

**NHS Ayrshire and
Arran Medical
Records**

**Duncan John Henry
William Prowse
(1501900455)**

University Hospital Ayr
Dalmellington Road
Ayr

MMA Legal
Stok
43-59 Princes Street
Stockport
SK1 1RY

Date 18/05/2026
Our Ref CMcA1501900455
Your Ref 100884
Enquires to Charlene
Telephone 01292 616452

E-mail charlene.mcanally@aapct.scot.nhs.uk

Dear Sir/Madam

RE: Duncan John Henry William Prowse, 7 Park Crescent, Dalmellington, KA6 7RP

I refer to your recent request to myself regarding the above and enclose the relevant documents. I would be grateful if you could return the tear-off slip confirming receipt.

Yours faithfully,



Mr R H Bryden **PP**
Head of Health Records Services

Please return to: Charlene, Health Records, University Hospital Ayr, Dalmellington Road, Ayr, KA6 6DX

I acknowledge receipt of the copies of medical records pertaining to: Duncan John Henry William Prowse, 7 Park Crescent, Dalmellington, KA6 7RP 1501900455

Signed: -----

Date: -----

Designation: -----

To: HC.BROWN

University Hospital Ayr Emergency
Department
Dalmellington Road
Ayr
KA6 6DX
Tel: 01292 614578

DUTY CONSULTANT: DR ALI AL-SALIHI

PATIENT DETAILS

Patient Name Duncan Prowse
CHI Number 1501900455
DOB 15/01/1990
Address 7 PARK CRESCENT,DALMELLINGTON,AYR,,
KA6 7RP
Previous Attendances No Attendances in Last 12 months:1 Total Number of
Attendances:18

ATTENDANCE DETAILS

Arrival Date & Time 06/04/2026 22:49
Presenting Complaint Chest pain

Diagnosis

Treatment

Investigations

Additional Information

DISCHARGE DETAILS

Discharge Date & Time 07/04/2026 01:22

**Left Department Date &
Time**

Discharge, no follow up Not Known Patient
did not wait

Child Protection

**Adult Protection /Concern
Referral?**

Clinician Seen

Crosshouse Hospital
Emergency Department
Tel: 01563 577757 /
577758 Fax: 01563 572009

Emergency Department Discharge Letter

To: NOT KNOWN

Re: Duncan Prowse
24 MARGARET AVENUE, GALSTON,
KA4 8BZ
DOB: 15/01/1990
ED Attendance No: XH-19-052216-1
CHI No.: 1501900455

Attendance Details

Date of Attendance: 13/09/2019

Time of Attendance: 15:44:00

Presenting Complaint: Head inj

Duty Consultant: J Mardon

Additional Information: No Attendances in Last 12 months:4 Total Number of Attendances:17

Diagnosis Alcohol harmful use,,

Treatment Advice

Investigations

Discharge Information: Discharge, Usual place of residence no follow up

Additional Information

Further attendance after being found lying in public place. Admitted to further alcohol / cocaine / speed since discharge earlier today. No convincing evidence or hx of new head injury. Full ambulant and orientated. D/c.

Discharged by: Lisa Black, ED Consultant

Crosshouse Hospital
Emergency Department
Tel: 01563 577757 /
577758 Fax: 01563 572009

Emergency Department Discharge Letter

To: NOT KNOWN

Re: Duncan Prowse
24 MARGARET AVENUE, GALSTON,
KA4 8BZ
DOB: 15/01/1990
ED Attendance No: XH-19-052119-1
CHI No.: 1501900455

Attendance Details

Date of Attendance: 13/09/2019

Time of Attendance: 07:09:00

Presenting Complaint: Assault

Duty Consultant: L Brown

Additional Information: No Attendances in Last 12 months:3 Total Number of Attendances:16

Diagnosis Minor head injury,,

Treatment Advice

Investigations X-Ray,

Discharge Information: Discharge, Usual place of residence no follow up

Additional Information Fall with HI. Normal CTB/neck. Well after period of observation. Discharged with HI advice.

Discharged by: Kenneth Barclay, Spec Trainee Year 1

Confidential - Clinical Information

Clinical Decisions Unit
University Hospital Crosshouse
Kilmarnock Road
Kilmarnock
KA2 0BE
Switchboard 01563 521133
Fax 01563 827731
www.nhsaaa.net

Dr WS Nicoll
Galston Medical Practice
5A Henrietta Street
Galston
Ayrshire
KA4 8HW

Our Ref: JS/LR
Ref Date: 29/05/2014
Date Dictated: 29/05/2014
Date Typed: 03/06/2014
Enquiries to: Lorraine Ritchie
Direct Line: 01563 825056
Ext. Number: 25056
Email: Lorraine.Ritchie@aaaht.scot.nhs.uk

Dear Dr Nicoll,

DUNCAN PROWSE DOB: 15/01/1990 CHI No: 1501900455
1B KERR ROAD, KILMARNOCK, AYRSHIRE, KA3 7JH

DATE OF ADMISSION: 15/04/14
DATE OF DISCHARGE: 16/04/14
DIAGNOSIS: Headache with neck discomfort
Non specific chest pain
Drug abuse (cannabis)

Your patient was admitted, he gave a history of headache and lethargy which had been present over the previous week and the day prior to admission he had an episode of tight left sided chest pain. There was nothing from the clinical history to suggest an ischaemic cardiac cause for the pain. He smokes 10 cigarettes a day and regularly uses cannabis, in the past he has used cocaine and "moonshine."

He was admitted overnight and observed. He had no further episodes of chest pain and there was no abnormality on examination. His headache and neck discomfort settled. ECG showed no abnormality. Chest x-ray showed no abnormality. Troponin was negative.

He has been discharged with advice to stop smoking and stop using cannabis. No arrangements have been made for review in the Emergency Department.

Yours sincerely

This document has NOT been verified

Mr J Stevenson FRCS, DA(UK), FCEM, FACEM
Consultant in Emergency Medicine
GMC: 2821812

G.P.

* PLEASE PRINT HEAVILY
USING BALL POINT PEN

Write or attach label

HCR No:



CHI: 1501900455

Surrogate: Prouse, Duncan

Fore 1b Kerr Road

Add: Ki Imarnock

KA3 7JH

..... 15/01/1990

Date Dr WS Nicoll

Service MRN: 1501900455

Ward: CSD

Consultant: STEVENSON

Date of Admission: 15.04.14

Date of Discharge: 16.01.11

(or date of death)

Clinic Appointment:

Service MRN: 1501900455 _____ times week ☐ Meals on wheels ☐ District Nurse ☐ Other
Discharged to: ☐ Home ☐ Stay with relatives ☐ Other hospital ☐ Nursing home ☐ Other ☐ Died

Discharge Diagnosis (if admitted due to an injury, include place of accident & site of injury)

¹ chest pain - troponin < 0.03.

2. probable viral illness

1

4

1

If multiple Day Case admission, list dates of admission

Operations / Procedures

1. exl- nei focal

2 ECG. NSR

3. $\text{TRON} < 0.03$

4

Discharge Medication (7 days supply will be dispensed unless otherwise stated by doctor)

For Pharmacy use

Drug Name and formulation	Dose	Frequency	Route	Duration (cont/stop)	Quantity and strength	Notes
No charges to Neuroch.						
				pharmacy date	dispensed by	checked by

Additional Information (e.g. awaiting histology or other results, patients progress)

advised to stop smoking cigarettes & cannabis

A finished consultant episode letter will follow.

Signature Kenn G.

PRINT NAME Karen Higgins Date 16/04/2014

N.B. DISCHARGE MEDICATION IS FOR INFORMATION ONLY. FAXED COPY HAS NOT BEEN CHECKED BY DOCTOR. ON RECEIPT OF HARD COPY, FAXED COPY CAN BE DESTROYED.

Ward Clerkess : _____ / Dictated : _____ / Typed : _____ / Signed : _____ / Mailed : _____

**CROSSHOUSE HOSPITAL
EMERGENCY DEPARTMENT**

0125



Obs 2

A/E No:
XH-14-021937-1

CHI No: 1501900455

Date: 15 Apr 2014 Time: 22:25

Consultant:
Mr JAMES STEVENSON

**PROWSE
Duncan**

GP
**Dr. GILLIAN GC COLLISTER
GALSTON MEDICAL PRACTICE
5A HENRIETTA STREET
GALSTON
KA4 8JW**

Incident Date:
15 Apr 2014

Incident Time:
22:25

Marital Status:
Single

Date of Birth: 15 Jan 1990 Age: 24 Years

Sex:
M

Address:
**1B KERR ROAD
KILMARNOCK**

Next of Kin:
**1B KERR ROAD
KILMARNOCK
KA3 7JH**

Ethnicity **Scottish**

Religion **No Religion**

Attendances in last 12mths
2

KA3 7JH

Total Attendances Count
10

Phone Numbers:
Mobile: 07826509513

Accompanied By:
Unaccompanied

Special case

Employer/School
braehead foods Not at School

Triage Time **22:35**

Triage Nurse **Jennifer Frankland**

Triage Group **Orange**

Resp Rate 13 02 Sat% 100 PFR

Pulse 62 BP 138 /75 E 4 M 6 V 5

Triage details
patient complaining of neck pain and headaches for last 2 weeks and chest pain for last few days

Allergies: **No Known Allergy, Not Known**

Treatment
ECG

BMstix 4.3 Alcohol Temp 36.2 Weight

Special Needs
NONE

Visual Acuity R L Pain Score (Triage) 7 Pain Score (Discharge)

Re-assess in 15 30 60 minutes

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed.....Witness.....Witness.....

I give consent for details of my injury to be given to the Police.

Signed.....



Disch A+E clinic Paed Tr. # eye ENT Max Facial Ward OP Ward IP

Drug	Dose	route	time/frequency	signature	quantity/given by

PVC1	Size/Colour	Location	Initials	PVC2	Size/Colour	Location	Initials

	Device	Flow Rate l/min	%O2 for Venturi	Target SpO2	Prescribed by	Started by	Stopped by
Oxygen							
Changed to							

DOCTOR / ENP:

MAMUKH7

Time: 23-11

→ CDU Chest pain problems

Café navel

VITAL SIGNS

Cap refill (secs) <2 secs
 Blood sugar mmol/l 3/10
 Peak flow % 35.3
 Temp °C 100
 SpO2 % 15
 NEWS 1
 GCS Total 7.6
 ECG NSR
 RTs
 BP mm Hg 131 / 90
 Resp. rpm 18
 Pulse rhythm Reg
 Pulse bpm 70

SEPSIS

sis: Pneumonia
 sis: UTI
 sis: Other infection
 sis: Abdo pain
 sis: Diarrhoea
 sis: Abdo distension
 sis: Meningitis
 sis: Cellulitis
 sis: Septic arthritis
 sis: Wound infection
 sis: cted indwelling
 ce.

EYES AND PUPIL SIZE AND REACTION

Left Normal
 Right Normal
 il size Normal
 il reaction Normal

AMPLE

rgies
 er allergies
 lication
 t history
 : eaten
 PENICILLIN, CODENE
 NIL
 ASTHMA (AS A CHILD).
 >5 hrs
 999 CALL TO A 24 YOM SUFFERING FROM PAINS IN HIS HEAD AND NECK, TOLD CREW HE HAS FELT UNWELL FOR APPROX 1 WEEK AND LAST NIGHT HE DEVELOPED CHEST PAIN AT APPROX 1600 HRS THIS PAIN LASTEST UNTIL APPROX 0200HRS THIS MORNING, WHEN HE WOKE AT APPROX 0930HRS HE WAS EXPERIENCING PAIN IN IS HE AND NECK AND THIS HAS LASTED ALL DAY, PTS FRIEND CALL 999 BECAUSE WAS WORRIED ABOUT THE PT, O/E ALL PT OBS WERE WITHIN NORMAL PARMETERS HOWEVER WHEN CREW PERFORMED A 12 LEAD ECG IT RCOERD ACUTE PERICARDITIS/ST ELEVATION, CREW SET BOTH ECGS TO HAIRMYRES, HAIRMYRES HAPPY FOR CREW TO TAKE PT TO CROSSHOUSE A/E

EMERGENCY SERVICES ON SCENE

amedic
 arrival at scene
 ne removal
 nsportation
 e delivery at hospital
 ort ID
 Technician
 Seated
 Walking
 Seated
 Chair
 e525a458-32f3-42d6-b91e-58d21afe0e60

PATIENT HANDOVER

E-Pacer PATIENT REPORT

Time 22:16 Date 15/04/2014

PATIENT AND INCIDENT DETAILS

Incident number CR000245314.001
 Name DUNCAN BROWSE
 Address C/O 23C FULLARTON STREET, KILMARNOCK
 Age 23 year(s)
 Date of birth 15/01/1990
 Gender Male
 Incident location 1B KERR ROAD KILMARNOCK
 Incident post code KA3 7JH
 Incident type EMG
 Call received 15/04/2014, 21:25
 Call passed 15/04/2014, 21:25
 Crew mobile 15/04/2014, 21:27
 Crew at scene 15/04/2014, 21:32

PRIMARY SURVEY

RESPONSE

AVPU Alert

AIRWAY

Airway assessment Clear

BREATHING

Breathing rate Normal

Re atory rate

CIRCULATION

Pulse rate Normal

Most peripheral pulse Radial

Cap refill rate

Skin colour

Skin texture

Normal

Dry

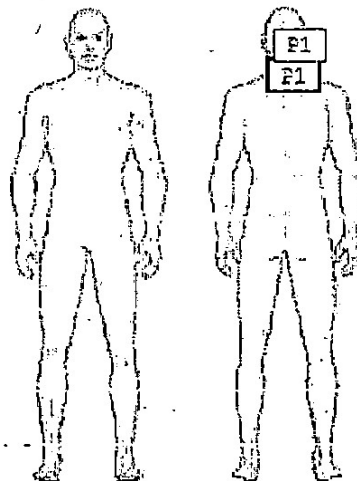
C-SPINE INJURY

No evidence of C-spine injury

PATIENT CONSENT

Treatment benefits explained, Risks of condition explained, Risk of refusal explained, Capacity to understand risks and treatment, Advice given to patient

INJURIES



PAIN
 P1. No pain relief provided
 P2.
 P3.
 P4.

AMPDS

Dispatch code 18C01
 Final code 32B01
 Headache and Not Alert
 Unknown Problem, Standing, sitting, moving or talking

GCS

Final GCS eye opening Spontaneous
 Final GCS verbal response Orientated
 Final GCS motor response Obeys commands



CHI Number: 1501900455



Accident & Emergency Nursing Documentation Form

SITUATION

PROWSE Duncan
1B KERR ROAD
KILMARNOCK
KA3 7JH

Date: 15 Apr 2014
Time: 22:25

DOB: 15/01/1990

Additional information for admission
complaint:
patient complaining of neck pain and
headaches for last 2 weeks and chest pain
for last few days

Receiving Nurse(s):

J. Frankland

BACKGROUND

Relevant PMH relating to presenting complaint:

Childhood Asthma

Allergies:

Penicillin 760mg

Warfarin: yes/no/unknown

Insulin: yes/no/unknown

Next of Kin details: (if difference from A&E Card)

Name:

Relationship:

Address:

Telephone no: (if diff from above)

With patient: Yes/No

To be contacted?

If yes-time contacted

If no - reason

Consent to displaying personal info: Yes No

ASSESSMENT

MEWS/PAWS score:

GCS:

Name band in-situ:

Y/N

Own medications

Y/N

Belongings taken for
safe-keeping:

Y/N

O2 therapy: yes/no

Amount:

Cognitive Impairment: Yes No

Any medications given by paramedics

XH-14-021937-1

Treatment plan/Nursing Notes:

Transferring Nurse Signature: _____ Receiving Nurse _____

Time of transfer: _____ Relatives aware yes/no

Clinical Decisions Unit (CDU)- Admission Proforma
Non- Traumatic Chest PainP
XH-14-021937-1

DOB: 15/01/1990

Male

PROWSE Duncan

18 KERR ROAD, KILMARNOCK
KA3 7JH

Date:

05/4/14

Time:

23-11

Admitting Doctor:

McNASTY

Receiving Consultant:

STEWARTSON

Presenting Complaint

Main presenting complaint is a crushing chest pain "like somebody giving you a bear hug". Associated with shortness of breath. Worst episode $\approx$ 1300 hrs today. Says it prevents him from walking. Also general malaise for several weeks - feeling very light-headed.

Time of onset-

Duration of chest pain-

History of pain (circle and insert score)

Time of onset:	Duration			Pain score	
Symptom / score	3	2	1	-1	G score
Site of pain	Substernal	Precordial	Neck, jaw, epigastrium	Apical	
Radiation		either arm	Shoulder, jaw, neck, back		
Character of pain	Crushing pressing squeezing	Heavy, tight		Stabbing catching	
Severity of pain		severe	moderate		
Influenced by			GTN	Breathing body position	
Exertional angina		yes			
Vomiting or nausea		yes			
SoB		yes			
Sweating		yes			
				Total G score	10
Other pain details Aggravation Relieving Intermittent increasing					

XH-14-021937-1

aph

DOB: 15/01/1990

Male

PROWSE Duncan

1B KERR ROAD, KILMARNOCK
KA3 7JH**Previous Medical History**

No other specific health problems

Known to have IHD- Yes/No

	Brief details	
Family history*		Y/N
Smoker – cigs/day	Very 10-20/day. Also smokes cannabis	(Y)N
Hypertension		Y/(N)
Exercise taken		(Y)/N
High Cholesterol		Y/(N)
Heavy Drinker		Y/(N)
Diabetes		Y/(N)
BMI > 30		Y/(N)
Total risk factors		1

Clinical Assessment/ Systemic Enquiry/ Examination

Tell this young man.

HR 62 reg

RS 1+2 +0

BP 136/75

oedema.

 Chest - PN normal & clear.
 AE normal & clear
 BS. Veni to

All alt. on limbs

PRL

Speech normal.

Normal power in limbs.

 ECG - SA.
 - high take-off

DOB: 15/01/1990

Male

PROWSE Duncan
18 KERR ROAD, KILMARNOCK
KA3 7JH



NHS Ayrshire and Arran – Crosshouse Hospital

Clinical Decisions Unit – Discharge Sheet

Please document the patient's journey here:

Admitted to Ward(state ward)

CDU

Discharged home

16/4/14

Reason for admission

CHEST PAIN

Date/Time discharged

16/4/14 11am

Time left CDU

Out-patient clinic
(specify)

NIL.

If patient is discharged please complete the following checklist BEFORE discharge:

MOBILITY INDEPENDANT	PERSONAL CLEANSING AND DRESSING INDEPENDANT.
-------------------------	---

EATING AND DRINKING NORMAL	SOCIAL SERVICE (Does care package require to be recommended) NURSING HOME —
-------------------------------	--

DISTRICT NURSE —	TRANSPORT Family
---------------------	---------------------

DISCHARGE PRESCRIPTION Date & Time written..... Date & Time available.....	Patient counselled on present and new medicines YES ☐ NO ☒ Signature <i>ne j.</i>
--	---

OUT PATIENT ARRANGEMENTS MADE Nil Required.	DISCHARGE ADVICE given.
COMMUNICATION WITH GP IMMEDIATE DISCHARGE LETTER Given	PATIENT INFORMATION LEAFLET ☐ awaiting ETT ☒ no ETT ☐ Negative ETT

Discharging Nurse Signature *M. J.* Print Name *M. Taylor*

Date/ Time *16/4/14*

XH-14-021937-1

DOB: 15/01/1990

Male

PROWSE Duncan
18 KERR ROAD, KILMARNOCK
KA3 7JH



Free text page (for use by all staff in CDU)

Date/Time	Comments/ Notes	Signature
	<i>Admission</i>	
	<i>1st rx taken N/A</i>	
	<i>ECG, re nitrate</i>	
	<i>OK 2 N/A</i>	
	<i>Examine Bp/HR/r (10/15) handover/review his report</i>	
	<i>Don't specify hand over report</i>	
	<i>Will do present.</i>	
	<i>→ Home advise stop smoking / carry drugs</i>	
		<i>De</i>
16/4/14	Note review by Mr Stevenson. For discharge	
1030	home. Advice given re smoking cessation.	
	Letter sent to GP	
1100	Patient now discharged	<i>ls</i>

Patient's name/addressograph

CHI: 1501900455
Prowse, Duncan
1b Kerr Road
Kilmarnock
KA3 7JH
15/01/1990
Dr MS Nicoll
MRN: 1501900455

[illegible]



Free text page (for use by all staff in CDU)

Date/Time	Comments/Notes	Signature
16/4/14 00:30	Patient admitted to CDU on chest pain pathway (via A&E) "crushing" pain at 1pm yesterday, although has felt lightheaded for 2/52. Pain free on admission, repeat ECG (1hr) = nil acute although bradycardic at 52 bpm. G score 10, risk factors x1. for 12hr troponin and ECG at 01-00. Mews ①. on Crawford	
07:25	12hr ECG taken and bloods taken for troponin at 01-00, troponin <0-03, ECG - normal but p 47. Settled and appeared to sleep for long periods. Complaining of slight head ache and neck pain this morning. 1g paracetamol given as prescribed. Mews ① as bradycardic. GCS 15/15 PERL, normal power all 4 limbs. No chest pain since admission. SNCR Crawford	
16/04/14 09:09	MEDICATION HISTORY CHECKED - PATIENT NOT ON ANY REGULAR MEDS. ALLERGIC TO PENICILLIN (SICK) AND CODEINE (SCRE HEAD).	SN Wallace PHARM DCT pg 3083

Criteria for Discharge	☐ Cardiac markers normal (Troponin < 0.03) after onset of pain ☐ ETT as per protocol (G- score of ≥ 11 or 3+ risk factors) ☐ No changes in ECG's ☐ Painfree ☐ Follow up arranged if required ☐ Patient advised of diagnosis and treatment plan ☐ Social circumstances permit discharge ☐ Letter to G.P.
Criteria for admission to CCU (at any time)	☐ Troponin > 0.03 and/or ☐ ECG changes and/or ☐ Recurrent pain
Criteria for admission to 4E	☐ No ECG changes ☐ Painfree

Consider appropriate Risk Assessment for individual patients.

Multidisciplinary Medicines Reconciliation Form
Must be started by admitting Clinician within 24 hours

Source of Information (Use at least two sources) (Tick)

Patient
 Relative/Carer
 Patient's Own Drugs
 GP Referral Letter
 GP Practice

☒	Emergency Care Summary	
☐	Nursing Home Chart	
☐	Previous Discharge Letter	
☐	Repeat Prescription slip	
☐	Other (Please state)	

XH-14-021937-1

DOB: 15/01/1990

Maleë

PROWSE, Duncan
1B KERR ROAD, KILMARNOCK
KA3 7JH

[illegible]

2/ Herbal/homeopathic/illicit substances	Further information eg compliance aid, recent discontinued medicines
--	--

Adverse Reactions/Allergies
None Known ☐

Medicine/ Substance	Reaction
PENICILLIN	SICK
CODEINE	SORE HEAD.

Are you satisfied this medication history is complete and accurate? Yes ☒ No ☐

If **No** what further action is necessary (Contact GP etc)

Tick when resolved

Wallace
Hire in DOT
pg 3085.

Management protocol for chest pain

Clinical assessment
History Examination ECG Chest X-ray

Category 1
Cardiac Pain
ECG - Stemi

Use STEMI protocol

ADMIT CCU(4F)

Category 2

- Persisting cardiac pain
- ST depression(>1mm) or dynamic ECG changes
- Cardiac Failure
- SBP<100
- Significant Arrhythmia

Treat as high risk Acute Coronary Syndrome

Category 3

Chest pain:

- Low risk ACS
- Single episode of possible ischaemic chest pain

Exclusion Criteria

- ☐ Significant Co-morbidity
- ☐ Discharge predicted > 24 hours

YES

ADMIT AMAU

NO

ADMIT CDU

Category 4

- Likely alternative diagnosis
- Known stable angina with no unstable features i.e. not increasing in frequency or duration

DISCHARGE advice with appropriate G.P follow-up or **TREAT APPROPRIATELY**

TnT >0.03
and/or
ECG changes
and/or
Recurrent pain

Management

- ☐ Troponin – 12 hours after the onset of pain
- ☐ ECG – 1 hour from ECG in A&E
- ☐ ECG - 12 hours from ECG in A&E
- ☐ ECG if recurrent or ongoing pain
- ☐ FBC, U's & E's, Glucose, Lipids, Cholesterol
- ☐ Appropriate pain relief
- ☐ Cannulation

No new ECG changes
and/or
Painfree

ADMIT 4E
Under diabetes/
cardiology

Dynamic ECG changes- STEMI- follow Optimal Reperfusion Instructions. Discuss further management with Hairmyers/ Golden Jubilee- transfer within 6 hours.

- ☐ Aspirin 300mgs ☐ Clopidogrel 300mgs ☐ LMWH (ACS dose)
- ☐ Oxygen (where appropriate) ☐ GTN (where appropriate)
- ☐ Morphine

Trit-ve

- ☐ Diabetes
- ☐ Previous CABG
- ☐ Geleijnse score ≥ 2
- ☐ New onset angina duration > 20 mins
- ☐ Known angina increasing in frequency
- ☐ >2 Coronary Risk Factors

YES

In pt. ETT

NO

Op ETT

In pt ETT

+ve - Copy of discharge letter must be sent to cardiologists
-ve - Discharge to GP

Op ETT

Copy to be sent to cardiologists

Pt not suitable for ETT

Copy of discharge letter to cardiologists

Patient label

DOB: 15/01/1990

Male

PROWSE Duncan
1B KERR ROAD, KILMARNOCK
KA3 7JH



Clinical Decisions Unit (CDU)
Non- Traumatic Chest Pain

Date: 16-4-14.

Time: 00.05

Next of Kin: KELLY PROWSE Relationship: SISTER Contact No: 07748351389
Patient contact details: 1E 23C FULLARTON ST KILMARNOCK

Patient consent to display limited information about care: YES

Date: 16/4/14

Patient responsible for own valuables: YES

Date: 16/4/14.

Summary of Results

	Time	Result	Signature
ECG in ED			
CXR			
ECG 1 hour after ECG in ED or if pain ongoing or returns	00.23	nil Acute SIB ATE or	Scrawford
U+E's	01.50	within normal parameters	
FBC		MCHC 353 - HF EOSINOPHILS. 0 - LO rest of FBC within normal parameters	Scrawford
Blood Glucose and Lipids		cholesterol 3.7 HDL CHOLESTEROL 1.75 HZ TRIGLYCERIDE 0.61 LO GLUCOSE 4.8	Scrawford
ECG if recurrent pain			
ECG 12 hours after ECG in A&E or if pain ongoing or returns)	01.15	Normal	Mawer
Troponin 12 hours from onset of pain	08.20	< 0.03	My
D-dimer (if reqd)			
ASSIGN risk stratification		N/A in pts < 25 yrs old → doesn't calculate score	A

XH-14-021937-1

DOB: 15/01/1990

Male

PROWSE Duncan
18 KERR ROAD, KILMARNOCK
KA3 7JH

**Clinical Impression/ Management Plan**

Venepuncture- FBC ☒ U+Es ☒ Glucose ☒ Lipids ☒ Admission Troponin (if pain > 12h ago) ☐

Chest XRay- ☒ No

Admission Troponin T- Yes/ ☒ No

12 hour Troponin T (12 hours from onset) due- 01-06

Call. normal

Name:

MWADH

Signature:

Date/ Time:

15/01/14 23-40

Disposal

STEMI	Follow STEMI pathway	PCI / 4F
Persisting cardiac pain OR arrhythmia OR heart failure or SBP < 100 or / ST depression / other dynamic ECG change	Treat as high risk ACS	4F
Low risk chest pain not suitable for CDU (co-morbidity, can't discharge in < 24 hours, known IHD with follow up 2+ times a year, recent abnormal cardiac test)	Treat as appropriate	3E
Pain resolved, low risk ACS: Single episode > 20 mins. 3 episodes cardiac pain > 3 mins in last 3 days.	Low risk acute ACS	CDU Discuss with senior
Non cardiac pain	Treat as appropriate	Discharge

**CROSSHOUSE HOSPITAL
EMERGENCY DEPARTMENT**



A/E No:
XH-19-042947-1

CHI No: 1501900455

Date: 29 Jul 2019 Time: 17:58

Consultant:
Dr Craig McRoberts

**PROWSE
Duncan**

GP
**Dr. NOT KNOWN
73 LOUDOUN ROAD
NEWMILNS
AYRSHIRE
KA16 9HQ**

Incident Date:
29 Jul 2019
Incident Time:
17:58

Marital Status:
Single

Date of Birth: 15 Jan 1990 Age: 29 Years

Sex:
M

Address:
**24 MARGARET AVENUE
GALSTON**

Next of Kin:
Prowse

Ethnicity **White Scottish**

Sister

Religion **No Religion**

Attendances in last 12mths
0

KA4 8BZ

Total Attendances Count
13

Phone Numbers:
Mobile: 07907004965

Accompanied By:
Relative, Son

Special case

Employer/School
braehead foods Not at School

Triage Time 18:56 Triage Nurse Catherine Cleary Triage Group Yellow

Resp Rate 02 Sat% PFR

Triage details
left dept not at triage when called on 3 attempts

Pulse BP E M V

Allergies: **No Known Allergy, Not Known**

Treatment
NONE
Clinical Frailty Score:
Special Needs
NONE

BMstix Alcohol Temp Weight

Visual Acuity
R L Pain Score (Triage) 10
Pain Score (Discharge)

Re-assess in 15 30 60 minutes

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed.....Witness.....Witness.....

I give consent for details of my injury to be given to the Police.

Signed.....



Disch A+E clinic Paed Tr. # eye ENT Max Facial Ward OP Ward IP

Drug		Dose	route	time/frequency	signature	quantity/given by	

PVC1	Size/Colour	Location	Initials	PVC2	Size/Colour	Location	Initials

	Device	Flow Rate l/min	%O ₂ for Venturi	Target SpO ₂	Prescribed by	Started by	Stopped by
Oxygen							
Changed to							

[illegible]



Ayrshire
& Arran

CAU Referral Information

Date: 13/9/19 Time call taken: 0925

Name call handler:



PROWSE Duncan

24 MARGARET AVENUE, GALSTON

KA4 8BZ

DOB: 15/01/1990



Referral source:

ED to: Acute Med/ED Ambulatory pathway ED Time of arrival: 07 09

GP Letter with patient/mailbox/fax from Home/NH

Other please state: Ambulance Y/N

Reason for referral:

Head injury - observation

CT head ruled ✓

Home from
ATE

Observations NEWS= or [RR SpO2 Sup' O2 Temp HR BP AVPU]

CLINICAL ALERT PRESENT

RED FLAG

FRAILTY SCORE

Delirium Y/N

Planned destination: ACU

Specific actions required on arrival:

Newsobs

Time of arrival IAA: NEWS= Immediate review required Y/N THINK SEPSIS 6

Scottish Structured Response for ALL patients with NEWS $\geq$ 5 single Red score or clinical concern

Complete on reverse

4AT= Mental Health Risk Assessment (if required)=

Comments:

Time referral to stroke team (if applicable):

Does patient have conditions that require medications pending medical review? Y/N

(Myasthenia Gravis Parkinson's disease Insulin dependent diabetes Seizures Steroid dependency/Addisons)

Review clinical alert printouts if present

Next of Kin:

Power of Attorney:

PVC - think DRIFT (Diagnostics, Resuscitation, IV medication, Fluids, Transfusion)

	Required	Performed		Required	Performed
U&Es			ABG		
FBC			LFTs		
Glucose			TnT		
Coag			ECG		
Lactate			CXR		
CRP			Urine		
VBG			Other tests		
Blood Cultures					

Brief clinical summary of review or events in IAA:

Scottish Structured Response Tool

Complete for ALL NEWS ≥ 5 , single red score or clinical concern

- Nursing Response to Deteriorating Patient -		Could deterioration be due to infection/sepsis? If YES commence Sepsis 6 Dual Response					
Date:	Ward:	SN:	Any Life Threatening Emergency Immediately Dial 2222	GIVE Complete within 1 hour	TIME	TAKE	TIME
Time of NEWS Trigger	TIME			Oxygen to achieve Sats $> 94-98\%$ 88-92% for hypercapnic patients		Blood Cultures	
Informed Nurse in Charge	TIME			IV Fluid		Measure Lactate	
Escalate as per NEWS	FY2 ☐ ANP ☐ Middle Grade Dr ☐ Consultant ☐			Antibiotics		Accurate Fluid Balance	
Frequency of NEWS	TIME						
ABCDE Assessment Intervention commenced if required (ie Oxygen)	TIME			Reason for non-compliance			
Manual Vital Signs	TIME			Sepsis not likely ☐ Unable to establish IV access ☐ Other ☐			
Blood Glucose (All Patients)	TIME						
DR/ ANP Response to Deteriorating Patient							
Time of First Assessment	TIME	If delayed, provide succinct rationale:					
Escalation of Care							
Full Escalation (including ICU) ☐ HDU ☐ CCU ☐ WARD ☐ Unclear ☐							
Management Plan documented in Notes	☐			For CPR ☐	DNACPR ☐	Form complete ☐	Discussed with Patient/ Family ☐
Date:	Time:	Signature:					
Please ensure robust documentation in medical notes							

Incident Number: CR00866564

Patient Information

DUNCAN PROWSE

Age/Gender: 29 years 7 months 29 days Old Male

Address: NO FIXED ABODE

DOB: 15/01/1990

CH:

Ethnicity:

Date: 13/09/2019

Incident Number: CR005856564

Incident Type: **EMG**

Incident Location: OS ON THE ROAD
DUBLIN ROAD DARVEL,
KA17 0EG



**Scottish
Ambulance
Service**
Hampden House

Presenting Complaint

2 HEAD INJURY

Additional Comments

999 CALL FOR A 29 YOM ? ASSAULT. FOUND LYING IN MIDDLE OF ROAD BY A PASSING CAR UNKNOWN HOW LONG PT HAS BEEN LYING IN ROAD. O/A PT LYING ON SIDE OF ROAD COMPLAINING OF HEAD AND LEFT HIP PAIN. O/E HAS A HÆMATOMA TO BACK OF HEAD LEFT SIDE ALSO LEFT HIP PAIN. INFORMED CREW THAT HE HAD A BLEED ON THE BRAIN LAST NOVEMBER ABOVE LEFT EYE. ALSO SAYS HE HAS HAD 2 LINES OF COCAINE LAST NIGHT SAYS HE WAS HIT WITH BASEBALL BATS.

PATIENT ASSESSMENT

AVPU		Alert		<C>		No									
A		Clear													
B		Normal Air Entry				UL Normal Air Entry ML Normal Air Entry LL Normal Air Entry									
		Normal Air Entry													
		Normal Air Entry													
C		Pulse Rate		BP		Cap Refill									
81		114/75		<2 Secs		Sinus Rhythm									
Rhythm		Arm		Central/Peripheral		ECG									
Reg		Left		Central		3 Lead									
D		GCS		Eyes		Voice									
15		Spontaneously (4)		Orientated (5)		Obeys Commands (6)									
		Motor		PEARL		Yes									
E				Wounds		Treatments									
		ID		Body Part		Wounds									
		W1		Back Head		Haematoma									
		Pain		Pain Scale		None									
		ID		Body Part		Pain Scale									
		P1		Right Upper Leg		6									
Observations															
Time	P	RR	BP	SpO2	CR	GCS	AVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
06:15	87	16	105/64	100	<=2s	15	Alert		35.2	4.0					E001297
08:00	76	18	113/72	100	<=2s	15	Alert		35.2	4.0	Sinus Rhythm				E001297
05:50	81	18	114/75	100	<=2 Secs	15	Alert		35.2	4.0	Sinus Rhythm	6	8		E001297
NEWS															
Time	Clinical Risk														NEWS

9/13/2019

Incident Number: CRTD635664

06:15 LOW Immediate Clinical Risk. Treat as per Clinical Practice Guidelines including considering the use of alternative pathways (if appropriate and available)

06:00	LOW Immediate Clinical Risk. Treat as per Clinical Practice Guidelines including considering the use of alternative pathways (if appropriate and available).	1
05:50	LOW Immediate Clinical Risk. Treat as per Clinical Practice Guidelines including considering the use of alternative pathways (if appropriate and available).	1

HISTORY

AMPLE

Allergies	None
Medication	MIRTAZAPINE,GABAPENTIN,VENTOLIN
Past Medical History	Asthma, ANXIETY,DEPRESSION,SUCIDAL THOUGHTS
Last Eaten	>4 Hours Ago
Events Prior	? ASSAULTED WITH BASEBALL BATS

Social History

Lives alone	Don't Know	Patient Occupation	Does Not Work
Patient's General Appearance	Normal		
Living Arrangement	Homeless		
Patient Mobility	Fully Mobile		
Patient Communication	No Help Required		
Patient Clinical Risk Factors	Alcohol, Recreational Substances		
Patient Environmental Risk Factors	None Identified		

Safeguarding

Safeguarding Assessment	Adult >= 16
-------------------------	-------------

OTHER

Additional Resources (On Scene)

Police

CLOSE RECORD

Treatment On Scene	Non Emergency
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Conveyance

Transport To Hospital	Normal driving	Pre Alert	No
-----------------------	----------------	-----------	----

INCIDENT LOG

Time Call Received	05:20	Allocated	05:21	Mobile	05:24
First Resource On Scene		Crew On Scene	05:44	Crew Left Scene	06:23
Crew At Hosp		Receiving Hospital	CROSSHOUSE HOSPITAL	Clear Time	
Crew ID	E101336X	Crew Grade	Ambulance Technician	Driver	YES
	E0012971		Paramedic		NO

Room 1

**CROSSHOUSE HOSPITAL
EMERGENCY DEPARTMENT**



A/E No:
XH-19-052119-1

CHI No: 1501900455

Date: 13 Sep 2019 Time: 07:09

Consultant:
Lesley Brown

GP
**Dr. NOT KNOWN
73 LOUDOUN ROAD
NEWMILNS
AYRSHIRE
KA16 9HQ**

Incident Date:
13 Sep 2019
Incident Time:
07:09

Marital Status:
Single

Sex:
M

Ethnicity **White Scottish**

Religion **No Religion**

Attendances in last 12mths
2

Total Attendances Count
15

PROWSE

Duncan

Date of Birth: 15 Jan 1990 Age: 29 Years

Address:
**24 MARGARET AVENUE
GALSTON**

KA4 8BZ

Phone Numbers:
Mobile: 07907004965

Employer/School
braehead foods Not at School

Next of Kin:
Prowse

Sister

Accompanied By:
Unaccompanied

Special case

Triage Time 07:18

Triage Nurse Catherine Martin

Triage Group Yellow

Resp Rate 17 02 Sat% 99 PFR

Pulse 83 BP 104 / 81 E 4 M 6 V 4

Allergies: **No Known Allergy, Not Known**

BMstix Alcohol Temp 35.9 Weight

Visual Acuity
R L

Pain Score (Triage) 4
Pain Score (Discharge)

Triage details

biba: ?assaulted in street, haematoma to back of head intoxicated

Treatment

NONE

Clinical Frailty Score:

Special Needs

NONE

Re-assess in 15 30 60 minutes

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed..... Witness.....

I give consent for details of my injury to be given to the Police.

Signed.....



* 1 5 0 1 9 0 0 4 5 5

Disch A+E clinic Paed Tr. # eye ENT Max Facial Ward OP Ward IP

[illegible]

Head Injury Over 5s / Adults


PROWSE Duncan
 24 MARGARET AVENUE, GALSTON
 KA4 8BZ
 DOB: 15/01/1990




Date, Time Of Injury: 13/09/19

Clinician: Murphy Time now: 09:00

Fall	<u><1m</u>	>1m		
RTA	Driver	Front passenger	Rear passenger	Pedestrian
Cyclist	Fell off bike	Knocked off bike		
Assault	<u>Blunt weapon</u>	Sharp weapon	Fists / feet	

Mechanism details and preventative measures (seat belt, helmet etc)

Unclear Mx. Patient been taking cocaine
Found lying on street w/ wounds scalp
No other injuries visible

	No	Yes		Symptoms and other details
Severe persisting headache	No		Yes	
Vomiting	No	<2	2 or more	
Age <16 + loss of consciousness	No	<5 min	>5 min	
Amnesia	No	<30 mins	>30 mins	
Seizure after injury	No		yes	

On anticoagulant?	Warfarin	Clopidogrel	Aspirin	other	<u>NO</u>
illicit drugs?	<u>Cocaine</u>				
Medication list (or print ECS)					

Past history relevant to this attendance / admission

CVS	Y / N	details
Resp	Y / N	
GI	Y / N	
GU	Y / N	
CNS / stroke	Y / N	
Diabetes	Y / N	
Renal	Y / N	
Prev falls	Y / N	
Dementia	Y / N	
Epilepsy	Y / N	
Coagulopathy	Y / N	
Other	Y / N	

Social circumstances:

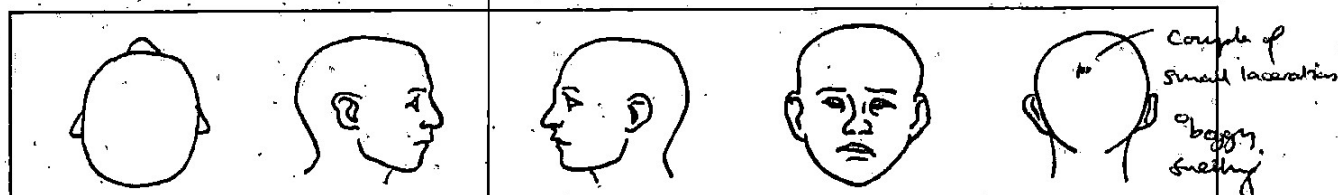
Lives alone? ☒

Any indication of NAI in children / elder abuse Y / N (if Yes discuss with senior and record outcome)

Examination

E	3	<table border="1"> <tr> <td>Size</td> <td>reacting</td> </tr> <tr> <td>Right pupil</td> <td>✓</td> </tr> <tr> <td>left pupil</td> <td>✓</td> </tr> </table>	Size	reacting	Right pupil	✓	left pupil	✓	Temp		Smell of alcohol	Y/N
Size	reacting											
Right pupil	✓											
left pupil	✓											
M	6	BMstix		Breath alcohol	Y/N							
V	4			Speech slurred	Y/N							
GCS	14			Co-operative	Y/N							
				Steady on feet	Y/N							

R Ear	Haemotympanum / Perf and blood in ear / CSF leak / blood from external wound / <u>normal</u>
L Ear	Haemotympanum / Perf and blood in ear / CSF leak / blood from external wound / <u>normal</u>
Fracture?	Any sign of basal fracture / depressed fracture / penetrating injury / visible fracture



Swelling		Tender		Bruise		Fracture	
----------	--	--------	--	--------	--	----------	--

Neck examination	Other findings / injuries - record details elsewhere
------------------	--

Wound type	size	Clean / dirty	?	Treatment
1				
2				
3				
Primary TT course required		TT Booster required		HATI required

Investigations

IMMEDIATE CT if:		CONSIDER CT within 8 hours if:	
GCS < 13			
GCS 13-15 and...	Any RED indicator		Orange indicator +/- other features
	GCS falling or not improving		Skull fracture but no immediate concerns
	Basal or depressed or penetrating		Retrograde amnesia > 30 mins
	Failure to improve to GCS 15 in < 1 hour		age > 65 and either LoC or amnesia
	Impaired Coagulation and amnesia		Dangerous mechanism of injury
	Impaired Coagulation and neurological deficit		

X Ray / CT result	→ CT head + neck - <u>NED</u> anti Br (H) when awake
-------------------	---

Discharge Criteria

level of consciousness impaired (GCS < 15/15)	Y/N	Discharge with verbal and written advice if all answers are "No" Admit CDU/SSW if any answer is "Yes" Or Admit Surgery if skull fracture present or discharge predicted > 24 hours
Any indication for delayed CT	Y/N	
Significant medical problems, eg anticoagulant	Y/N	
Social problems or lack of supervision	Y/N	
Unable to assess due to alcohol / drugs	Y/N	
Fracture or significant risk of fracture	Y/N	



Accident & Emergency Nursing Documentation Form

PROWSE Duncan
24 MARGARET AVENUE
GALSTON
KA4 8BZ

Date: 13 Sep 2019

Time: 07:09

DOB: 15/01/1990

PRF: ☒NHS24 doc: ☐

Catherine Martin
Staff Nurse
Emergency Department

Additional information for admission
complaint:

biba: ?assaulted in street, haematoma to
back of head. intoxicated

Receiving Nurse(s): _____

Care taken over by: _____

BACKGROUND

Relevant PMH relating to presenting complaint:

Allergies: Yes No Unknown

Penicillin

Anticoagulant: Yes ☒ No UnknownInsulin: Yes ☒ No Unknown

Next of Kin details (if different from A&E Card):

Name:

Relationship:

Contact No:

ASSESSMENT

MEWS/PAWS score:

GCS: 14/15

Name band in situ: ☒ Yes ☐ NoOwn medications: Yes ☒ NoCognitive impairment: Yes ☐ No 4ATECG Yes ☐ NoX-ray Yes ☐ NoCT Yes ☐ No

Any medications given by paramedics?

O2 therapy ☒ Yes ☐ No Amount:PVC inserted pre-hospital Yes ☐ No

McKillop Tool Sepsis Six Big Six

Delirium Bundle

IV	Bloods	Cultures	Gases	Trop	Waterlow
PVC	Yes No	Size/Colour	Location		

Mobility status:

Independent

Package of Care

Yes

☒ No

Ongoing Assessment					
Y (yes)	N (no)	(NA) Not Applicable	(I) Independent	(R) Refused	(S) Sleeping
Area	Room 1				
Clothing Bag	N				
Skin inspected	I				
Pain assessed	Y				
Possessions to hand	Y				
Fluid/Food offered	N/A				

13.09.19.	Nursing Notes
	obs as charted PEARL GCS 14/15 E=4 M=4
	Patient unwilling to take wet clothes off. blankets given.
	Await review in A+E Mark
0830	Care taken over. PEARL GCS 13/15 E-3 V-4 M-6
	Attended for CT head + neck D
	Await result Jm
1000	CT head D NAD
1100	Tea and sandwich taken
	Dr McKenzie happy for discharge home
	Bus pass issued Jm

Ward Admitted To

NEWS SCORE using Systolic BP		Alert		Verbal		Pain		Unresponsive	
120									
110									
100									
90									
80									
70									
60									
50									
Conscious		Alert		Verbal		Pain		Unresponsive	
Level		Alert		Verbal		Pain		Unresponsive	
Mark		Alert		Verbal		Pain		Unresponsive	

Eyes Open		Spontaneous		To speech		To pain		None		Orientated		Confused		Inapp. words		Incomp. sounds		None	
Best Verbal Response		4		3		2		1		5		4		3		2		1	
Best motor response		6		5		4		3		2		1		0		1		0	
GCS TOTAL		14		13															
PUPILS		R		L		R		L		R		L		R		L		R	
LIMB MOVEMENT		Normal power		Mild weakness		Severe weakness		Spastic flexion		Extension		No response		Normal power		Mild weakness		Severe weakness	
LEGS		Normal power		Mild weakness		Severe weakness		Extension		No response		Normal power		Mild weakness		Severe weakness		Extension	
Total NEWS (with all obs)		Obs due		Pain		Nausea		Initials		Date		Time		Signature		Nurse		Doctor	

Pupil size (mm)

Bm 49

Neuro NEWS

National Early Warning Score



PROUSE Duncan
24 MARGARET AVENUE, GALSTON
KA4 8BZ
DOB: 15/01/1990



NHS
Ayrshire
& Arran

	Date	Ward
Admitted	13.09.19	ED
Transferred		
Transferred		

Special Instructions - to be completed by Medical Team

A total NEWS score of _____ due to _____ or individual parameter range of _____ is acceptable for this patient because _____

Please escalate if _____

Print _____ Sign _____ Designation _____
Date _____ Time _____ (only valid if signed and dated)

A total NEWS score of _____ due to _____ or individual parameter range of _____ is acceptable for this patient because _____

Please escalate if _____

Print _____ Sign _____ Designation _____
Date _____ Time _____ (only valid if signed and dated)

See NEWS Actions Reference Tool for local escalation policy

News score	Frequency of monitoring	Clinical Response
0	Minimum 2 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 any single red score	Increase frequency to a minimum of 1 hourly	- Trained Nurse assessment - Inform medical team caring for the patient and dual response - 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 6 or more or any two red scores	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. If unable to attend promptly, escalate to consultant or Emergency Response Team. - Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. - Consider referral to high dependency or ITU

Ward:	ED	ED
Date:	3/9	13/04
Time:	07:18	0820

35		
30		
25		
20		
16		
12		
8		

≥ 96			
94-95			
92-93			
≤ 91			
value %			
room air			A

39°					
38.5°					
38°					
37.5°					
37°					
36.5°					
36°					
35.5°					
35°					


 01301900435-
PROWSE Duncan
 24 MARGARET AVENUE, GALSTON
 KA4 8BZ
 DOB: 15/01/1990

 KH-19-032119-1

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 required. If the patient is unable to communicate, refer to an alternative pain scoring tool eg. Abbey, and use your clinical skills to determine level of pain severity.

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

Nausea and Vomiting	
0	None
1	Mild (Not distressing - no retching/vomiting)
2	Moderate (Troublesome - occasional retching/vomiting)
3	Severe (Distressing - frequent retching/vomiting)

Physiological Parameter	NEWS - NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate				12-20		21-24	
Oxygen Saturations		92-93		>96			
Any Supplementary Oxygen		Yes		No			
Temperature			35.1-36.0	36.1-38.0	38.1-39	≥39.1	
Pulse			41-60	51-90	91-110	111-130	
Systolic BP		91-100	101-110	111-219			
Conscious Level				A			

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

Notes



**CROSSHOUSE HOSPITAL
EMERGENCY DEPARTMENT**

WHEELCHAIR
AND
NHS
Ayrshire
& Arran

A/E No:
XH-19-052216-1

CHI No: **1501900455**

Date: **13 Sep 2019** Time: **15:44**

Consultant:
Dr Julie Mardon

PROWSE

Duncan

GP
**Dr. NOT KNOWN
73 LOUDOUN ROAD
NEWMILNS
AYRSHIRE
KA16 9HQ**

Incident Date:
13 Sep 2019
Incident Time:
15:44

Marital Status:
Single

Date of Birth: **15 Jan 1990** Age: **29 Years**

Sex:
M

Address:
**24 MARGARET AVENUE
GALSTON**

Next of Kin:
Prowse

Ethnicity: **White Scottish**

Sister

Religion **No Religion**

Attendances in last 12mths
3

KA4 8BZ

Total Attendances Count
16

Phone Numbers:
Mobile: 07907004965

Accompanied By:
Unaccompanied

Special case

Employer/School
braehead foods Not at School

Triage Time 15:58

Triage Nurse Michelle Spears

Triage Group Green

Resp Rate **02** Sat% **PFR**

Pulse **BP** **E M V**

Allergies: **No Known Allergy, Not Known**

BMstix **Alcohol Temp Weight**

Visual Acuity
R L

Pain Score
(Triage) **4**
Pain Score
(Discharge)

Triage details

return from this morning, hit head again ? further drugs

Treatment

NONE

Clinical Frailty Score:

Special Needs

NONE

Re-assess in **15 30 60 minutes**

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed..... Witness..... Witness.....

I give consent for details of my injury to be given to the Police.

Signed.....

Disch A+E clinic Paed Tr. # eye ENT Max Facial Ward OP Ward IP



Drug	Dose	route	time/frequency	signature	quantity/given by

PVC1	Size/Colour	Location	Initials	PVC2	Size/Colour	Location	Initials

Device	Flow Rate l/min	%O2 for Venturi	Target SpO2	Prescribed by	Started by	Stopped by
Oxygen						
Changed to						

DOCTOR / ENP:

BLACK (cont)

Time:

18.20

(29) → ? Head injury

Attended @ 7am today after being found in street intoxicated & occipital head injury. Admitted to alcohol/cocaine - unclear if fall or assault. Had @ CT head/neck. Now brought in again by ambulance found lying on cycle path & ? new head injury. Admitted to SATS he had been drinking since early 2/c and had fallen. Alcohol/spiked & unclear where living currently as "kicked out" his sister's house few days ago & refuses to disclose current arrangements.

V16

Well. GCS 15

Smells of alcohol ++ but not obviously intoxicated

Independently mobile

No convincing evidence new head injury as only wound seen was documented this morning

Imp/ Risky lifestyle / substance misuse
No indications for acute admission

P1

2/c

Dr Lisa Black
ED Consultant
GMC 612851

UNIVERSITY HOSPITAL CROSSHOUSE

Medical Imaging Department

CROSSHOUSE

Kilmarnock

KA2 0BE



17 SEP 2019

Lisa Black
E.D. Consultant
GMC. 6128517

RADIOLOGY REPORT

CHI NUMBER: 1501900455 Examination Number: 37727009 Examination Date: 13/09/2019	
Name: Prowse, Duncan DOB: 15/01/1990	
Address: 1b Kerr Road, Kilmarnock, KA3 7JH -- CC: -	
Referring Department / Location: Accident & Emergency Crosshouse Hospital Kilmarnock Road Crosshouse Ayrshire KA2 0BE	
Referring Consultant: Brown, Lesley (Cons)	Clinical Specialty: Accident & Emergency
Date Dictated: 13/09/2019	Typed by: None
Examination: CT Head and Neck	

Clinical Indication

Assaulted last night, found on street with wounds to head, ?hit with baseball bat, taken drugs, GCS-13/15, confused ?intracranial bleed/fracture

Report:

Noncontrast CT of head and neck.

The brain parenchyma appears unremarkable. There are no features to suggest acute cortical infarction, space-occupying lesion or intracerebral haemorrhage. There is no extraaxial collection.

The ventricles and peripheral CSF spaces are congruent. The base of skull and skull vault are intact. The visualised para-nasal sinuses and mastoid air cells are clear.

There is no prevertebral soft tissue swelling. Bony alignment of the cervical spine is normal and there is no evidence of fracture. The spinal canal appears capacious.

Please note that ligamentous injury cannot be excluded on the basis of CT:

Visualised lung apices are clear.

Dictating Radiologist / Clinical Specialist Dr J Kelly Consultant Radiologist

Verified by: Dr J Kelly Consultant Radiologist

1501900455

Examination Number: 37727009 **Examination Date:** 13/09/2019
Name: Prowse, Duncan **DOB:** 15/01/1990
Dose :- 994.3 mGy cm2

Incident Number: CB005857428

Patient Information		Date:	13/09/2019
DUNCAN PROUSE		Incident Number:	CRC05857429
Age/Gender:	29 years 7 months 29 days Old Male	Incident Type:	EMG
Address:	24 MARGARET AVENUE, GALSTON	Incident Location:	ON THE CHRIS HOY WAY CYCLE PATH NEAR GAUCHALLAND ROADS DEPOT:AYR ROAD GALSTON, KA6 6LE
DOB:	15/01/1990		
CHI:			
Ethnicity:			



Scottish
Ambulance
Service
SCOTTISH AMBULANCE SERVICE

Presenting Complaint

FALL HEAD INJ

Additional Comments

999 CALL FOR THIS PT WHO HAS BEEN FOUND LYING ON A CYCLE PATH WITH AN INJURY TO HIS HEAD. STATES HE WAS DISCHARGED FROM HOSPITAL AT 11AM THIS MORNING AFTER AN ASSAULT WITH A BASEBALL BAT, HAS BEEN DRINKING SINCE THEN AND STAGGERED AND FELL INJURING HEAD AGAIN. WAS UNABLE TO GET UP AND WALK BY HIMSELF. O/A PT CONSCIOUS AND BREATHING. O/E APPEARS DROWSY, COMPLAINTING OF A SEVERE HEADACHE AND PAIN BEHIND EYES. OBS OK AS RECORDED, ?LEFT PUPIL SLIGHTLY SMALLER THAN RIGHT, NO OTHER INJURIES, NO CSPINE PAIN. HEAD CLEANED AND DRESSED. HIS SISTER STATED HE HAS BEEN TAKING COCAINE, STREET VALIUM AND SPEED AS WELL AS ALCOHOL, HE DENIES ANY DRUG USE TODAY.

PATIENT ASSESSMENT

AVPU	Voice	<C>	No								
A	Clear										
B	Normal Air Entry Normal Air Entry Normal Air Entry		UL Normal Air Entry ML Normal Air Entry LL Normal Air Entry								
C	Pulse Rate 74 Rhythm Reg	BP 124/88 Arm Right	Cap Refill ≤2 Secs Central/Peripheral Central ECG Rhythm Sinus Rhythm ECG 3 Lead								
D	GCS 15 Eyes Spontaneously (4)	Voice Orientated (5)	Motor Obeyes Commands (6) PEARL								
E		Wounds <table border="1"> <thead> <tr> <th>ID</th><th>Body Part</th><th>Wounds</th><th>Treatments</th></tr> </thead> <tbody> <tr> <td>W1</td><td>Back Head</td><td>Laceration, Haemorrhage, Swelling</td><td>Irrigation, Swabs, Dressing</td></tr> </tbody> </table>	ID	Body Part	Wounds	Treatments	W1	Back Head	Laceration, Haemorrhage, Swelling	Irrigation, Swabs, Dressing	
ID	Body Part	Wounds	Treatments								
W1	Back Head	Laceration, Haemorrhage, Swelling	Irrigation, Swabs, Dressing								

Observations

Time	P	RR	BP	SpO2	CR	GCS	AVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
14:55	78		119/84	100											E1022709
14:45	80	16	122/85	99			Alert								E1022709
14:25	74	16	124/88	100	≤2 Secs	15	Voice		35.5	6.2	Sinus Rhythm	3	4		E1022709

NEWS

Clinical Risk

NEWS

9/19/2018

Incident Number: CR00667429

14:55

0

14:45

0

14:25 MEDIUM Immediate Clinical Risk. Treat as per Clinical Practice Guidelines. This patient should be conveyed to hospital.

4

HISTORY**AMPLE**

Allergies

None

Medication

NONE

Substances

Alcohol, Cocaine

Substances Affecting Condition

CLOSE RECORD

Treatment On Scene

Emergency

Conveyance

Transport To Hospital

Normal driving

Pre Alert

No

INCIDENT LOG

Time Call Received

13:45

Allocated

14:01

Mobile

14:02

First Resource On Scene

Crew On Scene

14:15

Crew Left Scene

14:40

Crew At Hosp

Receiving Hospital

CROSSHOUSE HOSPITAL Clear Time

Crew ID

E9886498

Crew Grade

Student Technician Level 4

Driver

YES

E1022709

Paramedic

NO

Accident & Emergency Nursing Documentation Form

PROWSE Duncan

Date: 13 Sep 2019

24 MARGARET AVENUE

Time: 15:44

GALSTON

KA4 8BZ

Additional information for admission

DOB: 15/01/1990

complaint:

PRF: ☐

return from this morning, hit head again?

NHS24-doc: ☐

further drugs

Receiving Nurse(s): _____

Care taken over by: _____

BACKGROUND

Relevant PMH relating to presenting complaint:

Allergies: Yes No Unknown

Anticoagulant: Yes No Unknown

Insulin: Yes No Unknown

Next of Kin details (if different from A&E Card):

Name:

Relationship:

Contact No:

ASSESSMENT

MEWS/PAWS score:

GCS:

Name band in situ: Yes No

Own medications: Yes No

Cognitive impairment: Yes No 4AT

Any medications given by paramedics?

O2 therapy Yes No Amount:

PVC inserted pre-hospital Yes No

ECG Yes No

X-ray Yes No

CT Yes No

McKillop Tool Sepsis Six Big Six

Delirium Bundle

IV Bloods Cultures Gases Trop Waterlow

PVC Yes No Size/Colour Location

Mobility status:

Package of Care Yes No

Ongoing Assessment					
Y (yes)	N(no)	(NA) Not Applicable	(I) Independent	(R) Refused	(S) Sleeping

N(no).

(1) Independent

(S)Sleeping

	On Arrival	Time	Time	Time	Time	Time	Time	Time
Area								
Clothing Bag								
Skin inspected								
Pain assessed								
Possessions to hand								
Fluid/Food offered	N/A							

[illegible]

Ward Admitted To	
------------------	--

NEWS key
0
2

* XH-19-052216-1 *

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 required. If the patient is unable to communicate, refer to an alternative pain scoring tool eg. Abbey, and use your clinical skills to determine level of pain severity.

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

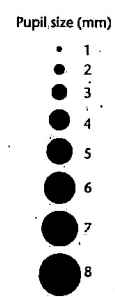
Nausea and Vomiting	
0	None
1	Mild (Not distressing - no retching/vomiting)
2	Moderate (Troublesome - occasional retching/vomiting)
3	Severe (Distressing - frequent retching/vomiting)

Physiological Parameter	NEWS - NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate			≤11	12-20		21-24	
Oxygen Saturations		92-93	94-95	>96		97-98	
Any Supplementary Oxygen		Yes		No			
Temperature			35.1-36.0	36.1-38.0	38.1-39.0	≥39.1	
Pulse			41-50	51-90	91-100	111-130	
Systolic BP		91-100	101-110	111-219			
Conscious Level		2	1	A			

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

[illegible]

NEWS SCORE using		120	115
System		110	105
BP	90		
	80		
	70		
	60		
	50		
Conscious Level Mark:	Alert		
	Verbal		
	Pain		
	Unresponsive		
Eyes Open	Spontaneous	4	/
	To speech	3	
	To pain	2	
	None	1	
Best Verbal Response	Orientated	5	
	Confused	4	/
	Inapp. words	3	
	Incomp. sounds	2	
Best motor response	None	1	
	Obeys commands	6	/
	Localise pain	5	
	Withdrawal to pain	4	
	Abnorm. flexion to pain	3	
	Extension to pain	2	
GCS TOTAL		14	14
PUPILS	R	Size	4
		Reaction	+
	L	Size	4
		Reaction	+
LIMBS MOVEMENT	ARMS	Normal power	RL RL
		Mild weakness	
		Severe weakness	
		Spastic flexion	
		Extension	
	LEGS	No response	RL RL
		Normal power	
		Mild weakness	
		Severe weakness	
		Extension	
Total NEWS (with all obs)		0	0
Obs due			
Pain			
Nausea			
Initials		MM	



**CROSSHOUSE HOSPITAL
EMERGENCY DEPARTMENT**



A/E No:
XH-19-045839-1

CHI No: **1501900455**

Date: **12 Aug 2019** Time: **20:30**

Consultant:
Dr Jamie Adams

PROWSE

Duncan

GP
**Dr. NOT KNOWN
73 LOUDOUN ROAD
NEWMILNS
AYRSHIRE
KA16 9HQ**

Incident Date:
12 Aug 2019

Incident Time:
20:30

Martial Status:
Single

Date of Birth: **15 Jan 1990** Age: **29 Years**

Sex:
M

Address:
**24 MARGARET AVENUE
GALSTON**

Next of Kin:
Prowse

Ethnicity **White Scottish**

Religion **No Religion**

Sister

Attendances in last 12mths
1

KA4 8BZ

Total Attendances Count
14

Phone Numbers:
Mobile: 07907004965

Accompanied By:
Relative

Special case

Employer/School
brachead foods Not at School

Triage Time 20:42

Triage Nurse Fiona Marshall

Triage Group Green

Resp Rate **15** O2 Sat% **100** PFR

Pulse **68** BP **150/83** E M V

Triage details
right sided sharp chest pains, worse on inspiration, ongoing since yesterday

ECG A.

Allergies: **No Known Allergy, Not Known**

Treatment
NONE

Clinical Frailty Score:

BMstix Alcohol Temp **36.1** Weight

Special Needs
NONE

Visual Acuity
R L Pain Score (Triage) **10**
Pain Score (Discharge)

Re-assess in **15** **30** **60 minutes**

Against Medical advice I decline the treatment offered. I know this may affect my recovery.

Signed.....Witness.....Witness.....

I give consent for details of my injury to be given to the Police.

Signed.....



* 1 5 0 1 9 0 0 4 5 5

Disch A+E clinic Paed Tr. # eye ENT Max Facial Ward OP Ward IP

[illegible]

Neuro NEWS

National Early Warning Score


PROWSE Duncan
 24 MARGARET AVENUE, GALSTON
 KA4 8BZ
 DOB: 15/01/1990




	Date	Ward
Admitted		
Transferred		
Transferred		

Special Instructions: to be completed by Medical Team

A total NEWS score of _____ due to _____ or individual parameter range of _____ is acceptable for this patient because _____

Please escalate if _____

Print _____ Sign _____ Designation _____

Date _____ Time _____ (only valid if signed and dated)

A total NEWS score of _____ due to _____ or individual parameter range of _____ is acceptable for this patient because _____

Please escalate if _____

Print _____ Sign _____ Designation _____

Date _____ Time _____ (only valid if signed and dated)

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 any single red score	Increase frequency to a minimum of 1 hourly	- Trained Nurse assessment - Inform medical team caring for the patient and dual response - 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 of 6 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. If unable to attend promptly, escalate to consultant or Emergency Response Team. - Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. - Consider referral to high dependency or ITU.

Ayr Hospital EMERGENCY DEPARTMENT



A/E No: AYR-26-008463-1 Date & Time: 06 Apr 2026 22:49		CHI No: 1501900455		Duncan PROWSE	
GP: HC Brown Dalmellington Medical Practice Dalmellington Area Centre 33 Main Street KA6 7QL 01292 550238		Duty Consultant: DR ALI AL-SALIHI		Date of Birth: 15 Jan 1990 Age: 36 Years Sex: M	
		Marital Status: Single		Address: 7 Park Crescent Dalmellington AYR KA6 7RP	
		Religion: No Religion Ethnicity: White Scottish			
		Attendances Last 12mths: 1 Total: 18			
Next of Kin: [REDACTED] Sister		Special Case:		Phone Numbers: Home: Mobile: 07521153151	
[REDACTED]		Accompanied by: Partner		Employer/School: braehead foods Not at School	

Triage Time: 22:55 **Triage Nurse:** Michelle Garman **Triage Group:** Yellow

Resp Rate		O2 Sat%		PFR	
Pulse	BP	E	M	V	Triage details: sudden onset sharp chest pain. states pain in lt arm and wrist. states incresed sob. Treatment ECG Special Needs NONE Clinical Frailty Score: Re-assess in 15 30 60 minutes <i>DNW @</i> <i>0120</i> <i>OTW</i>
Allergies: No Known Allergy, Not Known					
BMstix	NEWS	Temp	Weight		
Visual Acuity R: L:		Pain Score Triage: 5			
I give consent for details of my injury to be given to the Police. Signed:.....					

Against Medical advice I decline the treatment offered. I know this may affect my recovery.
 Signed: Witness: Witness:

Disch	A+E clinic	Paed Tr.	# Eye	ENT	Max Facial
Ward OP.		Ward IP.....			

* 1501900455 *

DUNCAN

PROWSE

CHI: 1501900455

A/E No: AYR-26-008463-1

[illegible]

Clinical Indication	IV Fluids / IV Drugs	Urgent access	Blood Products	Diagnostic Procedures
---------------------	----------------------	---------------	----------------	-----------------------

Clean Field	Hand Hygiene	Skin antisepsis	No touch critical parts	Dated/ Timed	
-------------	--------------	-----------------	-------------------------	-----------------	--

PVC 1	Size	Site	Sign	PVC 2	Size	Site	Sign
-------	------	------	------	-------	------	------	------

Clinician Name: _____	Date: ____/____/____
Grade: _____	Time: _____

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or printed text on the paper.

Dead – have you notified:	NOK?	GP?	Fiscal?	Police?	Letter?
ED Dr x-ray report:					

A/E No: AYR-26-008463-1

Arrival Date/Time: 06 Apr 2026 22:49

Nursing Notes

[illegible]

DUNCAN

PROWSE

CHI: 1501900455

A/E No: AYR-26-008463-1

Address: 7 Park Crescent Dalmellington AYR KA6 7RP

Arrival Date/Time: 06 Apr 2026 22:49

ED Care Round Checklist:

Frequency to be prescribed in relation to the patient's greatest need.

To be completed by the member of staff delivering care. If unable to use the nurse call bell prescribe care and comfort at one hourly.

Date /Time	Name	Designation	Signature	Circle frequency prescribed			
06/04/26	D. Cawley	SN	[Signature]	1	2	3	4
				1	2	3	4
				1	2	3	4

Use the following codes: Y - Yes N - No NA - not applicable

NT - No Thanks

S - Sleeping

O - Out of department

I - Independent

	Date	06/04/26							
	Time								
	THINK DELIRIUM: Is the patient more confused or drowsy than normal? (if yes escalate and update 4AT)	N							
	PAIN: ASSESS AND ADDRESS Is the patient distressed and/or in pain? If yes inform nurse in charge	N							
S	SKIN INSPECTION Pressure areas checked? R-red D-discolouration U- pressure ulcer E-moisture/excoriation N-no damage Barrier Cream applied Y-Yes N-No	St I							
	Cushion/heel protector appropriate: Y-Yes N- No Type	N							
K	Keep moving Has the patient changed position or walked? Bed: R:right side L: left side B: back I: independent	St I							
	Chair: W/ST: Assisted to walk/stand I: independent	I							
	Sliding Sheet used	I							
I	Elimination: Patient offered the toilet? I independent A assistance given IC incontinence (urine/faeces) BO Bowels open C Catheter	N I							
N	Food/Fluid and Nutrition Fasting F Nil by mouth NBM	I							
	Drink taken	N							
	Food, snack or supplement taken	N							
	Oral hygiene carried out	N							
	Environmental check: is the nurse call bell to hand, area clutter free, belongings within reach	I							
	Is the trolley/bed at the lowest level	N							
	Information: is there anything I can help you with? Inform patient of return time	N							
	Escalation required to nurse in charge?	N							
	Move bed/trolley to visible area if taking risks	N							
	Patient stay > 12 hours? - Consider moving to a bed	N							
	If patient on bed, complete a bedrail risk assessment	N							
	Initials	[Signature]							
	Designation	SN							

Address: 7 Park Crescent Dalmellington AYR KA6 7RP

Arrival Date/Time: 06 Apr 2026 22:49

Preliminary Pressure Ulcer Risk Assessment (PPURA), update daily:

Mobility: Patient requires assistance to mobilise/change position. Contenance: Patient has continence issues which may/has compromise/d skin. Nutrition: Patient appears malnourished and/or unable to eat/drink. Skin: Patient has a pressure ulcer/skin is compromised (medical devices, neurological deficit, medication, co-morbidities).
If YES to any of above, activate care plan below

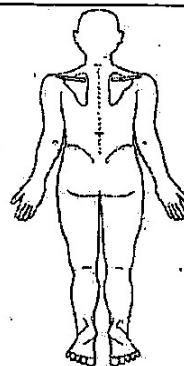
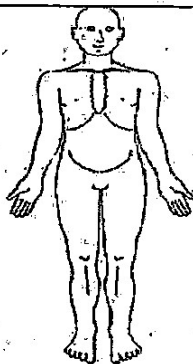
Date	Time	Mobility		Contenance		Nutrition		Skin		Sign
		Y	N	Y	N	Y	N	Y	N	
		Y	N	Y	N	Y	N	Y	N	

Pressure Prevention Care PlanPatient is at risk of developing a pressure ulcer?Y ☒ N ☐Patient has a pressure ulcer?Y ☐ N ☒

(If yes to either, initiate care plan below)

Date	Initial	Nursing intervention	Discontinued	Date/Time	Sign
		Ensure regular repositioning is carried out and documented on SSKIN bundle			
		The patient should not sit out of bed for longer than 2 hours without being repositioned (for acutely ill patients return to bed for a minimum of 1 hour)			
		Use sliding sheets to prevent shear and friction during movement in bed and record use in care round. Sliding sheets should not be left under the patient.			
		If the patient is incontinent use a PH balanced cleanser to clean and barrier products to protect as per: 'Scottish excoriation and moisture related skin damage tool'.			
		Encourage a healthy, well-balanced diet and adequate fluid intake.			
		If the patient has a grade 2 or above pressure ulcer a wound assessment chart is required. Available from AthenA			
		Plan of care discussed and agreed with the patient as appropriate. Evaluate care in the nursing records.			

Date/Time	Location of ulcer	Grade of ulcer	Signature



DUNCAN

PROWSE

CHI: 1501900455

A/E No: AYR-26-008463-1

Address: 7 Park Crescent Dalmellington AYR KA6 7RP

Arrival Date/Time: 06 Apr 2026 22:49

Nurse Signature on initial assessment: [Signature]Print Name: D. CANNON

Triage Comments:		sudden onset sharp chest pain. states pain in lt arm and wrist. states increased sob.	
Past Medical History		CHD, HT	
DNAR	Y	N/A	AWI
Y	N/A	Insulin	Y
Y	N/A	On Anticoagulant?	Y
Y	N/A		
Allergies		Medications given by Paramedics	
Nursing Notes: Care taken over by			
Date/Time		Name Printed	
Name band in situ		Patient prepared for exam & clothes bagged	
ECG	1st	2nd	Other
Y	N/A	Y	N
IV Access		Valuables with patient:	
PVC Size/Colour:		If yes, please specify action taken	
PVC Location:		Relative/Carer/Next of kin present:	
Inserted by:		Name: Relation:	
		Contact Number:	
Blood samples		Y	N
Blood gases		Y	N
Blood cultures		Y	N
PCR Test		Y	N
Radiology	X Ray	Y	N
Screening tools Assessment		Package of Care? NA	
Date	6/4	Date	6/4
Time		Time	
SEPSIS SCREEN	Y	N	Y
FAST Score	Y	N	Y
AAMAWS commenced	Y	N	Y
Big Six (hip fracture)	Y	N	Y
Mobility	Bed Rest	Independent	Assistance/walking aid, specify:
If YES to any Falls Risk Assessment questions complete the safety intervention section. Repeat if the patient has a fall, is taking risks, has a change in condition/cognition.			
Falls risk Assessment		Safety interventions	
DATE	6/4	DATE	
TIME		TIME	
Admitted with a fall?	Y	N	Y
Recent fall (last 6 months)?	Y	N	Y
Cognitive impairment or possible delirium?	Y	N	Y
Attempts to walk alone is unsteady/unsafe.	Y	N	Y
Is patient at high risk of falling?	Y	N	Y
		Nonslip socks provided?	
		Behaviour monitoring chart	
		Supervision required in bathroom/commode?	
		Falls warning sign on whiteboard/symphony	
		Bed in Visible area.....	

DUNCAN

PROWSE

CHI: 1501900455

A/E No: AYR-26-008463-1

Address: 7 Park Crescent Dalmellington AYR KA6 7RP

Arrival Date/Time: 06 Apr 2026 22:49

ED 4AT Delirium Assessment: Complete / update for all Patients over 65, anyone of any age, with a cognitive impairment/previous delirium, current hip fracture, acute illness or SQID positive (is your patient more confused or drowsy than normal?)				N/A?
ALERTNESS: This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient, if asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating. Circle relevant number below				
		Date		
		Time		
Normal (fully alert, but not agitated, throughout assessment)		0	0	0
Mild sleepiness for <10 seconds after waking, then normal		0	0	0
Clearly abnormal		4	4	4
AMT4: Age, date of birth, place (name of the hospital or building), current year				
No Mistakes		0	0	0
One Mistake		1	1	1
Two or more mistakes		2	2	2
ATTENTION: Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "What is the month before December?" is permitted.				
Achieves 7 months or more correctly		0	0	0
Starts but scores < 7 months / refuses to start		1	1	1
Untestable (cannot start because unwell, drowsy, inattentive)		2	2	2
ACUTE CHANGE OR FLUCTUATING COURSE: Evidence of significant change or fluctuation in: alertness, cognition, other mental function (e.g. paranoia, hallucinations) over the last 2 weeks and still evident in the last 24 hours.				
No		0	0	0
Yes		4	4	4
		Total	0	
		Signature	00	
4AT Score of 4 and above. Possible delirium +/- cognitive impairment (Complete the TIME bundle below)				
4AT Score of 1-3: Possible cognitive impairment				
4AT Score of 0: Delirium or severe cognitive impairment unlikely (but delirium still possible if [4AT] incomplete)				
TIME BUNDLE: Complete the TIME bundle if the 4AT Score is 4 and above.				
		Date		
		Time		
T	Think possible triggers for delirium applicable	Use Codes: Y-Yes N-No NA- Not		
	Is the patient in pain? (start pain chart, review analgesia)			
	Is the patient constipated or at risk of constipation? (Commence bowel chart and aperients).			
	Is the patient in urinary retention? (Palpate bladder/scan)			
	Is the patients' oral intake sufficient to prevent dehydration? (Encourage hourly fluids start FBC)			
	Could any drugs trigger delirium? (Doctor to review medication)			
	Blood sugar, high or low?			
	Is there a history of alcohol intake/drug abuse? (Intoxication or withdrawal, GMAWS/drug misuse)			
I	Investigate			
	Record NEWS			
	Screen for infection (and consider urinalysis)			
	Take bloods and ensure ECG/appropriate imaging			
M	Management: Diagnose causes & initiate treatment			
	Document diagnosis of delirium			
	Document potential causes of delirium			
	Document treatment plan			
E	Engage and Explore			
	If appropriate, explain diagnosis of delirium to patient/family/carers and provide delirium leaflet			
	Engage with patient/family/carers. ("What matters to me"/ "Getting to know me")			
	Does the patient have capacity to consent to care? (If no, complete AWI document)			
		Signature:		

NHS Ayrshire & Arran NEWS – National Early Warning Score



Affix Patient ID

	Ward	Date	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

	Resp rate	BP	HR
Acceptable parameter's			
Dr/ANP initials			
Date			
Dr/ANP discontinue date/sign			

SpO2 Scale 2 Target 88-92%
Signature: _____
Print Name: _____
Dr/ANP initials ONLY: _____
Date: _____

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

Document all actions and interventions

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

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

Discontinuation of NEWS2

Following MDT discussion, it has been agreed that this patient no longer has a requirement for NEWS2

Responsible Clinician: Print Name _____

Designation: _____

Date: _____ Time: _____

NEWS2

[illegible]

Pupil Size (mm)

1 2 3 4 5 6 7 8

R Recommendation - what do you need & when.

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

NHS Ayrshire & Arran

Area Laboratory Haematology

PROWSE, DUNCAN
18 KERR RD
KILMARNOCK
KA3 7JH

CHI No: 1501900455
Unit No:
DOB: 15/01/1990
Sex: M

Clinician: Dr J Stevenson
Request Location: XH Hosp: Clinical Decisions Unit

This report to: Dr J Stevenson, XH Hosp: Clinical Decisions Unit

	Result	Units	Normal Range
Haemoglobin	143	g/L	133 - 176
White Cell Count	8.4	$10^9/L$	3.7 - 9.5
Platelets	209	$10^9/L$	150 - 400
RBC	4.91	$10^{12}/L$	4.32 - 5.66
Haematocrit	0.41	%	0.39 - 0.50
MCV	83	fL	82 - 98
MCH	29.1	pg	27.3 - 32.6
MCHC	High 353	g/L	316 - 349
Neutrophils	3.5	$10^9/L$	1.5 - 6.5
Lymphocytes	4.1	$10^9/L$	1.1 - 5.0
Monocytes	0.7	$10^9/L$	0.2 - 0.9
Eosinophils	Low 0.0	$10^9/L$	0.1 - 0.7
Basophils	0.0	$10^9/L$	0.0 - 0.1

16 APR 2014

Karen Figgins
Charge Nurse (CDU)
N.M.C 840

Lab No: 14B179644

Date Collected: 15/04/14 23:30

Authorised By

BHI-W7AUQPRO Service
Account

Printed: 16/04/14 07:39

Sample Type: Blood

Page 1 of 1

If you have received this report in error, please return to the Haematology Laboratory

15/01/1990 (36 Years)

Vanbrane
PR Interval
QRS duration
QT/QTc Baz
QTc Baz

76 BPM
VA
30
354/405 ms
51/28/34

Normal sinus rhythm
Normal ECG

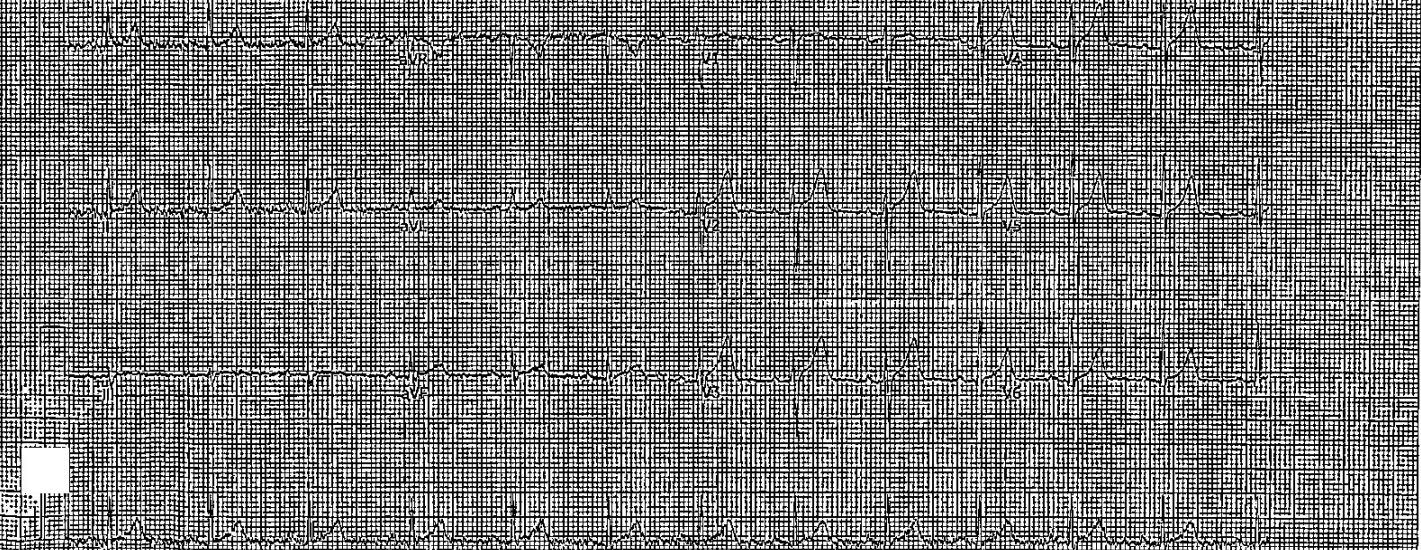
Ayr hospital

[Signature]

ECG comments
ECG comments

Unconfirmed

PROWSE Duncan
7 PARK CRESCENT, DALMELLINGTON
KA6 7RP
DOB: 15/01/1990



2 mm/s 100 mmV

0.50 150 Hz / 100 150 Hz

VAC 1701005000

1251 VZ01 05/05/2026 23:01:27

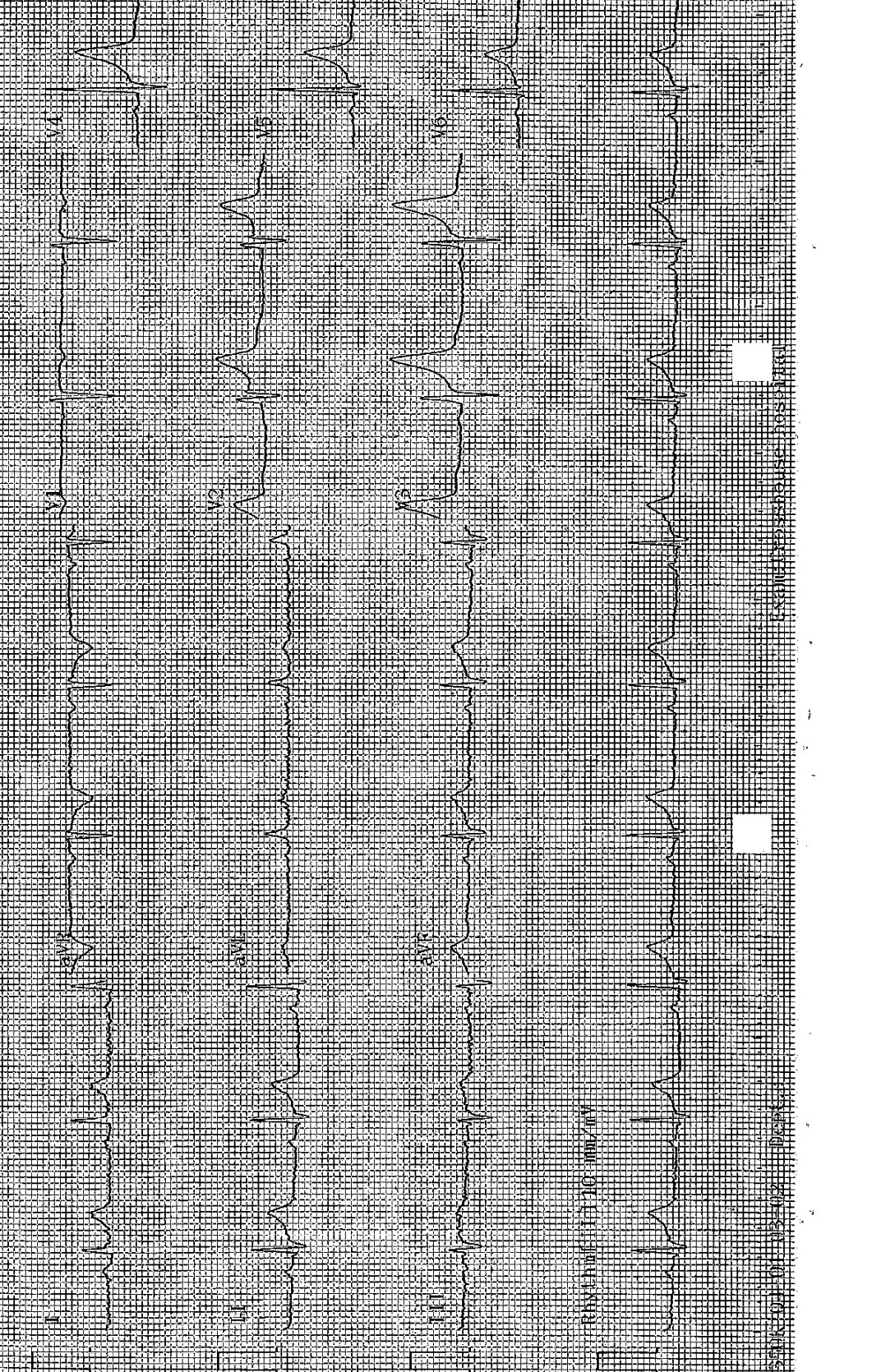
00000000

[illegible]

ventrate	50	bpm	
PK 1st	152	ms	
PK 2nd	88	ms	
PK 3rd	88	ms	

4. CONFIRMED RECORD	
DATE TIME	007-101 MS
CURS/T DIS	57 30/ 15
V5/SV1 amp	1.240/ 0.905 mV
V5-SV1 amp	2.645 mV

	10 mm/min	25 mm/min	Filter:	#50 d.	35 #12	10 mm/min	10 mm/min



Name: [redacted]
 Sex: Male Date: [redacted] Years: [redacted]
 GP: [redacted]
 Medical history:
 Symptoms:
 (as above)

130 Semi-regularly
 10503 Early repolarization
 9110 KC abnormal rhythm ECG 22

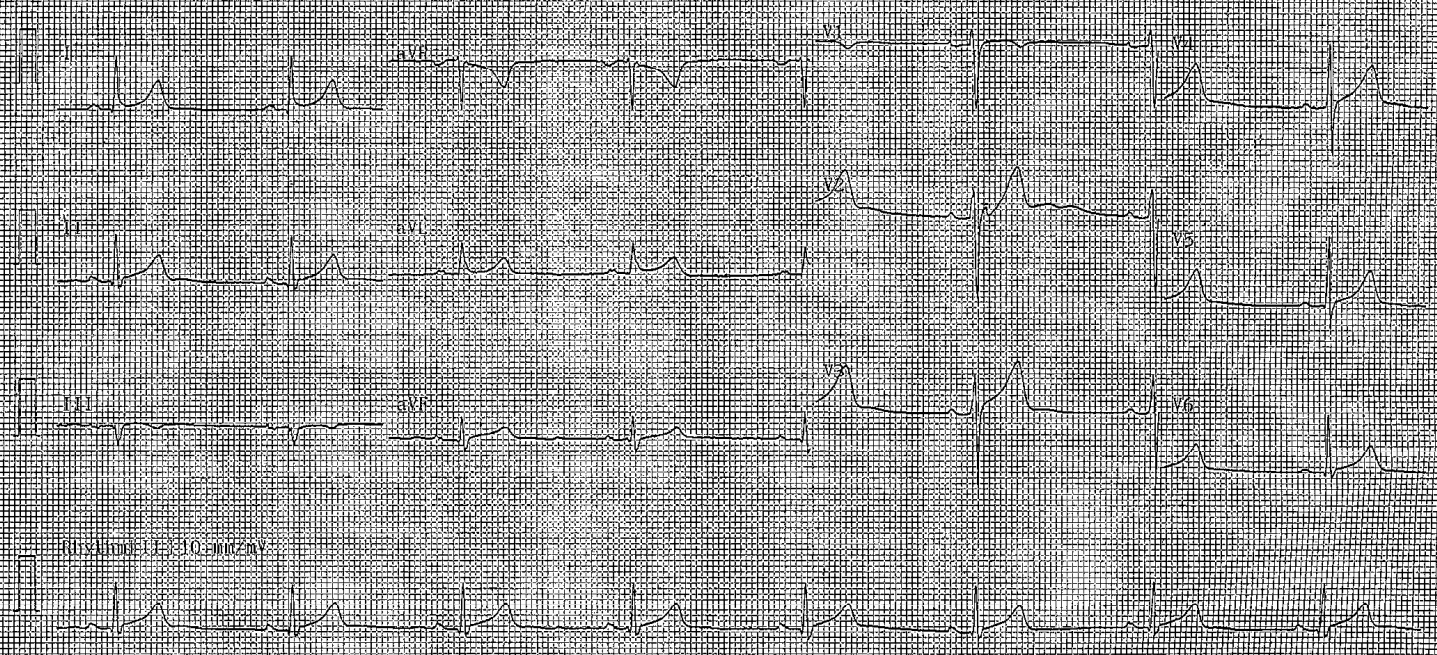
XH-14-021937-1
 DOB: 15/01/1990 Male
 PROWSE Duncan
 1B KERR ROAD, KILMARNOCK
 KA3 7JH



Heart rate 47 bpm
 PR interval 173 ms
 QRS duration 98 ms
 QT/QTc interval 450/413 ms
 P-QRS-T axis 27/-35/-26
 RV5-SVL amp 1.220/1.105 mV
 RV5-SVL amp 2.325 mV

SA
 Unconfirmed Report
 Reviewed by:

10 mm/mV 25 mm/s Filter 150 Hz 100 Hz 10 mm/mV 10 mm/mV



1550K 04-01-08-02 0641

Printed: 04-01-08-02 0641

Patient ID	1501900455:OHCP	Patient Name	PROWSE, Duncan
Sex	Male	Date Of Birth	15-Jan-1990
Collected	07-Apr-2026 12:01	Order Number	0026B839370
Ordering Provider	Dr Colette Scanlon	Status	Final

Test Name	Result	Ref. Range (Units)	Abnormality	Status
Urate	393	200-430 (umol/L)		Final

* Abnormal, ** Critically Abnormal

UREA AND ELECTROLYTES Cumulative

Number	LATEST 2 of 2	1 of 2	Ref. Range (Units)
Collected	07-Apr-26 12:01	15-Apr-14 23:30	
Source	Revive	Revive	
Urea	4.6	5.3	2.5-7.8 (mmol/L)
Creatinine	81	72	50-120 (μmol/L)
Sodium	142	139	133-146 (mmol/L)
Potassium	4.0	3.8	3.5-5.3 (mmol/L)
Chloride	102	104	95-108 (mmol/L)
eGFR result/1.73m2	>60	-	60-61 (mL/min)
Graph No tests selected			

Abnormal ** Critically Abnormal § Units or Reference Range differs

LIVER FUNCTION TEST Cumulative

Number	LATEST 2 of 2	1 of 2	Ref. Range (Units)
Collected	07-Apr-26 12:01	15-Apr-14 23:30	
Source	Revive	Revive	
Total Bilirubin	7	§ 6	§
ALP	83	—	30-130 (U/L)
AST	22	14	10-45 (U/L)
ALT	23	16	5-55 (U/L)
Total Protein	74	—	60-80 (g/L)
Albumin	46	—	35-50 (g/L)
Globulin	28	—	21-35 (g/L)

Graph

No tests selected

* Abnormal ** Critically Abnormal § Units or Reference Range differs

Patient ID	1501900455:OHCP	Patient Name	PROWSE, Duncan
Sex	Male	Date Of Birth	15-Jan-1990
Collected	07-Apr-2026 12:01	Order Number	0026B839370
Ordering Provider	Dr Colette Scanlon	Status	Final

Test Name	Result	Ref. Range (Units)	Abnormality	Status
Haemoglobin A1c (IFCC)	36	20-41 (mmol/mol)		Final

* Abnormal, ** Critically Abnormal

Patient ID	1501900455:OHCP	Patient Name	PROWSE, Duncan
Sex	Male	Date Of Birth	15-Jan-1990
Collected	07-Apr-2026 12:01	Order Number	0026B839370
Ordering Provider	Dr Colette Scanlon	Status	Final

Test Name	Result	Ref. Range (Units)	Abnormality	Status
GGT	28	2-50 (U/L)		Final

* Abnormal, ** Critically Abnormal

FULL BLOOD COUNT Cumulative

Number	LATEST 2 of 2	1 of 2	Ref. Range (Units)
Collected	07-Apr-26 12:01	15-Apr-14 23:30	
Source	Revive	Revive	
RBC	4.97	4.91	4.32-5.66 ($10^{12}/L$)
Monocytes	0.6	0.7	0.2-0.9 ($10^9/L$)
Haemoglobin	148	143	133-176 (g/L)
White Cell Count	6.9	8.4	3.7-9.5 ($10^9/L$)
Platelets	250	209	150-400 ($10^9/L$)
Haematocrit	0.44	0.41	0.39-0.5 (%)
MCV	88	§ 83	§
MCH	29.8	29.1	27.3-32.6 (pg)
MCHC	340	* 353	316-349 (g/L)
Neutrophils	2.9	3.5	1.5-6.5 ($10^9/L$)
Lymphocytes	3.2	4.1	1.1-5 ($10^9/L$)
Eosinophils	0.2	* 0	0.1-0.7 ($10^9/L$)
Basophils	0	0	0-0.1 ($10^9/L$)
Graph No tests selected *			

* Abnormal ** Critically Abnormal § Units or Reference Range differs

C-REACTIVE PROTEIN Cumulative

Number	LATEST 2 of 2	1 of 2	Ref. Range (Units)
Collected	07-Apr-26 12:01	15-Apr-14 23:30	
Source	Revive	Revive	
CRP	<5	§ <5	§
Graph No tests selected			

* Abnormal ** Critically Abnormal § Units or Reference Range differs

COMMENT REJECTED SAMPLES

Patient ID	1501900455:OHCP	Patient Name	PROWSE, Duncan
Sex	Male	Date Of Birth	15-Jan-1990
Collected	07-Apr-2026 12:01	Order Number	0026B839370
Ordering Provider	Dr Colette Scanlon	Status	Final

Test Name	Result	Ref. Range (Units)	Abnormality	Status
Comment	†1 NO TESTS ON REQUEST FORM			Final

* Abnormal, ** Critically Abnormal

†1 NO TESTS ON REQUEST FORM

BONE PROFILE Cumulative

Number	LATEST 2 of 2	1 of 2	Ref. Range (Units)
Collected	07-Apr-26 12:01	15-Apr-14 23:30	
Source	Revive	Revive	
Calcium	2.54	2.41	2.2-2.6 (mmol/L)
Adjusted Calcium	2.52	2.31	2.2-2.6 (mmol/L)
Phosphate	0.70	§ 1.26	§
ALP	—	69	42-132 (U/L)
Total Protein	—	71	60-80 (g/L)
Albumin	—	45	35-50 (g/L)
Globulin	—	26	21-35 (g/L)
Graph No tests selected			

* Abnormal ** Critically Abnormal § Units or Reference Range differs

CT

Performed
13-Sep-2019 08:33
Ordering Provider
Dr J Kelly Consultant Radiologist
Order Number
AA13772700901
Status
Final
FinalCT

:
: 13 September 2019, 08:33:00
: 13 September 2019, 08:37:00
:

: RADIOLOGY REPORT

: CHI NUMBER: 1501900455 Examination Number: 37727009 Examination Date:
13/09/2019

: Name: Prowse, Duncan DOB: 15/01/1990
: Address: 1b Kerr Road, , Kilmarnock, KA3 7JH -- CC: -
: Referring Department / Location: Accident & Emergency
: Crosshouse Hospital
: Kilmarnock Road
: Crosshouse
: Ayrshire
: KA2 OBE

: Referring Consultant: Brown.Lesley (Cons) Clinical Specialty:
Accident & Emergency

: Date Dictated: 13/09/2019 Typed by: None

: Examination: CT Head and Neck

: Clinical Indication

: Assaulted last night, found on street with wounds to head, ?hit with
baseball bat, taken drugs, GCS 13/15, confused ?intracranial bleed/fracture

: Report:

: Noncontrast CT of head and neck.

: The brain parenchyma appears unremarkable. There are no features to
suggest acute cortical infarction, space-occupying lesion or intracerebral
haemorrhage. There is no extraaxial collection.

: The ventricles and peripheral CSF spaces are congruent. The base of
skull and skull vault are intact. The visualised para-nasal sinuses and
mastoid air cells are clear.

: There is no prevertebral soft tissue swelling. Bony alignment of the
cervical spine is normal and there is no evidence of fracture. The spinal
canal appears capacious.

: Please note that ligamentous injury cannot be excluded on the basis of
CT.

: Visualised lung apices are clear.

: Dictating Radiologist / Clinical Specialist Dr J Kelly Consultant
Radiologist

: Verified by: Dr J Kelly Consultant Radiologist

Reported By: Dr J Kelly Consultant Radiologist

Released By: Dr J Kelly Consultant Radiologist
Released On: 16/09/2019 13:00

NHS Ayrshire & Arran

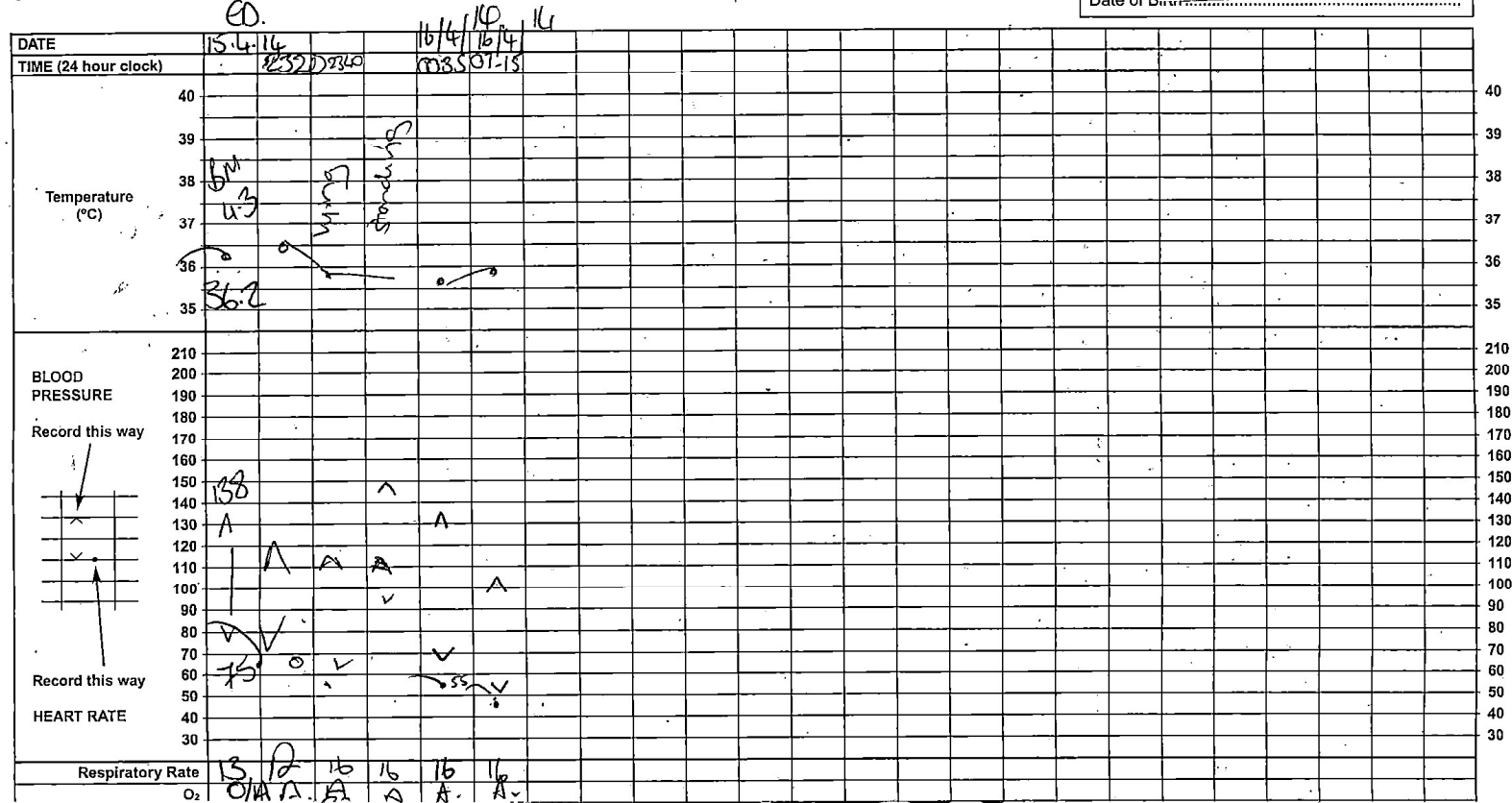
MEWS CHART

(with Neuro - Observations)

HCR No: XH-14-021937-1
 CHI No: DOB: 15/01/1990 Male
 Surname: PROWSE Duncan
 Forename: 18 KERR ROAD, KILMARNOCK
 Address: KA3 7JH



Date of birth: 15/01/1990



Saturation 100/100/100/54

NEWS SCORE for EACH of the INDIVIDUAL OBSERVATIONS

Temperature (°C)

0	0	0	0	0	0
0	0	0	0	0	0

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
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NHS Ayrshire & Arran

Bedrails Risk Assessment

XH-14-021937-1	
DOB: 15/01/1990	Male
PROWSE Duncan 1B KERR ROAD, KILMARNOCK KA3 7JH	
 * 1 5 0 1 9 0 0 4 5 5 *	

Date of admission: 16/4/14

Please assess ALL patients on admission to your ward /departments

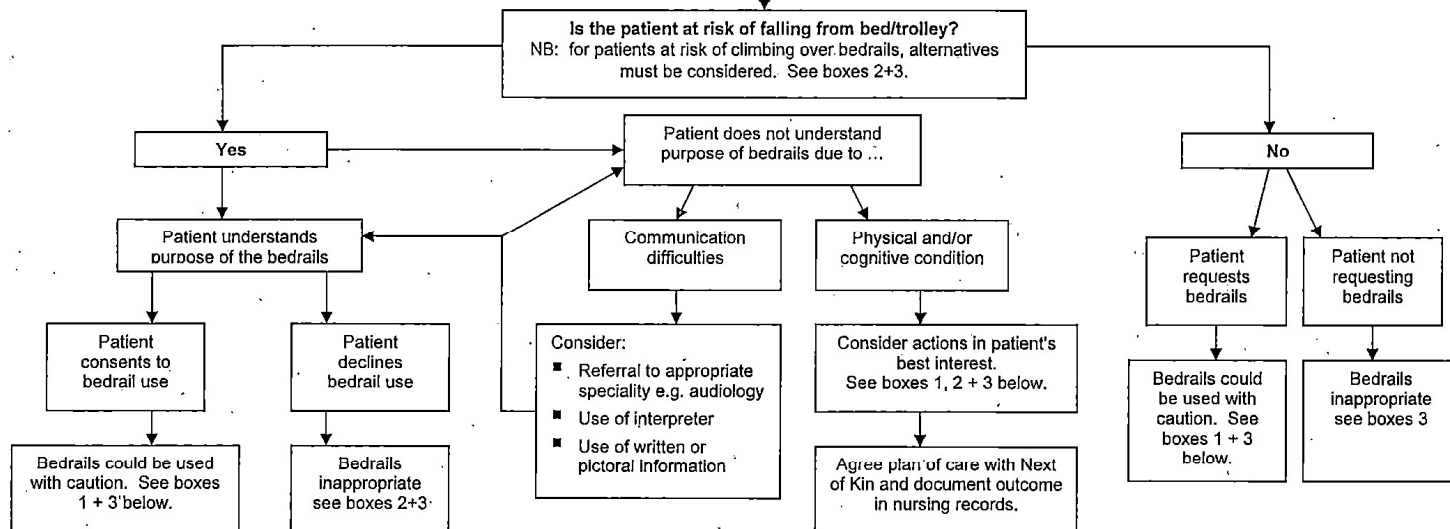
- Each statement must be answered – Circle answer
- Complete Risk Assessment in conjunction with Bedrails Algorithm overleaf
- Refer to Guidelines – Safe Use of Bedrails in In-patient Settings & Falls Management for in-patients

Re Assessment Occurs:

- Weekly
- When the patient's condition changes (i.e. patient falls/post surgery/change in medication/cognitive state changes.)
- Ensure clear identification of change in use of bedrails

Risk Factors	Ward: CDD Date: 16/5/14 Time: 00:00	Ward:	Ward:	Ward:
	Date: 16/5/14 Time: 00:00	Date: Time:	Date: Time:	Date: Time:
1. Is the patient at risk of falling from bed?	YES / NO ☒	YES / NO	YES / NO	YES / NO
2. Is the patient at risk of intentionally climbing over bedrails?	YES / NO ☒	YES / NO	YES / NO	YES / NO
3. Is the patient at risk of unintentionally falling from the bed / trolley?	YES / NO ☒	YES / NO	YES / NO	YES / NO
4. Does the patient understand the purpose of the bedrails? Consider communication difficulties and physical / cognitive condition.	YES / NO / NA ☒	YES / NO / NA	YES / NO / NA	YES / NO / NA
5. Does the patient consent to the use of bedrails?	YES / NO / NA ☒	YES / NO / NA	YES / NO / NA	YES / NO / NA
Has the Bedrails Algorithm been followed?	Yes ☒ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
According to the Bedrails Algorithm are bedrails required / appropriate?	Yes ☐ No ☒	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
If 'Yes', complete a bedrails care plan. If 'No', state reason why bedrails are not required: Patient fully mobile, GCS 15/15, independent + self caring.				
Signature and Designation: SN Crawford				

Complete the NHS Ayrshire and Arran Slips Trips and Falls Assessment Tool



1. If bedrails are used consider:

- Risk of entrapment and harm to limbs
- Risk of patient climbing over the top
- The psychological effect of their use on the patient
- Ensure bed returned to lowest height after care delivery
- Use of the Dynamic mattress increases the height of the bed

2. Alternatives to bed rails.

- Use of variable height bed
- Additional mattress/crash mat beside bed
- Close observation of patient
- Ensure bed returned to lowest height after care delivery
- Ensuring patient needs anticipated e.g. drinks are accessible, regular toileting, call bell to hand etc
- Nursing patient on mattress on the floor should be a last resort and safety checks should be made for hot pipes, electric sockets etc. Manual handling risk assessment for staff must be undertaken.

3. Remember to document in nursing records:

- Date and time assessment made
- Rationale for decision made in care plan
- Actions taken, including discussion with Next of Kin
- Care planning

Assessment should be made:

- On admission
- If patient's condition changes
- Weekly

MRSA SCREENING CLINICAL RISK ASSESSMENT (CRA)

COM/

XH-14-021937-1

TAL ADMISSIONS (Ayr & Crosshouse Hospital Only)

ATTACH	DOB: 15/01/1990	Male	Completed by if not using admission booklet Name: <u>S. CRAWFORD</u> Designation: <u>STAFF NURSE</u> Signature: <u>S Crawford</u> Date / Time: <u>16/4/14</u>
Patient N	PROWSE Duncan		
CHI:	18 KERR ROAD, KILMARNOCK, KA3 7JH		
Date of a			
Ward/Ho	* 1 5 0 1 9 0 0 4 3 5 *		

FORM COMPLETED IN	Pre-op	
	Admitting Ward	

	Yes	No	Don't know
1. Has the patient had any previous history of MRSA colonisation or MRSA infection at any time in the past?		☒	
2. Is the patient currently resident in a care home or institutional setting (ie prison, homeless, hostel) or transferred from another hospital?		☒	
3. Does the patient have a wound/ulcer or indwelling medical device which was present before admission to this hospital?		☒	

OUTCOME OF CRA

Any of the above three questions answered 'yes'	- Screen nose and perineum (& wound or device where applicable) - Manage patient as if MRSA positive (isolate if possible) - Complete next section of the CRA
All three of the above questions 'no' or 'don't know'	Patient is likely to be at low risk of MRSA and can be managed as normal in accordance with the Infection Control Policy. Do not complete the remainder of the form.
Direct admission to 4 high risk specialties (renal, orthopaedics, vascular / cardiothoracic, intensive care)	Complete CRA and take a screen from nose and perineum (& wound or device where applicable) regardless of the outcome of answering the 3 questions above.

SCREENING ACTIONS ('YES' TO ANY CRA QUESTION & 4 HIGH RISK SPECIALTIES)

	Nose	Perineum	Wound	Device	Other
MRSA screening swabs taken Tick all applicable (inc dates)					

ISOLATION ACTIONS ('YES' TO ANY CRA QUESTION) (See definitions in footer)

	Patient isolated in a single room	Patient cohorted, with other high risk patients, dedicated nursing	Patient cohorted, with no dedicated nursing staff	Patient separated
Detail of action completed Tick all applicable (inc dates)				
*Particularly if unable to isolate – please state reasons				

LABORATORY RESULTS

Date results received	Result of swab (positive or negative)	Name (PRINT)

****HPS ISOLATION DEFINITIONS**

Isolated: Patient is placed in a single room with hand washing facilities, ideally with ensuite toilet and shower where available. Isolation should be undertaken according to the HPS Infection Control Contact Precautions Policy

Cohorting: Patient is placed in a room and cared for by dedicated nursing staff along with other patients who are MRSA screen positive. Cohorting should be undertaken according to the HPS Infection Control Contact Precautions Policy.

Separated: Patients who are MRSA screen positive are housed within the same room as patients who are not MRSA positive but are separately by at least three feet from any adjacent persons by use of closed bed curtains. This is considered to be a step down from full cohorting. These patients do not have separate nursing staff. Separation should be undertaken according to the HPS Infection Control Contact Precautions Policy

<http://www.hps.scot.nhs.uk/haic/cic/standardinfectioncontrolprecautions-sicps.aspx>

XH-14-021937-1

DOB: 15/01/1990

Male

MEDICINE RECORDING SHEET

Enter code in box and initial when medicine is taken.

If medicine refused record

(A)

If patient unable to swallow record

~~A~~

If patient absent record

A

If medicine not available record

[illegible][illegible]

> 14-021937-1

MEDICINE PRESCRIPTION SHEET

DOB: 15/01/1990

Male

PROWSE Duncan
18 KERR ROAD, KILMARNOCK
KA3 7JH

Key: O ORAL SL SUBLINGUAL PR PER RECTUM
IM INTRAMUSCULAR ID INTRADERMAL PV PER VAGINA
IV INTRAVENOUS INH INHALATION IT INTRATHECAL
SC SUBCUTANEOUS NEB NEBULISED

KNOWN SENSITIVITY

1.	2.
SUSPECTED ADVERSE REACTION	
MEDICINE	ADVERSE EFFECT
1.	
2.	

MEDICINES TO BE GIVEN REGULARLY (BLOCK CAPITALS)

PHARM.	Date Commenced	APPROVED NAME OF MEDICINE	DOSE	TIMES OF ADMINISTRATION												OTHER	ROUTE (See Key)	OTHER INSTRUCTIONS	DOCTOR'S SIGNATURE	DISCONTINUED	
				6am	8am	10am	12md	2pm	6pm	8pm	10pm	12nn	DATE	INITIAL							
A		10414 PARACETAMOL	1g													oral - max 90s					
B																					
C																					
D																					
E																					
F																					
G																					
H																					
I																					
J																					
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