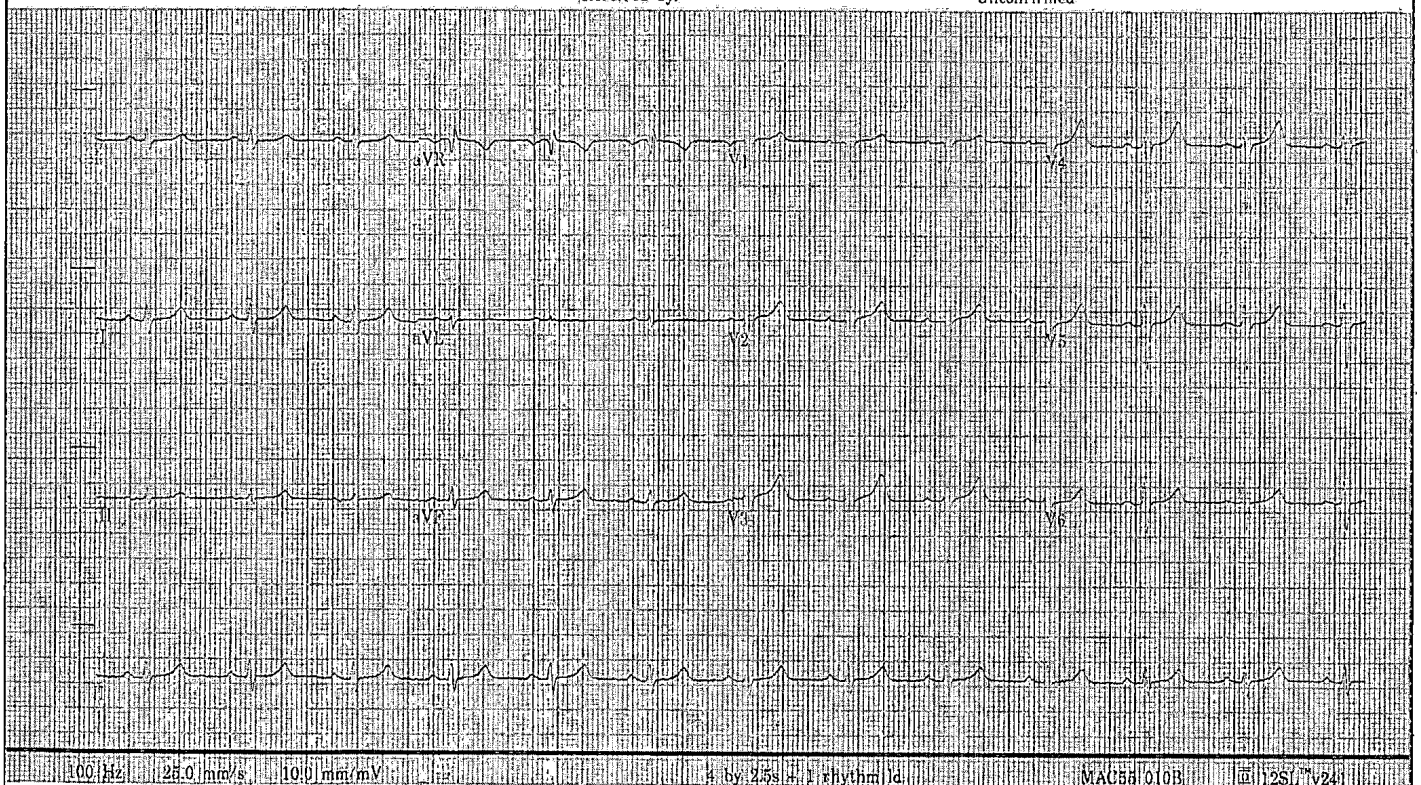
Normal sinus rhythm
Septal infarct, age undetermined
Abnormal ECG

Loc: 1368 Opt:

[redacted]

Technician:
Test ind:

Referred by: Unconfirmed



SHAW, ANDREW ID: 2104673933 18-Nov-2020 16:42:00 QUEEN ELIZABETH UNIVERSITY HOSPITAL

21-Apr-1967
Male

Loc: 1368 Opt:

[redacted]

Technician:
Test ind:

Vent. rate [illegible] bpm
PR interval 142 ms
QRS duration 98 ms
QT/QTc 394/434 ms
P-R-T axes 28 47 64

Normal sinus rhythm
Septal infarct, age undetermined
Abnormal ECG

Referred by:

Unconfirmed

100 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + 1 rhythm ld MAC55 010B 12SL v241

MQE-9402-024 Cmpic Controls Ltd Printed in UK

SHAW, ANDREW ID: 2104673933 15-Nov-2020 11:36:[illegible] QUEEN ELIZABETH UNIVERSITY HOSPITAL

Vent. rate	[illegible] bpm	mal sinus rhythm
PR interval	168 ms	ight axis deviation
QRS duration	80 ms	Anteroseptal infarct, age undetermined
QT/QTc	388/466 ms	Abnormal ECG
P-R-T axes	68 -130 66	

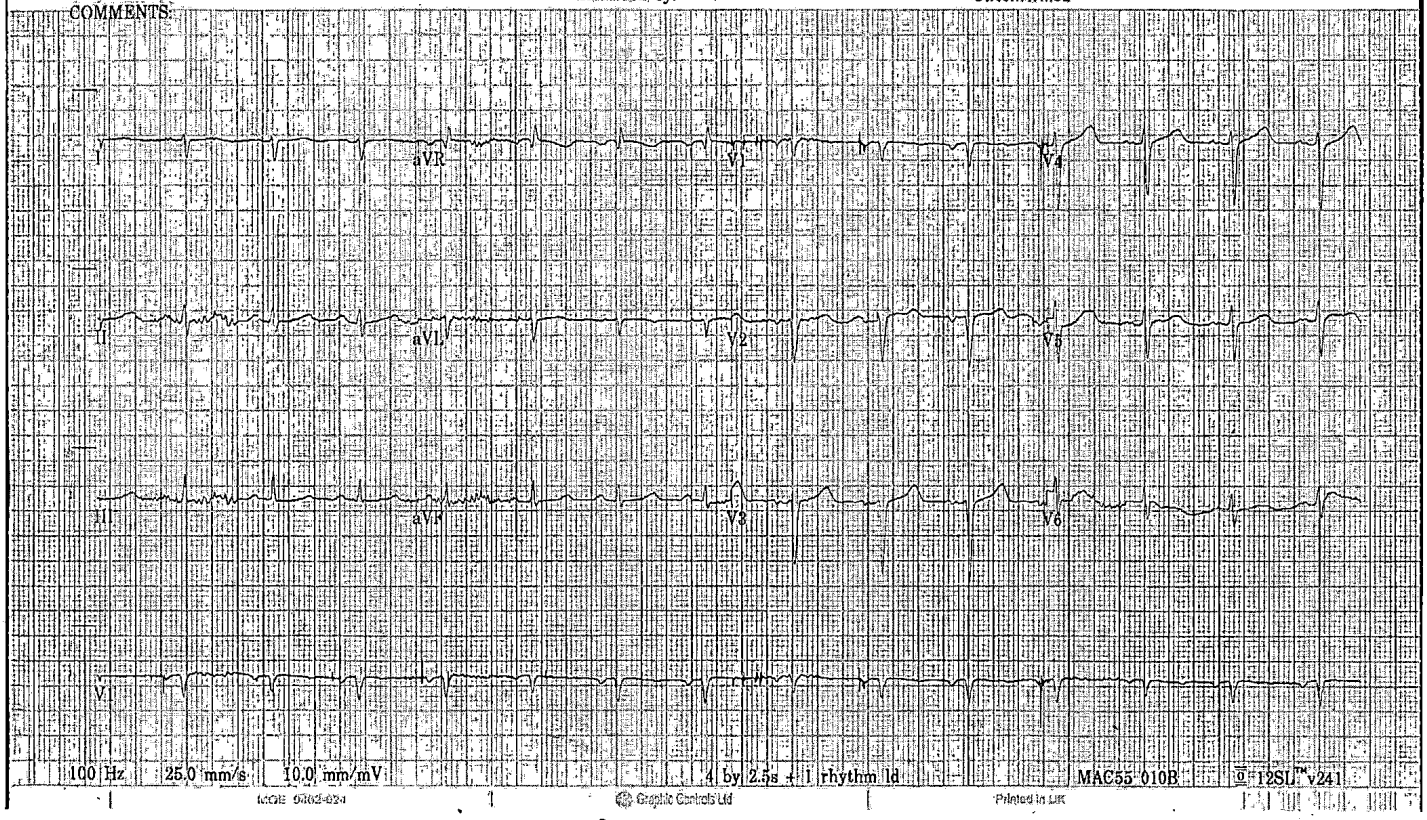
Loc: 1301

[redacted]

Technician:

Referred by: Unconfirmed

COMMENTS:



ID: 15-Aug-2020 21:22:28 SOUTH GLASGOW UNIVERSITY HOSPITAL

Vent. rate	7[illegible]	m
PR interval	15[illegible]	ms
QRS duration	84	ms
QT/QTc	382/435	ms
P-R-T axes	40 42 33	

Normal sinus rhythm
Septal infarct, age undetermined

Loc: 1362

[redacted]

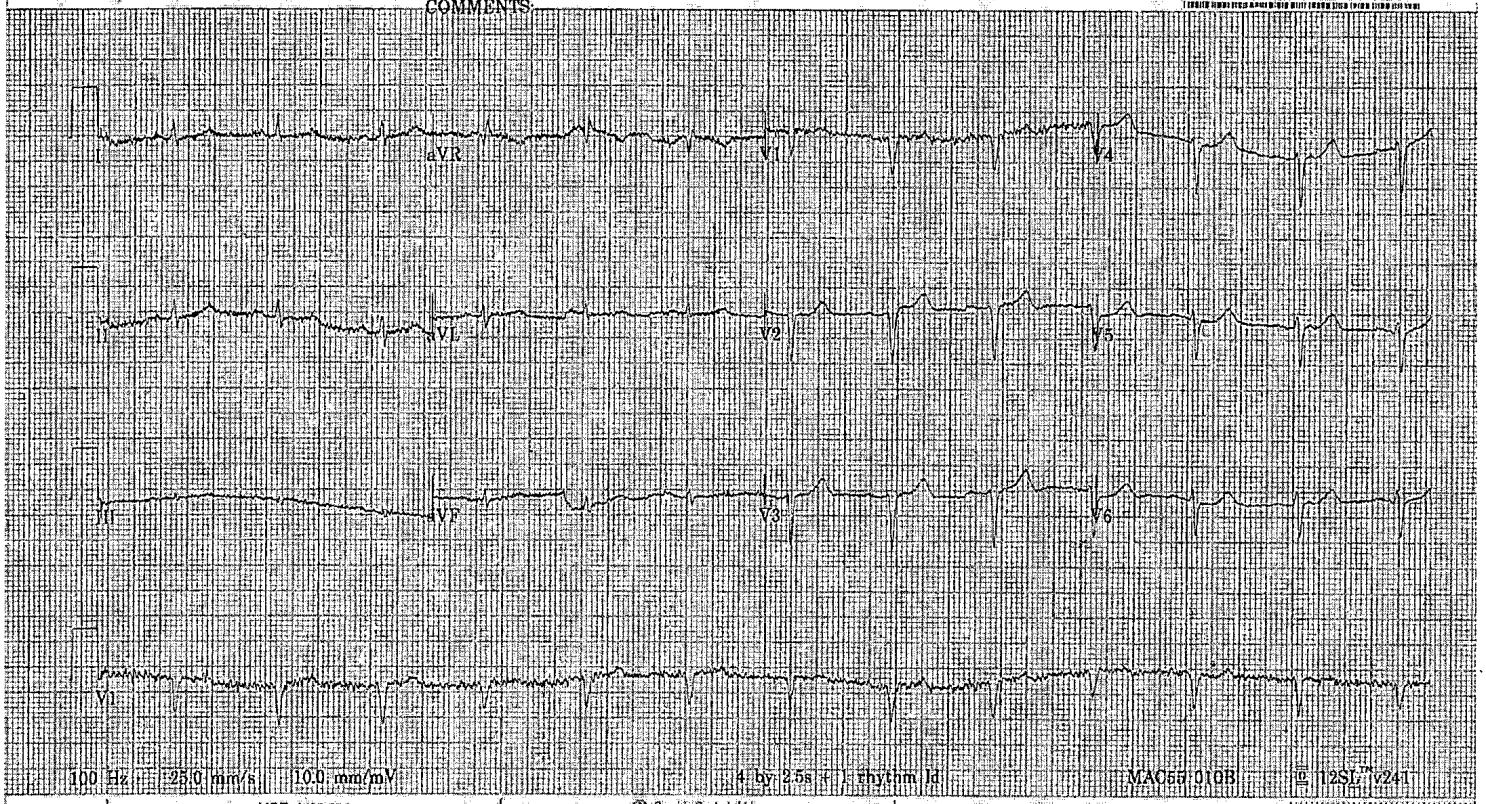
Technician:
Test ind:

2104673933
SHAW M
Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

Referred by:

Unconfirmed

COMMENTS:



100 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + 1 rhythm II MAC55 010B ® 12SL™ v241

MQE 9402-024 © Graphic Controls Ltd Printed in UK

ID: 15-Aug-2020 21:25:31 SOUTH GLASGOW UNIVERSITY HOSPITAL

Vent. rate	7	bm
PR interval	16v	ms
QRS duration	92	ms
QT/QTc	386/434	ms
P-R-T axes	43 98	55

Normal sinus rhythm
Rightward axis
Possible Anterior infarct, age undetermined

Loc: 1362

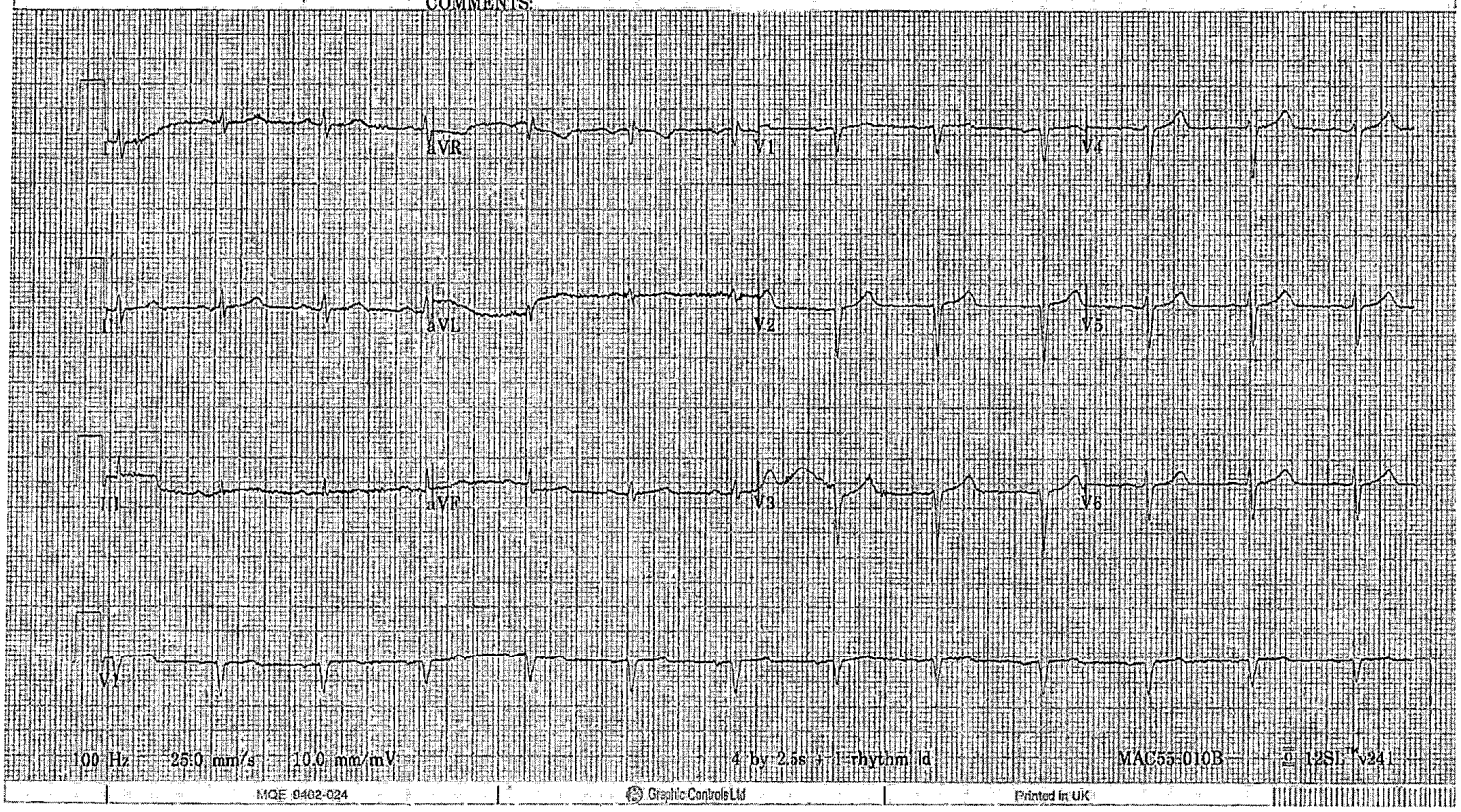
2104673933
SHAW
Andrew, M
M
21/04/1967

Technician:
Test ind:

Referred by:

Unconfirmed

COMMENTS:



100 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + 1 rhythm ld MAC55-010B 12SL v24

ID: 16-Aug-2020 21:25:45 SOUTH GLASGOW UNIVERSITY HOSPITAL

Vent. rate [redacted]
PR interval 154 ms
QRS duration 90 ms
QT/QTc 388/436 ms
P-R-T axes 49 90 43

Normal sinus rhythm
Rightward axis
Anterior infarct, age undetermined

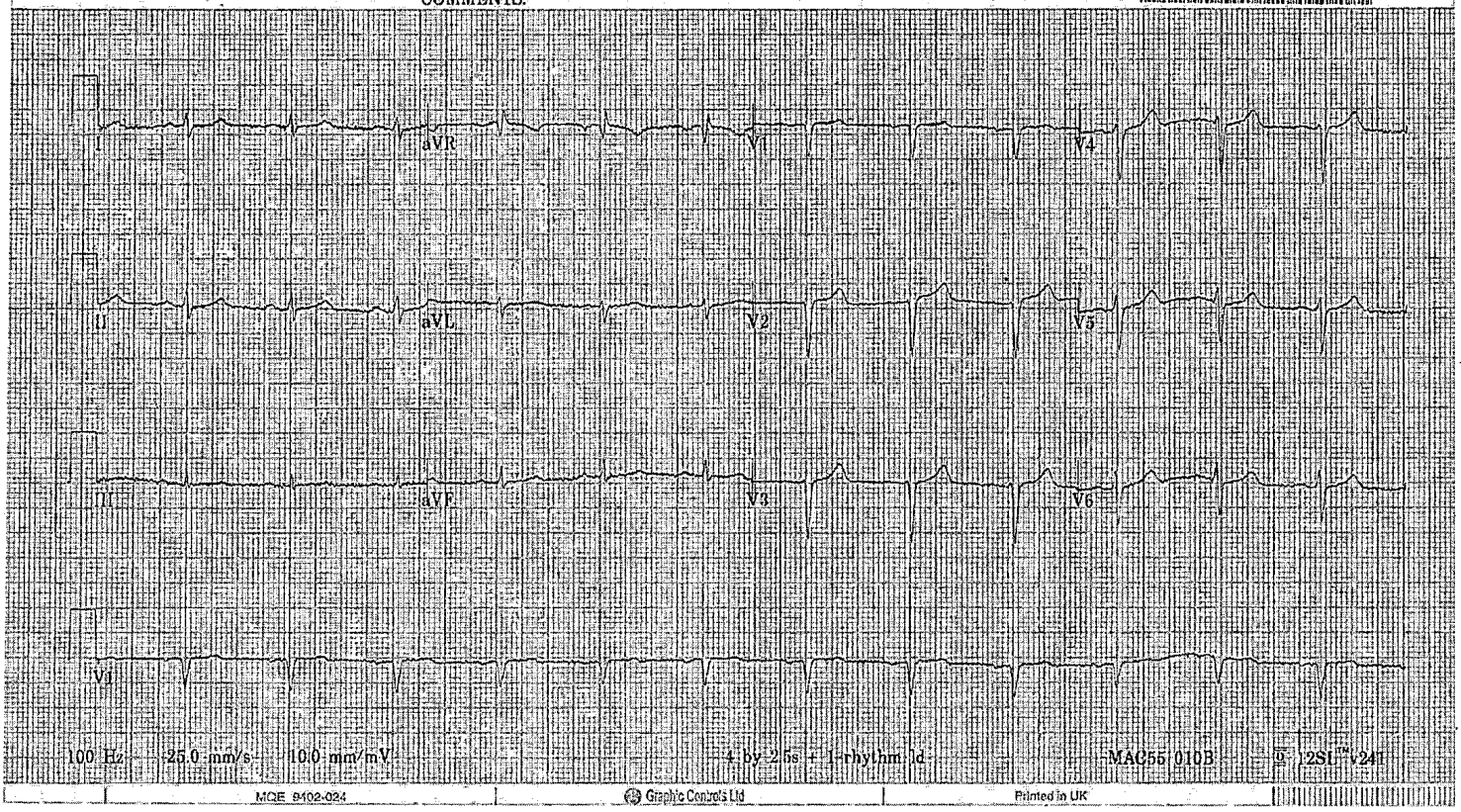
Loc: 1362

2104673933
SHAW M
Andrew, M 21/04/1957
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 0JJ

Technician: [redacted]
Test, ind:

Referred by: Unconfirmed

COMMENTS:



100 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + 1 rhythm ld MAC55 010B 12SL™ v241

Vent. rate 7[illegible] m
PR interval 14[illegible]
QRS duration 96 ms
QT/QTc 388/439 ms
P-R-T axes -3 125 33

*** Poor data quality, interpretatio[illegible] ay be adversely affected
Normal sinus rhythm
Right axis deviation
Low voltage QRS
Cannot rule out Anterior infarct, age undetermined

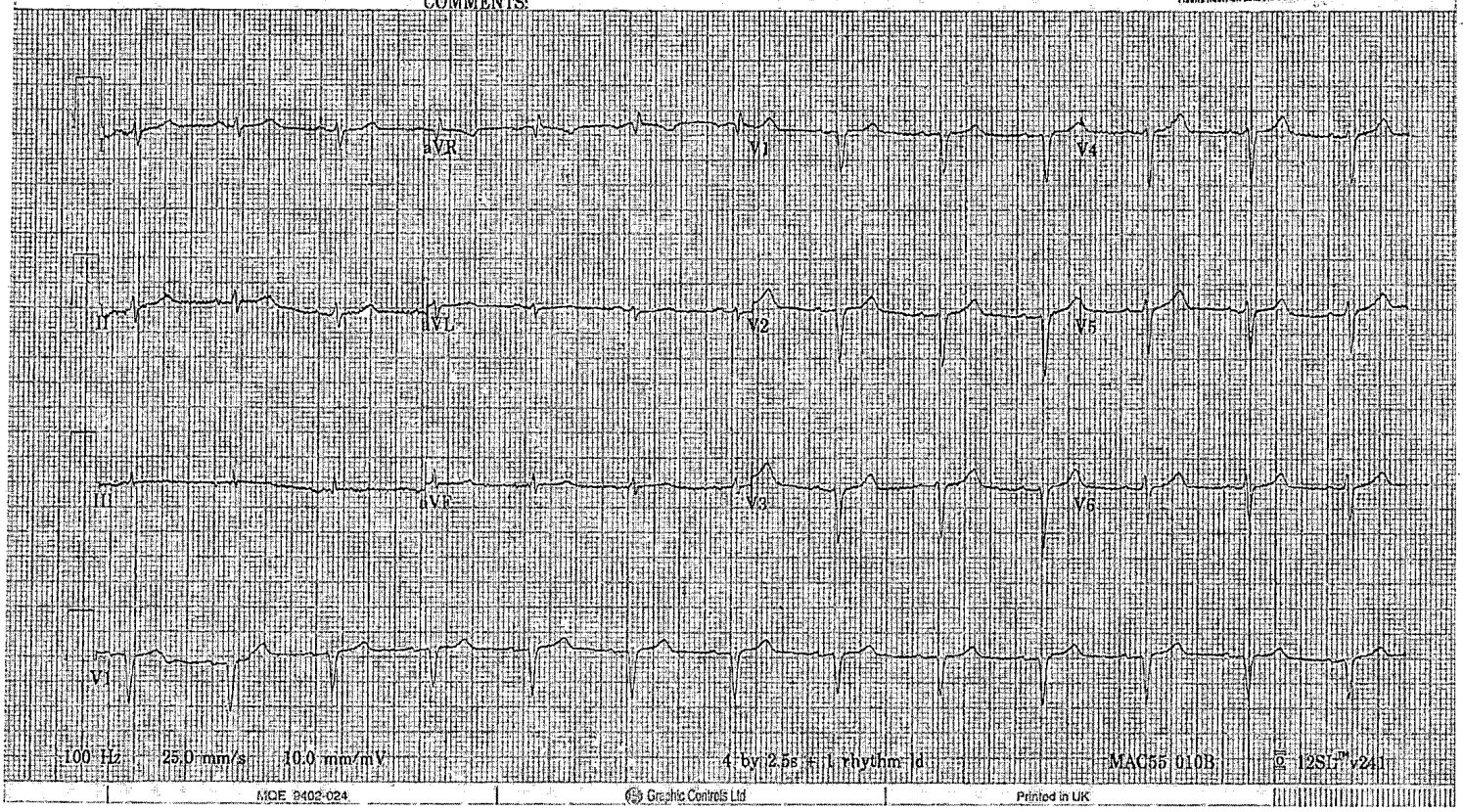
Loc: 1362

[redacted]
Technician:
Test ind:

2104673933
SHAW M
Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

Referred by: Unconfirmed

COMMENTS:



100 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + 1 rhythm Id MAC55 010B 12SL™ v241

MQE 9402-024 Graphic Controls Ltd Printed in UK

ID:

15-Aug-2020 21:49:21

SOUTH GLASGOW UNIVERSITY HOSPITAL

Vent. rate	7	bpm
PR interval	144	ms
QRS duration	96	ms
QT/QTc	386/440	ms
P-R-T axes	19 130	38

Normal sinus rhythm
Right axis deviation
Possible Anterior infarct, age undetermined

Loc: 1362

[redacted]

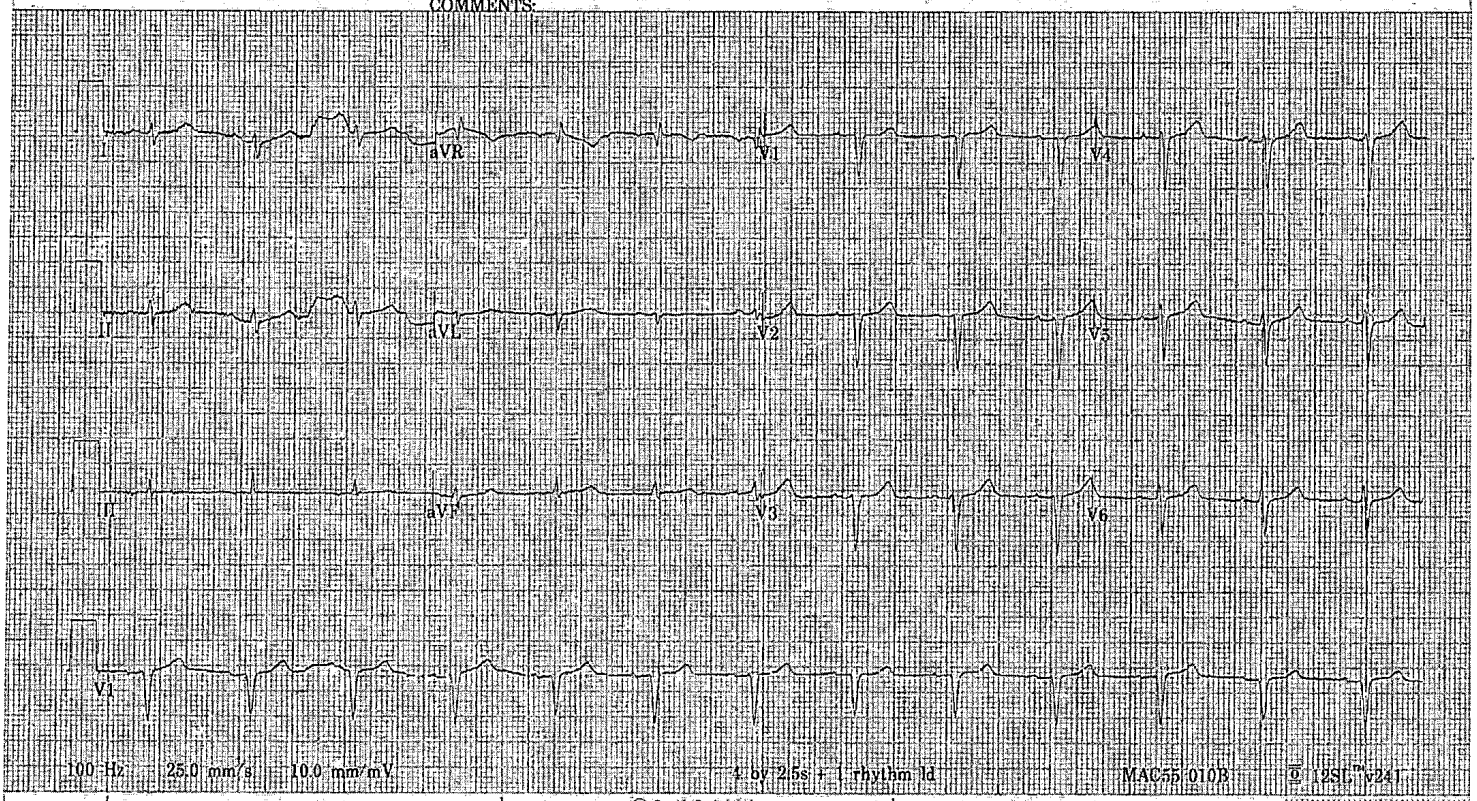
Technician:
Test ind:

2104673933
SHAW M
Andrew, M 21/04/1957
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

Referred by:

Unconfirmed

COMMENTS:



ID: 15-Aug-2020 21:49:42 SOUTH GLASGOW UNIVERSITY HOSPITAL

Vent. rate 7 m
PR interval 14
QRS duration 92 ms
QT/QTc 386/440 ms
P-R-T axes 5 121 38

Normal sinus rhythm
Right axis deviation
Possible Anterior infarct, age undetermined

Loc: 1362

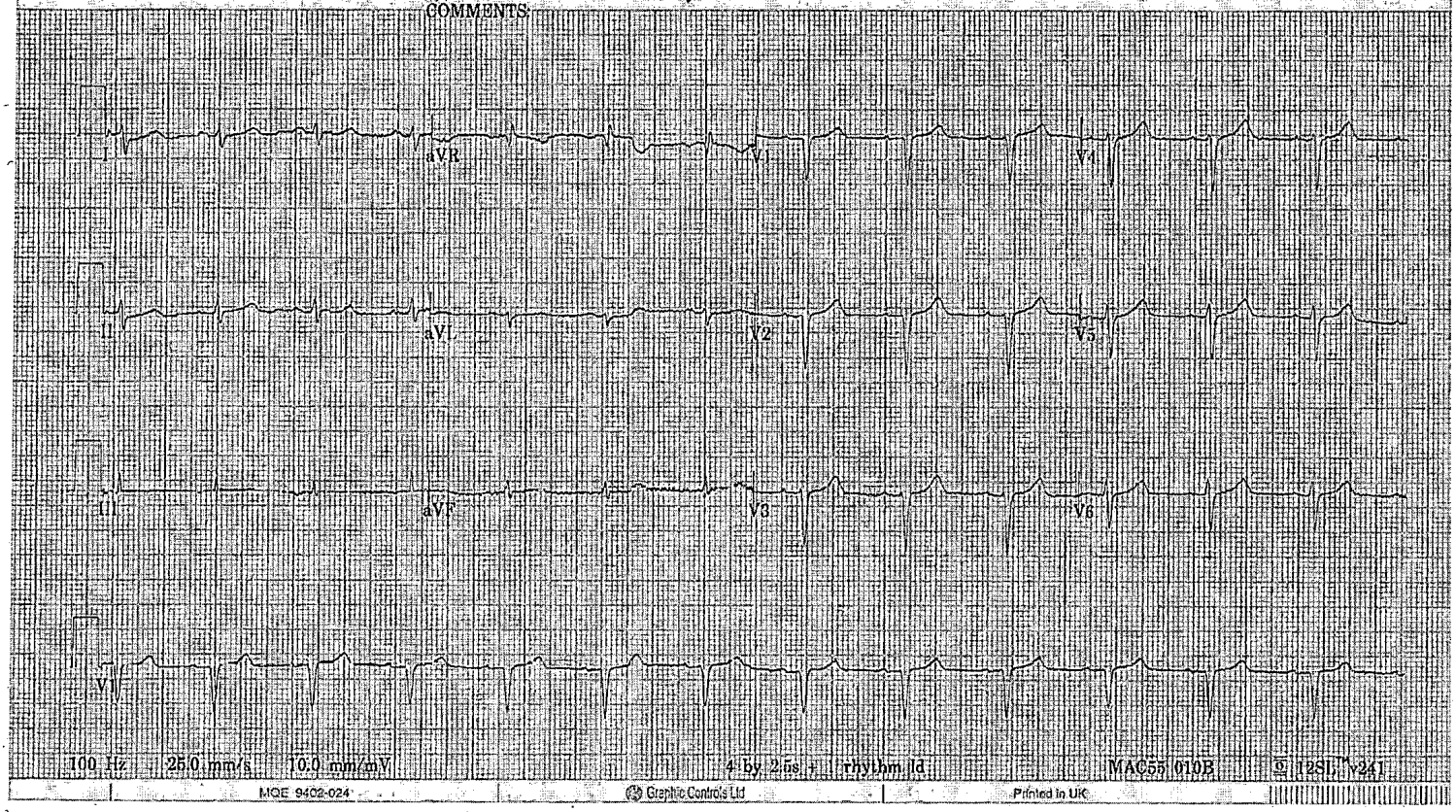
[redacted]

Technician:
Test ind:

2104673933
SHAW M
Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

Referred by: Unconfirmed

COMMENTS:



100 Hz 25.0 mm/s 10.0 mm/mV 4 by 2 ins rhythm ld MAC55 010B © 12SL v241

ID: 15-Aug-2020 21:40:57 SOUTH GLASGOW UNIVERSITY HOSPITAL

Vent. rate	7_ _m
PR interval	152 ms
QRS duration	94 ms
QT/QTc	386/436 ms
P-R-T axes	9 131 41

Normal sinus rhythm
Right axis deviation
Low voltage QRS
Cannot rule out Anterior infarct, age undetermined

Loc: 1362

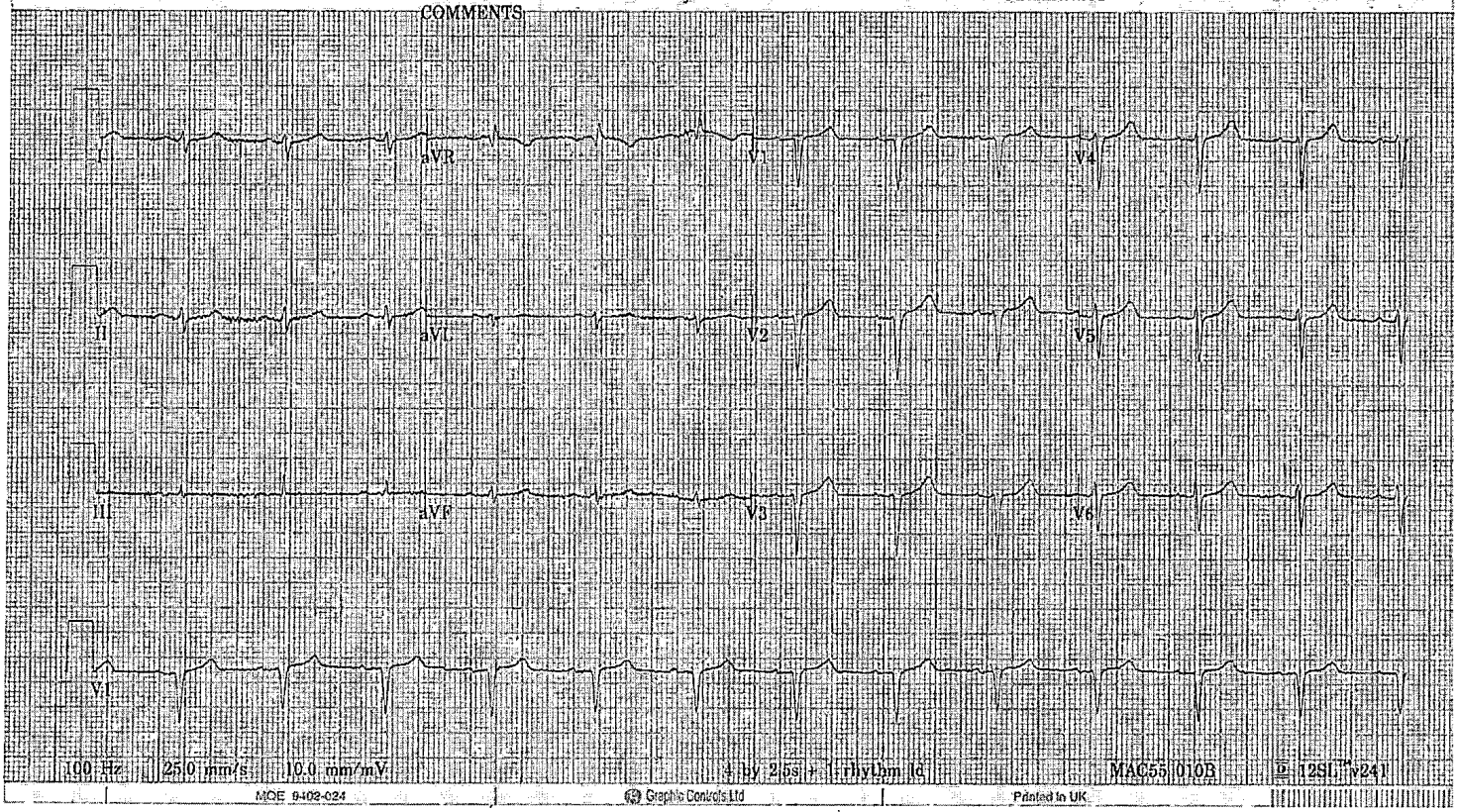
[redacted]

Technician:
Test ind:

2104673933
SHAW M
Andrew, M 21/04/1967

Referred by: Unconfirmed

COMMENTS



100 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + rhythm ld MAC55 010B 12SL v241

MOE 9402-024 Graphic Controls Ltd Printed in UK

ID: 14-Aug-2020 15:45:23 QUEEN ELIZABETH UNIVERSITY HOSPITAL

Vent. rate 71 m
PR interval 150 ms
QRS duration 92 ms
QT/QTc 384/428 ms
P-R-T axes 17 104 30

Normal sinus rhythm
Rightward axis
Borderline ECG

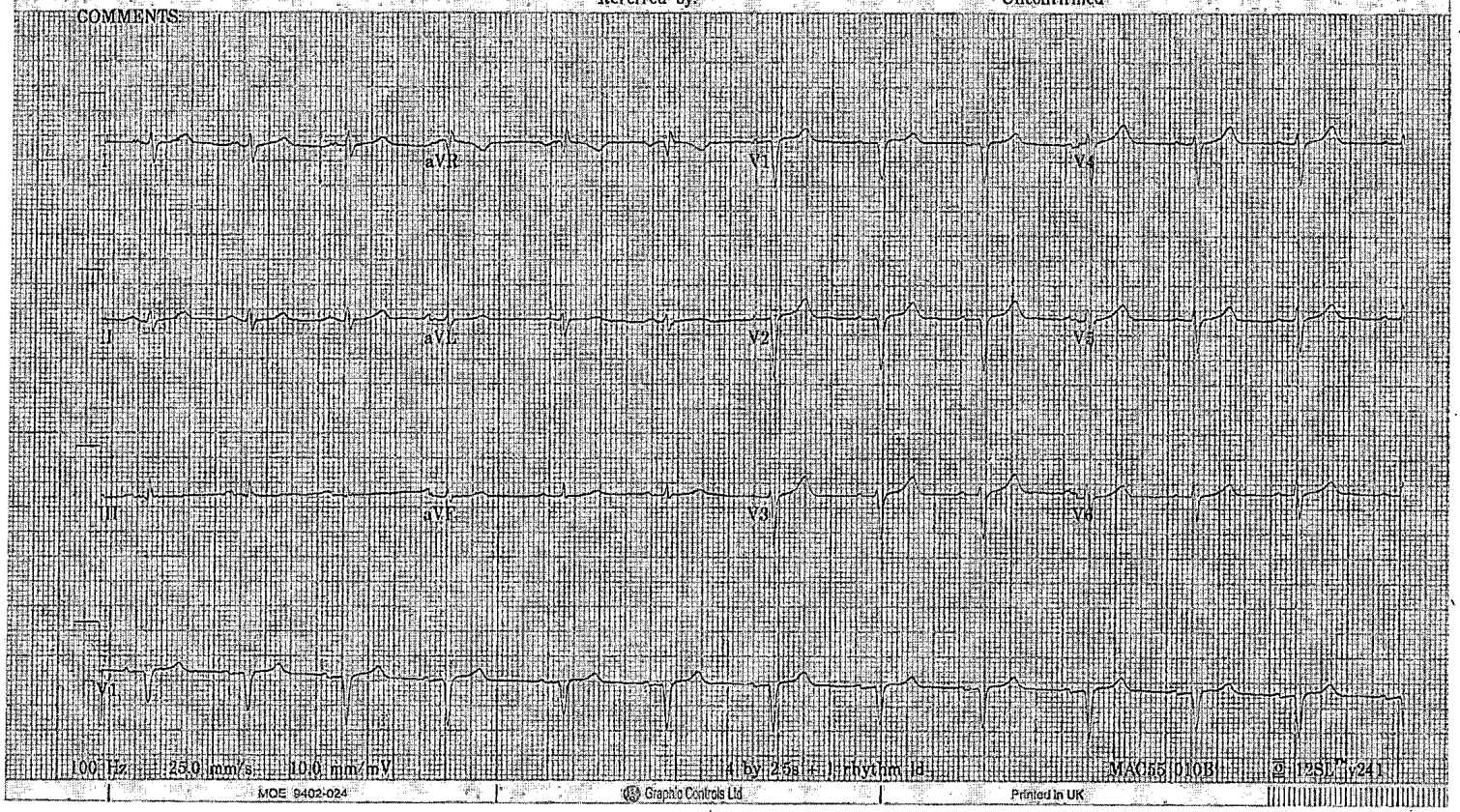
2104673933
SHAW M
Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

Loc: 1312 [redacted]

Technician:

Referred by: Unconfirmed

COMMENTS



100 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + rhythm II MAC55 010B 12SL v241

MOE 9402-024 Graphic Controls Ltd Printed in UK

SHAW, ANDREW ID: 14-Aug-2020 15:52:27 QUEEN ELIZABETH UNIVERSITY HOSPITAL

Male

Loc: 1312

[redacted] Technician:

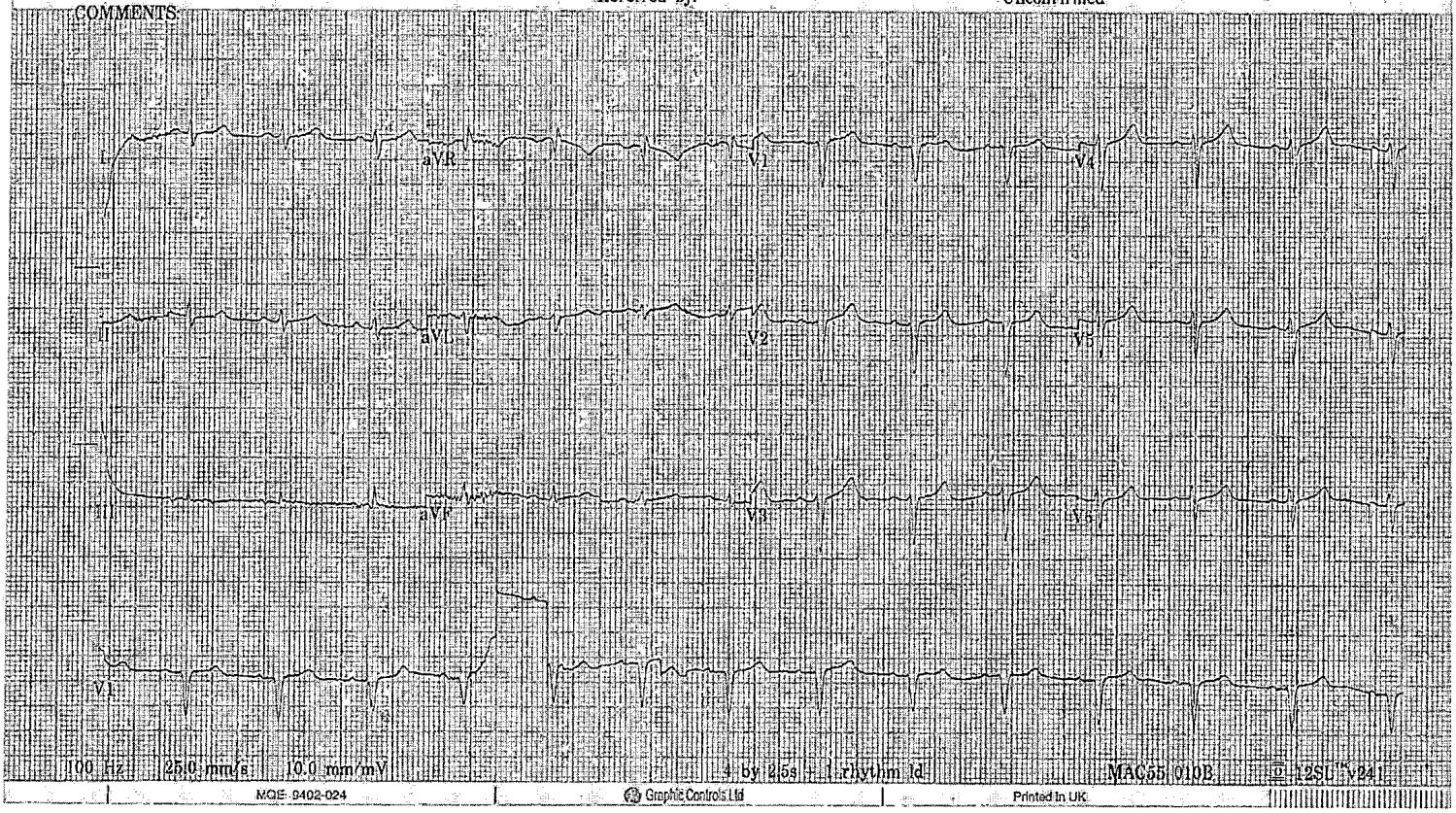
Vent. rate	8[illegible]	
PR interval	13[illegible]	ms
QRS duration	92	ms
QT/QTc	374/445	ms
P-R-T axes	17 111	18

Normal sinus rhythm
Right axis deviation
Abnormal ECG

2104673933 M
SHAW 21/04/1967
Andrew, M
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

Referred by: Unconfirmed

COMMENTS:



ID: 14-Aug-2020 8:35:58 EEN ELIZABETH UNIVERSITY HOSPITAL

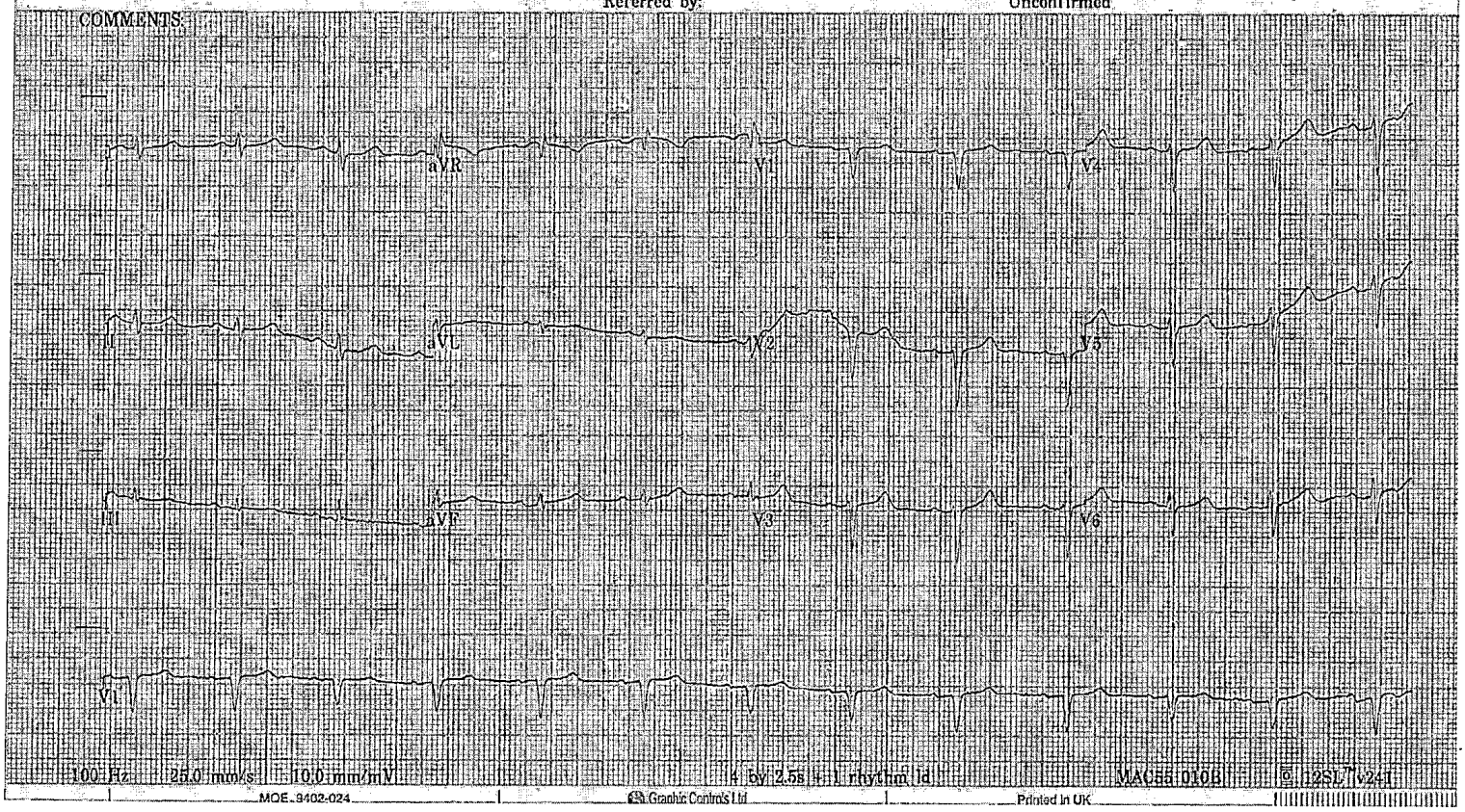
Vent. rate	76 m	Normal sinus rhythm
PR interval	164 ms	Rightward axis
QRS duration	92 ms	Septal infarct, age undetermined
QT/QTc	392/441 ms	Abnormal ECG
P-R-T axes	48 101 51	

Loc: 1312 [redacted]

Technician:

Referred by: Unconfirmed

COMMENTS:



ID: [redacted] 14-Aug-2020 16:1[redacted] QUEEN ELIZABETH UNIVERSITY HOSPITAL

Vent. rate 8[redacted] bpm
PR interval 150 ms
QRS duration 90 ms
QT/QTc 374/436 ms
P-R-T axes 40 112 29

[redacted]ormal sinus rhythm
[redacted]ight axis deviation
Septal infarct, age undetermined
Abnormal ECG

2104673933
SHAW M
Andrew, M 21/04/1967
30 DOUGLAS DRIVE
EAST KILBRIDE
Glasgow, Lanarkshire
G75 8JS

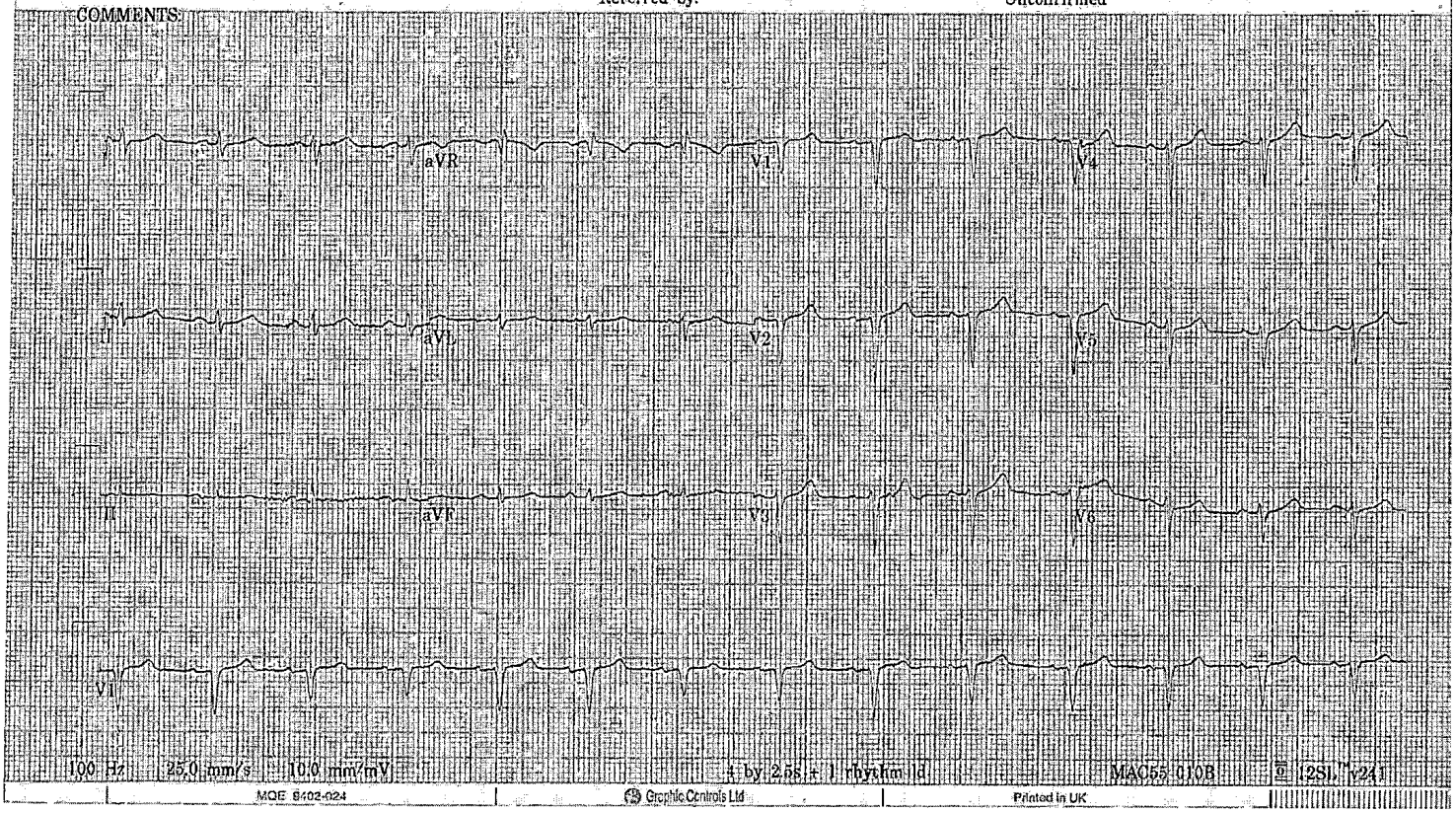
Loc: 1312 [redacted]

Technician: [redacted]

Referred by:

Unconfirmed

COMMENTS:



ID: 14-Aug-2020 8:36:41 QUEEN ELIZABETH UNIVERSITY HOSPITAL

Vent. rate	7	m	Normal sinus rhythm
PR interval	16	ms	Rightward axis
QRS duration	94	ms	Septal infarct, age undetermined
QT/QTc	390/447	ms	Abnormal ECG
P-R-T axes	52 104	11	

Loc: 1312

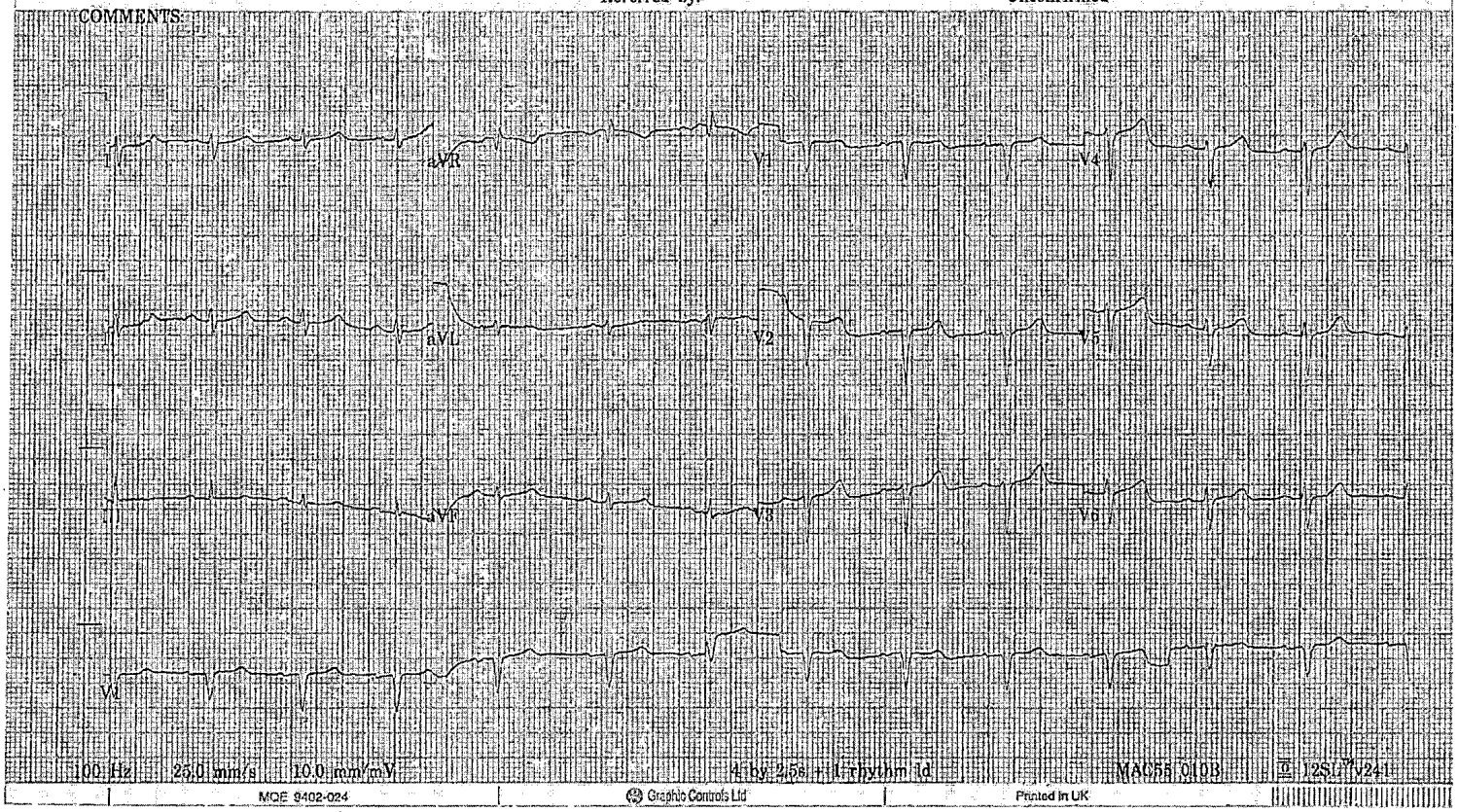
[redacted]

Technician:

Referred by:

Unconfirmed

COMMENTS:



100 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + 1 rhythm ld MAC55 0103 12SL v24.1

MQE 9402-024 Graphic Controls Ltd Printed in UK

SHAW, ANDREW ID: 18-Aug-2020 14:08:20 QUEEN ELIZABETH UNIVERSITY HOSPITAL

21-Apr-1967
Male

Loc: 1312

[redacted] Technician:

Vent. rate 7 m
PR interval 15_ _s
QRS duration 96 ms
QT/QTc 392/441 ms
P-R-T axes 5 133 42

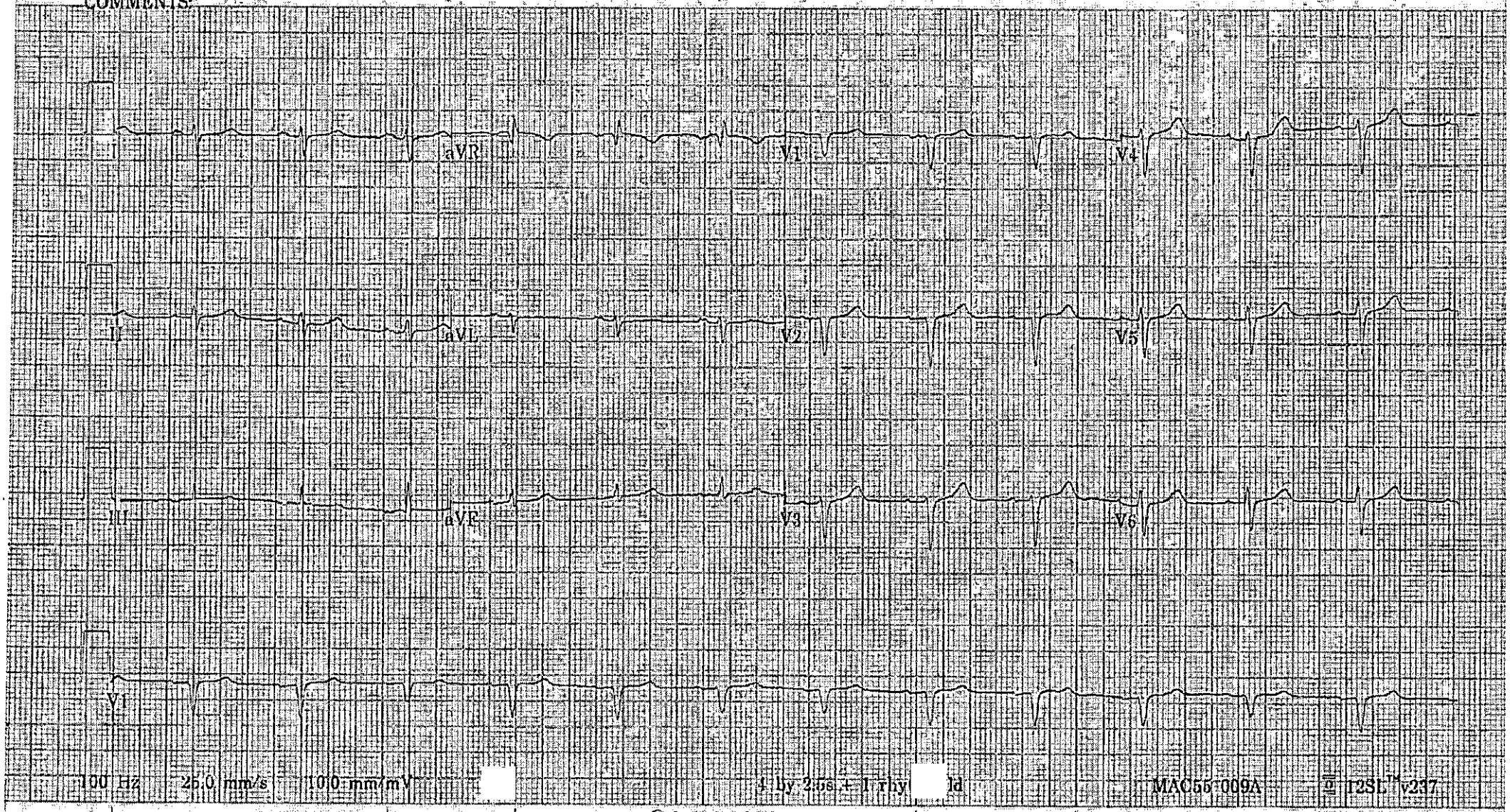
Normal sinus rhythm
Normal ECG

MCLYMONT GP2

Referred by:

Unconfirmed

COMMENTS:



ID:

13-Aug-2020 13:30:41

QUEEN ELIZABETH UNIVERSITY HOSPITAL

Vent. rate	71	m
PR interval	160	ms
QRS duration	92	ms
QT/QTc	390/435	ms
P-R-T axes	-2 136	20

Normal sinus rhythm
Septal infarct, age undetermined
Abnormal ECG

Loc: 1312

[redacted]

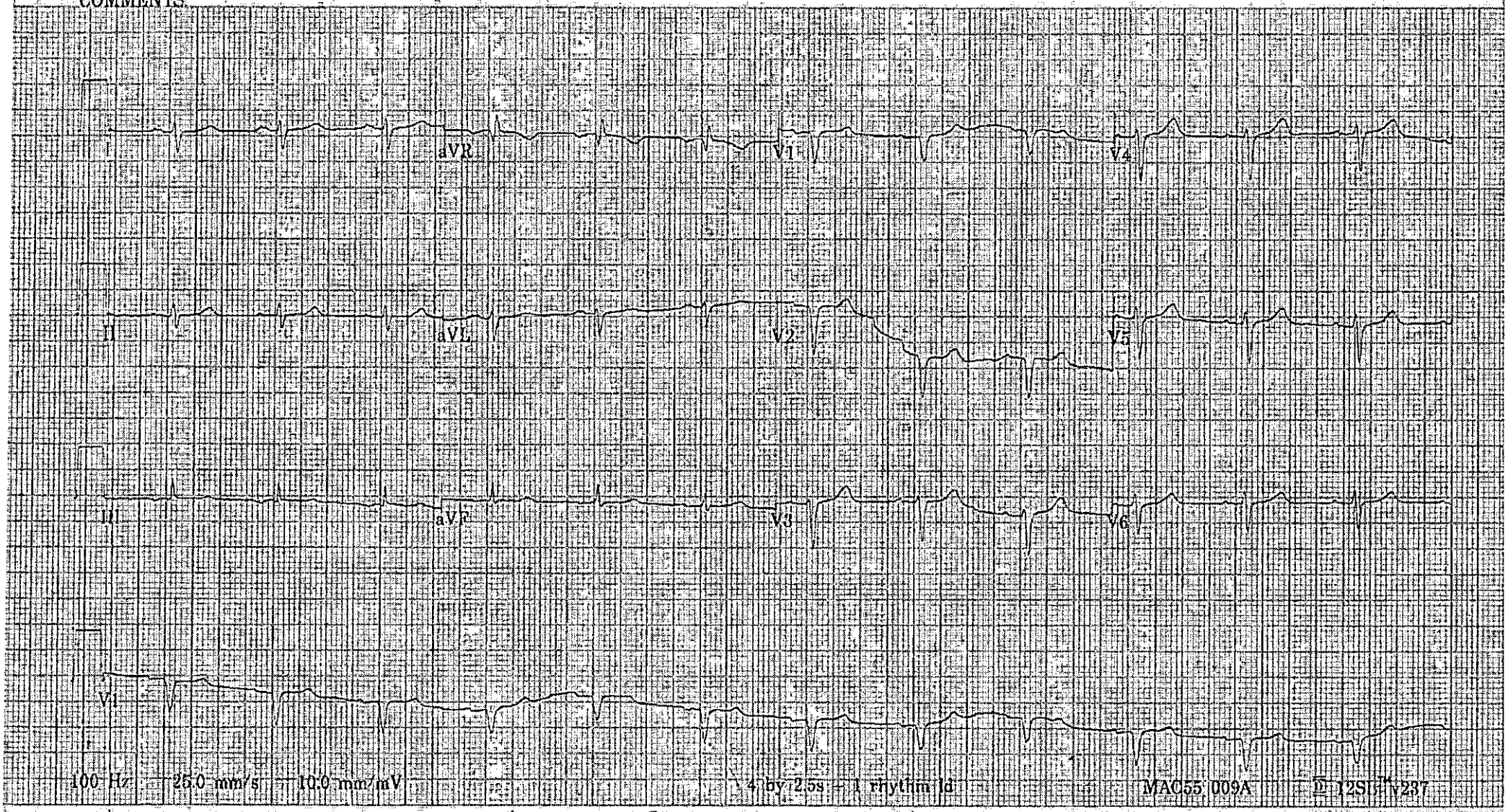
Technician:

PM McLYMONT
892

Referred by:

Unconfirmed

COMMENTS:



ID: [redacted] 13-Aug-2020 13:30:50 QUEEN ELIZABETH UNIVERSITY HOSPITAL

Vent. rate	7[redacted]	m	Normal sinus rhythm
PR interval	156	ms	Septal infarct, age undetermined
QRS duration	94	ms	Abnormal ECG
QT/QTc	390/438	ms	
P-R-T axes	3 138 34		

Loc: 1312

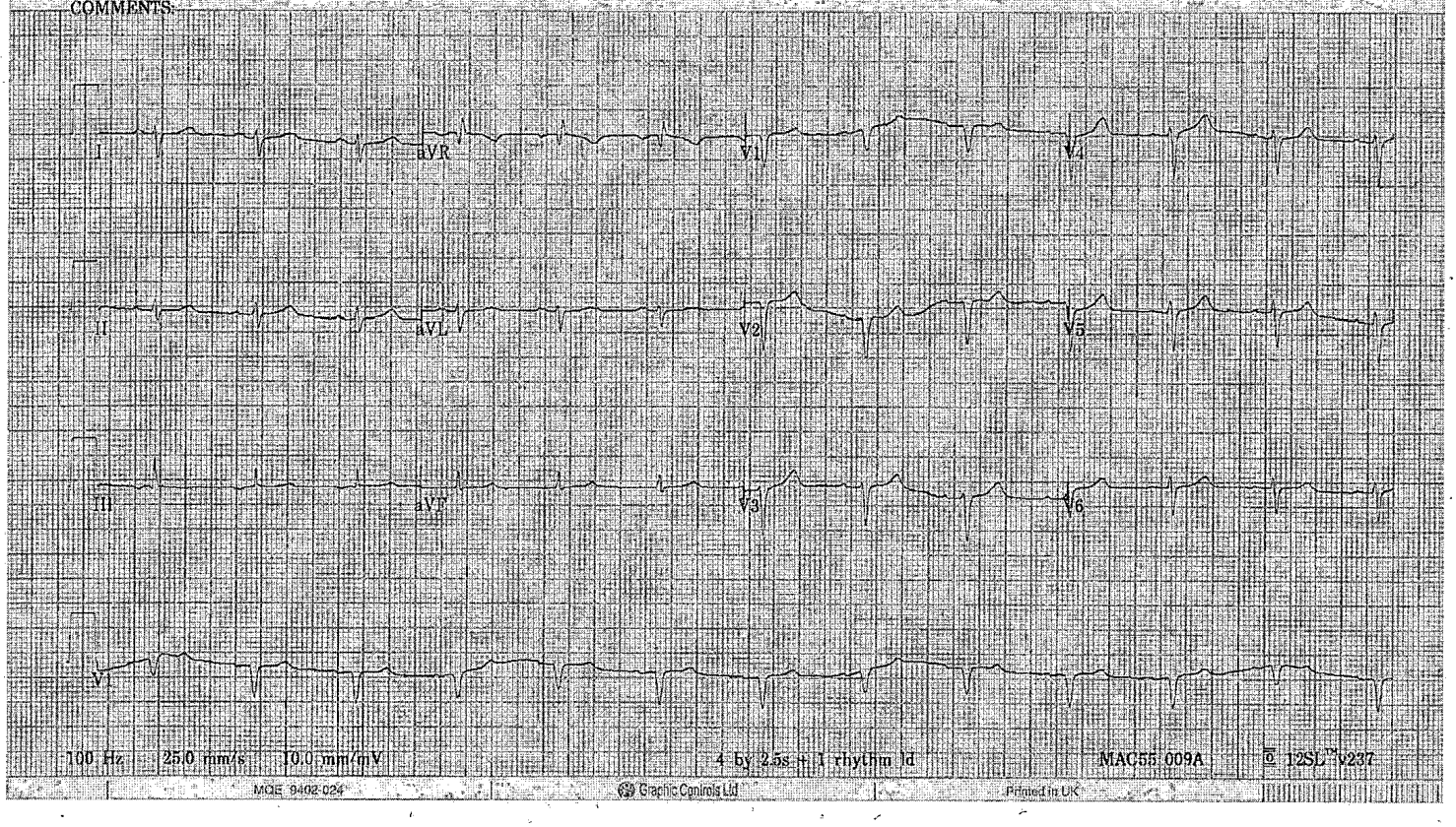
[redacted] Technician:

78bpm, SR, p waves present, No ST elevation Unconfirmed

MCLYMONT FZ

Referred by:

COMMENTS:



100 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + 1 rhythm ld MAC55 009A 12SL™ v237

SHAW, ANDREW ID: 2104673933 11-Aug-2020 0:42:57 QUEEN ELIZABETH UNI SITY HOSPITAL

21-Apr-1967
Male

Loc: 1301

Technician: 233
Test ind:

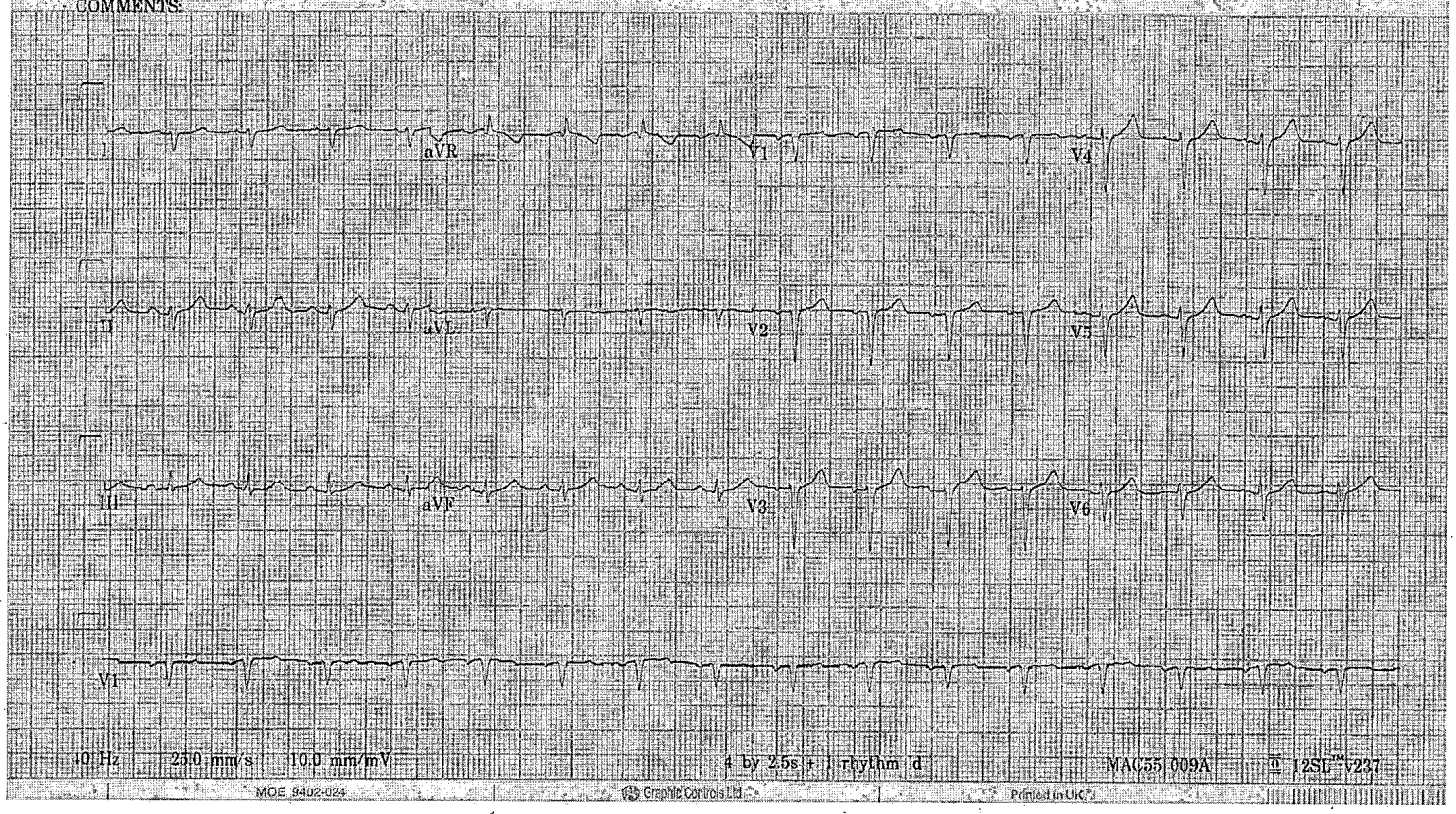
Vent. rate	9 m
PR interval	140 ms
QRS duration	86 ms
QT/QTc	352/451 ms
P-R-T axes	70 158 -68

Normal sinus rhythm
Normal ECG

2104673933
SHAW M
7 Andrew, M 21/04/1967

Referred by: Unco

COMMENTS:



40 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + rhythm ld MAC55 009A 12SL V237

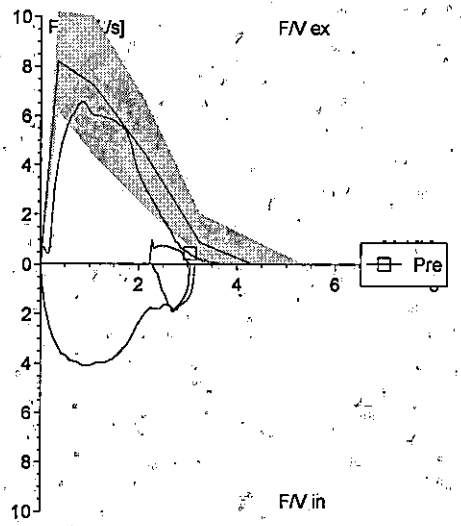
NHS
Greater Glasgow and Clyde

Respiratory Laboratory
Gartnaval General Hospital

Last Na...:	**Shaw**	**First N...:**	**Andrew**
Date of Birth:	21/04/1967	Gender:	male
Height:	172 cm	Weight:	141.0 kg
CHI:	2104673933	BMI:	48 kg/m²
Age:	58 Years	Race:	Caucasian
Physiologist:	Ploetner H	Ex Smoker:	
Ward:	--	Quit (Y/N):	
Physician:		Visit date	02.04.26

Pulmonary Function Tests

		Pred	Pred LL	Meas	Pred UL	% Pred	SR
SPIROMETRY							
FVC	L	4.32	3.31	3.63	5.35	84	-1.12
FEV 1	L	3.37	2.55	3.00	4.14	89	-0.76
FEV 1 % FVC	%	78	66	83	88	106	0.71
FEV 1 % VC MAX	%	78	66	83	88	106	0.71
MFEF 75/25	L/s	2.89	1.44	3.26	4.84	113	0.35
FEF 50 % FIF 50	%			134			
PEF	L/s	8.22	6.23	6.55	10.21	80	-1.38
PIF	L/s			4.10			



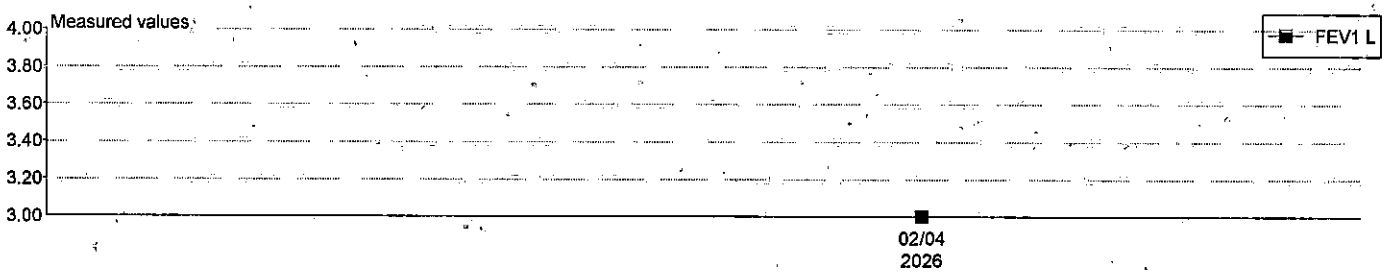
Comment

FeNO = 96ppb.
Maximum efforts achieved. Very variable technique throughout spirometry, ?patient comprehension of test instructions. Best effort selected, FVC underestimated. Back-extrapolation in most efforts. Reversibility criteria not met. Acceptability/Reproducibility criteria not met. Please interpret with caution.

SR Severity Scale
Normal +/- 1.64
Mild +/- 1.65 - 2.50
Moderate +/- 2.51 - 3.50

Interpretation

Last Name: Shaw **First Name:** Andrew **CHI:** 2104673933



Measurement	*Spiro*		*Diff SB*	*Body*
Parameter	*FEV1*	*MFEF*	*DLC...*	*TLC*
Date	*(L)*	*(L/s)*	*(m...*	*(L)*
02/04/2026	3.00	3.26		
ean value	3.00	3.26		
ır. coeff. [%]		0.01		

XR Chest

Performed	02-Apr-2026 10:31	Received	20-Jun-2026 08:40
Reported	20-Jun-2026 08:38	Order Number	G504H43298776
Status	Final	Source System	MiSys

XR Chest Final
Andrew Martin Shaw
Clinical History: sob/wheeze ?cause - please do when attends gartnavel resp clinic thurs 2/4

02/04/2026, 11:46, XR Chest
CHEST:
Clinical History:
Shortness of breath and wheeze.

Findings:
No acute lung disease. The lung fields are clear.
Heart is not enlarged.
Normal mediastinal outline.
No acute rib cage abnormality.
No interval change compared to the examination in August 2021

Reported by Dr Stephen D'Souza, Axon Diagnostics Radiologist, GMC 3262711
If you are a clinician and have a query on this report, please email clinicalqueries@axondiagnostics.com

Reported by: AXON Reporting
Verified by: AXON Reporting

XR Chest

Performed	17-Nov-2020 05:17	Received	19-Nov-2020 17:54
Reported	19-Nov-2020 17:52	Order Number	G405H36716117
Status	Final	Source System	MiSys

XR Chest Final
Andrew Martin Shaw
Clinical History :

RTA. New oxygen requirement. ?infection ?pneumothorax

XR Chest :
PA projection precludes accurate assessment of the cardiomediastinal contour.
No focal active lung pathology.
Normal bony thorax.
No significant interval change from 10/11/2013.

Reported by: Dr Kerrie Fitzgerald (SpR) and Dr Michal Gronski
Verified by: Dr Michal Gronski

CT Thorax abdomen pelvis with contrast

Performed	15-Nov-2020 07:48	Received	15-Nov-2020 10:49
Reported	15-Nov-2020 10:47	Order Number	G405H36711208
Status	Final	Source System	MiSys

CT Head Final
Andrew Martin Shaw
Clinical History :

involved in car chase with police, hit iron barrier at 40-50mph and car fell down 15ft embankment. patient confused and agitated. ?intracranial event ?bony injury bruising to upper chest wall ?intra thoracic or abdominal injury. pelvic binder in place.

CT Head :
Unenhanced head CT scan. Comparison made to previous images dated 11/8/2020.

No intra/extra-axial collection, acute infarct or space-occupying lesion.

Unremarkable appearances of the CSF spaces.
Incidental calcific focus noted within the left basal ganglia as before.

Inspissated secretions noted within the ethmoid sinuses. The visualised paranasal sinuses and mastoid air cells are otherwise unremarkable.

Skull vault and base are intact.

CT Spine cervical :
No acute bony injury. Vertebral body height and alignment are maintained. No prevertebral soft tissue swelling.
Please note CT cannot rule out ligamentous injury.

CT Thorax abdomen pelvis with contrast :
Dual phase scan through the chest, abdomen and pelvis. Comparison made to previous images of 11/08/2020.
Suboptimal images due to motion artefact and patient's high BMI.

Chest:
Bilateral basal atelectasis noted. Lungs are otherwise clear. No haemothorax, pneumothorax or flail chest. No pneumatocele. No pneumomediastinum or haemorrhage seen within the mediastinum.

Within the limits of this examination, the major thoracic vessels are intact.
The trachea and main bronchi are intact.
No major findings within the lower neck. Unremarkable appearances of the heart with no pericardial effusion.

Abdomen and pelvis:
No free air or fluid seen within the abdominal cavity. The portal vein and major branches of the descending abdominal aorta are patent.

The liver, spleen, pancreas, adrenal glands, gall bladder and urinary bladder are normal.

Uncomplicated sigmoid diverticulosis noted. within the limits of this study, the unprepared bowel is otherwise unremarkable.

Bony structures:

Background mild multilevel degenerative changes noted, most pronounced at C5/6. No acute

bony injury.

Summary:

Within the limits of this study, no acute findings identified.

Reported by: Dr Sanad Hadidi (SpR) and Dr Michael Sproule
Verified by: Dr Michael Sproule

CT Spine cervical

Performed	15-Nov-2020 07:48	Received	15-Nov-2020 10:49
Reported	15-Nov-2020 10:47	Order Number	G405H36711207
Status	Final	Source System	MiSys

CT Head Final
Andrew Martin Shaw
Clinical History :

involved in car chase with police, hit iron barrier at 40-50mph and car fell down 15ft embankment. patient confused and agitated. ?intracranial event ?bony injury bruising to upper chest wall ?intra thoracic or abdominal injury. pelvic binder in place.

CT Head :
Unenhanced head CT scan. Comparison made to previous images dated 11/8/2020.

No intra/extra-axial collection, acute infarct or space-occupying lesion.

Unremarkable appearances of the CSF spaces.
Incidental calcific focus noted within the left basal ganglia as before.

Inspissated secretions noted within the ethmoid sinuses. The visualised paranasal sinuses and mastoid air cells are otherwise unremarkable.

Skull vault and base are intact.

CT Spine cervical :
No acute bony injury. Vertebral body height and alignment are maintained. No prevertebral soft tissue swelling.
Please note CT cannot rule out ligamentous injury.

CT Thorax abdomen pelvis with contrast :
Dual phase scan through the chest, abdomen and pelvis. Comparison made to previous images of 11/08/2020.
Suboptimal images due to motion artefact and patient's high BMI.

Chest:
Bilateral basal atelectasis noted. Lungs are otherwise clear. No haemothorax, pneumothorax or flail chest. No pneumatocele. No pneumomediastinum or haemorrhage seen within the mediastinum.

Within the limits of this examination, the major thoracic vessels are intact.
The trachea and main bronchi are intact.
No major findings within the lower neck. Unremarkable appearances of the heart with no pericardial effusion.

Abdomen and pelvis:
No free air or fluid seen within the abdominal cavity. The portal vein and major branches of the descending abdominal aorta are patent.

The liver, spleen, pancreas, adrenal glands, gall bladder and urinary bladder are normal.

Uncomplicated sigmoid diverticulosis noted. within the limits of this study, the unprepared bowel is otherwise unremarkable.

Bony structures:

Background mild multilevel degenerative changes noted, most pronounced at C5/6. No acute

bony injury.

Summary:

Within the limits of this study, no acute findings identified.

Reported by: Dr Sanad Hadidi (SpR) and Dr Michael Sproule
Verified by: Dr Michael Sproule

CT Head

Performed	15-Nov-2020 07:48	Received	15-Nov-2020 10:49
Reported	15-Nov-2020 10:47	Order Number	G107H36711201
Status	Final	Source System	MiSys

CT Head Final
Andrew Martin Shaw
Clinical History :

involved in car chase with police, hit iron barrier at 40-50mph and car fell down 15ft embankment. patient confused and agitated. ?intracranial event ?bony injury bruising to upper chest wall ?intra thoracic or abdominal injury. pelvic binder in place.

CT Head :
Unenhanced head CT scan. Comparison made to previous images dated 11/8/2020.

No intra/extra-axial collection, acute infarct or space-occupying lesion.

Unremarkable appearances of the CSF spaces.
Incidental calcific focus noted within the left basal ganglia as before.

Inspissated secretions noted within the ethmoid sinuses. The visualised paranasal sinuses and mastoid air cells are otherwise unremarkable.

Skull vault and base are intact.

CT Spine cervical :
No acute bony injury. Vertebral body height and alignment are maintained. No prevertebral soft tissue swelling.
Please note CT cannot rule out ligamentous injury.

CT Thorax abdomen pelvis with contrast :
Dual phase scan through the chest, abdomen and pelvis. Comparison made to previous images of 11/08/2020.
Suboptimal images due to motion artefact and patient's high BMI.

Chest:
Bilateral basal atelectasis noted. Lungs are otherwise clear. No haemothorax, pneumothorax or flail chest. No pneumatocele. No pneumomediastinum or haemorrhage seen within the mediastinum.

Within the limits of this examination, the major thoracic vessels are intact.
The trachea and main bronchi are intact.
No major findings within the lower neck. Unremarkable appearances of the heart with no pericardial effusion.

Abdomen and pelvis:
No free air or fluid seen within the abdominal cavity. The portal vein and major branches of the descending abdominal aorta are patent.

The liver, spleen, pancreas, adrenal glands, gall bladder and urinary bladder are normal.

Uncomplicated sigmoid diverticulosis noted, within the limits of this study, the unprepared bowel is otherwise unremarkable.

Bony structures:

Background mild multilevel degenerative changes noted, most pronounced at C5/6. No acute

bony injury.

Summary:

Within the limits of this study, no acute findings identified.

Reported by: Dr Sanad Hadidi (SpR) and Dr Michael Sproule
Verified by: Dr Michael Sproule

XR Chest

Performed	17-Aug-2020 21:50	Received	10-Sep-2020 08:45
Reported	10-Sep-2020 08:43	Order Number	G405H36452348
Status	Final	Source System	MiSys

XR Chest Final
Andrew Martin Shaw
Clinical History :

chest pain

XR Chest :
There is generalised lung plethora which I think is more due to patient body habitus and underinspired AP projection. There is no convincing pathology.

Reported by: Dr Andrew Christie
Verified by: Dr Andrew Christie

XR Shoulder Lt

Performed	11-Aug-2020 17:59	Received	01-Sep-2020 09:43
Reported	01-Sep-2020 09:41	Order Number	G405H36436781
Status	Final	Source System	MiSys

XR Ankle Lt Final
Andrew Martin Shaw
Clinical History :

Patient admitted following RTC, car vs lamppost. Fracture on previous film of left ankle, orthopaedics have requested a repeat as initial was a poor film. Bruising over left ankle, tender on palpation. Shoulder XR due to ongoing left shoulder pain, left shoulder was not well visualised on CT thorax earlier today. ?humeral fracture

XR Ankle Lt :
Comparison is made to left ankle radiographs dated 11/08/2020 and 01/1955.
The previously described fracture through the left lateral malleolus is again demonstrated. No significant interval change is demonstrated.
The ankle mortise appears congruent.

XR Shoulder Lt :
The apical oblique projection is undiagnostic and a for the congruency of the glenohumeral joint cannot be fully assessed.
Within the limitations of the study no acute bony injury is identified. Repeat excluded projections are advised if there is any clinical concern regarding dislocation.

Report by Graham Johnstone reporting radiographer.

Reported by: Graham Johnstone
Verified by: Graham Johnstone

XR Ankle Lt

Performed	11-Aug-2020 17:59	Received	01-Sep-2020 09:43
Reported	01-Sep-2020 09:41	Order Number	G405H36436780
Status	Final	Source System	MiSys

XR Ankle Lt Final
Andrew Martin Shaw
Clinical History :

Patient admitted following RTC, car vs lamppost. Fracture on previous film of left ankle, orthopaedics have requested a repeat as initial was a poor film. Bruising over left ankle, tender on palpation. Shoulder XR due to ongoing left shoulder pain, left shoulder was not well visualised on CT thorax earlier today. ?humeral fracture

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XR Shoulder Lt :
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Within the limitations of the study no acute bony injury is identified. Repeat excluded projections are advised if there is any clinical concern regarding dislocation.

Report by Graham Johnstone reporting radiographer.

Reported by: Graham Johnstone
Verified by: Graham Johnstone

CT Thorax abdomen and pelvis

Performed	11-Aug-2020 14:20	Received	11-Aug-2020 15:40
Reported	11-Aug-2020 15:38	Order Number	G405H36435999
Status	Final	Source System	MiSys

CT Head Final
Andrew Martin Shaw
Clinical History :

admitted overnight following RTA- found by police having crashed traffic light at high speed and run traffic light flat over. Appeared intoxicated when in police custody. Currently fluctuating GCS but mainly only responding to pain. Deformity in ankle/legs, painful on moving ankles. Trauma CT please

CT Head :
Unenhanced acquisition. There is no prior relevant cross sectional imaging available for comparison.

No intra or extra-axial collection or haemorrhage. No established territorial infarction. Normal configuration of the ventricular system and basal cisterns. Normal cranio-cervical junction. The skull is unremarkable. Mucosal thickening within the right ethmoid sinus may reflect sinusitis.

CT Spine cervical :
Unenhanced acquisition. Image quality of the lower cervical spine is severely degraded due to photon starvation artefact, likely a result of the patient's large body habitus and also respiratory motion artefact. Images at the level of C5 and below are non-diagnostic.

Satisfactory alignment of the visualised cervical vertebrae and facet joints. No significant para vertebral soft tissue swelling. No definite cervical fracture, allowing for the technical factors. Significant osteophyte formation.

There is no definite radiographic evidence of cervical spine fracture, however images are not diagnostic and clinical review is advised.

CT Thorax abdomen and pelvis :
Portal venous phase study of the thorax, abdomen pelvis. Again images are markedly degraded due to photon starvation artefact likely secondary to the patient's large body habitus and respiratory motion artefact.

No pneumothorax. No rib fracture. Allowing for significant artefact, there is no discrete bony mass lesion or size significant nodule.

There is no intra-abdominal or pelvic free fluid. The no focal liver lesion. Unremarkable spleen, kidneys, adrenals, pancreas and unprepared large or small bowel. The bladder is catheterised. No abdominal or pelvic lymphadenopathy.

No significant skeletal pathology.

Summary:
Allowing for the significantly degraded imaging, no significant traumatic injury.

Reported by: Dr Mark Pringle (SpR) and Dr John Sheridan
Verified by: Dr John Sheridan

CT Head

Performed	11-Aug-2020 14:20	Received	11-Aug-2020 15:40
Reported	11-Aug-2020 15:38	Order Number	G405H36434194
Status	Final	Source System	MiSys

CT Head Final
Andrew Martin Shaw
Clinical History :

admitted overnight following RTA- found by police having crashed traffic light at high speed and run traffic light flat over. Appeared intoxicated when in police custody. Currently fluctuating GCS but mainly only responding to pain. Deformity in ankle/legs, painful on moving ankles. Trauma CT please

CT Head :
Unenhanced acquisition. There is no prior relevant cross sectional imaging available for comparison.

No intra or extra-axial collection or haemorrhage. No established territorial infarction. Normal configuration of the ventricular system and basal cisterns. Normal cranio-cervical junction. The skull is unremarkable. Mucosal thickening within the right ethmoid sinus may reflect sinusitis.

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There is no definite radiographic evidence of cervical spine fracture, however images are not diagnostic and clinical review is advised.

CT Thorax abdomen and pelvis :
Portal venous phase study of the thorax, abdomen pelvis. Again images are markedly degraded due to photon starvation artefact likely secondary to the patient's large body habitus and respiratory motion artefact.

No pneumothorax. No rib fracture. Allowing for significant artefact, there is no discrete bony mass lesion or size significant nodule.

There is no intra-abdominal or pelvic free fluid. The no focal liver lesion. Unremarkable spleen, kidneys, adrenals, pancreas and unprepared large or small bowel. The bladder is catheterised. No abdominal or pelvic lymphadenopathy.

No significant skeletal pathology.

Summary:
Allowing for the significantly degraded imaging, no significant traumatic injury.

Reported by: Dr Mark Pringle (SpR) and Dr John Sheridan
Verified by: Dr John Sheridan

CT Head

Performed	11-Aug-2020 04:36	Received	11-Aug-2020 07:57
Reported	11-Aug-2020 07:55	Order Number	G107H36433708
Status	Final	Source System	MiSys

CT Head Final
Andrew Martin Shaw
Auto reported

Not performed as patient unable to tolerate examination.

Reported by: Auto Reporting
Verified by: Auto Reporting

XR Chest

Performed	11-Aug-2020 01:50	Received	13-Aug-2020 13:18
Reported	13-Aug-2020 13:16	Order Number	G405H36433650
Status	Final	Source System	MiSys

XR Ankle Lt Final
Andrew Martin Shaw
Clinical History :
intoxicated, low gcs. Hypoxia ? LRTITender Left lat ,al. ? #

XR Ankle Lt :
There is a minimally displaced fracture of the lateral malleolus. There is associated soft tissue swelling.
As the patient was uncooperative with the examination instructions, limited views have been obtained. Full assessment of the talar dome cannot be made, although no obvious fracture is seen.

XR Chest :
Comparison is made with previous chest x-ray of 10/11/2013.
AP erect film. Projection precludes accurate assessment of the cardiomediastinal contours. The patient's mandible is partly obscuring the lung apices. Under-inspired film. Within those limits, no focal consolidation or pneumothorax. Some minor bibasal atelectasis noted. No obvious fracture of the visible ribs.

There has been a subsequent Polytrauma CT performed on 11/08/2020. Please refer to this report.

Reported by: Dr Mohammad Yunus Limbada (SpR) and Dr Khalid Ali
Verified by: Dr Khalid Ali

XR Ankle Lt

Performed	11-Aug-2020 01:50	Received	13-Aug-2020 13:18
Reported	13-Aug-2020 13:16	Order Number	G405H36433649
Status	Final	Source System	MiSys

XR Ankle Lt Final
Andrew Martin Shaw
Clinical History :
intoxicated, low gcs. Hypoxia ? LRTITender Left lat ,al. ? #

XR Ankle Lt :
There is a minimally displaced fracture of the lateral malleolus. There is associated soft tissue swelling.
As the patient was uncooperative with the examination instructions, limited views have been obtained. Full assessment of the talar dome cannot be made, although no obvious fracture is seen.

XR Chest :
Comparison is made with previous chest x-ray of 10/11/2013.
AP erect film. Projection precludes accurate assessment of the cardiomediastinal contours. The patient's mandible is partly obscuring the lung apices. Under-inspired film. Within those limits, no focal consolidation or pneumothorax. Some minor bibasal atelectasis noted. No obvious fracture of the visible ribs.

There has been a subsequent Polytrauma CT performed on 11/08/2020. Please refer to this report.

Reported by: Dr Mohammad Yunus Limbada (SpR) and Dr Khalid Ali
Verified by: Dr Khalid Ali