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

NHS
Greater Glasgow and Clyde

MMA Legal
43-59 Princes Street
Stockport
SK1 1RY

Date: 1st May 2026
Your Ref: 100013
Our Ref: LAT/ACCESS/ES
Enquiries to: Emily Svensson
Direct Line: 0141 211 3020
Email: Emily.svensson@nhs.scot

Re: Subject Access Request under the General Data Protection Regulation

PATIENT: DAVID BAILLIE **D.O.B: 23/08/1989**

Thank you for your request received **15TH 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:

QUEEN ELIZABETH UNIVERSITY HOSPITAL

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

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

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

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

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

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

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

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

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

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

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

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

Yours sincerely

Legal Aspects Team

ELECTRONIC PATIENT RECORDS

(1)

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

Including:

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

SOUTHERN GENERAL
SITU

Patient Sample Report

Patient

ID:	2308896337
Last Name:	BAILLIE
First Name:	DAVID
Gender/Age:	Male, 29 years
Birth Date:	23.08.1989
St[illegible]:	ACCEPTED
Analyzed:	27.09.2018 13:13:29
Sample Type:	Arterial
Operator ID:	MCAULEY0, KEVIN

Analyzer

Model:	GEM® *Premier 4000*
Area:	AH_L0ED_A
Name:	ED-POD
S/N:	06100193

Measured (37.0°C)		
cH	↑ 54.2	nmol/L
pCO_2	↑ 8.5	kPa
pO_2	↓↓ 3.0	kPa
Na^+	137	mmol/L
K^+	4.4	mmol/L
C[illegible]	106	mmol/L
[illegible]	4.1	mmol/L
Lac	↓ 0.8	mmol/L
CO-Oximetry		
tHb	122	g/L
O_2Hb	↓ 30.8	%
COHb	↑ 5.7	%
MetHb	0.9	%
HHb	↑ 62.7	%
sO_2	↓ 32.9	%
Derived		
BE(B)	1.1	mmol/L
HCO_3^-(c)	↑ 29.4	mmol/L
Operator Entered		
Temp	37.0	°C
O2 and Vent Settings		
FIO_2		%

↑↓ Outside Reference Range
↑↑ ↓↓ Outside Critical Range

My Admission Record

NHS Greater Glasgow and Clyde

Nam
Add 2308895337
BAILLIE M
David 23/08/1989
34 MONKSBRIDGE AVE
DoB Glasgow, Lanarkshire
G13 2DT
CHI:
Affix

Hospital: QEUH Ward: ITU2
Date of Admission: 27/9/18 Time: 1600
Information obtained from: Name:
Patient ☐ Relative ☐ Other ☐ _____
Preferred Name:
Age: Telephone Number:
Consultant: S. DAISLEY

Communication

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

Preferred first contact	**Preferred second contact**
Name: LORRAINE	Name:
Relationship: MOTHER	Relationship:
Address:	Address:
Telephone: 07856346709.	Telephone:
Is this person aware of your admission?	Is this person aware of your admission?
Yes ☒ No ☐	Yes ☐ No ☐
Can we share information with this person?	Can we share information with this person?
Yes ☐ No ☐	Yes ☐ No ☐

Presenting Complaint / Diagnosis

FOUND UNCONCIOUS AT BUS STOP – ITU FOR SEDATION + VENTILATION + MONITORING

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

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

No known allergies ☐ PENICILLINS - UNKNOWN REACTION BUT FAMILY HAVE FACIAL ERYTHEMA @ HOSPITAL ADMISSION

Relevant past medical history

CHRONIC BACK PAIN
PREVIOUS DRUG MISSUSE

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

Power of Attorney / Guardianship / Adult with Incapacity

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

Yes ☐ No ☐

OR

Does someone have Guardianship?

Yes ☐ No ☐

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

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

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

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

MRSA Screening – Complete if the patient will be an inpatient for >23hrs

1. Have you ever previously had MRSA? Yes ☐ No ☐ Not known ☒
2. Have you been admitted from another hospital or care home? Yes ☐ No ☒
3. Do you have a wound / skin ulcer or invasive device which you had before admission? Yes ☐ No ☐ Not known ☒

If yes, to any of the above questions OR if the patient is admitted into a 'high impact specialty' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabs

Creutzfeldt-Jakob Disease (CJD)

Have you ever been notified that you are at increased risk of CJD or vCJD for public health purposes?

Yes ☐ No ☐ Not known ☒

If yes, contact Infection Control Team. Infection Control Team Informed __/__/__

Healthcare outside Scotland

Have you ever been told that you are carbapenemase-producing enterobacteriaceae (CPE) positive?

Yes ☐ No ☐

In the past 12 months have you:

1. Been an inpatient in a hospital outside Scotland? Yes ☐ No ☐
2. Received holiday dialysis outside Scotland? Yes ☐ No ☐
3. Been a close contact of a person who has been colonised or infected with CPE? Yes ☐ No ☐

If the answer is yes to any of the questions in this section, isolate the patient and contact the Infection Control Team for advice and undertake the following screen:

Rectal swab obtained ☐ Patient refused rectal swab, stool specimen obtained ☐

Nam
Ad 2308896337
BAILLIE M
David 23/08/1989
34 MONKSBRIDGE AVE
Do Glasgow, Lanarkshire
CH G13 2DT
Aff

Lifestyle

Smoking

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

Never smoked ☐

Do you use eCigarettes? Yes ☐ No ☐

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

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why:_____

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

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

Drugs

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

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

_____

_____

Alcohol

Do you drink alcohol? Yes ☐ No ☐

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

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

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

Name (Please PRINT): SUSAN MCLEOD Signature: SMcLeod

Designation: RN Date: 28/9/18

My Assessment Record

2308896337
BAILLIE
David
M
23/08/1989

Affix patient ID label

1. Breathing and Circulation

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

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

2. Communication

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

2308896337
BAILLIE
David
M
23/08/1989

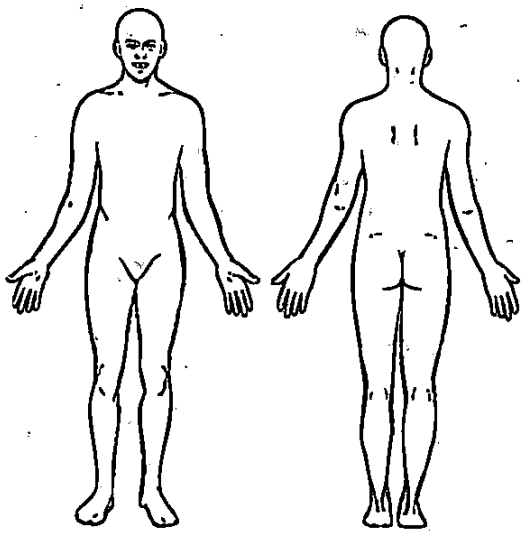
Affix patient ID label

3. Senses

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

Can you describe where and what the pain is like?

Mark current pain on body chart



Have you had treatment / intervention for the pain?

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

Can you describe any chronic pain that you have?

What makes the pain better?

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

4. Cognitive Status THINK DELIRIUM

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

N.B. Think Delirium

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

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

and follow the guidance

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

What do you like to eat and drink?

What do you not like to eat and drink?

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

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

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

Assessment of the patient's hydration and nutrition needs

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

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

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

6. Elimination

Bladder	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Pass urine with no problems		✓	CATHETERISED IN A+E ON ADMISSION
Frequently pass urine during the day			
Frequently pass urine overnight			
Sense of urgency when need to pass urine			
Urine retention			

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

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

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

What products do you normally use for this continence issue?

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

Date urinary catheter last changed 27/9/18

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

owels

When did your bowels last move?

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

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

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

What products do you normally use for this continence issue?

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

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

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

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

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

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

Pressure ulcer identified on admission Yes ☐ No ☒ **If yes, record on Pressure Ulcer Safety Cross**
Please describe location and grade of ulcer **Refer to Tissue Viability Service (as appropriate)**

Datix completed (if appropriate) Yes ☐ No ☐ Datix Ref. Number _____

Wound Care	Yes ✓	No ✓	Name: _____ Address: _____ _____ _____ DoB: _____ CHI: _____ Affix patient ID label
Do you have any wounds? **N.B. If yes, complete an assessment chart for wound management**			

8. Mobility

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

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

9. Maintaining a Safe Environment

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

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

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

10. Sleep and Rest

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

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

11. Social Circumstances

Do you:

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

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

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

Services	**Yes** ✓	**No** ✓
Do you have support from social work, social services or a care package?		

If yes, please provide details:

If yes, has contact been made to cancel arrangements during admission?		

Informal Support	**Yes** ✓	**No** ✓
Do you have someone who looks after you or someone that helps you, i.e. an informal carer?		

If yes, what do they do?

What involvement do you want them to have in your care while in hospital?

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

If yes, has the help or support listed above been confirmed with the patient's informal carer		

Required Support

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

Has the carer been advised of the Carers Information Line (provide carer information leaflet)?

Yes ☐ No ☐ Not appropriate at this time ☐

Are you:
Employed ☐ Self-employed ☐ Full Time Education ☐ Unemployed ☐ Retired ☐

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

Yes ☐ No ☐

Do you have any money worries? Yes ☐ No ☐ Not appropriate to ask at this time ☐

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

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

Would you like a referral to a service that can support you with employment/education/training/skills volunteering Yes ☐ No ☐ Not applicable ☐ Not appropriate to ask at this time ☐

If yes when was the patient referred ___/___/___

12. Person Centred Care

What do we need to know about you as a person to help give you the best possible care whilst in hospital?

Do you have any anxieties or fears that staff should be aware of?

Yes ☐ No ☐

If yes, how can we support you with these?

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

13. Emotional and Spiritual Care

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

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

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

Healthcare Chaplain informed Yes ☐ N/A ☐

Name (Please PRINT): Signature:

Designation: Date:

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

Risk Assessments/Other Documentation

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

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation

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

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
27/9/18 2000	PATIENT ADMITTED TO HOSPITAL AFTER	
	BEING FOUND UNCONSCIOUS AT A BUS	
	STOP. INTUBATED WITH SIZE 7 ETT AND	
	TRANSFERRED TO ITU FOR MONITORING.	
	PATIENT NOK HIS MOTHER IS ON HOLIDAY	
	IN SPAIN.	
	BELONGINGS LISTED AND GIVEN TO	SIGNED.
	PATIENTS SISTER	SIGNED BY

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

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation

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

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation

2308896337
BAILLIE M
David 23/08/1989
34 MONKSBRIDGE AVE
Glasgow, Lanarkshire
G13 2DT

FALLS INTERVEN ON CHECKLIST

NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

	Ward: ITU 2 Date: 28/9/18 Time: 01:00	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----
BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)	✓				
Assess if a low bed is required (Patient care plan 9)	✓				
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)	✓				
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)	✓				
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.	✓				
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)	N/A.				
Document continence problems and link to care rounding (Patient care plan 6)	✓				
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)	N/A				
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.	N/A				
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)	✓				
Update the ward team of the patient's mobility status. (Patient care plan 8)	✓				
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)	N/A				
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)	N/A				
Signature of nurse completing interventional plan / or update	SMcCO				

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

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

2308896337
BAILLIE
David M
34 MONKSBRIDGE AVE 23/08/1989
Glasgow, Lanarkshire
G13 2DT

FALLS RISK ASSESSMENT

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

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

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

	Ward: ITU2 Date: 28/9/18 Time: 04.00	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	Y				
2. Check walking aid (if required) is in reach and in use.	N/A				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	N/A				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	N/A				
5. If glasses are worn, check they are available and in use.	N				
6. If hearing aid/s are worn, check they are working and in use.	N				

RISK ASSESSMENT

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

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

Highlight risk of fall at the ward safety brief.

Person Specific (Inpatient) Moving and Handling Assessment Form

Person's Name:	DAVID BAMLE	Named Nurse:		Person is totally Independent (tick here and go to date box)	

1. General Information

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

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

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

3. Toileting

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

4. Move on / off bed pan

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

5. Move up / down bed

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

6. Lateral Transfer to / from trolley / bed

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

7. Sit up over side of bed

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

8. Into Bath or Shower

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

9. Walking

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

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:	28/9/18		
Assessor's signature:	SMCLEOD		
Proposed Review date:	29/9/18		

Continuation Sheet

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

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

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

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

3. Toileting

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

4. Move on / off bed pan

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

5. Move up / down bed

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

6. Lateral Transfer to / from trolley / bed

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

7. Sit up over side of bed

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

8. Into Bath or Shower

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

9. Walking

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

10. Other Instructions / Observations / Equipment Used

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

Care Rounds Checklist

Date: 28/9/18

Attach A 2308896337
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David 23/08/1989
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Glasgow, Lanarkshire
G13 2DT
Ward:

NHS Greater Glasgow and Clyde

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

1. Signed SMcLeod Name S. McLeod Designation RN -
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

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

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

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

Care Rounds Variance Sheet

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NHS
Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code.	Variance	Sign & Print Name

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MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date 27/9/18 Time 0900 of initial height and weight on admission to hospital		Actual	*Patient reported	*If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height	_____ cm	☐	☐	
Admission Weight	_____ Kg	☐	☐	

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

Patients reported normal weight _____ Unable to Recall ☐

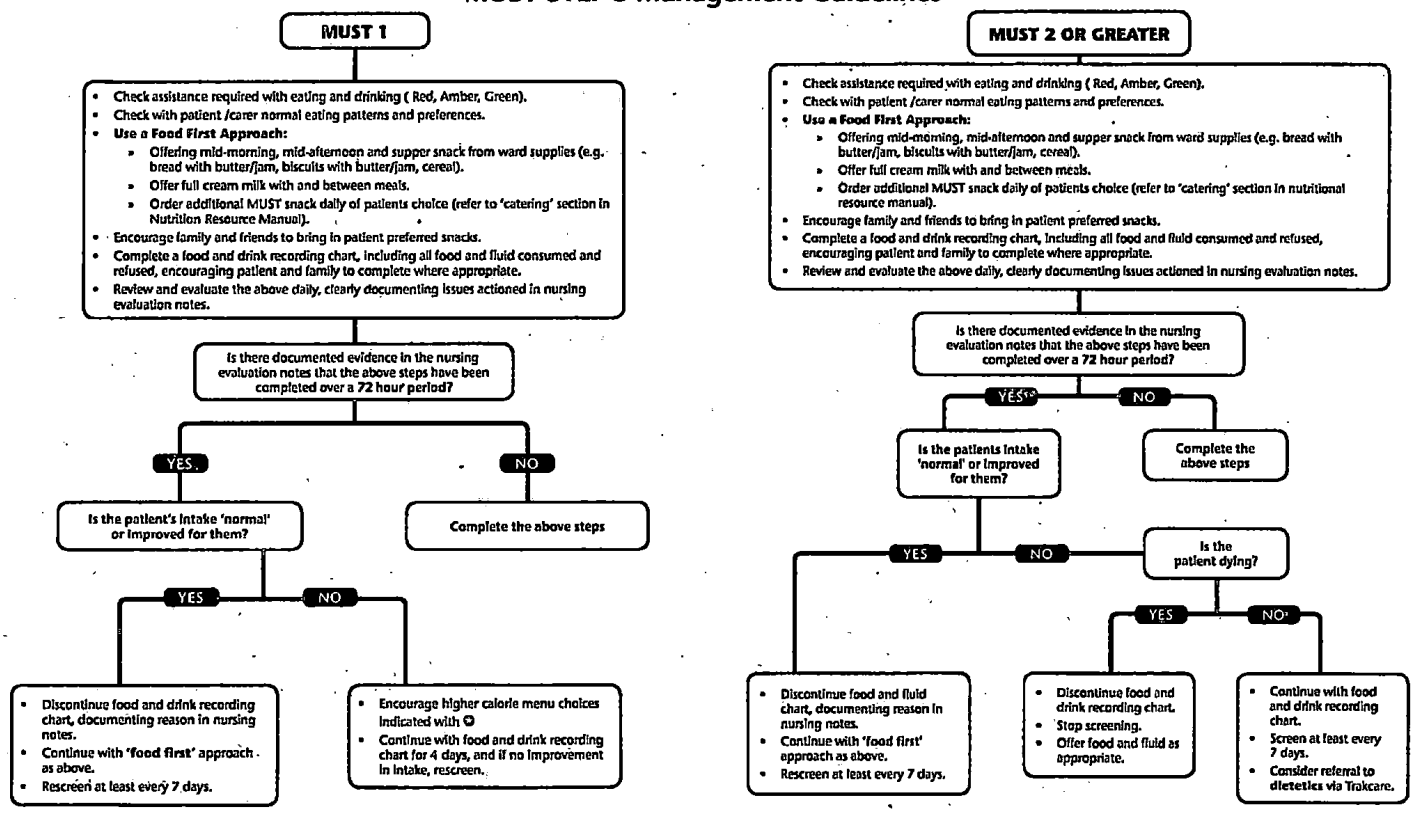
Any unplanned weight loss in the last 6 months Yes ☐ how much _____ No ☐ Don't Know ☐

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

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

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

MUST STEP 5 Management Guidelines



DISCHARGE

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

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

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Adult Urethral Urinary Catheter(UUC)

Insertion & Maintenance Care Plan

Catheter Batch Label

NHS Greater Glasgow and Clyde

Insertion – Complete all sections				
Date and time inserted 27/9/18	Urethral Urinary Catheter inserted Hospital _____ ED ☒ Theatre ☐ ITU/HDU ☐ Ward _____	Gauge	____ mls in balloon	Inserted by (Print name & designation [if known]) UNKNOWN
Clinical Indication for urethral urinary catheterisation	Long term urethral urinary catheter ☐ (> 28 days)	Short term urethral urinary catheter ☐ (≤ 28 days)		
Patient had urethral urinary catheter inserted in the community/out with NHS GGC	Yes ☐	No ☑	Date UUC inserted (if known) _____	

Insertion Criteria		Comments
Alternatives to urethral urinary catheterisation considered	Yes ☑ No ☐	
Hand hygiene is performed immediately before urethral urinary catheter insertion	Yes ☑ No ☐	
Aseptic technique performed at insertion	Yes ☑ No ☐	
Urethral Urinary catheter of smallest gauge used and balloon filled to recommended level	Yes ☑ No ☐	
Urethral meatus cleaned with sterile saline and sterile lubricant used	Yes ☑ No ☐	
Aseptic technique maintained when connecting urethral urinary catheter to closed drainage system	Yes ☑ No ☐	

DAILY MAINTENANCE: FOR ALL PATIENTS WITH A URETHRAL URINARY CATHETER:

- Staff must wear gloves and apron and perform hand hygiene before and after urinary catheter procedures
- The drainage bag must be emptied when clinically indicated using a clean disposable container for each patient. Please refer to Insertion and maintenance of adult indwelling urethral urinary catheter SOP.

Maintenance – To be completed daily (observe for signs and symptoms of infection)

Please regard Day 1 as day of insertion or the day patient is admitted to hospital with Urethral Urinary Catheter.	Ward	Does the patient still require a urethral urinary catheter?	Is the urethral urinary catheter connected to a closed drainage system and changed in line with manufacturer's instructions?	Daily meatal hygiene has been carried out? (soap and water)	Urine drainage bag is situated below the level of the bladder and not in contact with any surface e.g. floor?	Signature and Print Name
Day 1 27/9/18	ITU2	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	SMCLEOD SMCLEOD
Day 2 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 3 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	

Date removed: _____ Time removed: _____ Reason for Urethral Urinary Catheter removal: _____ Removed by: _____

CHI Number: _____

Maintenance – To be completed daily (observe for signs and symptoms of infection)						
	Ward	Does the patient still require a urethral urinary catheter?	Is the urethral urinary catheter connected to a closed drainage system and changed in line with manufacturer's instructions?	Daily meatal hygiene has been carried out?	Urine drainage bag is situated below the level of the bladder and not in contact with any surface e.g. floor?	Signature and Print Name
Day 4 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 5 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 6 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 7 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 8 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 9 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 10 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 11 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 12 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 13 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 14 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 15 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 16 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 17 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 18 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 19 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 20 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 21 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 22 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 23 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 24 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 25 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 26 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 27 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 28 ___/___/___		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	

NHSGGC Bedrail Risk Assessment

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NHS Greater Glasgow and Clyde

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

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

Patient Nar

CHI Numb

Use guidance on the reverse of this document when completing this Risk Assessment.									
	DATE	28/9/18							
	TIME	0400							
	WARD	ITU2							
	HOSPITAL	QEUH							
SECTION ONE – GENERAL		Y	N	Y	N	Y	N	Y	N
1	Is the patient likely to fall, roll, slip or slide from the bed?		✓						
2	Has the patient requested the use of bedrails?		✓						
IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED									
SECTION TWO – COGNITIVE AND PHYSICAL STATUS									
3	Is the patient at risk of climbing out of bed?		✓						
4	Is the patient stressed, delirious or restless?		✓						
5	Is the patient small in stature?		✓						
6	Does the patient have an unusually large or small head that might present an entrapment issue?		✓						
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?		✓						
IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
SECTION THREE – COMMUNICATION									
8	Has the patient been consulted regarding the use of bedrails?		✓						
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition		✓						
10	Has the use of bedrails been discussed with relatives/carers?		✓						
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?		✓						
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?	✓							
IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
SECTION FOUR – DECISION MAKING		Y	N	Y	N	Y	N	Y	N
13	Will bedrails be used for this patient at the present time?	✓							
14	Rationale for use of bedrails: (Please insert code in the box on the right)								
	A – Risk of falling from the bed								
	B – Risk of rolling from the bed								
	C – Risk of slipping from the bed								
	D – Risk of sliding from the bed	✓							
	E – Patient request								
15	Bedrail risk assessment completed by:	SMCLEOD							
16	Bedrails checked by:	SMCLEOD							
17	Date	28/9/18							

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

A. Alternatives to bed rails:-

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

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

Is patient:-

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

C. Safe use and application of bedrails:-

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

D. Record keeping:-

All of the following should be recorded:-

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

Bedrail risk assessments should be made as follows:-

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

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Peripheral Vascular Cannula (PVC) Insertion & Maintenance

NHS Greater Glasgow and Clyde

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

Insertion – Tick appropriate answer

Clinical indication:	Diagnostics ☐	Resuscitation / Chest Pain ☐	IV Drugs ☑	Fluids ☐	Transfusion ☐
PVC inserted:	Date 27/9/18	Hospital: QEUH	ED ☑	Theatre ☐	ITU/HDU ☐ Ward ☐ _____
Insertion site:	L Arm ☐	R Arm ☐	L Hand ☐	R Hand ☑	L Foot ☐ R Foot ☐ Other
Colour of cannula:	Blue ☐	Pink ☑	Green ☐	White ☐	Grey ☐ Orange ☐

PVC 1	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation **Record VIP score**	The PVC dressing is intact	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 27/9/18	Yes ☑ No ☐	VIP: 0	Yes ☑ No ☐	Left in situ ☑ Removed ☐	
After 24 hours – review clinical reason and / or justify rationale for PVC to remain in situ; if not required consider removal.					
Day 2 28/9/18	Yes ☑ No ☐	VIP: 0	Yes ☑ No ☐	Left in situ ☑ Removed ☐	
Day 3 ___/___/___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After 72 hours – review clinical reason and / or justify rationale for PVC to remain in situ; if not required consider removal.					
Day 4 ___/___/___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 ___/___/___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

Date removed_____ Reason for PVC removal_____ Reason PVC in greater than 72 hours_____

Date & time	Comments	Signature

IVOS – consider changing from IV to oral

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

Peripheral Vascular Cannula (PVC) Insertion & Maintenance

NHS Greater Glasgow and Clyde

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

Insertion – Tick appropriate answer					
Clinical indication:	Diagnostics ☐	Resuscitation / Chest Pain ☐	IV Drugs ☐	Fluids ☐	Transfusion ☐
PVC inserted:	Date: / /	Hospital: _____	ED ☐	Theatre ☐	ITU/HDU ☐ Ward ☐ _____
Insertion site:	L Arm ☐	R Arm ☐	L Hand ☐	R Hand ☐	L Foot ☐ R Foot ☐ Other
Colour of cannula:	Blue ☐	Pink ☐	Green ☐	White ☐	Grey ☐ Orange ☐

PVC 1	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 ___/___/___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After 24 hours – review clinical reason and / or justify rationale for PVC to remain in situ; if not required consider removal.					
Day 2 ___/___/___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 ___/___/___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After 72 hours – review clinical reason and / or justify rationale for PVC to remain in situ; if not required consider removal.					
Day 4 ___/___/___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 ___/___/___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

Date removed_____ Reason for PVC removal_____ Reason PVC in greater than 72 hours_____

Date & time	Comments	Signature

IVOS – consider changing from IV to oral

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name
Address

2308896337
BAILLIE M
David 23/08/1989
34 MONKSBRIDGE AVE
Glasgow, Lanarkshire
G13 2DT

CHI No.
DoB

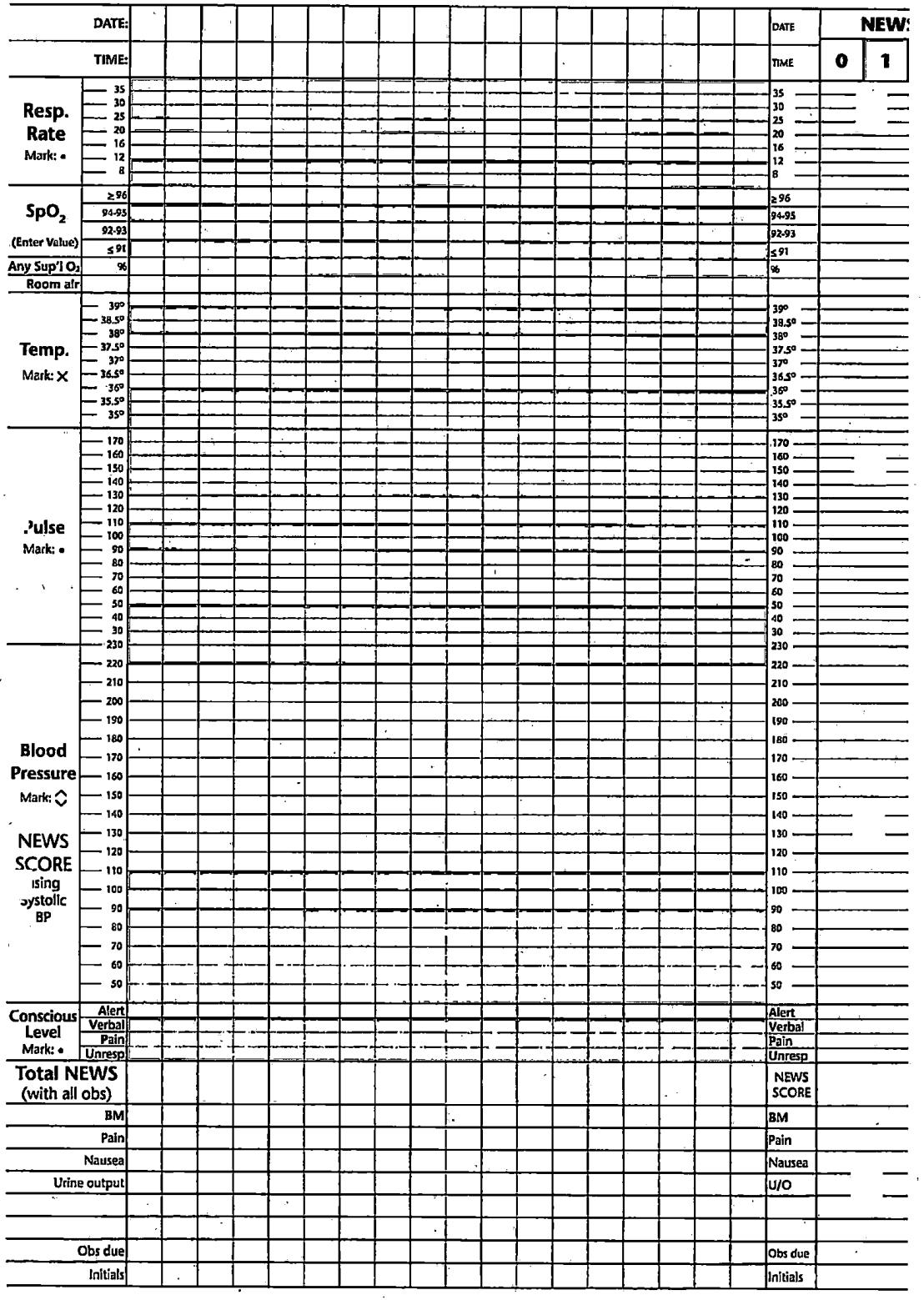
	Date	Ward
Admitted		
Transferred		
Transferred		

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.


DATE:
TIME:
DATE
TIME
NEWS
0
1
Resp. Rate
Mark: •
35
30
25
20
16
12
8
SpO2
(Enter Value)
≥ 96
94-95
92-93
≤ 91
Any Sup'l O2
96
Room air
Temp.
Mark: ×
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
Mark: •
170
160
150
140
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230
220
210
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190
180
170
160
150
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130
120
110
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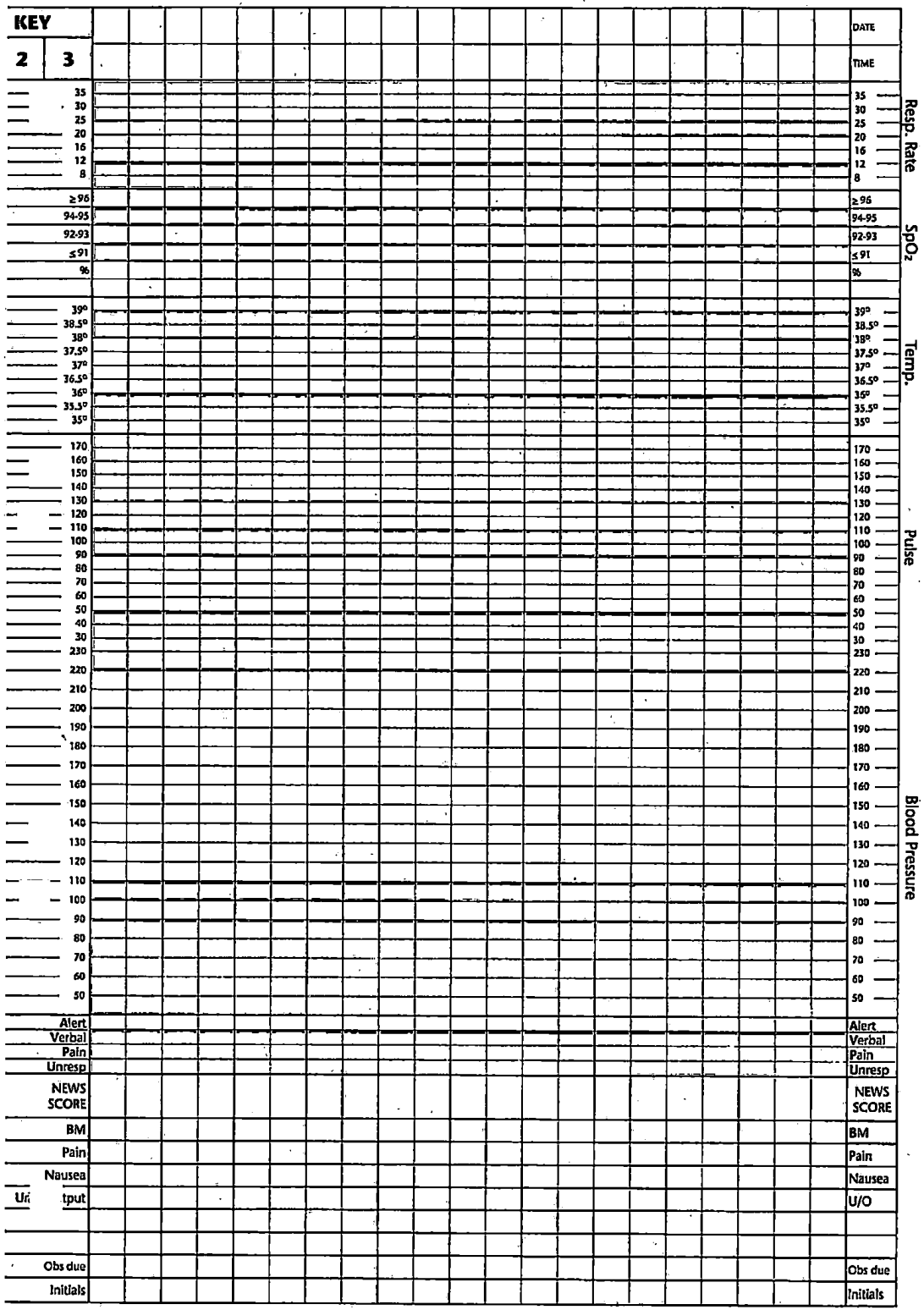
80
70
60
50
Blood Pressure
Mark: ⌃⌄
NEWS SCORE
ising
ystolic
BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
NEWS SCORE
BM
Pain
Nausea
Urine output
U/O
Obs due
Initials


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥96
94-95
92-93
≤91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
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35.5°
35°
Pulse
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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): 1 2 3 4 5 6 7 8

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

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Resus (6)

Name
Address

CHI No.
DoB

	Date	Ward
Admitted	27/08/18	A+E
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°	
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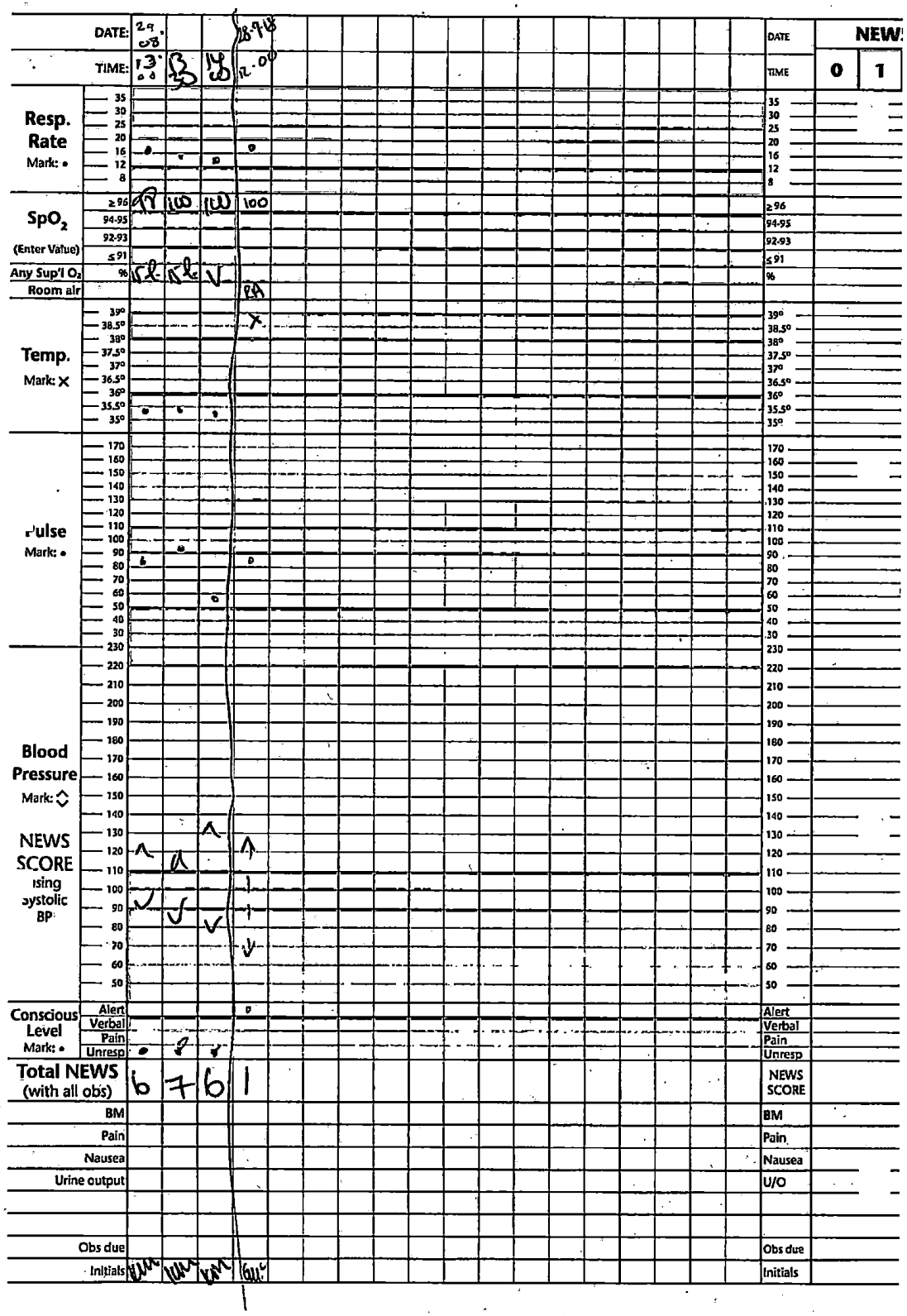
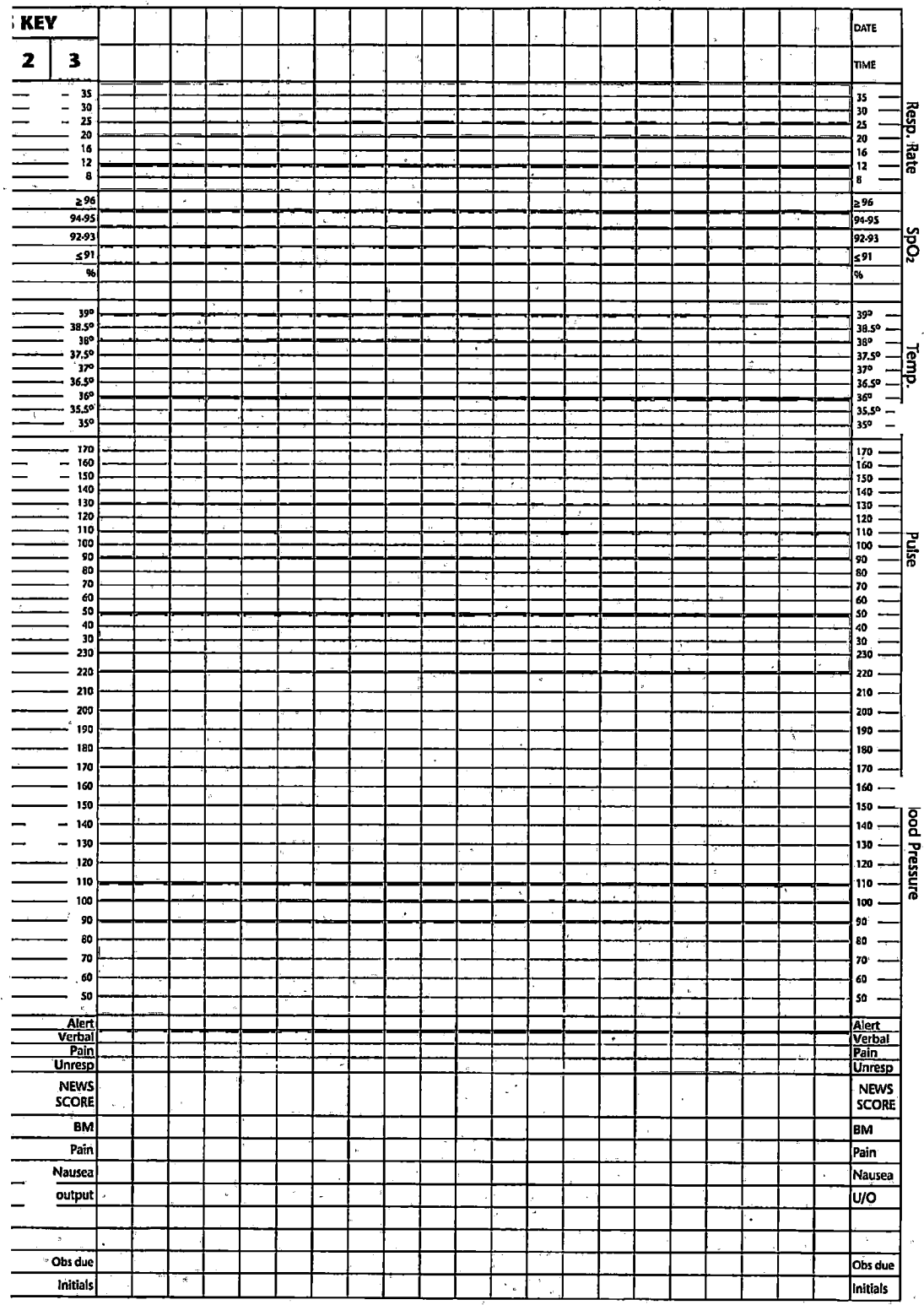

DATE
TIME
Resp. Rate
Mark: •
SpO2
(Enter Value)
Any Sup'l O2
Room air
Temp.
Mark: ×
Pulse
Mark: •
Blood Pressure
Mark: ◇
NEWS SCORE
rising systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
6 7 6 1
BM
Pain
Nausea
Urine output
Obs due
Initials
NEWS
0 1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94-95
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38.5°
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37°
36.5°
36°
35.5°
35°
Pulse
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40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
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Blood Pressure
Alert
Verbal
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NEWS SCORE
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Pain
Nausea
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Management Plan and Patient Exclusions

Date and Time	Notes	Signed

Patient Profile

QEUH ICU

NHS Greater Glasgow & Clyde

27/09/2018 10:49 - 27/09/2018 20:05

PATIENT NAME	CHI	ENCOUNTER ID
David Baillie	2308896337	

ATTENDING	PRIMARY DIAGNOSIS

AGE (ADT)	ALLERGIES & SENSITIVITIES
29 years	Has allergies

Patient Profile (27/09/2018 14:49) Katie Percival

Admission Form

Patient Name	* David Baillie
CHI	2308896337
Date of Birth	23/08/1989
Age (Admission)	29 years
Gender	Male
Allergies & Sensitivities	Has allergies Penicillins - Unknown but four family members all allergic and all get facial erythema/ have required hospital admission

Contact Details

Patient Address	34 MONKSBRIDGE AVE Glasgow Lanarkshire G13 2DT
Next of Kin	* William Baillie (Father)
Next of Kin Phone Number	07856346709
Other Contacts	mum Lorraine (NOK but currently in Spain, trying to arrange flight home) // sisters Michelle (07342679911) + Amanda (07802583780)
General Practitioner	EWART, PHILIP
GP Address	Fulton Street Medical Centre Fulton Street Surgery 94 Fulton Street Glasgow G13 1JE
GP Phone Number	0141 959 3391

AC	Amy Colloghan	27/09/2018 14:49 - 27/09/2018 14:49
KP	Katie Percival	27/09/2018 14:49 - 27/09/2018 18:52
HIS	HIS	27/09/2018 14:50 - 27/09/2018 15:43
PM	Peter Moffitt	27/09/2018 16:57 - 27/09/2018 16:57

	27/09/2018 13:35
HIS	15:43 Patient Name
HIS	14:50 Patient Name: DAVID BAILLIE
AC	14:49 Patient Name: David Baillie
AC	14:49 CHI
AC	14:49 Date of Birth
AC	14:49 Age (Admission)
AC	14:49 Gender
	27/09/2018 14:50
HIS	15:43 Patient Address
HIS	14:50 General Practitioner: GP Name: EWART, PHILIP;
HIS	14:50 GP Address
HIS	14:50 GP Phone Number
	27/09/2018 14:56
PM	16:57 Allergies & Sensitivities: Status: Has allergies; Latex Allergy?: No; Allergies: (1) Type: Drug allergy; Allergen: Penicillins; Reaction: Unknown but four family members all allergic and all get facial erythema / have required hospital admission;
	27/09/2018 15:43
KP	18:52 Next of Kin
HIS	15:43 Next of Kin: (Not known)

NHS GREATER GLASGOW AND CLYDE

INTERIM WARD RECEIPT

Receipt of Patients Money and Valuables handed over for safekeeping

HOSPITAL: _____

To be completed by Nursing Staff

Date: _____

Ward: _____ Unit No: _____ CHI No: _____

Patient's Name: _____

Home Address: _____

_____

Next of Kin: _____ or Relationship: _____

DETAILS OF MONEY AND VALUABLES RECEIVED

Cash £ p	Description
No. of Watches	
No. of Rings	
Credit cards	
Other Items	

Listed by _____ Date _____ Checked by _____ Date _____

FOR OFFICE USE:

Cashier	Signature	Date	
Night Safe	Signature	Date	
Returned by	Signature	Date	
*Taken by	Signature	Date	

Name _____ Relationship to patient _____ *(if not patient)

SUB.

NHS GGC Hospitals, Emergency Department

MAU (2)

NHS Greater Glasgow and Clyde

Affix Label

CHI: 2308896337

Queen Elizabeth University Hospital

Total Att: 6

12 Mth Att: 2

Title: MR

BAILLIE **David**

DOB: **23/08/1989** Age: **29y** Sex: **Male**

Chez Nous Guest House Glasgow

Glasgow
G13 2DT
07548377851

Next of kin: **BAILLIE, David**
Relationship: **Father**

GP: **PA Ewart**
0141 959 3391

Attendance Date: **21/01/2019** Arrival Time: **13:10**

Registration Time: **13:10** Date of Incident: **21/01/2019**

Major Incident Desc:

Reason for Attendance: **mental health issues**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **None Known** Pain Score:

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

Presenting Complaint: **Psychiatry Requesting Psych Help**

Observation Date: **21/01/2019 13:20** Nurse name: **Nurse Caroline McGoldrick**

Temp	**36.9**	C
HR	**60**	bpm
BP	**130/68**	mmHg
MAP	**88.67**	mmHg
RR	**15**	bpm
SpO2	**100**	%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/mir
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: **states hearing voices, brought in by sister, states cant be bothered doing anything**

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	21/1/19.	CLINICAL NOTES
	Seen by (Dr) H. BNATT	Time seen 1430

(29) Psych issues.

Self - presented with sister to seek for psychiatric help. as having ongoing audio-visual hallucinations.

for further info. look @ Mental health triage + assessment.

O/E Calm + coherent

Plan Refer to Liaision psych who will come rlv pt.

7861315

21/1/19 - Review - BK OPD. (Pearson 4)
- Long forensic history
- Released from prison last May → unable to adjust to day to day life
- Chaotic life style.
- Recent review by Social Work.

Date	CLINICAL NOTES
	no issues highlighted. Angry and unrealistic expectations regarding "help" from services. Denying pseudohallucinations. No evidence of depressed mood or psychosis Imp: Social difficulties. Plan ① Discharge Phone if all services available

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

BAILLIE, David (Mr) Date of Birth: **23-Aug-1989 (29y)**

Chez Nous, Hillhead St, Glasgow, G12 8PX

9 2308896337 23/08/198
BAILLIE
David

CHI Number: 230 889 6337 Usual GP:

Consultations

Date	Consultation Text
21-Jan-2019	Face to face consultation (Queen Elizabeth University Hospital) ROBERTSON, Lorraine (LiaisonMentalHealthNurse) Entered By: ROBERTSON, Lorraine (CrisisPractitioner)
Comment	Situation : Referral from ED at QEUH. David had self presented with his sister, stating to be hearing voices. I note his sister had contact homeless addiction team earlier today raising concerns re Davids mental health, inclusive of him loosing weight, hearing voices and struggling with withdrawal discomfort. Advised by homeless addiction team to present to ED. Liaison psychiatry requested to facilitate robust mental health and risk assessment and provide recommendations for post discharge planning, same facilitated by writer and Emma Vaughan (Liaison mental health nurse). David reports a deterioration in his mental health since Amy when he was liberated from Shotts prison having served five and half years of a ten year sentence. He states a combination of taking SPICE for eight months in prison and being segrated for the last four months of his sentence has impacted on his mental health. He reports hearing two male voices inside his head which are command in nature telling him to kill himself of kill somebody else. He reports having visions of seeing people on fire and unsure what this means. He spoke of difficulty adjusting from to life in the community and has thoughts of committing a crime to be sent back to prison. Background : David is currently active with homeless addiction services at Hunter Street, his last face to face contact 18/01/2019, at that time he reported his mood to be low and requested a mental health assessment. He is prescribed 8mg of buprenorphine which is supervised daily dispense, reports he has not has this today. He has a son who lives with his grandmother, David has no contact. Currently living with his girlfriend in Coatbridge. Liberated in May 2018 after serving a five and half year sentence. Assessment : On assessment David presented as a thin male, donned in clean attire, he wore a woollen hat which he would pull over his face from time to time during assessment. His sister was present throughout. Some rapport was established, eye contact appropriate. He was spontaneous in conversation which was normal in all parameters and content of conversation wholly appropriate and in keeping of assessment, no overt agitation or anxiety evident. Objectively mood relative to situation affect reactive, subjectively described low mood, significant weight loss over a 6 week period of 3 stone, fractured sleep. He reports lack of motivation and struggles to get of bed at times. No objective evidence of perceptual disturbances, no distraction or pre occupation related to this. Fully orientated, concentration grossly intact following flow of assessment without hesitation or repetition, thought process wholly in order. Subjectively reports "hearing voices" of a command nature telling him to kill himself or others. No thought plan or intent of harming himself states he would not do that, further suggesting he would harm others first, aware this would be a police matter. No significant history of self harm stating to have cut his wrist whilst in prison on one occasion, no other episodes disclosed. Reports daily smoking of cannabis denies any other form of illicit substance misuse, denies any alcohol misuse. Denies any pending charges. Following this assessment we contact homeless addiction team who agreed to discuss David at the senior meeting on Wednesday 23/01/2019 and arrange appropriate follow up thereafter, on discussing this with David and sister evidently not happy with outcome and seeking hosptial admission. David reported his dad wanted him "sectioned". His sister tearful and looking for "help" felt nobody was listening them. In light of this we felt it appropriate to have him reviewed by liaison psychiatirst Dr Oto who was agreeable to discharge him from ED. David becoming aggressive kicking obeservation machine and throwing a plastice bottle within the department, subsequently left abruptly.

Greater Glasgow & Clyde Emergency Departments' Mental Health Triage and Risk Assessment T

NHS Greater Glasgow and Clyde

9 2308896337 23/08/198

Pa BAILLIE
Cl David

Part One - Nursing Triage

triage nurse to complete this page

Triage Observations

document physiological measurements

GCS	BM	HR	BP	RR	SaO^2	Temp
15	6.5	87	130/80	16	100%	36.9

accompanied by

name, relationship, particular concerns

sister

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... sister	Summary requesting psyche help Black trainers, grey tracks, red hoodie, blue coat, scarf, black jacket (canada goose) skin head.
Blood sample time?	
Toxbase info printed? Y/N	
GMAWS considered? Y/N	

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

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

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

name/grade

signature

date and time

Part Two - Mental Health Assessment

(medical staff to complete this page)

Patient CHI _ 9 230889€ 7 23/08/198
BAILLIE
David

outline of current presentation and precipitating factors

Visual + audio hallucinations.

Voices telling him to kill himself + set people on fire.

Sees objects moving + also random passerbys on fire.

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

Cannabis user — says has reduced quantity.

Previous spice abuse

Previous O.D.

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 — no fixed abode.

Young son — lives with mother. — protective factor

Sister — protective factor

Appearance	Behaviour	Speech
well dressed	Withdrawn	Coherent
Mood	**Thought**	**Insight**
Low.		Yes.

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
CPN		

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
H. SNATT FY2

signature
[signature]

date and time
21/1/19 @ 1440

NHS GGC Hospitals, Emergency Department

NHS

Queen Elizabeth University Hospital

CHI: 2308896337

Total Att: 5

12 Mth Att: 1

Title: **MR**

BAILLIE **David**

DOB: **23/08/1989** Age: **29y** Sex: **Male**

Chez Nous Guest House Glasgow

Glasgow
G13 2DT

Next of kin: **UNKNOWN**
Relationship: **Unknown**

GP: **PA Ewart**
0141 959 3391

Attendance Date: **29/11/2018** Arrival Time: **21:57**

Registration Time: **21:57** Date of Incident: **29/11/2018**

Major Incident Desc:

Reason for Attendance: **psychiatric complaint**

Nursing Assessment

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

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

Presenting Complaint:

Observation Date: **29/11/2018 22:04**

Temp	**36**	C
HR	**78**	bpm
BP	**133/97**	mmHg
MAP	**109.00**	mmHg
RR	**18**	bpm
SpO2	**99**	%
Oxygen	**21**	%

Nurse name: **Nurse Rona Thomson**

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: **"pt feels suicidal and violent towards others "**

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES
	Seen by (Dr) Time seen

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

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

NHS Greater Glasgow and Clyde

2308896337 23/08/1989

Part One – Nursing Triage

Patient na BAILLIE
CHI David

Triage Observations

GCS	BM	HR	BP	RR	SaO²	Temp
		78	137/99	18	99	36

Accompanied by

name, relationship, particular concerns

Sister

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 minimal category of risk

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

Triage Category (H)

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 patient can be categorised as **Moderate Risk**

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

Immediate management

Patient location, accompanied by... Sister	Summary Dark blond hair. Black - jeans trainers top jacket
Blood sample time?	
Toxbase info printed? Y/N	
GMAWS considered? Y/N	

name/grade R. Monson

signature SJN

date and time 29/11/16 22-

Part Two - Mental Health Assessment

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

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

High / Moderate / Low

Discharge Advice and Plan for Further Assessment

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 _____

Patient Information		Date:	27/09/2018
DAVID BAILLIE		Incident Number:	PA004984971
Age/Gender:	29 years 1 months 4 days Old Male	Incident Type:	EMG
Address:	34 MONKBRIDGE AVE, GLASGOW,G13 2DT	Incident Location:	O/S SPAR STORES 629 (628 633) GREAT WESTERN ROAD ANNIESLAND GLASGOW, G12 8RE
DOB:	23/08/1989		
CHI:			
Ethnicity:			

Scottish Ambulance Service

Presenting Complaint

UNCONSCIOUS

Additional Comments

O/A PT SITTING SLUMPED IN BUS STOP. NO RESPONSE TO STIMULI..... O/E GCS 3, PUPILS PINPOINT AND FIXED. HYPOTENSIVE. NO RESPONSE THROUGHOUT. TOLERATED OP AIRWAY. NO EVIDENCE OF DRUG PARAPHENALIA.. NO EVIDENCE OF INJURY.

PATIENT ASSESSMENT

AVPU	Unresponsive		<C>	No
A	At Risk	Treatment: Positioning, OPA	Successful: Yes	
B				
C	Pulse Rate: 64	BP: 91/54	Cap Refill: <=2 Secs	ECG Rhythm
	Rhythm: Reg	Arm: Right	Central/Peripheral: Peripheral	ECG: 12 Lead.
	IV(R): Dorsum Of Hand			
D	GCS: 3	Eyes: No Response (1)	Voice: No Response (1)	Motor: No Response (1)
	PEARL: No			
E				

Observations

Time	P	RR	BP	SpO2	CR	GCS	AVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
13:00	61	12	89/53	100	<=2s	3	Unresponsive								E9888149
12:45	60	14	89/53	100	<=2s	3	Unresponsive								E9888149
12:30	64	14	91/54	100	<=2 Secs	3	Unresponsive		35.8	4.8	Sinus Rhythm	1	1		E9888149

NEWS

Time	Clinical Risk	NEWS
13:00	MEDIUM Immediate Clinical Risk. Treat as per Clinical Practice Guidelines. This patient should be conveyed to hospital.	6
12:45	MEDIUM Immediate Clinical Risk. Treat as per Clinical Practice Guidelines. This patient should be conveyed to hospital.	6
12:30	MEDIUM Immediate Clinical Risk. Treat as per Clinical Practice Guidelines. This patient should be conveyed to hospital.	6

Drugs

Time	Drug	Dosage	Units	Route	Drug Expiry Date	Pain Before	Pain After	CrewID
12:35	Naloxone (Narcan)	0.4	mcg	IM	02/2020			E0014443
12:38	Naloxone (Narcan)	0.4	mcg	IM	02/2020			E0014443
12:45	Naloxone (Narcan)	0.4	mcg	IM	02/2020			E0014443
12:50	Naloxone (Narcan)	0.4	mcg	IV	02/2020			E0014443
12:55	Naloxone (Narcan)	0.4	mcg	IV	02/2020			E0014443

HISTORY

AMPLE

Allergies	Unknown
Medication	SETRALINE?
Past Medical History	UNKNOWN
Last Eaten	Unknown
Events Prior	PC UNCONSCIOUS.....HPC FOUND IN BUS STOP UNRESPONSIVE. PT ALONE.....

CLOSE RECORD

Treatment On Scene	Emergency

Conveyance

Transport To Hospital	Emergency driving	Pre Alert	Yes

INCIDENT LOG

Time Call Received	12:11	Allocated	12:11	Mobile	12:12
First Resource On Scene		Crew On Scene	12:16	Crew Left Scene	12:48
Crew At Hosp	13:00	Receiving Hospital	QUEEN ELIZABETH UNIVERSITY HOSPITAL	Clear Time	

Crew ID	Crew Grade	Driver
E0014443	Paramedic	YES
E9888149	Paramedic	NO

NHS GGC Hospitals, Admission Document

Bed 32
Unit 4

NHS Greater Glasgow and Clyde

Affix Label

Queen Elizabeth University Hospital

CHI: 2308896337

Total Att: 4

12 Mth Att: 0

Title:

BAILLIE

David

DOB: 23/08/1989 Age: 29y

Sex: Male

34 MONKSBRIDGE AVE

Next of kin: UNKNOWN

Relationship: Unknown

Glasgow
Lanarkshire
G13 2DT

GP: PA Ewart
0141 959 3391

Attendance Date: 27/09/2018 Arrival Time: 13:05

Registration Time: 13:05 Date of Incident: 27/09/2018

Major Incident Desc:

Reason for Attendance: stand by

Affix Label

Nursing Assessment

Nursing Assessment

Alerts: Not Recorded Allergies: Not Recorded Pain Score:

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

Presenting Complaint:

Observation Date: 27/09/2018 13:09 Nurse name: Nurse Kevin McAuley

Temp	35.4	C
HR	58	bpm
BP	123/88	mmHg
MAP	99.67	mmHg
RR	16	bpm
SpO2	98	%
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: Stand by - OD

GGLU2I9 MD 283/91

Patient ID label

2308896337
BAILLIE
23/08/1989

Date: 27/09/18

Emergency Department Notes — RESUS STANDBY

Ambulance Proforma reviewed Yes / No   Seen by (Doctor) [signature]   Time seen 21[illegible]

male ID'd as David Baillie 29yo.

GCS 3/15 at bus stop.
no response to 3mg IM & 2mg IV naloxone
↓BP en route — IV fluids from SAS

O/A — A — guedel in mouth

B — RR16 good A/E R=L clear

C — HR 80 HS I+II+0

D — E_1 M_2 V_1 4/15 — moving (L) side only
PEARLA size 2   BM 4.1
no ↑ tone or clonus

E — Temp 35^4
no external evidence HI.

pre O2 (?) from monitoring
⇒ RSI 2 attempts by Dr Walker ST4.
grade I view with Mac4 but unable to pass tube   no desat'n 100%
→ 3rd attempt
— grade I view bougie & ETT
CO2 → ETCO2 (?)

alfentanil
ketamine
Rocuronium

Patient ID label

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen
	→ CT if neg CT → IV antibiotics ↑ LA → ? ICU 2 IVs Hawke ED SM	

Differential Diagnosis/Problem List	
	NEWS ☐ 0-7 RED FLAG ☐ (Tick) SEPSIS ☐ CURB 65 ☐

Done/ completed	Immediate Managment Plan

Signature:	Designation:	Page No:

PLEASE DO NOT WRITE HERE

In-Patient Admission Notes

Patient ID label

Seen By: **Print:** **Time Seen:** **Pg. No:**

PRF Reviewed Yes / No

Presenting Complaint(s)	
Presenting complaint	
History of presenting complaint	

Past Medical History / Review of portal

Systemic Enquiry

Patient ID label

MEDICINES RECONCILIATION – Acceptable to staple fully completed Emed Rec

Source of medication history (>1 source preferred)
☐ Patient/Relative/carer ☐ GP Phone call ☐ ECS
☐ Patient own drugs ☐ Com. Pharmacist ☐ GP letter/summary
☐ Repeat Prescription

Other (please specify)

Admission Medicines			Plan for Medicines (Dr complete)				Comments Reason for alteration
Name	Dose	Freq	Continue	Amend	Withhold	Stop	

Allergies	List any over-the-counter or alternative medicines
	Do medicines need further clarification ? ☐ Yes ☐ No
List collected by :	Plan approved by :
Designation : Date :	Designation : Date :

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

Patient ID label

Social History \ Family History

Smoking History

Ex-smoker/Smoker _____ cpd _____ yrs ☐ Never smoked

Alcohol History

_____ Units/week FAST score if excess _____

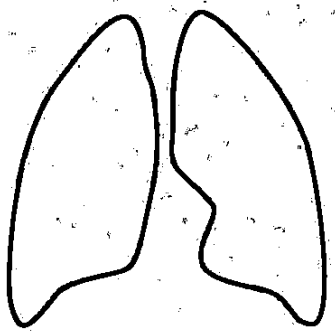
Recreational Drugs **Driving Status**

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

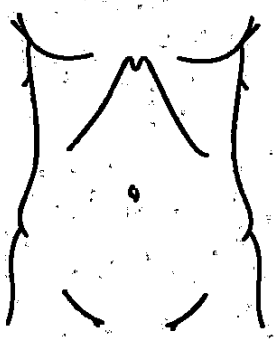
General Examination	
Temp:	RR:
Pulse:	CBG:
SpO_2:	Weight:
BP:	Urinalysis:

General Appearance:

Respiratory



Gastrointestinal System



Cardiovascular

Locomotor

Patient ID label

Neurological system

GCS: /15 E: /4 M: /6 V: /5

AMT 4 = age, DOB, place, year

AMT score ____ /4

Is the patient more confused/drowsy than normal: Y / N
If yes complete 4AT / TIME

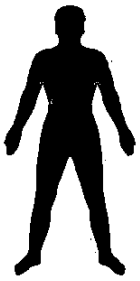
Pupils/fundoscopy:

Cerebellar and extrapyramidal:

Cranial Nerves:

Neck:

Reflexes:



	RUL	LUL	RLL	LLL
Tone				
Power				
Co-ordination				
Sensation				

Plantars: R L

Skin/Other

Patient ID label

Key Results

CXR ECG

(Differential) diagnosis

NEWS ☐

Red Flag ☐

Sepsis ☐

CURB 65 ☐

Management Plan

☐ Thromboprophylaxis assessed ☐ Medicine Reconciliation ☐ 4AT/TIME
☐ Antimicrobial

Signature: PRINT NAME

PRINT GRADE Page:

Patient ID label

Resuscitation Decision

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

If DNA CPR → Complete appropriate form

Senior Medical review

☐ Thromboprophylaxis assessed
☐ Antimicrobial
☐ Medicine Reconciliation
☐ DNACPR
☐ 4AT/TIME
☐ AWI if appropriate

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

Patient ID label

Medical patient thromboprophylaxis decision aid – ENSURE BLACK BOX COMPLETED

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

☐ Yes

☐ No

Does the patient have any of the following risk factors? Tick if apply

Active cancer or cancer treatment		Use of oestrogen containing contraceptive	
Age> 60		Hormone replacement therapy	
Dehydration		Pregnancy or <6 weeks post partum (seek specialist advice)	
Known thrombophillia		Critical care admission	
BMI >30		Varicose veins with phlebitis	
Personal/1st degree relative history of VTE		Current significant medical condition e.g. infection, inflammation, cardio resp disease	
Hip fracture			

- No thromboprophylaxis
- Reassess (every 72 hours minimum)and document
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)

☐ Yes

☐ No

Does the patient have any of the following contraindications? Tick if apply

Active bleeding		Untreated inherited bleeding disorder	
Acquired bleeding disorder		Thrombocytopaenia <75 x109/l	
Thyroid, spinal, posterior eye or neurosurgery		Other procedure with high bleeding risk (discuss with senior)	
Concurrent use of anticoagulants e.g. warfarin with INR>2		Uncontrolled hypertension (>230/120)	
Acute stroke		Varicose veins	
Recent (<4 hours) or expected (within 12 hours) lumbar puncture, epidural or spinal anaesthetic			
Other - Document			

- Discuss with senior clinical staff regarding thromboprophylaxis
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)
- Consider mechanical prophylaxis unless contraindicated
- Reassess (every 72 hours minimum)and document

☐ No

☐ Yes

Enoxaparin 40mg (reduce to 20mg if weighs < 50kg or eGFR <30)

- Reassess every 72 hours minimum
- Ensure patient informed (see information leaflet)

Patient informed ☐ Yes ☐ N/A
(only n/a if due to cognitive impairment or similar)
If N/A why? _____
Assessed by _____
Date _____

Patient ID label

Results

Date									
Time									
Parameter	Ref Range								
Hb	Male: 130-180 Female: 110-165								
WCC	4.0 - 11.0								
Plts	150 - 450								
MCV	80 - 100								
Neut	2.0 - 7.5								
PT	9.0 - 13.0								
APTT	27.0 - 38.0								
Fibrinogen	1.7 - 4.0								
INR	( )								
Thromb T	11-15 secs								
D-Dimer	0 - 250								
Na+	133 - 146								
K+	3.5 - 5.3								
Cl-	95 - 108								
HCO3-	22 - 29								
Urea	2.5 - 7.8								
Creat	40 - 130								
eGFR									
Glucose	3.5 - 6.0								
Protein	60 - 80								
Albumin	35 - 50								
AlkP	30 - 130								
Bil	<20								
ALT	<50								
AST	<40								
GGT	Male: <70 Female: <40								
ESR	Male: 1 -10 Female: 1 - 12								
CRP	<10								
Troponin hs I	Male: 0 - 34 Female 0 - 16								
CK	Male: 40 - 230 Female: 25 - 200								
Corr Ca++	2.20 - 2.60								
PO4-	0.8 - 1.5								
Mg++	0.70 - 1.00								
Alcohol									
Paracetamol	<100 @4 hr								
Salicylate									
AST	<40								
Amylase	<100								
LDH	170 - 380								
Folate									
B12	200 - 900								
Ferritin	Male: 20 - 300 Female: 15 - 200								
TSH	0.35 - 5.00								
Free T4	9.0 - 21.0								
Digoxin	0.5 – 2.0								

Patient ID label

Post Take Ward Round IAU/ARU

Consultant: _____ Date: _____ Time: _____

Summary

Temp:

Pulse:

BP:

SpO_2:

FIO2:

RR:

Diagnosis:

Plan:

Recommended Destination: _____

Suitable to board if required ☐ Yes ☐ No

Expected Date of Discharge: _____

Signature: _____

Designation: _____

Bleep Number: _____

Patient ID label

Continuation Sheet	
Date: Time	

Patient ID label

Continuation Sheet	
Date: Time	

Patient ID label

Continuation Sheet	
Date: Time	

Patient ID label

Continuation Sheet

Date: Time	

Patient ID label

Nursing Documentation

Done/ Time	

Once only prescriptions (inlcuding tetanus prophylaxis)

Date Given	Drug (Block Capitals)	Dose	Method of administration	Time of administration	Signature	Given by
1 hour before	ALFENTANIL	500mcg	IV	1330		
	KETAMINE	120mg	IV	1330		
	ROCURONIUM	80mg	IV	1330		

Discharge prescription packs

Date Given	Drug (Block Capitals)	Dose	Method of administration	Frequency	Signature	Given by

DISCHARGE CODES: Please Circle				Time Ready to Depart	
1. Admission	2. Discharge	3. Refer to G.P.	4. Transfer to other hospital (see below)		
5. Died	6. Refer to O.P. Clinic (see below)	7. Irregular Discharge	8. D.O.A.	Discharge Time	

Ward No. (If admitted)	Transfer to Hospital	Consultant (if admitted)

Outpatient clinic specialty						Admission or specialty clinic consultant		
Clinic Referred to	AE	OP DVT	DME Falls	TIA	Medical	Surgical	First Seizure	Others Specify

CHI	**2308896337**
Patient Name	**David Baillie**
Age (Admission)	**29 years**

NHS
Greater Glasgow and Clyde

Visiting Specialist Review

QEUH Critical Care Visiting Specialist Review (28-09-2018 14:55)

Visiting Specialist Review

If you have any questions about any of the information in this form, please contact the relevant Critical Care Unit:

QEUH ICU 1, Unit 3 - 0141 452(8)3038
QEUH ICU 2, Unit 4 - 0141 452(8)3048

CHI	2308896337
Patient Name	David Baillie
Age (Admission)	29 years

Relatives Communication Record

NHS Greater Glasgow and Clyde

QEUH Critical Care Relative Communication Record (28-09-2018 14:55)

Relatives Communication Record

Communication 1	Date: 27/09/2018 Persons Present: William Baillie (father), his partner & (sisters), 's husband) Spoken to by: CT2 Percival
Communication 1 Note	First formal communication with relatives. Presenting complaint and initial treatment discussed. At present we are unsure of cause of low GCS (drugs vs infection vs metabolic) but initial blood tests and CTB normal. Advised that lumbar puncture completed but some results will take a while to return. They confirm that patient has been known to take street Valium. Relatives spoke to him last night and said he sounded fine on the phone, and felt well. I advised current treatment is supportive, regular sedation breaks, await results of tests. We will extubate if neurologically appropriate. Advised if this is street Valium, we have seen a number of cases of prolonged neurological recovery with bizarre behaviour, but no specific treatment and we are keeping an open mind.

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