Subject Access Request Team
Health Records Department
Glasgow Royal Infirmary
8 – 16 Alexandra Parade
Glasgow
G31 2ER

NHS
Greater Glasgow and Clyde

MMA LEGAL
43-59 PRINCES STREET
STOCKPORT
SK1 1RY

Date: 14TH May 2026
Your Ref: 100150
Our Ref: SAR/ACCESS/ CD
Enquiries to: Chrissy
Direct Line: 0141 201 3379
Email: chrissy.davie@nhs.scot

Dear Sir/Madam

Re: Subject Access Request under the General Data Protection Regulation

Patient: GAYLE WILSON **D.O.B: 21/07/1979**

Thank you for your request received 22ND April 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:

GLASGOW ROYAL INFIRMARY & STOBHILL HOSPITAL RECORDS

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

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

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

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

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

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

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

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

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

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

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

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

Yours sincerely

Subject Access Request Team

ELECTRONIC PATIENT RECORDS

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

Including:

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

NHS SCOTLAND

New Stobhill Hospital
133 Balornock Rd
Glasgow
GGC
G21 3UW
Tel: 01412013000

Dr Georgi Georgiev
Abingdon Medical Practice
12 Stewartville Street
Glasgow
G11 5PE

12 Dec 2025

Dear Dr Georgiev,

Re: Gayle Wilson, 1-1, 37A DOWANHILL STREET, Glasgow, G11 5RN
DOB: 21 Jul 1979, CHI: 2107796165, CHI: 2107796165

History:

For review of B/L Nasal Nerve fibre loss

CT Head (29/11/2024) - Normal

Myopia

Diagnosis: B/L Nasal Nerve fibre loss - Stable

Visual Acuity:

Visual Acuity	Right Eye	Left Eye
Glasses	**6/9**	**6/9**

Intraocular Pressure:

17 mmHg on the right, and 16 mmHg on the left (recorded on 12 Dec 2025)

Clinical Management:

As patient is asymptomatic, no intervention reqd.

Review in 1 Year with repeat fields and Disc OCT.

Sincerely,

Manish Gupta

Signed on 12 Dec 2025, 15:14

Manish Gupta

To: GP : Dr Georgi Georgiev, Abingdon Medical Practice, 12 Stewartville Street, Glasgow, G11 5PE

Clinic Letter

NHS
Greater Glasgow and Clyde

Stobhill Hospital
133 Balornock Road
Glasgow
G21 3UW

Dr. GM Georgiev
Abingdon Medical Practice
12 Stewartville Street
Glasgow
G11 5PE

Main Switchboard: 0141 201 3000
Department: Ophthalmology
Contact Tel: 0141 355 1850
Enquiries to: alice.breslin@ggc.scot.nhs.uk
Letter Date: 11/02/2025
Reference:
Dictated Date: 11/02/2025
Transcribed Date: 12/02/2025

Dear Dr. GM Georgiev,

Gayle Wilson; D.O.B: 21 Jul 1979; CHI: 2107796165
1-1, 37A DOWANHILL STREET, Glasgow, Lanarkshire, G11 5RN

Attendance: Specialty - Ophthalmology; Clinic - STMGUEY3-EYE ACH MR M GUPTA TEACH AND TREAT TUESDAY AM
Date and Time of Appointment - 11/02/2025 11:00

Clinical Comments:
Presenting Complaint: Review of constricted Visual Fields

Diagnosis:
1. Bilateral constricted Visual Fields with bilateral loss of nerve fibres
2. CT scan head - unremarkable
3. Myopia

Visual Fields: Right 6/12 Pinhole NI Left 6/12 Pinhole NI

Intra Ocular Pressures: Right 17mmHg Left 17mmHg

Investigations: Fields grossly full to confrontations

Follow-up: Review in clinic 9 months

WoScott Optometrist Oliver Rose

Under the supervision of Dr M Gupta Consultant Ophthalmologist

Yours sincerely

Dr Manish Gupta

Consultant Ophthalmologist

Electronically Signed: Mr Manish Gupta, Consultant

cc. Maliha Francis
Forde Opticians Ltd
Glasgow
G11 6DD

Clinic Letter

NHS
Greater Glasgow and Clyde

Stobhill Hospital
133 Balornock Road
Glasgow
G21 3UW
0141 201 3000

Dr. GM Georgiev
Abingdon Medical Practice
12 Stewartville Street
Glasgow
G11 5PE

Main Switchboard:	
Department:	
Contact Tel:	0141 355 1782
Enquiries to:	bernadette.mclaughlin2@ggc.scot.nhs.uk
Letter Date:	08/10/2024
Reference:	
Dictated Date:	23/12/2024
Transcribed Date:	23/12/2024

Dear Dr. GM Georgiev,

Gayle Wilson; D.O.B: 21 Jul 1979; CHI: 2107796165
1-1, 37A DOWANHILL STREET, Glasgow, Lanarkshire, G11 5RN

Attendance: Specialty - Ophthalmology; Clinic - STMGUEY3-EYE ACH MR M GUPTA TEACH AND TREAT TUESDAY AM
Date and Time of Appointment - 08/10/2024 10:00

Clinical Comments:
Presenting complaint: Referred as OCT showing NRR loss both eyes. Patient asymptomatic. Patient attended with Carer today.

Diagnosis: Bilateral constricted visual fields with loss of bilateral nerve fibres.

Visual acuity: Right 6/9 Left 6/12

IOPs: Right 16mmHg Left 16mmHg

Investigations: OCT disc scan showing NRR thinning which may result in bitemporal VF loss. Visual fields not reliable.

Treatment: Arranging CT scan of head.

Follow up: Four months.

WoScott Optometrist Mariyah Anwar

Seen under the supervision of Dr Manish Gupta Consultant Ophthalmologist

Yours sincerely

Dr Manish Gupta

Consultant Ophthalmologist

I have Gayle's CT scan report in hand now. As the scan is unremarkable, no urgent intervention is required. She should keep her appointment to see me in February 2025.

Yours sincerely

Dr Manish Gupta

Consultant Ophthalmologist

Electronically Signed: Mr Manish Gupta, Consultant

cc. Ms Gayle Wilson
flat 1/1
37A Dowanhill Street
Glasgow
G11 5RN

Clinic Letter

NHS
Greater Glasgow and Clyde

Stobhill Hospital
133 Balornock Road
Glasgow
G21 3UW
0141 201 3000

Dr. GM Georgiev
Abingdon Medical Practice
12 Stewartville Street
Glasgow
G11 5PE

Main Switchboard:	
Department:	
Contact Tel:	0114 355 1782
Enquiries to:	bernadette.mclaughlin2@ggc.scot.nhs.uk
Letter Date:	08/10/2024
Reference:	
Dictated Date:	08/10/2024
Transcribed Date:	08/10/2024

Dear Dr. GM Georgiev,

Gayle Wilson; D.O.B: 21 Jul 1979; CHI: 2107796165
1-1, 37A DOWANHILL STREET, Glasgow, Lanarkshire, G11 5RN

Attendance: Specialty - Ophthalmology; Clinic - STMGUEY3-EYE ACH MR M GUPTA TEACH AND TREAT TUESDAY AM
Date and Time of Appointment - 08/10/2024 10:00

Clinical Comments:
Presenting complaint: Referred as OCT showing NRR loss both eyes. Patient asymptomatic. Patient attended with Carer today.

Diagnosis: Bilateral constricted visual fields with loss of bilateral nerve fibres.

Visual acuity: Right 6/9 Left 6/12

IOPs: Right 16mmHg Left 16mmHg

Investigations: OCT disc scan showing NRR thinning which may result in bitemporal VF loss. Visual fields not reliable.

Treatment: Arranging CT scan of head.

Follow up: Four months.

WoScott Optometrist Mariyah Anwar

Seen under the supervision of Dr Manish Gupta Consultant Ophthalmologist

Yours sincerely

Dr Manish Gupta

Consultant Ophthalmologist

Electronically Signed: Mr Manish Gupta, Consultant

cc.

CT Head

Performed	29-Nov-2024 08:06	Received	19-Dec-2024 23:09
Reported	19-Dec-2024 23:07	Order Number	G207H41464843
Status	Final	Source System	MiSys

CT Head Final
Gayle Wilson
SEE REPORT FOR CLINICAL INFORMATION

CT Head

Clinical Information: CT Brain to rule out any intracranial pathology. - B/L Constricted visual fields (Difficult to check Bitemporal field defect) with retinal thinning and Loss of nasal nerve fibres both eyes. - (Information via Order Comms)

CT Head

Clinical Information: CT Brain to rule out any intracranial pathology. - B/L Constricted visual fields (Difficult to check Bitemporal field defect) with retinal thinning and loss of nasal nerve fibres both eyes. -(Information via Order Comms)

Comparison: None.

Findings:
No evidence of acute intracranial bleed/mass effect/midline shift.
Cerebral parenchyma shows typical CT density.
Few prominent VR spaces in basal ganglia.
Ventricles, basal cisterns and sulci appear symmetric.
Brainstem and cerebellar hemispheres are unremarkable.
Bony calvarium appears intact.
Minimal mucosal thickening in bilateral ethmoid sinuses.

Conclusion:
- No evidence of acute intracranial pathology.
- No significant abnormality identified.

Recommended clinical correlation.

Dr. Leslie Chacko, GMC: 8011187 (signed date, 2024-12-19, 23:07)
Consultant Radiologist
Teleconsult www.teleconsult.net
Email: servicedesk.uk@teleconsult.net
01908 086289

Reported by: TELECONSULT
Verified by: TELECONSULT

ELECTRONIC PATIENT RECORDS

ALL HOSPITAL RECORDS HELD NHSGGC	☐		
ACS	☐		
BEATSON HOSPITAL	☐		
CANNIESBURN HOSPITAL	☐		
DENTAL HOSPITAL	☐		
GARTNAVEL GENERAL HOSPITAL	☐		
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INVERCLYDE ROYAL HOSPITAL	☐	MATERNITY	☐
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PRINCESS ROYAL MATERNITY	☐		
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ROYAL ALEXANDRA HOSPITAL	☐	MATERNITY	☐
ROYAL HOSPITAL FOR CHILDREN	☐		
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WEST CARE AMBULATORY HOSPITAL	☐		
WESTERN INFIRMARY RECORDS	☐		

Including:

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

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 14/01/2023

Consultant: Dr Stephen Boyce

NT Bhatti
Peel Street Medical Centre
11 Peel Street
Glasgow
Glasgow
G11 5LL

Dear NT Bhatti

Re: **Wilson Gayle** DOB: **21/07/1979** CHI: **2107796165**
52 DALHOUSIE ST
Glasgow G3 6PN

Attended on: **14/01/2023 at 02:09 hrs.** Departed on: **14/01/2023 at 05:14 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
mental health

Nursing Assessment:
MENTAL HEALTH. Polypharmacy OD at 16:00. Taken 4/7 worth of meds from Dausset box. Gliclazide 80mg, Sertraline 100mg, Atorvastatin 40mg, Dapagliflozin 10mg, Quetiapine 25mg NEWS: 34 Low Risk C19.

Investigations in ED:

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

Diagnosis:

Diagnosis	Side	Site
Self-poison By Other/unspec Drugs/medic/ Biol Subs In Unspecified Place		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:

Gayle presented with alleged intentional OD of 4 days of her regular meds (gliclazide, sertraline, quetiapine, atorvastatin, dapagliflozin) with suicidal intent. Her BM was > 11 and her bloods were fairly unremarkable. Exam found mild tenderness in her abdomen. ECG was unremarkable. She has been observed for well over the observation window for all drugs and remains asymptomatic. She was discussed with MHAU who felt this was a stress reaction to a potential housing move and given her previous presentations with OD, they felt they did not need to assess her tonight. They will let Springpark CMHT know of her attendance with a view to call her on Monday. She is happy with this plan and has been discharged home with worsening advice.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Lily Lei
Doctor

Copies to:

1. NT Bhatti (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 11/03/2021

Consultant: Dr Richard Stevenson

NT Bhatti
Peel Street Medical Centre
11 Peel Street
Glasgow
Glasgow
G11 5LL

Dear NT Bhatti

Re: **Wilson Gayle** DOB: **21/07/1979** CHI: **2107796165**
52 DALHOUSIE ST
Glasgow G3 6PN

Attended on: **09/03/2021 at 20:17 hrs.** Departed on: **09/03/2021 at 23:18 hrs.**
Discharge Type: **01b - Discharge with follow up by primary care team** Destination: **Private residence**
Previous ED Attendance in last 12 months: **3**

Presenting complaint
chest pain - no ft

Nursing Assessment:
CCP, tachycaria ad tightness in L calf. BM 19.5, no diabetes diagnosis. Denies covid symptoms.

Investigations in ED:

1. Coagulation screen	**2. Urea and Electrolytes**	**3. Glucose**
4. LFT	**5. CRP**	**6. Chol / Triglyceride**
7. Full Blood Count	**8. Troponin I hs**	**9. D - Dimer**
10. XR Chest		

Diagnosis:

Diagnosis	Side	Site
Type 2 Diabetes Mellitus With Other Specified Complications		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

****GP - diagnose T2DM and commence medication** 1. Attends with chest 'niggles' and calf tenderness posteriorly. Worked up for DVT/PE/MI, and troponin, D-Dimer negative. ECG tachycardic, patient mildly flushed, denies caffeine/energy drinks/drugs. Discharged with reassurance and safety net from this point of view. 2. Consistently high blood glucose without ketosis or acidosis. 27/02/21 - random blood glucose 27.3 09/03/21 - random blood glucose 20.7 She is very obese, relatively inactive, and I suspect malnourished. I've advised her on diet, and exercise, and I wonder if you could follow her up properly with regards to this? Many thanks**

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Joanna-Lee Kerr
Doctor

Copies to:

1. NT Bhatti (GP)

School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 05/03/2021

Consultant: Dr Stephen Boyce

NT Bhatti
Peel Street Medical Centre
11 Peel Street
Glasgow
Glasgow
G11 5LL

Dear NT Bhatti

Re: **Wilson Gayle** DOB: **21/07/1979** CHI: **2107796165**
52 DALHOUSIE ST
Glasgow G3 6PN

Attended on: **27/02/2021 at 00:10 hrs.** Departed on: **27/02/2021 at 04:08 hrs.**
Discharge Type: **04C Incomplete: Patient refused treatment** Destination: **Not known**
Previous ED Attendance in last 12 months: **2**

Presenting complaint
PER NHS 24

Nursing Assessment:
INTENTIONAL OD. 400MG SETRALINE, 150MG QUETIAPINE AND 80MG SIMVISTATIN approx. 14.30. NHS 24 was called by pt housing unit. Patient looks pale and sweaty in triage. low covid no FT

Investigations in ED:

1. CK
2. CRP
3. Glucose
4. LFT
5. Urea and Electrolytes
6. Coagulation screen
7. Full Blood Count
8. Ethanol
9. Paracetamol
10. Salicylate
11. SARS-CoV-2 (ED/IP use) (COVID-19)

Diagnosis:

Diagnosis	Side	Site
Self-poison By Antiepilep/antipark/psychotrop Drugs, In Unspecified Place		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:
Mixed overdose of medication. No ongoing suicidal ideation. Self-discharged after period of observation

Followup :
Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Charlotte Grain
Doctor

Copies to:
1. NT Bhatti (GP)

School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 30/09/2020

Consultant: Dr Sile MacGlone

NT Bhatti
Peel Street Medical Centre
11 Peel Street
Glasgow
Glasgow
G11 5LL

Dear NT Bhatti

Re: **Wilson Gayle** DOB: **21/07/1979** CHI: **2107796165**
52 DALHOUSIE ST
Glasgow G3 6PN

Attended on: **29/09/2020 at 23:08 hrs.** Departed on: **30/09/2020 at 06:04 hrs.**
Discharge Type: **01b - Discharge with follow up by primary care team** Destination: **Private residence**
Previous ED Attendance in last 12 months: **4**

Presenting complaint
overdose

Nursing Assessment:
MENTAL HEALTH. OD of x14 Paracetamol between 16:30 - 17:30. NEWS: 2 Low Risk COVID - 19, CPE.

Investigations in ED:
1. Coagulation screen **2. Paracetamol** **3. Urea and Electrolytes**
4. LFT **5. Bicarbonate** **6. Full Blood Count**
7. CRP

Diagnosis:

Diagnosis	Side	Site
Self-poison By Nonopioid Analges/antipyret/antirheum In Unspec Place		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Attended ED via SAS after paracetamol overdose with suicidal intent. Impulsive OD of 14x paracetamol. LFTs and coag normal. Nil else acute on bloods. Nil acute on examination. Did not require NAC. She was reviewed in department by CPNs and has been discharged to supported care with referral to crisis team for follow up as no longer expressing intent. Kind regards, Jillian Gisbey FY2 GRI ED

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Jillian Gisbey
Doctor

Copies to:

1. NT Bhatti (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 19/08/2020

Consultant: Dr Fiona Ritchie

NT Bhatti
Peel Street Medical Centre
11 Peel Street
Glasgow
Glasgow
G11 5LL

Dear NT Bhatti

Re: **Wilson Gayle** DOB: **21/07/1979** CHI: **2107796165**
52 DALHOUSIE ST
Glasgow G3 6PN

Attended on: **18/08/2020 at 20:15 hrs.** Departed on: **at hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **4**

Presenting complaint
overdose

Nursing Assessment:
OVERDOSE. taken 6 night nurse and 4 nurofen last night and 8 night nurse plus 4 neurofen today. no vomit states took these to end life known to CPNs. low covid risk NEWS - 2

Investigations in ED:
1. Urea and Electrolytes **2. LFT** **3. Full Blood Count**
4. Coagulation screen **5. Paracetamol**

Diagnosis:

Diagnosis	Side	Site
Self-poison By Nonopioid Analges/antipyret/antirheum In Unspec Place		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

PC: overdose. BG: EUPD, mild LD. HPC: took 6 night nurse (paracetamol) and 4 ibuprofen last night, 8 night nurse and 4 ibuprofen tonight. Own meds. No efforts to not be found. Immediately sought help from crisis team - they recommended to come to NHS. No acute medical issues. ECG NAD. Bloods: PCM 7; coag WNL; U&Es WNL. D/W CPN: agree that pt has made efforts not to come to harm - will arrange for F/U tomorrow. Plan: D/C. F/U in place.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Rowan Vincent
Doctor

Copies to:

1. NT Bhatti (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 19/10/2019

Consultant: Dr Steven Rainey

NT Bhatti
Peel Street Medical Centre
11 Peel Street
Glasgow
Glasgow
G11 5LL

Dear NT Bhatti

Re: **Wilson Gayle** DOB: **21/07/1979** CHI: **2107796165**
TALBOT CENTRE
Glasgow G3 6PN

Attended on: **18/10/2019 at 19:57 hrs.** Departed on: **19/10/2019 at 01:37 hrs.**
Discharge Type: **01c - Discharge with referral** Destination: **Residential institution**
Previous ED Attendance in last 12 months: **1**

Presenting complaint
self harm

Nursing Assessment:
c/o low mood and suicidal idation after berevement of sister. states having flash backs of the resuscitation. this pm sustained DSH to L wrist and attempted to take over dose of ibuprofen - gave tablets to police prior to ingestion. news 3 low cpe

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Deliberate self harm by sharp object		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

***NO GP ACTION* Presented with deliberate self harm and suicidal intent. Reviewed by CPNs and felt safe for discharge. Follow up with day CPNs the following morning. Ms Wilson was tachycardic during time in department. No underlying cause. Asymptomatic. ECG sinus tachycardia. No clear underlying cause - discharged with advice and staff at accommodation informed.**

Followup : **With CPNs**

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Oonagh Murray
Doctor

Copies to:

1. NT Bhatti (GP)

School Address:

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 29/08/2019

Consultant: Dr Caitriona Considine

NT Bhatti
Peel Street Medical Centre
11 Peel Street
Glasgow
Glasgow
G11 5LL

Dear NT Bhatti

Re: **Wilson Gayle** DOB: **21/07/1979** CHI: **2107796165**
TALBOT CENTRE
Glasgow G3 6PN

Attended on: **21/08/2019 at 20:53 hrs.** Departed on: **22/08/2019 at 00:39 hrs.**
Discharge Type: **01c - Discharge with referral** Destination: **Temporary residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
OD

Nursing Assessment:
deliberate OD of chlorphenamine 4mg x 30 tablets throughout day today. ongoing suicidal ideation in triage. discharged from gartnavel this am for same. recent family bereavements news: 2

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Deliberate self poisoning by unspecified drugs, medication and biological substances		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:
Dear Doctor, Gayle was assessed today in A+E after reporting taking 40 tablets of chlorphenamine throughout the day after being discharged from Gartnavel hospital inpatient psychiatry in the morning. Observations were stable. Gayle lives in a homeless unit and has been particularly low in mood since the passing of her sister in June. Gayle was reviewed by our psychiatry colleagues who documented that Gayle was for discharge and to be followed up with the West crisis team. Best wishes

Followup :
Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Jill Busgeeth
Doctor

Copies to:
1. NT Bhatti (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 16/11/2017

Consultant: Mr Tadhg Kelliher

NT Bhatti
Peel Street Medical Centre
11 Peel Street
Glasgow
Glasgow
G11 5LL

Dear NT Bhatti

Re: **Wilson Gayle** DOB: **21/07/1979** CHI: **2107796165**
TALBOT CENTRE
Glasgow G12 8EW

Attended on: **16/11/2017 at 17:57 hrs.** Departed on: **16/11/2017 at 23:40 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Temporary residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
mental health issues

Nursing Assessment:
DSH to left wrist with Stanley knife. hx - depression. suicidal thoughts ongoing in triage - support staff present. *at red seats*

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Deliberate self harm by sharp object		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

This 38y/o female with a background of learning difficulties, personality disorder and depression attended having intentionally harmed her forearm with a knife, inflicting superficial wounds, 1 steristrip applied after cleaning, then dressed. No suicidal intent/ideation. No acute psychosis/ mania. Seen by psych consultant earlier today. CPN r/v safe for home, and have called warden in her supported accommodation who is happy for her to come home. patient in agreement.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Gareth Lipton
Doctor

Copies to:

1. NT Bhatti (GP)

School Address:

CHI: 2107796165

Glasgow Royal Infirmary

8

Total Att: 23
12 Mth Att: 0

Title: MISS

WILSON **Gayle**

DOB **21/07/1979** Age: **43y** Sex: **Female**

52 DALHOUSIE ST

Glasgow
Lanarkshire
G3 6PN
07771241541

Next of kin: **WINTERS, Rita**
Relationship: **Aunt**
01412301448

GP: **NT Bhatti**
0141 334 9331

Attendance Date: **14/01/2023** Arrival Time: **02:09**

Registration Time: **02:09** Date of Incident: **14/01/2023**

Major Incident Desc:

Reason for Attendance: **mental health**

Nursing Assessment

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

Triage Category: **2** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **14/01/2023 02:14** Nurse name: **Nurse Michael Harkins**

Temp	**35.7**	C
HR	**102**	bpm
BP	**102/64**	mmHg
MAP	**76.67**	mmHg
RR	**16**	bpm
SpO2	**95**	%
Oxygen		%

BM	**11.3 SAS**	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	**4**
Motor	**6**
Verbal	**5**
Total	**15**

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

Nursing Notes: **"MENTAL HEALTH. " "Polypharmacy OD at 16:00. " "Taken 4/7 worth of meds from Dausset box. " Gliclazide 80mg, Sertraline 100mg, Atorvastatin 40mg, Dapagliflozin 10mg, Quetiapine 25mg NEWS: 34 "Low Risk C19. "**

To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified			
Date	**Clinical Notes**		
	Seen By	Time Seen	

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By

Patient Information

GAYLE WILSON

Age/Gender:	43y Old Female
Address:	ROOM 8 TALBOT ASSOCIATION LTD 52 DALHOUSIE STREET GARNETHILL GLASGOW G3 6PN
DOB:	21/07/1979
CHI:	2107796165
Ethnicity:	

Date:	14/01/2023
Incident Number:	CR009479342
Incident Type:	EMG
Incident Location:	ROOM 8 TALBOT ASSOCIATION LTD 52 DALHOUSIE STREET GARNETHILL GLASGOW, G3 6PN

2107796165
WILSON F
Gayle 21/07/1979
52 DALHOUSIE ST
Glasgow, Lanarkshire
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Presenting Complaint

MENTAL HEALTH

Additional Comments

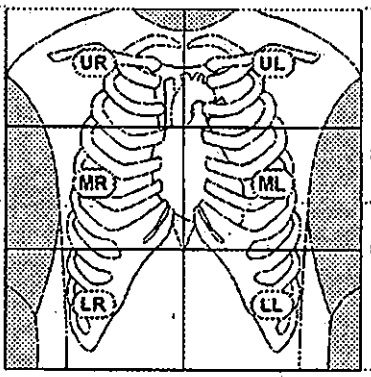
As1 for 43yo female overdose. S/ taken 4 out of 7 days meds at once - with alcohol. Intent on suicide. B/ mental health, type 2 diabetic. A/ obs as noted. Pt advised wanted to be with sister who passed away 5 years ago. Does not have a cpn/mental health team involvement. R/ a/e.

PATIENT ASSESSMENT

ACVPU Alert <C> No

A Clear

B Breathing Adequately: Yes | Respiratory Rate: 18 | SPO2: 100

Normal Percussion, Normal Breath Sounds, Normal Air Entry	UR		UL	Normal Percussion, Normal Breath Sounds, Normal Air Entry
Normal Percussion, Normal Breath Sounds, Normal Air Entry	MR		ML	Normal Percussion, Normal Breath Sounds, Normal Air Entry
Normal Percussion, Normal Breath Sounds, Normal Air Entry	LR		LL	Normal Percussion, Normal Breath Sounds, Normal Air Entry

C

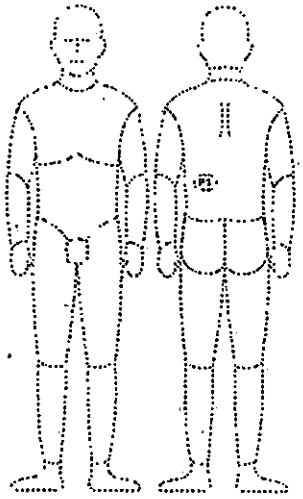
Pulse Rate	BP	Cap Refill	ECG Rhythm
120	130/81	<=2 Secs	Sinus Tachy

Rhythm	Arm	Central/Peripheral	ECG
Reg	Right		3 Lead

D

GCS	Eyes	Voice	Motor	PEARL
15	Spontaneously (4)	Orientated (5)	Obeys Commands (6)	Yes

E



Pain

ID	Body Part	Pain Scale
P1	Back Body	6

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID

01:45	121	18	127/84	100	<=2s	15	Alert	37.3	11.3	Sinus Rhythm	4	4	E0022128
01:28	120	18	130/81	100	<=2 Secs	15	Alert	37.3	11.2	Sinus Tachy	5	5	E0022128

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
01:45	18 (0)	100 (0)		0	127 (0)	121 (2)	Alert (0)	37.3 (0)	2
01:28	18 (0)	100 (0)		0	130 (0)	120 (2)	Alert (0)	37.3 (0)	2

HISTORY

AMPLE

Allergies	PENICILLAN
Medication	SEE ECS
Past Medical History	Diabetes (Type 2)
Last Eaten	Unknown
Events Prior	LOW MOOD

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Social History

Lives alone	No	Patient Occupation	Unemployed

Patients General Appearance	Normal
Patient Mobility	Fully Mobile
Patient Communication	No Help Required
Patient Clinical Risk Factors	Alcohol, Smoker
Patient Enviromental Risk Factors	None Identified

Substances Affecting Condition

Substances	Alcohol

CLOSE RECORD

Treatment On Scene: Non-Emergency

Conveyance

Transport To Hospital	Normal driving	Pre-Alert	No

INCIDENT LOG

Time Call Received	23:44	Allocated	01:10	Mobile	01:10
First Resource On Scene		Crew On Scene	01:22	Crew Left Scene	01:49
Crew At Hosp		Receiving Hospital	QUEEN ELIZABETH UNIVERSITY HOSPITAL	Clear Time	

Crew ID	Crew Grade	Driver
E9885759	Ambulance Technician	YES
E0022128	Paramedic	N

Glasgow Royal Infirmary
Emergency Department

NHS
Greater Glasgow and Clyde

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Initial Investigations Ordered

FBC ☐	COAG ☐	DD ☐	INR ☐		G+S ☐		X-match units			
U+Es ☐	LFT ☐	GLU ☐	CRP ☐	TROP ☐	Para ☐	Sal ☐	Ethanol ☐	Mg ☐	VBG ☐	ABG ☐
B culture ☐		C/MSSU ☐		Urinalysis ☐		BHCG ☐		Other		
CXR ☐	AXR ☐	Other imaging:								ECG ☐
Current location:								Sent by:		

Clinical Notes

Date 14/11/23 Time 3:38 Name L-Lei Grade COF Speciality

(48) F p/w intentional OD of own meds

HPC: Intentional OD of 4/7 worth of own meds at 11:00. Told staff at Talbot ASIC when they came to check on her. Had small amount of alcohol along with. Denies drugs c/o abdo pain only. ✓vomiting ✓chest pain ✓palpitations ✓drowsiness ✓agitation ✓seizures ✓headache ✓unresponsive.

estimated ingestion (93kg)

- sertraline 800 mg → 8.6 mg/kg 6° observation
- quetiapine 400 mg → 4.3 mg/kg 6° observation
- atorvastatin 160 mg → 1.7 mg/kg 4° observation
- dapagliflozin 40 mg → 0.4 mg/kg 4° observation
- gliclazide 320 mg → 3.4 mg/kg 6° observation

* see mental health Asp form

PMH:
- mild learning disability
- EUPD
- prev F/P admission @ Gartnavel Y
- T2DM
- depression (known to Springpark CMHT).
- multiple prev OD

Drug Hx (GMSOA)
- sertraline 200 mg OD
- quetiapine 25mg mane 25mg 13:00 50mg nocte
- atorvastatin 40 mg OD
- dapagliflozin 10mg OD
- gliclazide 80mg OD

Social Hx
- lives in Talbot Assn (housing for learning disabled people)
- non-smoker, occasional alcohol, no drugs

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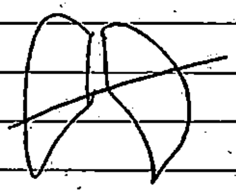
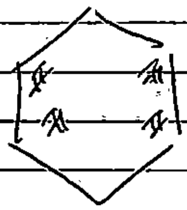
Clinical Notes

Date	Time	Name	Grade	Speciality

O/E NEWS = 3 (temp 35.7, BP 102/68, HR 102)





soft, mild tenderness (L) & (R) sides upper > lower BS+

HS I+II+0
no oedema

GCS 15
- PEARL, 2-3 mm
- no clonus
- BM 11.3

ECG/ ~~[illegible]~~ NSR, VR 98, QTc 459
nil acute

Bloods/ U&E (N) CK 52
CRP 6
bicarb 21
glu 11.1
LFT (N)
WCC 9.2
Neut 5.9
APTT 44

Imp - alleged polypharmacy OD

Plan - add on CK

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F
21/07/1979

Clinical Notes

Date	Time	Name	Grade	Specialty

well outwith observation period ↓ UK (N), refer to MHAT

Has social worker and support worker. Spoke to Siobhan @ MHAT who feels this is more help-seeking behaviour and stress response rather than a genuine suicide attempt. Has 24° supported accommodation with a view to move her somewhere else which may have precipitated low mood. In the process of getting CPN and has FUA with Psychiatrist (Dr. Pasha). Doesn't think she needs to be assessed as they will not change her Tx plan or admit her. Will let her own team at Spring Park know of her presentation.

D/C (H) + worsening advice.

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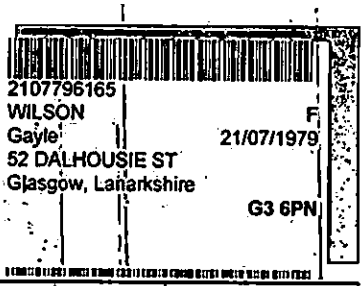
Emergency Department



HAEM	DATE or TIME		BIOCH	DATE or TIME			DATE or TIME		V/ABG	DATE or TIME	
WCC			Na			Bil			FiO_2		
Hb			K			ALT			H^+		
Plat			Cl			AST			$PaCO_2$		
Neut			Ur			GGT			PaO_2		
DD			Creat			A'phos			Bic		
PT			eGFR			Alb			BE		
PTT			Glu			AdjCa			Lactate		
TT			CRP			Amyl			Ethanol		
INR			Mg			TropI HS			Para		
			Phos			BHCG			Sal		

Diagnosis and Plan

Review/Discussed with:

Handover

- ☐ Provisional Diagnosis
- ☐ Liquids/Fluids
- ☐ Analgesic/Medicines
- ☐ NEWS
- ☐ Investigations & Results
- ☐ Talk to receiving team/ward

mi • 287967 Version 1_0 • GGC0226

Greater Glasgow & Clyde Emergency Departme
Mental Health Triage and Risk Assessment Too

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G3 6PN

Glasgow
lyde

Patien
CHI

Part One - Nursing Triage
triage nurse to complete this page

Triage Observations
document physiological measurements

GCS	BM	HR	BP	RR	SaO^2	Temp
15/15	11.3	102	102/64	16	95	35.7

accompanied by
name, relationship, particular concerns

Alone.

Describe the appearance/clothing of those attending alone, as they may leave before review.

Is the patient a young person in foster care or in a residential care placement? **YES/NO**

Is the patient a carer for a child or a dependent adult? **YES/NO**

Is there a child protection concern or concern for a vulnerable adult at risk? **YES/NO**

Outline of Presentation
tick all the categories which apply

Overdose (will also require medical assessment)	✓
Self-injury (will also require wound management)	
Other Mental Health Presentation	

Initial Presentation, Appearance and Behaviour
respond yes or no to each question in any order which seems appropriate

Is the patient violent, aggressive or threatening?	Y		(N)
Is the patient obviously distressed, markedly anxious or highly aroused?		Y	(N)
Is the patient preoccupied, erratic or impulsive?	Y		(N)
Is the patient quiet and withdrawn?		Y	(N)
Do you think the patient is behaving inappropriately to their situation?		Y	(N)
Do you think the patient presents an immediate risk to you, to others, or to themselves?	Y		(N)
Do you think the patient is likely to abscond prior to assessment?	Y		(N)
Do you think the patient's presentation suggests either hallucinations or delusions?*	Y		(N)
Do you think the patient feels their actions are being controlled?	Y		(N)
Are you aware of a history of mental health problems or psychiatric illness?		(Y)	N
Are you aware of a history of violence or self-harm?		(Y)	N
Is the patient currently expressing suicidal thoughts?	Y		(N)
Is the patient currently intoxicated, with alcohol, or other substances?		Y	(N)

*Delusions: false but firmly held views and ideas. Hallucinations: false external stimuli (for example, visual or vocal) the patient thinks are real

Triage Risk Assessment
identify an initial category of risk; select one or more risks

High / Moderate / Low – risk
of self-harm / violence / absconding

Triage Category		High risk – accompanied *and* in the clinical area. Moderate risk – accompanied *or* in the clinical area. Low risk – can be asked to wait *if necessary*.

Immediate management
print toxbase information and in paracetamol overdose, note 4-hour time for blood sample.

Patient location, accompanied by...	Summary Blue Nike tracksuit Black Nike Hat White / Pink Trainers Heavy Set
Blood sample time?	
Toxbase info printed? Y/N	
GMAWS considered? Y/N	

Any responses in the first column **High Risk**

Other patients can be categorised as **Moderate Risk**

If *all responses* are in the third column **Low Risk**

name/grade
M. HARKINS

signature
M. Harkins

date and time
14/1/22, 02:10

Version 3.0. Jan 2017

Part Two - Mental Health Assessment

medical staff to complete this page

Patient name _____

CHI _____

outline of current presentation and precipitating factors

(45) intentional OD of own regular meds c suicidal intent. Said it was planned but no evidence of planning. NO precipitant. Still ongoing suicidal ideation. Told staff member of OD when they checked on her. Has felt more low in recent months but no reason as to why. Took meds c some alcohol. Says she no longer wants to be alive.

current and previous mental health problems, self-harm episodes, problematic alcohol and/or drug use, contacts with mental health services

DSH (cutting) c H/P at Gartnavel c many prev OD

other relevant information, (relationships, finances, employment, housing, physical health, childcare responsibilities, current medications, etc) - protective factors (beliefs, relationships, plans for future) - views of relatives/carers/significant others

has contact c mum and niece → says relationship is good

Appearance	Behaviour	Speech
Kempt	no evidence of psychomotor agitation or retardation	(P)

Mood	Thought	Insight
mood - low affect - restrict	no evidence of thought disorder	unsure how much insight she has

Risk Factors

(this is not an exhaustive list)

alcohol or drug use	✓
planning or concealment	
evidence of psychosis	
ongoing suicidal intent	✓
family concern about risk	
access to lethal means	
lack of social support	
age and gender	
chronic illness/pain	
family history of suicide	
disengaged/noncompliant	
unemployed/retired	✓
previous violent methods	
history of self-harm	✓
current psychiatric treatment	-
previous psychiatric treatment	✓

Careful consideration should be given to patients who may present particular risks, including patients who may have post-natal depression, or patients with 'first presentations' of mental health problems, especially in adolescence or old age.

Risk Assessment

based on clinical assessment indicate a category of risk for a further episode of self-harm in the short term (48hrs) - consider protective as well as precipitating factors.

High / Moderate / Low

If young people in foster care or residential care are assessed, their social work team should be informed (via stand-by SW if out-of-hours) as well as giving information and advice to carers present.

Discharge Advice and Plan for Further Assessment

indicate the follow-up plan – referral to Liaison Psychiatry, duty doctor, out-of-hours CPN service, CMHT, GP, addiction services, SW, etc - indicate the advice given to the patient, and identities of others informed.

summary	follow up and advice given
polypharmacy OD not requiring treatment or admission WDN ongoing suicidality	

service referred to	name/relationship of carer informed	consultant/middle-grade involved in decision or review
MHAAU		N. French

name/grade ULM (E) CDF

signature

date and time 14/1/23 433

2107796165
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Gayle 21/07/1979
52 DALHOUSIE ST
Glasgow, Lanarkshire
G3 6PN

420

7 ATORVASTATIN 40MG TABLETS

ONE to be taken DAILY

Instalment 2 of 4
Miss Gayle Wilson(6416) 12/01/2023

DUNNET PHARMACY
1399 Dumbarton Road, Glasgow G14 9XS. Tel: 0141 959 2196
KEEP OUT OF REACH & SIGHT OF CHILDREN

DISP RC CHKD

COLOUR	SHAPE	NOTE 1
White	Oval	
MARK	TAB/CAP	

7 DAPAGLIFLOZIN 10MG TABLETS (FORXIGA)

ONE to be taken DAILY Read the printed advice. Swallow whole with water.

Instalment 2 of 4
Miss Gayle Wilson(6416) 12/01/2023

DUNNET PHARMACY
1399 Dumbarton Road, Glasgow G14 9XS. Tel: 0141 959 2196
KEEP OUT OF REACH & SIGHT OF CHILDREN

DISP RC CHKD

COLOUR	SHAPE	NOTE 2
Yellow	Diamond	
MARK 10	TAB/CAP —	

308

7 GLICLAZIDE 80MG TABLETS (GLICLAZIDE)

~~Initially half or~~ one to be taken each morning with breakfast.

Instalment 2 of 4
Miss Gayle Wilson(6416) 12/01/2023

DUNNET PHARMACY
1399 Dumbarton Road, Glasgow G14 9XS. Tel: 0141 959 2196
KEEP OUT OF REACH & SIGHT OF CHILDREN

DISP RC CHKD

COLOUR	SHAPE	NOTE 3
White	Round	
MARK G03	TAB/CAP	

532

28 QUETIAPINE 25MG TABLETS (QUETIAPINE)
ONE to be taken in the MORNING and at 1pm and TWO to be taken at NIGHT If sleepy do not drive/use machines. Avoid alcohol.

Instalment 2 of 4
Miss Gayle Wilson(6416) 12/01/2023

DUNNET PHARMACY
1399 Dumbarton Road, Glasgow G14 9XS. Tel: 0141 959 2196
KEEP OUT OF REACH & SIGHT OF CHILDREN

DISP RC CHKD

COLOUR	SHAPE	NOTE 4
Orange	Round	
MARK Q	TAB/CAP —	

560

14 SERTRALINE 100MG TABLETS (SERTRALINE)

TWO to be taken DAILY Avoid grapefruit juice during treatment with this medicine. Read the printed advice.

Instalment 2 of 4
Miss Gayle Wilson(6416) 12/01/2023

DUNNET PHARMACY
1399 Dumbarton Road, Glasgow G14 9XS. Tel: 0141 959 2196
KEEP OUT OF REACH & SIGHT OF CHILDREN

DISP RC CHKD

COLOUR	SHAPE	NOTE 5
White		
MARK	TAB/CAP —	

6

COLOUR	SHAPE	NOTE 6
MARK	TAB/CAP	

7

COLOUR	SHAPE	NOTE 7
White		
MARK	TAB/CAP —	

8

COLOUR	SHAPE	NOTE 8
MARK	TAB/CAP	

MON TUE WED THUR FRI SAT SUN MOR

ITEM # 3

P - 120
SPO2 97
BM 11·3
Temp 37·3
BP 130/81 ~~127/84~~
RR 18

Took 4/7 days worth meds.

? Sucidal

Emergency Department Nursing Documentation

Presenting Complaint -

Date: 14 / 01 / 2023 Time: 0243

2107796165
WILSON F
Gayle 21/07/1979
52 DALHOUSIE ST
Glasgow, Lanarkshire
G3 6PN

NHS Greater Glasgow and Clyde

Assessment Complete by: Name NURSE (Please Print) Lorna, ANNA

Patient Prep / Investigations (Please tick/circle when completed)		Communication (Please Circle Tick)	
Prepare patient for examination / Clothing bag labelled + stored	☑	NEWS Chart complete / NEWS SCORE - (Record pain, blood sugar and Neuro Obs on NEWS Chart)	1
GGC RED BAG - with patient	☐		
12 Lead ECG	☐	ID Band	☑
Weight:	☐	Peak Flow	☐
Blood Samples Obtained: Yes ☑ No ☐		Xrays / CT Scan Performed:	☐
IV Access: Yes ☐ No ☑		Relatives / NOK informed (Carers)	☐
Blood Gas: VBG ☑ ABG ☐		Child Protection Concern (considered in line with policy)	Y/N
		Adult Support and Protection	Y/N

Urinalysis

Leucocytes ☐	Nitrites ☐	Protein ☐	Blood ☐
Ketones ☐	Glucose ☐	PH	S.G.
MSSU / CSU ☐	Toxiclogy ☐		
HCG ☐	+VE ☐	-VE ☐	Strip No -

Screening Tools (Please tick/circle when completed)			
SEPSIS RISK? / SIRS Criteria 2 or more	Y/N	**SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)**	YES
Mental Health Triage Assessment	Y/N	If NOT WHY? - (details)	NO
GMAWS	Y/N	Date - 14 01 2023. Time - 0244 Signature - LornaBurns	

4AT	
AMT	Correct
Age	
Date of Birth	
Place	
Current year	

No mistakes	= 0
1 mistake	= 1
> 1 mistake	= 2

Attention (months of year backwards)	
> = 7 correct	0
< 7 correct	1
Untestable	2

Alertness	
Normal	0
Mild sleepiness	0
Clearly abnormal	4

Mental status according to family/carer		
Acute change or fluctuating	4	YES
Acute change or fluctuating	0	NO

4AT score

0 /12

STEP 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?

All over 75s and care home residents over 65. For younger patients use clinical judgement and consult local guidelines.

		YES	NO
F	**F**unctional impairment (new or worsening) eg difficulty with self care		
R	**R**esident in a care home?		
A	**A**ltered mental state such as acute confusion or dementia use the 4AT		
I	**I**mmobility/instability. New decline in mobility, difficulty mobilising without help or fall leading up to admission		
L	**L**ikely to require support for discharge? (either new or increase in existing support)		

Are any of the above criteria met? If YES to any of the above move to step 2

STEP 2 Would this person be better managed by another specialty team at present?

Indicator for care by another acute specialty regardless of age.

	YES	NO
Clear need for other specialty input eg exacerbation of known long term condition such as COPD		
Need for HDU/ITU (including non-invasive ventilation)		
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit		
Head injury with loss of consciousness		
Acute abdominal pain/surgical presentation		
Upper GI Bleed		
Chest pain with suspected acute coronary syndrome		
Trauma with suspected fracture		

Are any of the above 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 **NO** to the list in step 2:

- Prioritise transfer of care to specialist geriatric assessment service in line with local guidance.

Screening Tools / ACTIVE CARE

(Please tick/circle when completed)

		Y/N
1) Pressure Damage Does the person have redness and/or existing damage? If YES - continue with a minimum of 2 hourly Active Care + Complete PUDRA		Y/N
2) Mobility	Does the person require assistance?	Y/N
3) Continence		Y/N
4) Nutrition		Y/N

Date	Location of Redness/Ulcers	Grade of Ulcer

5) Skin	Is skin compromised by other source, eg neurological deficit, medication, substance, diabetes, co-morbid?	Y/N
6) Judgment	In your clinical judgment is this person at risk for developing pressure damage? IF YES - DETAILS	Y/N

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.

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At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc) *At risk complete risk assessment*	
YES	NO

Pause for Transfer / Discharge (Please tick when completed)		Tick when completed	N/A	Notes
Relatives Informed of Admission / Discharge		☐	☐	Information on discussion with relatives
Relatives/carer with patient on transfer to ward		☐	Always	
GGC RED BAG - with patient		☐	Always	
Name Band		☐	Always	
Nursing Screening Tools completed		☐	Always	
Bed requested, SBAR COMPLETE		☐	☐	
NEWS chart		☐	Always	
Prescriptions / Charts signed	Infusions	☐	☐	
Cannula		☐	☐	
Notes: medical notes, GP letter, PRF		☐	☐	
Patients requiring analgesia: sufficient		☐	☐	
Belongings (including patients medication)		☐	Always	Please note here if any other tasks required prior to transfer
SAS Transport required and ref. no.		☐	☐	
Print Name Sign -				

Nursing Notes

Date and Time		Print Name and Signature
14/01/2023	NEWS 3	
0245	GCS 15/15 all care commenced.	
	Transferred into Room 8.	
	all nursing care continues.	LBurns
0312	Bloods obtained.	RGN.
0410	ECG traced.	

Nursing Notes

Date and Time		Print Name and

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8 Gayle Wilson

NEWS 2 Key | 1 | 2 | 3

	Example	Entry
Date	1/11	11/1/23
Time	11.00	0215

A + B Respirations Breaths/min

Range	Score	Example	Entry
≥25	3		
21-24	2		
12-20	0	•	16
9-11	1		
≤8	3		

A + B SpO2 Scale 1 Oxygen saturation (%)

Range	Score	Example	Entry
≥96	0	97	96
94-95	1		
92-93	2		
≤91	3		

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

Only use scale 2 under direction of qualified clinician

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

Air or oxygen?

Range	Score	Example	Entry
Air (A) or O2 device	0	A	(A)
O2 L/min 2	2		

C Blood Pressure mmHg (Score uses systolic BP only)

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

C Pulse Beats / min

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

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

Range	Score	Example	Entry
A Alert	0	•	•
C New Confusion	3		
V Verbal	3		
P Pressure	3		
U Unresponsive	3		

E Temperature

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

	Example	Entry
NEWS Total	0	3
Blood glucose	7.0	11.3
Pain / function score	OA	✓
Time Pt last passed urine	10.20	✓
Fluid balance chart indicated Y/N	N	/
GCS indicated Y/N	N	Y
Time NEWS due	23.00	
Escalation of care Y / N	N	Y
Initials	AB	TR

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Abbreviations for recording oxygen device

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

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NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

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

Think ACE

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

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

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

NHSGGC NEWS – National Early Warning Score

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	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

SpO2 Scale 1 Target >96%	SpO2 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP initials ONLY:	Dr/ANP initials ONLY:	
Date:	Date:	

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed...

Medical: ....

Date: ....

Pupil Reaction and size

s = sluggish
+ = reaction
- = no reaction
c = eyes closed

Pupil Size (mm) 1 2 3 4 5 6 7 8

Glasgow Coma Scale

Date: 11/1
Time: 11.00

EYES – Eyes closed by swelling = NT: Spontaneously 4, To sound 3, To pressure 2, None 1, Non testable NT

VERBAL – Endotracheal tube or tracheostomy = NT: Orientated 5, Confused 4, Words 3, Sounds 2, None 1, Non testable NT

MOTOR – Always record the best response: Obeys command 6, Localising pressure 5, Normal flexion 4, Abnormal flexion 3, Extension 2, None 1, Non testable NT

TOTAL 15

PUPILS – Right size, Right reaction, Left size, Left reaction

ARMS – Record right (R) and left (L) separately if there is a difference between the two sides: Normal power, Mild weakness, Severe weakness, Spastic flexion, Extension, No response

LEGS – Record right (R) and left (L) separately if there is a difference between the two sides: Normal power, Mild weakness, Severe weakness, Spastic flexion, Extension, No response

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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

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

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Glasgow Royal Infirmary

CHI: 2107796165

Total Att: 21

12 Mth Att: 3

Title: **MISS**

WILSON **Gayle**

DOB **21/07/1979** Age: **41y** Sex: **Female**

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07771241541

Next of kin: **WINTERS, Rita**
Relationship: **Aunt**
01412301448

GP: **NT Bhatti**
0141 334 9331

Attendance Date: **09/03/2021** Arrival Time: **20:17**

Registration Time: **20:17** Date of Incident: **09/03/2021**

Major Incident Desc:

Reason for Attendance: **chest pain - no ft**

Nursing Assessment

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

Triage Category: 2 Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **09/03/2021 20:19** Nurse name: **Nurse Paige Cairns**

Temp	**36.7**	C
HR	**127**	bpm
BP	**131/92**	mmHg
MAP	**105.00**	mmHg
RR	**20**	bpm
SpO2	**97**	%
Oxygen		%

BM	**19.5(SAS)**	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	**4**
Motor	**6**
Verbal	**5**
Total	**15**

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

Nursing Notes: **"CCP, tachycaria ad tightness in L calf. BM 19.5, no diabetes diagnosis. Denies covid symptoms. "**

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To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

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

Date	**Clinical Notes**		
	Seen By	Time Seen	

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By

Patient Information		Date:	09/03/2021
GAYLE WILSON		Incident Number:	CR007244720
Age/Gender:	41 years 7 months 19 days Old Female		
Address:	52 DALHOUSIE STREET GARNETHILL GLASGOW,G3 6PN	Incident Type:	EMG
DOB:	21/07/1979	Incident Location:	52 DALHOUSIE STREET GARNETHILL GLASGOW, G3 6PN
CHI:			
Ethnicity:	White Scottish		

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Presenting Complaint

CHEST PAIN/ HIGH BM

Additional Comments

41 yof, central chest pain, fast heart rate and tightness in left calf. Pt was admitted 2 weeks ago following an overdose, advised to remain in the hospital but pt self discharged. O/a crew met by support worker, pt sitting in office, alert, speaking in full sentences. O/e baseline obs as charted, pain score 5/10, bm 19.5 pt not diagnosed with diabetes but it was noticed on last hospital admission.

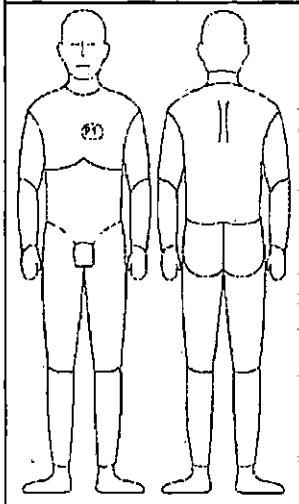
PATIENT ASSESSMENT

ACVPU	Alert		<C>	No			
A	Clear						
B	Breathing Adequately	Yes	Respiratory Rate 20		SPO2	98	
	Oxygen Given	No					

C	Pulse Rate	BP	Cap Refill	ECG Rhythm
	136	139/91	<=2 Secs	Sinus Tachy
	Rhythm	**Arm**	**Central/Peripheral**	**ECG**
	Reg	Right	Peripheral	12 Lead

D	GCS	Eyes	Voice	Motor	PEARL
	15	Spontaneously (4)	Orientated (5)	Obeys Commands (6)	Yes

E



Pain

ID	Body Part	Pain Scale
P1	Chest	5

Observations

Time	P	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
19:35	138	20	135/92	98	<=2s		Alert								E9887455
19:30	136	20	139/91	98	<=2 Secs	15	Alert		36.9	19.5	Sinus Tachy	4	4		E9887455

NEWS2

Time	RR	SpO2 Scale 1	SpO2 Scale 2	Air/O2	BP	P	ACVPU	T	Total
19:30	20 (0)	98 (0)		0	139 (0)	136 (3)	Alert (0)	36.9 (0)	3

HISTORY

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F
79
N

21/07/19;

AMPLE

Allergies	PENICILLIN
Medication	Sertraline, Quetiapine, Simvastatin
Past Medical History	BOARDERLINE PERSONALITY DISORDER, LEARNING DISABILITIES
Last Eaten	>4 Hours Ago
Events Prior	BUILD UP OVER THE PAST 3 DAYS

Social History

Patient Occupation	Does Not Work
Patients General Appearance	Normal
Living Arrangement	SUPPORTED ACCOMMODATION
Patient Mobility	Fully Mobile
Patient Communication	No Help Required
Patient Clinical Risk Factors	Smoker
Patient Enviromental Risk Factors	None Identified

CLOSE RECORD

Treatment On Scene	Non Emergency

Conveyance

Transport To Hospital	Normal driving	Pre Alert	No

INCIDENT LOG

Time Call Received	19:08	Allocated	19:10	Mobile	19:10
First Resource On Scene		Crew On Scene	19:20	Crew Left Scene	20:07
Crew At Hosp	20:14	Receiving Hospital	QUEEN ELIZABETH UNIVERSITY HOSPITAL	Clear Time	

Crew ID	Crew Grade	Driver
E0017051	Paramedic	YES
E9887455	Ambulance Technician	NO

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Initial Investigations Ordered

FBC ☐	COAG ☐	DD ☐	INR ☐		G+S ☐		X-match units			
U+Es ☐	LFT ☐	GLU ☐	CRP ☐	TROP ☐	Para ☐	Sal ☐	Ethanol ☐	Mg ☐	VBG ☐	ABG ☐
B culture ☐		C/MSSU ☐		Urinalysis ☐		BHCG ☐		Other		
CXR ☐	AXR ☐	Other imaging:								ECG ☐
Current location:								Sent by:		

Clinical Notes

20.37 J. Kelly — 36.7°C
09/03/21 41♀: 'chest pain' — 127
131/92

Recent r/v by psychiatry: Feb 2021. Struggling w/ covid, impulsivity + emotional dysregulation. Unresolved bereavement issues. — RR20 — 97%A

5/7 'niggling' intermittent sharp chest pains. development of left calf "tightness" this morning - all day. This evening felt heart start to race + heaviness in chest. No respiratory or covid symptoms. No collapse. — BM 19.5

2UNS
- mild learning disability

OE: looks well, obese. RR20 36.7
97%A 127
BM 19.5
131/92

A ✓
B ✓
C radial ✓✓
left focal posterior calf tenderness → not swollen, no varicose veins
warm, well perfused all 4x limbs
pale.
non oedematous.

sertraline
statin
quetiapine

centripetal obesity
soft, non tender

D AVPU GCS 15 No FN — ECG NSR 123 — denies OD.
comfortable — QTc 407. — medications kept in "office" + supervised.

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Clinical Notes

Impression: chest pain, tachycardic, calf pain

? DVT/PTE

Plan: analgesia - comfortable, 12 lead ECG,
full routine + troponin + D dimer, CXR
Admit + Rx w/ LMWH if +ve.
Will need CTPA + calf USS if so.

Wells:

MGENEVA: 8 : Moderate risk

D dimer <100. Await troponin.
M Geneva → if -ve consider stopping wells.
CXR normal.
Serious ECG normal. DIC: Redheck ECG +
ensure VK settled. If all normal H.

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Clinical Notes

Trop<4. glucose 20.4. Bicarbonate normal + not acidotic
Likely diabetes T2DM. Soup had ad approximately
His morning to start antidiabetic medications.
'Step in'.

Now to d/c to ed. Commence anti-hyperglycaemic
treatment.
→ am 20. today.
09/09/21 20.2
22/02/21 27.3

Letter written to GP + d/c.
Repeat ECG normal + patient well.

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HAEM			BIOCH						V/ABG		
WCC			Na			Bil			FiO_2		
Hb			K			ALT			H^+		
Plat			Cl			AST			$PaCO_2$		
Neut			Ur			GGT			PaO_2		
DD			Creat			A phos			Bic		
PT			eGFR			Alb			BE		
PTT			Glu			AdjCa			Lactate		
TT			CRP			Amyl			Ethanol		
INR			Mg			TropI HS			Para		
			Phos			BHCG			Sal		

Diagnosis and Plan

Review/Discussed with:

Handover

- ☐ Provisional Diagnosis
- ☐ Liquids/Fluids
- ☐ Analgesic/Medicines
- ☐ NEWS
- ☐ Investigations & Results
- ☐ Talk to receiving team/ward

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21/07/197

Printed: 09/03/2021 20:53:33

ample Report

CCEPTED

Analyzed: 09/03/2021 20:51:33
Sample Type: **Venous**
Account Number:
Clinician:
Operator ID: EMMA CAMERON0

Patient	
ID:	2107796165
Last Name:	**WILSON**
First Name:	**GAYLE,**
Gender/Age:	Female, 41 years
Birth Date:	21/07/1979
Cartridge	
Lot No.:	210121D
S/N:	00000000500136557
Exp. Date:	30/03/2021
Analyzer	
Model:	GEM® *Premier 5000*
Area:	GRI
Name:	CASU
S/N:	16090423

Results			Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)						
cH	39.0	nmol/L	--	--	--	--
pCO_2	5.6	kPa	--	--	--	--
pO_2	5.8	kPa	--	--	--	--
Na^+	↓ 132	mmol/L	--	133	146	--
K^+	3.8	mmol/L	--	3.5	5.3	--
Cl^-	97	mmol/L	--	95	108	--
Ca^{++}	1.19	mmol/L	--	1.15	1.27	--
Glu	↑ 24.2	mmol/L	--	3.5	6.0	--
Lac	↑ 2.6	mmol/L	--	0.6	2.2	--
CO-Oximetry						
tHb	164	g/L	--	--	--	--
O_2Hb	↓ 70.2	%	--	95.0	98.0	--
COHb	↑ 3.6	%	--	0.5	1.5	--
MetHb	0.7	%	--	0.5	1.5	--
HHb	↑ 25.4	%	--	0.0	5.0	--
sO_2	↓ 73.4	%	--	95.0	98.0	--
Derived						
BE(B)	1.7	mmol/L	--	--	--	--
HCO_3^-(c)	26.6	mmol/L	--	--	--	--
Hct(c)	49	%	--	--	--	--

↑↓ Outside Reference Range

Other Information

Operator Entered		
Temp	37.0	°C

(4)

Emergency Department Nursing Documentation

chest pain

Presenting Complaint -

Date: 9/3/2021 Time: 2020

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NHS Greater Glasgow and Clyde

Assessment Complete by: Name NURSE (Please Print)

Patient Prep / Investigations (Please tick/circle when completed)		Communication (Please Circle Tick)	
Prepare patient for examination / Clothing bag labelled + stored	☑	NEWS Chart complete / NEWS SCORE - (Record pain, blood sugar and Neuro Obs on NEWS Chart)	☑
GGC RED BAG - with patient	☐		
12 Lead ECG	☑	ID Band	☐
Weight:	☐	Peak Flow	☐
Blood Samples Obtained: Yes ☑ No ☐		Xrays / CT Scan Performed:	☐
IV Access: Yes ☑ No ☐		Relatives / NOK informed (Carers)	☐
Blood Gas: VBG ☑ ABG ☐		Child Protection Concern (considered in line with policy)	Y/N
		Adult Support and Protection	Y/N

Urinalysis

Leucocytes ☐	Nitrites ☐	Protein ☐	Blood ☐
Ketones ☐	Glucose ☐	PH	S.G.
MSSU / CSU ☐	Toxiclogy ☐		
HCG ☐	+VE ☐	-VE ☐	Strip No -

Screening Tools (Please tick/circle when completed)			
SEPSIS RISK? / SIRS Criteria 2 or more	Y/N	**SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)**	YES
Mental Health Triage Assessment	Y/N	If NOT WHY? - (details) N/A	NO
GMAWS	Y/N	Date - 09.03 2021 Time - 2050 Signature - nmurphy	

4AT	
AMT	Correct
Age	
Date of Birth	
Place	
Current year	

No mistakes	= 0
1 mistake	= 1
> 1 mistake	= 2

Attention (months of year backwards)	
> = 7 correct	0
< 7 correct	1
Untestable	2

Alertness	
Normal	0
Mild sleepiness	0
Clearly abnormal	4

Mental status according to family/carer		
Acute change or fluctuating	4	YES
Acute change or fluctuating	0	NO

4AT score /12

STEP 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?

All over 75s and care home residents over 65. For younger patients use clinical judgement and consult local guidelines.

		YES	NO
F	**F**unctional impairment (new or worsening) eg difficulty with self care		
R	**R**esident in a care home?		
A	**A**ltered mental state such as acute confusion or dementia use the 4AT		
I	**I**mmobility/instability. New decline in mobility, difficulty mobilising without help or fall leading up to admission		
L	**L**ikely to require support for discharge? (either new or increase in existing support)		

Are any of the above criteria met? If YES to any of the above move to step 2

STEP 2 Would this person be better managed by another specialty team at present?

Indicator for care by another acute specialty regardless of age.

	YES	NO
Clear need for other specialty input eg exacerbation of known long term condition such as COPD		
Need for HDU/ITU (including non-invasive ventilation)		
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit		
Head injury with loss of consciousness		
Acute abdominal pain/surgical presentation		
Upper GI Bleed		
Chest pain with suspected acute coronary syndrome		
Trauma with suspected fracture		

Are any of the above 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 **NO** to the list in step 2:

- Prioritise transfer of care to specialist geriatric assessment service in line with local guidance.

Screening Tools / ACTIVE CARE

(Please tick/circle when completed)

			Date	Location of Redness/Ulcers	Grade of Ulcer
1) Pressure Damage Does the person have redness and/or existing damage? If YES - continue with a minimum of 2 hourly Active Care + Complete PUDRA		Y/N			
2) Mobility	Does the person require assistance?	Y/N			
3) Continence		Y/N	**5) Skin**	Is skin compromised by other source, eg neurological deficit, medication, substance, diabetes, co-morbid?	Y/N
4) Nutrition		Y/N	**6) Judgment**	In your clinical judgment is this person at risk for developing pressure damage? IF YES - DETAILS	Y/N

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.

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At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc) *At risk complete risk assessment*	
YES	NO

Pause for Transfer / Discharge (Please tick when completed)		Tick when completed	N/A	Notes
Relatives Informed of Admission / Discharge		☐	☐	Information on discussion with relatives
Relatives/carer with patient on transfer to ward		☐	Always	
GGC RED BAG - with patient		☐	Always	
Name Band		☐	Always	
Nursing Screening Tools completed		☐	Always	
Bed requested, SBAR COMPLETE		☐	☐	
NEWS chart		☐	Always	
Prescriptions / Charts signed	Infusions	☐	☐	
Cannula		☐	☐	
Notes: medical notes, GP letter, PRF		☐	☐	
Patients requiring analgesia: sufficient		☐	☐	
Belongings (including patients medication)		☐	Always	Please note here if any other tasks required prior to transfer
SAS Transport required and ref. no.		☐	☐	
Print Name Sign -				

Nursing Notes

Date and Time		Print Name and Signature
9.3.2021	Presents with central chest	
2050	pain and tightness in (L)	
	calf Bm elevated not	
	known diabetic	nmurphy SN
	Bloods & ecg rtd bloodgases &	
	cyanosed around region	
	by Dr	
2120	Remains settled and pain free	
	attends xray awaits blood	
	results for plan	nmurphy SN

Nursing Notes

2107796165
WILSON
Gayle F
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Glasgow, Lanarkshire
G3 6PN

Date and Time		

4

Gayle wilson.

2107796165
WILSON
Gayle F
21/07/1979
52 DALHOUSIE ST
Glasgow, Lanarkshire
G3 6PN

NEWS 2 Key	1	2	3

Date	1/11	9 a3					
Time	11.00	20 10	21 20	22 20	23 10		
A + B Respirations Breaths/min					≥25	3	
					21-24	2	
	•	20	19	0	12-20	0	
					9-11	1	
					≤8	3	
A + B SpO2 Scale 1 Oxygen saturation (%)	97	97	98	96	≥96	0	
					94-95	1	
					92-93	2	
					≤91	3	
SpO2 Scale 2 Oxygen saturation (%) Use Scale 2 if target range is 88-92% e.g. in chronic hypercapnic respiratory failure. Only use Scale 2 under direction of qualified clinician					≥97 on O2	3	
					95-96% on O2	2	
					93-94% on O2	1	
					≥93 on air	0	
					88-92	0	
					86-87	1	
					84-85	2	
					≤83	3	
Air or oxygen?	A	A	A	A	Air (A) or O2 device	0	
					O2 L/min 2	2	
C Blood Pressure mmHg (Score with systolic BP only)		151			≥220	3	
					201-219	0	
					181-200	0	
					161-180	0	
					141-160	0	
					121-140	0	
					111-120	0	
					101-110	1	
					91-100	2	
					81-90	3	
					71-80	3	
					61-70	3	
					51-60	3	
					≤50	3	
C Pulse Beats / min		87			≥131	3	
					121-130	2	
					111-120	2	
					101-110	1	
					91-100	1	
	•				81-90	0	
					71-80	0	
					61-70	0	
					51-60	0	
					41-50	1	
					31-40	3	
					≤30	3	
D Any changes in neuro response, do GCS. Immediate medical review. Check Blood Glucose. Think Delirium.	•	A	A	A	A Alert	0	
					C New Confusion	3	
					V Verbal	3	
					P Pressure	3	
					U Unresponsive	3	
E Temperature					≥39	2	
					38.1-39.0	1	
	•	37			37.1-38.0	0	
					36.1-37.0	0	
					35.1-36.0	1	
					≤35.0	3	
NEWS Total	0	2		2			
Blood glucose	7.0	9.5					
Pain / function score	0A						
Time Pt last passed urine	10.20			/			
Fluid balance chart indicated Y/N	N	N		N			
GCS indicated Y/N	N	N		N			
Time NEWS due	23.00						
Escalation of care Y / N	N	N					
Initials	AB	AB		AL			

Abbreviations for recording oxygen device

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

NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

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

Think ACE

A	Action: Working diagnosis (consider SEPSIS). Consider frequency of observations. Management plan. Set review time. Document.
C	Communicate: Inform nurse of plan. Inform senior medic if necessary. Document the discussion.
E	Escalate: Document the treatment escalation plan. Should include need for next level of care & consideration of resuscitation status.

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

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	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

SpO2 Scale 1 Target >96%	SpO2 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP Initials ONLY:	Dr/ANP Initials ONLY:	
Date:	Date:	

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed.......................................

Medical:.......................................

Date:.......................

Glasgow Coma Scale

Pupil Reaction and size: s = sluggish, + = reaction, - = no reaction, c = eyes closed

Pupil Size (mm): 1 2 3 4 5 6 7 8

Eyes: Spontaneously 4, To sound 3, To pressure 2, None 1, Non testable NT (Eyes closed by swelling = NT)

Verbal: Orientated 5, Confused 4, Words 3, Sounds 2, None 1, Non testable NT (Endotracheal tube or tracheostomy = NT)

Motor: Obeys command 6, Localising pressure 5, Normal flexion 4, Abnormal flexion 3, Extension 2, None 1, Non testable NT (Always record the best response)

TOTAL

Pupils: Right size; Right reaction; Left size; Left reaction

Arms: 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)

Legs: 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)

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

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

MI • 316654 v5.1 • GGC0264

Glasgow Royal Infirmary

CHI: 2107796165

Total Att: 20

12 Mth Att: 2

Title: **MISS**

WILSON **Gayle**

DOB **21/07/1979** Age: **41y** Sex: **Female**

Talbot Association Ltd
52 Dalhousie Street
Glasgow
G3 6PN
07771241541

Next of kin: **WINTERS, Rita**
Relationship: **Aunt**
01412301448

GP: **NT Bhatti**
0141 334 9331

Attendance Date: **27/02/2021** Arrival Time: **00:10**

Registration Time: **00:10** Date of Incident: **27/02/2021**

Major Incident Desc:

Reason for Attendance: **PER NHS 24**

Nursing Assessment

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

Triage Category: **2** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **27/02/2021 00:25** Nurse name: **Nurse Louise Patterson**

Temp	**36.6**	C
HR	**129**	bpm
BP	**140/92**	mmHg
MAP	**108.00**	mmHg
RR	**18**	bpm
SpO2	**96**	%
Oxygen		%

BM	**26.2**	mmol/L
PF		l/min
Expected PF		l/min
Weight	**94.70**	kg
Height		cm

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	**4**
Motor	**6**
Verbal	**5**
Total	**15**

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

Nursing Notes: **INTENTIONAL OD. 400MG SETRALINE, 150MG QUETIAPINE AND 80MG SIMVISTATIN approx. 14.30. NHS 24 was called by pt housing unit. Patient looks pale and sweaty in triage. low covid no FT**

2107796165 21/07/1979 WILSON Gayle
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To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

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

Date	Clinical Notes	
	Seen By	Time Seen

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By

To Whom it may concern.

Gayle has been instructed by an NHS 24 GP to present at A +E to get an ECG, Gayle at 2.30pm earlier today took 400mg of sertraline, 150mg Quetiapine and 80mg of simvastatin.

GP's concern was that high dose sertraline and quetiapine could cause problems to the heart and to air the side of caution would like Gayle to get a scan.

If NHS staff would like more information then contact David at The Dalhousie Street Project on 0141 332 3512.

2107796165
WILSON F
Gayle 21/07/1979

Glasgow Royal Infirmary
Emergency Department

NHS
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Initial Investigations Ordered										
FBC ☐	COAG ☐	DD ☐	INR ☐		G+S ☐		X-match units			
U+Es ☐	LFT ☐	GLU ☐	CRP ☐	TROP ☐	Para ☐	Sal ☐	Ethanol ☐	Mg ☐	VBG ☐	ABG ☐
B culture ☐		C/MSSU ☐		Urinalysis ☐		BHCG ☐		Other		
CXR ☐	AXR ☐	Other imaging:								ECG ☐
Current location:								**Sent by:**		

Clinical Notes

Date 27/12/2021 Time Name GPST [illegible] Grade ST[illegible] Speciality EM

41 ♀ Intentional overdose

Background: EUPD
Mild learning disability

Today she took 'double the medication' ~ 14⁰⁰ 400mg [illegible]
Told night warden @ [illegible] 80mg [illegible]
accommodation who phoned NHS 24.

Unsure why she took tablets today

Denies drug/alcohol

Glasgow Royal Infirmary
Emergency Department

Patient Name
DoB
CHI Number

or affix label

Clinical Notes

Date | Time | Name | Grade | Speciality

(S) Struggles with suicidal ideation
insomnia
Lost sister in 2019 - OD
Struggles with this
close with her niece

(S) States she does not get on with current psychiatrist

(O) O/E looks clammy / sweaty
GCS 15/15
No clonus Pupils 3+ 3+

ECG: NSR QTc 450
Tachy 125bpm

HR 129 (→98)
BP 140/92
RR 18 SpO2 90%
(A)

VBG H+ 40.2 lactate 3.3
Glu - 11.0

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Clinical Notes

Date	Time	Name	Grade	Specialty

Not known to be diabetic
(currently drinking bottle c/ pepsi)

Imp: out with OD obs which are
fine but clammy / sweaty
+ raised ketones
Hyperglycaemic
not acidotic

(P) IV fluids
Admit medical for observation
POC COVID - NEGATIVE

Apt VBG - ketones now 2.9 ?
GU 23
Awaiting blood results

[illegible]

Glasgow Royal Infirmary
Emergency Department

Patient Name
DoB
CHI Number

or affix label

HAEM	DATE or TIME		BIOCH	DATE or TIME			DATE or TIME		V/ABG	DATE or TIME	
WCC			Na			Bil			FiO_2		
Hb			K			ALT			H^+		
Plat			Cl			AST			$PaCO_2$		
Neut			Ur			GGT			PaO_2		
DD			Creat			A phos			Bic		
PT			eGFR			Alb			BE		
PTT			Glu			AdjCa			Lactate		
TT			CRP			Amyl			Ethanol		
INR			Mg			TropI HS			Para		
			Phos			BHCG			Sal		

Diagnosis and Plan

Review/Discussed with:

Handover

- ☐ Provisional Diagnosis
- ☐ Liquids/Fluids
- ☐ Analgesic/Medicines
- ☐ NEWS
- ☐ Investigations & Results
- ☐ Talk to receiving team/ward

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Emergency Department Nursing Documentation

Presenting Complaint - Overdose

Date: 27/2/21 Time: 0045

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52 Dalhousie Street
Glasgow
G3 6PN
Label

NHS Greater Glasgow and Clyde

Assessment Complete by: Name NURSE (Please Print)

Patient Prep / Investigations (Please tick/circle when completed)		Communication (Please Circle Tick)	
Prepare patient for examination / Clothing bag labelled + stored	☑	NEWS Chart complete / NEWS SCORE - (Record pain, blood sugar and Neuro Obs on NEWS Chart)	☑
GGC RED BAG - with patient	☐		
12 Lead ECG	☑	ID Band	☐
Weight:	☐	Peak Flow	☐
Blood Samples Obtained: Yes ☐ No ☐		Xrays / CT Scan Performed:	☐
IV Access: Yes ☐ No ☐		Relatives / NOK informed (Carers)	☑
Blood Gas: VBG ☐ ABG ☐		Child Protection Concern (considered in line with policy)	Y/N
		Adult Support and Protection	Y/N

Urinalysis

Leucocytes	☐	Nitrites	☐	Protein	☐	Blood	☐
Ketones	☐	Glucose	☐	PH		S.G.	
MSSU / CSU	☐	Toxiclogy	☐				
HCG	☐	+VE	☐	-VE	☐	Strip No -	

Screening Tools
(Please tick/circle when completed)

SEPSIS RISK? / SIRS Criteria 2 or more	Y/N	**SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)**	YES
Mental Health Triage Assessment	Y/N	If NOT WHY? - (details) N/A	NO
GMAWS	Y/N	Date - 27/2/21 Time - 0045 Signature - Plasms	

4AT

AMT	Correct
Age	
Date of Birth	
Place	
Current year	

No mistakes	= 0
1 mistake	= 1
> 1 mistake	= 2

Attention (months of year backwards)	
> = 7 correct	0
< 7 correct	1
Untestable	2

Alertness	
~~Normal~~	0
Mild sleepiness	0
Clearly abnormal	4

Mental status according to family/carer		
Acute change or fluctuating	4	YES
Acute change or fluctuating	0	NO

4AT score

/12

STEP 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?

All over 75s and care home residents over 65. For younger patients use clinical judgement and consult local guidelines.

		YES	NO
F	**F**unctional impairment (new or worsening) eg difficulty with self care		
R	**R**esident in a care home?		
A	**A**ltered mental state such as acute confusion or dementia use the 4AT		
I	**I**mmobility/instability. New decline in mobility, difficulty mobilising without help or fall leading up to admission.		
L	**L**ikely to require support for discharge? (either new or increase in existing support)		

Are any of the above criteria met? If YES to any of the above move to step 2

STEP 2 Would this person be better managed by another specialty team at present?

Indicator for care by another acute specialty regardless of age.

	YES	NO
Clear need for other specialty input eg exacerbation of known long term condition such as COPD		
Need for HDU/ITU (including non-invasive ventilation)		
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit		
Head injury with loss of consciousness		
Acute abdominal pain/surgical presentation		
Upper GI Bleed		
Chest pain with suspected acute coronary syndrome		
Trauma with suspected fracture		

Are any of the above 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 **NO** to the list in step 2:

- Prioritise transfer of care to specialist geriatric assessment service in line with local guidance.

Screening Tools / ACTIVE CARE

(Please tick/circle when completed)

1) Pressure Damage Does the person have redness and/or existing damage? If YES - continue with a minimum of 2 hourly Active Care + Complete PUDRA		Y/N	**Date**	**Location of Redness/Ulcers**	**Grade of Ulcer**	
2) Mobility	Does the person require assistance?	Y/N				
3) Continence		Y/N	**5) Skin**	Is skin compromised by other source, eg neurological deficit, medication, substance, diabetes, co-morbid?		Y/N
4) Nutrition		Y/N	**6) Judgment**	In your clinical judgment is this person at risk for developing pressure damage? IF YES - DETAILS		Y/N

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.

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At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc) *At risk complete risk assessment*	
YES	NO

Pause for Transfer / Discharge (Please tick when completed)		Tick when completed	N/A	Notes
Relatives Informed of Admission / Discharge		☐	☐	Information on discussion with relatives
Relatives/carer with patient on transfer to ward		☐	Always	
GGC RED BAG - with patient		☐	Always	
Name Band		☐	Always	
Nursing Screening Tools completed		☐	Always	
Bed requested, SBAR COMPLETE		☐	☐	
NEWS chart		☐	Always	
Prescriptions / Charts signed	Infusions	☐	☐	
	Cannula	☐	☐	
	Notes: medical notes, GP letter, PRF	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	
Belongings (including patients medication)		☐	Always	Please note here if any other tasks required prior to transfer
SAS Transport required and ref. no.		☐	☐	
Print Name Sign -				

Nursing Notes

Date and Time		Print Name and Signature
27/2/21 0045	Pt into ~~acute~~ resus from triage following overdose. Pt feels well and settled in dept. Awaiting medical review at present ——	Plaums (S/N)
0140	Pt offered food and tea, refused at present ——	Plaums (S/N)

Nursing Notes		
Date and Time		Print Name and Signature

Patient r... 2107796165
WILSON
Date of b... Gayle F
Talbot Association Ltd 21/07/1979
CHI No:... 52 Dalhousie Street Glasgow
G3 6PN
... label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg) ..... Height (cm) .....

Prescription details									Administration details				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments
27/2		0.9% NaCl	500	IV	10				27/2				
27/2		0.9% NaCl	100	IV	1				27/2				
27/2		0.9% NaCl	100	IV	2				27/2	0400	RM		

*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.

NHS Greater Glasgow and Clyde

GLASGOW ROYAL INFIRMARY
EMERGENCY DEPARTMENT

2107796165 F
WILSON 21/07/1979
Gayle
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52 Dalhousie Street
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G3 6PN

Self discharge against advice (Refusal of treatment)

Notes for Medical and Nursing Staff

- Patients are under no obligation to follow the advice of medical and nursing staff and may wish to take their own discharge against advice.
- However in order to allow an "irregular discharge" some criteria must be checked and documented (listed at bottom of page).
- Ensure that the patient is aware of what to look out for and when to return.
- Try to offer an alternative acceptable practice or treatment and consider notifying an outside agency for follow-up (e.g. relative, GP).
- Although alcohol or drugs can impact on a situation they may not by themselves nullify a patient's competence.
- If the patient appears to lack capacity or competence to have reached their decision, or you are unsure, then seek senior help.

INFORMATION FOR PATIENTS

- You have indicated that you wish to leave the Emergency (A&E) Department / Ward contrary to the advice of Medical and/or Nursing Staff.

Patients declaration	***"I have had the risks of this action explained to me and accept full responsibility for my action contrary to the advice of staff"***
Patients Signature	G WILSON
or	**Patient did not wish to sign form but fulfilled the criteria listed below** ☐

I certify that the patient has fulfilled the following criteria	*Witness to initial to confirm item checked*
1. Understands proposed treatment – purpose, benefits, risks.	G
2. Understands consequences of refusal to follow advice – actual and potential.	G
3. Able to retain information long enough to make a free and effective decision and explain their reasoning (even if you may disagree with their final decision).	G

C Witness Name	Signature	ST Designation
27/2/20 Date	Time 0420	

Greater Glasgow & Clyde Emer[...]
Mental Health Triage and Risk A[...]

2107796165
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Gayle
F
21/07/1979

NHS
Greater Glasgow and Clyde

Name: Gayle Wilson
2107796165

Part One - Nursing Triage

Triage Observations document physiological measurements

GCS	BM	HR	BP	RR	SaO2	Temp
15	26.2	129	160/92	18	96	36.6

accompanied by name, relationship, particular concerns

Describe the appearance/clothing of those attending alone, as they may leave before review.

Is the patient a young person in foster care or in a residential care placement? YES/NO

Is the patient a carer for a child or a dependent adult? YES/NO

Is there a child protection concern or concern for a vulnerable adult at risk? YES/NO

Outline of Presentation tick all the categories which apply

Overdose (will also require medical assessment)		
Self-injury (will also require wound management)		
Other Mental Health Presentation		

Initial Presentation, Appearance and Behaviour respond yes or no to each question, in any order which seems appropriate

Question			
Is the patient violent, aggressive or threatening?	Y		(N)
Is the patient obviously distressed, markedly anxious or highly aroused?		Y	(N)
Is the patient preoccupied, erratic or impulsive?	Y		(N)
Is the patient quiet and withdrawn?		(Y)	N
Do you think the patient is behaving inappropriately to their situation?		Y	(N)
Do you think the patient presents an immediate risk to you, to others, or to themselves?	(Y)		N
Do you think the patient is likely to abscond prior to assessment?	(Y)		N
Do you think the patient's presentation suggests either hallucinations or delusions?*	Y		(N)
Do you think the patient feels their actions are being controlled?	Y		(N)
Are you aware of a history of mental health problems, or psychiatric illness?		(Y)	N
Are you aware of a history of violence or self-harm?		(Y)	N
Is the patient currently expressing suicidal thoughts?	(Y)		N
Is the patient currently intoxicated, with alcohol, or other substances?		Y	(N)

*Delusions: false but firmly held views and ideas. Hallucinations: false external stimuli (for example, visual or vocal) the patient thinks are real

Any responses in the first column: **High Risk**

Other patients can be categorised as **Moderate Risk**

If all responses are in the third column: **Low Risk**

Triage Risk Assessment identify an initial category of risk, select one or more risks

(High) / Moderate / Low – risk of self-harm / violence / absconding

Triage Category 2 — High risk – accompanied *and* in the clinical area. Moderate risk – accompanied *or* in the clinical area. Low risk – can be asked to wait *if necessary*.

Immediate management print toxbase information, and in paracetamol overdose: note 4-hour time for blood sample.

Patient location, accompanied by...	Summary
	Due to ?Gary bottoms black [illegible]
Blood sample time?	
Toxbase info printed? Y/N	
MAWS considered? Y/N	

name/grade

signature

date and time

NHSGG&C Mental Health and Acute Services Interface Group.

Version 3.0 Jan 2017

Part Two – Mental Health Assessment

medical staff to complete this page

Patient name _____

CHI _____

outline of current presentation and precipitating factors

current and previous mental health problems, self-harm episodes, problematic alcohol and/or drug use, contacts with mental health services

other relevant information, (relationships, finances, employment, housing, physical health, childcare responsibilities, current medications, etc) - protective factors (beliefs, relationships, plans for future) - views of relatives/carers/significant others

Appearance	Behaviour	Speech

Mood	Thought	Insight

Risk factors
(this is not an exhaustive list)

alcohol or drug use	
planning or concealment	
evidence of psychosis	
ongoing suicidal intent	
family concern about risk	
access to lethal means	
lack of social support	
age and gender	
chronic illness/pain	
family history of suicide	
disengaged/noncompliant	
unemployed/retired	
previous violent methods	
history of self-harm	
current psychiatric treatment	
previous psychiatric treatment	

Careful consideration should be given to patients who may present particular risks, including patients who may have post-natal depression, or patients with 'first presentations' of mental health problems, especially in adolescence or old age.

Risk Assessment

based on clinical assessment indicate a category of risk for a further episode of self-harm in the short term (48hrs) – consider protective as well as precipitating factors.

High / Moderate / Low

Discharge Advice and Plan for Further Assessment

indicate the follow-up plan – referral to Liaison Psychiatry, duty doctor, out-of-hours CPN service, CMHT, GP, addiction services, SW, etc – indicate the advice given to the patient and identities of others informed

summary/ follow up and advice given

service referred to	name/relationship of carer informed	consultant/middle-grade involved in decision or review

If young people in foster care or residential care are assessed, their social work team should be informed (via stand-by SW if out-of-hours) as well as giving information and advice to carers present.

name/grade _____

signature _____

date and time _____

3)

NEWS 2 Key | 1 | 2 | 3 GAYLE WILSON.

2107796165
WILSON F
Gayle 21/07/1979
Talbot Association Ltd
52 Dalhousie Street
Glasgow
G3 6PN

Parameter	Example	Obs 1	Obs 2	Score ranges
Date 2020	1/11	27/2		
Time	11.00	[illegible]	45 00	
A + B Respirations Breaths/min	• (12-20)	o (12-20)	o (12-20)	≥25: 3; 21-24: 2; 12-20: 0; 9-11: 1; ≤8: 3
A + B SpO2 Scale 1 Oxygen saturation (%)	97	96	96	≥96: 0; 94-95: 1; 92-93: 2; ≤91: 3
SpO2 Scale 2 Oxygen saturation (%) Use Scale 2 if target range is 88-92% e.g. in chronic hypercapnic respiratory failure. Only use scale 2 under direction of qualified clinician				≥97 on O2: 3; 95-96% on O2: 2; 93-94% on O2: 1; ≥93 on air: 0; 88-92: 0; 86-87: 1; 84-85: 2; ≤83: 3
Air or oxygen?	A	A	A	Air (A) or O2 device: 0; O2 L/min: 2
C Blood Pressure mmHg (Score uses systolic BP only)	↕ (121-140 to 71-80)	^ (121-140) v (91-100)	^ (121-140) v (81-90)	≥220: 3; 201-219: 0; 181-200: 0; 161-180: 0; 141-160: 0; 121-140: 0; 111-120: 0; 101-110: 1; 91-100: 2; 81-90: 3; 71-80: 3; 61-70: 3; 51-60: 3; ≤50: 3
C Pulse Beats/min	• (71-80)	o (121-130)	o (111-120)	≥131: 3; 121-130: 2; 111-120: 2; 101-110: 1; 91-100: 1; 81-90: 0; 71-80: 0; 61-70: 0; 51-60: 0; 41-50: 1; 31-40: 3; ≤30: 3
D Any changes in neuro response, do GCS. Immediate medical review. Check Blood Glucose. Think Delirium.	•	A	A	A Alert: 0; C New Confusion: 3; V Verbal: 3; P Pressure: 3; U Unresponsive: 3
E Temperature	• (36.1-37.0)	o (36.1-37.0)	o (36.1-37.0)	≥39: 2; 38.1-39.0: 1; 37.1-38.0: 0; 36.1-37.0: 0; 35.1-36.0: 1; ≤35.0: 3
NEWS Total	0	2	2	
Blood glucose	7.0	6.2		
Pain / function score	0A			
Time Pt last passed urine	10.20			
Fluid balance chart indicated Y/N.	N			
GCS indicated Y/N	N			
Time NEWS due	23.00			
Escalation of care Y/N	N			
Initials	AB	[illegible]		

Abbreviations for recording oxygen device

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

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NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

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

Think ACE

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

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

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

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

2107796165
WILSON
Gayle F
Talbot Association Ltd 21/07/1979
52 Dalhousie Street
Glasgow
G3 6PN

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

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

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed...

Medical:...

Date:.....................................

Glasgow Coma Scale

			11/1
Date:			11/1
Time:			11.20
Eyes closed by swelling = NT	EYES	Spontaneously 4 / To sound 3 / To pressure 2 / None 1 / Non testable NT	•
Endotracheal tube or tracheostomy = NT	VERBAL	Orientated 5 / Confused 4 / Words 3 / Sounds 2 / None 1 / Non testable NT	•
Always record the best response	MOTOR	Obeys command 6 / Localising pressure 5 / Normal flexion 4 / Abnormal flexion 3 / Extension 2 / None 1 / Non testable NT	•
TOTAL			15
Right size:	PUPIL		4
Right reaction:			+
Left size:			4
Left reaction:			+
Record right (R) and left (L) separately if there is a difference between the two sides	ARMS	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	LEGS	Normal power / Mild weakness / Severe weakness / Spastic flexion / Extension / No response	•

Pupil Reaction and size

s = sluggish
+ = reaction
- = no reaction
c = eyes closed

Pupil Size (mm): 1 2 3 4 5 6 7 8

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**

Affix Patient ID

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name
Addre: 2107796165
WILSON F
) Gayle 21/07/1979
52 DALHOUSIE ST
Glasgow, Lanarkshire
G3 6PN
CHI Nc
DoB

	Date	Ward
Admitted	29-9-20	
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0		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 -39°	≥39.1°	
Pulse	≤40		41-50	51-90	9 10	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

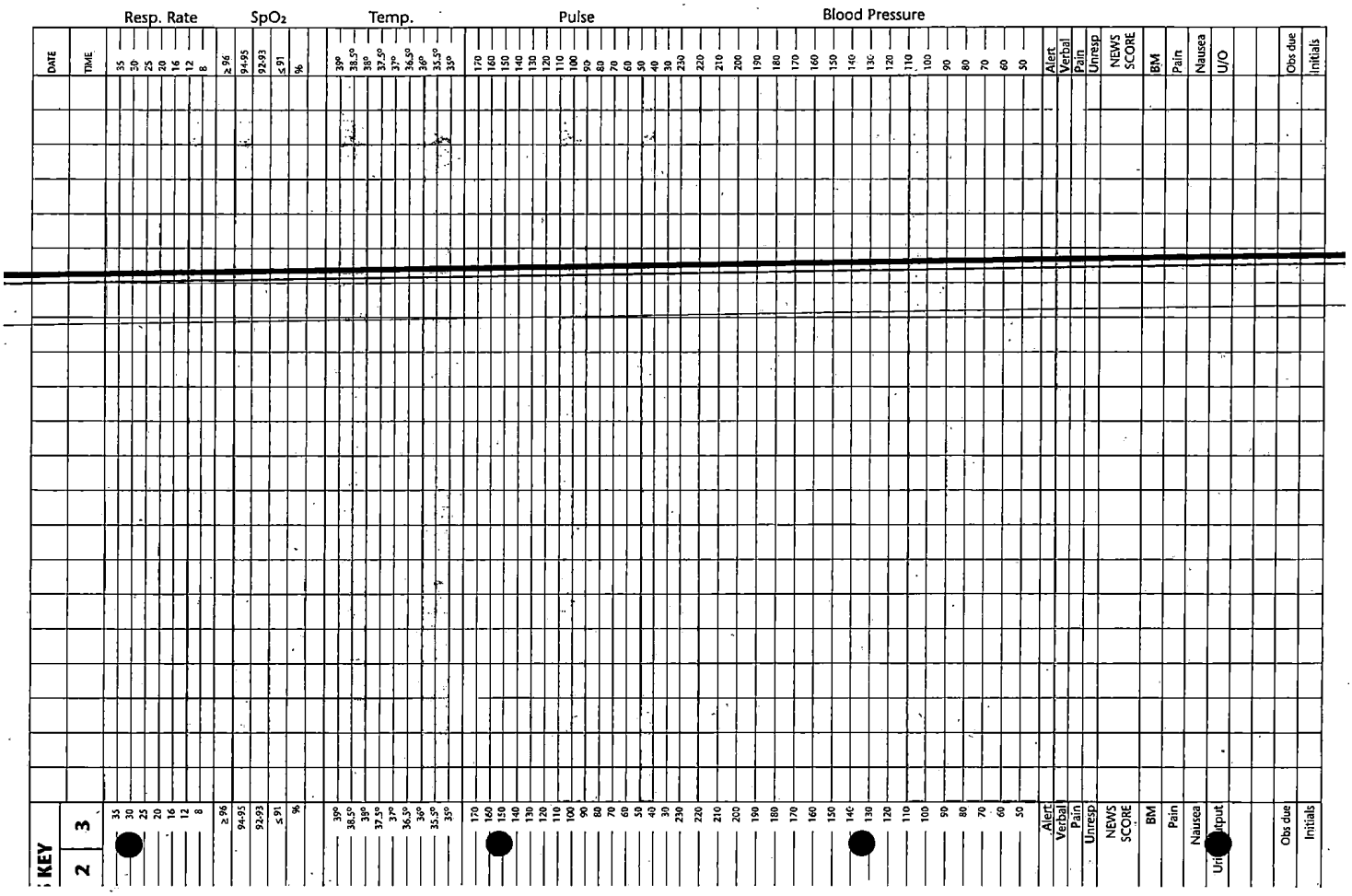
NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

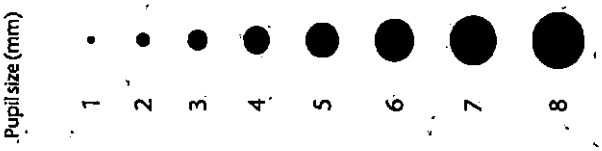
NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need 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.

Gale Wilson.

(18)				NEWS
DATE:		[illegible]	[illegible]	
TIME:		23 35	08 00	0 1
Resp. Rate Mark: •	35 / 30 / 25 / 20 / 16 / 12 / 8	20	16	
SpO2 (Enter Value)	≥96 / 94-95 / 92-93 / ≤91	97%	97%	
Any Sup'l O2	%			
Room air		Air	Air	
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	120	112	
Blood Pressure Mark: ◇ / NEWS SCORE using Systolic BP	230 / 220 / 210 / 200 / 190 / 180 / 170 / 160 / 150 / 140 / 130 / 120 / 110 / 100 / 90 / 80 / 70 / 60 / 50	144 / 61	↕	
Conscious Level Mark: •	Alert / Verbal / Pain / Unresp	• (Alert)	• (Alert)	
Total NEWS (with all obs)		2	2	NEWS SCORE
BM		11.1		
Pain				
Nausea				
Urine output				U/O
Obs due				
Initials		[illegible]	[illegible]	


Resp. Rate
SpO2
Temp.
Pulse
Blood Pressure
DATE
TIME
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials
KEY
2
3

Glasgow Coma Scale



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Neurological Observations

Date:																															
Time:																															
COMA SCALE	E	Eyes open	Spontaneously	4																											
			To speech	3																											
			To pain	2																											
			None	1																											
	V	Best Verbal response	Orientated	5																											
			Confused	4																											
			Inappropriate words	3																											
			Incomprehensible sounds	2																											
			None	1																											
	M	Best motor response	Obeys	6																											
			Localises	5																											
			Flexion - withdrawal	4																											
			Flexion - abnormal	3																											
			Extension to pain	2																											
			None	1																											
TOTAL SCORE																															
PUPILS	R		Size																												
			Reaction																												
	L		Size																												
			Reaction																												
LIMB MOVEMENT	ARMS		Normal power																												
			Mild weakness																												
			Severe weakness																												
			Spastic flexion																												
			Extension																												
			No response																												
	LEGS		Normal power																												
			Mild weakness																												
			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

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At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc) *At risk complete risk assessment*	
YES	NO

Pause for Transfer / Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Relatives Informed of Admission / Discharge	☐	☐	Information on discussion with relatives
Relatives/carer with patient on transfer to ward	☐	Always	
GGC RED BAG - with patient	☐	Always	
Name Band	☐	Always	
Nursing Screening Tools completed	☐	Always	
Bed requested, SBAR COMPLETE	☐	☐	
NEWS chart	☐	Always	
Prescriptions / Charts signed — Infusions	☐	☐	
Cannula	☐	☐	
Notes: medical notes, GP letter, PRF	☐	☐	
Patients requiring analgesia: sufficient	☐	☐	
Belongings (including patients medication)	☐	Always	Please note here if any other tasks required prior to transfer
SAS Transport required and ref. no.	☐	☐	
Print Name Sign -			

Nursing Notes

Date and Time		Print Name and Signature
30/9/20 0040	Admitted with Paracetamol OD. Patient vomiting & tachycardic. IVI ready bloods & ECG.	
0430	PT bloods back. Normal paracetamol levels For physcn r/v in dept due to risk of absconsiment.	

Nursing Notes

Date and Time		Print Name and Signature

Emergency Department Nursing Documentation

2107796165
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Glasgow, Lanarkshire
G3 6PN
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NHS Greater Glasgow and Clyde

Presenting Complaint -

Date: 29/9/20 Time: 0040

Assessment Complete by: Name NURSE (Please Print)

Patient Prep / Investigations (Please tick/circle when completed)		Communication (Please Circle Tick)	
Prepare patient for examination / Clothing bag labelled + stored	☐	NEWS Chart complete / NEWS SCORE - (Record pain, blood sugar and Neuro Obs on NEWS Chart)	☑
GGC RED BAG - with patient	☐		
12 Lead ECG	☐	ID Band	☐
Weight:	☐	Peak Flow	☐
Blood Samples Obtained: Yes ☐ No ☐		Xrays / CT Scan Performed:	☐
IV Access: Yes ☐ No ☐		Relatives / NOK informed (Carers)	☐
Blood Gas: VBG ☐ ABG ☐		Child Protection Concern (considered in line with policy)	Y/N
		Adult Support and Protection	Y/N

Urinalysis							
Leucocytes	☐	Nitrites	☐	Protein	☐	Blood	☐
Ketones	☐	Glucose	☐	PH		S.G.	
MSSU / CSU	☐	Toxiclogy	☐				
HCG	☐	+VE	☐	-VE	☐	Strip No -	

Screening Tools (Please tick/circle when completed)			
SEPSIS RISK? / SIRS Criteria 2 or more	Y/N	SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)	YES
Mental Health Triage Assessment	Y/N	If NOT WHY? - (details) N/A	NO
GMAWS	Y/N	Date - Time - Signature -	

4AT	
AMT	Correct
Age	
Date of Birth	
Place	
Current year	

No mistakes	= 0
1 mistake	= 1
> 1 mistake	= 2

Attention (months of year backwards)	
> = 7 correct	0
< 7 correct	1
Untestable	2

Alertness	
Normal	0
Mild sleepiness	0
Clearly abnormal	4

Mental status according to family/carer		
Acute change or fluctuating	4	YES
Acute change or fluctuating	0	NO

4AT score

/12

STEP 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?

All over 75s and care home residents over 65. For younger patients use clinical judgement and consult local guidelines.

		YES	NO
F	**F**unctional impairment (new or worsening) eg difficulty with self care		
R	**R**esident in a care home?		
A	**A**ltered mental state such as acute confusion or dementia use the 4AT		
I	**I**mmobility/instability. New decline in mobility, difficulty mobilising without help or fall leading up to admission		
L	**L**ikely to require support for discharge? (either new or increase in existing support)		

Are any of the above criteria met? If YES to any of the above move to step 2

STEP 2 Would this person be better managed by another specialty team at present?

Indicator for care by another acute specialty regardless of age.

	YES	NO
Clear need for other specialty input eg exacerbation of known long term condition such as COPD		
Need for HDU/ITU (including non-invasive ventilation)		
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit		
Head injury with loss of consciousness		
Acute abdominal pain/surgical presentation		
Upper GI Bleed		
Chest pain with suspected acute coronary syndrome		
Trauma with suspected fracture		

Are any of the above 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 **NO** to the list in step 2:

- Prioritise transfer of care to specialist geriatric assessment service in line with local guidance.

Screening Tools / ACTIVE CARE

(Please tick/circle when completed).

1) Pressure Damage Does the person have redness and/or existing damage? If YES - continue with a minimum of 2 hourly Active Care + Complete PUDRA		Y/N	**Date**	**Location of Redness/Ulcers**	**Grade of Ulcer**
2) Mobility	Does the person require assistance?	Y/N			
3) Continence		Y/N	**5) Skin**	Is skin compromised by other source, eg neurological deficit, medication, substance, diabetes, co-morbid?	Y/N
4) Nutrition		Y/N	**6) Judgment**	In your clinical judgment is this person at risk for developing pressure damage? IF YES - DETAILS	Y/N

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.

CHI: 2107796165

Glasgow Royal Infirmary

18

Total Att: 19

12 Mth Att: 4

Title: MISS

WILSON **Gayle**

DOB **21/07/1979** Age: **41y** Sex: **Female**

52 DALHOUSIE ST

Glasgow
Lanarkshire
G3 6PN
07770460540

Next of kin: **WINTERS, Rita**
Relationship: **Aunt**
01412301448

GP: **NT Bhatti**
0141 334 9331

Attendance Date: **29/09/2020** Arrival Time: **23:08**

Registration Time: **23:08** Date of Incident: **29/09/2020**

Major Incident Desc:

Reason for Attendance: **overdose**

Nursing Assessment

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

Triage Category: **2** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **29/09/2020 23:21** Nurse name: **Nurse Michael Harkins**

Temp	**36.1**	C
HR	**122**	bpm
BP	**144/61**	mmHg
MAP	**88.67**	mmHg
RR	**17**	bpm
SpO2	**97**	%
Oxygen		%

BM	**11.1 sas**	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

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

Nursing Notes: **"MENTAL HEALTH. " "OD of x14 Paracetamol between 16:30 - 17:30. " NEWS: 2 "Low Risk COVID - 19, CPE. "**

2107796165 21/07/1979 WILSON Gayle
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Created on 29 Sep 2020 23:22 by Michael Harkins

To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

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

Date	Clinical Notes
	Seen By 0141-332-8512 Time Seen

REVEIW BY S.SWAN(CPN) + S.QUIQLEY(CPN) FROM STOBHILL MHAU - REFERRED TO MHAU, CONCERNS ABOUT WALKING IN FRONT OF CAR IF LEFT DEPT - SO REQUESTED ASSESSMENT IN DEPT (05:40AM) OPEN TO SPRINGBURN - MOT YESTERDAY
0/0 OF 14 PARACETEMOL → MEDICALLY FIT. → SISTER DIED
HISTORY OF SELF HARM CUT HERSELF SUPERFICIALLY (L) ARM
STANLEY KNIFE -
TODAY WENT OUT BOUGHT TABS 14 PARACETEMOL, SHE SAYS SHE CALLED AUNTY WHOM CALLED SUPPORT WORKER, HAVE ASLEEP.
CHRONIC SUICIDAL IDEAS LONG STANDING
24 HOUR SUPPORT TALBOT - GET ON WELL WITH STAFF
TELLS US SHE HATES LIFE SINCE LAST JUNE → SINCE SISTER RITA - BLAMES HERSELF FULL OF GUILT - SISTER SENT MESSAGE SHE DIDNT SEE EITHER SISTER WHOM DIED -
TAKES REGULAR OVERDOSES - HATES SPRINGBURN WANTS RE REFERRED TO RIVERSIDE - WONT HAPPEN
DUE TO INCREASE IN SELF HARM REFER TO CRISIS FOLLOW UP
MEDS - SETRALINE, DIAZEPAM, QUETIAPINE (SEROQUEL) (SIMVASTIN)
NO DRUGS / ORUG IMPULSIVE
SLEEPING PROBS / PREVIOUS KNOWN TO HOMELESS PERSONALITY
DIETARY INPUT TEAM + DISCHARGED.
MOOD FLAT / REACTIVE ← WE FOUND HER REACTIVE.

- REFER TO CRISIS - GAYLE DELIGHTED BY SAME, CHRONIC SUICIDAL BUT HAS OVERDOSED.

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By
30/11	PROCHLORPERAZINE	3mg	BUCCAL	0800		

Glasgow Royal Infirmary
Emergency Department

NHS
Greater Glasgow and Clyde

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G3 6PN

(8)

Initial Investigations Ordered

FBC ☐	COAG ☐	DD ☐	INR ☐		G+S ☐		X-match	units		
U+Es ☐	LFT ☐	GLU ☐	CRP ☐	TROP ☐	Para ☐	Sal ☐	Ethanol ☐	Mg ☐	VBG ☐	ABG ☐
B culture ☐		C/MSSU ☐		Urinalysis ☐		BHCG ☐		Other		
CXR ☐	AXR ☐	Other imaging:								ECG ☐
Current location:								Sent by:		

Clinical Notes

Date	Time	Name	Grade	Specialty
30/9	00:30	Jobsbury	FY2	weight: 93.6kg.

41 y/o female Obs: temp 36.1
HR 122 BP 144/61
RR 17 sats 97%

SH:
Lives in Talbothouse
Smoker
Non driver
Denies recreational drugs.

Took 14x paracetamol at 16:00-16:30 with intention of ending life. Ongoing suicidal thoughts. No triggering event to state: her life. Has been vomiting & has had abdominal pain since OD.

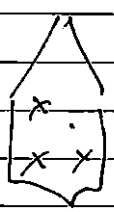
PMH:
Low mood
Prev ODs.
mild LD
ECPD

Denies cough/cold/fever/chest pain. Feels heart racing. Denies UTIs. Bowels opening.

Meds:
Sertraline
Simvastatin
Quetiapine
Diazepam PRN

O/E: A - patent own
B - RR 17 sats 97% RA
C - NS HR 110, BP 144/61
D - GCS 15/15, calm SNT AMT 2/4
Oriented to self.
Aware in hospital, not sure which one.
Not sure of day or month.

Allergies:
~~NKDA~~
Penicillin



P.T.O.

Glasgow Royal Infirmary
Emergency Department

2107796165
WILSON
Gayle F
21/07/197
52 DALHOUSIE ST
Glasgow, Lanarkshire
G3 6PN

Clinical Notes

Date	Time	Name	Grade	Speciality

30/9 Jobbing cont.

Imp: Paracetamol OD with suicidal intent.

Plan: Bloods ± NAC
Liaison ψ

Paracetamol level below toxicity threshold.
Bloods otherwise normal.
Contacted CPNs for review - will kindly callback

04:25
Ongoing suicidal thoughts and plans
'wants to leave and walk in front of a bus to end it all'
CPNs will kindly review in department due to ongoing risk.

Glasgow Royal Infirmary
Emergency Department

2107796165
WILSON F
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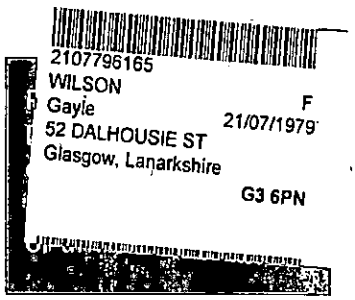
Clinical Notes

Date	Time	Name	Grade	Specialty

Glasgow Royal Infirmary
Emergency Department


2107796165
WILSON
Gayle F
52 DALHOUSIE ST 21/07/1979
Glasgow, Lanarkshire
G3 6PN

HAEM	DATE or TIME		BIOCH	DATE or TIME			DATE or TIME		V/ABG	DATE or TIME	
WCC	10.1		Na	135		Bil	19		FiO_2		
Hb	156		K	4.1		ALT	26		H^+		
Plat	233		Cl	96		AST	26		$PaCO_2$		
Neut	7.0		Ur	3.8		GGT			PaO_2		
DD			Creat	54		A phos	98		Bic	24	
PT	12		eGFR	>60		Alb	45		BE		
PTT	32		Glu			AdjCa			Lactate		
TT			CRP	6		Amyl			Ethanol		
INR			Mg			TropI HS			Para		
			Phos			BHCG			Sal		

Diagnosis and Plan

Review/Discussed with:

Handover

- ☐ Provisional Diagnosis
- ☐ Liquids/Fluids
- ☐ Analgesic/Medicines
- ☐ NEWS
- ☐ Investigations & Results
- ☐ Talk to receiving team/ward

mi • 287967 Version 1_0 • GGC0226

Greater Glasgow & Clyde Emergency Departments' Mental Health Triage and Risk Assessment Tool

NHS Greater Glasgow and Clyde

Part One - Nursing Triage — triage nurse to complete this page

Patient name G. Wilson
CH 2107796165

Triage Observations — document physiological measurements

GCS	BM	HR	BP	RR	SaO^2	Temp
15/15	11.1	122	144/61	17	97	36.1

accompanied by — name, relationship, particular concerns

Alone

Describe the appearance/clothing of those attending alone as they may leave before review.

Is the patient a young person in foster care or in a residential care placement? YES/NO

Is the patient a carer for a child or a dependent adult? YES/NO

Is there a child protection concern or concern for a vulnerable adult at risk? YES/NO

Outline of Presentation — tick all the categories which apply

Overdose (will also require medical assessment)	✓
Self-injury (will also require wound management)	
Other Mental Health Presentation	

Initial Presentation, Appearance and Behaviour — respond yes or no to each question, in any order which seems appropriate

Is the patient violent, aggressive or threatening?	Y	N
Is the patient obviously distressed, markedly anxious or highly aroused?	Y	N
Is the patient preoccupied, erratic or impulsive?	Y	N
Is the patient quiet and withdrawn?	Y	N
Do you think the patient is behaving inappropriately to their situation?	Y	N
Do you think the patient presents an immediate risk to you, to others, or to themselves?	Y	N
Do you think the patient is likely to abscond prior to assessment?	Y	N
Do you think the patient's presentation suggests either hallucinations or delusions?	Y	N
Do you think the patient feels their actions are being controlled?	Y	N
Are you aware of a history of mental health problems or psychiatric illness?	Y	N
Are you aware of a history of violence or self-harm?	Y	N
Is the patient currently expressing suicidal thoughts?	Y	N
Is the patient currently intoxicated, with alcohol, or other substances?	Y	N

*Delusions; false but firmly held views and ideas. Hallucinations; false external stimuli (for example, visual or vocal) the patient thinks are real

Triage Risk Assessment — identify an initial category of risk, select one or more risks

High / Moderate / Low – risk of self-harm / violence / absconding

Triage Category

High risk – accompanied *and* in the clinical area.
Moderate risk – accompanied *or* in the clinical area.
Low risk – can be asked to wait *if necessary*.

Immediate management — print toxbase information and in paracetamol overdose, note 4 hour time for blood sample.

Patient location, accompanied by...	Summary Grey Nike hoodie Black Nike joggers Black trainers Short hair
Blood sample time?	
Toxbase info printed? Y/N	
GMAWS considered? Y/N	

Any responses in the first column **High Risk**

Other patients can be categorised as **Moderate Risk**

If *all responses* are in the third column **Low Risk**

name/grade M. HARKINS

signature M. Harkins

date and time 29/9/20, 23:20

Part Two - Mental Health Assessment

medical staff to complete this page.

Patient name _____

CHI _____

outline of current presentation and precipitating factors

OD paracetamol 7000mg with intention of ending life.
BIBA - called from staff at Talbot house. Ongoing suicidal thoughts.
No triggering event. Longstanding low mood.

current and previous mental health problems, self-harm episodes, problematic alcohol and/or drug use, contacts with mental health services

Multiple prev. OD & self harm by cutting.
Known to CPNs
Last OD attendance for OD - Aug 2020

other relevant information, (relationships, finances, employment, housing, physical health, childcare responsibilities, current medications, etc) - protective factors (beliefs, relationships, plans for future) - views of relatives/carers/'significant others'

Not employed.
Lives in Talbot Ho.

Appearance	Behaviour	Speech
Unkempt		Ordered

Mood	Thought	Insight
Low	Suicidal	Aware actions are harmful.

Risk Factors
(this list is not an exhaustive list)

alcohol or drug use	
planning or concealment	
evidence of psychosis	
ongoing suicidal intent	✓
family concern about risk	
access to lethal means	
lack of social support	✓
age and gender	
chronic illness/pain	
family history of suicide	
disengaged/noncompliant	
unemployed/retired	✓
previous violent methods	✓
history of self-harm	✓
current psychiatric treatment	
previous psychiatric treatment	

Careful consideration should be given to patients who may present particular risks, including patients who may have post-natal depression, or patients with 'first presentations' of mental health problems, especially in adolescence or old age.

Risk Assessment

based on clinical assessment indicate a category of risk for a further episode of self-harm in the short term (48hrs) - consider protective as well as precipitating factors.

(High) / Moderate / Low

Discharge Advice and Plan for Further Assessment

Indicate the follow-up plan – referral to Liaison Psychiatry, duty doctor, out-of-hours CPN service, CMHT, GP, addiction services, SW, etc - indicate the advice given to the patient, and identities of others informed.

summary	follow up and advice given

service referred to	name/relationship of carer informed	consultant/middle-grade involved in decision or review

If young people in foster care or residential care are assessed, their social work team should be informed (via stand-by SW if out-of-hours) as well as giving information and advice to carers present.

name/grade
[illegible] FY2

signature
[signature]

date and time
10/9 01:20.

Patient Information		Date:	29/09/2020
GA[illegible]		Incident Number:	CR006837697
Age/Ge	2107796165		
Addres:	WILSON FEET Gayle 21/07/1979	Incident Type:	EMG
DOB:		Incident Location:	TALBOT HOUSE 52 DALHOUSIE STREET GARNETHILL GLASGOW, G3 6PN
CHI:			
Ethnicit			

Scottish Ambulance Service

Presenting Complaint

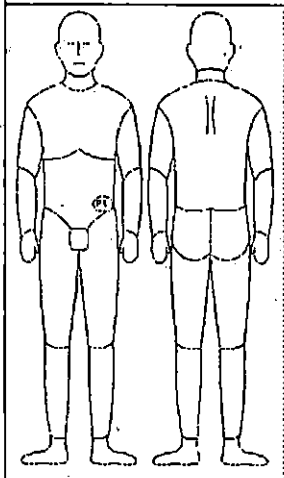
OVERDOSE / MENTAL HEALTH.

Additional Comments

as1 [yellow] call for 41 yof ? Overdose. [hopc] = mental health crisis, struggling to cope after loss of sister, does not wish to live anymore. took x14 paracetamol 1630 1730 hours. Developed LLQ abdo pain since. o/a met by staff, pt lying on bed, alert and orientated to crew. o/e obs as noted. No covid type symptoms. [a] clear. [b] normal wob, nil concern. [c] warm, well perfused, radial pulse, denies cp, feels sick, non diaphoretic. [d] apyrexial, gcs 15, bm = 11.1, pearl 4/4. [e] states within last 2/24 has developed LLQ abdominal pain, staff withheld nightly meds. Passing urine / moving bowels.

PATIENT ASSESSMENT

AVPU	Alert		<C>	No			
A	Clear						
B	Breathing Adequately	Yes	Respiratory Rate 16		SPO2	96	
	Oxygen Given No						
C	Pulse Rate		BP		Cap Refill	ECG Rhythm	
	118		143/87		<=2 Secs	Sinus Rhythm	
	Rhythm		Arm		Central/Peripheral	ECG	
	Reg		Right		Peripheral	3 Lead	
D	GCS	Eyes	Voice		Motor	PEARL	
	15	Spontaneously (4)	Orientated (5)		Obeys Commands (6)	Yes	
E							



Pain

ID	Body Part	Pain Scale
P1	Abdomen	0

Observations

Time	P	RR	BP	SpO2	CR	GCS	AVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
22:44	116	16	144/85	96	<=2s	15	Alert				Sinus Rhythm				E9888376
22:35	118	16	143/87	96	<=2 Secs	15	Alert		36.4	11.1	Sinus Rhythm	4	4		E9888376

NEWS

Time	Clinical Risk	NEWS
22:44	LOW Immediate Clinical Risk. Treat as per Clinical Practice Guidelines including considering the use of alternative pathways (if appropriate and available).	2

22:35 LOW Immediate Clinical Risk. Treat as per Clinical Practice Guidelines including considering the use of alternative pathways (if appropriate and available). 2

HISTORY

AMPLE

Allergies	PENICILLIN,
Medication	QUETIAPINE, SERTRALINE, SIMVASTATIN, DIAZEPAM
Past Medical History	DEPRESSION.

Overdose	Unknown	Suicide Attempts	Unknown

Last Eaten	>4 Hours Ago
Events Prior	OVERDOSE.

Social History

Lives alone	No	Patient Occupation	Does Not Work,

Patients General Appearance	Normal,
Living Arrangement	Sheltered Accommodation,
Patient Mobility	Fully Mobile,
Patient Communication	No Help Required,
Patient Clinical Risk Factors	Smoker,
Patient Enviromental Risk Factors	None Identified,

2107796165
WILSON F
Gayle 21/07/1979

MEDICAL

Overdose

Mode Of Poisoning	Ingested,
OD Poisoning Substance Type	Paracetamol,

Poisoning Date	29/09/2020	Poisoning Time	16:30
Substance Amount	14		

Mental Health

Suicide Plan	Yes Lethal:Don't Know
Signs/Symptoms	Suicide Attempt,
Risk Factors	Killing Themselves,
Known To Services	Psychiatrist, SPRINGPARK CENTRE HASN'T LIAISED WITH SINCE PREVIOUS HOSPITAL ADMISSION.

CLOSE RECORD

Treatment On Scene	Non Emergency

Conveyance

Transport To Hospital	Normal driving	Pre Alert	No

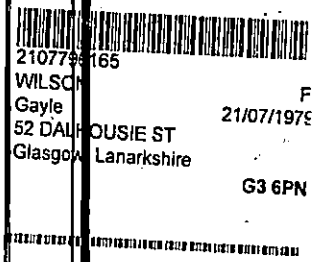
INCIDENT LOG

NHS
Greater Glasgow and Clyde

NHSGGC Adult Paracetamol Overdose Protocol and Shortened NAC Administration Chart

PILOT

March – June 2020

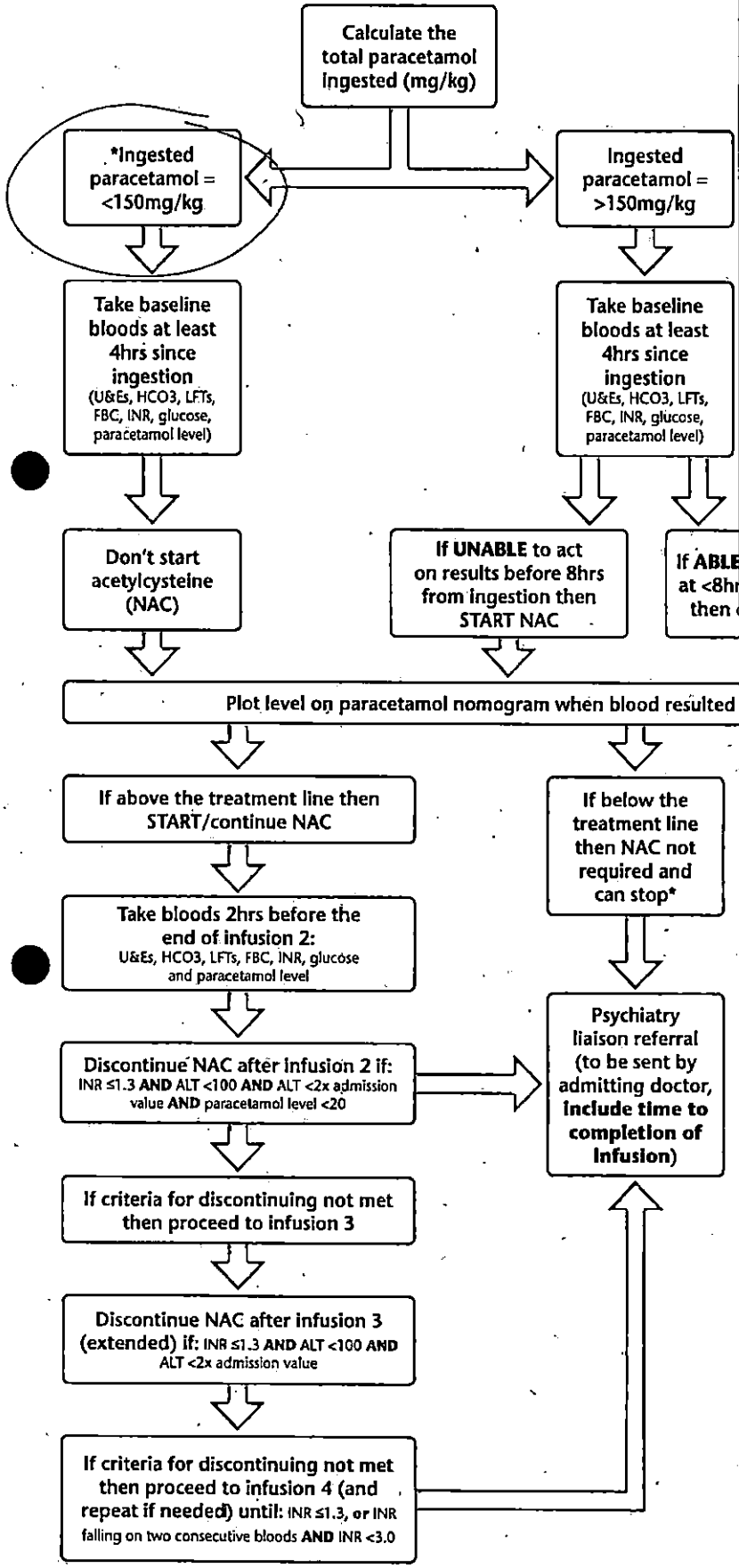


NOTE: This protocol differs from advice on TOXBASE, however the general paracetamol overdose guidance still applies.

Please ensure the EDLs/IDLs are given a diagnosis of paracetamol overdose to allow auditing of this pilot.

Paracetamol overdose presenting 0-8hrs

(Ingested total overdose in ≤1 hour time per od)



Weight 93.6kg.
Paracetamol: 7800mg.

***Clinical judgement required**

- If doubt then assume >150mg/kg

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***Clinical judgement required**

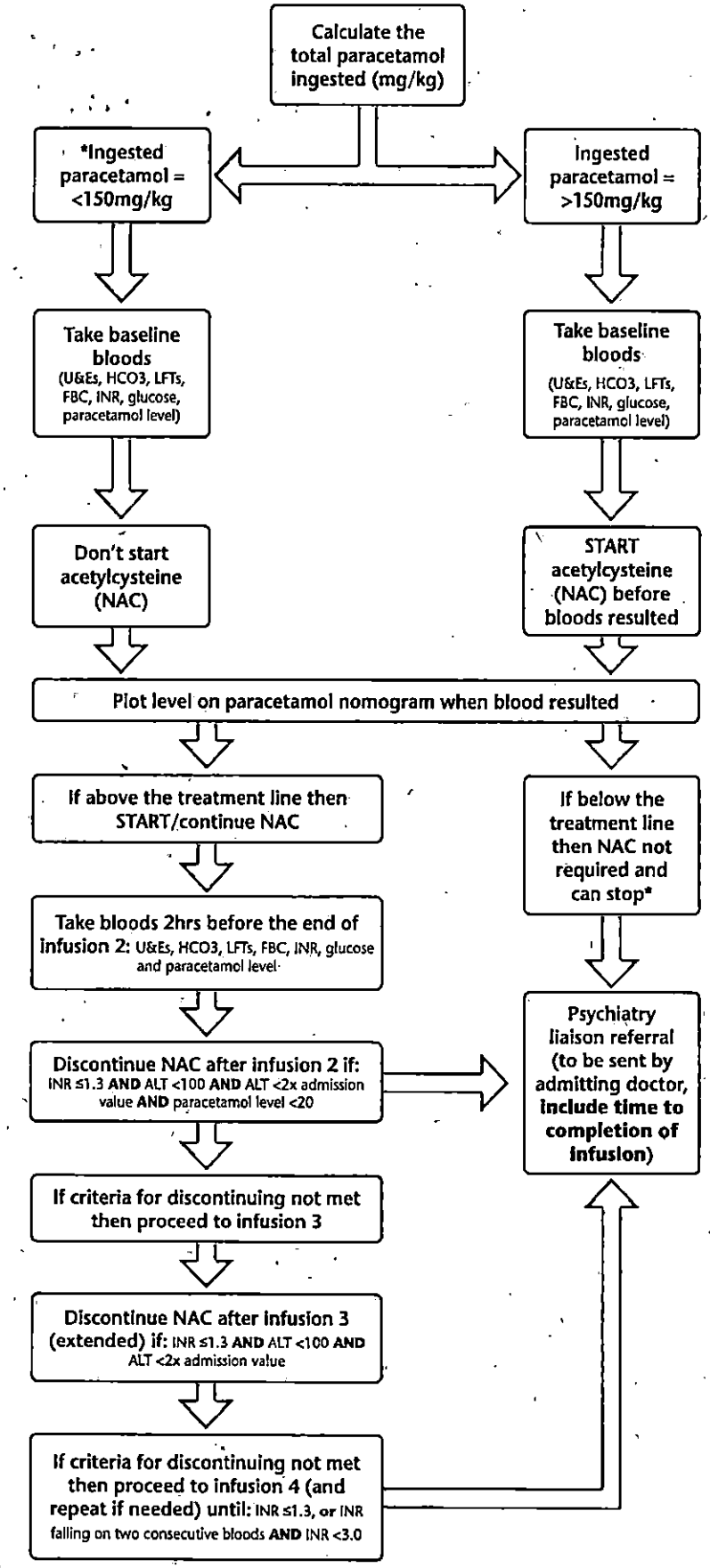
- Ensure no doubt about time of ingestion or type
- If ALT abnormal even if paracetamol concentration normal then consider treating
- Ensure INR normal
- If uncertainty then treat and review

Blood monitoring

- Checking a paracetamol level 2hrs before the end of bag 2 is NEW for this protocol
- U&E, HCO3, LFTs, FBC and INR should be done 2hrs before the end of each infusion 2. Ensure results are READY for the end of the infusion.
- CBG 6 hourly while on NAC
- If rapid or progressive biochemical deterioration then discuss with senior and consider referral to regional transplant centre.

Paracetamol overdose presenting 8-24hrs

(Ingested total overdose in ≤1 hour time period)



***Clinical judgement required**

- If doubt then assume >150mg/kg

***Clinical judgement required**

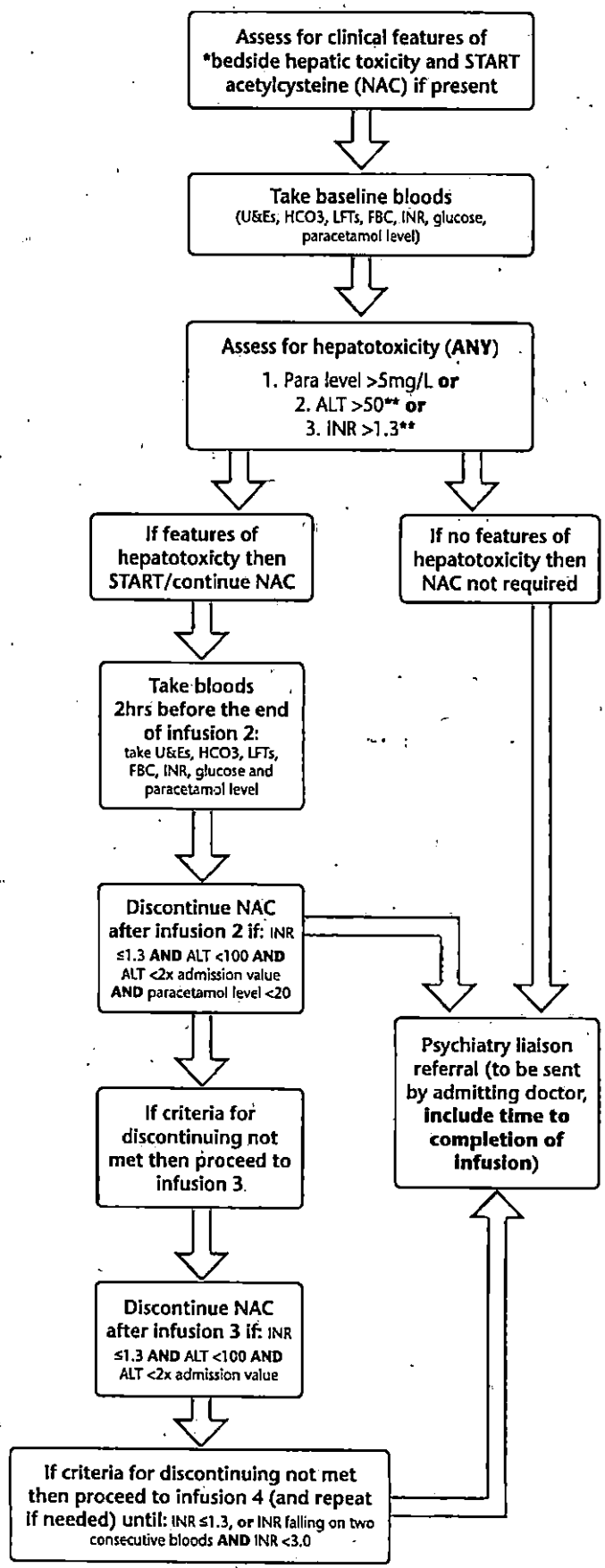
- Ensure no doubt about time of ingestion or type
- If ALT abnormal even if paracetamol concentration normal then consider treating
- Ensure INR normal
- If uncertainty then treat and review

Blood monitoring

- Checking a paracetamol level 2hrs before the end of bag 2 is NEW for this protocol
- U&E, HCO3, LFTs, FBC and INR should be done 2hrs before the end of each infusion 2. Ensure results are READY for the end of the infusion.
- CBG 6 hourly while on NAC
- If rapid or progressive biochemical deterioration then discuss with senior and consider referral to regional transplant centre.

Paracetamol overdose presenting >24hrs

(Ingested total overdose in ≤1 hour time period)



***Clinical judgement required**

- Bedside hepatic toxicity: jaundice, tender liver, hypoglycaemia, encephalopathy, unexplained lactic acidosis.
- Ensure no doubt about time of ingestion or type.
- If uncertainty then treat and review with bloods.

****Clinical judgement required**

- Some patients have a chronically raised ALT/INR.
- Review old LFTs/INRs and if chronic derangement discuss with a senior clinician before proceeding to NAC.

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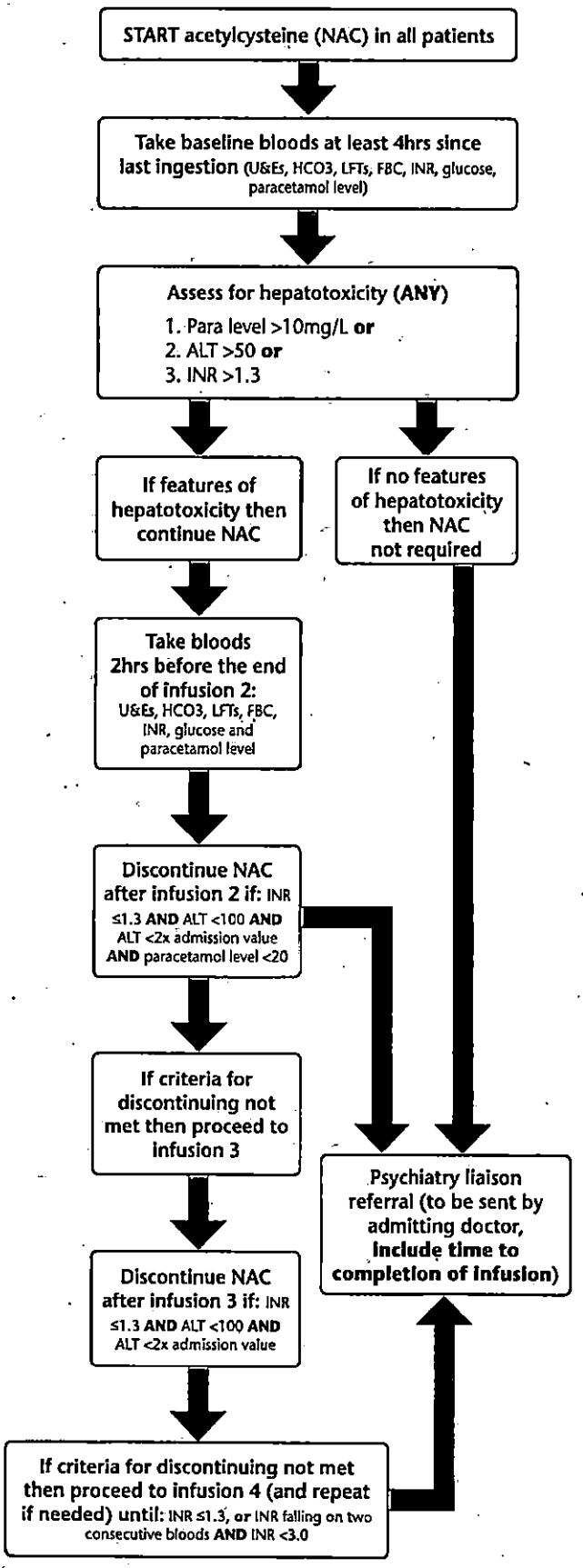
Gayle
F
21/07/1979

Blood monitoring

- Checking a paracetamol level 2hrs before the end of bag 2 is NEW for this protocol
- U&E, HCO3, LFTs, FBC and INR should be done 2hrs before the end of each infusion 2. Ensure results are READY for the end of the infusion.
- CBG 6 hourly while on NAC
- If rapid or progressive biochemical deterioration then discuss with senior and consider referral to regional transplant centre.

Staggered paracetamol overdose

(Ingested total overdose in >1 hour time period in the context of self harm)

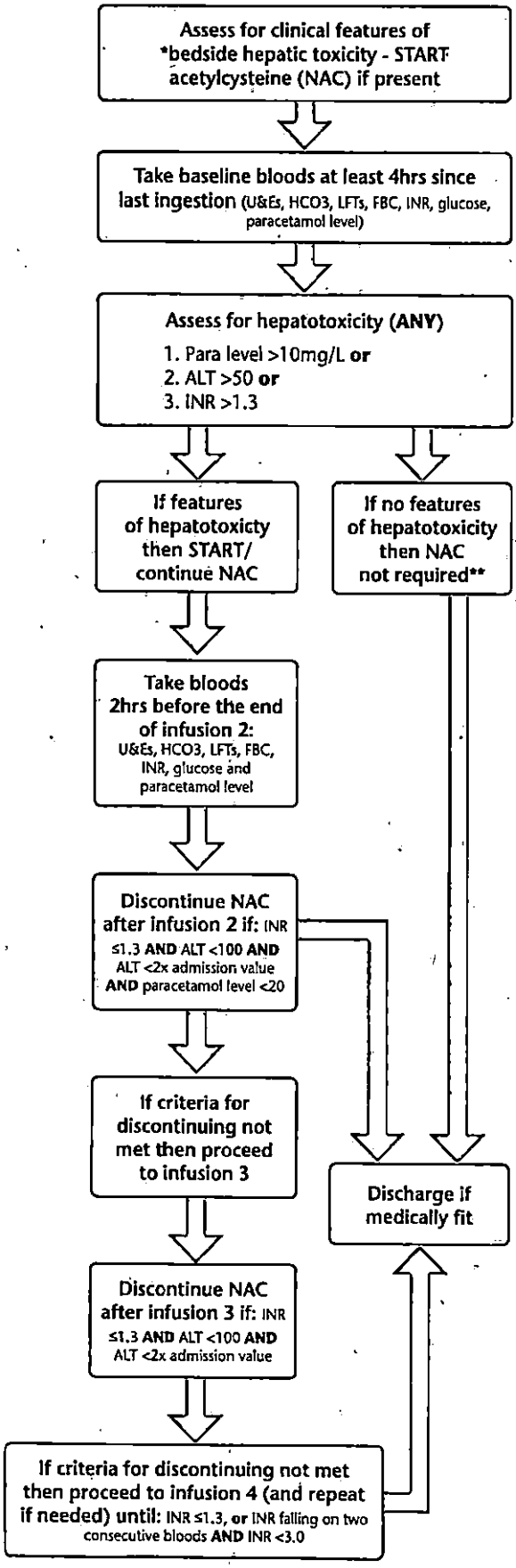


Blood monitoring

- Checking a paracetamol level 2hrs before the end of bag 2 is **NEW** for this protocol
- U&E, HCO3, LFTs, FBC and INR should be done 2hrs before the end of each infusion 2. Ensure results are **READY** for the end of the infusion.
- CBG 6 hourly while on NAC
- If rapid or progressive biochemical deterioration then discuss with senior and consider referral to regional transplant centre

Therapeutic excess paracetamol overdose

(Ingested total overdose in >1 hour time period with no self harm intent)



***Clinical judgement required**

- Bedside hepatic toxicity: Jaundice, tender liver, hypoglycaemia, encephalopathy, unexplained lactic acidosis.
- Ensure no doubt about time of ingestion or type.
- If uncertainty then treat and review with bloods.

****Clinical judgement required**

- Ensure no doubt about time of ingestion or type
- If uncertainty then treat and review with bloods

2[illegible]7796165
W[illegible]SON F
G[illegible]le 21/07/197[illegible]
52 DALHOUSIE ST
Glasgow, Lanarkshire
G3 6PN

Blood monitoring

- Checking a paracetamol level 2hrs before the end of bag 2 is **NEW** for this protocol
- U&E, HCO3, LFTs, FBC and INR should be done 2hrs before the end of each infusion 2. Ensure results are **READY** for the end of the infusion.
- CBG 6 hourly while on NAC
- If rapid or progressive biochemical deterioration then discuss with senior and consider referral to regional transplant centre

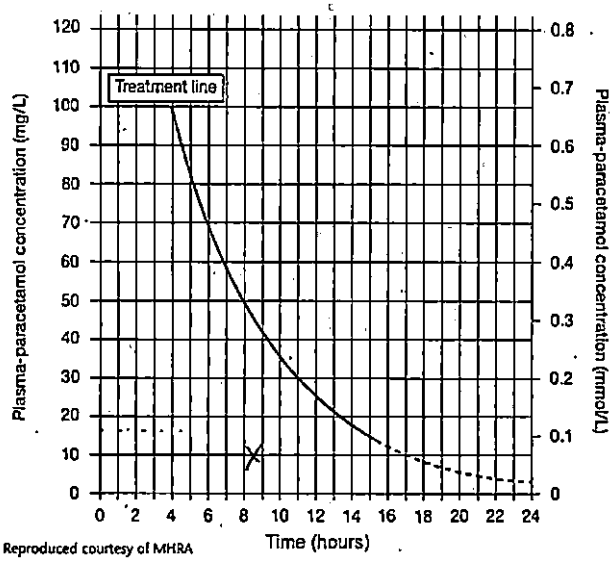
Shortened Adult Acetylcysteine Prescribing and Administration Chart (SNAP regimen PILOT Mar-June)

NHS Greater Glasgow and Clyde

2107796165
Name: WILSON F
Address: Gayle 21/07/1979
52 DALHOUSIE ST
DoB: Glasgow, Lanarkshire
G3 6PN
CHI:

Ingestion date & time: 29/9 16:30
Quantity ingested (mg): 7000
Weight (kg): 93.6kg
Calculated paracetamol ingested (mg/kg): 75
Serum paracetamol concentration (mg/L):
Hours between ingestion & sampling: 8.5hours

Paracetamol overdose treatment nomogram



Reproduced courtesy of MHRA

- **Refer to protocols overleaf for guidance.**
- If unclear which protocol to use, discuss with a senior clinician.
- Determine the need for acetylcysteine by plotting the measured plasma paracetamol concentration (in mg/L) against the time since ingestion. If plasma level falls **above the line** then give acetylcysteine as detailed below.
- Patients <30kg –this protocol is inappropriate, access paediatric dosing table through www.toxbase.org.
- For pregnant patients, use pre-pregnancy weight to calculate toxic dose and actual weight when prescribing acetylcysteine
- Reactions to acetylcysteine include flushing, nausea & vomiting. Consider pausing infusion for 30 minutes and symptomatic relief i.e. antiemetic and/or chlorphenamine.

Table 1. Acetylcysteine IV dosing & administration

Regimen	First infusion		Second (& extended) infusion	
Infusion fluid	200mL sodium chloride 0.9% or 5% glucose		1000mL sodium chloride 0.9% or 5% glucose	
Preparation	Use 250mL infusion bag and remove 50mL and add required volume of acetylcysteine		Add required volume of acetylcysteine to 1000mL infusion bag	
Duration of infusion	2 hours		10 hours	
Drug dose	100mg/kg acetylcysteine		200mg/kg acetylcysteine	
Weight (kg)	Ampoule volume (mL)	Infusion rate (mL/h)	Ampoule volume (mL)	Infusion rate (mL/h)
30-39	18	109	35	104
40-49	23	112	45	105
50-59	28	114	55	106
60-69	33	117	65	107
70-79	38	119	75	108
80-89	43	122	85	109
90-99	48	124	95	110
100-109	53	127	105	111
> 110	55	128	110	111

Each ampoule = 200mg/L acetylcysteine. Dose calculation based on weight in middle of band. Ampoule rounded to nearest whole number.

Shortened Adult Acetylcysteine Prescribing and Administration Chart (SNAP regimen PILOT Mar-June)

Name: _____
Address: 2107796165 WILSON F
Gayle 21/07/1979
52 DALHOUSIE ST
Glasgow, Lanarkshire
G3 6PN
DoB: _____
CHI: _____

Infusion 1	Acetylcysteine 100mg/kg over 2 hours									
Prescription						Preparation	Administration checks			
Date	Time	Dose (mL)	Diluent (200mL)	Infusion rate (mL/hr)	Prescriber's signature	Prepared/ Checked by	Date Time	Volume remaining (mL)	Volume infused (mL)	Checked by

Infusion 2	Acetylcysteine 200mg/kg over 10 hours									
Prescription						Preparation	Administration checks			
Date	Time	Dose (mL)	Diluent (1000mL)	Infusion rate (mL/hr)	Prescriber's signature	Prepared/ Checked by	Date Time	Volume remaining (mL)	Volume infused (mL)	Checked by

2107796165
WILSON F
Gayle 21/07/1975
52 DALHOUSIE ST
Glasgow, Lanarkshire
G3 6PN

Extended treatment

Extended treatment with acetylcysteine should be continued at the dose and infusion rate used for the second infusion (see overleaf).

Recheck U&Es, bicarbonate, LFTs, FBC and INR 2 hours before the end of each 10 hour infusion to reassess need to continue.

Refer to appropriate protocol regarding discontinuation of extended treatment

Shortened Adult Acetylcysteine Prescribing and Administration Chart (SNAP regimen PILOT EXTENDED Treatment)

Name: 2107796165
Address: WILSON Gayle F
DoB: 52 DALHOUSIE ST 21/07/1975
CHI: Glasgow, Lanarkshire G3 6PN

Infusion 3 (extended treatment)	Acetylcysteine 200mg/kg over 10 hours

Prescription						Preparation	Administration checks			
Date	Time	Dose (mL)	Diluent (1000mL)	Infusion rate (mL/hr)	Prescriber's signature	Prepared/ Checked by	Date Time	Volume remaining (mL)	Volume infused (mL)	Checked by

Infusion 4 (extended treatment)	Acetylcysteine 200mg/kg over 10 hours

Prescription						Preparation	Administration checks			
Date	Time	Dose (mL)	Diluent (1000mL)	Infusion rate (mL/hr)	Prescriber's signature	Prepared/ Checked by	Date Time	Volume remaining (mL)	Volume infused (mL)	Checked by

If the patient meets criteria for a further infusion then repeat infusions 3 and/or 4 (extended). Refer to protocols for discontinuation criteria.

2107796165
WILSON
Gayle
52 DALHOUSIE ST
Glasgow, Lanarkshire
F
21/07/1979
G3 6PN

Printed: 30/09/2020 01:10:15

Patient Sample Report

Status: **ACCEPTED**
Analyzed: 30/09/2020 01:10:01
Sample Type: **Venous**
Account Number:
Clinician:
Operator ID: JILLIAN GISBEY0

Patient

ID:	2107796165
Last Name:	WILSON
First Name:	GAYLE
Gender/Age:	Female, 41 years
Birth Date:	21/07/1979

Cartridge

Lot No.:	200710C
S/N:	00000000050008134
Exp. Date:	20/10/2020

Analyzer

Model:	GEM® *Premier 5000*
Area:	GRI
Name:	CASU
S/N:	16093423

Results

				Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)							
cH	37.0	nmol/L	[--	--	--	--]
pCO_2	5.0	kPa	[--	--	--	--]
pO_2	6.0	kPa	[--	--	--	--]
Na^+	↓ 131	mmol/L	[--	133	146	--]
K^+	4.2	mmol/L	[--	3.5	5.3	--]
Cl^-	98	mmol/L	[--	95	108	--]
Ca^{++}	1.20	mmol/L	[--	1.15	1.27	--]
Glu	↑ 15.9	mmol/L	[--	3.5	6.0	--]
Lac	↑ 3.2	mmol/L	[--	0.6	2.2	--]
CO-Oximetry							
tHb	159	g/L	[--	--	--	--]
O_2Hb	↓ 72.6	%	[--	95.0	98.0	--]
COHb	↑ 3.2	%	[--	0.5	1.5	--]
MetHb	0.8	%	[--	0.5	1.5	--]
HHb	↑ 23.5	%	[--	0.0	5.0	--]
sO_2	↓ 75.5	%	[--	95.0	98.0	--]
Derived							
BE(B)	1.0	mmol/L	[--	--	--	--]
HCO_3(c)	25.2	mmol/L	[--	--	--	--]
Hct(c)	48	%	[--	--	--	--]

↑↓ Outside Reference Range

Other Information

Operator Entered

Temp	37.0	°C

CHI: 2107796165

Glasgow Royal Infirmary

10

Total Att: 18

12 Mth Att: 4

Title: **MISS**

WILSON **Gayle**

DOB **21/07/1979** Age: **41y** Sex: **Female**

52 DALHOUSIE ST

Glasgow
Lanarkshire
G3 6PN
07770460540

Next of kin: **WINTERS, Rita**
Relationship: **Aunt**
01412301448

GP: **NT Bhatti**
0141 334 9331

Attendance Date: **18/08/2020** Arrival Time: **20:15**

Registration Time: **20:15** Date of Incident: **18/08/2020**

Major Incident Desc:

Reason for Attendance: **overdose**

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **18/08/2020 20:28** Nurse name: **Nurse Nicole Pratt**

Temp	**36.1**	C
HR	**115**	bpm
BP	**149/116**	mmHg
MAP	**127.00**	mmHg
RR	**17**	bpm
SpO2	**96**	%
Oxygen		%

BM	**6.8**	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	**4**
Motor	
Verbal	**5**
Total	

Pupils Right		Pupils Left	
Size (mm)	**3**	Size (mm)	**3**
Reaction	**Y**	Reaction	**Y**

Nursing Notes: **"OVERDOSE. taken 6 night nurse and 4 nurofen last night and 8 night nurse plus 4 neurofen today. no vomit states took these to end life known to CPNs. low covid risk NEWS - 2 "**

To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

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

Date	Clinical Notes	
	Seen By	Time Seen

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By

Greater Glasgow & Clyde Emergency Departments' Mental Health Triage and Risk Assessment Tool

NHS Greater Glasgow and Clyde

Part One - Nursing Triage

triage nurse to complete this page

Patient name Gayle Wilson
CHI 2107796165

Triage Observations

document physiological measurements

GCS	BM	HR	BP	RR	SaO²	Temp
15	6·8	115	149/116	17	96%	36·1

accompanied by

name, relationship, particular concerns

on mojos 13-18.
grey tracksuit, short hair.

Describe the appearance/clothing of those attending alone, as they may leave before review.

Is the patient a young person in foster care or in a residential care placement? **YES/NO**

Is the patient a carer for a child or a dependent adult? **YES/NO**

Is there a child protection concern or concern for a vulnerable adult at risk? **YES/NO**

Outline of Presentation

tick all the categories which apply

Overdose (will also require medical assessment)	✓
Self-injury (will also require wound management)	
Other Mental Health Presentation	

Initial Presentation, Appearance and Behaviour

respond yes or no to each question, in any order which seems appropriate

Is the patient violent, aggressive or threatening?	Y	(N)
Is the patient obviously distressed, markedly anxious or highly aroused?	Y	(N)
Is the patient preoccupied, erratic or impulsive?	Y	(N)
Is the patient quiet and withdrawn?	Y	(N)
Do you think the patient is behaving inappropriately to their situation?	Y	(N)
Do you think the patient presents an immediate risk to you, to others, or to themselves?	Y	(N)
Do you think the patient is likely to abscond prior to assessment?	Y	(N)
Do you think the patient's presentation suggests either hallucinations or delusions?*	Y	(N)
Do you think the patient feels their actions are being controlled?	Y	(N)
Are you aware of a history of mental health problems or psychiatric illness?	(Y)	N
Are you aware of a history of violence or self-harm?	(Y)	N
Is the patient currently expressing suicidal thoughts?	(Y)	N
Is the patient currently intoxicated, with alcohol, or other substances?	Y	(N)

*Delusions; false but firmly held views and ideas. Hallucinations; false external stimuli (for example, visual or vocal) the patient thinks are real

Triage Risk Assessment

identify an initial category of risk, select one or more risks

High / Moderate / Low – risk of self-harm / violence / absconding.

Triage Category	3	High risk – accompanied *and* in the clinical area. Moderate risk – accompanied *or* in the clinical area. Low risk – can be asked to wait *if necessary*.

Immediate management

print toxbase information, and in paracetamol overdose, note 4-hour time for blood sample.

Patient location, accompanied by...	Summary OD of neurofen + night nurse from last night.
Blood sample time?	
Toxbase info printed? Y/N	
GMAWS considered? Y/N	

Any responses in the first column → **High Risk**

Other patients can be categorised as **Moderate Risk**

If *all responses* are in the third column → **Low Risk**

name/grade S/N Pratt

signature N Ratt

date and time 18/8/20 2020.

Part Two - Mental Health Assessment

medical staff to complete this page

Patient name Gayle Wilson
CHI 2107796165

outline of current presentation and precipitating factors

O-D. tonight. 6 night wise, 4 months last night. 8 night wise, 4 months tonight (+ reg. meds) @ 1845.
States mood often low, lower than (N) recently - no clear precipitant. Misses visits (passed away 12/12)
Meds in home (supported accommodation). Called Psych crisis team who advised call NHS → came to A&E.
°vomit. °abdo pain °palpitation. °note left °recent malaise. °psychosis.
Engaged in bereavement counselling Friday - offered appt. in 1/52.
States ongoing suicidal ideation.
No intents of harming other.

* on informing pt of plan for D/C: pt states that she wants seen by CPN now, that she will "jump off bridge". Pt fit for D/C medically. F/U arranged.

current and previous mental health problems, self-harm episodes, problematic alcohol and/or drug use, contacts with mental health services

PMHx: mild LD
EUPD

Known to Ψ.
Requested Bereavement Counselling.

4x ED presentation in last 12/12 w similar O.D.
- nil admissions.

other relevant information, (relationships, finances, employment, housing, physical health, childcare responsibilities, current medications, etc) - protective factors (beliefs, relationships, plans for future) - views of relatives/carers/'significant others'

Bereavement 12/12 of sister.
Lives supported accommodation.
Close to mum.
Mother unwell.

Little sleep recently.
Ranges Fc Pain

DHx: diazepam PRN.
sertraline
simvastatin
quetiapine

Allergies: Penicillin.

Appearance	Behaviour	Speech
Tracksuit + Rangers top. Black mark M BMI.	Settled. Appropriate. Calm. Engaging. Eye contact ✓.	Coherent. Reactive. Rate (N). Articulate.
Mood	**Thought**	**Insight**
Low. Affect generally flat, reactive re football.	Linear. °delusions °hallucinations.	Expressed regret. Aware of suicidal.

Risk Factors

(this is not an exhaustive list)

alcohol or drug use	
planning or concealment	
evidence of psychosis	
ongoing suicidal intent	
family concern about risk	
access to lethal means	
lack of social support	
age and gender	
chronic illness/pain	
family history of suicide	
disengaged/noncompliant	
unemployed/retired	✓
previous violent methods	
history of self-harm	✓
current psychiatric treatment	
previous psychiatric treatment	✓

Careful consideration should be given to patients who may present particular risks, including patients who may have post-natal depression, or patients with 'first presentations' of mental health problems, especially in adolescence or old age.

Risk Assessment

based on clinical assessment indicate a category of risk for a further episode of self-harm in the short term (48hrs) - consider protective as well as precipitating factors.

High / Moderate / Low

If young people in foster care or residential care are assessed, their social work team should be informed (via stand-by SW if out-of-hours) as well as giving information and advice to carers present.

Discharge Advice and Plan for Further Assessment

indicate the follow-up plan – referral to Liaison Psychiatry, duty doctor, out-of-hours CPN service, CMHT, GP, addiction services, SW, etc - indicate the advice given to the patient, and identities of others informed.

summary	follow up and advice given
D/W CPN: can't mind stay, they believe concrete evidence to avoid home tonight. They will ensure F/U tomorrow.	CPN F/U tomorrow.

service referred to	name/relationship of carer informed	consultant/middle-grade involved in decision or review
CPN.	Pt wishes no info. passed to support worker.	F. Rutkie

name/grade R. VINCENT FY2
signature
date and time 23:30

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name	2107796165
Address	WILSON Gayle F 52 DALHOUSIE ST 21/07/1979 Glasgow, Lanarkshire G3 6PN
CHI No.	
DoB	

	Date	Ward
Admitted	18-8-20	
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

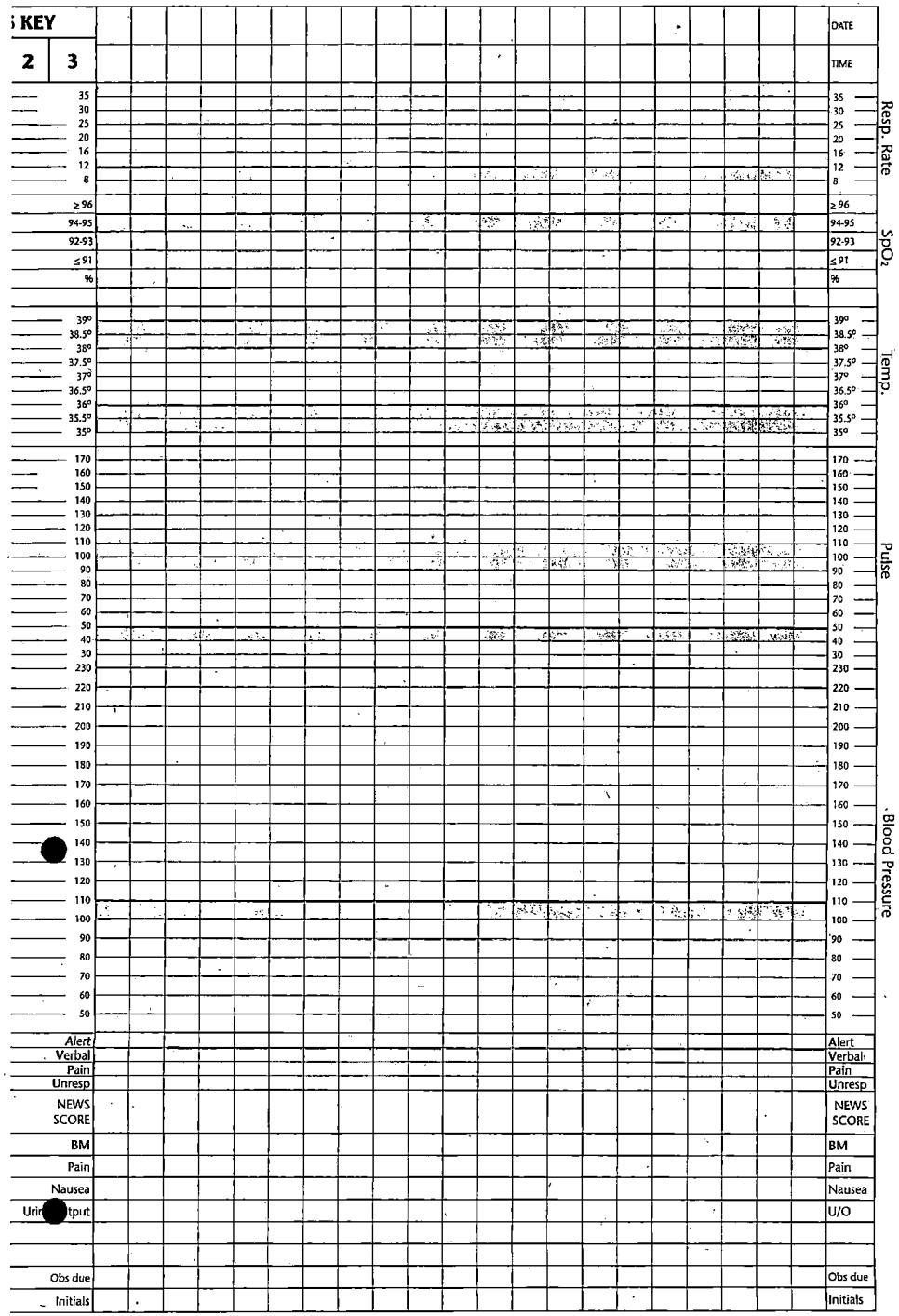
NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

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.

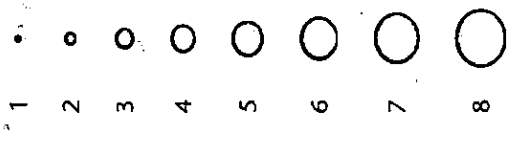
Sarah Wilson

		DATE			DATE	NEWS	
(6)		TIME			TIME	0	1
Resp. Rate Mark: •	35 30 25 20 16 12 8		12		35 30 25 20 16 12 8		
SpO_2 (Enter Value)	≥ 96 94-95 92-93 ≤ 91		99		≥ 96 94-95 92-93 ≤ 91		
Any Sup'l O_2 Room air	%		A		%		
Temp. Mark: ×	39° 38.5° 38° 37.5° 37° 36.5° 36° 35.5° 35°		35.8		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		98		170 160 150 140 130 120 110 100 90 80 70 60 50 40 30		
Blood Pressure Mark: ◇	230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50		133		230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50		
NEWS SCORE using Systolic BP							
Conscious Level Mark: •	Alert Verbal Pain Unresp		A		Alert Verbal Pain Unresp		
Total NEWS (with all obs)			1		NEWS SCORE		
BM					BM		
Pain					Pain		
Nausea					Nausea		
Urine output					U/O		
Obs due					Obs due		
Initials					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
U/O
Obs due
Initials

Glasgow Coma Scale

Pupil size (mm)



2107796165
WILSON
Gayle
F
52 DALHOUSIE ST
21/07/1979
Glasgow, Lanarkshire
G3 6PN

Neurological Observations

Date:																									
Time:																									
COMA SCALE	E Eyes open	Spontaneously	4																						Eyes closed by swelling = C
		To speech	3																						
		To pain	2																						
		None	1																						
	V Best Verbal response	Orientated	5																						Endotracheal tube or tracheostomy = T
		Confused	4																						
		Inappropriate words	3																						
		Incomprehensible sounds	2																						
		None	1																						
	M Best motor response	Obeys	6																						Usually record the best arm response
		Localises	5																						
		Flexion - withdrawal	4																						
		Flexion - abnormal	3																						
		Extension to pain	2																						
		None	1																						
	TOTAL SCORE																								
PUPILS	R	Size																							+ reacts – no reaction c. eyes closed
		Reaction																							
	L	Size																							
		Reaction																							
LIMB MOVEMENT	ARMS	Normal power																							Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness																							
		Severe weakness																							
		Spastic flexion																							
		Extension																							
		No response																							
	LEGS	Normal power																							
		Mild weakness																							
		Severe weakness																							
		Spastic flexion																							
		Extension																							
		No response																							

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

Emergency Department Nursing Documentation

Presenting Complaint - ? overdose Night shift

Date: 18/8/20 Time: 22:50

2107796165
WILSON F
Gayle 21/07/1979
52 DALHOUSIE ST
Glasgow, Lanarkshire
G3 6PN

NHS Greater Glasgow and Clyde

Assessment Complete by: Name NURSE (Please Print) [illegible]

Patient Prep / Investigations (Please tick/circle when completed)		Communication (Please Circle Tick)	
Prepare patient for examination / Clothing bag labelled + stored	☑	NEWS Chart complete / NEWS SCORE - (Record pain, blood sugar and Neuro Obs on NEWS Chart)	☑
GGC RED BAG - with patient	☐		
12 Lead ECG	☑	ID Band	☐
Weight:	☐	Peak Flow	☐
Blood Samples Obtained: Yes ☐ No ☐		Xrays / CT Scan Performed:	☐
IV Access: Yes ☐ No ☐		Relatives / NOK informed (Carers)	☐
Blood Gas: VBG ☐ ABG ☐		Child Protection Concern (considered in line with policy)	Y/N
		Adult Support and Protection	Y/N

Urinalysis							
	Leucocytes ☐	Nitrites ☐	Protein ☐	Blood ☐
	Ketones ☐	Glucose ☐	PH	S.G.
	MSSU / CSU ☐	Toxiclogy ☐		
	HCG ☐	+VE ☐	-VE ☐	Strip No -

Screening Tools (Please tick/circle when completed)			
SEPSIS RISK? / SIRS Criteria 2 or more	Y/N	**SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)**	YES
Mental Health Triage Assessment	Y/N	If NOT WHY? - (details) N/A	NO
GMAWS	Y/N	Date - Time - 18/8/20 2210 Signature - [signature]	

4AT	
AMT	Correct
Age	
Date of Birth	
Place	
Current year	

No mistakes	= 0
1 mistake	= 1
> 1 mistake	= 2

Attention (months of year backwards)	
> = 7 correct	0
< 7 correct	1
Untestable	2

Alertness	
Normal	0
Mild sleepiness	0
Clearly abnormal	4

Mental status according to family/carer		
Acute change or fluctuating	4	YES
Acute change or fluctuating	0	NO

4AT score /12

STEP 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?

All over 75s and care home residents over 65. For younger patients use clinical judgement and consult local guidelines.

		YES	NO
F	**F**unctional impairment (new or worsening) eg difficulty with self care		
R	**R**esident in a care home?		
A	**A**ltered mental state such as acute confusion or dementia use the 4AT		
I	**I**mmobility/instability. New decline in mobility, difficulty mobilising without help or fall leading up to admission		
L	**L**ikely to require support for discharge? (either new or increase in existing support)		

Are any of the above criteria met? If YES to any of the above move to step 2

STEP 2 Would this person be better managed by another specialty team at present?

Indicator for care by another acute specialty regardless of age.

	YES	NO
Clear need for other specialty input eg exacerbation of known long term condition such as COPD		
Need for HDU/ITU (including non-invasive ventilation)		
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit		
Head injury with loss of consciousness		
Acute abdominal pain/surgical presentation		
Upper GI Bleed		
Chest pain with suspected acute coronary syndrome		
Trauma with suspected fracture		

Are any of the above 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 **NO** to the list in step 2:

- Prioritise transfer of care to specialist geriatric assessment service in line with local guidance.

Screening Tools / ACTIVE CARE

(Please tick/circle when completed)

1) Pressure Damage Does the person have redness and/or existing damage? If YES - continue with a minimum of 2 hourly Active Care + Complete PUDRA		Y/N	Date	Location of Redness/Ulcers	Grade of Ulcer	
2) Mobility	Does the person require assistance?	Y/N				
3) Continence		Y/N	**5) Skin**	Is skin compromised by other source, eg neurological deficit, medication, substance, diabetes, co-morbid?		Y/N
4) Nutrition		Y/N	**6) Judgment**	In your clinical judgment is this person at risk for developing pressure damage? IF YES - DETAILS		Y/N

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.

2107796165
WILSON
Gayle F
52 DALHOUSIE ST 21/07/1979
Glasgow, Lanarkshire
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At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc) *At risk complete risk assessment*	
YES	NO

Pause for Transfer / Discharge (Please tick when completed)		Tick when completed	N/A	Notes
Relatives Informed of Admission / Discharge		☐	☐	Information on discussion with relatives
Relatives/carer with patient on transfer to ward		☐	Always	
GGC RED BAG - with patient		☐	Always	
Name Band		☐	Always	
Nursing Screening Tools completed		☐	Always	
Bed requested, SBAR COMPLETE		☐	☐	
NEWS chart		☐	Always	
Prescriptions / Charts signed	Infusions	☐	☐	
	Cannula	☐	☐	
Notes: medical notes, GP letter, PRF		☐	☐	
Patients requiring analgesia: sufficient		☐	☐	
Belongings (including patients medication)		☐	Always	Please note here if any other tasks required prior to transfer
SAS Transport required and ref. no.		☐	☐	
Print Name Sign -				

Nursing Notes

Date and Time		Print Name and Signature
18/8/20	2310 - patient brought into cubicle	
	? taken extra dose of night nurse. drowsy	
	bladder ok to see CMO in morning	
	discharged	

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name	2107796165
Address	WILSON F Gayle 21/07/1979 TALBOT CENTRE 52 DALHOUSIE STREET Glasgow, Lanarkshire
CHI No.	G3 6PN
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
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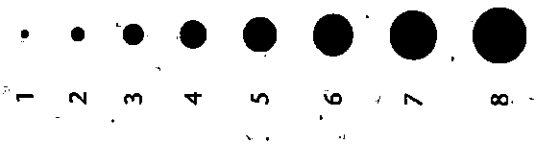
13 Gayle Wilson

		DATE:	18/10		19/10																DATE	NEWS	
		TIME:	20 27	23 45	01 20																TIME	0	1
Resp. Rate Mark: •	35																				35		
	30																				30		
	25																				25		
	20	o	o	o																	20		
	16																				16		
	12																				12		
	8																				8		
SpO_2 (Enter Value)	≥ 96	100	96	96																	≥ 96		
	94-95																				94-95		
	92-93																				92-93		
	≤ 91																				≤ 91		
Any Sup'l O_2 %	%																				%		
Room air		A	A	A																			
Temp. Mark: X	39°																				39°		
	38.5°																				38.5°		
	38°																				38°		
	37.5°																				37.5°		
	37°	X	X	X																	37°		
	36.5°																				36.5°		
	36°																				36°		
	35.5°																				35.5°		
	35°																				35°		
Pulse Mark: •	170																				170		
	160																				160		
	150																				150		
	140																				140		
	130	o																			130		
	120		o	o																	120		
	110																				110		
	100																				100		
	90																				90		
	80																				80		
	70																				70		
	60																				60		
	50																				50		
	40																				40		
	30																				30		
	230																				230		
	220																				220		
	210																				210		
	200																				200		
	190																				190		
	180																				180		
Blood Pressure Mark: ◇	170																				170		
	160																				160		
	150	^																			150		
	140																				140		
NEWS SCORE using Systolic BP	130		^	^																	130		
	120																				120		
	110																				110		
	100	✓																			100		
	90		✓	✓																	90		
	80																				80		
	70																				70		
	60																				60		
	50																				50		
Conscious Level Mark: •	Alert		o	o																	Alert		
	Verbal																				Verbal		
	Pain																				Pain		
	Unresp																				Unresp		
Total NEWS (with all obs)		3	2	2																	NEWS SCORE		
BM		11·6																			BM		
Pain																					Pain		
Nausea																					Nausea		
Urine output																					U/O		
Obs due																					Obs due		
Initials		TRI	SK	SK																	Initials		

Glasgow Coma Scale



GAYLE WILSON
PATIENT
2079961 65

Neurological Observations

Date:																										
Time:																										
COMA SCALE	E Eyes open	Spontaneously	4																							Eyes closed by swelling = C
		To speech	3																							
		To pain	2																							
		None	1																							
	V Best Verbal response	Orientated	5																							Endotracheal tube or tracheostomy = T
		Confused	4																							
		Inappropriate words	3																							
		Incomprehensible sounds	2																							
		None	1																							
	M Best motor response	Obeys	6																							Usually record the best arm response
		Localises	5																							
		Flexion - withdrawal	4																							
		Flexion - abnormal	3																							
		Extension to pain	2																							
		None	1																							
TOTAL SCORE																										
PUPILS	R	Size																								+ reacts – no reaction C eyes closed
		Reaction																								
	L	Size																								
		Reaction																								
LIMB MOVEMENT	ARMS	Normal power																								Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness																								
		Severe weakness																								
		Spastic flexion																								
		Extension																								
		No response																								
	LEGS	Normal power																								
		Mild weakness																								
		Severe weakness																								
		Spastic flexion																								
		Extension																								
		No response																								

Pain Score

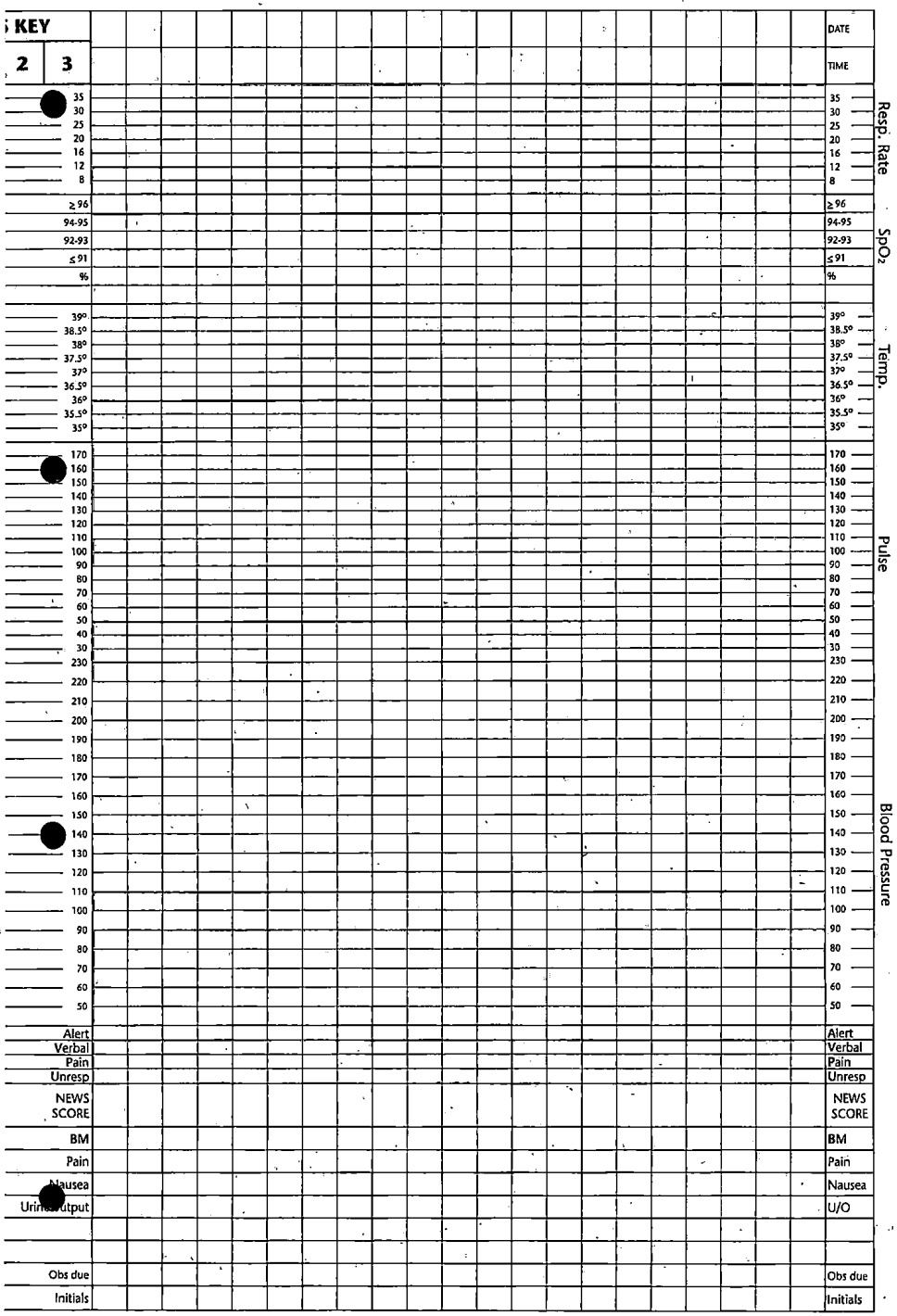
Ask the patient to rate his/her pain by choosing a number between 0 and 10. Use the diagram below to assist the patient. If patient's pain is chronic, use generic tool. If patient is unable to communicate, use observational tool.

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


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
Urine output
U/O
Obs due
Initials

Emergency Department Nursing Documentation

Presenting Complaint - Mental Health

Date: 18 / 10 / 19 Time: 20:45

2107796165
WILSON F
Gayle 21/07/1979
TALBOT CENTRE
52 DALHOUSIE STREET
Glasgow, Lanarkshire
G3 6PN

NHS Greater Glasgow and Clyde

Assessment Complete by: Name NURSE (Please Print)

Patient Prep / Investigations (Please tick/circle when completed)		Communication (Please Circle Tick)	
Prepare patient for examination / Clothing bag labelled + stored	☑	NEWS Chart complete / NEWS SCORE - (Record pain, blood sugar and Neuro Obs on NEWS Chart)	☑
GGC RED BAG - with patient	☐		
12 Lead ECG	☑	ID Band	☐
Weight:	☐	Peak Flow	☐
Blood Samples Obtained: Yes ☐ No ☐		Xrays / CT Scan Performed:	☐
IV Access: Yes ☐ No ☐		Relatives / NOK informed (Carers)	☐
Blood Gas: VBG ☐ ABG ☐		Child Protection Concern (considered in line with policy)	Y/N
		Adult Support and Protection	Y/N

Urinalysis							
	Leucocytes ☐	Nitrites ☐	Protein ☐	Blood ☐
	Ketones ☐	Glucose ☐	PH	S.G.
	MSSU / CSU ☐	Toxiclogy ☐		
	HCG ☐	+VE ☐	-VE ☐	Strip No -

Screening Tools (Please tick/circle when completed)			
SEPSIS RISK? / SIRS Criteria 2 or more	Y/N	**SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)**	**YES**
Mental Health Triage Assessment	Y/N	If NOT WHY? - (details) NA	NO
GMAWS	Y/N	Date - Time - Signature -	

4AT

AMT	Correct
Age	
Date of Birth	
Place	
Current year	

No mistakes	= 0
1 mistake	= 1
> 1 mistake	= 2

Attention (months of year backwards)	
> = 7 correct	0
< 7 correct	1
Untestable	2

Alertness	
Normal	0
Mild sleepiness	0
Clearly abnormal	4

Mental status according to family/carer		
Acute change or fluctuating	4	YES
Acute change or fluctuating	0	NO

4AT score /12

STEP 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?

All over 75s and care home residents over 65. For younger patients use clinical judgement and consult local guidelines.

		YES	NO
F	**F**unctional impairment (new or worsening) eg difficulty with self care		
R	**R**esident in a care home?		
A	**A**ltered mental state such as acute confusion or dementia use the 4AT		
I	**I**mmobility/instability. New decline in mobility, difficulty mobilising without help or fall leading up to admission		
L	**L**ikely to require support for discharge? (either new or increase in existing support)		

Are any of the above criteria met? If YES to any of the above move to step 2

STEP 2 Would this person be better managed by another specialty team at present?

Indicator for care by another acute specialty regardless of age.

	YES	NO
Clear need for other specialty input eg exacerbation of known long term condition such as COPD		
Need for HDU/ITU (including non-invasive ventilation)		
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit		
Head injury with loss of consciousness		
Acute abdominal pain/surgical presentation		
Upper GI Bleed		
Chest pain with suspected acute coronary syndrome		
Trauma with suspected fracture		

Are any of the above 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 **NO** to the list in step 2:

- Prioritise transfer of care to specialist geriatric assessment service in line with local guidance.

Screening Tools / ACTIVE CARE

(Please tick/circle when completed)

1) Pressure Damage Does the person have redness and/or existing damage? If YES - continue with a minimum of 2 hourly Active Care + Complete PUDRA		Y/N	**Date**	**Location of Redness/Ulcers**	**Grade of Ulcer**	
2) Mobility	Does the person require assistance?	Y/N				
3) Continence		Y/N	**5) Skin**	Is skin compromised by other source, eg neurological deficit, medication, substance, diabetes, co-morbid?		Y/N
4) Nutrition		Y/N	**6) Judgment**	In your clinical judgment is this person at risk for developing pressure damage? IF YES - DETAILS		Y/N

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.

Gayle Wilson 2107796165

Nursing Notes		
Date and Time		Print Name and Signature

Patient Addressograph Label

At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc) *At risk complete risk assessment*	
YES	(NO)

Pause for Transfer / Discharge (Please tick when completed)		Tick when completed	N/A	Notes
Relatives Informed of Admission / Discharge		☑	☐	Information on discussion with relatives
Relatives/carer with patient on transfer to ward		☐	Always	
GGC RED BAG - with patient		☐	Always	
Name Band		☐	Always	
Nursing Screening Tools completed		☐	Always	
Bed requested, SBAR COMPLETE		☐	☑	
NEWS chart		☐	Always	
Prescriptions / Charts signed	Infusions	☐	☑	
	Cannula	☐	☑	
	Notes: medical notes, GP letter, PRF	☐	☑	
	Patients requiring analgesia: sufficient	☐	☑	
Belongings (including patients medication)		☐	Always	Please note here if any other tasks required prior to transfer
SAS Transport required and ref. no.		☐	☑	
Print Name S.KAY Sign - Sarah kay				

Nursing Notes		
Date and Time		Print Name and Signature
19/10/19	Has been reviewed by CPN's who are happy for discharge but remains tachycardic. Discussed with senior. Await plan	S.KAY Sarah kay
0135	Patient discharged, police will escort home. Talbot association informed	Sarah kay

Glasgow Royal Infirmary

13

CHI: 2107796165

Total Att: 15

12 Mth Att: 1

Title: MISS

WILSON **Gayle**

DOB: **21/07/1979** Age: **40y** Sex: **Female**

TALBOT CENTRE
52 DALHOUSIE STREET
Glasgow
Lanarkshire
G3 6PN
07770460540

Next of kin: **WILSON, VIOLET**
Relationship: **Parent**
0141 563 8676

GP: **NT Bhatti**
0141 334 9331

Attendance Date: **18/10/2019** Arrival Time: **19:57**

Registration Time: **19:57** Date of Incident: **18/10/2019**

Major Incident Desc:

Reason for Attendance: **self harm**

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **18/10/2019 20:27** Nurse name: **Nurse Melanie Gartshore**

Temp	37.0	C
HR	135	bpm
BP	156/95	mmHg
MAP	115.33	mmHg
RR	18	bpm
SpO2	96	%
Oxygen		%

BM	11.6	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	4
Motor	6
Verbal	5
Total	**15**

Pupils-Right		Pupils-Left	
Size (mm)	3	Size (mm)	3
Reaction	Y	Reaction	Y

Nursing Notes: **"c/o low mood and suicidal idation after berevement of sister. states having flash backs of the resuscitation. this pm sustained DSH to L wrist and attempted to take over dose of ibuprofen - gave tablets to police prior to ingestion. news 3 low cpe"**

To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

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

Date	Clinical Notes
8/10/19	Seen By: D. MURRAY FY2 Time Seen 2200

See yellow mental health proforma

PC - Suicidal ideation + DSH

HPC - see mental health proforma.

Looks well.

D/E DSH Lacerations to (L) forearm. Patient sweating.

Does not require any sedation → Wearing 4 layers

Coherent. ☒ Clear HSL+HT+O

No thought disorder. ☐ SNT ☑ BS

T° 37.0
HR 135
BP 156/95
RR 18
SpO2 96%

Imp (1) Hyponatraemia risk due to ongoing suicidal ideation.
(2) Tachycardia due to breakfast consumption.

22:30 DIW CPN. will review patient in ED.

Plan (1) Repeat obs on triage
(2) ECG.

D. MURRAY
7600484

Notes continue on full clerk in sheet

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By

Glasgow Royal Infirmary
Emergency Department

NHS
Greater Glasgow and Clyde

2107796165
WILSON F
Gayle 21/07/1979
TALBOT CENTRE
52 DALHOUSIE STREET
Glasgow, Lanarkshire
G3 6PN

Initial Investigations Ordered

FBC ☐	COAG ☐	DD ☐	INR ☐		G+S ☐		X-match units			
U+Es ☐	LFT ☐	GLU ☐	CRP ☐	TROP ☐	Para ☐	Sal ☐	Ethanol ☐	Mg ☐	VBG ☐	ABG ☐
B culture ☐		C/MSSU ☐		Urinalysis ☐		BHCG ☐		Other		
CXR ☐	AXR ☐	Other imaging:								ECG ☐
Current location:								Sent by:		

Clinical Notes

Date 19/10/17 Time 0100 Name O. MURRAY Grade FY2 Speciality ED

Continued from front sheet.

Patient reviewed by CPNs + deemed psychiatrically fit for discharged. F/u with crisis team this morning.

Patient remains tachycardic
ECG - sinus tachycardia. Rate 125 bpm.
QRS 66ms. QTc 485ms.

Pulse 125
BP 138/68
T° 36.7
SpO2 96%
RR 17

Continues to deny chest pain / palpitations.
No infective symptoms.

O/E Sweating PEARL. Chest clear. Pulse regular + tachycardic. Eye movements intact No ocular clonus.

	RUL	LUL	RLL	LLL
Tone	(N)	(N)	(N)	(N)
Reflexes	(N)	(N)	(N)	(N)

No clonus. Abdo SNT.

VBG H+ 36.2, Lactate 1.9, BE -1.1, HCO_3^- 22.4

Glasgow Royal Infirmary
Emergency Department

2107795165
WILSON
Gayle F
21/07/1979
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G3 6PN

Clinical Notes

Date 19/10/19 Time 0100 Name O. Murray Grade FY2 Speciality EM

On review of Portal patient was tachycardic (135/128) on in ED on 21/08/19

DIW consultant Dr Reiny as no clear cause of tachycardia + patient clinically well + obs reflected tachycardia on previous admission Patient can be discharged No features of serotonin syndrome.

DIW patient admitted psychiatric ward in place Some nursing advice re. tachycardia

Informed David at Talbot House of patient discharge + plan

O. Murray
7606484

Glasgow Royal Infirmary
Emergency Department

2107796165
WILSON F
Gayle 21/07/1979
TALBOT CENTRE
52 DALHOUSIE STREET
Glasgow, Lanarkshire
G3 6PN

Clinical Notes

Date	Time	Name	Grade	Speciality

Glasgow Royal Infirmary
Emergency Department

2107796165 F
WILSON 21/07/1979
Gayle
TALBOT CENTRE
52 DALHOUSIE STREET
Glasgow, Lanarkshire G3 6PN

HAEM	DATE or TIME		BIOCH	DATE or TIME			DATE or TIME		V/ABG	DATE or TIME	
WCC			Na			Bil			FiO_2		
Hb			K			ALT			H^+		
Plat			Cl			AST			$PaCO_2$		
Neut			Ur			GGT			PaO_2		
DD			Creat			A phos			Bic		
PT			eGFR			Alb			BE		
PTT			Glu			AdjCa			Lactate		
TT			CRP			Amyl			Ethanol		
INR			Mg			TropI HS			Para		
			Phos			BHCG			Sal		

Diagnosis and Plan

Review/Discussed with:

Handover

- ☐ Provisional Diagnosis
- ☐ Liquids/Fluids
- ☐ Analgesic/Medicines
- ☐ NEWS
- ☐ Investigations & Results
- ☐ Talk to receiving team/ward

mi • 287967 Version 1_0 • GGC0226

2107796165
WILSON F
Gayle 21/07/1979

Printed: 19/10/2019 00:58:44

Patient Sample Report

Status: **ACCEPTED**
Analyzed: 19/10/2019 00:58:32
Sample Type: **Venous**
Account Number:
Clinician:
Operator ID: OONAGH MURRAY0

Patient

ID:	2107796165
Last Name:	**WILSON**
First Name:	**GAYLE**
Gender/Age:	Female, 40 years
Birth Date:	21/07/1979

Cartridge

Lot No.:	190612A
S/N:	000000000500014116
Exp. Date:	03/11/2019

Analyzer

Model:	GEM® *Premier 5000*
Area:	GRI
Name:	CASU
S/N:	16090423

Results

				Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)							
cH	36.2	nmol/L	[	--	--	--	--]
pCO_2	4.4	kPa	[	--	--	--	--]
pO_2	9.1	kPa	[	--	--	--	--]
Na^+	137	mmol/L	[	--	133	146	--]
K^+	3.6	mmol/L	[	--	3.5	5.3	--]
Cl^-	104	mmol/L	[	--	95	108	--]
Ca^{++}	1.16	mmol/L	[	--	1.15	1.27	--]
Glu	↑ 9.1	mmol/L	[	--	3.5	6.0	--]
Lac	1.9	mmol/L	[	--	0.6	2.2	--]
CO-Oximetry							
tHb	148	g/L	[	--	--	--	--]
O_2Hb	↓ 90.7	%	[	--	95.0	98.0	--]
COHb	↑ 4.8	%	[	--	0.5	1.5	--]
MetHb	0.8	%	[	--	0.5	1.5	--]
HHb	3.6	%	[	--	0.0	5.0	--]
sO_2	96.2	%	[	--	95.0	98.0	--]
Derived							
BE(B)	-1.1	mmol/L	[	--	--	--	--]
$HCO_3^-(c)$	22.4	mmol/L	[	--	--	--	--]
Hct(c)	44	%	[	--	--	--	--]

↑↓ Outside Reference Range

Other Information

Operator Entered

Temp	37.0	°C

Greater Glasgow & Clyde Emergency Departments' Mental Health Triage and Risk Assessment Tool

NHS Greater Glasgow and Clyde

Part One - Nursing Triage

triage nurse to complete this page

Patient name Gayle Wilson
CHI 2107796165

Triage Observations

document physiological measurements

GCS	BM	HR	BP	RR	SaO^2	Temp
15	11.6	135	156/95	18	96	37.6

accompanied by

name, relationship, particular concerns

Police

Describe the appearance/clothing of those attending alone, as they may leave before review.

Is the patient a young person in foster care or in a residential care placement? **YES/NO**

Is the patient a carer for a child or a dependent adult? **YES/NO**

Is there a child protection concern or concern for a vulnerable adult at risk? **YES/NO**

Outline of Presentation

tick all the categories which apply

Overdose (will also require medical assessment)	
Self-injury (will also require wound management)	✓
Other Mental Health Presentation	✓

Initial Presentation, Appearance and Behaviour

respond yes or no to each question, in any order which seems appropriate

Is the patient violent, aggressive or threatening?	Y		(N)
Is the patient obviously distressed, markedly anxious or highly aroused?		Y	(N)
Is the patient preoccupied, erratic or impulsive?	Y		(N)
Is the patient quiet and withdrawn?		(Y)	N
Do you think the patient is behaving inappropriately to their situation?		Y	(N)
Do you think the patient presents an immediate risk to you, to others, or to themselves?	Y		(N)
Do you think the patient is likely to abscond prior to assessment?	Y		(N)
Do you think the patient's presentation suggests either hallucinations or delusions?*	Y		(N)
Do you think the patient feels their actions are being controlled?	Y		(N)
Are you aware of a history of mental health problems or psychiatric illness?		(Y)	N
Are you aware of a history of violence or self-harm?		(Y)	N
Is the patient currently expressing suicidal thoughts?	(Y)		N
Is the patient currently intoxicated, with alcohol, or other substances?		(Y)	N

*Delusions; false but firmly held views and ideas. Hallucinations; false external stimuli (for example, visual or vocal) the patient thinks are real

Triage Risk Assessment

identify an initial category of risk, select one or more risks

High / Moderate / Low – risk of self-harm / violence / absconding

Triage Category	3	High risk – accompanied *and* in the clinical area. Moderate risk – accompanied *or* in the clinical area. Low risk – can be asked to wait *if necessary*.

Any responses in the first column **High Risk**

Other patients can be categorised as **Moderate Risk**

If *all responses* are in the third column **Low Risk**

Immediate management

print toxbase information, and in paracetamol overdose, note 4-hour time for blood sample.

Patient location, accompanied by...	Summary
Blood sample time?	
Toxbase info printed? Y/N	
GMAWS considered? Y/N	

name/grade MCMORRISMORE

signature

date and time 18/10/19 2030

Part Two - Mental Health Assessment

(medical staff to complete this page)

Patient name G. WILSON
CHI 210779 6165

outline of current presentation and precipitating factors

Having ongoing low mood + suicidal ideation since bereavement of sister. Sister had cardiac arrest in house and Gayle witnessed resuscitation attempts in the house - Been having flashbacks of this.
Mood low since discharge from hospital -
Left suicide note tonight. Contacted crises team. Unable to tell me what was said.
Drank ½ bottle of brandy + Naltrexone police as told them she was going to overdose on tablets. Did not ingest any tablets.

current and previous mental health problems, self-harm episodes; problematic alcohol and/or drug use, contacts with mental health services

Previous overdose + DSH attempts. Overdose attempt a day of discharge from Gartnavel Royal Mental. Detained at this occasion.

other relevant information, (relationships, finances, employment, housing, physical health, childcare responsibilities, current medications, etc) - protective factors (beliefs, relationships, plans for future) - views of relatives/carers/'significant others'

States nil protective factors.
Ongoing suicidal ideation - States would take paracetamol.

Appearance	Behaviour	Speech
Unkempt	Appropriate	Intact
Mood Subjectively low	**Thought** Intact	**Insight** Intact

Risk Factors (this is not an exhaustive list)

alcohol or drug use	✓
planning or concealment	
evidence of psychosis	
ongoing suicidal intent	✓
family concern about risk	
access to lethal means	
lack of social support	
age and gender	
chronic illness/pain	
family history of suicide	
disengaged/noncompliant	✓
unemployed/retired	
previous violent methods	
history of self-harm	✓
current psychiatric treatment	
previous psychiatric treatment	✓

Careful consideration should be given to patients who may present particular risks, including patients who may have post-natal depression, or patients with 'first presentations' of mental health problems, especially in adolescence or old age.

Risk Assessment

based on clinical assessment indicate a category of risk for a further episode of self-harm in the short term (48hrs) - consider protective as well as precipitating factors.

(High) / Moderate / Low

If young people in foster care or residential care are assessed, their social work team should be informed (via stand-by SW if out-of-hours) as well as giving information and advice to carers present.

Discharge Advice and Plan for Further Assessment

Indicate the follow-up plan – referral to Liaison Psychiatry, duty doctor, out-of-hours CPN service, CMHT, GP, addiction services, SW, etc - indicate the advice given to the patient, and identities of others informed.

summary	follow up and advice given

service referred to	name/relationship of carer informed	consultant/middle-grade involved in decision or review
CPNs - will	David C	Dr Reilly

name/grade
O. Murray

signature

date and time
18/10/19 22:20

briefly review. Talbot Ward

WILSON, Gayle (Miss) Date of Birth: **21-Jul-1979 (40y)**

52 Dalhousie Street, Glasgow,, Lanarkshire, G3 6PN

CHI Number: 210 779 6165 Usual GP: GHOURI, NA (Dr)

Consultations

Date		Consultation Text
19-Oct-2019	Comment	Face to face consultation (Glasgow Royal Infirmary) GOLDIE, Charles (OOH) Situation .Request from ED at GRI for OOHs CPN assessment. Brought to department by police following a request by support staff for police welfare visit after Gayle had verbalised plans to overdose . Gayle had informed the staff of her thoughts , had then visited local shops and bought Ibuprofen tablets and returned to her supported accomodation with them . She did not consume any of the tablets and voluntary surrendered them to the police when they arrived . Had superficially cut her left wrist , no medical treatment required . Police report that during their contact with Gayle she has been settled and calm . She had not repeated her suicidal thoughts of earlier and informed them she feels she requires her medication to be reviewed .Had also drank a half bottle of Buckfast . Background ,Known to the Springpark RC , previously Riverside . Had called the crisis team earlier on Friday evening reporting that she felt her mood was low , describing struggling with her sisters death and described experiencing " flash backs " relating to her death. At this point reporting thoughts of a suicidal nature . Following this support staff advised to request police welfare visit . Presently on Sertraline 200mg daily . Assessment .Assessed by Stephen Wilkie and Charlie Goldie . Gayle was dressed in a tracksuit to and bottom , throughout assessment she pulled her hood over her face and tended to look towards the floor making engagement difficult . She was an inconstistant historian and tended to contradict herself throughout. She was rather negative in her view of the services and suport she recieves . Verbalising an opinion that nothing is helping with the emotional difficulties she experiences following her sisters death. She reported feeling low in mood , however during contact she presented as reactive in her affect , with no obvious symptoms of depressive illness . She generally presented as disgruntled and frustrated . She described needing to be " put somewhere " tonight . She repeated her earlier threats of taking paracetamol if this was not facilitated . However these threats were vague in content and she described no actual concrete plan . She presented having capacity for her decision making and had shown over the course of yesterday and last night that she had the ability to keep herself safe and access appropriate support when required . As the interview progressed there were periods when she became quite reactive , describing future plans and a wish to be re-housed in the near future . At assessment there was no firm evidence of immediate risk to herself . There was no evidence of psychotic features or formal thought disorder . Presentation similar to previous contacts with OOHs and keeping with her diagnosis of EUPD and Mild Learning Difficulties . Appears to struggle at periods to identify approriate coping strategies when emotionally overwhelmed . By the end of assesment more settled and agreed to return to supported accomodation and maintain her safety. Recommendation .Will request telephone contact from Day Crisis tomorrow to offer verbal support , in an attempt to defuse further crisis . Agreed to same . Prior to CPNs leaving department the medical staff again reviewed Gayle as following initial review her blood pressure was found to be slightly raised . Following these proceedures police will transport home .
	Additional	Discharge from care Appointment Outcome:

CHI: 2107796165

Glasgow Royal Infirmary

10

Total Att: 14

12 Mth Att: 0

Title: **MISS**

WILSON **Gayle**

DOB: **21/07/1979** Age: **40y** Sex: **Female**

TALBOT CENTRE
52 DALHOUSIE STREET
Glasgow
Lanarkshire
G3 6PN
07770460540

Next of kin: **WILSON, VIOLET**
Relationship: **Parent**
0141 563 8676

GP: **NT Bhatti**
0141 334 9331

Attendance Date: **21/08/2019** Arrival Time: **20:53**

Registration Time: **20:53** Date of Incident: **21/08/2019**

Major Incident Desc:

Reason for Attendance: **OD**

Nursing Assessment

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

Triage Category: **2** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **21/08/2019 20:57** Nurse name:

Temp	**36.4**	C
HR	**128**	bpm
BP	**138/98**	mmHg
MAP	**111.33**	mmHg
RR	**16**	bpm
SpO2	**100**	%
Oxygen		%

BM	**8.5**	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	**4**
Motor	**6**
Verbal	**5**
Total	**15**

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

Nursing Notes: **deliberate OD of chlorphenamine 4mg x 30 tablets throughout day today. ongoing suicidal ideation in triage. discharged from gartnavel this am for same. recent family bereavements news: 2**

2107796165 21/07/1979 WILSON Gayle
2107796165 21/07/1979 WILSON Gayle
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2107796165 21/07/1979 WILSON Gayle

To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

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

Date	Clinical Notes
	Seen By / Time Seen

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By

Patient Information		Date:	21/08/2019
GAIL WILSON		Incident Number:	CR005796634
Age/Gender:	40 years 1 months 0 days Old Female		
Address:	HOSTEL 52 DALHOUSIE STREET GARNETHILL GLASGOW,G3 6PN	Incident Type:	EMG
DOB:	21/07/1979	Incident Location:	HOSTEL 52 DALHOUSIE STREET GARNETHILL GLASGOW, G3 6PN
CHI:			
Ethnicity:			

Scottish Ambulance Service

Presenting Complaint

OD

Additional Comments

999 CALL FOR A 40 Y/O F TAKEN AN OD OF CHLORPHENAMINE. O/A PT SAT IN OFFICE, ALERT, GOOD COLOUR. O/E PT TACHYCARDIC, OTHERWISE OBS UNREMARKABLE. PT REPORTS SHE TOOK 30 4MG TABLETS OVER 4 HOURS. 10 AT 14:00, THEN 5 TABLETS 2 HOURS LATER AND 5 AND 5 EACH HOUR AFTER UNTIL 6PM. INTENTION WAS TO END HER LIFE. PT OUT OF GARTNAVAL ROYAL FOR SUICIDAL INTENTIONS AFTER AN 18 DAY STAY THIS MORNING. FEELING VERY LOW, CANT STOP CRYING AND LOST INTEREST IN EATING AND HYGEINE. PT HAS EXPERIENCED LOSS OF FATHER THROUGH CA LAST YEAR THEN SISTER SUDDENLY IN JUNE. MOTHER HAS END STAGE COPD. NIECE IS CNLY OTHER FAMILY. TAKEN TO GRI FOR FURTHER ASSESSMENT.

PATIENT ASSESSMENT

AVPU	Alert		<C>	No	
A	Clear				
B					
C	Pulse Rate	BP	Cap Refill	ECG Rhythm	
	127	151/105	<=2 Secs		
	Rhythm	Arm	Central/Peripheral	ECG	
	Reg	Left	Peripheral		
D	GCS	Eyes	Voice	Motor	PEARL
	15	Spontaneously (4)	Orientated (5)	Obeys Commands (6)	Yes
E					

Observations

Time	P	RR	BP	SpO2	CR	GCS	AVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
20:45	122	16	123/90	97	<=2s	15	Alert				Sinus Rhythm				E1022458
20:30	127	16	151/105	97	<=2 Secs	15	Alert		36.5	8.5		4	4		E1022458

NEWS

Time	Clinical Risk	NEWS
20:45	LOW Immediate Clinical Risk. Treat as per Clinical Practice Guidelines including considering the use of alternative pathways (if appropriate and available).	2
20:30	LOW Immediate Clinical Risk. Treat as per Clinical Practice Guidelines including considering the use of alternative pathways (if appropriate and available).	2

HISTORY

AMPLE

Allergies	PENICILLIN
Medication	SETRILINE, SIMVASTATIN, SLEEPING TABLET
Past Medical History	DEPRESSION
Last Eaten	>4 Hours Ago
Events Prior	SISTER DIED SUDDENLY IN JUNE AND BEEN DEPRESSED SINCE, FINDING IT REALLY HARD TO COPE. NOT EATING OR SLEEPING PROPERLY.

Social History

Lives alone	No	Living With	HOSTEL	Patient Occupation	Does Not Work

Patients General Appearance	Normal
Patient Mobility	Fully Mobile
Patient Communication	No Help Required
Patient Clinical Risk Factors	Smoker
Patient Enviromental Risk Factors	None Identified

MEDICAL

Overdose

Mode Of Poisoning	Ingested
OD Poisoning Substance Type	CHLORPHENAMINE
Other Considerations	TAKEN IN BATCHES OVER 4 HOURS

Poisoning Date	21/08/2019	Poisoning Time	14:00
Substance Amount	1.2G		

Mental Illness

Suicide Plan	Yes Lethal: No
Signs/Symptoms	Suicide Attempt, Disinterested, Withdrawn
Risk Factors	Killing Themselves
Known To Services	Community Psychiatric Nurse, Psychologist, Psychiatrist

CLOSE RECORD

Treatment On Scene	Non Emergency

Conveyance

Transport To Hospital	Normal driving	Pre Alert	No

INCIDENT LOG

Time Call Received	17:21	Allocated	20:15	Mobile	20:16
First Resource On Scene		Crew On Scene	20:22	Crew Left Scene	20:39
Crew At Hosp		Receiving Hospital	GLASGOW ROYAL INFIRMARY	Clear Time	

Crew ID	Crew Grade	Driver
E9886902	Ambulance Technician	YES
E1022458	Paramedic	NO

WILSON, Gayle (Miss) Date of Birth: **21-Jul-1979 (40y)**

52 Dalhousie Street, Glasgow,, Lanarkshire, G3 6PN

CHI Number: 210 779 6165 Usual GP: GHOURI, NA (Dr)

Consultations

Date	Consultation Text
22-Aug-2019 00:04	Face to face consultation (Glasgow Royal Infirmary) GOLDIE, Charles (OOH)
Comment	Situation .Request from ED at the Glasgow Royal Infirmary for assessment from the OOHs CPN Service . Brought to,department by ambulance following a reported overdose of 4mg x 30 tablets of Chlorphenramine tablets . Support staff from the Talbot Centre called the ambulance . Reports having taken the tablets over the course of the day . Difficult getting an accurate account of how the support staff became aware of the reported overdose . Gayles account was rather vague and contradictory . She reported they had approached her when she was leaving her accomodation and at that point she informed of her actions . However she could not described why she had shared the information about the reported overdose. Background .Recent difficulties well documented . Known to psychiatric services at Riverside RC . Diagnosis of EUPD and mild learning difficulty . Discharged from Garthavel Royal Hospital after being admitted on the 4/8/19 under detention following expressing suicidal intent . Gayles sister had recently died , which appears to have been the catalyst to her most recent period of crisis . Discharged yesterday afternoon . Documented that on discharge there was no evidence of suicidal intent . Crisis follow-up had been arranged via West Crisis Team. Assessment .Assessed by Donna Munro and Charlie Goldie . Gayle was casually dressed , although she reported that she had not been " washing " , her personal hygiene was reasonable . She wore a black skip hat , which throughout the assessment she pushed down over her face , bloking any attempt at eye contact . She presented as orientated . Her speech was of normal rate and tone , her speech content was rather basic and straight to the point . She quickly indicated she was feeling tired and wanted to get home to her accomodation . There was no evidence of sedation and her concentration levels were good . Her mood appeared reactive , though her general demeanor was pessimistic . She suggested that she had been feeling suicidal when she left the ward , which contradicted earlier documentation . However on exploring this further , she was a rather vague historian and had a tendency to " rubbish " the involvement of any individual or services involved with her . Throughout contact she was calm in manner , no evidence of distress and presented as having capacity for her decision making and behaviour. At no point did she disclose further plans to harm herself and seemed more concerned about how she would be transported to her accomodation . She described at times how she struggles since the death of her sister , but was unwilling to discuss the process of bereavement or possible supports . Recommendation . Documented that West Crisis plan to follow-up Gayle later today . However when discussing this she was negative about engaging with same . She suggested she would be out when they attempt to contact her and will not answer her phone . We asked if it would be more helpful for contact from her own keyworker , but again this was met with a negative response . We informed her we would be requesting the contact from Crisis and it would beneficail if she communicated with the service . Risk .No evidence of immediate plans to harm herself . However possible risk of further impulsive acts of harm to self when emotionally distressed .
Additional	Discharge from care Appointment Outcome:

Glasgow Royal Infirmary
Emergency Department

NHS
Greater Glasgow and Clyde

2107796165
WILSON F
Gayle 21/07/1979
TALBOT CENTRE
52 DALHOUSIE STREET
Glasgow, Lanarkshire
G3 6PN

Initial Investigations Ordered

FBC ☐	COAG ☐	DD ☐	INR ☐		G+S ☐		X-match units			
U+Es ☐	LFT ☐	GLU ☐	CRP ☐	TROP ☐	Para ☐	Sal ☐	Ethanol ☐	Mg ☐	VBG ☐	ABG ☐
B culture ☐		C/MSSU ☐		Urinalysis ☐		BHCG ☐		Other		
CXR ☐	AXR ☐	Other imaging:								ECG ☐
Current location:								Sent by:		

Clinical Notes

Date 21.8.19 Time 23.25 Name Dr Burgeon Grade GPST2 Speciality ED

4 of

Re-avoidance "4mg x 30 tablets chlorphenamine"

throughout the day

ongoing suicidal wishes

HPC: D/C today from Gartnavel Y

Admitted 4.8.19 suicidal. Sister died June. Gayle witnessed her being resuscitated

- Low mood
- Not washing
- Distanced self from niece & friend
- Was in homeless unit.

on 200mg Sertraline but really cannot get on top of anxiety.

Anxious about feeling so low

"Does not want to be here"

T 36.4 HR 109 SR ECG no chest pain BP 138/98 ER 16 SOB 100 on

Passing urine GCS 15/15

Plan

- Referred to psychiatry

Glasgow Royal Infirmary
Emergency Department

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Clinical Notes

Date	Time	Name	Grade	Speciality

Glasgow Royal Infirmary
Emergency Department

2107796165
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Clinical Notes

Date	Time	Name	Grade	Speciality

Glasgow Royal Infirmary
Emergency Department

Patient Name
DoB
CHI Number

or affix label

HAEM	DATE or TIME		BIOCH	DATE or TIME			DATE or TIME		V/ABG	DATE or TIME	
WCC			Na			Bil			FiO_2		
Hb			K			ALT			H^+		
Plat			Cl			AST			$PaCO_2$		
Neut			Ur			GGT			PaO_2		
DD			Creat			A phos			Bic		
PT			eGFR			Alb			BE		
PTT			Glu			AdjCa			Lactate		
TT			CRP			Amyl			Ethanol		
INR			Mg			TropI HS			Para		
			Phos			BHCG			Sal		

Diagnosis and Plan

Review/Discussed with:

Handover

- ☐ Provisional Diagnosis
- ☐ Liquids/Fluids
- ☐ Analgesic/Medicines
- ☐ NEWS
- ☐ Investigations & Results
- ☐ Talk to receiving team/ward

mi • 287967 Version 1_0 • GGC0226

Greater Glasgow & Clyde Emergency Departments' Mental Health Triage and Risk Assessment Tool

NHS Greater Glasgow and Clyde

Part One - Nursing Triage

triage nurse to complete this page

Patient name Gayle Wilson
CHI 2107996165

Triage Observations

document physiological measurements

GCS	BM	HR	BP	RR	SaO²	Temp
15	8.5	128	118/98	18	97	36.4

accompanied by

name, relationship, particular concerns

self   dark clothe
ready to run
MWA   short hair

Describe the appearance/clothing of those attending alone, as they may leave before review.

Is the patient a young person in foster care or in a residential care placement? YES/NO

Is the patient a carer for a child or a dependent adult? YES/NO

Is there a child protection concern or concern for a vulnerable adult at risk? YES/NO

Outline of Presentation

tick all the categories which apply

Overdose (will also require medical assessment)	✓
Self-injury (will also require wound management)	
Other Mental Health Presentation	

Initial Presentation, Appearance and Behaviour

respond yes or no to each question, in any order which seems appropriate

Is the patient violent, aggressive or threatening?	Y		(N)
Is the patient obviously distressed, markedly anxious or highly aroused?		Y	(N)
Is the patient preoccupied, erratic or impulsive?	(Y)		N
Is the patient quiet and withdrawn?		(Y)	N
Do you think the patient is behaving inappropriately to their situation?		(Y)	N
Do you think the patient presents an immediate risk to you, to others, or to themselves?	(Y)		N
Do you think the patient is likely to abscond prior to assessment?	(Y)		N
Do you think the patient's presentation suggests either hallucinations or delusions?*	Y		(N)
Do you think the patient feels their actions are being controlled?	Y		(N)
Are you aware of a history of mental health problems or psychiatric illness?		(Y)	N
Are you aware of a history of violence or self-harm?		(Y)	N
Is the patient currently expressing suicidal thoughts?	(Y)		N
Is the patient currently intoxicated, with alcohol, or other substances?		Y	N

*Delusions; false but firmly held views and ideas. Hallucinations; false external stimuli (for example, visual or vocal) the patient thinks are real

Any responses in the first column: (High Risk)

Other patients can be categorised as Moderate Risk

If *all responses* are in the third column Low Risk

Triage Risk Assessment

identify an initial category of risk, select one or more risks

High / Moderate / Low – risk
of self-harm / violence / absconding

Triage Category: 2

High risk – accompanied *and* in the clinical area.
Moderate risk – accompanied *or* in the clinical area.
Low risk – can be asked to wait *if necessary*.

Immediate management

print toxbase information, and in paracetamol overdose, note 4-hour time for blood sample.

Patient location, accompanied by...

Blood sample time?

Toxbase info printed? Y/N

GMAWS considered? Y/N

Summary
intentional OD.
chlorphenamine 4mg x 30
throughout day.
remains suicidal.
d/c for Gartnavel for
care this am

name/grade S Gunning

signature [signature]

date and time 21/8/15 2000

 Version 3.0. Jan 2017

Part Two - Mental Health Assessment

medical staff to complete this page

Patient name _____

CHI _____

outline of current presentation and precipitating factors

current and previous mental health problems, self-harm episodes, problematic alcohol and/or drug use, contacts with mental health services

other relevant information, (relationships, finances, employment, housing, physical health, childcare responsibilities, current medications, etc) - protective factors (beliefs, relationships, plans for future) - views of relatives/carers/'significant others'

Appearance	Behaviour	Speech
Mood	Thought	Insight

Risk Factors

(this is not an exhaustive list)

alcohol or drug use	
planning or concealment	
evidence of psychosis	
ongoing suicidal intent	
family concern about risk	
access to lethal means	
lack of social support	
age and gender	
chronic illness/pain	
family history of suicide	
disengaged/noncompliant	
unemployed/retired	
previous violent methods	
history of self-harm	
current psychiatric treatment	
previous psychiatric treatment	

Careful consideration should be given to patients who may present particular risks, including patients who may have post-natal depression, or patients with 'first presentations' of mental health problems, especially in adolescence or old age.

Risk Assessment

based on clinical assessment indicate a category of risk for a further episode of self-harm in the short term (48hrs) - consider protective as well as precipitating factors.

High / Moderate / Low

Discharge Advice and Plan for Further Assessment

Indicate the follow-up plan – referral to Liaison Psychiatry, duty doctor, out-of-hours CPN service, CMHT, GP, addiction services, SW, etc - indicate the advice given to the patient, and identities of others informed.

summary	follow up and advice given

service referred to	name/relationship of carer informed	consultant/middle-grade involved in decision or review

If young people in foster care or residential care are assessed, their social work team should be informed (via stand-by SW if out-of-hours) as well as giving information and advice to carers present.

name/grade _____

signature _____

date and time _____

Emergency Department Nursing Documentation

NHS Greater Glasgow and Clyde

2107796165
WILSON
Gayle F
TALBOT CENTRE 21/07/1979
52 DALHOUSIE STREET
Glasgow, Lanarkshire
G3 6PN

Presenting Complaint - Overdose

Date: 21 / 8 / 19 Time: 2110

Assessment Complete by: Name NURSE (Please Print) David + James

Patient Prep / Investigations (Please tick/circle when completed)		Communication (Please Circle Tick)	
Prepare patient for examination / Clothing bag labelled + stored	☑	NEWS Chart complete / NEWS SCORE - (Record pain, blood sugar and Neuro Obs on NEWS Chart)	☑
GGC RED BAG - with patient	☐		
12 Lead ECG	☐	ID Band	☐
Weight:	☐	Peak Flow	☐
Blood Samples Obtained: Yes ☐ No ☐		Xrays / CT Scan Performed:	☐
IV Access: Yes ☐ No ☐		Relatives / NOK informed (Carers)	☐
Blood Gas: VBG ☐ ABG ☐		Child Protection Concern (considered in line with policy)	Y/N
		Adult Support and Protection	Y/N

Urinalysis

Leucocytes	☐	Nitrites	☐	Protein	☐	Blood	☐
Ketones	☐	Glucose	☐	PH		S.G.	
MSSU / CSU	☐	Toxicology	☐				
HCG	☐	+VE	☐	-VE	☐	Strip No -	

Screening Tools (Please tick/circle when completed)			
SEPSIS RISK? / SIRS Criteria 2 or more	Y/N	**SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)**	YES
Mental Health Triage Assessment	Y/N	If NOT WHY? - (details) N/A	NO
GMAWS	Y/N	Date - 21/8/19 Time - 2110 Signature - MM	

4AT	
AMT	Correct
Age	
Date of Birth	
Place	
Current year	

No mistakes	= 0
1 mistake	= 1
> 1 mistake	= 2

Attention (months of year backwards)	
> = 7 correct	0
< 7 correct	1
Untestable	2

Alertness	
Normal	0
Mild sleepiness	0
Clearly abnormal	4

Mental status according to family/carer		
Acute change or fluctuating	4	YES
Acute change or fluctuating	0	NO

4AT score /12

STEP 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?

All over 75s and care home residents over 65. For younger patients use clinical judgement and consult local guidelines.

		YES	NO
F	**F**unctional impairment (new or worsening) eg difficulty with self care		
R	**R**esident in a care home?		
A	**A**ltered mental state such as acute confusion or dementia use the 4AT		
I	**I**mmobility/instability. New decline in mobility, difficulty mobilising without help or fall leading up to admission		
L	**L**ikely to require support for discharge? (either new or increase in existing support)		

Are any of the above criteria met? If YES to any of the above move to step 2

STEP 2 Would this person be better managed by another specialty team at present?

Indicator for care by another acute specialty regardless of age.

	YES	NO
Clear need for other specialty input eg exacerbation of known long term condition such as COPD		
Need for HDU/ITU (including non-invasive ventilation)		
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit		
Head injury with loss of consciousness		
Acute abdominal pain/surgical presentation		
Upper GI Bleed		
Chest pain with suspected acute coronary syndrome		
Trauma with suspected fracture		

Are any of the above 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 **NO** to the list in step 2:

- Prioritise transfer of care to specialist geriatric assessment service in line with local guidance.

Screening Tools / ACTIVE CARE

(Please tick/circle when completed)

1) **Pressure Damage** Does the person have redness and/or existing damage? If YES - continue with a minimum of 2 hourly Active Care + Complete PUDRA		Y/(N)	**Date**	**Location of Redness/Ulcers**	**Grade of Ulcer**	
2) Mobility	Does the person require assistance?	Y/(N)				
3) Continence		Y/(N)	**5) Skin**	Is skin compromised by other source, eg neurological deficit, medication, substance, diabetes, co-morbid?		Y/(N)
4) Nutrition		Y/(N)	**6) Judgment**	In your clinical judgment is this person at risk for developing pressure damage? IF YES - DETAILS		Y/(N)

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.
21/8/19	2135	JF												

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At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc) *At risk complete risk assessment*	
YES	NO

Pause for Transfer / Discharge (Please tick when completed)		Tick when completed	N/A	Notes
Relatives Informed of Admission / Discharge		☐	☐	Information on discussion with relatives
Relatives/carer with patient on transfer to ward		☐	Always	
GGC RED BAG - with patient		☐	Always	
	Name Band	☐	Always	
Nursing Screening Tools completed		☐	Always	
Bed requested, SBAR COMPLETE		☐	☐	
	NEWS chart	☐	Always	
Prescriptions / Charts signed	Infusions	☐	☐	
	Cannula	☐	☐	
Notes: medical notes, GP letter, PRF		☐	☐	
Patients requiring analgesia: sufficient		☐	☐	
Belongings (including patients medication)		☐	Always	Please note here if any other tasks required prior to transfer
SAS Transport required and ref. no.		☐	☐	
Print Name Sign -				

Nursing Notes		
Date and Time		Print Name and Signature
21/8/19 2115	Patient has been admitted with overdose	
	NEWS = 2 (Pulse 128 b/m) 3d x	
	4mg chlorphenamine and suicidal	
	ideation Awaiting medical review	MM JFerry (5)

Nursing Notes		
Date and Time		Print Name and Signature

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Nam
Addr 2107796165
WILSON
Gayle
TALBOT CENTRE
52 DALHOUSIE STREET
Glasgow, Lanarkshire
CHI
DoB

F
21/07/1979
G3 6PN

	Date	Ward
Admitted		
Transferred		
Transferred		

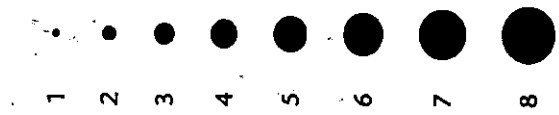
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic 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.

Glasgow Coma Scale



2107796165 F
WILSON
Gayle
21/07/1979

Neurological Observations

Date:																										
Time:																										
COMA SCALE	E Eyes open	Spontaneously	4																							Eyes closed by swelling = C
		To speech	3																							
		To pain	2																							
		None	1																							
	V Best Verbal response	Orientated	5																							Endotracheal tube or tracheostomy = T
		Confused	4																							
		Inappropriate words	3																							
		Incomprehensible sounds	2																							
		None	1																							
	M Best motor response	Obeys	6																							Usually record the best arm response
		Localises	5																							
		Flexion - withdrawal	4																							
		Flexion - abnormal	3																							
		Extension to pain	2																							
		None	1																							
		TOTAL SCORE																								
PUPILS	R	Size																								+ reacts – no reaction c. eyes closed
		Reaction																								
	L	Size																								
		Reaction																								
LIMB MOVEMENT	ARMS	Normal power																								Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness																								
		Severe weakness																								
		Spastic flexion																								
		Extension																								
		No response																								
	LEGS	Normal power																								
		Mild weakness																								
		Severe weakness																								
		Spastic flexion																								
		Extension																								
		No response																								

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

CHI: 2107796165

Glasgow Royal Infirmary

Total Att: **13**

12 Mth Att: **0**

Title: **MISS**

WILSON **Gayle**

DOB: **21/07/1979** Age: **38y** Sex: **Female**

TALBOT CENTRE
494 GREAT WESTERN RD
Glasgow
Lanarkshire
G12 8EW

Next of kin: **WILSON, VIOLET**
Relationship: **Parent**
0141 563 8676

GP: **NT Bhatti**
0141 334 9331

Attendance Date: **16/11/2017** Arrival Time: **17:57**

Registration Time: **17:57** Date of Incident: **16/11/2017**

Major Incident Desc:

Reason for Attendance: **mental health issues**

Nursing Assessment

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

Triage Category: **4** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **16/11/2017 18:16** Nurse name: **Nurse Sarahjane Gordon**

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: **DSH to left wrist with Stanley knife. hx - depression. suicidal thoughts ongoing in triage - support staff present. ~~*at red-seats*~~** in waiting area

2107796165 21/07/1979 WILSON Gayle
2107796165 21/07/1979 WILSON Gayle
2107796165 21/07/1979 WILSON Gayle
2107796165 21/07/1979 WILSON Gayle
2107796165 21/07/1979 WILSON Gayle

To be Completed by Clinician		
Child Assessment Questionnaire	**Yes**	**No**
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

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

Date	**Clinical Notes**	
	Seen By	Time Seen

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By

WILSON, Gayle (Miss) Date of Birth: **21-Jul-1979 (38y)**

Belmont House,, 494 Great Western Road,, Glasgow,, Lanarkshire, G12 8EW

CHI Number: 210 779 6165 Usual GP: GHOURI, N/

Consultations

Date	Consultation Text
16-Nov-2017	Face to face consultation (NHS GG&C Mental Health Services) IRVINE, Tony (OOH)
Comment	SELF PRESENTED AT A/E GRI WITH SUPERFICIAL CUTS TO ARM,FELT LOW AND FLEETING SUICIDAL IDEATION REPORTED.ACCOMPANIED INITIALLY BY SUPPORT STAFF.CLIENT KNOWN TO RIVERSIDE,UNDER DR WILSON,ALSO HAS A CPN J WEST.SAW CONSULTANT TODAY AND NO MAJOR ISSUES NOTED. NEXT CPN OPA NEXT WEEK AND VERY POSITIVE ABOUT RELATIONSHIP WITH CPN. NO OBVIOUS TRIGGERS TODAY,IMPULSIVE ACT,FLEETING SELF HARM THOUGHTS,FEELS UNSETTLED SINCE FATHERS DEATH 9 MONTHS AGO.ALSO CHANGED MEDCIATION AS DOCUMENTED 4 WEEKS AGO.CLIENT SOUGHT IMMEDIATE HELP AFTER CUTTING SELF. FEELS POOR SLEEP LAST NIGHT LOWERED HER NORMAL COPING SKILLS.FEELS CURRENT SUPPORT STAFF HELPFUL AND SUPPORTIVE BUT TODAY DID NOT EXPRESS ISSUES. DID NOT FEEL NEED TO COME TO A/E,FELT SELF HARM HAD AIDED COPING AND WANTED TO GO TO BED AND CATCH UP WITH SLEEP BUT STAFF HAD INSISTED. ASSSESSED AT GRI BY OOH CPN TIRIVNE/C GOLDIE CLIENT CASUALLY DRESSED BUT APPEARED CLEAN AND TIDY.ENGAGED WELL IMMEDIATELY.SPOKE CLEAR AND CONCISE,CALM,COHERANT,GOOD EYE CONATCT, QUITE REACTIVE THROUGHOUT CONSIDERING CONTEXT,SPEECH CLEAR,COOPERATIVE AND PLEASANT MANNER. APPEARED TO ENJOY TALKING TO STAFF. NO CURRENT SUICDAL IDEATION OR PLAN.SAFE PLAN AGREED.EARLIER APPEARED MORE SELF HARM AND FRUSTRATION. PREVIOUS SELF HARM AND IS CONCENRED THAT SELF HARM IS INCREASING . NO THOUGHT DISORDER,NO ALCOHOL OR DRUG MISSUE. POOR SLEEP LAST NIGHT.WENT TO FRIENDS HOUSE LAST NIGHT TO HELP BUILD FURNITURE AND ENDED UP STAYING THERE WITH NO NIGHT SEDATION. FEELS THIS WAS A TRIGGER FOR TONIGHT.FELT OK AT OPA TODAY,DOES ADMIT TO FLEETING THOUGHTS WHICH IS NOT THAT UNUSAL CLIENT KEEN FOR BED,DID NOT FEEL NEED FOR ANY EXTRA OR IMMEDIATE SUPPORT AND WOULD FEEL BETTER JUST SPEAKING TO JUNE. AGREED WE WOULD LET OWN TEAM KNOW OF CRISIS AND ENCOURAGED OVERNIGHT SUPPORT IF NEEDED.

Greater Glasgow & Clyde Emergency Departments' Mental Health Triage and Risk Assessment Tool

2107796165
WILSON
Gayle F
TALBOT CENTRE, 21/07/197
494 GREAT WESTERN RD
Glasgow, Lanarkshire
G12 8EW

Patient name
CHI

Part One - Nursing Triage

triage nurse to complete this page

Triage Observations

document physiological measurements

GCS	BM	HR	BP	RR	SaO^2	Temp
15						

accompanied by

name, relationship, particular concerns

Support staff (2 x) Black tracksuit. Short dark hair

Describe the appearance/clothing of those attending alone, as they may leave before review.

Is the patient a young person in foster care or in a residential care placement? YES/NO

Is the patient a carer for a child or a dependent adult? YES/NO

Is there a child protection concern or concern for a vulnerable adult at risk? YES/NO

Outline of Presentation

tick all the categories which apply

Overdose (will also require medical assessment)	
Self-injury (will also require wound management)	✓
Other Mental Health Presentation	

Initial Presentation, Appearance and Behaviour

respond yes or no to each question, in any order which seems appropriate

Is the patient violent, aggressive or threatening?	Y		N
Is the patient obviously distressed, markedly anxious or highly aroused?		Y	N
Is the patient preoccupied, erratic or impulsive?	Y		N
Is the patient quiet and withdrawn?		Y	N
Do you think the patient is behaving inappropriately to their situation?		Y	N
Do you think the patient presents an immediate risk to you, to others, or to themselves?	Y		N
Do you think the patient is likely to abscond prior to assessment?	Y		N
Do you think the patient's presentation suggests either hallucinations or delusions?*	Y		N
Do you think the patient feels their actions are being controlled?	Y		N
Are you aware of a history of mental health problems or psychiatric illness?		Y	N
Are you aware of a history of violence or self-harm?		Y	N
Is the patient currently expressing suicidal thoughts?	Y		N
Is the patient currently intoxicated, with alcohol, or other substances?		Y	N

*Delusions; false but firmly held views and ideas. Hallucinations; false external stimuli (for example, visual or vocal) the patient thinks are real

A A A

Triage Risk Assessment

identify an initial category of risk, select one or more risks

High / Moderate / Low – risk of self-harm / violence / absconding

Triage Category		
	✓	High risk – accompanied *and* in the clinical area. Moderate risk – accompanied *or* in the clinical area. Low risk – can be asked to wait *if necessary*.

Immediate management

print toxbase information, and in paracetamol overdose, note 4-hour time for blood sample.

Patient location, accompanied by...
Support staff

Blood sample time?

Toxbase info printed? Y/N

GMAWS considered? Y/N

Summary
@ ~~Reception~~ waiting area.

Any responses in the first column **High Risk**

Other patients can be categorised as **Moderate Risk**

If *all responses* are in the third column **Low Risk**

name/grade

signature

date and time 16/11/17 1819

357 5200. Paul
2500

Part Two - Mental Health Assessment

medical staff to complete this page

Patient name _____

CHI _____

outline of current presentation and precipitating factors

Felt down for sometime, had medication changed 4/52 ago to Fluoxetine. Intermittently suicidal. Felt suicidal today, took Stanley knife to (L) arm, multiple superficial wounds. Ongoing suicidality, says would go + jump off a bridge.

Concern from staff at accomodation that no support overnight.

current and previous mental health problems, self-harm episodes, problematic alcohol and/or drug use, contacts with mental health services

Emotionally unstable personality disorder. Prev. self harm w wounds to arm.
Learning difficulties.

other relevant information, (relationships, finances, employment, housing, physical health, childcare responsibilities, current medications, etc) - protective factors (beliefs, relationships, plans for future) - views of relatives/carers/'significant others'

Homeless accomodation.

Appearance	Behaviour	Speech
Appropriately dressed.	Happy to talk	Short sentences.
Mood	**Thought**	**Insight**
Euthymic	Suicidal intent.	Self-aware.

Risk Factors

(this is not an exhaustive list)

alcohol or drug use	
planning or concealment	✓
evidence of psychosis	
ongoing suicidal intent	✓
family concern about risk	✓
access to lethal means	
lack of social support	
age and gender	
chronic illness/pain	
family history of suicide	
disengaged/noncompliant	
unemployed/retired	✓
previous violent methods	✓
history of self-harm	✓
current psychiatric treatment	✓
previous psychiatric treatment	

Careful consideration should be given to patients who may present particular risks, including patients who may have post-natal depression, or patients with 'first presentations' of mental health problems, especially in adolescence or old age.

Risk Assessment

based on clinical assessment indicate a category of risk for a further episode of self-harm in the short term (48hrs) - consider protective as well as precipitating factors.

High / Moderate / Low

Discharge Advice and Plan for Further Assessment

Indicate the follow-up plan – referral to Liaison Psychiatry, duty doctor, out-of-hours CPN service, CMHT, GP, addiction services, SW, etc - indicate the advice given to the patient, and identities of others informed.

summary	follow up and advice given
Suicidal intent, shallow lacerations to wrist.	Referred to CPNs

service referred to	name/relationship of carer informed	consultant/middle-grade involved in decision or review
CPN.		Dr Connelly

If young people in foster care or residential care are assessed, their social work team should be informed (via stand-by SW if out-of-hours) as well as giving information and advice to carers present.

name/grade
M. LINZEE GORDON GP ST2.

signature
[signature]

date and time
16/11/17. 2030.

Emergency Department Nursing Documentation

2107796165
WILSON F
Gayle 21/07/1979
TALBOT CENTRE
494 GREAT WESTERN RD
Glasgow, Lanarkshire
G12 8EW

Presenting Complaint - DSH · Suicidal thoughts

Date - 16/11/17. **Time –** 2035.

Assessment Complete by: Name NURSE (Please Print)

Lorraine.

Patient Prep / Investigations (Please tick/circle when completed)		Communication (Please Circle / Tick)	
Prepare patient for examination / Clothing bag labelled + Stored	☐	NEWS Chart complete / NEWS SCORE – (Record pain, blood sugar and Neuro Obs on NEWS Chart)	☐
12 Lead ECG	☐	ID Band	☐
Weight :	☐	Peak Flow	☐
Blood Samples Obtained : YES ☐ NO☐		Xrays / CT Scan Performed:	☐
IV Access : YES ☐ NO☐		Relatives / NOK informed	☐
Blood Gas : VBG☐ ABG☐		Child Protection Concern (considered in line with policy)	Y/N
		Adult Support and Protection	Y/N

Urinalysis

Leucocytes ☐	Nitrates ☐	Protein ☐	Blood ☐
Ketones ☐	Glucose ☐	PH	S.G
MSSU / CSU ☐	Toxiclogy ☐		
HCG ☐	+VE ☐	-VE ☐	Strip No -

Screening Tools (Please tick/ circle when completed)			
SEPSIS RISK? / SIRS Criteria 2 or more	Y/N	**SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)**	YES
Mental Health Triage Assessment	Y/N	IF NOT WHY? – (details)	NO
GMAWS	Y/N	**Time –**	
AMT 4 (> 65 YEARS)	Y/N	**Date –**	
At risk of falls? (clinical judgement) (consider alcohol; mobility, age, illness, cognitive impairment etc) *If at risk complete risk assessment*	Y/N	**Signature -**	
Frailty Screen (Would this person benefit from Comprehensive Geriatric Assessment (CGA)? *(Age 75 or over/age 65+ from Nursing/Residential care or admitted from community hospital?)*		2 Resident in a care home	Y/N
1 Functional impairment in context of significant multiple conditions)new or pre-existing)	Y/N	3 Acute confusion (Think Delirium) is there a diagnosis of dementia or a history of chronic confusion	Y/N
		4 Immobility or Falls in the last 3/12 months	Y/N

Screening Tools / ACTIVE CARE (Please tick/circle when completed)					
1) Pressure Damage Does the person have redness and/or existing damage? If YES – continue with a minimum of 2 hourly Active Care + Complete PUDRA		Y/N	**Date**	**Location of Redness/Ulcers**	**Grade of Ulcer**
2) Mobility	Does the person require assistance?	Y/N			
3) Continence		Y/N	**5) Skin**	Is skin compromised by other source, eg neurological deficit, medication, substance, diabetes, co-morbid?	Y/N
4) Nutrition		Y/N	**6) Judgment**	In your clinical judgment is this person at risk for developing pressure damage? IF YES - DETAILS	Y/N

2107796165 F Label
WILSON 21/07/197
Gayle
TALBOT CENTRE
494 GREAT WESTERN RD
Glasgow, Lanarkshire G12 8EW

Pause for Transfer / Discharge (Please tick when completed)		Tick when completed	N/A	Notes
Relatives informed of Admission / Discharge		☐	☐	Information on discussion with relatives
Name band		☐	Always	
Nursing Screening Tools completed		☐	Always	
Bed requested, SBAR COMPLETE		☐	☐	
NEWS chart		☐	Always	
Prescriptions / Charts signed	Infusions	☐	☐	
	Cannula	☐	☐	
Notes: medical notes, GP letter, PRF		☐	☐	
Patients requiring analgesia: sufficient		☐	☐	
Belongings (including patient's medications)		☐	Always	Please note here if any other tasks required prior to transfer
SAS Transport. REQ / REF No		☐	☐	
Print Name Sign –				

Nursing Notes

Date & Time		Print Name & Signature
16/11/17	Nursing night 20[30]	
	Patient prepared presents with.	
	DSH. Social ideation ongoing	
	Support staff Present.	
11:50	Discharged home. Lorraine Miller	

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name
Address

2107796165
WILSON
9 Gayle
TALBOT CENTRE 21/07/1979 F
494 GREAT WESTERN RD
Glasgow, Lanarkshire
G12 8EW

CHI No.
DoB

	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	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.

Glasgow Coma Scale

Pupil size (mm)

Neurological Observations

Date:																															
Time:																															
COMA SCALE	E Eyes open	Spontaneously	4																												Eyes closed by swelling = C
		To speech	3																												
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	TOTAL SCORE																														
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		Spastic flexion																													
		Extension																													
		No response																													
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		Spastic flexion																													
		Extension																													
		No response																													

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

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

15

Affix Label

Hospital (*circle*)	IRH	RAH	RHSC	GRI	WIG	VI	VIMIU	Stob	VOL	SGH

Title:	Sex: M ☐ F ☑
SURNAME: Wilson	Forename: Gail
CHI: 2107796165	Dob:: 21.7.79 Age:
Local address: 1655 Dumbarton Rd. 0/1	Next of kin:
	Relationship:
	Tel:
	GP:
Postcode:	
Tel:	Tel:
Attendance date: 1.10.13 Arrival time: 17.15	Date of incident:
Registration time:	Major incident description:
Reason for attendance: Collapse.	

Affix Label

Nursing Assessment	Alerts:
Presenting complaint: Found collapsed in street. Unsure how she got there, looks pale, vague & detached at triage. No limb weakness, no pain no injury Denies fainting	
Triage category: 3	Pain score: Tetanus up-to-date / fully immunised?
Allergies:	

Observations date: 1/10/13			Time: 1715			Nurse's name:			
Temperature	35.6	°C	BM	6.6	mmol/L	GCS			
HR	81	bpm	PF		l/min	Eyes	4		
BP	121/77	mmHg	Expected PF		l/min	Motor	6		
MAP		mmHg	Weight		kg	Verbal	4		
RR	16	bpm	Height		cm	Total	14/15		
SpO_2	95	%	Visual Acuity			Pupils – Right		Pupils – Left	
Oxygen	ON	%	Left	6/		Size	4	Size	4
			Right	6/		Reaction	Y	Reaction	Y
			With correction?						

Nursing Notes:

97607

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES
	Seen by (Dr) C. JOHNSTONE CT1 Time seen 19.00

1/10/13

(34)

+

PC Brought in by ambulance

HPC Smoked legal high. Doesn't know name.
Smoked in cigarette.
Strong smelling.
Went for a walk, reverberations being in town.
Found confused in street.
- tired, vomiting, clammy.

No hallucinations.
No palpitations.

Denies taking any other drugs.
Previously taken speed.

PMH depression → fluoxetine.

SH lives in hostel.

O/E Alert + orientated GCS is
warm well perfused

HS I+II+0
BP 121/77
P81
RR16
SPO2 96%
T35.6.

BM 6.6.

Reviewed by Dr. Stevenson - likely synthetic cannabinoid.
>2 hours in department.
Imp legal high.

Plan Discharged. No follow up

Date	CLINICAL NOTES

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

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

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

Discharge Prescription Packs

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

Designed by Medical Illustration Services ref 243836

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name
Address Gail Wilson.
21-7-79
CHI No.
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

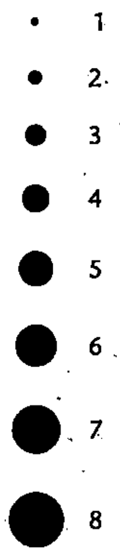
NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need 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.

Neurological Observations

Date:																							
Time:																							
COMA SCALE	E Eyes open	Spontaneously	4																				Eyes closed by dwelling = C
		To speech	3																				
		To pain	2																				
		None	1																				
	V Best Verbal response	Orientated	5																				Endotracheal tube or tracheostomy = T
		Confused	4																				
		Inappropriate words	3																				
		Incomprehensible sounds	2																				
		None	1																				
	M Best motor response	Obeys	6																				Usually record the best arm response
		Localises	5																				
		Flexion - withdrawal	4																				
		Flexion - abnormal	3																				
		Extension to pain	2																				
		None	1																				
		TOTAL SCORE																					
PUPILS	R	Size																					+ reacts – no reaction c. eyes closed
		Reaction																					
	L	Size																					
		Reaction																					
LIMB MOVEMENT	ARMS	Normal power																					Recordright (R) andleft (L) separatelyif there is a difference between the two sides
		Mild weakness																					
		Severe weakness																					
		Spastic flexion																					
		Extension																					
		No response																					
	LEGS	Normal power																					
		Mild weakness																					
		Severe weakness																					
		Spastic flexion																					
		Extension																					
		No response																					

Glasgow Coma Scale

Pupil size (mm)



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

PATIENT AND INCIDENT DETAILS

Incident number	PA004730910.001
Name	GAYLE WILSON
Address	1655 DUMBARTON ROAD FLT 0/1
Age	34 year(s)
Date of birth	21/07/1979
Gender	Female
Incident location	O/S ALPINE LODGE 25 HOPE STREET GLASGOW
Incident post code	G2 6AB
Incident type	EMG
Call received	01/10/2013, 16:08
Call passed	01/10/2013, 16:08
Crew mobile	01/10/2013, 16:09
Crew at scene	01/10/2013, 16:13
Crew left scene	01/10/2013, 16:47
Receiving hospital and department	GRIN Glasgow Royal Infirmary

PRIMARY SURVEY

RESPONSE	
AVPU	Alert
AIRWAY	
Airway assessment	Clear
BREATHING	
Breathing rate	Normal
Respiratory rate	
CIRCULATION	
Pulse rate	Normal
Most peripheral pulse found	Radial
Cap refill rate	
Skin colour	Pale
Skin texture	Dry
C-SPINE INJURY	
Suspicion of CSI	No evidence of C-spine injury
PATIENT CONSENT	
Patient consent	Treatment benefits explained, Risks of condition explained, Risk of refusal explained, Capacity to understand risks and treatment, Immediate risk to life, Advice given to patient

AMPDS		
Dispatch code	32B03	Unknown Problem - Unknown Status/Other Codes N/A
Final code	26A010	Sick Person, Unwell/ill

GCS	
Final GCS eye opening	Spontaneous
Final GCS verbal response	Confused
Final GCS motor response	Obeys commands

VITAL SIGNS

Time hr : min	Pulse bpm	Pulse rhythm	Resp. rpm	BP mm Hg	Cap refill (secs)	Peak flow %	Blood sugar mmol / l	Pain score	Temp °C	SpO2 %	GCS Total	NEWS	RTS	ECG	Sepsis
16:30	88	Reg	20	124 / 84	<2 secs	-	8.4	0/10	35.7	95	14	2	7.6	NSR	1
16:43	82	Reg	18	97 / 61	<2 secs	-	8.4	0/10	35.6	94	15	4	7.6	NSR	1
-	-	-	-	- / -	-	-	-	-	-	-	-	-	-	-	0

Sepsis: Diarrhoea Sepsis: Abdo distension Sepsis: Meningitis Sepsis: Cellulitis Sepsis: Septic arthritis Sepsis: Wound infection Sepsis: Infected indwelling device

EYES AND PUPIL SIZE AND REACTION

	Left	Right
Pupil size	Normal	Normal
Pupil reaction	Normal	Normal

AMPLE

Allergies	Antibiotics
Other allergies	PENICILLIN
Medication	FLUOXETINE, SIMVASTAIN.
Past history	DEPRESSION.
Last eaten	>5 hrs
Events prior	PATIENT FOUND IN STREET PRESENTING ....CONFUSED UNSURE HOW SHE GOT INTO CITY CENTRE, PALE PALLOR, VOMITING, CLAMMY TO TOUCH, SHE FEELS TIRED/LETHARGIC, BECAME HYPOTENSIVE.

PSYCHIATRIC RISK ASSESSMENT

Situation	
Previous history of mental health problems	History of depression, History of threatening self harm
Action	Patient conveyed to hospital, Police contacted

SOCIAL ASSESSMENT

Situation	
Risk assessment	Low degree of risk
Action	Patient conveyed to hospital, Police contacted
Additional comments or concerns	STAYS IN HOSTEL.

FINAL OBSERVATION AND COMMENTS

12 LEAD ECG (NSR).	
Report ID	15378ce8-e842-40be-ad5e-11a2a88d964a

XR Chest

Performed	09-Mar-2021 21:22	Received	10-Mar-2021 09:32
Reported	10-Mar-2021 09:30	Order Number	G107H37039535
Status	Final	Source System	MiSys

XR Chest Final
Gayle Wilson
Clinical History :

chest film please query areas of oligaemia, chest pain and tachycardia in context of calf pain. query pte

XR Chest :
No previous chest x-ray for comparison.
Underinspired chest x-ray. The heart is not enlarged and the cardiomediastinal contours are unremarkable.
No focal lung lesion or active lung pathology. The bony thorax appears intact.

Reported by: Dr Siobhan Mathieson
Verified by: Dr Siobhan Mathieson